



## Life, Health & Variable Contracts (2-15 Agent)

**A COMPREHENSIVE COURSE OUTLINE  
BASED ON THE 35<sup>TH</sup> EDITION OF THE  
FLORIDA STATE STUDY MANUAL**



**Kevin R. Milner, MBA, CIC, ITP, CLCS**

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Congratulations on starting your new career in insurance and choosing Gold Coast as your school. Gold Coast is one of Florida's leading insurance schools and has helped thousands of students like you since 1970! As with learning anything new, the volume of material can seem somewhat daunting. Remember, thousands of students before you have completed the course, and you can too!

The key to passing this course and the state exam, on your first attempt, is preparation. We STRONGLY recommend that you read each chapter carefully, learn each of the key terms, and carefully answer the review and practice exam questions at the end of each unit.

This book is intended to be an educational resource. It is not intended as a substitute or replacement for the rules and statutes of the State of Florida.

The authors do not intend to give legal or accounting advice. If you are involved in a situation or transaction that requires a legal or financial opinion, we recommend that you seek the advice of a properly licensed attorney or accountant.

We want to personally thank you for choosing Gold Coast and wish you the best with your new career. If you have any questions or suggestions to improve this material or the course, we would like to hear from you. Please send all comments to [kmilner@goldcoastschools.com](mailto:kmilner@goldcoastschools.com).

Feedback from previous students is invaluable for future students.

Now let us get started.

Sincerely,



Kevin R. Milner, MBA, CIC, ITP, CLCS  
Insurance Program Director

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## **Online Login Instructions**

To complete the course and be eligible to take the state licensing exam, you must do all the following:

1. Complete the online portion of the course, and
2. Pass the online end-of-course final exam

To login to the online self-study, which also contains the end-of-course final exam, go to **www.goldcoastschools.com**, click on **Login** (upper right corner), and enter your username and password.

If you are unsure of your username and password, please review the email you received at the registration time. If an email was not provided at the time of registration, please contact Online Support (see below).

Once you are logged in, click on the appropriate title of your class found under "My Classes". Click on the link to start the course.

Click "**Quick Tips for Successfully Completing Your Course**" for instructions for completing the online self-study and the end-of-course online final exam.

For assistance logging in or running the online self-study portion of the course, please email your problem or question to **OnlineSupport@goldcoastschools.com** or call our online support specialist at (954) 315-7698 during regular business hours (Monday through Friday, 8:30 am – 5:00 pm).

Sincerely,

Gold Coast Schools

## QUICK FACTS

### I am taking the life only or health only course. Why does my study material include information on the other?

- Many of the units covered in this course overlap with both the life and health authority pre-licensing material.

### What units do I need to study for my exam?

- Life Insurance 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 26, 27, 28
- Health Units: 1, 2, 3, 4, 9, 12, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 29, 30
- Life & Health All

### What is the Live 1-Day Life & Health Exam Prep (CRAM)

- The Exam Cram is a review course designed to help you pass the state exam the first time! The tuition for this class is valid for one year and is available as an add-on or part of the full-service package. Included in Gold Coast's exclusive Q&A study manual, which includes both fill-in-the-blank questions (discussed during the live class) and over 850 multiple choice questions, some with and some without rationale.

To register for the Exam Cram, please contact a Gold Coast Career Counselor at (800) 732-9140. The Exam Cram schedule can be found at [www.GoldCoastSchools.com](http://www.GoldCoastSchools.com).

LIVE 1-DAY LIFE & HEALTH EXAM PREP (CRAM)	
2-15 Agent: Life, Health & Annuity Contracts	9:00 am – 6:00 pm
2-14 Agent: Life & Annuity Contracts	9:00 am – 3:00 pm
2-40 Agent: Health Insurance	1:00 pm – 6:00 pm

### Fingerprinting

- To schedule for fingerprinting, visit [www.L1enrollment.com/FLInsurance](http://www.L1enrollment.com/FLInsurance)

### State Exam

- To register for the state exam, visit Pearson VUE at [pearsonvue.com/fl/insurance](http://pearsonvue.com/fl/insurance) or call (888) 204-6289.

### Contact Us

#### Gold Coast Schools

- Online Technical Support [onlinesupport@goldcoastschools.com](mailto:onlinesupport@goldcoastschools.com) | (954) 315-7698
- Online Instructor Support [insuranceinstructor@goldcoastschools.com](mailto:insuranceinstructor@goldcoastschools.com) | (954) 315-8257
- Insurance Program Director [kmilner@goldcoastschools.com](mailto:kmilner@goldcoastschools.com) | (954) 315-8257
- Career Counselor (800) 732-9140

#### Department of Financial Services

##### Insurance Agent & Agency Services

- **Phone** (850) 413-3137
- **Web** [myflorida.com/division/agents](http://myflorida.com/division/agents)
- **Email** [agentlicensing@myfloridacfo.com](mailto:agentlicensing@myfloridacfo.com)



## GUIDE TO PASSING THE STATE EXAM ... THE FIRST TIME!

### *Passing the Course*

Whether you are taking the course online or in the classroom, it is imperative for your success to study all the information and utilize all the tools provided for you.

- Read and study each unit
- Complete each end-of-unit practice test
- Take the Final Exam Review in the back of the State Study Manual
- Understand Key Concepts found in each unit

When reading the unit material, you will find many references to the Florida Statutes and Florida Administrative Code. It is good to look up these references and read the actual text of these laws and rules.

Students should also complete end-of-unit practice tests. These questions are carefully designed to help you review the major topics for your end-of-course final exam. Students who do well on the end-of-unit tests generally score better on the end-of-course exam than those who do not.

To best prepare you, follow these guidelines for taking practice tests:

1. Take the whole practice test and thoughtfully attempt to answer each question. Record your answers on a separate piece of paper. For math questions, write down the steps you took to arrive at the answer.
2. Note any questions that you do not understand or where you simply guessed at the answers. You will want to go back and review these topics.
3. After answering all the questions, look up the answer key's answers, and mark your incorrect answers.
4. For any questions you missed or guessed on, go back and review the State Study Manual topic and try to determine the rationale for the correct answer.
5. You might even find it helpful to retake the practice exam later, as if you were taking it for the first time. Think through every question and redo any math to make sure you have retained the concept.

Additional online practice exams are available for purchase from the Gold Coast website if you want additional review and practice options after completing the above steps.

### *Passing the Course*

In addition to the above recommendations, we recommend reviewing the "Student Resources" tab found on the Gold Coast Schools website ([www.goldcoastschools.com](http://www.goldcoastschools.com)). Click on the "Student Resources" tab, "Downloads & Links," and "Insurance – Life, Health & Variable Annuities."

**NOTE:** Special Accommodations Request made to Gold Coast Schools **DO NOT** transfer, nor are they accepted by the state testing facility. A formal request, following the state testing facility guidelines, must be completed.

If you are a 'Full Service' student, complete all the 850 plus Cram Review questions before attending the Cram. These questions have been compiled over many years from the feedback we have received from students after taking the state exam. After completing the questions, score the exams. Look up every incorrect answer and learn why it was incorrect. We suggest completing this process three (3) times. By the third time, you should be scoring in the 90% range and be ready for the Cram review course.

Attend the live Cram review course (included with 'Full Service' enrollment). The instructor will review the material and clear up any questions that are still not clear. To register or purchase the Life & Health Exam Cram, you must contact a Career Counselor at (800) 732-9140.

Take the state exam within a reasonable time of completing the course (one to three weeks). Students who attempt the state exam months after completing the course generally do not pass. If you cannot take the state exam soon after the class, it will be necessary to ramp up studying efforts and possibly review the course again.

## SCHOOL RULES, PROCEDURES, AND POLICIES

### ***The information provided herein provides a broad overview***

You have enrolled in an online pre-licensing course. Depending on the course package you have selected, your tuition may include the Florida State Study Manual and other Gold Coast course supplements. If you upgraded or enrolled in the 'Full Service' course, your tuition will also include our Live - Life & Health Exam Cram).

The course encompasses 30 units and over 375 end-of-unit test questions. A cumulative school final exam is also administered. A minimum passing grade of 70% is required on all quizzes and examinations. All course quizzes and exams will be administered online.

### ***Department rules do require us to advise you of our refund policy***

Office of Insurance Regulation rules do not require refunds unless the school cancels the class.

#### *Pre-License Online Courses*

No refunds are given after accessing Unit 2 of any course. Materials must be returned in brand-new and saleable condition for any courses that include books or other course materials (no writing, highlighting, or any other damage). If materials are not returned in a brand-new and saleable condition, the cost of said materials will be deducted from any refund. Any request for a refund must be received no later than 30 days after the scheduled class start date. Gold Coast does not charge a cancellation fee if the student needs to cancel or re-schedule at least 24 hours before the start of class.

Students who do not show up for a scheduled class without 24 hours prior notice (no show) relinquish their right to a refund. However, the student will have a class credit with Gold Coast for one year from the date payment was made.

### ***Pre-registration is REQUIRED to attend the Cram.***

Class schedules can be found in the Gold Coast Schools Brochure or by visiting our website at [www.goldcoastschools.com](http://www.goldcoastschools.com). Crams are scheduled from 9:00 am to 6:00 pm. An hour break will be provided for lunch (on your own). **NO REFUNDS ON FULL SERVICE OR CRAM MATERIALS.**

### ***Questions***

The nature of the State required material and the time frame allowed requires that class be presented in a highly structured format. Each instructor has his or her specific policy on answering student questions, which will be explained at the start of class.

### ***Attendance***

Office of Insurance Regulation Rules require that we accurately record your attendance.

You must complete the entire course within 12 months. **ATTENDANCE HOURS MORE THAN 12 MONTHS OLD ARE LOST. NEW CLASS TUITION WILL BE REQUIRED.**

### ***Final course exam***

Life, Health and Variable candidates must successfully pass an end of course cumulative final exam. The exam is administered online and consists of 150 questions. Candidates are allotted 2¾ hours (165 minutes) to complete the exam. A passing score of 70% or higher is required. **IN THE EVENT A CANDIDATE DOES NOT PASS THE EXAM, THE CANDIDATE MAY RETAKE THE EXAM AS MANY TIMES AS THEY WISH DURING THEIR TUITION PERIOD (1 YEAR FROM THEIR ORIGINAL DATE OF ENROLLMENT).**

**Note: Makeup exams are different from the original exam.**

Life only and Health only candidates must successfully pass an end of course cumulative final exam with 100 questions.

### ***Copyright ©***

All materials utilized with your course are protected by and fall within the United States Copyright laws.

# BE PREPARED FOR YOUR STATE EXAM

**Health and Life Insurance and Annuity (Including Variable Contracts) Exam (2-15 License)**

- 2¾ hour time limit (165 minutes)
- 150 scored questions
- 15 random unscored 'pretest' questions

**Life Insurance and Annuity (Including Variable Contracts) Exam (2-14 License)**

- 2-hour time limit (120 minutes)
- 85 scored questions
- 15 random unscored 'pretest' questions
- 

**Health (2-40 License)**

- 2-hour time limit (120 minutes)
- 85 scored questions
- 15 random unscored 'pretest' questions

**Note: Answer all questions. Any unanswered question will be marked as incorrect.**

To schedule an appointment for fingerprinting, visit [www.L1enrollment.com/FLInsurance](http://www.L1enrollment.com/FLInsurance)

To register for the state exam, visit Pearson Vue at [www.pearsonvue.com/fl/insurance](http://www.pearsonvue.com/fl/insurance)  
or call (888) 204-6289

Department of Financial Services: (850) 413-3137

***FL Statute 626.833 – NO PERSON employed by the US Department of Veterans Affairs shall be licensed as a Health Agent.***

We will be covering the required material to ensure that you meet the proper certification guidelines during this course. However, due to the high concentration of these time constraints, **we strongly encourage you to read the state manual** (cover to cover) at least once before taking your state exam.

As always, your instructor will be available to answer any questions that you may have. An online instructor can be reached at: [insuranceinstructor@goldcoastschools.com](mailto:insuranceinstructor@goldcoastschools.com).

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UNIT

## 1

**PURPOSE OF LIFE & HEALTH INSURANCE****OVERVIEW**

In this unit, we will look at the purpose and role of life and health insurance by explaining the concept of risk and showing how insurance is uniquely designed to replace the uncertainties of risk and guarantees.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- The Role of Insurance
- An Industry Overview
- The Nature of Insurance
- The Concept of Risk
- Economic Basis of Life & Health Insurance

**KEY TERMS**

Adverse Selection

Elements of Insurable Risk

Hazards

Law of Large Numbers

Methods of Handling Risk

Peril

Pure Risk

Risk Pooling

Speculative Risk

## THE ROLE OF INSURANCE

### ***Why Sell Insurance?***

Between now and retirement, one could earn a fortune! However, only five out of every 100 people ever reach that goal.

Here is what might happen in 40 years to a group of 100 people who are 25 years old:

- 36 die
- 54 are dependent on friends, relatives, or charity
- 5 are forced to keep on working
- 5 reach financial independence

The 95 people who did not reach financial independence, **did not plan to fail, but simply failed to plan!**

### ***What is Life Insurance?***

Life insurance is a legally binding contract that, for a specified premium, the insurance company agrees to pay a beneficiary a definite sum of money when the insured dies; thus, creating an estate.

### ***What is Health Insurance?***

Health insurance involves contracts of insurance that provide funds for medical expenses due to injury, sickness, or disability. Additional areas of coverage include long-term care, Social Security, Medicare, Medicaid, and supplemental policies.

### ***What is an Annuity?***

An annuity is a contract in which a lump sum or series of payments are made to the annuitant to provide a steady stream of income during or for retirement. Along with providing an income at a later age, they are also designed to liquidate estates.

## THE NATURE OF INSURANCE

The purpose of insurance is to provide economic protection against losses incurred due to a chance happening or event, such as death, sickness, disability, or accident.

An insurance policy is a legally binding contract that sets forth the company's obligations whereby one party agrees to pay another party a set sum upon the occurrence of a covered event with the sole purpose of bringing the effected party back to a similar condition they were in before the covered event.

### ***Basic Insurance Principles***

Insurance is based on two fundamental principles. Loss sharing (also known as spreading or pooling of risks) and the theory of probability (also known as law of large numbers).

### ***Basic Insurance Principles***

Insurance is based on two fundamental principles: loss sharing (also known as spreading or pooling of risks) and the law of large numbers (also known as the theory of probability).

#### *Risk Pooling (Social Device to Transfer Risk)*

Insurance is a device that transfers the risk of a large financial loss from the individual to the insurance company. Insurance distributes losses of a large group of people. This is possible by combining single exposures into one large group with everyone contributing a small share to cover their portion of the cost. This cost is the premium or money that puts insurance into effect, commonly called consideration.

#### *Law of Large Numbers (Theory of Probability)*

**The law of large numbers** (also known as **the theory of probability**) simply means that if something is done or occurs often enough (in large numbers), then it can be predicted with a high degree of accuracy. Based on this theory, the law of large numbers predicts the probability of losses due to death (**mortality**) and sickness and accident (**morbidity**). For example, flipping a coin.

## THE CONCEPT OF RISK (UNCERTAINTY VS. CERTAINTY)

### ***Risk Defined***

**Risk** is defined as the uncertainty regarding a financial loss. Insurance is the financial tool that transfers a risk, thus creating a certainty for uncertainty. The term is used to designate an insured or a peril insured against.

Risk is categorized into two categories: *speculative risks* and *pure risks*. Speculative risk is not insurable because it involves both the chance of success (gain) or loss. Pure risk is insurable as it is limited only to the chance of a loss.

### **Examples of Risk**

Examples of Risk	
Speculative Risks	Pure Risks
Betting at a racetrack	Job-related accidents
Investing in the stock market	Catastrophic medical expenses

### ***Perils and Hazards***

A **peril** is a cause of a loss which triggers (or activates) the process of transferring a risk. A hazard is the behavior of an item that increases the likelihood of a risk. Perils and hazards are factors that cause or give rise to risk.

### **Examples of Perils**

Examples of Perils		
Types of Policy	Peril	Benefit
Life	Death	Death Benefit
Health	Sickness	Medical Benefits

**Hazards** are broken down into three levels: *physical, moral, and morale*.

Physical hazards may be expressed to include physical characteristics of an individual, past and current medical conditions, or congenital defects or disabilities. For example: blindness and deafness.

Moral hazards are tendencies that affect an individual's living habits, reputation, character, or insurability. For example: alcoholism, drug addiction, and dishonesty.

Morale hazards are reflections of an individual's attitude or state of mind causing indifference towards a loss. For example: the lack of concern from suffering an injury while doing something reckless.

### **Examples of Hazards**

Examples of Hazards		
Physical Hazard	Moral Hazard	Morale Hazard
Blindness	Alcoholism	Lack of concern of suffering an injury
Deafness	Drug addiction	Intentionally doing something reckless
Congenital defects or disabilities	Dishonesty	Attitude; state of mind

## TREATMENT OF RISK (4 METHODS)

There are four methods on how to treat risk: *risk avoidance*, *risk reduction*, *risk retention*, *risk transfer*.

Risk avoidance, although effective, is not always practical. With this method, an individual avoids the risk. For example, by choosing not to fly, one could eliminate the risk of being in an airplane crash. A similar type of results could exist if an individual did not drive an automobile.

Risk reduction is used when the practicality of avoidance does not work. With this method, we attempt to lessen the loss by taking an action that may reduce the risk. For example: installing hand sanitation stations may not stop the spread of disease but may reduce the possible spread.

Risk-retention is a form of confronting the risk when it occurs. For example: setting up a fund to offset the cost of a potential loss (self-insurance).

Risk Transfer is the most effective and ideal way of handing a risk. The concept of risk involves replacing certainty for uncertainty. With risk transfer, we transfer the chance of a loss from the individual to the insurance company. Although purchasing insurance does not eliminate the risks being insured against, it does transfer the financial consequences from the individual to the insurance company.

## ELEMENTS OF INSURABLE RISK

There are six (6) elements or characteristics that must be evident before a pure risk can be insured:

- a. Loss must be due to chance. - Must be fortuitous (happening by accident) and beyond the insured's control.
- b. Loss must be definite and measurable. - How much will the benefit be, and when will it become payable?
- c. Loss must be predictable. - Enables insurers to estimate the average frequency and severity of future losses and set appropriate premiums.
- d. Loss cannot be catastrophic. - Insuring a single life for \$1 trillion would create a catastrophic loss to the company.
- e. Loss exposures to be insured must be large. - "Law of Large Numbers" (Theory of Probability)
- f. Loss exposures to be insured must be randomly selected.

*Adverse Selection (sub-standard risk; pre-existing conditions; selection against the insurer)*

The tendency of more poor risks than good ones to buy insurance or maintain existing insurance in force.

For example: an insurance company receives an application from an individual. The individual is a smoker. Actuaries predict, based on the law of large numbers, that the chance of this individual suffering an adverse event is greater than an individual that may not be a smoker. Therefore, the insurance company must choose if to accept or decline the risk. If the insurance company accepts the risk, they will need to off-set this 'selection against the insurance company' (higher risk).

This is done by charging an additional premium, sometimes known as rating the policy.

## ECONOMIC BASIS OF LIFE AND HEALTH INSURANCE

### *Human Life Value*

Human life value is the approach of measuring life's insurance needs, specifically an individual's future earning potential. It goes beyond the everyday numbers and considers the financial needs of a family if the primary breadwinner was to die.



UNIT**2****THE INSURANCE INDUSTRY****OVERVIEW**

The insurance industry is one of the most efficiently organized and effectively operated industries in our country today. The purpose of this unit is to provide a broad overview of the insurance industry, how it operates, and how it is regulated. Please note that Florida, like every other state, has its own laws and regulations regarding insurance, and a review of Florida's state laws is recommended.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Types of Insurers
- How Insurance Is Sold
- Evolution of Industry Oversight

**KEY TERMS**

Fair Credit Reporting Act

Federal Regulation

Financial Services Modernization Act

Insurance Company Rating Systems

McCarran-Ferguson Act

NAIC

NAIFA / NAHU

Organization and Ownership of Insurers

Prohibited Practices

State Regulation

Types of Insurers

Types of Marketing/Distribution

U.S. vs. Southeastern Underwriters Association

## OBJECTIVES

1. Types of insurers
2. How insurance is sold
3. Evolution of industry oversight

*Each state has its laws and regulations regarding insurance, and a review of your specific state laws are recommended.*

**CARRIER = COMPANY = INSURANCE COMPANY = INSURER**

## TYPES OF INSURERS (COMMERCIAL)

The insurer is the company or organization that issues a policy of insurance. There are many ways to classify these organizations. The three (3) most common methods are (1) private insurers, (2) government as insurers, and (3) self-insurers.

### **Private Insurers**

Private insurers can be broken down into a variety of different types. Some of these companies write only one form of insurance, for example, life insurance or health insurance. Some companies write more than one type of insurance, such as life, health, auto, business, etc. These companies are called multi-line insurers.

Private companies can be categorized as (1) stock insurers, (2) mutual insurers, (3) assessment mutual insurers, (4) reciprocal insurers, (5) Lloyd's of London, (6) reinsurers, (7) risk retention groups (RRG), (8) fraternal benefit societies, (9) home service insurers, and (10) service providers.

*Stock insurer.* A stock insurance company is a private organization that is organized and incorporated under state laws for the primary purpose of earning a profit for its stakeholders. These companies are owned and controlled by the stockholder (shareholder or stakeholder) who provides the financial support (capital) necessary to operate the company. The stockholders elect the officers of a stock company (shareholders or stakeholders). Stock insurers are typically non-participating (do not pay dividends to policyowners; however, taxable dividends are paid to stockholders).

*Mutual insurers.* Unlike a stock insurer, whereas the company is owned by the stockholders (shareholders or stakeholders), mutual insurers are owned by policyholders. The policyholders choose the officers of the company. Mutual companies do not have permanent capital stock. Hence, if they did, they would not be a mutual insurer but a stock insurer. The operating objective of a mutual insurer is to provide insurance to its owners (policyowners) at the lowest possible net cost. Mutual companies are commonly referred to as participating companies because the policyholders participate in policy dividends.

Policy dividends represent a refund of the portion of premiums that remains after the insurance company has set aside the necessary reserves and had made deductions for claims and expenses. Since only participating mutual companies can pay dividends, some stock companies will convert into participating mutual companies through a process of mutualization. Likewise, mutual companies can demutualize by converting to a stock company.

Assessment mutual insurers. Defined by the way they charge premiums, pure assessment mutual or advance premium assessment. A pure assessment mutual insurer bases premium costs on the loss-sharing method. Members do not pay premiums in advance, and the total loss experience is divided among the members, so each pay a portion of the total. Advance premium assessment charges specific amounts. If the actual loss is less than the total of the collected premiums, members receive a refund in the form of dividends. If the actual loss is more than the total premium amount collected, members' premium rates will be increased to adjust accordingly. **Assessment insurance companies are not permitted in Florida.**

*Reciprocal insurers:* An unincorporated association (exchange) with each member insuring the other insureds within the association. The association is not "owned" but run by an attorney-in-fact appointed by the members. (Thus, each member is both an insurer and an insured.) An attorney-in-fact is one given specific authority to act for another in certain clearly defined matters.

*Lloyd's of London (Lloyd's).* Lloyd's is not an insurance company but rather an organization or association of individuals and companies that individually underwrite insurance. Lloyd's function is to gather and disseminate underwriting information, help its associates settle claims and disputes, and, through its member underwriters, provide coverage that might otherwise be unavailable in certain areas. Lloyd's is known to find coverage for unusual risks. For example: model or ballerina insuring each of their legs for \$5M each.

*Reinsurers.* The concept behind reinsurers is when the originating (ceding insurer) insurers itself with another insurer (assuming or reinsurer) on part of an insurance risk.

*Risk-retention groups (RRG).* An RRG is a mutual insurance company formed to insure people in the same occupation, business, or profession. For example: pharmacists, doctors, realtors, etc.

*Fraternal benefit societies.* Fraternal societies are non-profit entities that sell insurance only to its members. Members are issued insurance certificates and annuities with many of the same provisions found in commercial insurance companies' policies. A fraternal life insurance organization operates as a corporation, society, or association to provide life insurance primarily for its members and beneficiaries' mutual benefit. It has a lodge or social system with certain rituals and a representative form of government. Fraternal benefit societies are also noted for their social, charitable, and benevolent activities.

*Home service insurers (Debt insurers).* These insurers market a specialized form of insurance called industrial insurance. Industrial insurance policies are relatively small faced amounts (\$1,000 - \$2,000) with premiums collected in person every week.

*Service providers.* These providers offer benefits to subscribers in return for the payment of a premium. Benefits are in the form of services provided by the hospitals and physicians participating in the plan. They sell medical and hospital care services, not insurance. These services are packaged into various plans, and those who purchase these plans are known as subscribers.

There are two (2) main types of service providers; health maintenance organization (HMO) and preferred provider organization (PPO).

HMOs known for stressing preventive health care and early treatment programs, offer a wide range of health care services to member subscribers. For a fixed periodic premium paid in advance of any treatment, subscribers are entitled to services of hospitals and physicians that are contracted to work with the HMO.

PPOs are contracts between the employer groups and the health care professional (hospital or physician) that spell out what types of services will be provided. Employer groups will obtain price discounts or special services from select providers in exchange for referring its members (employees) to them. (*Service Providers are discussed in detail in Unit 16*)

**Government:** Also known as social insurance providers, are funded with taxes and serve national and state social purposes. Some examples of programs include: (1) OASDI, (2) Social Security, and (3) Medicaid, (4) SGLI, (5) VGLI, and (NSLI).

**Self-Insurers:** Both private and government insurers follow the concept of transference of risk (risk transfer); however, self-insurers do not. Self-insurance is not a method of transferring risk; thus, it retains the risk. Self-insurer establishes its own reserves to cover potential losses. Commonly, self-insurers will also look to add private insurance to cover losses that exceed the amount they wish to self-insure. Three areas that are commonly self-insured are (1) pension plans, (2) medical insurance, and (3) sick leave. Self-insures plans are typically administered by Administrative-Service Only (ASO) or Third-Party Administrator (TPA) organizations, which handle paperwork and process claims. ASOs and TPAs are paid a fee for their services.

**Forms of Government Insurance**

Forms of Government Insurance	
<b>Federal Insurance</b>	
OASDI	Old-Age Survivors and Disability Insurance (Social Security)
HI	Social Security Hospital Insurance (Part A of Medicare)
SMI	Supplemental Medical Insurance (Part B of Medicare)
SGLI	Servicemembers Group Life Insurance
VGLI	Veteran’s Group Life Insurance
NSLI	National Service Life Insurance
<b>State Insurance</b>	
Medicaid	Florida Agency for Health Care Administration
Worker’s Compensation	

*The major difference between private and government programs is that the government programs are funded with taxes and serve national and state social purposes.*

**HOW INSURANCE IS SOLD**

***Producers, Agents, & Brokers***

Insurance products are purchased through a licensed individual known as an insurance producer. The insurance producer represents an insurance company by acting as either an agent or broker. As an agent, the producer’s first loyalty is with which they have an agent’s contract. As a broker, the producer may represent multiple insurers and has a broker’s contract. Additionally, the broker represents the buyer, not the insurer.

Agents may be classified as captive (career) or independent agents. A captive insurance agent is appointed by one insurance company and can only sell, solicit, and negotiate policies from that company. An independent agent can work for themselves or other agents and sell products and services from multiple carriers.

There are three (3) systems that support the sale of insurance through agents and brokers, they are (1) career agency system, (2) personal producing general agency system, and (3) independent agency system.

Florida law stipulates that no life or health insurance policy may be issued for delivery unless the application is taken by, and the policy is delivered through a licensed agent.

**Insurance Agency Systems**

Insurance Agency Systems		
Type of System	Agent Relationship	Compensation Status
Career Agency System	Recruited, trained, and supervised by manager or GA	Employees of the insurance company
Personal Producing General Agent	<b>Do not</b> recruit, train or supervise the agents	PPGAs are responsible for all expenses of their agency
Independent Agency System	An independent relationship between multiple companies through a contractual agreement.	Compensated on a commission or a fee basis for the business they produce.

## EVOLUTION OF INDUSTRY OVERSIGHT

### *History of Regulation*

*Paul vs. Virginia (1868)*. The Supreme Court ruled that the sale and issuance of insurance is not interstate commerce, thus upholding states' right to regulate insurance.

*U.S. vs. Southeastern Underwriters Association (S-EUA) (1944)*. This decision did not affect the State's power to regulate insurance. However, it did nullify state laws that conflicted with federal legislation. This resulted in shifting the balance of regulatory control to the federal government.

McCarran-Ferguson Act 1945 / Public Law 15 (PL15). Maintained that the states should regulate insurance. Made possible the application of federal anti-trust laws where the business was not regulated by state law. Each state revised its insurance laws to conform to the federal law.

*Fair Credit Reporting Act of 1970*. Requires fair and accurate reporting of information about consumers, including applications for insurance. Insurers must inform applicants about investigations being made and the name of the reporting agency conducting the investigation.

*Financial Services Modernization Act 1999 / Gramm-Leach-Bliley. Repealed Glass-Steagall Act* Commercial banks, investment banks, retail brokerages, and insurance companies can now enter each other's lines of business.

USA PATRIOT Act of 2001. Congress passed the USA PATRIOT ACT (**U**niting and **S**trengthening **A**merica by **P**roviding **A**ppropriate **T**ools **R**equired to **I**ntercept and **O**bstruct **T**errorism) to provide the federal government broad powers to curtail attempts to launder money and finance terrorism. As part of this act, insurers and other financial institutions must: (1) develop new compliance systems and training, (2) designate anti-money laundering officers, (3) share information with other financial institutions and enforcement entities, and (4) adopt robust procedures to verify the identity of any person opening an account.

## STATE REGULATION OF THE INSURANCE INDUSTRY

In Florida, insurance regulation includes:

- Issuing rules and regulations.
- Licensing and supervising insurance companies formed within the state.
- Licensing, appointing, and supervising agents and brokers.
- Regulating the investment activities of insurers.
- Controlling the kinds of insurance contracts and policies that may be sold in the state.
- Determining the amount of reserves an insurer must maintain.
- Overseeing insurance companies marketing practices and investigating all consumer complaints.

All insurance companies doing business within the State of Florida must be licensed or certified.

### **Corporate Charters of Insurance Companies**

Companies are described according to their site of incorporation.

*Domestic Company*. A name given to an insurance company in the state of its incorporation, as a Florida insurance company is domestic (domicile) in the State of Florida, foreign as to all other states, and alien as to all other countries.

*Foreign Company*. An insurance company formed under the laws of the United States but operates in a state other than the one in which it has been incorporated.

*Alien Company*. An insurance company organized under the laws of a foreign country

### **Insurance Producers**

Selling, soliciting, negotiation, or binding financial products requires a high level of ethics and professionalism. Therefore, every state requires that individuals who partake in this insurance-related conduct pass a producer licensing examination. In Florida, an agent's license is perpetual unless suspended or revoked. Agents must complete at a minimum of 24 hours of approved continuing education

every 24 months. Agents who have been licensed for six (6) or more years must complete 20 hours biennially. An agent's license will terminate if the agent allows 48 months to elapse without being appointed for each insurance authority listed on their license.

### **Florida Law Regarding Insurance Agents' Continuing Education**

<b>Requirements (Licensed 1- 5 years)</b>	<b>Requirements (Licensed 6+ years)</b>
24 credits every 2 years	20 credits every 2 years
5-Hour Law & Ethics Update	5-Hour Law & Ethics Update
19 Elective Credits	15 Elective Credits

Licensed 25 + years and CLU, CPCU, Bachelor of Science in Risk Management, or 18 + semester hours in insurance-related courses; 5-Hour Law and Ethics Update and 5 hours of elective credits every two years.

#### ***Buyers' Guides and Policy Summaries***

A buyer's guide is a document approved by the Florida Department of Insurance that provides generic information about an insurance policy. It provides the buyer with an explanation on how to choose the type of insurance, the amount, costs, and more. The insurer must provide a buyer's guide to all prospective policy applicants before accepting their initial premium. If the policy contains an unconditional refund provision of at least a 10-day (free-look period), a buyer's guide can be delivered with the policy.

A policy summary is a document written by the insurance company that describes specific features and elements of the policy being issued. The policy summary must include the name and address of the agent, full name and home office or administrative office address of the insurer, and the generic name of the basic policy and each rider. A policy summary document will also provide premium, cash value (CV), dividend, surrender value, and death benefit figures for specific policy years. The policy summary also contains two cost indexes that help the consumer evaluate the recommended products' suitability. The policy summary must be provided when the policy is delivered.

#### ***National Association of Insurance Commissioners (NAIC)***

This organization is comprised of all state insurance commissioners and directors. The NAIC has four broad objectives: (1) to encourage uniformity in-state insurance laws and regulations; (2) to assist in the administration of those laws and regulations by promoting efficiency; (3) to protect the interests of policyholders and consumers; and (4) to preserve state regulation of the insurance business. The members of the NAIC do not prosecute and punish violators. The NAIC most notable accomplishment is the "Advertising Code and the Unfair Trade Practices Act."

#### ***Advertising Code***

This code, established by NAIC, specifies certain words and phrases that the industry considers misleading and cannot be used in advertising of any kind.

#### ***Unfair Trade Practices Act includes:***

The NAIC's Unfair Trade Practices Act provides state insurance commissioners and directors (CFO in Florida) the ability and power to investigate, issue cease and desist orders, and impose penalties on violations made by insurance carriers and producers.

Some unfair or deceptive practices that may be enforced include: (1) misrepresentation and false advertising; (2) coercion and intimidation; (3) unfair discrimination, and (4) inequitable administration or claims settlements

#### ***State Guaranty Association***

Suppose an insurance company is insolvent or becomes financially unable to pay its claims. In that case, a fund, maintained through assessments by all voluntary companies in the state, provides coverage (up to specified amounts) to cover the consumers' unpaid claims. All states have established guaranty funds or guaranty associations to support insurers and protect consumers if they become insolvent.

***NAIFA and NAHU***

NAIFA: National Association of Insurance and Financial Advisors

HAHU: National Association of Health Underwriters

These organizations' members are life and health insurance agents dedicated to supporting the industry and advancing the quality of service provided by insurance professionals.

***Rating Services***

An insurer's strength and stability are two factors that are vitally important to both an insurance company and its customers. Rating services such as (1) A.M Best, (2) Standard and Poor's, (3) Moody's, (4) Fitch's, and (5) Demotech Inc. publish these findings regularly.

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UNIT**3****LAW & THE INSURANCE CONTRACT****OVERVIEW**

Life and health insurance policies are legal contracts. They are governed by many of the same legal principles that are applicable to the formation of any contract, plus specific principles that are pertinent to insurance only. In this unit, we will first review the general principles that are pertinent to insurance only. In addition, we will review the general principles of contract law, and how they apply to insurance contracts.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- General Law of Contracts
- Special Features of Insurance Contracts
- Agents and Brokers
- Other Legal Concepts

**KEY TERMS**

Adhesion	Estoppel	Parol Evidence Rule
Aleatory	Express Authority	Personal Contract
Apparent Authority	Fraud	Representations
Competent Parties	Implied Authority	Unilateral
Concealment	Insurable Interest	Valued Versus Reimbursement
Conditional	Legal Purpose	Void Versus Voidable Contract
Consideration	Offer and Acceptance	Waiver
		Warranties

## **GENERAL LAW OF CONTRACTS**

Insurance Policies are legal contracts. A contract is an agreement enforceable by law by which one or more parties bind themselves to a promise. There are four (4) elements of a legally valid and binding contract. They are: (1) offer and acceptance, (2) consideration, (3) legal purpose, and (4) competent parties.

### ***Offer and Acceptance***

To legally enforce a contract, an offer must be made by one party and accepted by another. The acceptance of the offer must be exact to the terms of the original offer. As applied to life insurance, the handing over of the policy to the applicant and the payment of the premium is intended to be concurrent acts of “offer and acceptance.” When the first full premium is paid before the policy’s physical delivery, the applicant has “accepted the offer,” and the contract comes into being at that moment (providing applicant is found insurable, as of time of application, and policy subsequently is issued as applied for). The payment of the premium means the client accepts the policy.

If an applicant does not submit an initial full premium with the application, the applicant asks the insurance company to make a contract offer based on the application submitted. The company may respond to the request by either issuing a policy or counteroffer (offer). The applicant can accept the offer by providing a consideration (acceptance) or reject it. Until an offer has been accepted, the party making the offer has the right to rescind it. Any premiums received by the insurance company must be returned.

### ***Consideration (Premium)***

Consideration can be defined as something of value in exchange for something of value. In life insurance, the consideration is the application and payment of the initial modal premium.

### ***Application and Policy (Entire Contract)***

The entire contract is a standard provision that simply states that the policy and copy of the application are the entire contract. The application is attached to the back of the policy. An application and policy constitute an entire contract.

### ***Legal Purpose***

An insurance contract must have a legal purpose. For example, a promise to pay a provider (hospital) if a covered individual (patient) seeks medical attention is legal. However, a contract to commit a crime is not; thus, no legal purpose exists. A contract that does not have a legal purpose is void.

### ***Competent Parties (Parties of legal Capacity)***

This provision states that to have a legally binding contract, the parties entering the contract (the applicant and insurance company) must be competent. An applicant is considered competent unless they fall into one of the following three (3) categories. (1) minors (age 14 or younger), (2) persons under the influence of alcohol or narcotics, or (3) the mentally infirm (insane person).

For the insurance company to be considered competent, they must be “authorized” within the state it is conducting business.

Beneficiaries and insureds (if different from the applicant) are not parties to an insurance contract as they do not have contractual capability (the legal capability to form a binding contract).

Other parties of legal capacity include business entities, trusts, and estates.

## **SPECIAL FEATURES OF INSURANCE CONTRACTS**

### ***Aleatory***

Most insurance contracts are aleatory that (1) there is an element of chance for both contracting parties and (2) the considerations exchanged may not be equal. An aleatory contract is conditioned upon the occurrence of an event. For example, an insured purchased a \$500,000 life insurance policy. The premium is \$1,000 a year. During year 4, the insured dies. The insurance company has collected \$4,000 but will disperse \$500,000. The opposite applies too. The insurance company may collect more in premiums than it pays out. This is common in temporary (term) insurance.

The opposite of an aleatory contract is a commutative contract. For example, an automobile dealership agrees to sell a vehicle for a certain sum, and the buyer agrees to buy the vehicle for the same sum.

### ***Adhesion***

An insurance contract that has been prepared by one party (insurer) and is accepted (adhered to) by another party without negotiation is a contract of adhesion. This form of contract follows the "take it or leave it" premise, thus giving one party no ability to negotiate because of their unequal bargaining position, thus contract of adhesion is not a bargaining contract.

Concerning contract law, adhesion contracts are viewed or interpreted in favor of the party that did not draft the contract. Thus, ambiguities are favored to the insured or beneficiary, not the insurer.

### ***Unilateral***

A one-sided contract. Whereas, one party (offeror) makes a promise in exchange for an act (or abstention from acting) by another party (offeree). Suppose the offeree acts on the offeror's promise. In that case, the offeror is legally obligated to fulfill the contract, but an offeree cannot be forced to act (or not act) because no return promise has been made to the offeror. After an offeree has performed, only one enforceable promise exists, that of the offeror. Example: "I will pay you \$1,000 if you bring my car from Cleveland to San Francisco." Bringing the car is acceptance".

A bilateral contract is where each party entering the contract makes an enforceable promise as opposed to a unilateral contract.

### ***Not a Personal Contract***

Life insurance is not a personal contract or personal agreement between the insurance company and the insured. This is because the policyowner has no bearing on the risk that the insurance company as assumed. If the policyowner wishes to give up their rights to the policy, they can transfer their ownership through a concept called "assignment." To assign a policy, the policyowner must notify the insurance company in writing. The new owner is then granted all the rights of policy ownership.

Unlike life insurance, most other insurance policies are personal contracts. They constitute a personal agreement between the insured and the insurance company, and they cannot be transferred to another person without the insurance company's approval.

### ***Conditional***

A contract in which an offeree accepts an offer by performing an act indicates their agreement with the bargain. For example, upon receiving proof of an insured's death, the insurer has an obligation to pay the death claim.

### ***Valued or Indemnity***

A contract that pays a stated sum regardless of the actual loss is known as a "valued contract" For example, life insurance contracts are valued contracts. If a policy is acquired for \$500,000, then when the individual dies, the policy amount paid is \$500,000. The amount is not subject to actual financial loss.

An indemnity policy is settled differently. Indemnity means to bring one back to the position they were in before the covered loss. Fire and health policies are examples of indemnity contracts.

"Subrogation" is the process by which an insurance company seeks recovery of the amount paid to the insured from a third party who may have caused the loss. The concept is utilized with indemnity contracts. It is not used in valued or life insurance contracts.

**Valued Contracts Example**

Valued Contracts		
Type of Policy	Policy Face Amount	Amount Paid
Life Insurance	\$100,000	\$100,000
Disability Income	\$2,000 per month	\$2,000 per month
Accidental Death	\$1,000	\$1,000

**Indemnity Contracts Example**

Indemnity Contracts			
Type of Policy	Policy Limit	Loss Amount	Amount Paid
Fire Policy	\$100,000		
Kitchen Fire		\$5,000	\$5,000; the amount of the loss

***Utmost Good Faith***

Both the policyowner and the insurance company must know all material facts and relevant information. Neither party should have the capacity and or tendency to mislead, conceal, disguise, or deceive. Any of these actions may result in an insurance company not paying or voiding a contract.

***Warranty***

A guaranty that statements are true and correct in every respect. It is very important for the insured that statements are considered representations and not warranties. If statements were warranties, then the policy could be voided for any discrepancy, however minor, between any such statement and the actual fact. Warranties are not used in life or health insurance. Statements contained in applications for life insurance are deemed representations and not warranties.

***Representation***

Refers to the statements given by the insured in the application. This means that the person giving them believes them to be true and correct.

If a representation is untrue, the insurance company has the right to cancel the contract only if the representation was material to the creation of the contract.

Untrue statements on the application are considered misrepresentations and could void a contract. A material misrepresentation is a statement that, if discovered, would alter the underwriting decision of the insurance company. If material misrepresentations are intentional, they are considered fraud.

***Concealment***

This refers to the insured's failure to disclose to the company a fact that would materially affect acceptance of the risk (issuing of the policy) at the time of application.

In Florida, life insurance companies have a limited period to uncover false warranties, misrepresentations, or concealment. After that time, usually two (2) years from policy issue, the contract cannot be voided or revoked for these reasons (See "Incontestability Clause," Unit 6.) In health insurance, this is slightly different (See "Time Limit on Certain Defenses," Unit 22).

Reminder: The insurance company must prove concealment and materiality.

***Insurable Interest (Blood, Marriage, & Business)***

Insurable Interest must exist at the inception of the policy. Before issuing a life insurance policy, the person(s) who will receive the policy's benefits must show an interest in the continuation of the insured's life. The reasons for this are to prevent 'adverse selection' against the company from people purchasing an insurance policy on a person's life for the sole purpose of material gain when and if the insured dies.

Examples of persons having an insurable interest in the insured's life are all relatives, business partners, key-person, court-order (divorce), and of course, one's self.

## **Stranger Originated Life Insurance (STOLI) / IOLI (Investors Originated Life Insurance)**

An act, practice, arrangement, or agreement to initiate a life insurance policy for the benefit of a 3<sup>rd</sup> party investor, who at the time of the policy origination (application), has no insurable interest. This practice is prohibited in Florida.

## **AGENTS AND BROKERS**

**Agents represent the company | Brokers represent the client**

### ***The Concept of Agency***

The concept of agency entails four specific roles. (1) Describing the company's insurance policies to prospective buyers and explaining the conditions under which the policies may be obtained, (2) soliciting applications of insurance, (3) collecting premiums from policyowners (if necessary), and (4) rendering service to prospects (clients) and to those who have purchased policies from the company (orphan policyholders).

### ***Principles of Agency Law***

Agent means a person who acts for another person or entity (principal) about contractual arrangements with third parties. Based on this definition, an authorized agent can bind the principal to contracts. This is best demonstrated by these four (4) main principles of agency law. (1) Acts of the agent are acts of the principal. (i.e., company), (2) the Principal (i.e., the company) is responsible for the acts and deeds of the agent, (3) a contract completed by the agent is a Contract of the Principal, and (4) payment to the agent is payment to the principal and (5) is presumed to be knowledge of the principal.

### ***Agent Authority***

"Within the scope of his authority" mean which an agent is authorized to do on behalf of the company. An agents' authority is broken down into three (3) types: (1) express authority, (2) implied authority, and (3) apparent authority.



#### ***Express Authority***

This is the authority a principal gives to its agents. It is written in the agent's contract. An agent has the express authority to solicit applications of insurance on behalf of the company.

#### ***Implied Authority***

This authority is not expressly granted but is assumed to have to transact business on behalf of the principal. Implied authority is incidental to express authority because not every detail of an agent's authority can be spelled out. An agent's contract may not specifically state that an agent may print business cards; however, the authority to do so is implied.

#### ***Apparent Authority***

This authority is based on the appearance or assumption of a relationship with the company. If an insurance company is to provide an agent with forms, rate books, and other material, there is an impression that an agency relationship exists, thus an apparent authority.

The law will view the agent and the insurance company as one and the same when the agent acts within the scope of their authority.

## **Agent as Fiduciary**

A fiduciary is someone in a position of trust. As an insurance agent, one has a fiduciary responsibility to both their clients and the insurance companies they represent. Acting as a fiduciary requires the agent: (1) to be fit and proper, (2) be qualified to perform insurance functions, (3) be honest and trustworthy, (4) act in good faith, (5) know of, and abide by all local, state, and federal laws, rules and regulations, and (6) have a good business reputation



## **Professional Liability Insurance (E&O) - Errors & Omissions**

Like other industries, insurance professionals can be protected against wrongful actions by carrying malpractice insurance. This form of insurance is also known as E&O (errors and omissions). With this form of insurance, the insurance company agrees to pay, on behalf of the covered agent, a sum it is legally obligated to pay for injuries resulting from professional services they may or may not have rendered appropriately. Besides, E&O policies will defend any suit covered by the policy, even if the suits are groundless, fraudulent, or false.

## **OTHER LEGAL CONCEPTS**

### **Waiver**

Waiver means the giving up or voluntary abandonment of a known or legal right or advantage. For example, if an insurance company opts to waive a provision in their contract, they cannot deny a claim based on the violation of that provision.

### **Estoppel**

Estoppel is when an insurance company voluntarily gives up a right. Specifically, it is stopped, barred, or legally forbidden from denying the validity of a statement. For example, suppose an insurance company severs its agency relationship with an agent but later accepts an application from the same agent (thereby reasserting the agency relationship). In that case, the company will be estopped from claiming that an agency relationship did not exist when it entered into the contract with the insured.

### **Parol Evidence Rule**

Parol evidence means verbal or oral evidence that is given in a court of law. The rule states that once an agreement is made in writing, all previous oral or verbal statements cannot be changed or modified by parol evidence. For example: when an insurance agent delivers a policy to the policyholders, all written statements in the contract supersede and verbal descriptions made by the agent made during the sales process.

### **Void vs. Voidable Contracts**

There is a significant difference between these two terms. "Void Contract" means an agreement without legal effect. Either party cannot enforce this type of contract, such as a contract having an illegal purpose.

#### *"Voidable Contract"*

A voidable contract is also an agreement that one of the contract parties may set aside due to a court reasoning. A contract may be voidable if the policyholder fails to meet on the requirements (provisions) outlined in the contract, such as failure to pay a premium in time.

### **Fraud (Life Policy)**

Fraud is the misrepresentation of a material fact made knowingly and intentionally by the applicant to deceive the insurance company. In life insurance, an insurance company can challenge the validity of a contract (including the representations contained within) for two (2) years. After that period, the insurance company cannot contest the policy or deny benefits based on any material misrepresentations, concealment, or fraud. *This time frame is different in health insurance.*

UNIT**5****LIFE INSURANCE POLICIES****OVERVIEW**

There are many types of life insurance policies, all of which are designed to serve different needs. This unit will introduce you to these various policies. We will begin by defining the general categories of life insurance coverage and then move to the basic kinds of life insurance plans today's insurers provide. From there, we will focus on special types of policies as well as some of the newer, nontraditional policies.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Categories of Life Insurance
- Term Life Insurance
- Whole Life Insurance
- Endowment Policies
- Special Use Policies
- Nontraditional Life Policies

**KEY TERMS**

Adjustable Life

Credit Life

Decreasing Term

Endowment Policies

Enhanced Whole Life

Graded Premium Whole Life

Group Insurance

Increasing Term

Indexed Whole Life

Industrial Insurance

Interest-Sensitive Whole Life

Joint and Last Survivor Policy

Juvenile Insurance

Level Term

Limited Pay Whole Life

Minimum Deposit

Modified Endowment Contract

Modified Whole Life

Multiple Protection Plan

Ordinary Insurance

Single-Premium Whole Life

Universal Life

Variable Life

Variable Universal Life

Whole Life

## CATEGORIES OF LIFE INSURANCE

Life insurance companies issue three (3) basic types of coverage: (1) ordinary insurance, (2) industrial insurance, and (3) group insurance.

### Ordinary Insurance

Ordinary insurance, a form of individual insurance, includes many forms of temporary and permanent insurance protection plans written with monthly, quarterly, semi-annually, or annually paid premiums.

### Industrial / Debit / Burial Insurance (sold by “home service” companies)

Industrial insurance, also known as debit or burial insurance, is sold by “home service” companies typically written on small face amounts, such as \$1,000, with premiums collected by debit agents weekly at a policyowner’s residence.

### Group Insurance

Contrary to individual insurance where coverage and underwriting are based on one-person, group insurance is a single contract written on multiple people who fall under an employer-employee group, association, creditor, or union.

## TERM LIFE INSURANCE (DEATH BENEFIT ONLY)

Temporary ‘term’ insurance is the simplest and most common type of life insurance plan. It provides life insurance protection to an insured for a specified period (term) and pays a death benefit only if the insured dies during that covered period.

### Basic Forms of Term Life

In this chapter, we will discuss four (4) basic forms of temporary life insurance: (1) level term, (2) decreasing term, (3) increasing term, and (4) annual renewable term.

#### Level Term

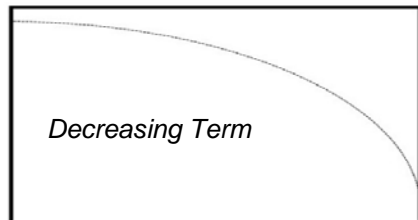
In a level term policy, both the premiums and death benefit remain level for the term. When the term expires, so does the insurance.

**\$50,000 5 – Year Level Term**  
Premium remains level for 5 years  
Death benefits remain level for 5

#### Decreasing Term

In a decreasing term policy, the death benefit decreases over time, but the premium amount remains constant (level). This type of policy is primarily used to cover loan issued by automotive, mortgage, college, or other credit (financial) companies.

**\$100,000 30 Year Mortgage**



Age 30

Age 60 = 0

#### Increasing Term

Opposite to decreasing term, increasing term policies increase the benefit period at periodic intervals. The primary purpose of using an increasing term policy is that of inflation. Increasing term policies are typically tied to a cost of living index, such as the Consumer Price Index (CPI). They can be purchased as a stand-alone insurance policy or a rider to a permanent life insurance policy. As a rider, the policyowner is billed for the additional coverage.

#### Annual Renewable Term (ART) / Yearly Renewable Term (YRT)

In this type of policy, the benefit is level, but the premiums increase each year. As time progresses, the policy becomes cost-prohibitive to the policyowner as the annual premium is based on the insured ‘attained age.’ This form of policy represents the most basic form of life insurance.

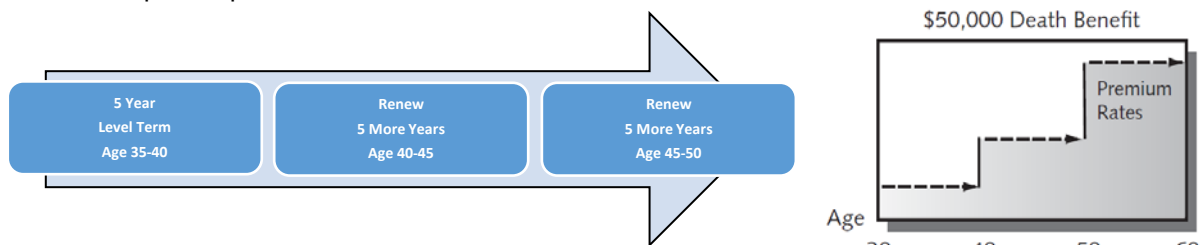
### Features of Term Life

Two concepts found within term life policies are the option to renew and convert. These optional provisions, not riders, are typically embedded in the policy and may be subject to an additional premium.



*Option to Renew*

Policies with this option allow a policyowner to renew before the policy termination date without proving evidence of health insurability. Like an ART where premiums increase every year at renewal, policyowners may incur a premium increase based on the policy's renewal provisions. Premium increases at set intervals are known as "step-rate" premiums

*Re-Entry Option*

Some renewable term plans offer an option for re-entry at the end of a policy term. With this option, the policyowner can renew coverage at a guaranteed rate specified in the policy, without evidence of health insurability.

*Option to Convert*

When exercising this option, the insured has the right to exchange or convert the term policy for a permanent (whole life) policy without evidence of health insurability. The new (converted) policy will be issued at a premium rate reflecting the insured's age as stipulated in the policy, attained age method or original age method.

The option to convert generally specifies a time limit and is commonly lumped with the option to renew under one timeframe. Term policies that include the option to renew, convert, or both will carry a higher premium than those that do not have these features.

*Deposit Term Insurance*

An exception to the level premium approach is deposit term insurance. This type of term policy requires a premium payment in the first year that is much higher than the second and subsequent years' level premiums. At the end of the policy's term, the policyowner receives some of the premium back; the amount returned is typically multiple between the higher first-year premium and the lower second-year premium. Deposit term insurance accounts for a very small percentage of the term insurance sold today.

**WHOLE LIFE INSURANCE**

Whole life insurance, also known as straight life, permanent life, and cash-value life insurance, provides permanent protection for the entire "whole" life of an insured (from the date of issue to the date of the insured's death) if premiums are paid.

***Features of Whole Life***

Unlike a term policy that only has a death benefit and expires after a specified period, permanent or whole life insurance earns cash-value and matures (does not expire) at the age of 100.

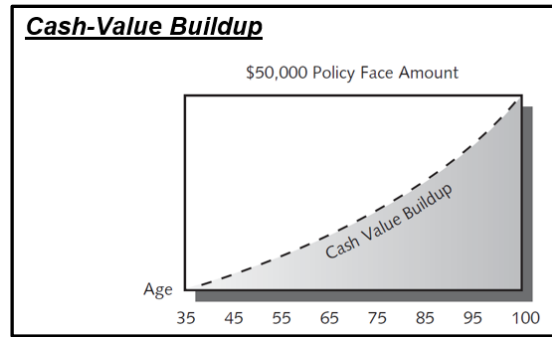
*Cash Values*

Whole life insurance combines insurance protection with a savings or accumulation element commonly referred to as the policy's cash value. This savings element builds over the policy's life and represents the amount of money a policyowner may receive if the policy is ever canceled or surrendered.

The policy's cash-value depends on three (3) main factors: (1) the face amount of the policy, (2) the duration and amount of the premium payments, and (3) how long the policy has been in force.

**Maturity at Age 100**

Permanent insurance is designed to mature at age 100. It is actuarially assumed that every insured is presumed to be dead by that age. At age 100, the cash-value equals the policy's face amount and will be paid to the policyowner (usually the insured) or a beneficiary as a "living benefit" if the beneficiary is still living. At age 100, the policy has completely matured or endowed. No additional premiums are required, and the policy is 'paid-up.'



**Living Benefits**

Cash-value in a permanent policy belongs to the policyowner and cannot be forfeited. Therefore, a policyowner can take a loan against the policy. This is typically limited to a percentage of the cash-value and subject to a reasonable rate of interest. Although not a requirement to be repaid, any loan outstanding when the insured dies will be deducted from the death benefit (plus interest) before it is paid to a beneficiary or estate.

**Whole Life Premiums**

Whole life is designed as if the insured will live to age 100. The full premium-paying period is calculated based on the number of years between the insured's age at the time of issue and age 100, the time of presumed death. This amount, equally spread over the premium-paying period, is known as the "level premium approach."

**Basic Forms of Whole Life (Method of Payment)**

Three (3) notable forms of while life plans are (1) straight whole life, (2) limited pay whole life, and (3) single-premium whole life.

**Straight Whole Life**

Straight whole life is whole life insurance providing permanent level protection with level premiums from the time the policy is issued until the insured's death (or age 100).

**Limited Pay Whole Life (i.e., 10 Pay Life, 20 Pay Life, Life Paid Up at age 65)**

This variation of whole life is designed to pay premiums over a shorter period (not lifetime) but with protection remaining enforce until the insured's death or age 100.

**Single-Premium Whole Life (Single Pay Life)**

Also, a limited pay policy but instead of a series of payments over a specified period, this premium is paid as a large one-time-only premium payment at the beginning of the policy period. The policy is completely paid-up, and protections remain enforce to age 100.

**Premium Periods**

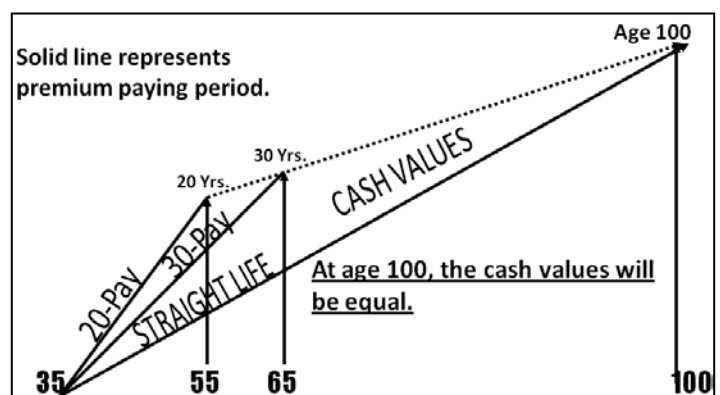
Premium rates for life insurance are based on per \$1,000 of insurance. The length of a premium-paying period influences both the premium, and with permanent insurance, the speed in which the accumulation or cash-value grows.

**Premium-Paying Periods**

The shorter the premium-paying period, the higher the premium.

The shorter the premium-paying period, the quicker the cash-values grows.

The longer the premium-paying period, the slower the cash-values grow.



## **Other Forms of Whole Life**

### *Modified Whole Life*

As an alternative to traditional whole life insurance where the premium is level for the lifetime, modified whole life insurance provides a smaller initial premium in the beginning years (slightly higher than a term policy). As time progresses, the premium rises to a level that would be greater than the typical whole life rate at the age of issue. Overall, the premiums paid are equivalent to the standard whole life policies, but they are modified here.

This product is used by individuals who have limited financial resources but have the promise of an improved financial position in the future.

### *Graded Premium Whole Life*

An attractive policy that makes purchasing a whole life policy easier and more affordable to individuals whose current financial resources are limited but demonstrate the ability to have an improved financial position in the future. Like a modified whole life that redistributes the premiums over a specified premium, this policy offers a lower premium in year one. It then increases and levels off after a "preliminary period" at a rate equivalent to a typical straight whole life rate.

### *Minimum Deposit Whole Life (Financed Insurance)*

Unlike other whole life policies where cash value begins building no later than year three, minimum deposit whole life begins earning cash values immediately upon payment of the first payment. The policyowner systematically borrows from the cash value to pay some or all of the premium from that point.

### *Indeterminate Premium Whole Life*

Indeterminate premium whole life policies are those in which the premium rate can be adjusted based on the insurance company's anticipated future experience. The maximum premium that the insurer can charge is stated in the contract.

### *Indexed Whole Life*

With an indexed whole life policy, the face amount automatically increases as the Consumer Price Index (CPI) increases. Additionally, the premiums for an indexed whole life policy fall under two pricing methods. (1) The policy owner pays an additional premium with each face amount increase, or (2) the insurer assumes the risk. Thus, the policyowner does not pay a higher premium with face amount increases. However, no matter which method is utilized, the policyowner is exempted from furnishing insurability evidence to obtain the face amount increases.

## **Endowment Policies**

An endowment is a policy that pays the face amount if death occurs (death benefit) or pays the face amount at the end of the premium-paying period (living benefit). It is the most expensive type of insurance written today. The most common and best use of this policy is for educational purposes.

The policy is designed to give a high-cash value at a specified time if the policyholder lives and pays a lump sum benefit if death should occur before a predetermined maturity date/age. The policy can be for the long-term, but it does not provide lifetime protection. The components are level term and increasing cash value.

Endowment policies are compared to level term insurance because it pays a death benefit if the insured dies during a certain period. However, when the contract pays the living benefit, the endowment is considered a pure endowment, thus is guaranteeing a specified sum payable only if the insured is living at the end of a stated period.

## **Endowment Premiums**

As stated previously, endowments are considered the most expensive form of insurance written because of its rapid cash value build-ups (increasing cash value). However, due to changes in the tax code, the popularity of endowments has declined for many years. The most recent Tax Code change specifies that life insurance products cannot endow before age 95; thus, endowments generally do not qualify as life insurance.

**Modified Endowment Contracts (MECs)**

In 1988, a new class of insurance, known as modified endowment contracts (MECs), was created. These products were a result of a revised tax law definition of “life insurance contracts.” When Congress enacted the Technical and Miscellaneous Revenue Act (TAMRA), its purpose was to discourage the sale and purchase of life insurance for investment purposes or as a tax shelter.

20-year Multiple Protection Policy
Level Term-- \$200,000--20 years
Whole Life-- \$100,000--age 100

Suppose a policy is deemed a MEC, and the policyowner receives any amount from it in the form of a withdrawal or loan that exceeds what was paid in the contract as premiums. In that case, that amount will be taxed first as ordinary income and second as return of premium.

There may also be a 10% penalty imposed on the withdrawal or loan amounts

**IMPORTANT FACTS**  
 Technical and Miscellaneous Revenue Act of 1988

Resulted in MEC  
Must pass the 7 Pay Test to avoid becoming a MEC.


Products affected  
 a. Single Pay Life                      b. Some Limited Pay Life                      c. Universal Life

Special Facts  
 First taxed as ordinary Income  
 Second as Return of Premium  
 If received before age 59½  
 Tax Penalty = 10%

Purpose of Law: Misuse or Abuse of using Life Insurance as a Tax Shelter instead of the purpose of life insurance “Protection Guarantees”

Making sure that policies meet the definition of life insurance and comply with the 7-pay test is the responsibility of the insurers and their actuaries.

MECs have the same tax-free death benefit as non-MEC life insurance.



**Special Use Policies**

A family plan, sold in units, is designed to insure all family members under one inclusive policy. It may be written as a separate contract or as a rider on a basic plan. The format usually provides permanent (whole life) insurance on the policyholder, temporary (term) or whole life on the spouse and decreasing or level term on the children until they reach a specified age.

Coverage for children is generally limited to those older than 14 days and younger than 21. All future children born to the primary insured are automatically covered without any additional premium. Children’s coverage is typically convertible without evidence of insurability.

Primary Insured	\$10,000 WL
Spouse	\$3,000 Term
Children	\$1,000 Term (Convertible)

**Multiple Protection Policies - Whole Life and Level Term**

A multiple protection policy pays a benefit that a factor of the face amount if death occurs during a predetermined specified period. If death occurs after that period has expired, only the face amount is paid.

**Joint Life (1<sup>st</sup> to Die)**

This contract covers two or more people being insured under one permanent insurance policy. The policy is designed to pay the death benefit when the first of the insureds dies. After this, the surviving insureds have the option of purchasing a single individual policy without providing evidence of insurability.

**Joint and Last Survivor Policy (2<sup>nd</sup> to Die)**

A variation to the joint-life policy is the "last-survivor policy" or second-to-die policy. This policy also covers multiple lives but is designed to pay the death benefit upon the last surviving insured's death.

**Juvenile Insurance**

An insurance policy issued on an individual aged one (1) day to 15 years is classified as juvenile insurance. The insured is the child, and the policyowner is an insurable-interest-bearing-adult, such as a parent or guardian. The premium-payor is typically the adult policyowner, until the insured child reaches a specified age indicated in the contract.

*Payor-Provision*

Available under certain juvenile policies, a payor-provision is attached to a juvenile policy. For an additional premium, the policy will waive future premiums of the policy if the person responsible for the payment of the premiums dies or is. Parents must show evidence of insurability to purchase this provision (rider).

*Jumping Juvenile or Junior Estate Builder*

A special form of juvenile insurance is the "jumping juvenile" or "junior estate building policy." This policy is written on children ages one (1) to fifteen (15) in until of \$1,000. These units automatically increase to five (5) times the face amount at age 21, hence the term "jumping." A benefit of this form of insurance is that although the face amount jumps' five times, the premium remains the same, and no evidence of insurability is required.

**Credit Life**

Credit life insurance is a decreasing term policy designed to cover a debtor's life in the event of their death before paying off a covered loan. The policy's length is matched to the loan's length, and the amount of insurance is matched to declining loan balance. The policy amount shall never exceed the indebtedness of the loan.

**NON-TRADITIONAL*****Interest-Sensitive Whole Life / Current Assumption Whole Life***

This form of insurance reflects the insurer's changing experience regarding mortality (death), investment, and expense factors. With interest-sensitive products, the cash value levels earned may be greater than the guaranteed levels provided in an indeterminate-premium whole life policy. This may be possible due to more favorable than expected insurer underlying mortality, investment, and expense experiences.

On the contrary, if the underlying experience is less favorable than anticipated, the policyowner may choose from paying a higher premium (premium increase) or reduce the policy's face amount and pay the same premiums. Adjustments are normally made annually.

***Adjustable Life***

Adjustable life is a flexible form of insurance contract. It is a combination of temporary (term) and permanent (whole life) into one plan. The policyowner determines how much protection is needed and how much premium they are willing to invest, whereas the insurer then selects the appropriate plan to meet those needs.

A benefit of adjustable life, as the financial needs and objectives of the insured change, the policyowner can make annual adjustments to the coverage. The policy can be converted from term to whole life or from whole life to term, or from a higher premium contract to a lower premium or limited pay contract.

These types of policies vary per insurer and contain limits and restrictions on conversions. Adjustable life insurance is typically more expensive than conventional temporary and permanent policies.

## Universal Life = UL

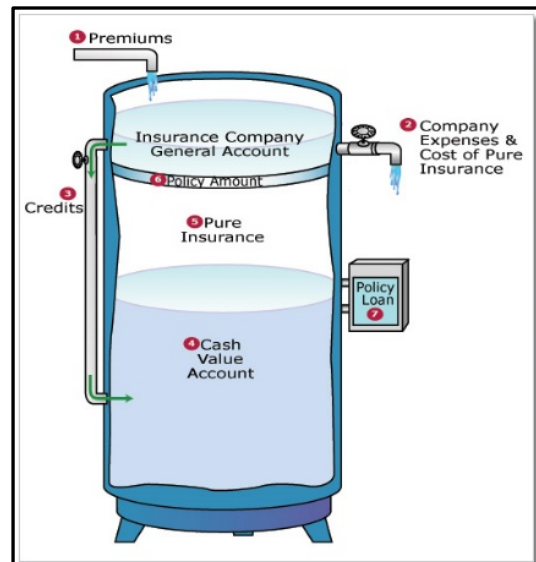
Universal life is a variation of whole life insurance. However, unlike whole life, with its fixed premiums, face amounts, and cash value accumulations, universal life allows its policyowners to determine the amount and frequency of premium payments along with the ability to adjust the policy face amount up or down to reflect changes in needs. When changes to a policy are made, no new policy needs to be issued, showing the desired changes.

Universal life provides this flexibility by “unbundling” or separating the basic components of a life insurance policy, the insurance (protection) element, the savings (accumulation) element, and the expense (loading) element. With each month’s premium, a mortality charge is deducted from the policy’s cash value account for the cost of the insurance protection. This mortality charge may also include an expense, or loading, charge.

As premiums are paid, and as cash values accumulate, interest is credited to the policy’s cash value. Interest may be accrued at either the current interest rate or the guaranteed minimum rate. If the cash value account is sufficient to pay the monthly mortality and expense costs, the policy will continue in force, whether the policyowner pays the premium. If the cash value account is not large enough, the policy terminates.

A distinguishing factor between universal life and whole life is that partial withdrawals can be made from the policy’s cash value account. (Whole life insurance allows a policyowner to tap cash values only through a policy loan or a complete cash surrender of the policy’s cash values, in which case the policy terminates.) Also, the policyowner may surrender the universal life policy for its entire cash value at any time.

- ① Premiums
- ② Company Expenses and Cost of Pure Insurance
- ③ Credits
- ④ Cash Value Account
- ⑤ Pure Insurance
- ⑥ Policy Amount
- ⑦ Policy Loan



## UL Death Benefit Options

Universal life insurance offers two death benefit options; (1) Option One and (2) Option Two.

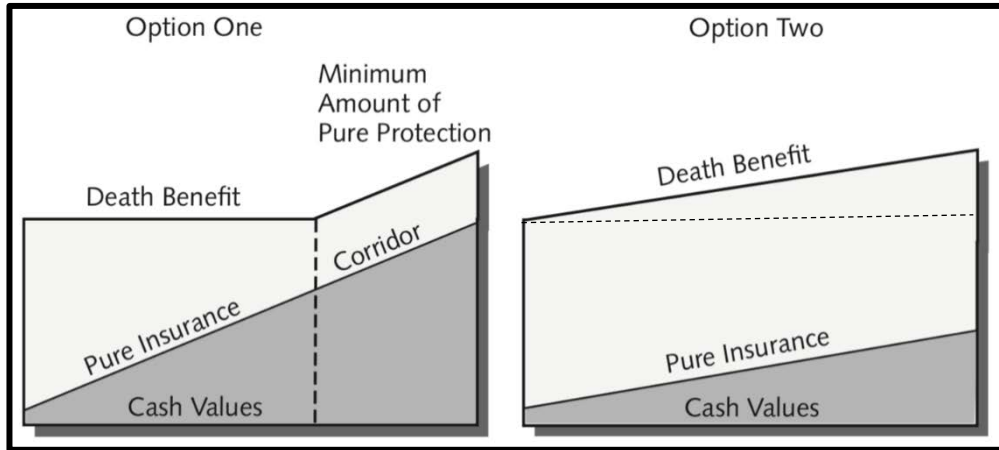
Under Option One, the policyowner may designate a specified amount of insurance. The level death benefit is equal to the cash values plus remaining pure insurance (decreasing term plus increasing cash values).

Suppose the growing cash value-total death benefit ratio exceeds a certain percentage fixed by federal law. In that case, an additional amount of pure insurance, called the “corridor” is added to maintain the minimum death benefit requirement.

Under Option Two, the death benefit equals the face amount (pure insurance) plus the cash values (level term plus increasing cash values).

To comply with the Technical and Miscellaneous Revenue Act of 1988 definition of life insurance, the cash values cannot be disproportionately larger than the term insurance portion.

**Universal Life Death Benefit**

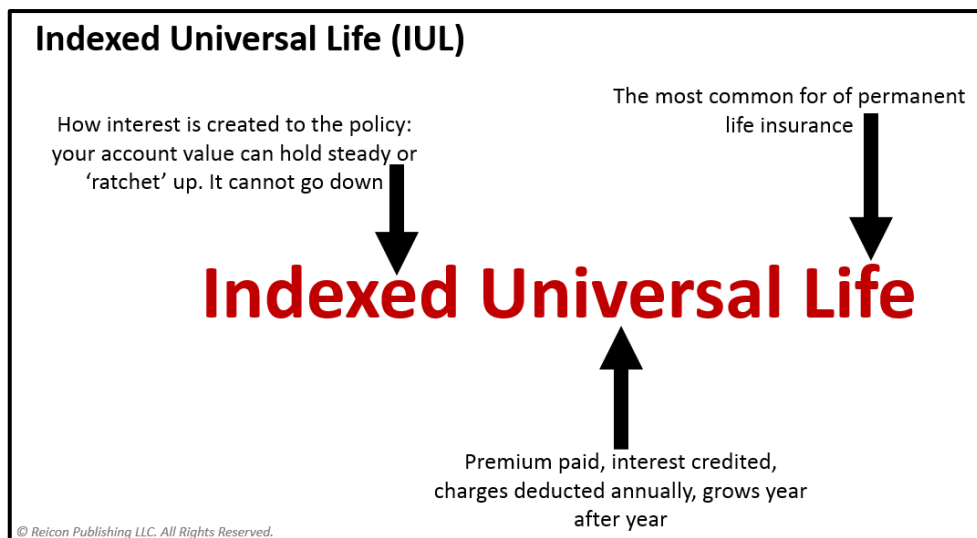


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**Indexed Universal Life Insurance (IULi)**

This type of policy provides an index feature that offers cash-value accumulation and basic interest guarantees. IULi policies allow for more flexibility than the traditional UL policy. For example, policy cash-value can be transferred from a fixed account that offers traditional fixed interest rates to an indexed account.

Indexed Universal Life accounts use an outside index, like the Nasdaq-100 Index or Standard & Poor's 500 Index, when calculating interest credits. The maximum interest crediting rate varies by insurer but typically is limited by a growth cap of 0% to 2%, which varies by insurance company.



**Variable Insurance Policies and Securities**

The term variable life insurance refers to a form of whole life insurance contracts designed to counteract the effects of inflation on the value (purchasing power) of fixed-face-amount whole life policies. Variable insurance policies are securities and do not guarantee contract cash values. Besides, it is the policyowner who assumes the investment risk.

Variable products fall under the Florida Department of Financial Services' regulatory arm and the Securities and Exchange Commission (SEC). To sell variable insurance products, an individual must hold a Florida Life, Health including Variable Annuity (2-15), Life including Variable Annuity (2-14), or Variable Annuity (2-19) agents' license and a Financial Industry Regulatory Authority (FINRA) registered representative's license. [Variable Annuity 2-19 agent can only sell variable annuities, not variable life products.]

Because variable insurance policies are securities, policyowners must be provided a prospectus. This document contains information about the nature and purpose of the insurance plan, the separate account, and the risk involved, either before or during the sales presentation.

**General Accounts versus Separate Accounts**

General accounts, which represent the company's general assets, are used to support the contractual obligations of an insurance company's fixed traditional policies. The company is considered insolvent if the general account assets fail to support its reserve liability; thus, the assets become subject to claims of both the company's credits (including policyowners).

Separate accounts are separate from the general accounts. It is maintained for the sole purpose of allowing policyowners to participate directly in the account's investment performance. Separate accounts earn a variable return as compared to the fixed return of general accounts.

Separate accounts are not subject to the claims of the insurance company's general credits. Therefore, policyowners cannot lose the physical assets underlying their variable contracts in the event of the company's insolvency.

**Variable Life Insurance**

Variable life insurance is a form of permanent life insurance. It mimics many of the same characteristics of traditional whole life insurance. The most significant difference is the way the policy's values are invested.

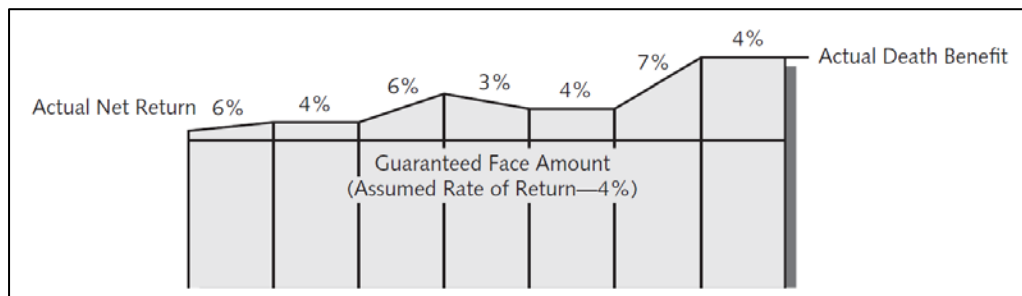
The policy values are invested in the insurer's separate accounts with variable life insurance policies that house common stock, bond, money-market, and other securities investment options. Values held in these separate accounts are invested in riskier but potentially higher-yielding assets than those held in the general account.

With variable life insurance, the benefit increase (and decrease) in relation to the policy's values' performance. However, the death benefit will never drop below the face amount guaranteed at the policy issue.

Variable life insurance requires the payment of set premiums on a scheduled basis. Failure to make these premium payments results in policy lapse. Variable life insurance policyowners can access their policy values through policy loans. The loan is limited, usually 75% - 80% of the cash value. Conventional whole life policies typically permit loans up to 100% of the cash value.

**Variable Life Death Benefit**

*The following graph shows how the investment performance of a variable life insurance policy's values affect the death benefit. Here, the assumed rate of return is 4%. If the net investment results were equal to 4% throughout the policy's life, the death benefit would remain the same – that is, the face amount of the policy at issue. However, as is more likely, the actual investment results will vary. A return greater than 4% produces a rise in the death benefit; a return less than 4% produces a drop in the death benefit from the previous year.*



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***Variable Universal Life (VUL)***

The VUL product blends features of three types of products: (1) whole life, (2) universal life, and (3) variable life. The most notable features are: (1) premium flexibility, (2) cash value investment control, and (3) death benefit flexibility.

Every variable universal life insurance policy is issued with a minimum scheduled premium based on an initial specified death benefit. This initial premium establishes the plan, meets first-year expenses, and provides funding to cover insurance protection costs. Once this initial premium has been paid, policyowners can pay whatever premium amount they wish, with certain limitations. Provided adequate cash value is available to cover periodic charges and the cost of insurance; they can suspend or reduce premium payments.

VUL policies generally offer both a level or fixed death benefit and a variable death benefit that fluctuates in response to investments' performance.

***Loan or Withdrawal?***

Policyowners have access to partial cash value distributions by taking a loan or withdrawal against their cash value.

A loan against one's own money is a withdrawal with the presumption that it will be repaid (with accrued interest) or the loan and interest amount will reduce that future benefits. Policy loan proceeds are received federal income tax-free unless the policy is a MEC (modified endowment contract).

A withdrawal is similar to a loan, but there is no presumption that the loan will be repaid. The withdrawn amount is treated as a permanent withdrawal, therefore immediately reducing the death benefit and cash value.

Only UL and VUL policies permit withdrawals. Withdrawals are tax-free up to the cost basis and are subject to federal income tax.

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**UNIT****6 LIFE INSURANCE POLICY PROVISIONS,  
OPTIONS & RIDERS****OVERVIEW**

Life insurance is property and policyowners have important rights, as well as responsibilities, inherent in this special type of property. The policy provisions spell out the owner's rights, responsibilities, and limitations. In addition, life insurance, like many other forms of property, can be customized to meet the specific needs of the owner through policy riders and options. This unit will look at policy rights, provisions, riders, and options that give the life insurance contract its form and flexibility.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Rights of Policy Ownership
- Standard Policy Provisions
- Policy Exclusions
- Nonforfeiture Values
- Policy Dividends
- Policy Riders

**KEY TERMS**

Accelerated Benefits Rider

Accidental Death Benefit

Assignment Provision

Automatic Premium Loan

Consideration Clause

Cost of Living Adjustments

Entire Contract Provision

Free Look

Grace Period

Guaranteed Insurability Rider

Incontestable Clause

Insuring Clause

Misstatement of Age of Sex Clause

Nonforfeiture Options

Other Insureds Rider

Owner's Rights

Payor Benefit

Policy Dividends and Options

Policy Exclusions (Optional) Provisions

Policy Loans

Reinstatement

Suicide Provision

Waiver of Premium

## RIGHTS OF POLICY OWNERSHIP

Life Insurance is a property you own. Just like any other property, you have important rights inherent to that property. The person who pays the premium for an insurance contract is designated as the policyowner or policyholder. Although there are no specifically labeled provisions called “Rights of Ownership” in a life policy, the contract policy provisions spell out the policyowner’s rights, responsibilities, and limitations of the contract.

There are six (6) significant ownership rights that a policyowner has: (1) The right to designate and change the beneficiary of the policy proceeds. (2) The right to select how the death proceeds will be paid to the beneficiary. (3) The right to cancel the policy and select the Nonforfeiture option. (4) The right to take out a policy loan, assuming the policy is a whole life or universal life policy, and a cash value exists. (5) The right to receive policy dividends and select a dividend option, if it is a participating policy, and (6) The right to assign ownership of the policy to someone else.

## STANDARD POLICY PROVISIONS

To promote state-by-state uniformity of the insurance industry regulations, most states have adopted the standard wording of the National Association of Insurance Commissioners (NAIC) Model Regulations. There are thirteen (13) NAIC Model Regulations.

### 13 NAIC Model Regulations

NAIC Model Regulations	
Entire Contract Provision	Incontestable Clause
Insuring Clause	Assignment Provision
Free-Look Provisions	Accelerated Benefits Provision
Consideration Clause	Suicide Provision
Grace Period Provision	Misstatement of Age or Sex Provision
Reinstatement Provision	Automatic Premium Loan Provision
Policy Loan Provision	



### ***Entire Contract Provision (same in Life and Health)***

Found at the beginning of the policy, this provision states that the policy document, the application attached to the policy, and any attached riders constitute the entire contract. The entire contract clause prohibits the insurance company from making any changes to the policy, except for those mutually agreeable in writing or by application, such as changing the face amount of an adjustable life policy.

### ***Insuring Clause (same in Life and Health)***

The insuring clause sets forth the insurance company's promise to pay benefits if a covered event takes place. The insuring clause is typically signed by the president and secretary of the insurance company.

#### **Insuring Agreement Example**

*The Insurance Company agrees, in accordance with the provisions of this policy, to pay to the beneficiary the death proceeds upon receipt at the Principal Office of due proof of the insured's death before the maturity date. Further, the Company agrees to pay the surrender value to the owner if the insured is alive on the maturity date.*

### ***Free-Look Provision***

Required by most states, this provision provides the policyowners the right to return the policy within a specified period for a full premium refund. In Florida, the free-look period for life insurance is fourteen (14) days from policy delivery.

### ***Consideration Clause (same in Life and Health)***

Consideration is the value given for something in exchange for something else in a contractual promise. In a life insurance policy, the consideration clause specifies the frequency and amount of premium payments the policyowner must provide to keep the insurance in place.

### ***Grace Period Provision***

A period after the premium due date during which the premiums may still be paid, the policy and its riders remain in force. This provision is designed to help prevent an unintentional lapse. However, if a premium remains unpaid after the expiration of the grace period, insurance will be in force only to the extent provided under the policies non-forfeiture provisions. If the insured's death should occur during the grace period, the unpaid premiums will be deducted from the death benefit.

Each type of policy has its own grace period associated with it. For example, an ordinary life or fixed annuity product has a thirty (30) day grace period. Industrial life products have a four (4) week grace period of twenty-eight (28) days.

Florida law states that for a person, 64 years of age and older is granted an additional twenty-one (21) day grace period if the policy has been in force for greater than one (1) year.

### ***Reinstatement Provision***

In the event a policy lapses, policyowners are granted a limited amount of time, usually three years, but as long as seven, to reinstate the policy. To restore the policy to its original status and bring its values up to date, the policyowner must: (1) pay all back premiums along with any applicable interest, (2) pay any outstanding loans on the lapsed policy, and (3) prove insurability. Additionally, a new contestable period goes into effect; however, no suicide exclusion period applies.

### ***Policy Loan Provision***

Suppose a life insurance policy provides for cash-value. In that case, state laws require the policy include a policy loan provision, thus allowing the policyowner to borrow money from the cash values of their policies if they wish to do so. Because the policy loan is an advance on proceeds rather than a true "loan," the insurance company does not have any right to "call" or request repayment at any specified time.

As with any loan balance present when the insured dies, the balance and any interest accrued will be deducted from the policy proceeds at the time of claim. The same applies if the policy is surrendered for cash. The cash-value available to the policyowner will be reduced by the amount of any outstanding loan plus interest.

Interest rates on policy loans vary. Florida law stipulates a maximum allowable rate of 10%.

### ***Incontestable Clause***

The incontestable clause specifies that after a certain period, usually two (2) years from the issue date and while the insured is living, the insurance company no longer has the right to contest the life insurance policy's validity as the contract continues in force. Suppose the insurer learns that an error was deliberately made on the application. In that case, it must pay the death benefit at the insured's death if the policy has passed the contestable period.

Although the incontestable clause applies to death benefits, it does not apply to accidental death benefits or disability provisions if they are part of the policy.

There are three (3) situations that the incontestable clause does not apply and would always void the policy: (1) impersonation, (2) no insurable interest, and (3) intent to murder.

### ***Assignment Provision***

The transfer of ownership is known as assignment. The assignment provision in a life insurance contract requires that the policyowner, in writing, notify the insurance company of the assignment. As indicated under the rights of policy ownership, the policyowner does not need the permission of the insurance company to assign a policy.

Once the policy is assigned, the new owner is known as the assignee. Unlike at the time of policy inception, insurable interest does not have to exist between the insured and the assignee. The assignee is granted all the rights of policy ownership, including the right to name a new beneficiary. However, if the original

beneficiary designation is irrevocable, the policy owner must first obtain that beneficiary’s approval for any assignment or beneficiary change.

There are two types of assignments (1) absolute and (2) collateral.

**Absolute Assignment**

The transfer of ownership is complete, irrevocable, and final. The assignee receives full control over the policy and rights to its benefits.

**Collateral Assignment**

The assignment is one in which the policy is assigned to a creditor to guarantee payment for a debt. If the insured dies, the creditor is entitled to be reimbursed out of the benefit proceeds for the amount owed. The insured’s beneficiary is then entitled to any excess of policy proceeds over the amount due to the creditor. Once the debt is repaid, the policyowner is entitled to the return of the rights assigned.

**Accelerated Benefits Provision**

Standard in life insurance policies, the accelerated benefits provision provides a partial payment of the face amount if the insured suffers from a terminal illness or injury. This provision is given without an increase in premiums. Some companies deduct an interest charge from the proceeds paid out.

\$250,000	Death Benefit*
\$187,500	Accelerated Benefit
\$ 62,500	To the Beneficiary
*75% Accelerated Benefit	

**Suicide Provision**

In most policies, if the insured commits suicide within the first two years, the company will not pay benefits but will return the premium. If a death is to occur during a time stipulated in this provision (usually two years from the date of policy issue), the insurance company must prove, beyond a reasonable doubt, that the death was the result of suicide; otherwise, the policy proceeds generally will be paid to the beneficiary.



**Misstatement of Age and or Sex Provision**

The misstatement of age or sex provision is a critical factor in determining the premium rate for a life insurance policy. Unlike other statements that are only contestable for a specified period, this provision reserves the company’s rights to make an adjustment at any time.

Normally, such adjustments are made either in the premium charged or in the amount of insurance. If the insured were younger than stated in the application, a higher death benefit would be paid. If the insured were older than stated, a reduced benefit would be paid.

**Automatic Premium Loan Provision = APL**

Depending on the insurance company, this provision may be standard to the contract or added as a rider, with no additional charge to the policyowner. If elected by the policyowner, at the time of application, the provision authorizes the insurance company to withdraw from the policy’s cash-value the amount of premium due if it has not been paid by the end of the grace period. The amount withdrawn becomes a loan on the policy, and interest will be charged. The policy will eventually lapse when the cash-value is reduced to zero.

**POLICY EXCLUSIONS**

Most life insurance policies contain exclusions the protect the insurance company from paying a claim on certain risks. The most common types of exclusions found in life insurance policies are: (1) War (2) Aviation (3) Hazardous occupations and hobbies, (4) Commission of a felony (5) Suicide.

**NON-FORFEITURE VALUES**

Nonforfeiture options are how cash values can be paid out to or used by policyowners in the event they choose to lapse or surrender their policies. There are three (3) nonforfeiture values from which policyowners can choose from: (1) Cash Surrender Option (2) Reduced Paid-Up Option (3) Extended Term Option

**Cash Surrender Option**

Any outstanding policy indebtedness reduces the amount of cash value the policyowner receives. Insurers are required to make cash surrender values available after the first three policy years and, for industrial insurance, after five years. Most states permit insurers to postpone payment of cash surrender values for up to six months after policyowners request payment. This delayed payment provision is a protective measure for companies should an economic crisis arise, but such delays are rarely invoked.

**Reduced Paid-Up Option**

Under a reduced-paid up option, the policy's face amount is reduced, and no further premiums are due. Technically, the cash value is used to purchase a single premium whole life policy at the attained-age rate.

The cash value will continue to grow, and at age 100, it will equal the death benefit. Any term insurance rider and disability or accidental death benefits from the original policy are excluded when the amount of paid-up life insurance is calculated.

<b>Table of Guaranteed Values</b>				
Face Amount \$100,000		Annual Premium: \$2,000		
End of Term Policy Year	Cash Surrender Value	Reduced Paid-Up	Extended Years Days	
1	\$ 0	\$ 0	0	0
2	50	210	0	66
3	960	3,600	2	290
4	2,150	7,250	6	09
5	4,000	12,000	8	111
6	5,975	16,110	10	147
7	7,210	19,880	12	22
8	9,340	23,800	14	18
9	11,415	27,620	15	312
<b>10</b>	<b>13,005</b>	<b>30,990</b>	<b>16</b>	<b>362</b>
11	14,770	34,010	17	202
12	16,785	37,880	18	116
13	19,430	40,940	18	220
14	23,000	43,985	17	144
15	26,990	47,010	13	02
16	30,215	50,600	15	347
17	34,600	53,815	15	88
18	38,910	56,910	14	17
19	43,020	60,010	13	361
<b>20</b>	<b>47,910</b>	<b>63,715</b>	<b>13</b>	<b>47</b>
Age 65	56,770	78,700	11	36

<b>Example:</b>	\$100,000
	- 47,910 -- cash value 20 <sup>th</sup> year
	\$ 52,090 -- amount at risk

Once the paid-up policy has been issued, the new policy will begin to earn cash values.

**Extended Term Option**

The final nonforfeiture option is extended term. Here, the cash value is used to purchase term insurance on the original face amount for as long a period as the cash value will purchase. If the policy has any supplemental benefits, such as a term or accidental death or disability rider, those benefits are dropped.

**Policy Dividends**

Life insurance policies may be either participating (par) or nonparticipating (non-par). People who purchase participating policies normally encounter slightly higher premiums than those who purchase nonparticipating policies. The reason is that there is an extra charge built into participating policies to cover unexpected contingencies.

Policy dividends are monetary returns stemming from positive operating or investment income. The policy dividend payments, which are never guaranteed and generally not taxable income, are a return of part of the premiums paid. Policy dividends can be taxes when they exceed the cost of the policy.

**Dividend Options [CARP-5 (mnemonic)]**

Insurance Companies generally provide five dividend options to their policyowners.

*Take dividends in cash (Cash)*

Paid on the policy anniversary date, the policyowner who elect to take their dividends in cash receive a dividend check after the insurance company approves the dividend.

*Allow dividends to accumulate at interest (Accumulate at Interest)*

Although policy dividends are not taxable, and interest paid on them is taxable income in the year, the interest is credited to the policy, whether the policyowner receives it or not.

*Apply dividends against premium payments (Reduced Premiums)*

To lower the policyowner’s out-of-pocket expenses, dividends can also be applied directly to the policyowner’s premium payments.

*Use dividends to buy paid-up additions (Paid-up Additions)*

This option is used to purchase paid-up additions of life insurance identical to the original or base policy. The premium rate is based on the insured’s attained-age when the paid-up additions are purchased.

*Use dividends to purchase one-year term insurance (5<sup>th</sup> Dividend Option)*

This dividend option allows the policyowner to buy as much as one-year term insurance at net rates with the dividends received equal to the base policy’s cash value. The 5<sup>th</sup> Dividend Option provision allows for any excess dividend portions to be applied under any of the other regular options.

<b>Dividend Options [CARP-5]</b>
<b>C</b> ash
<b>A</b> ccumulate at Interest
<b>R</b> educe Premiums
<b>P</b> aid-up Additions
<b>5<sup>th</sup></b> Dividend Option

**POLICY RIDERS (MOST POLICY RIDERS COST ADDITIONAL MONEY)**

Most of the optional riders described below must be selected at the time the policy is applied for. The automatic premium loan rider (if it is an option and not a standard policy feature) is the only optional rider available at no cost to the policyowner. It can sometimes be added after the policy is in force.

**Guaranteed Insurability Rider**

Attached to a permanent life insurance policy at the time of purchase, this rider allows the insured to purchase additional insurance at stated age intervals without evidence of insurability.

<b>3-Year Intervals</b>
Ages 25 – 28
Ages 31 – 34
Ages 37 - 40

Beginning with the policy anniversary date nearest the insured’s 25<sup>th</sup> birthday and ending at the anniversary date nearest the insured’s 40<sup>th</sup> birthday, the insured has ninety (90) days to exercise an option to purchase additional insurance without proof of medical insurability. Failure for the insured to purchase additional insurance during an allotted period will not affect future offerings.

**Waiver of Premium Rider (WP)**

The waiver of premium rider, available on permanent and temporary insurance policies, prevents a policy from lapsing for nonpayment of premiums while the insured is disabled and unable to work. If the insured meets the policy’s definition of “totally disabled,” the policyowner is relieved of paying premiums if the disability continues. The waiver may be added to a policy either by rider or endorsement for an additional premium.

Before premiums being waived, the policy must undergo a “waiting period.” This deductible of time is usually ninety (90) days or six months. During this time, the policyowner continues paying premiums. If the insured is still classified as disabled at the end of this period, the company will retroactively refund all the premiums paid by the policyowner from the start of the disability. If the insured recovers and can return to work, premium payments will resume.



A waiver of premium rider generally remains in effect until the insured reaches the age of 60 or 65 (as indicated in the policy). When the provision of waiver of premium expires, the policy premium will be reduced by the additional premium.

#### *Waiver of Monthly Deduction*

Also known as the waiver of cost of insurance rider for flexible premium policies (such as universal life), this rider pays the cost of insurance deductions and the monthly administrative fee that are made from the account value if the insured becomes disabled. Unlike a WP rider on whole life, the rider does not waive the entire premium payment the policyowner may be paying. With a flexible premium policy (placed on waiver of monthly deduction), the policy will stay enforce because the insurer is paying the monthly charges. The cash values continue to grow with the interest that is credited monthly.

#### ***Disability Income Rider***

If an insured is disabled and unable to work, this rider provides a monthly income payment to the insured for the disability duration. The income paid by this rider is not tied to the earnings of the insured. Rather, it is defined as a small percentage of the life insurance policy's face amount to which the rider is attached. This rider normally has a waiting period of 90 days or six months, and the insured must meet the insurer's standard of totally disabled.

#### ***Automatic Premium Loan (APL) Rider***

As discussed earlier in this unit, the automatic premium loan rider is available to the policyowner at no additional charge. If elected by the policyowner, at the time of application, the provision authorizes the insurance company to withdraw from the policy's cash-value the amount of premium due if it has not been paid by the end of the grace period. The amount withdrawn becomes a loan on the policy, and interest will be charged. The policy will eventually lapse when the cash-value is reduced to zero.

#### ***Payor Rider / Payor Provision Rider / Death and Disability Payor Benefit***

A form of waiver of premium that applies to the payor of a juvenile policy. If the payor dies or becomes disabled, the premium will be waived until the child reaches a stipulated age. The child then becomes the owner and is responsible for paying the premium. The payor must prove insurability to purchase this rider, and there is an extra premium for the privilege. The rider drops off when the child reaches age 21 or 25.

#### ***Accidental Death Benefit Rider / Double Indemnity Provision***

This insurance rider/provision provides an additional amount of insurance if death occurs from an "accidental death." "Accidental death" is strictly defined and does not include accidents resulting, directly or indirectly, from a physical disability, ailment, or sickness, relating to the insured. For the policy to trigger a benefit payment, death must occur within a specified time frame, usually ninety (90) days following the accident.

When sold as an accidental death and dismemberment rider, an additional lump sum is payable if the insured loses a qualifying body part (eye, arm, or leg) in a qualifying accident.

#### ***Long Term Care (LTC) Rider***

Attached to a life insurance policy, the LTC rider pays an acceleration of the death benefit, that provides a set monthly income used to help pay for long term needs in long term care facilities. The benefits will be a percentage of the policy's face amount and may or may not cover the actual costs of care. The total benefits paid for this rider cannot exceed the policy face amount.

#### ***Return of Premium (ROP) Rider***

This specific rider provides that in the event of the insured's death within a specified period, the policy will pay, in addition to the face amount, an amount equal to the sum of all premiums paid to date. This rider does not return premiums but pays an additional benefit equal to premiums paid upon the date of death.

#### *Return of Premium Term Life Insurance Policy*

Unlike the return of premium rider, this term policy returns 100% of the premiums paid at the end of a term if no death benefit has been paid. The returned money may be tax-free. If an ROP term life policy is

surrendered, the insured will receive a portion of the premiums in return based on a sliding scale, if the policy has been in force for a few years. If the insured dies during the term, the beneficiaries will receive the death benefit only. They will not receive the additional return of premiums.

### ***Cost of Living Rider (COL / COLA)***

The cost of living (COL) or cost of living adjustment (COLA) rider can provide increases in the amount of insurance protection without requiring the insured to provide evidence of insurability. The increase is tied to an increase in an inflation index, most commonly the Consumer Price Index (CPI). For standard whole life policies, a COL rider is offered as an increasing term insurance rider attached to the base policy. COL agreements are frequently used with adjustable life insurance and other term and whole life policies.

### ***Other Insureds /Term Rider***

A rider useful in providing insurance for more than one family member is the “other insureds rider.” Depending on who is being covered, it is also known as a children’s or family rider. The term rider is attached to the base policy (which can be either a whole life or term policy) covering the primary insured.

**UNIT****10****GROUP LIFE INSURANCE****OVERVIEW**

One of the general categories of insurance is *group insurance*. Group insurance is a way to provide life insurance, health insurance, or both kinds of coverage for several people under on contract. Typically, group insurance is provided by an employer for its employees; however, it is available to other kinds of groups, as we will see. In this unit, we will look at the principles of group insurance in general, focusing specifically on group life insurance plans.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Principles of Group Insurance
- Features of Group Insurance
- Eligible Groups
- Group Life Insurance
- Other Forms of Group Life Coverage

**KEY TERMS**

Annually Renewable Term

Blanket Life Insurance

Certificate of Insurance

Enrollment Period

Experience Rating

Group Credit Life Insurance

Group Ordinary

Group Paid-Up

Group Universal Life

Master Policy

Multiple Employer Trusts

Multiple Employer Welfare Arrangements

Probationary Period

Group insurance is a way to provide life insurance, health insurance, or both kinds of coverage for several people under one contract.

## **PRINCIPLES OF GROUP INSURANCE**

Group insurance provides insurance coverage for a number of people under a single master contract or master policy. The employer is the applicant and contract policyholder. The employees, subscribers, or group members are not parties to the contract. Each employee who is eligible to participate in the plan fills out an enrollment card (application) and is provided a certificate of insurance, which summarized the coverage terms and employee's rights under the group contract.

When an employer pays the entire premium, the plan is categorized as noncontributory. If a group plan requires its members to pay a portion of the premiums, they are thereby contributing; thus, it is a contributory plan.

## **FEATURES OF GROUP INSURANCE**

### ***Master Contract (Same in Group Health)***

In group insurance, the master contract is given to the employer. Individuals insured under the plan receive certificates of insurance to evidence their coverage under the plan.

When establishing a premium for a group plan, underwriters look at an employer's experience rating (previous claims experience). The larger and more homogeneous the group, the closer it comes to reflecting standard morbidity and mortality rates.

### ***Lower Cost***

Due primarily, to the lower administrative, operational, and selling expenses associated with group contracts, group insurance provides more insurance coverage for far less than what one would normally pay for an individual or personal plan.

### ***Flow of insureds***

The number of employees entering and exiting under the policy due to hiring, firing, and retiring. This process assists in keeping the age and health of the group stable.

## **ELIGIBLE GROUPS (SAME IN GROUP HEALTH)**

Natural groups are those formed for a purpose other than to obtain insurance and must have been in existence for at least two years. Groups typically fall into one of the following categories: (1) single-employer groups, (2) multiple-employer groups, (3) labor unions, (4) trade associations, (5) creditor/debtor groups, or (6) fraternal organizations.

Insurance companies often issue coverage to groups with as few as 10 (or fewer) members; however, once a policy is issued, insurance companies usually require that a certain number or percentage of eligible members participate in keeping the coverage in force.

### **Eligibility of Group Members (Same in Group Health)**

Employers and insurance companies may set minimum requirements for group eligibility. For example, employees must be full-time workers and actively at work to be eligible to participate. If the plan is contributory, a plan where the employee pays a portion of the premium, they must authorize payroll deductions for their share.

A probationary period, a time frame where new employees must wait before they can enroll, is designed to minimize the administrative expense involved with those who remain with the employer for only a short period of time. The enrollment period, which follows the probationary period, is when new employees can enroll for the group coverage. If the employee does not enroll during this period (typically 31 days), they may be required to provide evidence of insurability if enrollment is desired later.

## GROUP LIFE INSURANCE

Group life plans may be contributory or noncontributory. If the employer pays the entire premium, the plan is noncontributory. If the employees pay part of the premium, the plan is contributory. Florida law requires 100%

participation by eligible employees in noncontributory group life insurance plans.

### ***Types of Group Term Life***

Group life can be either term or permanent.

#### *Group Term Life*

Annual Renewable Term (ART)

Most group life plans are term insurance. The most common form used in group plans is the annual renewable term (ART) insurance. Coverage is renewed each year without evidence of insurability, and it uses provides for low group cost compared to other products.

#### *Group Permanent Life*

The most common forms of permanent group plans are: (1) group ordinary, (2) group paid-up, and (3) group universal life. Group ordinary is any type of group life plan with cash values. A group paid-up plan is a combination of whole and term life. Usually, the employer pays for the term portion, and the employee's contributions to purchase the whole life. Group Universal life contains the same features as individual universal life, but the policy administration is the same as a group ordinary policy. Characteristic of a group universal life plan is that the employees pay most of the premium; however, they are given certain rights to policy ownership that are not found in ordinary group life plans.

#### **Taxation of Group Life Premiums and Proceeds**

- Employees who are provided with more than \$50,000 of coverage must declare as taxable income the employer's premiums for the excess coverage.
- Proceeds paid under a group life plan to a deceased employee's beneficiary are exempt from income tax if paid in a lump sum. If the proceeds are paid in installments, the interest portion is taxed.
- For a group life insurance plan to receive favorable tax treatment, the plan must benefit at least 70% of all employees. At least 85% of all participating employees must not be key employees.
- Regarding benefits, plans cannot discriminate in favor of key employees.
- If a group life insurance plan fails to meet the nondiscriminatory requirements, the cost of the first \$50,000 of coverage, normally excluded from gross income, will be included in a key employee's gross income for tax purposes.
- Rank-and-file employees are no penalized.

### ***How Are Benefits Determined?***

Most employers will establish a benefit schedule based on one of three possible schedules: (1) earnings, (2) employment position, or (3) flat benefit amount.

#### **Benefit Schedule Options**

	<b>EARNINGS (multiple of salary)</b>	<b>EMPLOYMENT POSITION</b>	<b>FLAT BENEFIT (to all employees)</b>
<b>PHARMACIST</b>	2.5 X	\$100,000	\$55,000
<b>TECHNICIAN</b>	2.0 X	\$75,000	
<b>MANAGER</b>	1.5 X	\$50,000	
<b>ASSOCIATE</b>	1.0 X	\$25,000	

### ***Conversion to Individual Plan***

In Florida, group life policies must contain a conversion provision. This provision allows individual insured members (subscribers) to convert their group coverage to an individual plan without evidence of insurability,

if their employment is severed. Employees have a 31-day period in which to exercise this conversion privilege.

If a group-insured former employee were to die within 31 days after employment termination, the group insurance death benefit would be payable to the employee's beneficiary. Group conversion provisions require the individual to convert to a permanent life policy, as opposed to term. The new policy's premium is based on the individual's attained age at the time of conversion.

## **OTHER FORMS OF GROUP LIFE COVERAGE**

There are a variety of other group life insurance plans available. Some of these options include: (1) credit life insurance plans, (2) blanket life insurance plans, (3) multiple employer trusts (METs), and (4) multiple employer welfare arrangements (MEWAs).

### ***Group Credit Life Insurance***

Issued to creditors to cover the lives of debtors. This form of group insurance uses a type of decreasing term insurance. The policy proceeds are paid to the creditor to settle a remaining loan balance. With this form of coverage, the insurance amount cannot exceed the indebtedness of the loan. Being this is an optional coverage, debtors cannot be forced to take this coverage, and if they do, they have the right to select the insurer of their choice.

### ***Blanket Life Insurance (Same in Group Health)***

A temporary (limited time) form of coverage, blanket life insurance covers a group of people exposed to a common hazard, such as airline passengers, cruise line passengers, students, teachers, sports teams, volunteer fire department newspaper carriers, etc. The insureds are not specifically named in the policy, nor do they receive a certificate of coverage. Members of the group are automatically covered under this plan while participating in the specific hazards named in the policy.

### ***Multiple Employer Trusts (MET) (Same in Group Health)***

Multiple employer trusts (METs) are designed to employ employers who have a small number of employees. METs provide either a single form of insurance (such as life or health insurance) or a wide range of coverages, such as life, disability income, and medical expenses. To obtain coverage, each employer must become a trust member, thus being issued a joinder agreement that spells out the relationship between the trust and the employer. Also, the joinder agreement must specify the coverages to which the employer has subscribed. METs may be self-insured or funded by purchasing benefits from an insurance company.

### ***Multiple Employer Welfare Arrangements (MEWA) (Same in Group Health)***

A multiple employer welfare arrangement (MEWA) is a type of MET for union employees that is self-funded and has tax-exempt status. Employees covered under a MEWA are required by law to have an employment-related common bond.

UNIT

## 7

## LIFE INSURANCE BENEFICIARIES

**OVERVIEW**

A right involved with owning a life insurance policy is the right to name beneficiary. The beneficiary is the party designated to receive the policy's proceeds upon the insured's death. Determining the proper beneficiary is a matter of utmost importance. To counsel their clients competently, life insurance agents must fully understand the laws and the practices involved with naming policy beneficiaries.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Who Can Be a Beneficiary?
- Types of Beneficiary Designations
- Special Situations

**KEY TERMS**

Beneficiary Designation Options

Classifications of Beneficiaries

Common Disaster Provision

Facility-of-Payment Provision

Irrevocable Beneficiary

Per Capita

Per Stirpes

Revocable Beneficiary

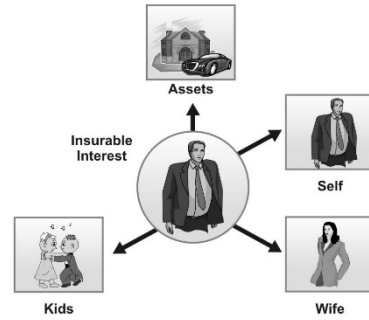
Spendthrift Trust Clause

Uniform Simultaneous Death Act

A right involved with owning a life insurance policy is the ability to name a beneficiary. The beneficiary is the party designated to receive the policy's proceeds upon the insured's death.

### WHO CAN BE A BENEFICIARY?

Anyone you wish. Insurable interest is not necessary when you are the owner and the insured. This is because Florida law states that individuals have an unlimited insurable interest in their own lives. However, when the policy's applicant is not the insured, a third-party applicant exists. When a third-party applicant names themselves as a beneficiary, insurable interest must exist between the applicant and the insured.



#### What is Stranger-Originated Life Insurance (STOLI)?

Engaging in a stranger-originated life insurance practice, an act, practice, arrangement, or agreement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured is prohibited in the State of Florida.

### Individuals as Beneficiaries

An individual may be selected to be the sole beneficiary of a life insurance policy. However, the policyowner can also name more than one beneficiary. For example, a policyowner could designate their spouse as their primary beneficiary and their children as the secondary or contingent beneficiary. In addition, several individuals can be named as primary or contingent beneficiaries if the total percentage of each beneficiary type equals 100%.

**G. BENEFICIARY INFORMATION** (Total percentage of primary beneficiary share must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.)

Individual as a Beneficiary (Complete the table below.)

Name (First, MI, Last)	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

### Businesses as Beneficiaries

Since business relationships are eligible as a form of insurable interest, policyowners may designate a business as a beneficiary.

#### Examples of Business Insurable Interest

	Insurable interest exists
Partnership	Lives of their partners
Corporations	Lives of their key employees
Creditors	Lives of their debtors
Professional Sports Clubs	Players

### Trusts as Beneficiaries

Managed by trustees to handle the trust and its funds for its beneficiaries, a trust is a legal arrangement for the ownership of property by one party for the benefit of another. As a beneficiary, the proceeds will be paid to the trust for the ultimate benefit and use of another.



### ***Estates as Beneficiaries***

When no beneficiary is designated, or all beneficiaries predecease the insured on a life insurance policy, benefits will be paid to the insured's estate. When money enters an estate, and there is no will, the court handling the disposition of that estate is required to distribute the assets according to state law (probate). When proceeds enter an estate, heirs receive them in cash, which is more vulnerable to creditors.

### ***Charities as Beneficiaries***

A benefit of naming a charity as the beneficiary of a life insurance policy is that disgruntled heirs cannot contest the gift.

### ***Minors as Beneficiaries***

In some states, minors are ineligible to receive proceeds until they reach an age of majority because of their inability to sign a valid receipt legally. If an insurance company were to pay out proceeds and not execute a valid receipt, the minor could legally demand a second payment of the benefit.

Insurers recognize that policyowners may want minors to benefit from an insurance policy, therefore in accordance with state laws, insurance company may (1) make limited payments to an adult legal guardian of the minor, (2) retain the policy proceeds with interest and pay them out when the child reaches the majority age, or (3) place the proceeds in a trust for present or future benefit of the minor, and have a court appoint a trustee.

### ***Classes as Beneficiaries***

Instead of specifying one or more beneficiaries by name, policyowners can designate a class or group of beneficiaries. This is known as class designation.

#### **Examples of Beneficiary Class Designations**

<b>Beneficiary Class Designations</b>
"children of the insured"
"my children"

## **TYPES OF BENEFICIARY DESIGNATIONS**

There are several ways to classify beneficiary designations: (1) order of preference (succession), (2) by the number named, (3) by line of descent, or (4) revocable or irrevocable.

### ***Order of Succession***

#### ***Primary Beneficiaries***

The primary beneficiary is the first in line to receive proceeds upon death of the insured. There may be more than one individual named as the primary beneficiary. The percentage of the proceed split is up to the policyowner.

#### ***Secondary (Contingent) Beneficiaries***

The secondary or more commonly known as contingent beneficiary, is the next to receive benefits if no primary beneficiary is living.

#### ***Tertiary (Contingent) Beneficiaries***

Tertiary, also known as a contingent beneficiary, is third in line if no primary or secondary beneficiary predeceases the insured.

If no beneficiary is named, or if all primary and contingent beneficiaries are deceased at the time of the insured's death, the proceeds are paid to the policyowner or the policyowner's estate, if the policyowner is deceased.

### ***Distribution by Descent***

When life insurance proceeds are distributed to a person's descendants, a *per stirpes* or a *per capita* approach is generally used.



## **Changing A Beneficiary**

The right to change a beneficiary designation is a right of ownership.

### *Revocable Beneficiary*

When a beneficiary is labeled as revocable, the policyowner can change whenever they deem desired or needed. A revocable beneficiary has no claim or vested rights on policy proceeds or cash value if the insured is living.

### *Irrevocable Beneficiary*

As an irrevocable beneficiary, the policyowner cannot exercise any right that would affect the beneficiary's vested rights without the beneficiary's written consent. For example, the policyowner cannot change beneficiaries, make a policy loan, or surrender the policy.

Irrevocable clauses can be categorized as absolute or reversionary. When absolute, the beneficiary has an absolute vested interest in the life insurance contract even if the beneficiary predeceases the insured. When reversionary, the right to modify the beneficiary clause and all other rights of ownership reverts to the policyowner when the beneficiary predeceases the policyowner.

### *Procedure for Changing Beneficiaries*

The common method used today in changing beneficiaries is known as the recording method. The policyowner notifies the insurance company in writing of the beneficiary change. When the insurance company records the change, it becomes effective on the date the request was made.

## **SPECIAL SITUATIONS**

### ***Simultaneous Death***

Who died first? What if the insured and the primary beneficiary die in the same accident, and there is no evidence to show who died first? The *Uniform Simultaneous Death Act* stipulates that if the insured and the primary beneficiary die in the same accident, and there is insufficient evidence to show whose death preceded whom, the policy proceeds are to be distributed as if the insured had survived the primary beneficiary and died last.

In Florida, if the insured and primary beneficiary die in the same accident, it is presumed that the insured died last. If the primary beneficiary outlives the insured by a definite period, typically 14 or 30 days, it still assumed the insured died last.

### ***Spendthrift Trust Clause***

The purpose of a spendthrift trust clause is to help protect beneficiaries from the claims of their creditors. The spendthrift trust shelters the life insurance proceeds that have yet to be paid from the beneficiary's or policyowner's creditors' claims.

Benefit proceeds held in a spendthrift trust are paid on an installment basis. Therefore, this protection does not apply to benefits paid in one lump sum. A spendthrift trust clause states that policy distributions payable after the insured dies are not transferable or assignable and may not be attached in any way. This clause protects only the money held in trust by the insurance company earmarked to be paid to the named beneficiary.

### ***Facility of Payment Provision***

Found only in industrial policies, this provision permits an insurer to pay all or a portion of the beneficiary proceeds to someone who has a valid right although not named in the policy.

#### **Examples of Facility-of-Payment Provision Situations**

Named beneficiary is a minor
Named beneficiary is deceased
No claim is submitted within a specified period
Another party incurred costs for the deceased insured's final medical expenses or funeral

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UNIT

## 8

# LIFE INSURANCE PREMIUMS & PROCEEDS

**OVERVIEW**

People buy life insurance for the same basic reason they buy any product; it satisfies a need. In the case of life insurance, the need is financial security. Policyowners pay for this product through premiums. Upon the insured's death, policy proceeds (the "death benefit") are payable to the beneficiary in any one of a variety of ways, depending on the unique situation and needs of the beneficiary. This unit examines these two important aspects of life insurance (premiums and proceeds) and reviews their tax treatment.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Life Insurance Premiums
- Primary Factors in Premium Calculations
- Morality Factor
- Life Insurance Policy Proceeds
- Tax Treatment of Proceeds

**KEY TERMS**

Level Premium Funding  
Premium Factors  
Settlement Options  
Policy Reserves  
Accelerated Benefits  
Viatical Settlement  
Cash Value  
Tax Treatment of Premiums, Cash Values, and Proceeds  
1035 Exchange

## LIFE INSURANCE PREMIUMS

Actuaries establish premiums. These mathematicians interpret financial and statistical data, along with its influence on life and/or health insurance, and establish premium rates so that an insurance company can cover the costs of paying for claims and the operation of a profitable business. Premium rates for life insurance are generally expressed as an annual cost per \$1,000 of face amount.

**Life Insurance Premiums**

Premium rates are generally expressed as an annual cost per \$1,000 of face amount (unit)

**For Example:**

Age/Gender.....35/Male


Face Amount .....\$50,000

Units of insurance.....50 = (\$50,000/\$1,000)

Cost per \$1,000.....\$13.73

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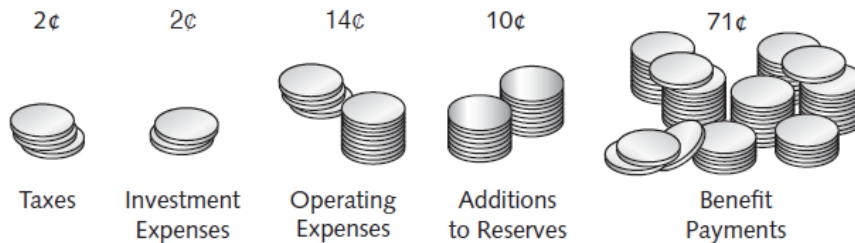
Premium Amount \$13.73 x 50 = \$686.50



## PRIMARY FACTORS IN PREMIUM CALCULATIONS

There are three primary factors used when computing the basic life insurance premium. (1) mortality, (2) interest, and (3) expense. Of these three, only one of them, mortality, has the greatest effect on life insurance rate-making (premium calculations).

### Example of How the Life Insurance Premium Dollar is Used



Source: 2018 ACLI Life Insurers Fact Book

### **Mortality Factor**

Mortality is defined as the average number of deaths that will occur each in each age period in each age group. For a mortality table to be accurate, it must be based on two parts: (1) a large cross-section of people and (2) a large cross-section of time.

A mortality table indicates two primary items: (1) the expectation of life at given ages (average number of years remaining for a group of persons of the same age) and (2) the probability of death (average number of deaths for a group of persons in a given time).

### **Interest Factor**

Assuming that all premiums being paid are at the beginning of the year, an insurance company expects the interest on all investments to be at a specific net rate. That one full year's interest is earned by each premium policyowners pay.

### **Expenses (“Loading”)**

Each life insurance premium must contain a small proportionate share of normal operating costs. These costs, also known as expenses or loading charges, may contain items such as personnel expenses, building maintenance, and taxes.

**Net vs. Gross Premiums**

Actuaries use assumptions and translate them into Net Single Premium (NSP), Net Level Premium (NLP), and Gross Premium (GP). The NSP is defined as the single amount needed today to fund future benefits. The NSP is converted into Net Annual Level (NAL) premiums.

<p><b>Primary Factors in Premium Calculations</b></p> <p><input type="checkbox"/> Net vs Gross Premiums</p> <p>The two key formulas you must know</p> <ul style="list-style-type: none"> <li>▪ <math>NSP = MC - I</math></li> <li>▪ <math>GP = NSP + E</math></li> </ul>	<p>MC = Mortality Cost                  I = Interest                  NSP = Net Single Premium                  GP = Gross Premium                  E = Expense (Loading)</p> <p><i>Gross premium is what the policyowners are required to pay.</i></p>
--	---

**Other Premium Factors**

When evaluating an individual life insurance application, other premium factors must be evaluated. All these factors have some effect on mortality. (1) age, (2) sex (gender), (3) health, (4) occupation, (5) avocation (hobby), and (6) habits.

**Other Premium Factors**

Age	The older the individual, the higher the premium
Sex (gender)	Men pay a higher premium than women Women are a better risk than men since women typically live 5 to 6 years longer.
Health	The poorer the health; the higher the premium
Occupation	The more hazardous; the higher the premium
Avocation (hobby)	The more hazardous; the higher the premium
Habits	If the habit increases the risk; the higher the premium <ul style="list-style-type: none"> <li>- Smoking</li> <li>- Overeating</li> <li>- Reckless driving</li> </ul>

**Methods of Rating Substandard Risks**

There are five main rating systems used when an insurance company needs to adjust premiums for substandard cases. (1) extra percentage tables, (2) permanent flat extra premiums, (3) temporary flat extra premiums, (4) rate-up in age, and (5) liens.

*Extra Percentage Tables: from 125% to 500% of Standard rate.*

This varies from insurance company to insurance company and is the one most widely used today.

**\$50,000 Life Insurance Policy – Age 35**

Standard Rate: \$13.73 per thousand

Rating 1:  $\$13.73 \times 1.25 = \$17.16$  per thousand  $\times 50$  (units) = \$858.13

Rating 2:  $\$13.73 \times 1.50 = \$20.60$  per thousand  $\times 50$  (units) = \$1,029.75

*Permanent Flat Extra Premium: flat dollar amount*

**\$50,000 Life Insurance Policy – Age 35**

Standard Rate: \$13.73 per thousand

Permanent Flat Extra Premium: \$1,000\*

$\$13.73 \times 50$  (units) = \$686.50 + \$1,000\* = \$1,686.50

*\*This does not increase the policy's cash value or non-forfeiture*

*Temporary Flat Extra Premium: flat dollar amount for a specified number of years.*

**\$50,000 Life Insurance Policy – Age 35**  
 Standard Rate: \$13.73 per thousand  
 Temporary Flat Extra Premium: \$1,000\* for the first 5 years of the policy.  
 Years 1–5:  $\$13.73 \times 50 \text{ (units)} = \$686.50 + \$1,000^* = \$1,686.50$   
 Years 6+:  $\$13.73 \times 50 \text{ (units)} = \$686.50$   
 \*This does not increase the policy's cash value or non-forfeiture values.

*Rate-up in age: policy issued with a premium base of an age higher than their attained age.*

**\$50,000 Life Insurance Policy – Age 35**  
 Standard Rate: \$13.73 per thousand  
 Attained Age 35:  $\$13.73 \times 50 \text{ (units)} = \$686.50$   
 Issued Age 40:  $\$17.71 \times 50 \text{ (units)} = \$885.50$

*Lien System: policy issued at standard rates on a substandard applicant, but with a lien against the policy. This rating process is triggered by the insured dying for a cause cited in the policy.*

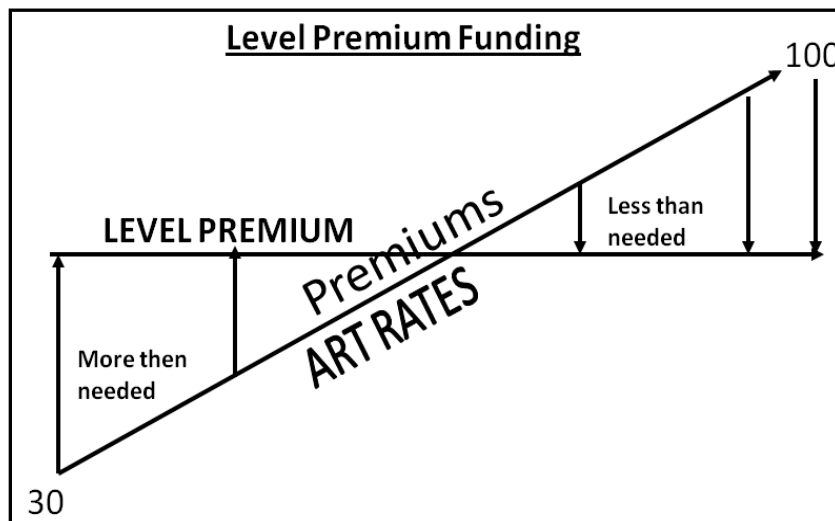
**\$50,000 Life Insurance Policy – Age 35**  
 Standard Rate:  $\$13.73 \text{ per thousand} \times 50 \text{ (units)} = \$686.50$   
 Lien System Rating: \$15,000  
 Trigger: Sky-diving  
 Cause of Death: Skydiving Accident  
 Death Benefit:  $\$35,000 - \$15,000 = \$20,000$

***Level Premium Funding***

Under the level premium funding method, the insured pays more than the insurance protection requires in the policy's early years; in the policy's later years, when the increasing mortality charge would normally increase the premium to a very high level, the excess paid in the early years is used to help fund the additional cost now required.

Level premiums collected under a permanent policy are actuarially equivalent to the sum of the increasing annual renewable term rates for the same insured risk and the same period.

**Level Premium Funding**





**Reserves vs. Cash Values**

There are some common confusions between cash and reserve values.

Reserves	Cash Values
Intangible	Tangible
Liability	Asset
Required to be set aside to ensure money is available to pay future claims	Savings element of a whole life policy

*The policy reserve is the amount which, when added to the present value of future net premiums, will equal the present value of future claims*

**38-Year old Male: Life Expectancy 40 Years (Age 78): \$50,000 Policy**  
 Annual Premium is \$450: Assumed Interest Rate is 4%

1. Present value of the future claim:	\$10,400
2. Present Value of the future premiums:	<u>- 8,900</u>
3. Reserve liability (1-2):	\$ 1,500

**Concept:**

- If you invested \$10,400 in a savings account earning 4% compounded per year, it would grow to \$50,000.
- #3 above represents the company’s reserve liability in the 1<sup>st</sup> year of the policy.
- From then on, part of each premium goes into the Reserve (AKA Cash Value).

**Modes of Premium Payment**

Policyowners typically pay their premiums under one of four premium modes: (1) annually, (2) semiannually, (3) quarterly, or (4) monthly (EFT, ACH, preauthorized check method). A policyowner can change the mode (frequency) on a policy anniversary date. All gross premiums are calculated on an annual basis and are payable in advance. The first full premium is usually paid to the agent at the time the initial application is taken. A conditional binding receipt must be issued. If the premium is not collected at that time, it must be paid when the policy is delivered. Premiums must be paid and current to keep a policy in force.

**Tax Treatment of Premiums**

As a rule, premiums paid for personal life insurance policies are personal expenses and are not deductible from gross income. On the contrary, premiums paid for business life insurance are not deductible. A few exceptions to this rule apply:

Premiums

- paid and owned by qualified charitable organizations are deductible.
- paid by ex-spouse, as alimony, is deductible.
- paid by a business creditor on the life of debtor, is deductible.
- paid by employer for employee group life insurance is deductible.

**Tax Treatment of Cash Values**

Cash value in a permanent policy is not taxed during its period of accumulation inside the policy. If the cash value is taken out while the insured is still living, the amount received is tax-free up to the amount the policyowner paid into the policy as premiums. Any amount in excess is taxed. The sum of the premiums paid is known as the policyowner’s cost basis.

		20 <sup>th</sup> Year Example
Cash value	=	\$47,910
Paid In	=	<u>(\$40,000)</u>
Difference	=	\$7,910
*Taxable as income in the year received.		

## LIFE INSURANCE POLICY PROCEEDS

Life insurance proceeds (the death benefit) can be paid out (settled) in various ways. The policyowner may choose any of the five settlement options. The five settlement options are: (1) lump-sum, (2) interest only, (3) fixed period, (4) fixed amount, and (5) life income.

### Death Benefits

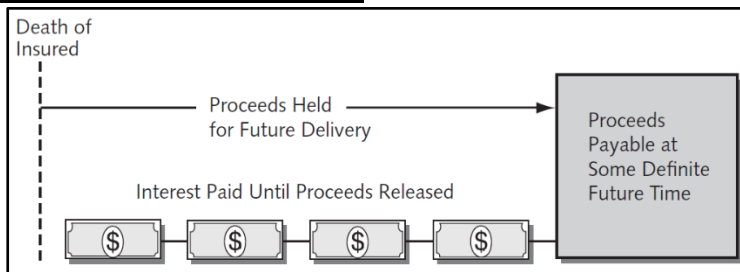
*Lump-sum; one-time single pay-out.*

Although still used today, due to its lack of protection, it is not favored to the extent of other options.

*Interest Only; insurer hold death benefit and pay interest earned on the proceeds only.*

The insurance company pays interest to the beneficiary at a regular interval, usually monthly. This interest-only benefit is recognized as taxable income. A common use of the interest-only option is to have the interest payments made to a surviving spouse for the remainder of that spouse's life, and the proceeds then divided among the children at that spouse's death.

#### Interest-Only Option Illustration

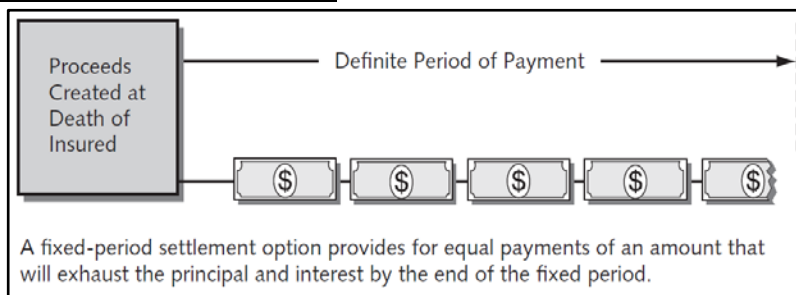


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*Period Fixed; years (Fixed-Period Option)*

Under this option, the insurance company will pay the beneficiary equal payments for a specified period of years. The amount of each payment is based on the length of the desired period of income. The longer the period, the smaller the payment. If excess interest is present, it will result in a larger check. It will not be used to extend the period.

#### Fixed Period Option Illustration

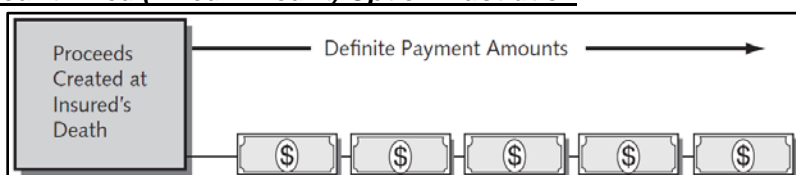


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*Amount Fixed (Fixed-Amount)*

In this settlement scenario, the proceeds (principal) plus interest are used to pay out a specified amount of income. Payments are designed to continue until the proceeds are used up. If any excess interest is credited, it will be used to extend the period, but the payment amount would not change.

#### Amount Fixed (Fixed-Amount) Option Illustration



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*Life Income Option / Single Premium Immediate Annuity (SPIA)*

The purpose of an annuity is to provide an income stream for the duration of an individual's life. With the life income option, the beneficiary receives a guaranteed income for life, no matter how long the beneficiary lives. A benefit of this option is that even if the proceed principal is depleted, income payments will continue to be made if the primary beneficiary is living.

This option is funded by the insurance company using the death benefit to purchase a single payment immediate annuity (SPIA).

**Living Benefits**

In addition to the cash surrender non-forfeiture benefit available to the insured, there are two additional policy benefits. (1) Accelerated benefits, and (2) viatical settlements.

*Accelerated Benefits*

Accelerated benefits provisions are standard in most individual and group life insurance policies. When triggered, terminally or chronically ill insureds will have tax-free access to policy death benefits before their death.

To be considered terminally ill, a physician must certify that the illness or condition can reasonably expect to result in death within two years. To be chronically ill, a licensed health care practitioner must have certified the insured, within the previous 12 months, that the person is (1) unable to perform at least two activities of daily living (ADLs) for at least 90 days, (2) have a similar level of disability as defined by regulations, or (3) require substantial supervision to protect the person from threats to health and safety because of severe cognitive impairment.

*Viatical Settlements*

After a policy has been in force beyond the contestable period, a terminally or chronically ill individual may sell their policies to viatical companies. To ensure fairness, the NAIC has adopted model guidelines; they typically ensure the insured receives 50% to 80% of the policy's face value. Upon transfer of the policy, the viatical company becomes the policyowner and is the premium payer. The company receives the entire death benefit when the insured dies. Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the insured receives the benefits tax-free.

*Life Settlements*

Life settlements are like viatical settlements, except the policyowner is not necessarily terminally or chronically ill. Many states are reclassifying viatical settlements as a form of life settlement. A life settlement transaction transfers an ownership interest in a life insurance policy to a third party for compensation less than the expected death benefit under the policy or the sale of a life insurance policy for a dollar amount that is less than the policy's face. It is important that the life settlement broker ensure that the transaction is suitable and appropriate for the seller. The broker should perform due diligence to obtain and evaluate offers from multiple providers. When a policyowner applies for a life settlement transaction, it is important that proper disclosures be made.

**TAX TREATMENT OF PROCEEDS**

Death benefits paid under a life insurance policy paid to a named beneficiary are generally free of federal income tax. However, interest paid on proceeds left with the insurance company is recognized as taxable income. Additionally, the proceeds paid over an installment basis are recognized as taxable because they include interest earned on the proceeds. Dividends are not taxable, but their interest is taxable in the year the interest is paid.

**Proceeds Paid at the Insured's Death**

When proceeds to an individual are paid out, each payment consists of a principal and interest portion. The portion of the proceeds attributed to interest is taxable, whereas the remaining portion of the proceeds is received tax-free. This method of taxing life insurance proceeds is known as the annuity rule.

Under the annuity rule, a fixed, unchanging fraction of each payment is considered a principal's return and therefore is excluded from gross income for tax purposes. That portion of the proceeds representing the principal is received tax-free. The balance of each payment representing interest income is taxable as

ordinary income. When the insurance company holds the death proceeds of a policy under the interest-only option, the interest payments are taxable as ordinary income to the beneficiary. The principal amount, when it is finally paid out, still represents tax-free income. Accumulated dividends, which are not properly classified as life insurance proceeds, are exempt from federal income tax.

### ***Proceeds Paid During Insured's Lifetime***

Three ways a living insured policyowner might receive proceeds from a life insurance are (1) policy surrender, (2) accelerated benefits, or (3) viatical settlement.

#### *Policy Surrender*

The taxation of accumulated values received when a policyowner surrenders a policy is determined by the policyowner's cost basis. The policyowner's cost basis is figured as total premiums paid, less policy dividends received, less any policy loan, and less extra premiums paid for supplementary benefits. A policyowner who receives the cash value for a surrendered policy must pay taxes on any gains.

Endowment policy proceeds will be partially taxed under the rule of "constructive receipt." The taxable amount will be the excess of the proceeds over the premiums paid. The policyowner has 60 days from the maturity date to exercise an annuity option before the rule takes effect.

### ***Accelerated Death Benefits and Viatical Arrangements***

Accelerated death benefits that terminally or chronically ill insureds receive from a life insurance policy may be tax-free. There is a limit on the maximum amount of accelerated benefits that can be excluded from income for chronically ill insureds. The income tax treatment of viaticals varies by state. In Florida, the law requires viatical settlement brokers and providers to inform viators that the proceeds of a viatical settlement could be taxable and that a professional tax advisor's services should be sought.

### ***1035 Policy Exchanges***

A provision of the Internal Revenue Code (IRC) allows for exchanging a life insurance policy for a "like-kind" policy without being taxed. This part of the Tax Code, known as Section 1035, stipulates that no gain (or loss) will be recognized if the exchange meets specified guidelines.

The following kinds of exchanges are allowed under this IRS code.

- (a) A life insurance policy for another life insurance policy, endowment policy, or annuity contract.
- (b) An endowment policy for an annuity contract.
- (c) An annuity contract for another annuity contract. An annuity contract cannot be exchanged for a life insurance contract.

#### ***Simplifying: 1035 Exchanges***

(For this illustration, think of endowments as life insurance)

Like policies can always be 1035  
 "LIFE" to "LIFE"  
 "ANNUITY" to "ANNUITY"

**If you ever see the word "LIFE" first, then this is a valid 1035**

"LIFE" to "LIFE" – valid 1035 Exchange  
 "ANNUITY" to "ANNUITY" – valid 1035 Exchange  
 "LIFE" to "ANNUITY" – valid 1035 Exchange

"ANNUITY" to "LIFE" – **NOT VALID**, the word "LIFE" was **NOT** first

### ***Life Insurance and the Insured's Estate***

Life insurance death benefits are federal income tax-free. However, when an insured dies, the value of any life insurance policy, along with any accumulated policy dividends, are included in their gross estate for federal estate tax purposes.

UNIT

## 11

## ANNUITIES

**OVERVIEW**

There are several options available when it comes to deciding how the proceeds of a life insurance policy are to be paid out or “settled.” One such option is the life income option. This option provides beneficiaries an important guarantee: they can never outlive the income provided under the contract. When individuals select a life income option, they are using proceeds to purchase an annuity and selecting an annuity payout option. Annuities are a means of providing a stream of income for a guaranteed period, a period which is most typically defined in terms of the recipient’s life.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Purpose and Function of Annuities
- Annuity Basics
- Structure and Design of Annuities
- Income Taxation of Annuity Benefits
- Uses of Annuities

**KEY TERMS**

Annuity Payout Options  
Indexed Annuities  
Exclusion Ratio  
Fixed and Variable Annuities  
Immediate and Deferred Annuities  
Periodic Payment Annuities  
Single-Premium Annuities  
Taxation of Annuities  
Tax-Sheltered Annuities

## PURPOSE AND FUNCTION OF ANNUITIES

An annuity is a mathematical concept used as a vehicle for liquidating a sum of money. An important factor with an annuity is the interest. The sum of money not yet been paid out is earning interest. That interest is also passed on to the annuitant (recipient) as income.

To calculate the payment amount of an annuity, all that is needed to be known is the original or starting sum (principal), the length of the payout period (income period), and an assumed rate of interest (interest).

Because of their experience with mortality tables, only life insurance companies are qualified to combine an extra factor into the standard annuity calculation. This factor is called a “survivorship” factor. Like the mortality factor, the concept provides insurance companies with the means to guarantee annuity payments for life, regardless of how long that life is.

### **Annuities vs. Life Insurance**

Annuities are not life insurance contracts. They look similar, but in theory, they are mirror images. Life insurance creates an estate (a sum of money), whereas an annuity liquidates it. Life insurance is concerned with when you will die. Annuities are concerned with how long you will live.

## ANNUITY BASICS

Annuities are primarily an investment product. They are simply cash contract with an insurance company. The annuities are funded with either a single sum or periodic payment wherefore, the insurance company then credits the annuity fund with a non-taxable rate of interest. Most annuities guarantee a death benefit payable if the annuitant dies before payout begins; however, it is usually limited to the amount paid into the contract plus interest credited.

There are two distinct periods involved with an annuity: (1) accumulation period and (2) annuity period. The accumulation period is the pay-in period, whereas the annuity period is the payout period. The benefits paid out can be monthly (most common), quarterly, semi-annually, or annually.

## STRUCTURE AND DESIGN OF ANNUITIES

To best meet the needs of the purchaser, annuities may be structured and designed in one of four options: (1) funding method, (2) date annuity benefit payments begin, (3) investment configuration, and (4) payment options.

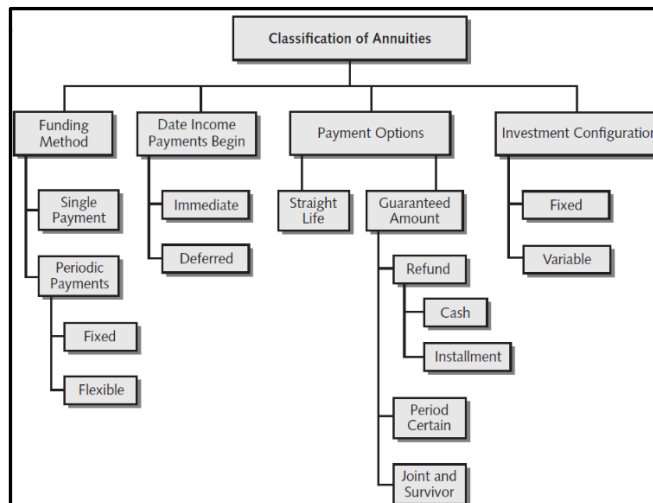
Funding method: A single lump-sum payment or periodic payment over time.

Date annuity benefit payments begin: A benefit payment that is immediate or deferred until a future date.

Investment configuration: A fixed (guaranteed) rate of return or a variable (nonguaranteed) rate of return.

Payment options: A specified term of years or for life, or a combination of both.

Annuities Classification Chart



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## ***Funding Method***

An annuity begins with a sum of money, called the principal sum. Annuity principal is created (or funded) in one of two ways: immediately with a single premium or overtime with a series of periodic premiums.

### *Single-Premium*

An annuity can be funded with a single lump-sum premium. This type of funding will result in the principal sum being created immediately.

### *Flexible (and Periodic) Payments*

The purpose of this type of funding is to create a certain amount of periodic annuity income. With flexible premium annuities, the benefit is expressed in terms of accumulated value. Annuities can also be funded through a series of period premiums that will create the annuity principal fund.

## ***Date Annuity Income Payments Begin***

Annuities can be classified by the date the income payments to the annuitant begin. Depending on the contract, annuity payments can begin immediately or deferred to a future date.

### *Immediate Annuities*

Since an immediate annuity typically pays its first payment one month from the purchase date, it is designed to have a relatively short accumulation period. Besides, immediate annuities can only be funded with a single payment and are often called single-premium immediate annuities, or SPIAs.

### *Deferred Annuities*

Deferred annuities are designed to provide an income payment at some specified future date. These types of annuities are funded with periodic payments over time. Periodic payment annuities are commonly called flexible premium deferred annuities (FPDAs). Deferred annuities can also be funded with single premiums, in which case they are known as single-premium deferred annuities (SPDAs).

Suppose a contract holder wishes to liquidate funds in their deferred annuities contract. In that case, they are typically assessed a surrender charge, which covers the costs associated with the selling and issuing of the annuity contract. Some annuities may offer a bailout provision that allows the annuity owner to surrender the annuity without surrender charges if the interest rates drop a specified amount within a specified period.

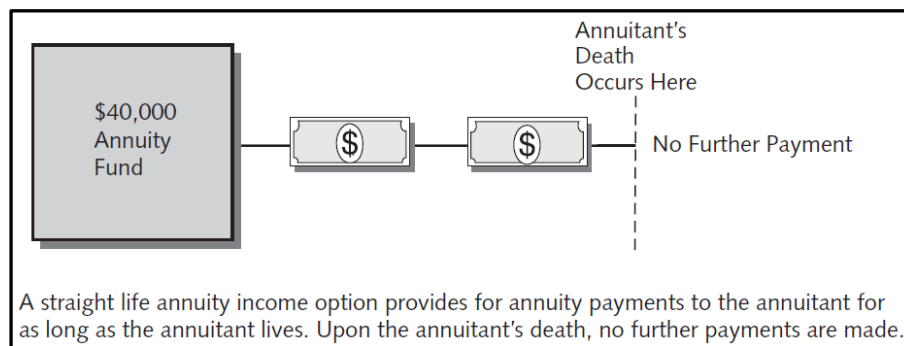
## ***Annuity Payout Options***

Annuitants have various income payout options. For example: (1) straight life income, (2) cash refund, (3) installment refund, (4) life with period certain, (5) joint and survivorship, and (6) period certain.

### *Straight Life Income Option*

A straight life income annuity option (often called a life annuity or a straight life annuity) pays the annuitant a guaranteed income for the annuitant's lifetime.

### ***Straight Life Income Option***

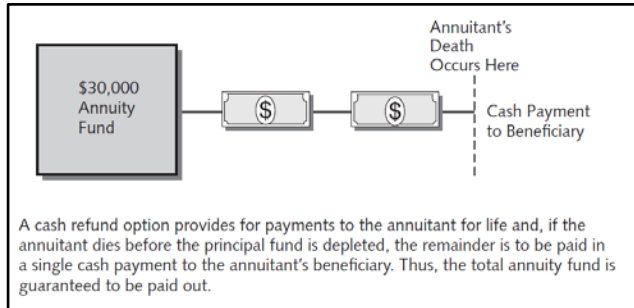


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**Cash Refund Option**

A cash refund option provides a guaranteed income to the annuitant for life. If the annuitant dies before the annuity fund (i.e., the principal) is depleted, a lump-sum cash payment of the remainder is made to the annuitant's beneficiary. Thus, the beneficiary receives an amount equal to the beginning annuity fund less than the amount of income already paid to the deceased annuitant.

**Cash Refund Option**

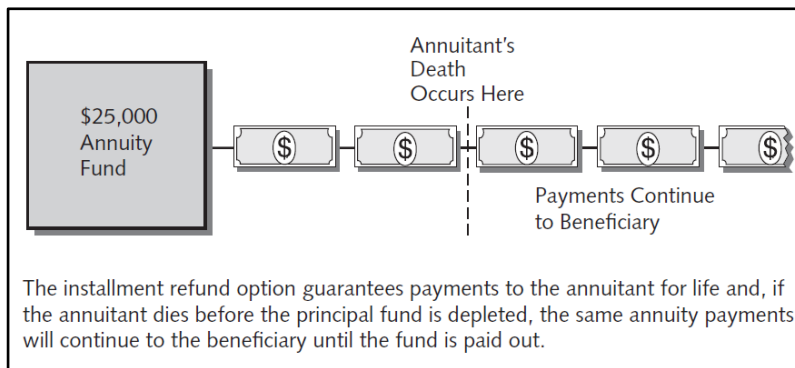


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**Installment Refund Option**

The installment refund option guarantees that the total annuity fund will be paid to the annuitant or the annuitant's beneficiary. Under this option, the fund remaining at the annuitant's death is paid to the beneficiary in the form of continued annuity payments, not a single lump sum. Under the cash refund or installment refund option, if the annuitant lives to receive payments equal to the principal amount, no future payments will be made to a beneficiary.

**Installment Refund Option**

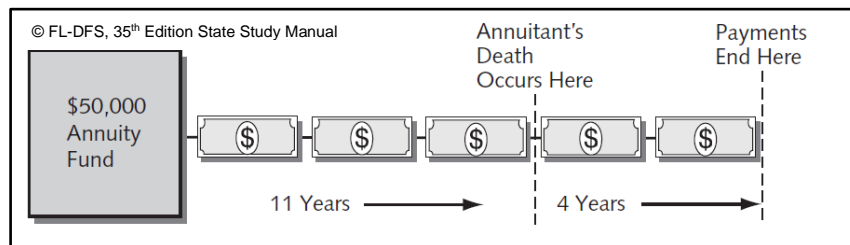


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**Life with Period Certain Option**

Life income with term certain option, this payout approach is designed to pay the annuitant an income for life but guarantees a definite minimum period of payments.

**Life with Period Certain Option**

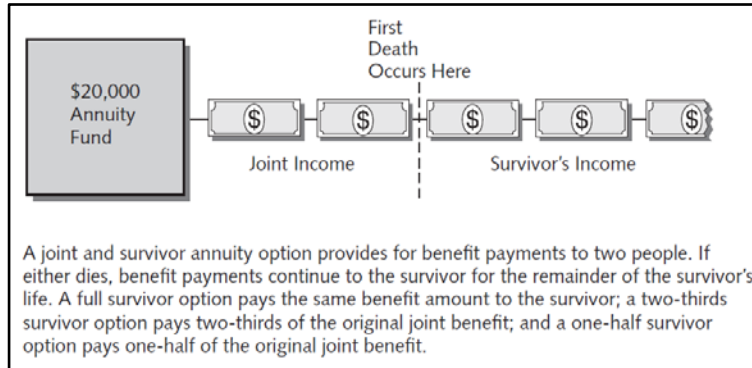


The life with period certain annuity option provides income to the annuitant for life but guarantees a minimum period of payments. Thus, if the annuitant dies during the specified period, benefit payments continue to the beneficiary for the remainder of the period.



***Joint and Full Survivor Option***

Joint and full survivor option provides for payment of the annuity to two people. If either person dies, the same income payments continue to the survivor for life. When the surviving annuitant dies, no further payments are made to anyone. Additional options for joint arrangements include: (1) joint and two-thirds survivor and (2) joint and one-half survivor.

**Joint and Survivor Option**

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***Period Certain Option***

A period certain income option guarantees benefit payments for a certain period whether the annuitant is living. At the end of the specified term, payments end.

***Investment Configuration***

Annuities can be defined according to their investment configuration. Two classifications are (1) fixed annuities and (2) variable annuities. Indexed annuities, a form of fixed annuity, is a new and popular configuration.

***Fixed Annuities***

Fixed annuities provide a guaranteed rate of return. For example, \$500 per month for life. During the period in which the annuitant is making payments to fund the annuity (the accumulation period), the insurer invests these payments in conservative, long-term securities (typically bonds). Fixed annuity has two interest rates: (1) minimum guaranteed rate and (2) current rate. The current rate is what the insurer credits to the annuity on a regular schedule. The current rate will never be lower than the minimum rate, which the insurer guarantees. The insurer bears the investment risk, and the payments are invested in the company's general accounts.

***Variable Annuities***

Developed to provide a hedge against inflation, variable annuities shift the investment risk from the insurer to the contract owner. Unlike fixed annuities, where payments are invested in the company's general account, variable annuities invest deferred annuity payments in a company's separate account. Because variable annuities are based on non-guaranteed equity investment, such as common stock, a sales representative who wants to sell such contracts must be registered with the Financial Industry Regulatory Authority (FINRA) and hold a state insurance license.

***Accumulation Units (Pay-in period)***

Within a variable annuity, contributions made by the annuitant during the accumulation period, less a deduction for expenses, are credited to the individual account as accumulation units. One accumulation unit's value is found by dividing the total value of the company's separate account by the total number of accumulation units outstanding.

***Annuity Units (Pay-out period; Client receives payments out of the annuity).***

When variable annuity benefits are to be paid out to the annuitant, the accumulation units in the participant's individual account are converted into annuity units. At the time of initial payout, the annuity unit calculation is made, and, from then on, the number of annuity units remains the same for that annuitant. However, the dollar value of the unit may fluctuate, thus causing the amount of the monthly check will vary.

### *Indexed Annuities (IA)*

An indexed annuity is a form of fixed annuity that provides the potential of higher credited rates of return and guarantees the owner's principal. Its primary purpose is accumulation. The interest credit to an indexed annuity is tied to the Standard & Poor's 500 Composite Stock Price Index.

To understand index products, there are some special terminology that you must be familiar with: (1) participation rates, (2) spread, (3) cap, (4) floor, (5) ratcheting, and (6) point-to-point.

*Participation rates.* The percentage of the index that is credited to values.

For example: If the participation rate is 80% and the stock market moves up 10%, the cash value would only move up 8%

*Spread.* Often expressed as an interest rate, it is subtracted from the percentage increase in the stock index.

For example: If the index increases by 20% but the spread is 4%, the contract cash values will go up 20% minus 4%, or 16%.

*Cap.* A limit, usually expressed as a percentage, on the increase in cash value.

For example: If the stock index rises 25%, but there is a 20% cap, the cash value will rise a maximum of 20%.

*Floor.* A limit, often shown as a percentage per year on the decrease in cash values over a specific period.

For example: If the stock index drops 15%, but there is a 10% floor, the cash value will drop a maximum of 10%.

*Ratcheting.* This guarantees that past increases in accumulated cash value, the previous years, will not be lost. The ratcheting effectively sets the previous value as a minimum floor, limiting the drop-in values; sometimes, it precludes all drops, allowing only gains.

*Point-to-point.* A point-to-point crediting method ignores all the values between anniversaries and base the credited interest entirely upon the change from one anniversary to the next. Contracts that do not use point-to-point usually use averages of stock market indices.

For Example: The average of all the index values at the first of each month, which would be compared with the average of the first-of-month values from the previous year to determine the change. Some contracts offer multiple funds simultaneously. These are often a combination of indexed and declared-rate funds, often called "cash value strategies" contracts.

## **INCOME TAXATION OF ANNUITY BENEFITS**

Annuity benefit payments are a combination of principal and interest. They are taxed in a manner consistent with other types of income: the portion of the benefit payments that represents a return of principal are not taxed; the portion representing interest earned on the declining principal is taxed.

The unique advantage of annuity taxation compared with other financial products is that it accumulates earnings on a tax-deferred basis; that is, no taxes are imposed until benefits are distributed. This method of taxation is called 'last-in, first-out' (LIFO). To discourage early withdrawal from annuities, a 10% penalty tax is imposed on withdrawals from a deferred annuity made before age 59½.

Annuity distributions that involve payments for life (straight life income, refund, life with period certain, or joint and survivor) are called annuitized settlements. Such settlements are not taxed using the LIFO and penalty method. Rather, they are taxed using an exclusion ratio applied to each payment the annuitant receives.

**Exclusion Ratio (Fixed Annuity Only)**

$\frac{\text{Investment in the contract}}{\text{Expected return}} = \text{Exclusion ratio}$	$\frac{\$100,000}{\$300,000} = \frac{1}{3} \text{ or } 33\frac{1}{3}\%$
---	---

The investment in the contract is divided by the expected return.  
The result is the exclusion percentage applied to each payment.

**1035 Contract Exchanges**

Section 1035 of the Internal Revenue Code provides tax-free exchanges of certain kinds of financial products, including annuity contracts. As discussed previously, no gain will be recognized (taxed) if an annuity contract is exchanged for another annuity contract or if a life insurance or endowment policy is exchanged for an annuity contract. An annuity contract cannot be exchanged tax-free for a life insurance contract. This is not an acceptable exchange under Section 1035.

**USE OF ANNUITIES*****Individual Uses***

The principal use of an annuity is to provide income for retirement. An annuity is designed to liquidate principal, but in a structured, systematic way that guarantees it will last a lifetime. As accumulation vehicles, annuities offer safety of principal, tax deferral, diversification, competitive yields, and liquidity. As distribution vehicles, they offer various payout options, which can be structured to conform to certain payment amounts or certain payment periods. Annuities are designed to create and accumulate income for retirement and special funds such as a college education.

***Qualified Annuity Plans***

Established by an employer to provide retirement plans for employees, this qualified annuity plan has been designed to meet government requirements. Qualified annuity plans are purchased as part of a tax-qualified individual or employer-sponsored retirement plan such as an individual retirement account (IRA), a tax-sheltered account (TSA), or another IRS-recognized plan.

A tax-sheltered annuity (TSA) is a special type of retirement plan for nonprofit organizations known as "403(b) plans" or 501(c)(3) plans. Whether made by the employer or the employee, the contributions are excludable from the employees' current taxable income. However, they are treated as taxable income when received.

TSAs and IRAs, annuities are an acceptable funding mechanism for other qualified plans, including pensions and 401(k) plans.

***Structured settlements***

Annuities are also used to distribute funds from the settlement of lawsuits or the winnings of lotteries and other contests. Such arrangements are called structured settlements.

***Annuity Investments Recommendations***

The State Legislature has established standards and procedures to ensure that recommendations appropriately address the insurance needs and financial objectives made to a consumer at the time of the transaction.

Agents are required to maintain procedures that are reasonably designed to detect or prevent violations of this law and get a disclaimer signed by the consumer if they do not wish to follow their recommended actions.

Agents are also required to maintain records relating to such transactions for five years. The insurer may maintain these records on behalf of the agent.

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UNIT**28****FLORIDA LAWS AND RULES  
PERTINENT TO VARIABLE  
CONTRACTS****OVERVIEW**

The Florida insurance exam for variable insurance contracts contains several topics that are common to the life agent exam. Many of the items discussed in this unit have been discussed previously in unit 11, thus they will not be discussed again here.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Introduction to Variable Products and Definitions
- Annuities
- Variable Annuities
- Regulation and Licensing
- Marketing Practices and Suitability

**KEY TERMS**

Accumulation Unit  
Annuity Unit  
Exclusion Ratio  
Fixed Premium Variable Life

Flexible Premium Variable Life  
Regulation and Licensing Requirements  
Role of the SEC  
Separate Account  
Variable Annuity

## INTRODUCTION TO VARIABLE PRODUCTS AND DEFINITIONS

Florida statute defines variable insurance contracts as contracts that derive their product values largely from the investment performance of a family of investment portfolios, called separate accounts.

*Indeterminate value contracts.* Annuity contracts, life insurance contracts, and contracts upon the lives of beneficiaries under life insurance contracts when such annuities or contracts provide variable or indeterminate benefits, premiums, or values.

*Variable contracts.* An indeterminate value contract for which assets are held in a separate account.

### **Separate Account**

A central element of all variable products that is created by either an insurer or investment company. The account contains a group of managed investment portfolios that fluctuate with the volatility of the market.

### **Fixed Premium Variable Life**

Also called scheduled premium variable life, variable whole life, or just variable life is a variable insurance contract built on a whole life contract framework. Fixed premium variable life has fixed, level, and required premiums, set by the insurer as to timing and amount. As with whole life, if a required premium is missed, the policy will lapse after the grace period. Fixed premium variable life insurance also has a fixed and level death benefit, called the guaranteed minimum death benefit, which runs to age 100 like whole life.

### **Flexible-Premium Variable Life**

Also called variable universal life, this contract is built on a universal life framework. Variable universal life policies are characterized by flexible premiums, which can be increased, decreased, or even omitted at will by the policyowner. Universal life policies do not lapse when a premium if the cash value is sufficient to pay the monthly mortality expense charge and monthly administrative fee. Variable universal policies have adjustable death benefits that may be increased or decreased at will by the policyowner.

Variable universal life policies have the same dual death benefit options as other universal life policies.

## ANNUITIES

*This section was discussed previously in unit 11. Please review unit 11 or the state study manual for additional information or material.*

### **VARIABLE ANNUITIES**

A variable annuity is an investment contract. The purchaser's account value and annuity benefits increase or decrease according to an underlying portfolio's investment performance, often common stocks. The basic tenet of the investment base of variable annuities is that as common stock price levels fluctuate with general price levels, the annuity payments, which are determined by the common stock performance, will provide an effective long-run inflation hedge.

The values in a variable annuity are expressed in terms of units rather than dollars. There are two types of units: (1) accumulation units and (2) annuity units.

Common stocks represent ownership in the companies that issue them. They promise no fixed rate of return on investment. If the company prospers, its shares of common stock will increase in value; if the company does not prosper, its shares will generally decrease and may even become worthless.

Bonds are instruments reflecting a debtor relationship. They carry a fixed coupon, or rate of return on investment, and generally have a fixed maturity date on which the principal amount will be repaid.

## **Accumulation Units Defined**

### *Accumulation Period*

Period during which funds accumulate (from contract's issue date to start of payments).

### *Accumulation Units (Pay-in period)*

Premiums paid into the company, less a deduction for expenses, are converted to accumulation units and credited to the individual's account.

### *Annuity Units (Pay-out period)*

Annuity units denote the number of shares of the funds an annuitant will receive from a variable annuity account after the accumulation period ends and benefits begin. A formula is used to convert accumulation units to annuity units.

### *Assumed Interest Rate (AIR)*

An arbitrary rate of return set by the insurer for any separate account it establishes. The AIR serves as an additional expense load for the benefit of the insurer. The AIR does not apply to all the values of a variable product.

For variable life, the AIR applies to the variable death benefit, but not to the variable cash value. For variable annuity, the AIR applies to the variable annuity unit value and any payouts, but not to the variable accumulation value.

## **Annuity Guarantees**

All annuities, including variable annuities, provide some guarantees. Most modern annuities will offer many additional guarantees either as contract provisions or as riders added for an additional premium. Two common guarantees are (1) accumulation death benefit and (2) maximum expenses and loads.

### *Accumulation Death Benefit*

A guarantee that the contract owners cannot suffer a principal loss if they should die during the accumulation period. The guarantee is a small life insurance commitment built into the annuity that says that should the contract owner die during the accumulation period; the insurer guarantees to pay a named beneficiary the account value or the basis (sum of the premiums), whichever is larger.

### *Maximum Expenses and Loads*

This is a disclosure guarantee. It states that the insurance company affirms that all expenses, loads, or other charges that may occur are disclosed in writing in the contract. The insurance company can choose to charge less than the amount disclosed, but nothing greater.

## **REGULATION AND LICENSING**

A Company that issues variable annuities may be chartered as a life insurance company or a variable annuity company and authorized to do business in Florida. Companies that engage in the sale of variable contracts are subject to federal regulation by the Securities and Exchange Commission (SEC) and Florida's Office of Insurance Regulation (OIR).

Agents must obtain both a federal securities license, issued by the Financial Industry Regulatory Authority (FINRA) and a Florida life (including annuities and variable contracts) license from the Florida Department of Financial Services (FL-DFS). No person may sell variable contracts in Florida unless duly licensed and is appointed as a life agent.

The Office of Insurance Regulation regulates insurers. The Security and Exchange Commission regulates the separate accounts. Both the Financial Industry Regulatory Authority and the Florida Department of Financial Services regulates the securities and variable licensed agents.

## **MARKETING PRACTICES AND SUITABILITY**

### ***Prospectus***

Before the act of selling a variable life or annuity product commences, the agent must furnish a prospectus to the prospect. A prospectus contains information about the nature and purpose of the insurance or annuity plan, the separate account, and the risk involved. It is prepared and furnished by the insurance company and reviewed by the SEC.

### ***Agent's Identification on Annuity Contracts***

Florida law requires that an application for an insurance policy or an annuity contract display the name of the insuring entity prominently on the first page of the application. The name and license identification number of the agent shall be typed, printed, stamped, or legibly handwritten on the application.

### ***Change of Address***

All the following must be reported in writing to the department within 30 days:

- a. Name change
- b. Change of residence address.
- c. Change of principal business street address or mailing address.
- d. Change of contact telephone numbers (including business phone number), or
- e. Change of e-mail address.

Failure to comply with this 30-day rule can result in penalties of up to \$250 for the first offense and at least \$500 for subsequent violations, which can also result in the suspension or revocation of the license.

### ***Suitability***

An agent is required to have a reasonable basis for believing the recommendation is suitable for the consumer based on facts provided by the consumer. Florida law states that this information must be collected on a form adopted by the Department of Financial Services and signed by the applicant and agent.

Suppose the consumer chooses not to provide any of the requested information. In that case, the agent must obtain from the consumer a signed verification form that the consumer refuses to provide the requested information and may be limiting protections regarding the sale's suitability. An agent is prohibited from dissuading or attempting to dissuade a consumer from truthfully responding to the insurer's request for suitability information, from filing a complaint, or from cooperating with the investigation of a complaint.

Where the consumer is exchanging or replacing an existing annuity, an agent must specifically consider whether the consumer will incur a surrender charge, be subject to commencement of a new surrender period, lose existing benefits, be subject to increased fees, benefit from product enhancements, or has recently had another annuity exchange or replacement.

An annuity policy sold to a senior (older than 65) consumer may not include a surrender charge or deferred sales charge for a withdrawal of money from an annuity more than 10% of the amount withdrawn with certain exceptions.

### ***Replacement or Exchange of Annuity Contracts***

In transactions involving the replacement or exchange of an annuity contract, the agent must provide, on an approved form, information concerning differences between the existing annuity contract and the one being recommended. Also, an agent must disclose if there may be any tax consequences as a result of the purpose or exchange, and that the applicant should consult a tax advisor for more information.

### ***Income Tax Treatment of Benefits***

All cash value life insurance policies defer any taxes on the growth of cash value inside the policies. With all annuities, income taxes are similarly deferred during the accumulation period. When annuities begin distribution, the taxation method will depend on the type of distribution taken by the annuitant. Gains distributed from life insurance cash value or annuity account value will be taxed as ordinary income in the year received.



UNIT**13****RETIREMENT PLANS****OVERVIEW**

Social Security benefits should be regarded as a basic floor of financial protection and not as a source that alone can provide a meaningful standard of living. Individuals must take the initiative if they want full security in meeting financial challenges. This means maintaining adequate life insurance to meet the costs of death, health insurance to cover the expenses of becoming ill, and a well-planned retirement program to maintain a desired standard of living when employment income ceases. In this unit, we will discuss the broad topic of retirement plans.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Qualified Versus Nonqualified Plans
- Qualified Employer Retirement Plans
- Qualified Plans for the Small Employer
- Individual Retirement Plans

**KEY TERMS**

401(k) Plans

457 Plans

Defined Benefit Plans

Defined Contribution Plans

Keogh Plans

Minimum Participation Standards

Qualified Versus Non-Qualified Retirement Plans

Rollover IRAs

Roth IRAs

SEP Plans

SIMPLE Plans

Spousal IRAs

Tax-Sheltered Annuity Plans --- 403(b) Plans

Traditional IRAs

Vesting

Retirement plans can be divided into two categories: (1) qualified plans and (2) nonqualified plans. Qualified plans meet certain requirements established by the federal government and receive favorable tax treatment. If a plan does not meet the specific requirements set forth by the federal government, it is termed a nonqualified plan and, thus, is not eligible for favorable tax treatment.

Four important fact about qualified plans:

1. Employer contributions are considered a deductible business expense; thus, lowers the business's income taxes.
2. The earnings of a qualified plan are deferred from current income taxation.
3. Employer contributions to a qualified plan are not currently taxable to the employee in the years they are contributed; however, they are taxable when paid out as a benefit.
4. Contributions to an individual qualified plan, such as an IRA or annuity, are deductible from income under certain conditions.

## QUALIFIED EMPLOYER RETIREMENT PLANS

An employer retirement plan is one that a business makes available to its employees. Typically, the employer makes all or a portion of the contributions on behalf of its employees and can deduct these contributions as ordinary and necessary business expenses. The employees are not taxed on the contributions made on their behalf, nor are they taxed on the benefit fund accruing to them until it is paid out. Additionally, an individual employee's contributions to a qualified employer retirement plan are not included in the individual's ordinary income and therefore are not taxable.

### **Basic Concepts**

*Employee Retirement Income Security Act of 1974 (ERISA)*

The purpose of ERISA is to protect the rights of workers covered under an employer-sponsored plan. ERISA imposes many requirements that retirement plans must follow to obtain IRS approval as a qualified plan eligible for favorable tax treatment. There are five (5) basic concepts that should be addressed. (1) participation, (2) coverage, (3) vesting, (4) funding, and (5) contributions.

### **General Qualification Requirements for Employer-Sponsored Retirement Plans**

- A plan must be written.
- A plan must be in effect.
- A plan must be communicated to employees.
- A plan must be established by the employer.
- Contributions must be made by the employer, the employees, or both.
- A plan must be for the exclusive benefit of the employees.
- A plan must be permanent.
- Any life insurance benefits must be incidental to retirement benefits.
- Minimum participation standards must be met.
- A plan must not discriminate in coverage.
- A plan must not discriminate in contributions or benefits on the basis of income or gender.
- Annuity payments under a plan must be available in the form of a joint and survivor annuity.
- Comprehensive vesting standards concerning the vesting of an employee's benefits must be followed.
- Minimum funding standards must be met.
- A plan must comply with limitations on contributions and benefits.
- There must be no assignment or alienation of benefits.
- A plan must meet Social Security integration rules.
- A plan must meet rules for mergers and consolidations.
- A plan must meet rules for multi-employer plans.
- A plan must meet rules pertaining to the reduction of benefits because of Social Security.
- A plan must fulfill plan termination requirements.
- A plan must fulfill special requirements for particular plans.
- A top-heavy plan must contain contingency provisions.

**Participation Standards**

All qualified employer plans must comply with minimum participation standards designed to determine employee eligibility. In general, employees who have reached age 21 and have completed one year of service must be allowed to enroll in a qualified plan. If the plan provides 100% vesting upon participation, they may be required to complete two years of service before enrolling.

**Coverage Requirements**

The purpose of coverage requirements is to prevent a plan from discriminating against rank-and-file employees in favor of the “elite” (shareholders, officers, and highly compensated employees) whose positions often enable them to make basic policy decisions regarding the plan. The IRS will subject these plans to coverage tests to determine if they are discriminatory.

**Vesting Schedules**

Vesting is defined as an employees’ legal right to a present or future payment, asset, or benefit. Once vested, the funds belong to the employee and cannot be taken away. An employer may choose between two types of vesting schedules: (1) cliff vesting and (2) grade vesting.

**Cliff Vesting.** Under a cliff-vesting schedule for employer contributions, such as profit-sharing contributions and employer matching contributions, the employee becomes fully vested at a specified time, such as after five years of service. If the employee leaves the company before that time, the employee will not receive any of the employer contributions.

**Graded Vesting.** Under a graded-vesting schedule for employer matching contributions, the employee is 20% vested in employer contributions after completing two years of vesting service. The vesting is increased by 20% for each subsequent year until it reaches 100%, which occurs after six years of service.

**Vesting Schedules**

Regular Employer Contributions			
Five-Year Cliff Vesting		Seven-Year Graded Vesting	
Years of Vesting Service	Vested %	Years of Vesting Service	Vested %
1	0	1	0
2	0	2	0
3	0	3	20
4	0	4	40
5+	100	5	60
		6	80
		7+	100

Employer Matching Contributions			
Two-Year Cliff Vesting		Six-Year Graded Vesting	
Years of Vesting Service	Vested %	Years of Vesting Service	Vested %
1	0	1	0
2+	100	2	20
		3	40
		4	60
		5	80
		6+	100

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**Funding Standards**

Qualified plans must be funded; thus, there must be real contributions on the part of the employee, the employer, or both. In addition, the funds must be held by a third party and invested. Federal minimum funding requirements are set to ensure that an employer’s annual contributions to a pension plan are sufficient enough to cover the costs of benefits payable during the year, plus administrative expenses.

### *Contributions*

Qualification standards regarding the amount and type of contributions that can be made vary depending on whether the plan is a defined contribution plan or a defined benefit plan.

### **Defined Contribution Plans**

A defined contribution plan addresses the amounts currently entering a plan, and the identifies the participant's vested (nonforfeitable) account. There are three types of defined contribution plans: (1) profit-sharing plans, (2) stock bonus plans, and (3) money purchase plans.

#### *Profit-sharing plans*

In a profit-sharing plan, contributions are tied to the company's profits. Employer does not have to contribute the same amount every year, but the plan must be maintained with "recurring and substantial" contributions.

#### *Stock bonus plans*

In a stock bonus plan, contributions do not depend on profits, and benefits are distributed in the form of company stock.

#### *Money purchase plans*

In a money purchase plan, both contributions and earnings must be allocated to participants in accordance with a definite formula. Distributions can be made only under amounts credited to participants, and the plan assets must be valued at least once a year, with participants' accounts being adjusted accordingly.

### **Defined Benefit Plans**

A defined benefit plan establishes a definite future benefit predetermined by a specific formula in contrast to a defined contribution plan. This type of plan is usually tied to the employee's years of service, amount of compensation, or both. When the term 'pension' is used, it typically refers to a defined benefit plan.

To qualify for federal tax purposes, a defined benefit plan must meet the following requirements. The plan must provide for (1) definitely determinable benefits, (2) systematic payments of benefits, (3) primarily retirement benefits, and (4) maximum annual benefit.

### **Cash or Deferred Arrangement (401(k) Plans)**

Another form of qualified employer retirement plan is the 401(k) plan. With the plan, employees can elect to take a reduction in their current salaries by deferring amounts into the retirement plan. The plans are called cash or deferred arrangements because employees cannot be forced to participate.

The amounts deferred are not included in the employees' gross income, and earnings credited to the deferrals grow tax-free until distribution. Typically, 401(k) plans include matching employer contributions.

A cash or deferred arrangement must be part of a profit-sharing or stock bonus plan. In addition to meeting the qualification rules applicable to defined contribution plans, 401(k) plans also must qualify under the following special set of rules:

1. Amounts deferred can be distributed penalty-free because of retirement, death, disability, separation from service, or attainment of age 59½.
2. Employee deferred contributions are nonforfeitable.
3. Special nondiscrimination requirements must be met to prevent highly compensated employees from deferring disproportionately higher amounts of their salaries.

### **Tax-Sheltered Accounts (403(b) Plans)**

403(b) plans, also known as "tax-sheltered annuities," is a special tax-favored retirement plan available only to certain groups of employees. Tax-sheltered accounts may be established for the employees of specified nonprofit charitable, educational, religious, and other 501(c)(3) organizations, including employees of school

systems. Funds are contributed by the employer or by the employees (usually through payroll deductions) to tax-sheltered accounts and, thus, are excluded from the employees' current taxable income. The

maximum annual salary reduction for an employee under a 403(b) plan is the same as that for a 401(k) plan. However, at retirement, all income is reportable for tax purposes as ordinary income.

### ***IRC Section 457 Deferred Compensation Plans***

Congress enacted IRC Section 457 to allow participants, in such plans, to defer compensation without current taxation. The amounts deferred will not be included in gross income until they are received or made available. The annual amounts an employee may defer under this plan are like those under a 401(k) plan. However, for the three years preceding retirement, each year's deferral limit will be twice the applicable limit.

## **QUALIFIED PLANS FOR THE SMALL EMPLOYER**

The Self-Employed Individuals Retirement Act of 1962 was created to treat small business owners and self-employed individuals as employees, thus enabling them to participate in a qualified plan. The result of this Act was the Keogh or HR-10 retirement plan.

### ***KEOGH (HR-10)***

A Keogh plan is a qualified retirement plan designed for unincorporated businesses that allows the business owner (or partner in a business) to participate and be treated as an employee. These plans may be set up as either defined contribution or defined benefit plans. Keogh plans are subject to the same maximum contribution limits and benefits as qualified corporate plans; they must comply with the same participation and coverage requirements as qualified corporate plans and are subject to the same nondiscrimination rules as qualified corporate plans.

### ***Simplified Employee Pensions (SEPs)***

Introduced in 1978, SEPs are suited for the small employer. A SEP is an arrangement whereby an employee or self-employed individual establishes and maintains an IRA to which the employer contributes. Employer contributions are not included in the employee's gross income, and the maximum amount that can be contributed is 25% of the employee's annual compensation. As with other qualified plans, SEPs must not discriminate in favor of highly compensated employees regarding contributions or participation.

#### *Salary Reduction SEP Plans*

SARSEPs are reserved for small employers, those with 25 or fewer employees, and had to be established before 1997. Due to new tax legislation, no new SARSEPs can be established. However, plans in place before the end of 1996 may continue to operate and accept new employee participants.

#### *SIMPLE Plans (Savings Incentive Match Plan for Employees)*

With the discontinuation of new SARSEP plans, a new form of qualified employer retirement plan was created. Savings Incentive Match Plan for Employees, or SIMPLE, is an arrangement that allows eligible employers to set up tax-favored retirement savings plans for their employees without having to address many of the burdensome qualification requirements.

SIMPLE plans are available to small businesses (including tax-exempt and government entities) that employ no more than 100 employees who received at least \$5,000 in compensation from the employer during the previous year. To establish a SIMPLE plan, the employer must not have a qualified plan in place.

SIMPLE plans may be structured as an IRA or 401(k) cash or deferred arrangement. Under these plans, employees who elect to participate may defer up to a specified amount each year. The employer then makes a matching dollar-for-dollar contribution, up to an amount equal to 3% of the employee's annual compensation. All contributions to a SIMPLE IRA or SIMPLE 401(k) plan are nonforfeitable; the employee is immediately and fully vested.

Taxation of contributions and their earnings is deferred until funds are withdrawn or distributed. In place of dollar-for-dollar matching contributions, an employer can choose to make non-elective contributions of 2% of compensation on behalf of each eligible employee.

*Catch-up Contributions*

Both SARSEP and SIMPLE plans allow participants who are at least 50 years old by the end of the plan year to make additional "catch-up" contributions.

**INDIVIDUAL RETIREMENT PLANS**

Three important facts regarding individual retirement plans.

1. Purpose: to save for your retirement
2. Incentive: you receive favorable tax treatment.
3. The amount contributed accumulates and grows tax-deferred

***Traditional IRA (Individual Retirement Accounts)***

An IRA is a vehicle by which individuals can save money for retirement and receive a current tax break. The amounts contributed to an IRA accumulate and grow tax-deferred. IRA funds are not taxed until they are taken out at retirement.

*IRA Participation*

Anyone ~~under the age of 70½~~ who has earned income may open a traditional IRA. The contribution limit is 100% of compensation or \$6,000, whichever is less. A nonwage-earning spouse may open an IRA and contribute up to the limit each year. A Roth IRA has the same contribution limits as a traditional IRA, but no maximum age limit.

Since 2002, persons who are age 50 and older have been allowed to make "catch-up" contributions to their IRAs, above the scheduled annual limit. These catch-up payments can be either deductible or made to a Roth IRA. The maximum additional catch-up amount permitted is \$1,000.

*Deduction of IRA Contributions*

Individuals not covered by an employer-sponsored plan may contribute up to the annual limit to a traditional IRA and deduct from their current income the full amount of the contribution (no matter their income level).

Individuals covered by an employer-sponsored plan are subject to different rules regarding the deductibility of traditional IRA contributions. Specifically, the amount of income they make is the determining factor. The more they make, the less IRA deduction they can take.

**NOTE:** Do not confuse the deductibility of contributions with the ability to make contributions. Anyone ~~under the age of 70½~~ who has earned income can contribute to a traditional IRA.

*Traditional IRA Withdrawals*

To discourage individuals from withdrawing funds before their retirement, several rules have been mandated.

1. Traditional IRA owners must begin to receive payments no later than April 1 following the year in which they reach age ~~70½~~ 72 or incur a STIFF penalty.
2. Withdrawals before age 59½ are subject to 10% penalty except if withdrawn for the following reasons:
  - a. if the owner dies or becomes disabled;
  - b. if the owner is faced with a certain amount of qualifying medical expenses;
  - c. to pay for higher education expenses;
  - d. to cover first-time home purchase expenses (up to \$10,000);
  - e. **to pay for childbirth or adoption expenses (up to \$5,000) – UPDATED 2020**
  - f. to pay for health insurance premiums while unemployed;
  - g. if the distribution is taken in equal payments over the owner's lifetime; or
  - h. To correct or reduce an excess contribution.
3. At retirement, or any time after age 59½, the IRA owner can elect to receive either a lump-sum payment or periodic installment payments from his or her fund.
4. If an IRA owner dies before receiving full payment, the remaining funds in the deceased's IRA will be paid to the named beneficiary.
5. If an IRA owner is a military reservist called to active duty for more than 179 days or an indefinite period, a 10% early-withdrawal penalty is waived; however, regular income taxes will apply.

6. If the IRA owner is a firefighter, police officer, or emergency medical technician with a pension or retirement plan who retires after age 50, they are exempt from the penalty.

**IRA Funding**

An ideal funding vehicle for IRAs is a flexible premium fixed deferred annuity. Other acceptable IRA funding vehicles include bank time deposit open accounts, bank certificates of deposit, insured credit union accounts, mutual fund shares, face amount certificates, real estate investment trust units, and certain U.S. gold and silver coins.

**ROTH IRA**

The 1997 Taxpayer Relief Act introduced a new type of IRA: The Roth IRA. The IRA is unique in that it provides for back-end benefits. No deduction can be taken for contributions made to a Roth, but the earnings on those contributions are entirely tax-free when they are withdrawn.

Any individual can open and contribute to a Roth regardless of whether they are covered by an employee plan or maintains and contributes to other IRA accounts. An amount up to the annual contribution limit can be contributed to a Roth IRA for any eligible employee.

In addition, a Roth IRA does not impose an age limit when it comes to withdrawals; Roth IRA has the same contribution limits as the traditional IRA, but no maximum age limit. Due to earning limitations that traditional IRAs do not have, high-income earners may not be able to contribute to a Roth IRA since the maximum annual contribution that can be made begins to phase out for individuals whose modified adjusted gross incomes reach certain levels.

**Qualified Roth Withdrawals**

Under a Roth IRA, a qualified withdrawal is one that provides for tax-free distribution of earnings. To be a qualified Roth withdrawal, two requirements must be met: (1) the funds must have been held in the account for a minimum of five years, and (2) the withdrawal must occur for one of the following reasons: (a) the owner has reached age 59½; dies, or becomes disabled; or (b) the distribution is used to purchase a first home. If these requirements are met, no portion of the withdrawal is subject to tax.

**Tax Consequences of IRA Distributions**

Reason for Distribution	Roth IRA Held Fewer Than 5 Years		Roth IRA Held 5 Years or More		Traditional IRA	
	Earnings Taxed	10% Penalty	Earnings Taxed	10% Penalty	Earnings Taxed	10% Penalty
Pre-59½	Yes	Yes	Yes	Yes	Yes	Yes
Death	Yes	No	No	No	Yes	No
Disability	Yes	No	No	No	Yes	No
First-time home purchase	Yes	No	No	No	Yes	No
Substantially equal payments	Yes	No	Yes	No	Yes	No
Medical payments	Yes	No	Yes	No	Yes	No
Health insurance while unemployed	Yes	No	Yes	No	Yes	No
Higher education expenses	Yes	No	Yes	No	Yes	No
Post 59½	Yes	No	No	No	Yes	No
Birth or adoption	Yes	No	Yes	No	Yes	No

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**Spousal IRA**

Persons eligible to set up IRAs for themselves may create a separate spousal IRA for a nonworking spouse and contribute up to the annual maximum to the spousal account, even if the working spouse is in an employer-sponsored plan. Non-working spouse; up to the annual maximum.

If the spousal account is a traditional IRA, the amount of the deduction that can be taken for contributions

may be reduced or eliminated if the partner is an active participant, and the couple's adjusted gross income exceeds certain amounts. If the spousal account is a Roth IRA, the maximum contribution may be reduced or eliminated if the couple's adjusted gross income exceeds certain thresholds. The spousal IRA contribution must be reported on the couple's joint tax return.

### ***Rollover IRA***

If an individual chooses to transfer funds from one plan to another, certain tax-free "roll-over" provisions provide for some form of portability.

Rollover IRAs provide a way for individuals who have received a distribution from a qualified plan to reinvest the funds in a new tax-deferred account and continue to shelter those funds and their earnings from current taxes.

The provisions necessary for the tax-free roll-over are:

1. Must be rolled over within 60 days following the receipt of the distribution.
2. Only the person who set up the IRA is eligible to benefit. One exception is that a spouse may inherit an IRA and set up a Rollover IRA in their name.

**Note:** Tax laws now allow non-spousal beneficiaries to take IRA proceeds over their lifetimes, plus the lifetimes of their oldest named beneficiary.

### ***Pension Protection Act of 2006***

The purpose of this act is to improve the pension system and increase opportunities to fund retirement plans. The act encourages workers to increase their contributions to employer-sponsored retirement plans and helps them manage their investments. The act also provides automatic deferrals into investment funds and automatic annual increases in employees' salary deferral rates.

The act's provisions carry out its intent on two fronts: (1) addressing employers' pension funds and (2) assisting employees who are saving for retirement.



UNIT**12****SOCIAL SECURITY****OVERVIEW**

How does one judge the justness of a society? One test is its willingness to provide its citizens with a floor of protection against the financial loss that often accompanies death, disability, or old age---events beyond people's control. The Social Security program, enacted in 1935, offers Americans just such a foundation of protection. This unit reviews this important government-sponsored program.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Purpose of Disability Social Security
- Who is Covered by Social Security?
- How Social Security Benefits Are Determined
- Types of OASDI Benefits

**KEY TERMS**

Average Indexed Monthly Earnings (AIME)

Currently Insured Status Credits

FICA Tax

Full Retirement Age (FRA)

Fully Insured Status

OASDI Benefits

PIA Earnings Test

Taxable Wage Base

Taxation of Social Security Benefits

## PURPOSE OF SOCIAL SECURITY

Social Security provides a basic floor of protection to all working Americans against the financial problems of death, disability, and aging, but does not replace a sound personal insurance plan. Enacted in 1935, it is administered at the federal level by the Social Security Administration.

OASDI = Old Age, Survivors, Disability Program	
OA	"Old Age" (retirement)
S	"Survivors (death benefit)
DI	"Disability Insurance (income replacement)

Formally called OASDI, its acronym identifies the types of protection provided under the program. Social Security is an entitlement program, not a welfare program. Social Security benefits augment, but do not replace a well-founded personal insurance program.

## WHO IS COVERED BY SOCIAL SECURITY?

All Americans paying into the payroll system are covered by Social Security except: (1) federal employees covered under civil service, (2) railroad workers covered under Railroad Retirement System, and approximately 25% of state and local government employees.

Social Security provides for spouses, dependent children, and, in some cases, dependent parents of covered workers. It is important to note that a basic condition for coverage is that a person must work; OASDI is funded by a payroll tax (Federal Insurance Contributions Act [FICA] tax), and eligibility for benefits is contingent upon a person contributing to the system during their working years.

### Coverage vs. Eligibility

Being covered means that a worker is actively participating in the program through FICA tax contributions but may or may not be eligible for benefits. Eligibility for benefits is based on a person's insured status, described as either (1) fully insured or (2) currently insured. Being fully insured entitles a worker and the worker's family to full retirement and survivor benefits. A currently insured status qualifies a worker for a limited range of survivor benefits.

### Quarters of Coverage



A person's insured status is based on that person's accrued credits. One credit is earned for each \$1,410 (2020) of annual earnings on which FICA taxes were paid. Adjusted for inflation each year. A maximum of four credits is allowed in any one year.

One credit for each \$1,410 earned in 2020  
 Example 1: Worker earned \$4,230 ÷ \$1,410 = 3 credits earned.  
 Example 2: Worker earned \$5,640 ÷ \$1,410 = 4 credits earned.  
 Example 3: Worker earned \$6,800 ÷ \$1,410 = 4 credits earned. (does not round up)

### Fully Insured vs. Currently Insured

Workers are fully insured if they have accumulated the required number of credits based on their age. For most people, the number of credits needed is 40, representing approximately ten years of work.

The status of "currently insured" indicates that the worker has not acquired the 40 credits and is only eligible for limited benefits. At a minimum, a worker must have earned six credits during the 13 quarters ending with the quarter in which the worker died.

## HOW SOCIAL SECURITY BENEFITS ARE DETERMINED

The amount of benefits to which a worker is entitled under Social Security is based on the worker's earnings over the years. There is a direct relationship between the amount of FICA taxes paid and the level of benefits a worker has earned.

### Social Security Taxes

The Social Security system is a pay-as-you-go system. The taxes paid by workers today are used to provide benefits today. Excess contributions are put into a fund for future benefits but are not earmarked for the individual contributor. OASDI is supported by a payroll tax paid by employees, employers, and self-

employed individuals. The employers pay an equal amount paid by the employee on behalf of each employee. Self-employed workers pay as an employer and an employee.

This payroll tax is known as the FICA tax. The tax is imposed on wages up to the maximum taxable wage base. Subject to increases.



### **FICA Tax Rate Breakdown (2020)**

Taxable Wage Base	\$137,000
Employees and Employers	7.65%
Self-Employed Individuals	15.3%
OASDI	6.20% on the maximum taxable wage base
Medicare	1.45% of all wages

### **Calculating Benefits**

Before 1979, Social Security benefits for retired workers was based on their **Average Monthly Wage** (AMW). Because these benefits did not take inflation into account, they resulted in low monthly checks. For workers retiring after 1979, calculations were based on a workers' **Average Indexed Monthly Earnings** (AIME). This method added "weighing" a worker's past earnings to take inflation into account, resulting in larger benefit checks based on current economic standards.

Once the AIME determines, it is next applied to a formula to yield the worker's primary insurance amount (PIA). The PIA is equal to the worker's full retirement benefit at age 66 or benefits to a disabled worker. Benefits payable to workers and their spouses and dependents are usually expressed as percentages of the worker's PIA. If workers elect to early retirement, they will only receive a percentage of their full retirement benefits. For example, if a worker were to elect early retirement at age 62 with Social Security benefits, they would only receive benefits equivalent to 80% of their PIA. If they were to wait until full retirement, age 66, they would receive 100% of their benefits.

## **TYPES OF OASDI BENEFITS**

There are three major benefit categories in Social Security; (1) death, (2) retirement, and (3) disability. Each of these categories can be dissected into smaller segments.

### **Death Benefits**

Upon the death of an eligible worker, Social Security provides death benefits to a surviving spouse, dependent children, and dependent parents. These benefits are commonly called "survivor benefits."

#### *Lump-Sum Death Benefit*

A one-time lump-sum death benefit is payable to a deceased worker's eligible surviving spouse or eligible children. The benefit is equal to three times the worker's PIA, up to a maximum of \$255.

#### *Surviving Spouse's Benefit*

At age 65, a fully-insured deceased worker's surviving spouse is entitled to a monthly life income equal to the worker's PIA. Also, a surviving spouse can be entitled to benefits on the deceased worker's record if the surviving spouse cares for a child entitled to the deceased spouse's record, and the child is either under the age of 16 or over age 15 and disabled.

#### *Child's Benefit*

A child under age 18 (or disabled before age 22) will receive 75% of the PIA until reaching the age of 18 (19 if still in high school). If the child marries before age 18, the benefit will cease.

#### *Parents' Benefits*

Beginning at age 62, each parent of a deceased fully insured worker is eligible to receive a monthly benefit if the parent was at least one-half supported by the worker at the time of death. When two parents are eligible, each receives 75% of the worker's PIA; if only one parent is eligible, that parent receives 82.5% of the worker's PIA.

*Maximum Survivor Benefits*

These are limits imposed by Social Security that dictate the total amount of survivor benefits that anyone family may receive.

**Retirement Benefits**

Social Security provides old age or retirement benefits to fully-insured workers and their families. These benefits are paid monthly.

*Worker's Retirement Benefit*

Fully insured workers are eligible for full retirement income benefits (100% of PIA) at their full retirement age. Benefits are reduced for early retirement and increased for delayed retirement.

<b>Full Retirement Age (FRA)</b>	
Age 65	born before 1938
Year 2000 – 2006	Increased to age 66
Year 2016	age 66
2017 - 2022	will gradually increase to age 67

*Spouse's Benefit*

The spouse of any worker eligible for retirement benefits is entitled to an old age income at the spouse's FRA, or a reduced benefit at age 62. At FRA, the spouse's benefit is 50% of the retired worker's PIA; at age 62, a spouse may receive permanently reduced benefits. If a dependent child is under age 16 (or disabled before age 22), the spouse is eligible to receive the 50% spousal benefit, regardless of the spouse's age.

*Child's Benefit*

An unmarried child of a worker on retirement income is generally eligible to receive a monthly benefit of 50% of the worker's PIA until the child turns 18. If the child is disabled before age 22, the child's benefit will continue indefinitely.

*Earnings Test (repealed in 2000)*

Although repealed in 2000, current rules allow for, starting with the month a person reaches full retirement age, that a person can continue working and receive Social Security benefits, with no limit on earnings. However, if a person age is below the full retirement age when they begin receiving Social Security benefits and continues to work, their benefits still will be reduced.

**Disabled Benefits**

A fully-insured worker who becomes disabled is entitled to disability benefits under Social Security, as are the worker's spouse and dependent children.

*Disabled Worker's Benefits*

A disabled worker is entitled to a monthly benefit equal to the worker's PIA at the time the disability occurred. There is no reduction in benefits if they begin before age 65; however, if the worker becomes disabled after age 63 and has been receiving a reduced retirement benefit, the worker's disability benefits will be reduced to account for the retirement benefits already received.

*Spouse's Benefit*

The spouse of a qualified disabled worker may also receive Social Security benefits, depending on the spouse's age. If the spouse is 65, the benefit is equal to 50% of the worker's PIA. A spouse who is 62 can elect reduced benefits.

If there is a dependent child under age 16 (or who is disabled, regardless of age), the spouse can receive the 50% spousal benefit, regardless of the spouse's age.

*Child's Benefit*

An unmarried dependent child of a disabled worker under 18 (or a disabled child before age 22) is eligible for monthly benefits equal to 50% of the worker's PIA. Maximum Disability Benefits  
Social Security disability benefits are subject to rigid requirements. A worker must meet Social Security's definition of disability, which is the inability to engage in any substantial gainful work. The disability must

result from a medically determinable physical or mental impairment that can be expected to last at least 12 months or to result in an earlier death.

Disability benefits begin after the worker has satisfied a waiting period of five (5) consecutive months, during which the worker must be disabled. The benefits may be paid retroactively for as long as 12 months (excluding the waiting period) preceding the date an application for benefits is filed.

**Social Security Benefit Chart**

	Survivor Benefits	Retirement Benefits	Disability Benefits
	PIA	PIA	PIA
Spouse - Age 65 or Full Retirement Age (FRA)	100%	50%	50%
Spouse - Age 62	-----	Reduced amount	Reduced amount
Spouse w/Child - Any Age	75%	50%	50%
Child Under Age 18 (19 if Still in High School)	75%	50%	50%
Parents (2)	75%	-----	-----
Parent (1)	82½%	-----	-----

***Taxation of Social Security Benefits***

Up to 85% of Social Security benefits may be treated as taxable income for recipients whose income exceeds certain base amounts.

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UNIT**14****USES OF LIFE INSURANCE****OVERVIEW**

The valuable role life insurance plays in providing a death benefit is easily recognized. What is often overlooked or not understood are the many “living benefits” of life insurance, especially whole life insurance. The cash value feature of permanent insurance and the owner’s right to borrow from the cash value make these policies an important source of funds to meet living needs. This unit reviews the more common uses of life insurance in meeting individual needs as well as business needs, not only at the death of the policyowner but during the owner’s life, too.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Determining Proper Insurance Amounts
- Individual Uses for Life Insurance
- Business Uses for Life Insurance

**KEY TERMS**

Business Uses for Life Insurance

Buy-Sell Plans

Coverdell Education Savings Accounts

Deferred Compensation Plans

Employee Benefits

Human Life Value Approach

Individual Uses for Life Insurance

Key-Person Insurance

Needs Approach

Salary Continuation Plans

Split-Dollar Life Insurance

## DETERMINING PROPER INSURANCE AMOUNTS

### *Human Life Value Approach: Dr. S.S. Heubner, 1924.*

A human life can be expressed as a dollar valuation; that is, determining a person's economic value by discounting estimated future net earnings used for family purposes at a reasonable rate of interest.

<b>Example:</b>	<b>Human Life Value Concept</b>	
Annual wage	\$40,000	
Minus	<u>\$15,000</u>	Personal living expenses
	\$25,000	Care and Maintenance of his family
Present age	35	
Retirement age	65	Needs 30 years income for family (\$750,000).
Needs today, \$432,300 @ 4% interest rate to generate \$25,000 per year for 30 years.		

### **Amount Necessary to Produce Future Income Streams**

This table illustrates the amounts of capital that must be on hand today to produce various annual incomes for specified time periods. The assumed interest rate is 4%.

Number of Years of Income	Annual Income Streams (4% Interest)			
	\$10,000	\$15,000	\$20,000	\$25,000
20	\$135,903	\$203,855	\$271,306	\$339,758
25	\$156,221	\$234,332	\$312,442	\$390,553
30	\$172,920	\$259,380	\$345,840	\$432,300
35	\$186,646	\$279,969	\$373,292	\$466,615
40	\$197,928	\$296,892	\$395,856	\$494,820

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### ***Needs Approach***

Considering the benefits from social security, a deceased's pension plans, and personal savings, the needs approach method is used to determine how much insurance protection a person should have by analyzing a family's or business's needs and objectives should the insured die, become retired or disabled.

## INDIVIDUAL USES FOR LIFE INSURANCE

### ***Final Expense Fund (a.k.a. Clean-up Fund)***

A final expense fund is designed to house enough cash to cover expenses such as funeral costs, outstanding debts, federal and state taxes, and other legal and executor's fees at the time of the breadwinner's death. Although Social Security provides a small survivorship (death) benefit, the maximum lump-sum of \$255 is only eligible to a surviving spouse or child.

### ***Housing Fund***

Consisting of a home mortgage or rental allowance fund, the cash in this fund helps a surviving family continue making mortgage or rental payments or perhaps paying off a mortgage in its entirety.

### ***Education Fund***

Planning for a child's future education can be expensive. The average 4-year higher education cost ranges from \$105,000 for in-state universities to approximately \$150,000 or more in private institutions.

### ***Monthly Income***

The income stream associated with a family's breadwinner will ultimately come to an end upon their death. Monthly income will be needed during the months and years ahead to support the surviving spouse's growing



and living and any non-self-supporting children. There are two distinct income needs periods to consider: (1) dependency period and (2) blackout period.

#### *Dependency Period*

The period following the death of a breadwinner during which the children are living at home.

#### *Blackout Period*

The period in which there are no Social Security benefits for the surviving spouse. The blackout period begins when the youngest child turns 16. If there are no eligible children with the surviving spouse when the breadwinner dies, the blackout period starts immediately and continues until, at the earliest, the spouse reaches age 60.

#### **Emergency Fund**

This fund is needed to provide money for unforeseen miscellaneous costs and expenses.

#### **Coverdell Education Savings Accounts (Education Savings Account)**

Coverdell Education Savings Accounts are special investment accounts that allow individuals and families to fund formal education expenses on a tax-favored basis.

Education savings accounts are designed to fund a designated beneficiary's education expenses by allowing after-tax (non-deductible) contributions to accumulate on a tax-deferred basis. The earnings are taxed when they are not used to pay qualified education expenses, and then they are also subject to a 10% penalty.

Contributions to education savings accounts are not deductible and are limited to \$2,000 each year per child and must be made before the beneficiary turns 18 years of age. Single taxpayers whose adjusted gross incomes are \$95,000 or less, and joint filers with adjusted gross incomes of \$190,000 or less can contribute \$2,000. As income exceeds these levels, the amount of allowable education savings account contribution is phased down until it is eliminated at \$110,000 for single taxpayers and \$220,000 for joint filers.

If the child for whom an account has been established does not use the funds for education, or if any amounts remain in an account when the beneficiary reaches age 30, remaining funds can be rolled over to another education savings account benefiting another family member with no penalty. Any account distributions that are not used to pay for a beneficiary's education expenses will be included in the recipient's income and subject to a 10% penalty.

Nothing prevents more than one individual from contributing to an education savings account. The annual limit applies to each beneficiary only. Consequently, parents and grandparents can contribute to a single account, so long as the annual limit is not exceeded in any year. Excess contributions will still be subject to a 6% excise penalty.

#### **Income Needs if Disabled**

Except for a final expense fund, the same cash and monthly income needs that arise at the breadwinner's death exist when disability strikes. Because the need for income is often greater with disability, medical expense insurance, and disability income insurance should also be considered in a personal insurance program.

#### **Retirement Income**

Upon retiring, it is expected that one will need income to supplement their Social Security or other retirement benefits. Utilizing financial contracts such as universal life, variable life, and adjustable life, or the cash value from a whole life policy, are all vehicles that can be used to supplement this fund.

**Individual Uses of Life Insurance Case Study**

Final Expenses		<u>Totals</u>
<input type="checkbox"/> Funeral	\$ 20,000	
<input type="checkbox"/> Hospital	\$ 83,000	
<input type="checkbox"/> Credit Card Debt	\$ 17,000	
<input type="checkbox"/> Death Taxes	\$ 5,000	
<input type="checkbox"/> Court Costs	<u>\$ 5,000</u>	
Final Expense Costs	\$130,000	\$130,000
Housing (mortgage/rental)	\$300,000	\$300,000
Education (2 children)	\$280,000	\$280,000
Income (5 years)	\$400,000	\$400,000
Dependency Period		
Blackout Period		
Emergency Fund	\$ 40,000	<u>\$ 40,000</u>
<b>Total Needs</b>		<b><u>\$1,150,000</u></b>

**BUSINESS USES FOR LIFE INSURANCE**

Life insurance is used in business in a variety of ways. Three popular uses are: (1) as a funding method, (2) as a form of business interruption insurance, and (3) as an employee benefit.

*Funding Medium*

Life insurance can be utilized to fund a business continuation agreement or transfer of ownership between business partners or stockholders, or to fund a deferred compensation plan.

*Business Interruption Insurance*

Although life insurance cannot prevent the interruption of business activity caused by death or disability, it can help indemnify the business for losses created by these interruptions.

*Employee Benefit*

Life insurance can protect employees and their families from the financial problems encountered upon one's death.

**A Funding Medium**

As mentioned previously, life insurance can be utilized to fund a business continuation agreement. The most common form of agreement is an insured buy-sell agreement. This agreement guarantees that cash will be available upon the business owner's death to purchase the deceased's interest in the business.

**Sole Proprietor Buy-Sell Plans**

When the sole proprietor of a business dies, the business's operation will cease unless some predetermined arrangement has been made. There are typically three directions one can take in this event.

First, a member of the proprietor's family can take over. Next, if there are no interested takers in the family, the business can be shut down. Third, the business can be sold to a competent and faithful employee.

If option three is selected, then a two-step buy-sell plan can be arranged. Step 1 is to have an attorney draft a buy-sell agreement. Step 2 is to purchase an insurance policy to fund the agreement.

**Partnership Buy-Sell Plans**

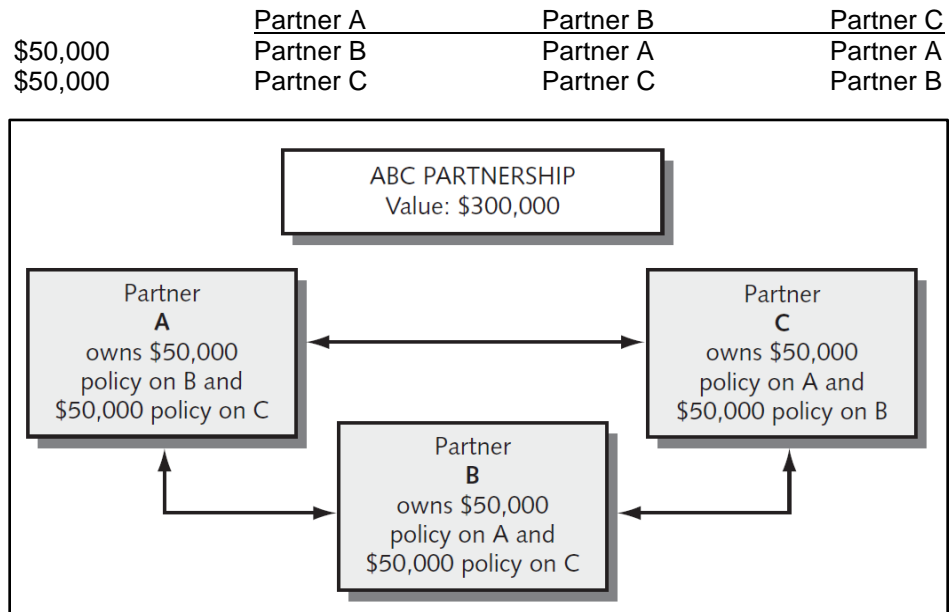
By law, partnerships are dissolved automatically upon the death of a partner. Therefore, a buy-sell agreement is vital to the surviving partner. It will allow the surviving partner to purchase the interest of the deceased partner. There are two kinds of partnership insured buy-sell agreements: (1) partnership cross-purchase plan and (2) partnership entity buy-sell plan.

**Partnership Cross-Purchase Plan.**

Under a cross-purchase buy-sell plan, the partners agree to purchase the interest of the deceased partner. The estate of the deceased partner agrees to sell the interest to the surviving partner or partners. The partnership itself is not a party to the agreement, and the agreement is between the partners, not the partnership. Each partner owns the policy and is the beneficiary and premium payer on the other partners' lives.

**Partnership Cross-Purchase Buy-Sell Plan**

Three-person partnership: The value of the business is \$300,000. Each partner owns a policy on the other two partners in the amount of \$50,000. A total of six policies are required for this partnership cross-purchase plan.



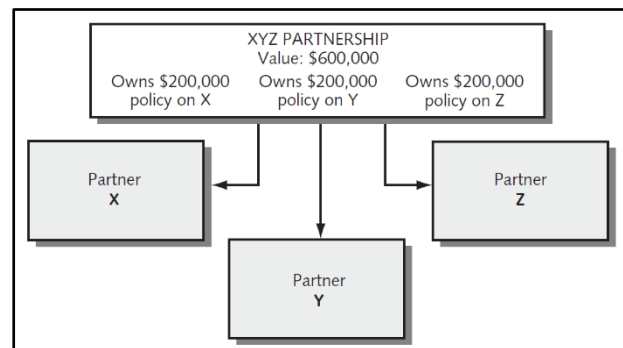
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**Partnership Entity Plan**

Under the partnership entity buy-sell plan, the partnership owns, pays for, and is the beneficiary of the policies on the individual partners' lives. The partnership itself is a party to the buy-sell agreement.

**Partnership Entity Buy-Sell Plan**

Three-person partnership: The value of the business is \$600,000. The partnership purchases a \$200,000 insurance policy of the life of each partner. When the first partner dies, the partnership buys that partner's interest from their estate with the insurance proceeds, and then re-divides this newly acquired interest between the remaining partners. Proportionately, the shares of the other partners would increase from 33⅓% to 50%.



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**Close Corporation Buy-Sell Plans**

A close corporation is generally an incorporated family business. Each member is a stockholder and owns shares of stock in the corporation. A corporation is an entity that continues to function after the death of a stockholder. Just as in partnerships, the corporate insured buy-sell plan can take one of two forms: cross-purchase or entity. In a corporate plan, however, the entity type of agreement is known as a stock redemption plan.

*Close Corporation Cross-Purchase Plan.*

This type of plan is like that used in a partnership. Each surviving stockholder agrees to purchase the deceased stockholder's interest, and the estate must sell the interest to the surviving stockholders. Unlike a partnership, the corporation is not a party to the agreement. Each stockholder owns, pays for, and is the beneficiary of policies on the other stockholders' lives. The amount of insurance would be equivalent to the stockholder's share of the purchase price.

*Close Corporation Stock Redemption Plan*

This plan operates similarly to a partnership entity buy-sell plan. Here, the corporation is the owner, premium payer, and beneficiary of policies on the stockholders' lives. The amount of insurance would be equivalent to the stockholder's share of the purchase price, and proceeds are paid to the corporation to be used to purchase the stock of the deceased stockholder. The corporation is a party to the agreement, and the premiums are not tax-deductible to the corporation, and the benefits are received income tax-free.

**Key-Person Insurance**

Another use of life insurance in a business is to protect against interruptions caused by losing one of the business's valuable assets: a key employee or key executive, such as a top salesperson, executive board member, or highly skilled employee. With key-person insurance, the business organization is the owner, premium payer, and beneficiary of the policy on the key person's life.

The following are the four primary purposes that key-person insurance serves: (1) business indemnification, (2) a reserve fund, (3) business credit, and (4) favorable tax treatment.

*Business indemnification*

To compensate a business for the financial loss brought on by the death of a key employee.

*Reserve fund*

This fund provides a business with a living benefit. When a business purchases key-person insurance, it automatically acquires an asset that can perform valuable services for the business while the key person is still alive. For example, the cash value in the policy provides for a cash reserve fund. In addition, the cash values are carried as an asset on the company's balance sheet.

*Business credit*

Key-person life insurance can offset the danger of business disruption caused by the death of a business' key-person in two ways: (1) tangible evidence of business character and (2) as a guarantee of loan repayment at the death of the key person.

*Favorable tax treatment*

Key-person life insurance receives favorable tax treatment. The death proceeds received by the business are not taxable. The premiums are not deductible for income purposes, but the proceeds may be used in whatever manner the company chooses.

**Employee Benefit Plans***Split-Dollar Plans*

This type of plan aims to provide an effective way to attract and retain quality employees. The split-dollar policy is a method of, rather than a reason for buying life insurance. Split-dollar plans are nonqualified plans and do not need IRS approval. It offers a low premium outlay and uses cash value whole life and term insurance protection to guarantee the premium money's return to one party while ensuring a death benefit to the policy beneficiary. In the traditional split-dollar plan, the employer and employee share the premium costs.

Generally, the employer contributes to the premium each year equal to the policy's cash value increase. The employee pays only the balance of the premium. Upon the insured employee's death, the amount of death proceeds equal to the cash value generally goes to the employer. The balance of the proceeds goes to the insured's beneficiary.

*Deferred Compensation Plans*

Deferred compensation plans are a popular way for businesses to provide an important benefit for their owners or select employees. As a nonqualified plan, the employer can discriminate in favor of highly paid employees, officers, and executives. A deferred compensation plan is an arrangement whereby an employee, or owner, agrees to relinquish some portion of their current income, such as bonuses or raises, until retirement.

Life insurance is a popular funding vehicle for deferred compensation plans, in that the amounts deferred are used to pay premiums on cash value life insurance. At retirement, the cash values are available to the employee to supplement income. If the employee dies before retirement, the employee's beneficiary will receive the policy's proceeds.

*Salary Continuation Plan*

Deferred compensation and salary continuation plans appear similar but are quite different. With a salary continuation plan, the employer agrees to pay the employee continuing payments at retirement.

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UNIT

## 9

# LIFE INSURANCE UNDERWRITING & POLICY ISSUE

**OVERVIEW**

Who is qualified to purchase life insurance and who is not? The process of answering this question is called risk selection, a function that is performed by insurance company underwriters. Sales representatives are sometimes called field underwriters, indicating the important role they also play in helping the company decide if an applicant is an insurable or uninsurable risk. This unit looks at the overall underwriting process, as well as the important processes of policy issue and policy delivery.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- The Purpose of Underwriting
- The Underwriting Process
- Field Underwriting Procedures
- Policy Issue and Delivery

**KEY TERMS**

Application

Binding Receipts

Conditional Receipts

Consumer and Investigative Reports

Effective Date of Coverage

Explanation of the Policy to the Client

Fair Credit Reporting Act

Initial Premium Deposits

Insurable Interest

Medical Information Bureau

Policy Delivery

Preferred Risk

Proper Solicitation

Required Signatures

Standard Risk

Standard Versus Substandard (Rated) Policies

Statement of Good Health

Substandard Risk

Underwriting Process

## THE PURPOSE OF UNDERWRITING

During the underwriting process, an insurance company decides if it is going to issue a policy to an applicant. The underwriter seeks to determine if the proposed insured is insurable, and if so, at standard, substandard, or preferred rates. Underwriters assign rates to proposed insureds, based on the risks the applicants represent to the insurers.

Underwriting is another term for risk selection. Its purpose is to answer two basic questions regarding an applicant: (1) is the applicant insurable and (2) If the applicant and insured are two different people, does an insurable interest exist between them?

### ***Does Insurable Interest Exist?***

Although laws differ slightly between states, an insurable interest exists when the death of the insured would have a clear financial impact on the policyowner. Individuals are presumed to have an insurable interest in themselves. Some relationships are automatically presumed to qualify as an insurable interest (spouses, parents, children, and certain business relationships). However, the burden is upon the applicant to show that an insurable interest exists. In life insurance, an insurable interest must exist only at the inception of the policy; it does not have to exist when the policy proceeds are paid.

Three areas where insurable interest always exists are: (1) blood, (2) marriage, and (3) business.

## THE UNDERWRITING PROCESS

The underwriting process is completed by reviewing and evaluating the applicant's information and applying it to the insurance company's standards and guidelines for insurability and premium rates.

### ***The Application***

The application is the first and primary source of insurability information that an insurance company uses to evaluate an applicant. The application consists of three basic parts: (1) Part I – General, (2) Part II – Medical, and (3) Part III – Agent's Report. The application's information is thoroughly evaluated; thus, it is the agent's responsibility to see that an applicant's answers to questions on the application are recorded fully and accurately.

#### ***Part I—General***

This part of the application asks general questions about the proposed insured, including their name, age, address, birth date, gender, income, marital status, and occupation. Also, it will indicate the type of policy (whole life, life paid-up, adjustable life, etc.), the face amount or the death benefit requested, the name and relationship of the beneficiary, other insurance the proposed insured owns, other additional insurance applications the insured has, and information about hazardous hobbies or activities the proposed insured engages in.

#### ***Part II—Medical***

This part of the application focuses on the applicant's personal and family health history. This information is commonly supplemented with medical reports (attending physician statements (APS)), and the insurance company paid medical exams.

#### ***What Constitutes Insurable Interest?***

- An individual has an insurable interest in their own life.
- A husband or wife has an insurable interest in a spouse.
- Parents have an insurable interest in their children.
- A child has an insurable interest in a parent or grandparent.
- A business has an insurable interest in the lives of its officers, directors, and key-employees.
- Business partners have an insurable interest in each other.
- A creditor has an insurable interest in the life of a debtor (but only to the extent of the debt).



#### **Genetic Testing**

Florida statute states that insurance companies may not require or solicit genetic information, use genetic testing results, or consider a person's decisions or actions relating to genetic testing in any manner for any insurance purpose. [F.S. 627.4301]



***Part III—Agent's Report***

This part of the application comprises the agent's accurate and truthful observation of the proposed insured's background, character, and purpose of sale.

***The Medical Report***

If the application's medical section raises questions specific to a condition, the underwriter may also request additional information from the physician who has treated the applicant.

The medical exams must be completed by a qualified person, which can be a paramedic, registered nurse, or physician. In most cases, the expenses for the exam are borne by the insurance company.

When completed, the medical report is forwarded to the insurance company, where it is reviewed by the company's medical director or a designated associate.

***The Medical Information Bureau***

Another source of underwriting material that focuses on the applicant's medical history is the Medical Information Bureau or MIB. This nonprofit information agency serves as a reliable source of medical information concerning applicants, and aids in disclosing information where an applicant fails to provide or submit erroneous or misleading medical information.

To obtain information from the bureau, the insurance company must be a member of the bureau and may only use the information obtained for underwriting and claims purposes. Each member company and its medical director sign a pledge to follow the MIB rules and principles.

***Basic Requirements of being a member company of the MIB***

- applicants must be notified in writing that the insurer may make a brief report on their health to the MIB
- applicants must be advised that, should they apply to another company for coverage or if a claim is submitted to such a company, the MIB will supply any requested information in its files to the company
- applicants must sign authorization forms for information from the MIB files to be given to a member company
- The MIB will arrange the disclosure of any information it has concerning an applicant upon request by the applicant. Medical information, however, will be disclosed only to the individual's physician, who then can interpret best the facts for the applicant (patient).

***Special Questionnaires***

If an insurance company needs additional detailed information about an applicant, a special questionnaire may be required. Some common questionnaires provide information on alcohol usage, drug use, aviation, avocation, foreign residences, finances, military service, or age 71+.

***Inspection / Investigative Reports***

Designed to provide a picture of an applicant's general character and reputation, mode of living, finances, and any exposure to abnormal hazards, these reports are usually obtained by insurance companies on applicants who apply for large amounts of life insurance. Investigators or inspectors may interview employees, neighbors, associates of the applicant, and the applicant.

***Credit Reports***

Applicants who have questionable credit ratings can cause an insurance company to lose money. Based on historical data, applicants with poor credit standings commonly allow their policies to lapse within a short time, thus preventing the insurance company from recovering their policy start-up expenses.

### ***The Fair Credit Reporting Act of 1970***

The FCRA is a federal law that applies to financial institutions that request information on their consumers. The law requires that companies, including insurance companies, report fair and accurate information about consumers.

The following are important requirements pertaining to insurance companies:

1. Applicants must be notified within 3-days that the report has been requested.
2. If the applicant requests such disclosure, the insurer must provide a summary within 5-days of the request.
3. Applicants must be provided with the names of all people contacted during the preceding six months for the report's purposes.
4. People contacted who are associated with the consumer's employment place must be identified as far back as two years.
5. If, based on the report, the insurer rejects the application, the company must provide the reporting agency's name and address.
6. The reporting agency, not the insurance company, must disclose all information (except medical) contained in the report.
7. If consumers disagree with the information in the file, they may file a statement giving their opinion on the issue.

### ***HIPAA Disclosures (Health Insurance Portability and Accountability Act)***

The Health Insurance Portability and Accountability Act (HIPAA) imposes specific healthcare providers' requirements concerning the disclosure of patients' health and medical information.

When examining an applicant for underwriting purposes, all medical information remains confidential, and the agent and insurer must protect the applicant's privacy. Suppose the insurer needs to share this information (such as with medical professionals), including information related to possible HIV infection. In that case, the applicant must be given full notice of the insurer's practices with respect to the treatment of this information, the applicant's right to maintain privacy, and an opportunity to refuse permission to disseminate the information.

### ***Classification of Applicants***

After information about an applicant has been reviewed and evaluated, the underwriter classifies the risk on one of three categories: (1) preferred risk, (2) standard risk, and (3) substandard risk.

#### *Preferred risk*

Risks where certain conditions like weight, occupation, personal characteristics (non-smoker and favorable cholesterol levels), are exceptionally good or favorable. These conditions typically result in a lower consumer premium.

#### *Standard Risk*

Standard risks are designed for individuals who fit the insurance company's policy issue guidelines without special restrictions or additional ratings.

#### *Substandard Risk*

This classification identifies risks that are below the standard or average risk guidelines of the company. Along with poor health, applicants may be classified as substandard because of their occupation and or hobbies.

## **FIELD UNDERWRITING PROCEDURES**

An agent plays an important role in underwriting. As a field underwriter, the agent initiates the process and is responsible for many important tasks: proper solicitation, completing the application thoroughly and accurately, obtaining appropriate signatures, collecting the initial premium, and issuing a receipt.

### ***Proper Solicitation***

As a representative of the insurer, an agent has the duty and responsibility to solicit good business. This means that the cases the agent works on should fit within the company's guidelines and represent profitable

business. Also, as a licensed insurance professional, the agent has a responsibility to the public to observe the highest professional standards when conducting insurance business. This is accomplished by helping applicants select the appropriate policies to fit their needs.

When soliciting or selling insurance, it is a violation of unfair trade practices to false advertise. All advertising must be truthful, and all sales presentations must not be deceptive.

In Florida, insurers are required to deliver to the applicant a Life Insurance Buyer's Guide and a Policy Summary. The buyer's guide is a generic publication that explains life insurance in a way that average consumers can understand. The policy summary addresses the specific product being presented for sale. It identifies the agent, the insurer, the policy, and each rider. It includes information about premiums, dividends, benefit amounts, cash surrender values, policy loan interest rates, and life insurance cost indexes of the specific policy being considered.

### ***Completing the Application***

The application is one of the most important sources of underwriting information, and it is the agent's responsibility to see that it is completed fully and accurately. Statements made in the application are considered representations: statements an applicant makes and believes to be true best of their knowledge but is not warranted to be exact in every detail. Representations must be true only to the extent that they are material to the risk. Statements made in insurance applications are considered representations, not warranties.

Warranties are statements that are considered true in every respect. If an insurer rejects a claim based on a representation, it bears the burden of proving materiality. Representations are considered fraudulent only when they relate to a matter material to the risk and when they were made with fraudulent intent.

There are several signatures required to complete an application. In Florida, a child must be a minimum age of 15 years of age to sign a life insurance application; otherwise, an adult-aged parent or legal guardian must sign.

Each application requires the proposed insured's signatures, the policyowner, and the agent who solicits the application. The beneficiary does not sign the application.

In Florida, the insurance company's name and the agent's name and license identification number must appear on the application. If premium payments are made according to an automatic check or debit plan, forms for that purpose must also be signed.

### ***Changes in the Application***

The insurance application must be completed accurately, honestly, and thoroughly, and it must be signed by the insured and witnessed. When attached to the insurance policy, the application becomes part of the legal contract between the insurer and the insured. When an applicant makes a mistake in the information given to an agent in completing the application, the applicant can correct the information but must initial the correction.

### ***Initial Premium and Receipts***

If a premium deposit is not paid with the application, the policy will not become valid until the initial premium is collected. One of the requirements for a valid contract is a consideration; typically, money but defined as something of value in exchange for something of value. In the case of an insurance contract, the consideration is the first full premium plus the application. An insurance company will not allow an applicant to possess a policy without receipt of the first initial premium.

Applicants who pay the first full premium with the application are entitled to a premium receipt. There are two major types of receipts: (1) conditional receipts and (2) binding receipts (sometimes called temporary insurance agreements).

**Conditional Receipts**

A conditional receipt indicates that certain conditions must be met for the insurance coverage to go into effect. Some companies refer to a conditional receipt as a temporary receipt. There are two types of conditional receipts (1) insurability type and (2) approval type.

**Insurability Receipt.** This type of conditional receipt provides that when the applicant pays the initial full premium, coverage is effective either on the date the application is signed or the date of the medical exam, provided the applicant proves to be insurable.

<b>"Insurability Type"</b>	
Client Signed Up and Gave Agent the Check	Jan. 10
Took Medical Exam	Jan. 21
Insurance Company Issued Policy	Feb. 15
Agent Delivered It	Feb. 28
<b>When Was the Policy in Force?</b>	<b>Jan. 21</b>

**Approval Receipt.** This approval type is more restrictive, whereas coverage is effective only after the insurance company has approved the application. This type of receipt is rarely used today.

**Conditional Receipts**

When a conditional receipt is given, the applicant and the company form what might be called a conditional contract; contingent upon conditions that exist at the time the application is signed (or when the medical exam is completed, if required). In providing early coverage, the insurer conditionally assumes the risk and will provide coverage from the specified date, on the condition that the applicant is approved for policy issue.

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**Binding Receipts**

Under a binding receipt, or temporary insurance agreement, coverage is guaranteed, even if the proposed insured is found to be uninsurable, until the insurer formally rejects the application. The binding receipt stipulates a maximum amount that would be payable during the special protection period, generally not greater than \$100,000.

Upon payment of the initial premium at the time of the application, a binding receipt provides the following provisions:

1. The applicant is covered at the time of application for insurance applied for, but usually not to exceed a maximum of \$100,000 under all outstanding receipts.
2. The temporary coverage continues until the policy is issued as requested, until the company offers a different policy or until the company rejects the application. However, in no event for more than 60 days from the date the agreement was signed.
3. If a medical examination is required, the temporary insurance coverage does not begin until the examination has been completed. Nevertheless, if death accidentally occurs within 30 days from the agreement's date, the death benefit is paid even though the medical examination was not taken.
4. The applicant must pay in advance at least one month's premium for the policy being applied for.
5. There must be no material misrepresentations, and death must not be suicide.

**Policy Effective Date**

Suppose a receipt (either conditional or binding) was issued in exchange for the payment of an initial premium deposit. In that case, the receipt's date will generally be noted as the policy effective date in the contract. If a premium deposit is not given with the application, the policy effective date is usually left to the insurer's discretion. Often, it will be the date the insurance company issues the policy. However, the policy will not be truly effective until it is delivered to the applicant, the first premium is paid, and a Statement of Continued Good Health is obtained.

**Backdating to Save Age = 6 months.**

Backdating a policy allows a proposed insured an earlier effective date. Doing so, the age of the insured can be reduced up to 6 months. This will result in a lower premium. However, upon issuance, the policyowner will be required to pay all back-premium up to the backdated anniversary date.

## **POLICY ISSUE AND DELIVERY**

After the underwriting is complete and the company has decided to issue the policy. The policy document is sent to the sales agent for delivery to the new policyowner. The policy is not sent directly to the policyowner since the sales agent should explain it to the policyowner.

### ***Constructive Delivery***

Constructive delivery has nothing to do with actual delivery. It relates to when the insurance company releases the policy to you, its agent. Even though you never actually delivered it, it has been “constructively delivered.” Suppose the insurance company instructs you not to deliver the policy unless the applicant is in good health. In that case, there is no “constructive delivery” as mere possession of a policy is not “constructive delivery.”

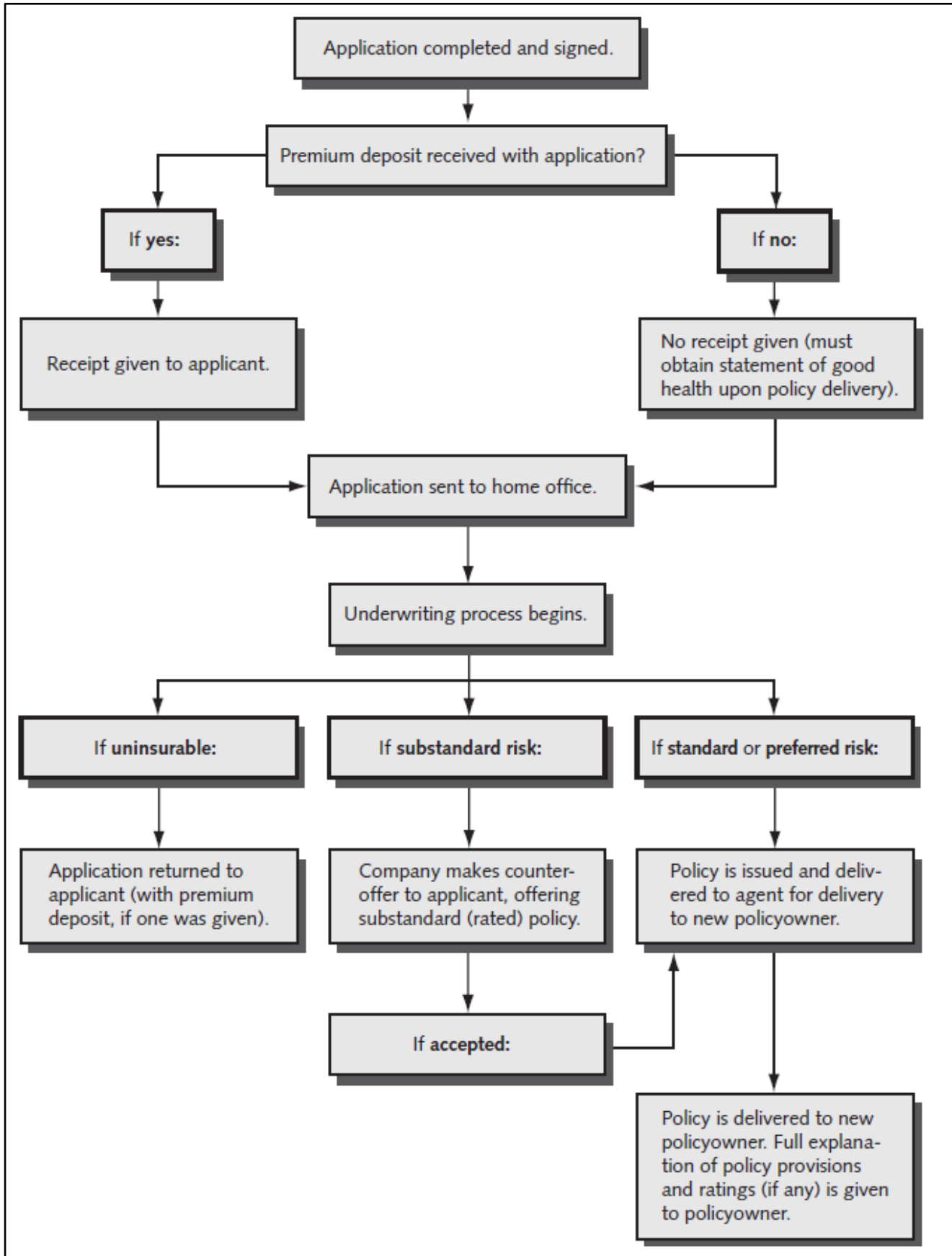
### ***Explaining Policy and Rating to Client***

Explaining the policy and how it meets the policyowner’s specific objectives helps avert misunderstandings, policy returns, and potential lapses. The agent’s review is especially important. It helps to reinforce the sale, it can lead to future sales, it helps avert misunderstandings, the free-look period can be explained, and it prevents potential lapse.

### ***Obtaining a Statement of the Insured’s Good Health***

If the initial premium has not been paid at the time of application, the agent must obtain from the insured a signed statement attesting to his or her good health. The purpose of this document is to ensure that the policyowner represents the same risk to the company as when the application was first signed.

**From Application to Policy**



UNIT**15****INTRODUCTION TO  
HEALTH INSURANCE****OVERVIEW**

The terms “health and accident insurance,” “accident and sickness insurance,” and “health insurance” are used interchangeably in the health insurance industry, from state to state and company to company. No matter what it is called in the industry, it all means the same thing to consumers; a critically important type of insurance that provides financial protection from the high costs of illness and injury.

This unit is designed to provide an overview of the broad field of health insurance, focusing on the basics. We will look at the types of health insurance plans including plans for the elderly; the providers of health insurance coverages; policy provisions; underwriting standards; and more.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Basic Forms of Health Insurance Coverage
- How Health Insurance Is Purchased
- Characteristics of Health Insurance
- Health Care Reform Act

**KEY TERMS**

Accidental Death and Dismemberment Insurance  
 Disability Income Insurance  
 Medical Expense Insurance  
 Morbidity  
 Participating Versus Nonparticipating Policies

Renewability Provisions  
 Reserves  
 Valued Versus Reimbursement Contracts

## **BASIC FORMS OF HEALTH INSURANCE COVERAGE**

In Florida, the term “accident and health” (A&H) refers to health insurance. This broad field protects against financial consequences for accidents, sickness (illness), disability, and injury. Also, areas of long-term care insurance (LTCi), accidental death and dismemberment, and social insurance, such as Medicare and Medicaid, fall into this category.

Three (3) distinct categories of health coverage within the field of health insurance are: (1) medical expense insurance, (2) disability income insurance, and (3) accidental death and dismemberment insurance.

### **Health Coverages and What They Provide**

Type of Coverage	Provisions and Benefits
Medical Expense Insurance	Provides benefits for the cost of medical care. Depending on the type of policy (and its specific provisions), coverage can range from limited (e.g., coverage for hospital costs only) to very broad (e.g., coverage for all aspects of medical services and care).
Disability Income Insurance	Provides a specified periodic income to the insured—usually on a monthly basis—in the event he becomes disabled.
Accidental Death and Dismemberment Insurance	Provides a lump-sum payment in the event the insured dies due to an accident or suffers the loss of one or more body members due to an accident.

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### ***Medical Expense Insurance***

This form of insurance provides financial protection against the cost of medical care by reimbursing the insured, either in part or fully, for the costs incurred. Medical expense insurance includes plans covering hospital care, physician and surgical expenses, medical treatment programs, and outpatient care. Plans that cover the elderly, like Medicare supplement insurance and long-term care insurance, are examples of medical expense insurance plans designed for the elderly.

### ***Disability Income Insurance***

This form of insurance is designed to provide an insured income when they suffer the inability to work due to a covered loss (disability). The plan does not provide for medical expenses associated with the disability. It only provides an income replacement up to the limits of specifications of the policy.

### ***Accidental Death and Dismemberment (AD&D)***

AD&D is the purest form of accident insurance, providing the insured with a lump-sum benefit amount in the event of accidental death or dismemberment under accidental circumstances.



## HOW HEALTH INSURANCE IS PURCHASED

Health insurance is available in many formats. For example, individuals can purchase plans to cover themselves or their family, or purchased as a group plan to protect employees, subscribers, or members.

### ***Individual Health Insurance***

Commercial insurance service organizations issue individual health insurance, whereas the individual can select options and or benefits to meet their insurance needs best. An individual health contract requires and application, and depending on the type of coverage, proof of insurability.

### ***Group Health Insurance***

Group health insurance, also issued by commercial insurance companies and service organizations, is available to employers, trade and professional associations, labor unions, credit unions, and other organizations. The employer is issued a "master contract," and the employees receive a "certificate of insurance" Since underwriting is gauged on a group level, individual evidence of insurability is seldomly required. As the master contract holder, an employer or association is responsible for submitting the entire premium amount. Although employers may provide for a payroll deduction for an employees' portion of a premium, full payment of the premium to the insurance company must still be tendered by the employer or association.

### ***Health Insurance is also provided by State and Federal Programs.***

Health insurance can be provided through both state and federal government programs. At the federal level, protection is afforded to assist the elderly, disabled, and program eligible participants through programs such as Medicare and Social Security. At the state level, a plan like Medicaid is available to assist low-income individuals in meeting medical care costs.

## CHARACTERISTICS OF HEALTH INSURANCE

Health insurance differs from life insurance in several important ways. Life insurance, particularly whole life insurance and annuities, is characterized by permanence; the insurer cannot cancel the policies unless the policyowner fails to make a required premium payment.

With health insurance policies, the permanence of a plan is subject to the renewability provision. There are five principal renewability classifications, each which individually defines the rights the insurance company has to cancel the policy at different points during the policy's life.

The five classes are: (1) cancellable, (2) optionally renewable, (3) conditionally renewable, (4) guaranteed renewable, and (5) noncancelable.

### ***Premium Factors and Modes***

Like life insurance, health premiums can be paid by selecting from one of several different payment modes. The least expensive premium mode is annual, followed by semiannual, quarterly, monthly, and weekly, including annual, semiannual, quarterly, monthly, and even weekly. Most insurance companies require that if premiums are to be paid frequently, such as monthly or weekly, the funds will be paid in the form of a pre-authorized check method.

Besides the numerous premium payment modes, various factors can influence the premium rates for health insurance. These include morbidity, interest, expense, types of benefits, claims experience, and the insured's age, sex, and occupation.

### Participating vs. Nonparticipating Policies

Health insurance policies may be written on either a participating (par) or nonparticipating (non-par) basis. Participating policies pay dividends, whereas nonparticipating policies do not.

<i>(Most Frequently)</i>	Participating (PAR)	Nonparticipating (Non-Par)	Dividends	Stock Company	Mutual Company
Participating	YES	NO	YES	NO	YES
Nonparticipating	NO	YES	NO	YES	NO
Individual Health - Stock	NO	YES	NO	YES	NO
Individual Health - Mutual	YES	NO	YES	NO	YES
Group Health – Stock	NO	YES	NO	YES	NO
Group Health - Mutual	YES	NO	YES	NO	YES

Whereas group health plans, issued by mutual companies, most frequently provide dividends, a group health plan issued by a stock company most frequently issue an experience-rated plan.

Two major factors influence whether dividends or experience-rated refunds are payable: the insurer’s (1) expenses and (2) claims costs. Suppose these cost items are less than anticipated, the group policyowner benefits by receiving a dividend or refund credit. If expenses and claims costs are higher than expected, the group policyowner may not qualify for a dividend or refund credit.

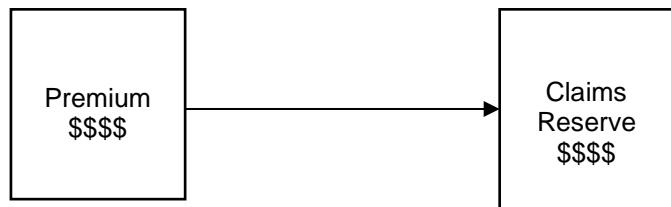
### Reserves

Reserves are monies set aside by an insurance company to pay future claims. Each part of a premium has a designated amount set for reserves.

There are two types of health insurance reserves: (1) premium reserves and (2) claims (loss) reserves.

*Premium Reserves.* These reflect the insurer’s liability for losses that have not occurred but for which premiums have been paid.

*Claims Reserved.* Represents the insurer’s liability for losses that have occurred but for which settlement is not yet complete. When a notice of claim is received, money is transferred from the premium reserve to the claims reserve.



### Claims

The health insurance claims process differs from that of life insurance. With health insurance, the claims process is not so clearly defined. For example, with medical expense insurance, the plan is typically based on a contract of reimbursement, meaning that the benefit received is not a fixed benefit but depends on the amount of the loss.

**Must Know: Review Unit 3**

**Valued Contracts are:**

Life Insurance	= \$100,000
AD&D	= \$100,000
Disability Income	= \$ 2,000 per month

The purpose is to reimburse the insured for the amount of loss sustained rather than a valued amount that is seen in life insurance, accidental death and dismemberment (AD&D), and disability income insurance plans.

## AFFORDABLE CARE REFORM ACT

### Subsidies



Individuals and families who make between 100% - 400% of the federal poverty level and want to purchase their insurance on an exchange are eligible for subsidies EXCEPT those eligible for Medicare, Medicaid, or on a group plan. Buyers will receive premium credits and will have a cap on the amount they have to contribute to the premiums on a sliding scale.

~~According to the ACRA, the Medicare prescription drug “donut hole” will be closed by 2020, and seniors currently hitting the “gap” will receive a 50% discount on brand name drugs.~~

## Medicaid



Regarding Medicaid, the Affordable Care Reform Act will expand Medicaid to include incomes within **138%** of the federal poverty level. Additionally, it will require states to expand Medicaid to include childless adults. **Illegal immigrants are not eligible for Medicaid**

## Insurance Reforms

The following insurance reforms have occurred because of the Affordable Care Reform Act.

1. Six months after enactment, insurance companies could no longer deny children coverage based on a preexisting condition.
2. Starting in 2014, insurance companies cannot deny coverage to anyone with preexisting conditions.
3. Insurance companies must allow children to stay on their parent’s insurance plans until age 26.

## Individual Mandate

In 2014, the ACRA stated that everyone must purchase health insurance. The ACA imposed an annual fine for individuals of \$695 for those that did not purchase health insurance; some exceptions applied for low-income people.

The federal Tax Cuts and Jobs Act (TCJA) eliminated the fine for tax years after 2018. Although the individual mandate still exists, there is no monetary penalty if a person does not purchase the ACA-required health insurance coverage. **NOTE:** some states have enacted local legislation to penalize individuals that do not acquire health insurance.

## Employer Mandate



“Employers with 50 or more full-time employees may have to pay a penalty if they do not offer qualifying health insurance to at least 95% of full time employees and their dependents. An employer with fewer than 25 employees who average less than \$50,000 in annual compensation may get a tax credit of up to 50% of its pre-costs (35% for tax-exempt employers) if it pays at least half of the premium for qualifying health insurance coverage”.

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**UNIT****16****HEALTH INSURANCE PROVIDERS****OVERVIEW**

Health insurance providers can be divided into three main categories: commercial insurers, service providers, and state and federal government. In all cases, the objective is the same: to provide protection against the financial costs associated with illness, injury, or disability. In this unit, we will look at some of the specific types of providers in each of these groups. We will also introduce Medicare and Medicaid, which play an important role in providing health insurance for a large segment of our population.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Commercial Insurance Providers
- Service Providers
- Government Insurance Programs
- Alternative Methods of Providing Health Insurance

**KEY TERMS**

Administrative-Services-Only (ASO) Plans

Commercial Health Insurers

Health Maintenance Organizations (HMOs)

Medicaid

Medicare

Multiple Employer Trusts (METs)

Multiple Employer Welfare Arrangements (MEWAs)

Preferred Provider Organizations (PPOs)

Self-Insured Plans

Service Providers

Social Security Disability Income

Third-Party Administrator (TPA) Plans

Worker's Compensation

## COMMERCIAL INSURANCE PROVIDERS

- Life and Health Insurance Companies
- Casualty Company
- Mono-line Company
- “Ordinary” and “Debit” (Home Service) Companies.
- Commercial insurers use the reimbursement approach.
- The “Right of Assignment” is built into most commercial policies.
  - Benefit payments are paid directly to the health care providers.
  - The patient is still held responsible for the bill.
  - It is still a contract of reimbursement.

## SERVICE PROVIDERS

### ***Service Providers are not insurance companies.***

1. Members are called *subscribers*, not policyholders.
  - a. Subscribers pay a premium and receive medical care services.
  - b. Not billed for services.
  - c. A contract exists between the medical care providers and the service organization to provide medical care to its subscribers.
  - d. The medical care providers are paid directly by the service organization.
    1. Opposite of the reimbursement approach.
2. This service approach is used primarily by two organizations: health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

### ***Health Maintenance Organizations (HMO)***

1. Offers comprehensive pre-paid health care services to its subscribers.
2. The plans are available to:
3. Groups, families, and individuals.
4. Subscribers pay a fixed periodic fee for a broad range of health services.
5. Doctors and hospitals provide the care through contracts with the HMO.
6. HMOs stress preventive care through early treatment programs.
7. Rarely Assess Deductibles.
  - a. If they do, it is nominal.
    - i. Called a co-payment
8. An HMO may be:
  - a. Self-Contained (Closed Panel HMO's)
  - b. Self-Funded Based on Dues or Fees
9. They May Contract For
  - a. Excess Insurance, or
  - b. Administrative Services by Insurance Companies.
12. Some HMOs are owned and sponsored by insurance companies.
13. The HMO Act of 1973, which provided some federal funding, spurred the HMO forward.
  - a. Requires employers with 25 or more employees to offer enrollment in an HMO if they provide health care benefits for their workers.

### ***Preferred Provider Organizations (PPO)***

1. A group of doctors, hospitals in private practice who offer their services at a discount rate.
  - a. Doctors join to broaden their patient-base.
2. Groups that contract with a PPO are:
  - a. Employers
  - b. Insurance companies
  - c. Health benefit providers
3. Members are not mandated to use the PPO but receive a reduced benefit if they do not. Example:
 

\$100 Co-Insurance in PPO	\$500 Co-Insurance outside PPO
---------------------------	--------------------------------

### ***Point of Service (POS)***

1. Form of managed care
2. Subscriber choice
3. In-Network
  - a. Insured receives care through a network of participating doctors and hospitals
  - b. Care Physician required (PCP)
4. Referrals and hospitalizations require PCP referral
  - a. Highest level of coverage within the plan
  - b. Plan pays more for medical services
5. Out-of-Network Care
  - a. Care received from a non-participating provider.
  - b. Care not coordinated by PCP
  - c. Subscriber pays more for medical services
  - d. Must submit claim forms

*Example:*

Chris is a member of a point-of-service plan. Chris develops a cardiovascular condition but decides not to follow the PCP's recommendations and see an in-network specialist.

Instead, Chris becomes the patient of a specialist in a neighboring city, who is not a participating provider (in the network).

Chris can expect that the POS plan will pay less than if an in-network participating provider had seen Chris.

## **GOVERNMENT INSURANCE PROGRAMS**

### ***Medicare***

1. For age 65 and older or any age if they suffer from kidney disease or on Social Security disability.
  - a. Marginal note = After 2 Years on Disability.

### ***Social Security Disability Income***

1. Requirements
  - a. Individuals must be so mentally or physically disabled that they cannot perform any substantial gainful work.
  - b. The impairment must be expected to last at least 12 months or result in an earlier death.
  - c. A five-month waiting period is required.
  - d. No second (5 months) waiting period is required if the disabled worker recovers and becomes disabled again within five years.

### ***Medicaid (Title XIX – Kerr-Mills Act 1965)***



1. Medicaid is a state and federal program.
  - a. Each state administers its own plan through federal guidelines.
  - b. Matching federal funds to states.
2. Its purpose is to help eligible needy persons, regardless of age who need medical care such as:
  - a. Low Income
  - b. Blind
  - c. Disabled
  - d. Under Age 21
  - e. Medicaid benefits may be used to pay Medicare deductibles and co-payment requirements.
  - f. **Individuals who qualify for both Medicare and Medicaid are known as dual eligible.**

### **State Worker's Compensation**

1. All states have enacted a worker's compensation program that benefits workers for occupational injuries, illnesses, and disabilities.
  2. Employers are responsible for providing these benefits to their employees and may purchase coverage through:
    - a. State Programs
    - b. Private Insurers
    - c. Self-Insuring
- ❖ Suppose a worker is killed in an industrial accident. In that case, the law provides for payment of burial expenses, subject to a maximum amount, and compensation for the surviving spouse or other dependents of the worker at the time of death.
  - ❖ Regardless of any negligence or due care by the employer, they are liable for work-related disabilities that employees suffer.
  - ❖ Under the law, a disabled employee is entitled to benefits as a matter of right without suing the employer for benefits. However, in return for the law's benefits, the employee gives up the right to sue the employer.
  - ❖ Under most laws, a disabled employee is paid benefits weekly or monthly, rather than in a lump sum.
  - ❖ The employer must provide the required benefits; the employee does not contribute to the plan.

The law provides for a schedule of benefits, which is based on such factors as the severity of the disability and the employee's wages. (at 60%)

## **ALTERNATIVE METHODS OF PROVIDING HEALTH INSURANCE**

### **Self-Insurance**

1. Large corporations generally self-insure their sick-leave plans.
2. Others may self-insure part of a plan and use insurance to protect against large, unpredictable losses.
  - a. Some groups adopt a minimum premium plan (MPP).
3. Many of these self-insured plans are administered by insurance companies or other organizations and pay a fee to handle the paperwork and process the claims.
  - a. When an outside organization provides these functions, it is called an administrative-services-only (ASO) or third-party administrator (TPA) arrangement.

### **Multiple Employer Trusts (MET)**

1. Group benefits to employers who have a small number of employees.
2. Each employer must become a member of the trust and sign a Joinder Agreement.
3. The MET may self-insure or purchase benefits from an insurance company.
4. Administered by an insurance company or a third-party administrator.

### **Multiple Employer Welfare Arrangements**

A multiple employer welfare arrangement (MEWA) is a type of MET for union employees. MEWAs are self-funded and tax-exempt. Employees covered under a MEWA are required by law to have an "employment-related common bond."

### **Direct Primary Care Agreements (DPCA)**

1. Contract between a primary care provider and a patient
  - a. In writing
  - b. Signed by both parties
  - c. Monthly fee (paid by patient)
  - d. Does not pay for services provided by a 3<sup>rd</sup> Party
  - e. Does not qualify as minimum coverage for PPACA. [624.27]



UNIT**30****HEALTH MAINTENANCE  
ORGANIZATIONS****OVERVIEW**

One of the biggest problems facing our state and our nation today is to furnish quality health care to our citizens while trying to control spiraling costs. The development of health maintenance organizations, or HMOs as they are commonly called, is one method of addressing this challenge. In Unit 16, we gave a brief overview of HMOs. Here, we will look more closely at these organizations in the context of Florida statutes and the rules and regulations of the Office of Insurance Regulation.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Purpose of Health Maintenance Organizations
- How an HMO Operates
- Definitions
- Regulation and Licensing
- Marketing Practices
- Required Benefits

**KEY TERMS**

Defamation	Open Enrollment
Extension of Benefits	Provider
Health Maintenance Contract	Subscriber
Health Maintenance Organization	Twisting
HMO Consumer Assistance Plan	Unfair Claim Settlement Practice

## **PURPOSE OF HEALTH MAINTENANCE ORGANIZATIONS**

### ***Provide an alternative method of health care.***

1. To provide comprehensive health care.
2. Deliver quality health care.
3. Control the cost of health care.
  - a. Early doctor visits. (Preventive care)
  - b. Volume discounts with doctors, hospitals, etc.
  - c. Cap on doctor's fees. (Capitation)
  - d. Encourages members to see doctors early.

### ***Comprehensive Health Care***

1. Means service, medical equipment, and supplies furnished by a provider.

## **HOW AN HMO OPERATES**

### ***They operate almost exclusively through the group enrollment system.***

1. Each subscriber pays a fixed monthly premium. (Periodic fee)
2. Stresses preventive care. (As opposed to just curative care)

## **DEFINITIONS**

### ***Health Maintenance Contract***

1. A contract between the subscriber or group of subscribers and the HMO.
2. For a fixed fee (monthly premium), the subscribers receive health care services.

### ***Insolvency***

1. All assets of the HMO would not be enough to discharge all of its liabilities.
2. The HMO is unable to pay its debts as they occur in the ordinary course of business

### ***Provider***

1. Physician
2. Hospital
3. Organizations that furnish health care services.
4. All must be licensed or authorized to practice in Florida.

### ***Subscriber***

1. The person who joins the HMO and pays a periodic fee. (Monthly premium)

### ***Capitation***

1. A fixed amount is paid to a doctor or provider for services rendered.

### ***Co-payment***

1. The specified dollar amount that the HMO subscriber must pay for certain covered health care services.

### ***Pre-paid Health Clinic***

1. Organization that delivers basic medical services at a specified location for members of a group who make regular premium payments in exchange for services.
2. Differs from HMO
  - a. Requirements are much less stringent
  - b. Limited to only the delivery of basic health services
3. Basic Health Services
  - a. Emergency care
  - b. Physician care other than hospital inpatient physician services
  - c. Ambulatory diagnostic treatment

- d. Preventative health care services
4. May not use the following words (or any derivative of) in a description of their services
  - a. "HMO"
  - b. "Surety"
  - c. "Insurance"
  - d. "Mutual"
  - e. "Casualty"

## REGULATION AND LICENSING

### Important Facts

- An HMO cannot offer insurance
- An HMO can offer only HMO contracts approved by FL-OIR and cannot engage in any other type of activity, including insurance
- An insurance company or service corporation can own or sponsor an HMO

### ***What are the requirements to start an HMO in Florida?***

1. HMO must be issued a certificate of authority by the Office of Insurance Regulation.
2. It will not do so until the HMO has received a health care provider certificate from the agency for Health Care Administration of Florida.
3. HMOs must file a report of activities to the Department of Insurance within three (3) months of the end of each fiscal year.

### ***Who May Sell HMOs?***

1. No person, unless licensed **and** appointed as a health insurance agent, may
  - a. Solicit contract or procure applications
2. Licensed health agents, or full-time salaried employees and officers not soliciting from the public and receives NO compensation for those sales

### ***Marketing Practices (with Regard to HMOs, Unfair Trade Practices Under Florida Law)***

1. Misrepresentations in HMO applications
2. Twisting
3. Illegal dealing in premiums
4. False claims; obtaining money dishonestly
5. Prohibited discriminatory practices
6. Misrepresentation in availability of providers
7. Adverse action against a provider
8. Rebating (exceptions apply)

*See State Study Manual  
for complete list*

### ***Defamation***

1. Anything oral or written that is false and intended to harm or injure any person.

### ***Misrepresentation***

1. Knowingly making a false or fraudulent representation on or relative to an application of an HMO contract, for the purpose of obtaining a fee, commission, money, or other benefit from any HMO, agent, or representative, broker, or individual.

### ***Unfair Claim Settlement Practice***

1. Failure to act on a claim upon the written request of the subscriber within a reasonable period.
  - a. Not to exceed 30 days after the HMO has received a proof-of-loss statement.

### ***Twisting***

1. Replacing a policy through misleading representations or fraudulent comparisons in order to:
  - a. Lapse
  - b. Forfeit

- c. Terminate
- d. Surrender

### **Penalties**

1. Penalty for violating the Unfair Trade Practices Act may include:
  - a. Probation
  - b. Suspension or revocation of the license or the HMO Certificate of Authority
2. Fines
  - a. Maximum fine up to \$200,000
  - b. If crime is determined to be criminal, it can result in imprisonment.

### **Special Procedures for Medicare Benefits**

1. The agent must also ask if this person is covered under a health insurance policy or a Medicare Supplement policy.
2. Subscribers must be informed that when they enroll in an HMO, they are disenrolled from Medicare.
3. The agent must ask if this person has been previously enrolled in the same or any other HMO as a Medicare participant.
4. There shall be no attempt to use fraud, deceit, force, fright, threat, intimidation, harassment, or undue pressure to make the sale.

### **HMO Consumer Assistance Plan (CAP)**

1. Provides coverage for subscribers of HMOs that become insolvent.
2. Florida law prohibits using the CAP in any way in the sale of an HMO contract, even if it is to reassure the prospect. [F.S. 631.827]

## **REQUIRED BENEFITS**

**FLORIDA LAW:** The HMO contract, certificate, or member's handbook must be delivered within ten working days after approval of the enrollment by the HMO. The contract must contain all of the provisions and disclosures required by the law.

### **Requirements Regarding an HMO Contract**

1. The rates must be fair.
2. HIV or AIDS is covered as any other sickness.
3. Fibrocystic condition cannot be excluded unless diagnosed through a breast biopsy that shows an increased disposition to developing breast cancer.
4. All services covered must be clearly stated.
5. Does not have to list surgical schedules.
6. The premium must be clearly stated.
7. Emergency treatment procedures for emergency treatment outside the HMO's geographic area.
8. Disenrollment and re-enrollment provisions must be noted.
9. Grace Period for an HMO and a PPO is Ten days.
10. Restrictions on preexisting conditions must be noted.
11. A statement defining the immediate coverage for newborn children.
12. Adopted children must be covered.
13. Preexisting conditions in children must be covered.
14. If covered, maternity services must allow for nurse-midwives, midwives, or birth centers, if located within the service area.
15. An ophthalmologist or optometrist may provide ocular services.
16. Anesthesia may be performed by a medical doctor or by a nurse anesthetist.
17. A time limit on certain defense clauses must be included.
  - a. After two years, only fraudulent statements may void a contract or deny payment for a claim.
18. A detailed ID card must be attached to the contract, certificate, or handbook.

**Definition of “Extension of Benefits”**

1. Every HMO contract must provide an extension of benefits such that if the HMO terminates the contract, claims approved, and benefits started while the contract was in force will continue to be paid until the earliest of the following:
  - a. Twelve months have expired.
  - b. The member is no longer totally disabled.
  - c. Another carrier assumes the coverage, or
  - d. Maximum benefits under the contract have been paid.

**Definition of “Open Enrollment”**

1. A group plan in Florida must have an open enrollment period of not less than 30 days every 18 months.
  - a. Each eligible group member may enroll regardless of health history

**Conversion of HMO Contracts**

2. A subscriber is entitled to a converted contract if they have been enrolled for at least three (3) months before the termination of a group HMO plan for any reason except:
  - a. Failure to pay premiums
  - b. Fraud in applying for benefits
  - c. Replacement by similar coverage within 30 days
  - d. Subscriber has left the geographic area of the HMO

**Required Benefits (Dermatologist)**

1. HMOs and EPOs must give subscribers/members direct access to dermatologists under contract with the HMO or EPO for office visits, minor procedures, and testing without the subscriber/member's need to go through a primary care physician.
2. The number of visits to a dermatologist without prior authorization may be limited to five office visits within 12 months.

**Required Benefits (Newborn Child)**

1. Contracts that provide coverage for a family member of the insured must also provide that the health insurance benefits for children will be payable for a newborn child of the insured from the moment of birth.
2. The law also requires that coverage be provided for a newborn child of a covered family member (for example, the newborn of a covered daughter or son) for 18 months.

**HMO Claim Payment to Providers**

1. Must pay directly to any contracted hospital, ambulance provider, physician, or dentist to which a subscriber has specifically authorized benefits to under the contract.
2. A subscriber may submit an attestation of assignment of benefits in writing or digital form
3. HMO has 12-months after payment of a claim to submit a claim for overpayment to the provider.
4. Florida law requires HMO to reimburse all claims within 20 days after the claim is received.
  - a. if additional information is requested
    - i. It must be submitted within 35 days of request.
    - ii. Contested claim must be paid or denied within 90 days, but no later than 120 days.

**FLORIDA LAW****What is a health maintenance organization (HMO)?**

A health maintenance organization is a health care delivery system that provides comprehensive health care services for its members. The members are typically enrolled on a group basis by their employer. The employer pays a fixed periodic contribution in advance for the services of participating physicians and cooperating hospitals. The employee may also contribute to the prepayment in some groups. [F.S. 641.31]

**How do HMOs differ from traditional health insurance plans?**

A major difference is that the HMO provides medical service while emphasizing preventive medicine and early treatment through routine physical examinations and diagnostic screening techniques. At the same time, the HMOs also provide complete hospital and medical care for sickness and injury.

Traditional health insurance plans are designed to provide reimbursement for medical costs incurred in treating sickness or injury. These plans emphasize **curative rather than preventive medicine and contribute** toward the cost of medical services rather than delivering the service.

**What is a "preferred provider organization" (PPO)?**

Following the passage of legislation in 1983, insurance companies were authorized to enter into "alternative rates of payment" agreements with licensed health care providers. Those entering into the agreements are called preferred provider organizations (PPOs).

The concept is that if one provider or a group of providers has a large volume of business from a group of insureds, it can afford to give them health care at lower guaranteed costs. This savings in health care costs can then be used to prevent health insurance premiums from increasing for that particular group of insureds. [Sec. 627.6375]

**What is an exclusive provider organization (EPO)?**

An EPO, or exclusive provider organization, is a new type of entity authorized by the 1992 Legislature. It is a provider that has entered into a written agreement with a health insurance company to provide health care services for certain insureds. It can offer these services through its own facilities or a network of health care professionals, or it may use another facility, such as an HMO. [Sec. 627.6472]

**What is a prepaid limited health service organization (PLHSO)?**

It is any person, corporation, partnership, or any other entity that, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers for the following services:

Ambulance services	Substance abuse services
Dental care services	Chiropractic services
Vision care services	Podiatric care services
Mental health services	Pharmaceutical services

These limited health service plans differ from typical, broad-ranged HMO services. The law does not allow for the provision of inpatient, hospital surgical services or emergency services, except as such services are provided incident to the limited health service.

A formal complaint system that provides reasonable procedures for resolving written complaints initiated by enrollees and providers is mandatory for all PLHSOs.

PLHSOs are prohibited from using the words "insurance," "casualty," "surety," "mutual," or "HMO" as part of their name, contracts, or other literature.

Florida law provides that no person may solicit contracts or procure applications or hold himself or herself out as engaging in the business of analyzing or abstracting prepaid limited health services contracts or of counseling or advising or giving opinions to persons relative to such contracts, other than as a consulting actuary, unless licensed and appointed as a health insurance agent.

UNIT**17****MEDICAL EXPENSE INSURANCE****OVERVIEW**

When people speak of their health insurance, they are usually referring to insurance that protects against the costs of medical care. Medical expense insurance, which is available in several different forms, reimburses policyowners for part or all costs of obtaining medical care. It is a vital form of insurance considered by many to be the one type of insurance they cannot do without.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Purpose of Medical Expense Insurance
- Basic Medical Expense Plans
- Major Medical Expense Plans
- Other Types of Medical Expense Coverage

**KEY TERMS**

Deductibles

Preexisting Condition

Basic Medical Expense Policies

Basic Surgical Expense

Basic Physicians' (Nonsurgical) Expense

Basic Hospital Expense

Stop-loss Feature

Limited Risk Policy

Coinsurance

Supplementary and Comprehensive  
Major Medical Expense Policies

## PURPOSE OF MEDICAL EXPENSE INSURANCE

Available in many forms, “medical expense” insurance provides for financial protection against the cost of your medical care for accidents and sickness. Provides coverage for doctors, surgical, drugs, nursing, convalescent care, diagnostic, lab, dental, etc. Medical expense insurance is available through two different policy plans, (1) basic medical insurance and (2) major medical insurance.

Basic medical insurance provides limited coverage, whereas major medical insurance offers broader coverage that works either as a supplement to a basic plan or a comprehensive stand-alone plan. Major medical insurance has limits that may be expressed as “per year,” “per cause,” or “lifetime” basis or combinations of those.

### ***Reimbursement vs. Fixed Rate Approach***

The reimbursement approach pays benefits as a reimbursement of actual expenses incurred.

#### Example

Kevin has this type of policy that pays a maximum benefit of \$200,000. He is hospitalized for ten days and has expenses of \$10,000.

- The policy would provide benefits of \$10,000 (the expenses incurred).

Dianne has an indemnity type policy that provides a \$100-per-day benefit for each day she is in the hospital. She is also in for ten days.

- Her policy will indemnify her by providing benefits of \$1,000. (\$100 per day for ten days)
- The money may be used for any purpose.

## BASIC MEDICAL EXPENSE PLANS

Basic medical expense insurance is sometimes called “first dollar insurance.” It provides limited benefits, and there are no deductibles and no coinsurance.

Basic medical expense policies classify their coverages according to general categories of medical care: (1) hospital expenses, (2) surgical expenses, and (3) physicians’ (non-surgical) expenses. Additional plans are available for nursing expenses and convalescent care.

### ***Basic Hospital Expense (“First Dollar Insurance”)***

Along with no deductibles and no coinsurance, basic hospital expense plans reimburse for hospital confinement costs, such as room and board and other miscellaneous expenses. The plan may also pay for outpatient care.

### ***Daily Room and Board (R&B)***

The basic hospital expense policies cover the daily cost of room and board. There are no set standards, the amounts payable vary, as do the length of time the benefits are payable. For example, some plans pay an in-hospital benefit for as long as 365 days, whereas others pay for only 30-60-90 days period. A flat amount paid per day, also known as an indemnity basis),

### ***Miscellaneous Expenses***

Also known as hospital extras, miscellaneous charges are also covered under basic medical expense plans. Some of the expenses include drugs, x-rays, anesthesia, lab fees, dressings, use of the operating room, and supplies.

Generally expressed as a multiple of the room and board benefit (10 times or 20 times room and board), the amount covered may also be a stated dollar amount. In addition, the plan may also set maximum benefits.

**Example:** If the maximum benefit is \$150 for anesthesia and the hospital charge is \$200, the policy will pay only \$150 even if the maximum has not been reached.



**Note:** Physician's services are not covered under a basic expense policy even in the case of surgery but are covered only under basic surgical or basic physicians (non-surgical). Usually, we find all categories under one umbrella policy, but they can be written as separate coverages.

**Basic Surgical Expense**

Pays the cost of the surgeon's services in or out of the hospital and the cost of the anesthesiologist and post-operative care. There are three (3) different approaches used.

*Surgical Schedule*

An insurer assigns every surgery a dollar amount if the surgeon's bill is more the insured pays the balance. If the less, the insurer only pays the amount billed.

*Reasonable and Customary Approach - (R&C)*

Under this approach, the charge is compared to what is deemed "R&C" for a geographical part of the country where the surgery was performed. If it is within the "R&C" parameters, the bill is usually paid in full. This is a more open approach than surgery schedules.

*Relative Value Scale - (RVS)*

Here, a set of points are assigned to every surgical procedure instead of a flat dollar amount.

- a. A triple-heart-bypass is considered a maximum procedure and is assigned a high number of points (500 or 1000).
- b. Appendectomy is major, but not as serious, thus may be assigned 200 points
- c. A broken finger may be allocated 5 points.

Based on a dollar-per-point amount, a conversion factor is utilized to determine a benefit amount.

**For example:**

\$5.00 per point conversion factor would pay:  
 \$1,000 for a 200-point procedure.  $200 \times \$5.00 = \$1,000$   
 Remember: Larger the conversion factor. Higher the premium.

**Basic Physicians (Non-Surgical)**

Basic physicians' expense insurance provides benefits for non-surgical physicians' services. The plan covers office visits and care while in hospital for no surgical reasons. Benefits are paid on an indemnity approach, which is a flat fee. The plans carry several exclusions, such as x-rays, drugs, dental treatment, as they are covered under a different plan.

**Other Basic Plans**

Two other plans that fall under medical expenses are nurses' expense benefits and convalescent care facility benefits.

Nurses' expense benefits are generally limited to private duty nursing care ordered by the doctor while in the hospital.

Convalescent care facility coverage provides a maximum daily benefit for confinement in a "skilled nursing facility" following discharge from a hospital for a specified recovery period. Rest cures (respite) and custodial care are not covered.

Medical Expense Category	What Is Covered
Hospital expense	Daily room and board Miscellaneous expenses
Surgical expense	Cost of surgeon's services Anesthesiologist
Physicians' expense	Office visits Nonsurgical care by a physician while hospitalized
Nurses' expense	Private duty nursing care
Convalescent care expense	Skilled nursing facility expenses

Basic medical expense policies provide coverage according to general categories of medical care. Policies covering all categories are available, as are policies that cover only select categories.

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## MAJOR MEDICAL EXPENSE PLANS

### Major Medical Plans

1. Provides for high benefit limits
2. Available as individual and group
3. Provides broad coverage
  - a. Hospital room and board
  - b. Blood and oxygen
  - c. Prosthetic devices
  - d. Surgery
  - e. Physician fees
  - f. Nursing services (in-home and hospital)
  - g. Ambulance
  - h. Dental – **AS A RESULT OF AN ACCIDENTAL INJURY**

### Supplementary Major Medical

1. Broad coverage.
  - a. \$250,000, 500,000 or \$1,000,000 Maximum.
2. Covers expenses are not covered under the basic plan.
3. Also covers excess expenses not covered under basic.

### Comprehensive Major Medical

Comprehensive plans cover virtually all medical expenses-hospital expenses, physician and surgeon expenses, nursing care, drugs, physical therapy, diagnostic x-rays and laboratory services, medical supplies and equipment, transfusions, and more under a single policy.

### Deductibles

A deductible is an amount that the insured must pay before plan benefits are paid. For example: if a plan has a \$2,500 annual deductible, the insured is responsible for the first \$2,500 of expenses each year. The plan then pays covered expenses above \$2,500. (Subject to any coinsurance).

There are three kinds of deductibles: (1) flat deductible, (2) corridor deductible, and (3) integrated deductible

#### Flat Deductible

1. Used with a comprehensive policy.
2. Insured must pay the deductible before policy benefits are paid.
3. Usually, policies will include a family deductible.
  - a. Equal to three times the deductible amount.

**Example:** A policy with a \$500 deductible:

Total Expenses:	\$2,000
Deductible	<u>-\$500</u>
Balance	\$1,500 (insurer basis for

payments)

#### Corridor Deductible

1. Typical for a supplementary major medical policy.
2. Backs up a basic medical expense policy.
3. The basic covers hospital costs until the benefits are exhausted.
4. The insured then pays the deductible.
5. The supplementary major medical then picks up where basic left off.

**Example:** A supplementary policy with a \$500 Corridor deductible 80/20 Coinsurance:

Total Expenses:	\$8,500
Basic Paid	<u>-\$2,000</u>
Balance	\$6,500
Corridor Deductible	<u>-\$500</u>
Balance	\$6,000 (Insurer basis for payments)

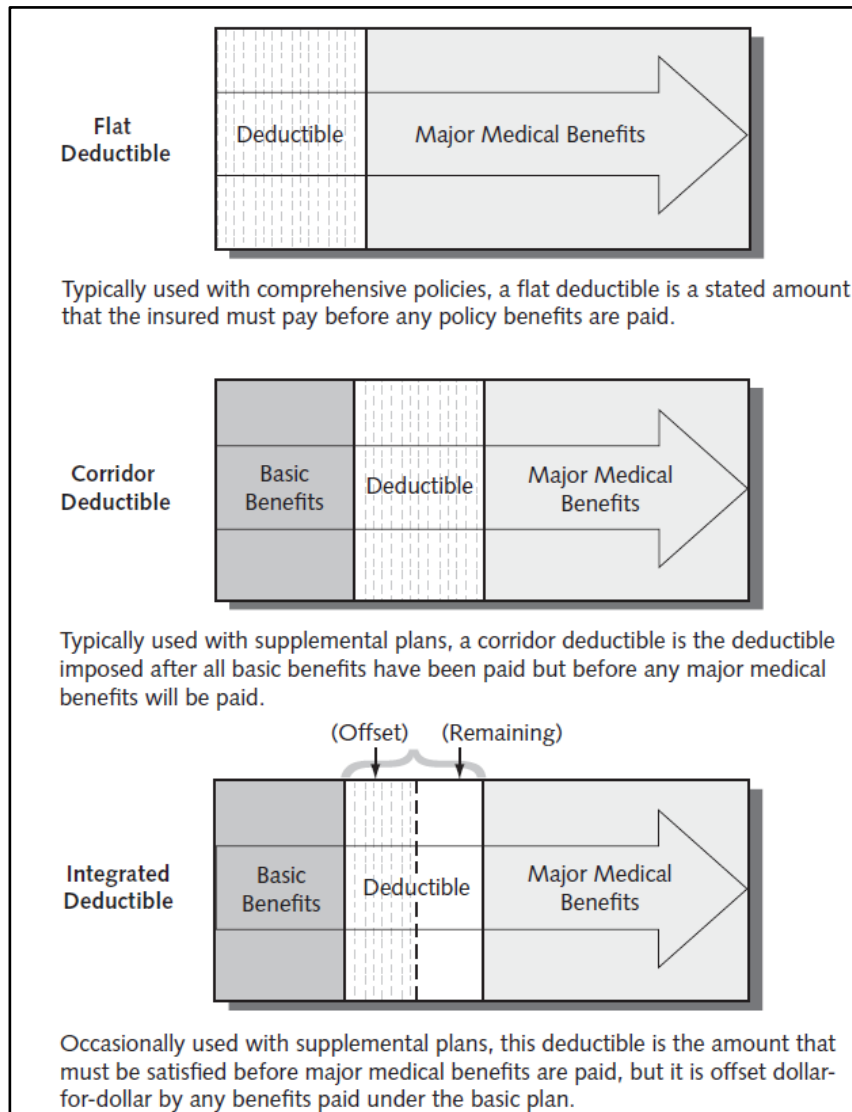
*Integrated Deductible*

1. Used with a supplementary major medical policy.
2. Coordinated with the basic medical plan.
  - a. The benefits paid by the basic plan will be applied to satisfy the deductible in the major medical plan.

A supplementary policy with a \$3,000 integrated deductible:		
Coinsurance: 80/20	Total Expenses: \$20,000	Deductible: \$3,000
Basic Paid	\$10,000	\$10,000
Balance	\$10,000	(\$7,000)
Deductible	\$ 0	
Balance	\$10,000	
Insured Paid 20%	\$ 2,000	
Major Medical Paid 80%	\$ 8,000	

Because the basic benefits paid was more than the deductible, the result was \$0 deductible to be paid by the insured. The Major Medical Plan paid the remaining \$8,000 balance.

Because the basic benefits paid were more than the deductible, the result was 0 deductible to be paid by the insured. The Major Medical Plan paid the remaining \$8,000 balance.



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Each of the preceding deductibles may be figured on one of two bases. (1) Calendar year deductible and (2) per cause deductible.

With a calendar year deductible, the deductible is applied only once each year. With a per cause deductible, the deductible is required for each separate accident or each separate illness. It may be stated as "each sickness or each injury."

**Coinsurance or percentage participation.**

1. The insured shares the company's cost on a percentage basis (i.e., 80%/20%).
2. Coinsurance must be paid by the insured for the life of the contract.

Example – Joe 80/20 Coinsurance			
		Insurer	Joe
Total Expense	\$12,000		
Deductible	\$ 2,000		\$2,000
Balance	\$10,000	\$8,000	
	x 80%		<u>\$2,000</u>
	x 20%	<u>\$8,000</u>	<u>\$4,000</u>

**Stop-Loss Feature**

1. Found in many major medical policies.
2. Limits the insured's out-of-pocket expenses.
  - a. After the insured pays the specified amount, the insurer pays 100% of covered expenses after that point.

**Comprehensive Major Medical Policy with a Stop-Loss Feature**

Total Bill	\$20,000
Deductible	<u>\$ -500</u>
Balance	\$19,500
Insured Pays 20% of the next \$5,000	<u>\$ -1,000</u>
Major Medical Pays	\$18,500
The Insured Paid the Stop-Loss amount	\$1,000
The Insured Paid the deductible amount	<u>\$ 500</u>
The total amount paid by the Insured	\$1,500
The total amount paid by the policy	<u>\$18,500</u>
Total Bill	<u>\$20,000</u>

Wayne has a policy with a \$2,000 deductible with an 80/20 coinsurance on the next \$10,000 in covered expenses. The policy fully absorbs the amounts above that. Wayne incurs hospital and surgical bills of \$20,000. How are the payments assigned?

Total Bill	\$ _____
Deductible	(\$ _____)
Balance	\$ _____
Insured Pays 20% of the next \$5,000	(\$ _____)
Major Medical Pays	\$ _____
The Insured Paid the Stop-Loss amount	\$ _____
The Insured Paid the deductible amount	\$ _____
The total amount paid by the Insured	\$ _____
The total amount paid by the policy	\$ _____
Total Bill	\$ _____

### **Stop-Loss / Maximum Out-of-Pocket Feature**

This is a feature that limits the insured's out-of-pocket expenses. Once the insured has paid-out a specified amount towards their covered expenses, the company will pay 100% of covered expenses after that point.

There are two methods on how a stop-loss cap is defined; (1) maximum out-of-pocket (MOOP) or stop-loss Provision.

The MOOP policy may stipulate that the contract will cover 100% of eligible expenses after the insured incurs a set amount of out-of-pocket expenses, including the deductible.

Another method, known as the stop-loss provision, specifies that the coinsurance provision applies only to the next sum of covered expenses after the deductible is paid, with full coverage for any remaining expenses.

### **Preexisting Conditions**

1. A preexisting condition is an illness or physical condition that existed before the policy's effective date and usually is excluded from coverage.
2. Federal law has impacted this provision
  - a. HIPAA has limited employer-sponsored groups and insurers.
3. ACA eliminated preexisting exclusions for approved ACA medical expense plans



### **High Deductible Health Plans (HDHP)**

1. HDHP is a health plan that offers very low premiums but requires the insured to pay a relatively high deductible.
2. For an individual, a qualified HDHP has a minimum deductible of \$1,400 and a cap on out-of-pocket expenses of \$6,900
3. A family HDHP has a minimum deductible of \$2,800 and a cap of \$13,800.  
**These limits are for 2020. They are indexed for inflation and change annually.**
4. HDHPs require substantial deductible and co-payments from participants. They are usually paired with one of the health savings accounts discussed in the following (HSAs, FSAs, and HRAs).
5. These accounts allow employers or employees to put aside contributions that are tax-free and grow tax-free so long as they are used to pay qualified medical expenses.

#### *Health Savings Accounts (HSAs)*

1. A tax-favored vehicle for accumulating funds to cover medical expenses.
2. Individuals under age 65 are eligible to establish HSAs if they have a qualified high-deductible health plan.
  - a. For 2020, annual pretax contributions of up to \$3,550 for an individual or \$7,100 for a family could be made to an HSA. Individuals with HSAs who are age 55 and older may make additional annual contributions of \$1,000.
3. Earnings in HSAs grow tax-free, and account beneficiaries can make tax-free withdrawals to cover current and future qualified healthcare costs.
4. Nonqualified withdrawals are subject to income taxes and a 10% penalty tax.
5. Ages 55 to 65 can make additional catch-up contributions. (\$1,000 per year)
6. Upon death, HSA ownership may be transferred to a spouse tax-free.

#### *Flexible Spending Accounts (FSA)*

1. The flexible spending account (FSA) is a cafeteria plan that is funded with pretax employee contributions called salary reductions;
  - a. The employee agrees to a reduction in compensation,
  - b. These funds are set aside to pay certain medical expenses.
2. When paired with an HDHP, this results in lower employer costs for the health care plan, and the employees are provided with a convenient, tax-advantaged way to meet their higher plan obligations.
3. FSAs are usually found in medium to large sized employers.

*Health Reimbursement Accounts (HRA's).*

1. In this arrangement, the employer sets aside pretax contributions for each employee to pay deductibles, coinsurance, and co-payments.
2. The employer sets plan limits and authorized uses of these funds, and typically unused funds may roll over from year to year.
3. HRAs are the dominant funding form for HDHPs.

**OTHER TYPES OF MEDICAL EXPENSE*****Hospital Indemnity (Hospital Fixed Rate Policy)***

1. Hospital Indemnity pays a daily, weekly, or monthly amount specified.
  - a. For Example: \$100 per day – Based on the number of days hospitalized.

***Limited Risk Policies***

1. Also known as dread disease or critical illness.
  - a. Pays only specific kinds of illness (i.e., cancer, aids, heart disease, etc.).
  - b. Pay a lump sum to help defray medical costs.
2. Accident only insurance
  - a. Coverage for accidents only – NO SICKNESS
3. Short-Term Medical expense
  - a. Coverage for a specific time frame
  - b. Time frame is chosen at the time of application
  - c. Non-renewable
  - d. Term coverage only. Expires at the end of term

UNIT**18****DISABILITY INCOME INSURANCE****OVERVIEW**

The risk associated with disability is not merely the loss of income; there is also the additional cost of caring for a disabled breadwinner who no longer can earn an income. Because a disability can be permanent, the financial consequences rank in severity with the deal of the wage earner. The sudden loss of income resulting from a disabling accident or illness would, in most cases, lead to serious financial consequences. Fortunately, protection is available. The purpose of this unit is to describe the important role disability income insurance serves and to explain the different features found in these types of policies.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Purpose of Disability Income Insurance
- Disability Income Benefits
- Disability Income Policy Provisions
- Disability Income Policy Riders

**KEY TERMS**

Any Occupation	Probationary Period
Cost-of-Living Adjustment Rider	Residual Disability
Elimination Period	Residual Disability
Guaranteed Insurability Rider	Social Security Rider
Own Occupation	Total Disability
Partial Disability	Waiver of Premium Rider
Presumptive Disability	

**DISABILITY INCOME = DI**

- ❖ **Statistics prove that the probability of disability greatly exceeds the probability of death during an individual's working years. The risk associated with disability is not merely the loss of income; there is also the additional cost of caring for a disabled breadwinner who no longer can earn an income.**

**I. Purpose of Disability Income Insurance**

**A. Disability income insurance is designed to provide an individual with a stated amount of periodic income if they cannot work due to a disabling illness or accident.**

1. The need for protection against a wage earner's economic death cannot be overemphasized, and it is this need that disability income insurance fills.

**B. Available to:**

1. Individuals
2. Groups
3. Businesses

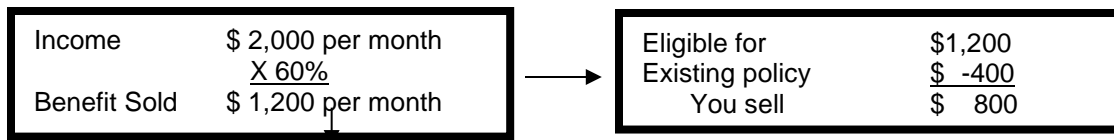
**C. Covers Accidents Only or Accident and Sickness.**

1. You cannot buy a sickness only policy.

**II. Disability Income Benefits**

**A. Insurers place a ceiling on the amount of benefit anyone can buy.**

1. It is 60% of Income.



2. If, in the example above, the client already owned a DI policy with a \$400 per month benefit, then you would sell him \$800.

**B. Extremely Hazardous Occupations**

1. Both job-related and non-job-related disabilities would be covered in an occupational policy.

**C. Disability Defined**

1. What constitutes "total disability" varies from policy to policy.
  - a. There are two definitions: any occupation or own occupation.
2. Any Occupation
  - a. Restrictive definition; cost less to purchase
  - b. The client must be totally disabled and unable to perform "any occupation," education, training, or experience reasonably suit him/her."
3. Own Occupation
  - a. Liberal definition; cost more to purchase
  - b. The insured must be unable to work at their own occupation due to an accident or sickness. (Usually two years, five years, ten years, etc., after that, any occupation).
  - c. Strict underwriting but is more advantageous to the client.
  - d. Products are said to use a "loss of earnings test."

**D. Presumptive Disability**

1. If the client suffers from blindness, deafness, loss of speech, or loss of two or more limbs, the company pays even if the client could work.
2. Benefits are often paid in a lump-sum settlement with the insured.



**E. Partial Disability**

1. Client's inability to perform "one or more important duties" of their job or the inability to work at that job on a full-time basis, either of which results in a decrease in income.
2. Designed to reduce the frequency and length of total payments as if one is capable of some form of work

**F. Methods Used to Determine Benefits**

1. Percent of insured pre-disability income benefits = Group Plans
2. Flat Amount Benefit = used in individual policies
  - a. Amount Paid: Usually, 50% of the monthly benefit. Set the amount stated in the policy.

Example:	\$1,000 Disability Policy
Partial Payment	\$500
<u>Conditions:</u>	Totally Disabled First
<u>Rationale:</u>	Encourages client to return to work even part time, without fear of loss of all benefits.

**G. Residual Disability**

1. Protects Income Lost.
2. Based on a percentage of lost income.
  - a. The client returned to work on a part-time basis earning only 60% of his pre-disability income. He lost 40% so that the policy would pay him 40% of the benefit.
3. Will pay as long as an income is reduced 20% or 25% below "pre-disability" income.
4. Provided through a rider
5. The insured does not have to have been totally disabled as such in partial disability

<u>Larry returned to work and took a 40% cut in salary.</u>	
<u>Partial (Totally Disabled First)</u>	<u>Residual—Until below 20 or 25%</u>
Pays 50% of the benefit	40% of the benefit
After 6 Months	Indefinite
\$0	\$\$\$\$\$

**H. Cause of Disability**

1. Definitions
  - a. Accidental Bodily Injury
    - i. Most liberal.
    - ii. Costs more.
    - iii. The client would collect.
    - iv. Only the "results" must be accidental.
  - b. Accidental Means
    - i. Is A Very Mean Definition
    - ii. Very Restrictive
    - iii. Costs Less
    - iv. Client Rarely Collects
    - v. The "Cause" must be accidental

You jump off your roof instead of climbing down the ladder and break your leg. This definition will pay. The **results** were accidental.

You jump off your roof instead of climbing down the ladder and break your leg. This definition will not pay. The **cause** was not accidental.

**III. Disability Income Policy Provisions (Seven Provisions)**

**A. Probationary Period**

1. "Probationary Period" is the period that must elapse following the effective date of the policy. (i.e., 15 or 30 Days. One Time Only Period).
  - a. *A disability income probationary period applies to sickness only; it does not apply to accidents. Whereas a person may anticipate a sickness-related disability, it is not possible to anticipate an accident.*

**B. Elimination Period**

1. "Elimination period."
  - a. Works like a deductible.
  - b. The time frame following the start of a disability when benefits are not payable.
    - i. Depending on the policy, the elimination period may apply to a disability from sickness but not accidents.
  - c. The longer the elimination period (waiting period), the lower the premium.
  - d. Sold in a variety of options (weeks, months, years)

**Example:** How much money does a client have to bank to carry themselves and their family?

30 Days' Worth\*

6 Months' Worth

1 Years' Worth

**C. Benefit Period**

1. "Benefit Period"
  - a. How Long Does Client Want Us to Pay?
    - i. The longer the payout, the higher the premium.
2. There are two types.
  - a. "Short Term" -- six months to two years
  - b. "Long Term"-- more than two years.
    - i. i.e., 5 Years--10 Years--20 Years--or To Your Age 65--AKA: LTD @ 65
3. However, it is not the same in-group disability policies.

These Two Provisions Set the Rate Along with the Amount of the Benefit.

- Elimination Period
- Benefit Period

Agent: If a prospect loves the plan but balks at the price, what could you do to reduce the premium?

- ✓ Reduce the benefit.
- ✓ Lengthen the Elimination Period
- ✓ Shorten the Benefit Period

**D. Delayed Provision**

1. After an accident, total disability does not occur immediately.
2. Some carriers permit for a delay not to exceed 30-60-90 days.
3. Varies per carrier

**E. Recurrent Disability**

1. Sometimes we recover, and weeks or months later suffer a recurrence of the same disability.
2. Most policies pay IF the recurrence is within 6 months.
3. No new waiting periods.
4. If back to work for more than six months, it is a new disability, so a new waiting period applies.

**F. Non-Disabling Injury**

1. Does not qualify for disability income
2. Provision pays for actual cost of medical treatment
3. Must be the result of an accident
4. The benefit is 10% of the monthly disability income benefit

**Example:** \$ 2,000 DI Benefit

@ 10%

\$200.00 per month

i.e., Whiplash needs to go to the doctor three times a week for an adjustment or ultrasound.

**G. Elective Indemnity**

1. Applicable with Short-Term Disability (STD) income policies
2. Provides for an optional lump-sum payment for certain named injuries.
3. Must be selected by the insured when applying for policy.

**IV. Disability Income Policy Riders - Additional \$\$\$\$**

**A. Waiver of Premium Rider**

1. Included in Guaranteed Renewable and Non-Cancellable Policies.
2. Exempts the policyowner from paying premiums during a disability.
  - a. Must be totally disabled for a period stated in the policy (typically, 3 or 6 months)
  - b. Premiums continue to be paid by the insurer as long as the disability continues, and the benefit period lasts.
3. Rider drops off at age 60 or 65.

**Example:**

The client bought a 10-year benefit period with a 6-month waiver. He pays six months premium; He is refunded, and the insurer pays.

Q. What happens if he is still in a wheelchair beyond the 10-year benefit period?

A. Benefits end.

**B. Social Security Rider / Social Insurance Substitute (SIS) Rider**

1. Pays additional income when insured is eligible for social insurance benefits, but these benefits:
  - a. Have not yet begun.
  - b. Have been denied.
  - c. Have begun, but the amount is less than the benefit amount of rider.
2. Covered under the definition of "social insurance" are:
  - a. Disability benefits from social security.
  - b. State and local government programs.
  - c. Workers' compensation programs.
3. The client must state the amount of Social Security benefits expected.
  - a. The expected level of benefits must be realistic.
    - i. i.e., Regarding Earnings Level.
  - b. Must show they applied to Social Security for benefits.
    - i. Social Security Administrator of a state or local program determines the benefits.
    - ii. Actual vs. Expected
      - (1) Rider is paid as an additional Disability Income benefit.

**Example:**

Client Bought	\$2,000 Month DI = 60% of income
SS Rider of	\$ 600 per Month
But SS Only Paid (PIA)	<u>\$ 400</u> per Month
SS Rider will pay	\$ 200
Policy paid	\$2,200
SS paid	<u>\$ 400</u>
Total	\$2,600 per month.

**C. Cost of Living Rider / Cost of Living Adjustment Rider (COLA)**

1. Uses the CPI = Change of at least 4%
2. Adjusted on each disability anniversary dates
3. When and IF disability ceases, the policyowner can
  - a. maintain the policy at the newly increased benefit level by paying the additional premium
  - b. Let the benefit return to the original amount for the same premium.

**D. Guaranteed Insurability Rider / Future Increase Option (FIO)**

1. Disability income is the only type of health insurance this rider may be attached to.
2. Guarantees the insured the right to purchase additional amounts of disability income coverage at predetermined times in the future without evidence of insurability.
  - a. Most guaranteed insurability riders require the insured to exercise the option for additional coverage before a specific age.
  - b. Guarantee may be contingent upon insured meeting and earnings test before each purchase – stipulated by insurer to avoid over insurance.
  - c. Most riders require the insured to exercise option before a specific age.

**Let us put it together**

Amount of Benefit

(60% of \$4,500) = \$2,700

Elimination Period-----No payments during this period.

(30, 60, 90, 120, etc.)

Benefit Period-----Maximum period for continuous payments

(Short term --- 6 months to 2 years)

(Long term --- to Age 65)

Probationary Period -- 15 or 30 days -- one time only from policy effective date.

UNIT**19****ACCIDENTAL DEATH &  
DISMEMBERMENT INSURANCE****OVERVIEW**

The risk associated with disability is not merely the loss of income; there is also the additional cost of caring for a disabled breadwinner who no longer can earn an income. Because a disability can be permanent, the financial consequences rank in severity with the deal of the wage earner. The sudden loss of income resulting from a disabling accident or illness would, in most cases, lead to serious financial consequences. Fortunately, protection is available. The purpose of this unit is to describe the important role disability income insurance serves and to explain the different features found in these types of policies.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Purpose of Disability Income Insurance
- Disability Income Benefits
- Disability Income Policy Provisions
- Disability Income Policy Riders

**KEY TERMS**

Accidental Death and Dismemberment Coverage  
Accidental Means Versus Accidental Results  
Capital Sum  
Limited Risk Policies  
Principal Sum  
Special Risk Policies

## Accidental Death and Dismemberment (AD&D)

### ❖ Is Considered a Hybrid

- Paying benefits in the event of an **Accidental Death** or **Dismemberment**

## I. Nature of AD&D Policies

### A. AD&D is pure accident insurance; it serves a limited purpose

1. Pays lump sum benefits in the event of accidental death.
2. Accidents
  - a. Violent    }
  - b. External   } Death Must Occur Within 90 Days.
  - c. Pure       }
3. Pays in the loss of body members
  - a. "Severance" of hands
  - b. "Severance" of feet
  - c. Loss of one or both eyes
4. "Severance" is defined as: At the wrist or ankle joint or entire irrevocable loss of sight.
5. Payment for Hospital - Surgical or medical expenses are generally not included.

## II. AD&D Benefits

### A. Principal Sum = Death Benefit; Is the Amount Purchased, i.e. \$50,000 Or \$100,000.

1. This is the maximum amount (purchased) that the policy will pay.

### B. Capital Sum = Pays for Loss of Sight or Dismemberment

- a. Expressed as a percentage of the **principal sum**. The benefit varies according to the severity of the injury.
- b. Loss of one (1) foot or one (1) hand = 50% of principal sum
- c. Loss of one (1) arm or one (1) leg = 2/3 of principal sum
- d. Extreme loss of both feet or loss of sight of both eyes = 100% of principal sum

#### Example:

Kevin Has AD&D Policy of \$50,000 "Principal Sum"  
 Pays \$50,000 Loss of Life. (Principal Sum)  
 \$50,000 Loss of Two Limbs or Loss of Sight Both Eyes. (Capital Sum)  
 \$25,000 Loss of Sight One (1) Eye or Dismemberment of One (1) Limb.  
 The \$25,000 is the "Capital Sum"

### C. Some AD&D Pay Double, Triple, or Quadruple the "Principal Sum."

1. Policy may state, "this policy will pay triple the principal sum if killed while riding as a fare-paying passenger in a commuter vehicle." (Bus, train, plane, etc.)
2. AD&D policies pay a stated benefit. They are valued contracts – not contracts of indemnity

### D. Accidental Means vs. Accidental Results

1. Accidental Means is a "MEAN" Definition.
  - a. "Means" require that both the cause and the result of an accident must be unintentional. However, the more liberal "Accidental Results" definition requires only the accident's injury must be unintentional.

#### Example:

Ted intentionally jumps off the roof of his house after fixing his antennae (instead of climbing down the ladder), and so severely injures his leg that it must be amputated. He would be paid the % of capital sum **ONLY** if his policy had used the "RESULTS" definition, but the "means" definition, no benefit would be payable. Because Ted intentionally jumped, causing the injury. Most states now require the "accidental results" definition to be used.

**III. Other Forms of AD&D**

**A. AD&D** may be purchased by individuals as a single policy or be part of an individual disability income policy. However, it is an aspect of group insurance plans, group life, or group health, or it may itself be comprised as a group plan. Pays both "occupation and non-occupation."

**B. Limited Risk Policies**

1. Aviation policy = Trip only.
2. Automobile policy = While riding in a car.
3. Travel Accident Policy, But Only One Year.

**C. Special Risk**

1. Covers Unusual Hazards Normally Not Covered under ordinary A&H insurance.
  - a. An Actress Insures Her Legs For 1 Million.
  - b. Test pilot, auto racer, Etc.

**Can You Name All Five (5) Uses Of AD&D?**

1. Individual
2. Group
3. Part of DI
4. Limited Risk
5. Special Risk

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UNIT**20****GOVERNMENT HEALTH  
INSURANCE PROGRAMS****OVERVIEW**

Many people receive health care cost protection through federal or state government programs. Government officials have long struggled to find a solution to the problem of affordable health care. In the mid-1960's, the problem of providing medical care for the poor and elderly was solved, in part, by the passage of the Social Security Amendments of 1965. Part of that legislation, called Title XIX, created Medicare and Medicaid. Medicare provides hospital and medical expense insurance protection to those aged 65 or older. Medicaid, jointly funded by the states and the federal government, reimburses hospitals and physicians for providing care to needy and low-income people who cannot finance their own medical expenses. In this unit, we will look at Medicare and Medicaid, as well as workers' compensation programs.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Medicare
- Medicaid
- State Worker's Compensation Programs

**KEY TERMS**

Benefit Period  
Lifetime Reserve  
Medicaid  
Medicare  
Medicare Advantage  
Medicare Part A  
Medicare Part B  
Medicare Part C  
Medicare Part D

## The Medicare Program

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure called End-stage Renal Disease (ESRD). Medicare covers many health care services and supplies, but there are many costs (“gaps”) it does not cover.

Medicare is administered by the Center for Medicare and Medicaid Services (CMS), which is a division of the United States Department of Health and Human Services. Medicare is divided into four parts: Part A, Part B, Part C, and Part D. Together, Part A and Part B are known as the Original Medicare Plan.

### Part A – Hospital Insurance (HI)

Part A, which covers hospitalization insurance, skilled nursing facilities, and some home health and hospice care, is financed through compulsory payroll taxes. Benefit is automatically provided once an individual qualifies for Social Security benefits.

Medicare Part A - Benefits and Deductibles		
Paid by	Time Period	Summary
<b>In-patient hospital services, including semi-private room and board, and nursing services.</b>		
Medicare, with patient deductible	First 60 days of benefit period	All covered services; Patient pays deductible (\$1,364 in 2019; \$1,408 in 2020)
Medicare, with patient co-pay	Days 61-90 of benefit period	Reduced covered services; Patient pays daily co-pay (¼ of the initial deductible)
Medicare with higher patient co-pay	Days 91-150 of benefit period Limited to 60 days total lifetime	Paid from 60-days lifetime reserve; Patient pays daily co-pay (½ of the initial deductible)
<b>Post-hospital skilled nursing care in an accredited skilled nursing facility (SNF)</b>		
Medicare	First 20 days after a minimum of 3 consecutive days in the hospital	Medicare pays in full for all covered services
Medicare with patient co-pay	Next 80 days (days 21-100)	Patient pays daily co-pay (⅓ of initial hospital deductible)
Patient	After 100 days (day 101+)	No Medicare benefits; Patient pays all
<b>Hospice care, skilled nursing (hospital or home), medications, and respite for caregivers</b>		
Medicare	Death expected within 7 months (210 days)	Medicare pays all covered services for terminally ill patients and families
<b>Home health services, nursing care, therapy, medical supplies, and part-time home health aide</b>		
Medicare	20 days per benefit period	Medicare pays home health benefits for services that are medically necessary

### Part B – Supplement Medical Insurance

**NOTE: Do not confuse Part B of Medicare with Medicare Supplements.**

Part B, which covers doctors’ services, outpatient care, medical supplies, physical and occupational therapy, is a voluntary program subject to a monthly premium and an annual deductible. After meeting the deductible, Part B will pay 80% of covered expenses, subject to Medicare’s standards for reasonable charges. Medicare Part B premiums are based on income tiers; the higher the income, the higher the premium. If a subscriber does not enroll in Medicare Part B during their initial enrollment, a penalty of 1% per month will be imposed.

<b>Medicare Part B – Covered Services</b>			
<b>Services</b>	<b>Benefits</b>	<b>Medicare Pays</b>	<b>Patient Pays</b>
<b>Medical Expenses</b>	Medicare pays for medical services in or out of the hospital	80% of approved amount after the deductible	Deductible* plus 20% of approved amount and limited charges above the approved amount
<b>Clinical Laboratory Services</b>	Unlimited if medically necessary	Generally, 100% of the approved amount	Nothing for services
<b>Home Health Care</b>	For as long as you meet Medicare requirements for home health care benefits	100% of approved amount; 80% of approved amount for durable medical equipment (DME)	Nothing for services; 20% of approved amount for durable medical equipment (DME)
<b>Outpatient Hospital Treatment</b>	Unlimited if medically necessary	Medicare payment to hospital based on hospital costs	20% of billed amount after the deductible
<b>Blood</b>	Unlimited in medically necessary	80% of approved amount after the deductible, and starting with 4 <sup>th</sup> pint	First 3 pints plus 20% of approved amount for additional pints after the deductible <sup>^</sup>

*\*To the extent that any of the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.*

*Medicare Part C - Medicare Advantage*

Part C – Medicare Advantage consists of managed care plans, preferred provider organizations, private-for-fee-service plans, and specialty plans. To be eligible for Medicare Part C, beneficiaries must be enrolled in both Medicare Parts A and B.

Managed-care plans consist of a network of approved hospitals, doctors, and other health care professionals who provide service to Medicare beneficiaries for a set monthly payment from Medicare. The healthcare provider receives the same fee every month, regardless of the actual services provided.

Preferred Provider Organizations are similar to managed care plans, except the beneficiaries do not require referrals to see specialists outside of their network.

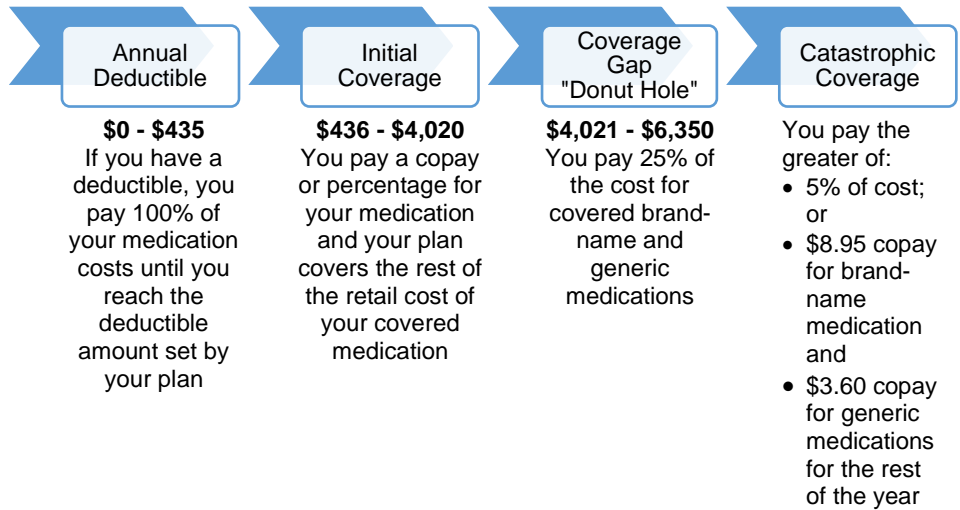
Private fee-for-service plans (PFFS) are Medicare-approved private insurance plans. The plan covers Medicare services and will pay up to a limit to a pre-determined limit. The Medicare beneficiary is then responsible for paying the difference between the amount that the PFFS pays and what Medicare charges.

Medicare Advantage specialty plans provide more focused care; for example, care for a specific disease or condition. To be eligible for this option, a Medicare beneficiary must be enrolled in both Medicare Parts A and B. All specialty plans are considered part of Medicare and will provide for all the Medicare-covered services.

*Medicare Part D – Prescription Drug Plan*

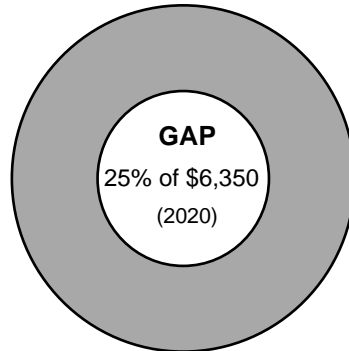
Available to anyone who is enrolled in Medicare Part A or Medicare Parts A and B, Medicare Part D is an optional coverage provided through private prescription drug plans that contract and approved with Medicare. Beneficiaries pay a monthly premium and an annual deductible, and then a copay or percentage up to an annual limit. Once the beneficiary reached that limit, coverage is stopped completely until the beneficiary’s out-of-pocket expenses reach a specified catastrophic limit. This stop in coverage is usually referred to as the donut hole.

**2020 DONUT HOLE**



**Donut Hole (GAP) Illustration**

Co-pays including total actual cost of drugs \$4,020



**Catastrophic Phase**

Generic	\$3.60
Brand Name	\$8.95
or 5% whichever is higher	

To receive Part D benefits, a beneficiary must enroll during an initial enrollment period. If the beneficiary decides to enroll later, a penalty of 1% for each month delayed enrollment will be assessed. This penalty remains indefinitely.

*Medicare Secondary Rule*

If a group has 20 or more subscribers, group coverage is primary, and Medicare coverage is secondary. If a group has less than 20 subscribers, Medicare is primary, and group coverage is secondary.

**Medicaid**

Medicaid is a jointly funded, federal, and state program designed to help low income and medically needy individuals with medical assistance. Individuals claiming benefit must be able to prove that they do not have the ability or means to pay for their medical care.

To prevent people from deliberately paying down their assets so that they are eligible for Medicaid, the government created the five-year look-back rule. Under this rule, the government can examine a Medicaid applicant's financial transactions for the 60 months before your Medicaid application. If it finds major transfers, then it will impose a penalty.

### ***The Medicaid Program***

Medicaid is government-funded

1. Federal and State
  - a. Individual states design and administer the Medicaid programs under broad guidelines established by the federal government.
    - i. The federal government contributes about 56¢ for every Medicaid dollar spent.
2. The goal of Medicaid is to offer medical assistance to the needy.
  - a. Individuals claiming benefits must prove they do not have the ability or means to pay for their own medical care.
  - b. To qualify for Medicaid, a person must be poor or become poor.
    - i. Such people frequently include children born to low-income mothers, babies born addicted to drugs, AIDS patients, and the indigent elderly.

### ***Qualifying for Medicaid Nursing Home Benefits***

1. Provides for custodial care or assisted care in a nursing home.
2. Must prove they cannot pay for nursing home care.
3. In addition, they must:
  - a. Be at least age 65, blind or disabled (as defined by the recipient's state).
  - b. Be a U.S. citizen or permanent resident alien.
  - c. Need the type of care that is provided only in a nursing home.
  - d. Meet certain asset and income tests.

### ***Medicaid Reform - The Deficit Reduction Act of 2005 (DRA)***

1. Gives states new options by which to reform and modernize their Medicaid programs. These options include cost-sharing, flexible benefits, and Health Opportunity Accounts.

### ***Florida Healthy Kids Corporation***

1. To improve access to comprehensive health insurance for Florida's uninsured children, the state legislature established the Florida Healthy Kids Corporation is a combined public and private venture in 1990. Participation in the program is voluntary.
2. Recipients of this service are school-age children with a family income below 200% of the federal poverty level, who do not qualify for Medicaid
3. Coverage can insure services ranging from preventative care to major surgery.

## **STATE WORKERS' COMPENSATION PROGRAMS**

- ❖ Workers' compensation laws cover employees for work-related injuries, illness, or death.

### ***Workers' compensation laws are designed to help injured workers recover and return to work.***

1. Benefits are paid without regard to who is at fault.
2. Offered by purchasing coverage through state programs, private insurers, or by self-insuring.

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UNIT**21****PRIVATE INSURANCE  
PLANS FOR SENIORS****OVERVIEW**

In this unit, we will focus on two types of health care policies designed to protect elderly people from the high cost of health care. These two types of coverages are Medicare supplements and Long-Term Care. Because of medical breakthroughs, individuals are living longer. However, as individuals live longer, they encounter more medical problems requiring more care. The cost of treating these problems has spiraled at a dizzying rate, leading to an ever-growing concern over how these costs will be paid.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Medicare Supplement Policies
- Long Term Care Insurance (LTCi)

**KEY TERMS**

Activities of Daily Living (ADLs)

Acute Illness

Adult Day Care

Chronically Ill

Continuing Care

Custodial Care

Home Health Care

Intermediate Nursing Care

Long-Term Care Policies

Medicare Supplement Policies

Respite Care

Skilled Nursing Care



## Medicare Supplement Insurance Policies (SMI)

Medicare Supplement plans, referred to as Medigap, are policies issued by private insurance companies that are designed to fill in some of the gaps in coverage of Medicare Part A and Part B. Medigap plans do not pay for the costs incurred in Medicare Part C and Part D.

Furthermore, it is prohibited for anyone to sell a Medigap policy to a person who is in a Medicare Advantage (Medicare Part C) plan.

Unlike Medicare, which is administered and operated by the federal government, Florida Medigap carriers are required to adhere to state and federal laws that are designed to protect consumers. Medigap plans must be identified as Medicare Supplement Insurance.

The Medigap plans are standardized by the National Association of Insurance Commissioners. Before May 31, 2010, there were 12 standardized plans. Today, effective January 1, 2020, there are only eight standardized plans. With the exception that two specific plans are only available to those who were first eligible for Medicare before January 1, 2020.

### Standard Medicare Supplement Benefit Plans

Four minimum standards apply to all policies designated as SMI

- The policy must supplement both Part A and Part B of Medicare
- The policy must automatically adjust its benefits to reflect statutory changes in Medicare
- If the policy excludes coverage for preexisting conditions, the exclusions cannot exist longer than six months
- The policy must include a minimum 30-day free-look provision

#### Medigap Plan A

- *Covers basic or core benefits*
- *Does not cover Part A deductible*
- *Must be offered in all plans (although percentages may vary).*

#### Medigap Plans B, D, G, M, and N

- Includes plan A basic benefits and some additional benefits

#### Medigap Plans K & L

- Offer different benefits than other Medigap plans and provide for a lower premium and higher out-of-pocket costs.

NOTE: Plans C, E, F, H, I, and J are no longer available. These plans will remain in force for those insured who purchased them when they were still available.

## Medicare Supplement Policies (Medigap)

- ❖ Medigap policies pick up where Medicare leaves off.
- ❖ Neither Medicare nor Medigap insurance will pay for most nursing home care.
- ❖ 30 day free-look
- ❖ Beginning January 1, 2020, there are eight (8) standardized Medicare supplement policies.
- ❖ It is illegal to sell a Medigap policy to a person who is in a Medicare Advantage Plan as the Medicare Advantage Plan covers many of the same benefits as a Medigap policy.

### FLORIDA LAW

#### Does Florida law require a free look for Medicare Supplement policies?

Yes. It states a Medicare Supplement policy must "contain a prominently displayed no-loss cancellation clause enabling the insured to return the policy within 30 days of the date of receipt of the policy, or the certificate issued thereunder, with return in full of any premium paid." [Sec. 627.674(4)(d)J]

### Plans

- A, B, D, G, K, L, M, & N
  - Plan "A" is "Core" or "Basic" and must be found in all the other plans.



- Certain percentages within Plan A will vary among the other policies.
  - Plan "A" does not cover the Part A deductible.
- A. Plans C and F are only available to those who are first eligible for Medicare before January 1, 2020.**
- B. Plans K, L, M, and N.**
1. These plans have higher copayments and coinsurance contributions and a limit on annual out-of-pocket expenditures incurred by a policyholder
- C. Four minimum standards apply to all policies designated as "Medicare Supplement Insurance."**
1. The policy must supplement both Part A and Part B of Medicare.
  2. The policy must automatically adjust its benefits to reflect statutory changes in Medicare.
  3. If the policy excludes coverage for preexisting conditions, the exclusion cannot exist for longer than six months.
  4. The policy must include a minimum 30-day free-look provision.

**Standardized Medicare Supplement Plans**

Medicare Supplement Plans A–N (January 1, 2020 and later)										
	A	B	C*	D	F*	G*	K	L	M	N
Medicare Part A Coinsurance and All Cost After Hospital Benefits are Exhausted	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment for Other Than Preventive Services	✓	✓	✓	✓	✓	✓	50%	75%	✓	Copayment: \$20/\$50
Blood (First 3 Pints)	✓	✓	✓	✓	✓	✓	50%	75%		✓
Hospice Care Coinsurance Or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓		✓					
Medicare Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up To Plan Limits) – \$250 Deductible			✓	✓	✓	✓			✓	✓
Medicare Preventive Care Part B Coinsurance (After Part B Deductible)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

\*Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. Also it is important to note: Plans F and G also have a high deductible option which require first paying a plan deductible before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count payment of the Medicare Part B deductible toward meeting the plan deductible.



**Long Term Care (30-day free look)**

- ❖ Americans are living longer; this creates the need for Long Term Care.
- ❖ The cost of this care is as much as \$85,000 per year for nursing home care.
- ❖ Home Health Care costs as much as \$4,500 or more per month.

**D. What is Long-Term Care? (LTC)**

1. Refers to a broad range of medical, personal services designed to assist individuals who have lost their ability to remain completely independent in the community.
2. LTC refers to care provided for an extended period, normally more than 90 days.
3. Assistance may be given at home, at an adult care center, or in a nursing home.

**E. What is Long-Term Care Insurance?**

1. Most policies pay a fixed dollar amount per day, regardless of what the care costs.
2. Example: \$40 to \$300 per day.
3. The daily benefit for at-home care is typically half the nursing home benefit.
4. Many policies include an inflation rider or option to purchase additional coverage.

**F. Long-Term Care Coverages**

1. Acute illness
  - a. A serious condition like pneumonia or the flu from which a client can fully recover.
2. Chronic illness
  - a. Arthritis, heart disease, or hypertension is treatable but not curable.
3. Three kinds of locations:
  - a. Institutional care
  - b. Home-based care
  - c. Community care

**G. Skilled Nursing Care**

1. Provides continuous, around-the-clock care provided by:
  - a. Licensed medical professionals under the direct supervision of a physician.
2. Skilled care is usually administered in nursing homes.

**H. Intermediate Nursing Care**

1. Provided by registered nurses, licensed practical nurses, and nurse's aides under a physician's supervision.
2. Provided in care facilities or in-home health settings, but not 24-hour supervision.

**I. Custodial Care**

1. Assists in meeting daily living requirements.
  - a. Bathing, dressing, getting out of bed, toileting, etc.
2. Usually provided by nursing homes
  - a. Can be given by adult day-care centers, respite centers, or at home

**J. Home Health Care**

1. Provided in the insured's home, usually part-time.
2. It can include skilled care:
  - a. Nursing.
  - b. Rehabilitative or physical therapy care ordered by a doctor.
  - c. Unskilled care, such as cooking or cleaning.

**K. Adult Day Care**

1. For those who need assistance with various "activities of daily living," while caregivers (family, friends) are absent.
2. These adult day care centers offer:
  - Skilled medical care in conjunction with:
  - Social and personal services.
  - Custodial care is usually their primary focus.

**L. Respite Care**

1. Provides for a short rest period for a family caregiver.
2. Two options:
  - a. The insured is moved to a full-time facility.
  - b. A substitute care provider moves into the insured's home for a temporary period.

**M. Continuing Care**

1. Provides benefits to those who live in a continuing care retirement community.
2. Geared to senior citizens full-time needs, both medical and social.
3. Are often sponsored by religious or nonprofit organizations.
4. It provides:
  - a. Independent and congregate living.
  - b. Personal, intermediate and skilled nursing care.
5. Attempts to create an environment that allows each resident to participate in the community's life.

**N. LTC Policy Provisions and Limits**

- ❖ Due to the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, must contain certain provisions in order that their benefits "qualify" for tax-exempt treatment.
- 1. These provisions include, for example:
  - a. A definition of the types of services offered by the plan.
  - b. When an individual becomes eligible for benefits under the plan.
- 2. LTC policies must adopt certain provisions of the NAIC's long-term care insurance model regulation. The NAIC model addresses such things as:

- Policy Renewability—must be guaranteed renewable
- Prohibitions on limits and exclusions
- Policy replacement
- Policy conversion
- Prohibition on post-claims underwriting
- The requirement to offer inflation-adjusted benefits
- Proper marketing standards
- Suitability and appropriateness of the recommended purchase
- A standard format for the outline of coverage

**O. LTC Services**

1. The definition of "qualified" LTC services encompasses:
  - a. Qualified LTC services are defined as diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and are provided under a plan of care established by a licensed health care practitioner.\

**P. Qualifying for Benefits**

- ❖ The benefit trigger is the individual must be diagnosed as "chronically ill."
- 1. Two levels:
  - a. Physical: One who has been certified as unable to perform at least two Activities of Daily Living (ADL).
    - i. Eating, toileting, transferring, bathing, dressing, and continence.
  - b. Cognitively
    - i. It requires substantial supervision due to severe cognitive impairment, and this condition was certified within the previous 12 months.

**Q. Benefits Limits**

1. Almost all policies set benefit limits.
2. Coverage periods extend anywhere from two to six years. Some policies offer unlimited lifetime coverage.

**R. Age Limits**

1. LTC policies typically set age limits for issue, the average age being about 79.
  - a. However, some newer policies can be sold to people up through age 89.
2. Some policies also set a minimum purchase age.

**S. Renewability**

1. Guaranteed Renewable
  - a. The insurer can raise premiums, but only for entire classes of insureds.

**T. Elimination Period**

1. Periods can range from 0 to 180 days.
  - a. The longer the deductible or probationary period, the lower the premium.

**U. Specified Exclusions**

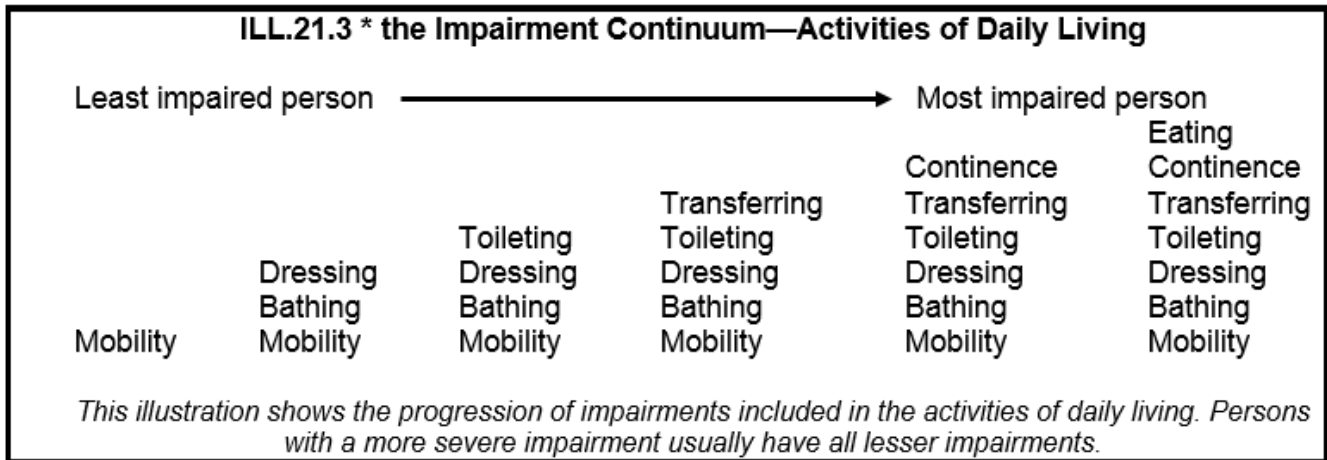
1. Drug and alcohol dependency, acts of war, self-inflicted injuries, and nonorganic mental conditions are excluded.
2. Organic cognitive disorders, such as Alzheimer's disease, senile dementia, and Parkinson's disease, are almost always included.

**V. Premiums**

1. N through R above set the premium.

**W. Group LTC**

1. It could be part of a benefit package but is usually a voluntary program paid by the employee.
2. Advantages are that the plans are NOT strictly underwritten, and more than one family member can share benefits
3. Premiums can be equal to or even greater than individual plans.



**X. Taxation of LTC Benefits**

1. Amounts received under an LTC contract are excluded from income because they are considered amounts received for personal injuries and sickness. There is a limit on these amounts (adjusted annually for inflation).

**Y. State Partnership Programs for Long-Term Care**

1. A partnership between state governments and the insurance industry to contain Medicaid expenses that allows individuals to access Medicaid reimbursement without impoverishing themselves.
2. Florida is 1 of 42 states that participate

UNIT**22****HEALTH INSURANCE  
POLICY PROVISIONS****OVERVIEW**

To understand health insurance, one must have a firm knowledge of the contract provisions that distinguish it from other insurance policies. Health insurance, more so than life insurance, is characterized by a number of mandatory provisions that must be included in the contract. The 12 mandatory provisions and 11 optional provisions covered in this unit evolved for the purpose of adding a uniformity to contracts that present themselves as health insurance policies, thus elevating health insurance to a very high level of regulatory protection.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- NAIC Model Health Insurance Policy Provisions
- Common Exclusions or Restrictions
- Renewability Provisions

**KEY TERMS**

Cancellable	Grace Period	Payment of Claims
Cancellation	Guaranteed Renewable	Physical Examination and Autopsy
Change of Beneficiary	Illegal Occupation	Preexisting Conditions
Change of Occupation	Insurance with Other Insurer(s)	Proof of Loss
Claims Forms	Insuring Clause	Reinstatement
Conditionally Renewable	Intoxicants and Narcotics	Relation of Earnings to Insurance
Conformity with State Statutes	Legal Actions	Time Limit on Certain Defenses
Consideration Clause	Misstatement of Age	Time of Payment of Claims
Conversion Privilege	Noncancelable	Unpaid Premiums
Entire Contract	Notice of Claims	
Exclusions and Waivers	Optionally Renewable	
Free Look	Other Insurance in This Insurer	

More so than life insurance, health insurance is characterized by a number of “mandatory provisions” that must be included in a health contract.

## I. NAIC Model Health Insurance Policy Provisions

### A. The National Association of Insurance Commissioners (NAIC) developed a model “Uniform Individual Accident and Sickness Policy Provisions Law.”

1. All states have adopted this law or similar legislation.
2. Result: twelve mandatory policy provisions and eleven optional policy provisions.
3. *These Provisions or Laws are to be followed “in substance.” The insurers may use wording that is different as long as the protection is provided and is no less favorable to the insured.*
4. Health insurance contracts obligate the Insurer to pay the insured (or a beneficiary) a stipulated benefit under circumstances specified in the contract.

## II. The Twelve (12) Mandatory Policy Provisions **Must Know (All Tested)**

### A. #1: Entire Contract (Same in Life and Health)

1. Nothing outside of the contract.
  - a. Includes: a copy of the signed application
  - b. Any riders,
  - c. Attached papers.
 Nothing can be incorporated by reference.

### B. #2: Time Limit on Certain Defenses

1. The policy is incontestable after it has been in force for two years. However, unlike life insurance, **a fraudulent statement on a health application is grounds for contest at any time.**
  - a. Unless it was “guaranteed renewable” (Because Of Very Strict Underwriting).
2. Preexisting Conditions
  - a. Under this provision, the insurance company cannot deny a claim because of this preexisting condition after the two years unless the condition was excluded specifically from the policy by name or description.

### **FLORIDA LAW**

#### What is the “time limit on certain defenses” provision?

This provision states in general that after two years, no misstatements except fraudulent ones, made by the applicant on the application, shall be used to void the policy or to deny a claim for loss incurred commencing after the end of such two-year period. It also provides that no claim for loss incurred after two years from the date of issue shall be denied on the grounds that a disease or physical condition, not specifically excluded by name, had existed prior to that date. **[Sec. 627.607]**

### C. #3: Grace Period (Grace’s Birthday is 7/10/31)

1. Industrial Policies--7 days.
2. Monthly Policies (HMO, PPO) - 10 days.
3. Ordinary Health--31 days.
4. After the grace period passes and still no premium received, policy lapses.
5. Under certain conditions, some people under the Affordable Care Act may get 90 days.

### D. #4: Reinstatement

1. Automatic reinstatement if the agent or the company accepts the premium without requiring an application for reinstatement.
  - a. If an application is required, the policy is not reinstated unless the company approves it.
  - b. After 45 Days = Automatic Reinstatement If They Took No Action on That Application.
  - c. Sickness is not covered for the first ten days.
  - d. To protect against adverse selection.
  - e. The accident is covered immediately.

**FLORIDA LAW****How does the grace period apply in a health insurance policy?**

The grace period is a stated period after the premium due date, during which the policy remains in force even though the premium has not been paid. The grace period applies to premiums other than the initial premium [Sec. 627.608]

**What is the length of the grace period in a health insurance policy?**

The law provides that there must be a grace period of not less than seven days on weekly premium policies, ten days for monthly premium policies, and 31 days for all others. [Sec. 627.608]

**What is meant by "reinstatement"?**

The term means placing a policy in force again after it has lapsed. [Sec. 627.609]

**An agent accepts a premium for a lapsed disability policy. When does the reinstatement become effective?**

The policy becomes effective for accident coverage immediately but does not become effective for any illness coverage until after ten days from the date of acceptance. [Sec. 627.609]

**Mr. "A" lapsed his disability policy on March 2. He reinstated it on March 22. He claimed coverage for an illness that occurred March 26. Is the claim valid? Why?**

In the first situation, the claim would not be valid. An illness would have had to occur more than ten days after reinstatement for a claim to be valid.

**If the same circumstances occurred except that the claim was for an accident rather than a sickness, would it be paid?**

In the accident, the insurance company would be liable for the claim because the insured would be entitled to full benefits as soon as the policy was reinstated.

**E. #5: Notice of Claim = Within 20 Days after the occurrence**

1. If the loss involves disability income payments that are payable for two or more years, the disabled claimant must submit proof of loss every six months.

**F. #6: Claims Forms = Within 15 Days**

1. It is the company's responsibility to send out. If not received, the client may send in, in any form, explaining the occurrence of the character and extent of loss.

**FLORIDA LAW****What must the insurance company do when it receives notice of claim?**

The insurance company must furnish the claimant with proof-of-loss forms within 15 days. If it does not furnish the claimant with its forms, the claimant may present proof in any reasonably written manner showing the nature of loss, extent of loss and other information. [Sec. 627.611]

**What is the agent's responsibility in the event a claim is reported to him or her?**

The agent must immediately report the claim to the insurance company. The law provides that the policyowner, in the event of claim, may notify the insurance company or any of its agents. [Sec. 627.610]

**Can an insurance company demand an independent medical examination during the pendency of a claim?**

Yes. It may request such an examination as often as it reasonably requires. [Sec. 627.615]

**What is the purpose of a medical examination during the pendency of a claim?**

The insurance company uses the medical examination to determine the extent of the disability of the insured.

**G. #7: Proof of Loss = Within 90 Days After A Loss Occurs**

1. Or "Reasonably Possible" up to 1 Year
2. Exception: Does not have "legal capacity" to comply. For example, in a coma

**H. #8: Time Payment of Claims = \*45 Days**

1. This provision provides for immediate payment of the claim after the insurer receives notification and proof of loss.
  - a. If the claim involves disability income payments, they must be paid at least monthly.
2. **Florida Law** Allows up to 45 days after the Insurer receives notification.

**I. #9: Payment of Claims**

1. Payments for loss of life are to be made to the designated beneficiary.
  - a. If no beneficiary has been named, death proceeds will be paid to the deceased insured's estate.
2. Claims other than death benefits are to be paid to the insured.
3. There are two optional provisions that insurers may add.
  - a. One gives the insurer the right to expedite payment of urgently needed claim funds and pay up to \$3,000 in benefits to a relative or individual who is considered to be equitably entitled to payment.
  - b. The other optional provision allows the insured to have medical benefits assigned--or paid directly--to the hospital or physician rendering the covered services.

**J. #10: Physical Exam and Autopsy**

1. Allows the insurance company at its own expense to:
  - a. Order (and pay for) physical exams at reasonable intervals during a claim, usually reserved for disability income policies.
2. Autopsy is allowed on the body of the insured, if not forbidden by Law

**K. #11: Legal Action**

1. The client can take no legal action from 60-days from the time of submission of a "proof of loss."
  - a. 120-days if contested
2. Legal Action must be taken against the company within five years.

**L. #12: Change of Beneficiary**

1. The insured has the right to change beneficiaries if he/she had not named the beneficiary irrevocable.

**FLORIDA LAW****May a policyowner bring suit against an insurance company to recover under a policy?**

Yes, provided:

- The suit is filed at least 60 days after proof of loss has been given;
- The loss is not paid within 120 days from the date of filing proof of loss as required by the policy if the claim is contested; and
- The suit is brought within five years after proof of loss is furnished to the insurance company.

**[Secs. 627.613, .616, 95.11(2)(b)]**

**M. Eleven Optional Provisions**

Companies may ignore or use them if "NEEDED."

**N. #1: Change of Occupation**

1. Sets changes to premium rates or benefits payable should your client change occupations.
2. Usually used in disability income policies because the occupation directly impacts the "risk profile," thus has a direct bearing on premium charges.
3. The company will reduce the maximum benefit payable if the client changes to a "more" hazardous occupation or
  - a. Reduce the premium if the client changes to a "less" hazardous occupation.
4. The benefit and premium changes take effect at the time the client changed occupations.
  - a. If discovered after a disability begins. The changes are made retroactively.



**O. #2: Misstatement of Age or Sex**

1. Allows the insurance company to adjust the benefits payable if age is misstated when the policy's application was made.
2. Benefits will be what the premium paid would have purchased at the correct age or sex.
3. The older the applicant, the higher the premium. If the client were older, benefits would be reduced.

**P. #3: Other Insurance in This Insurer**

1. Limits the company's risk with any individual insured.
2. The total amount to be underwritten by a company for one person is restricted to a specified maximum amount regardless of the number of policies issued.
3. Premiums for the excess coverage must be refunded.

**Q. #4: Insurance with Other Insurer**

1. Deals with the problem of over-insurance.
2. "Expenses incurred" will be prorated between the two companies.

**R. #5: Insurance with Other Insurers**

1. Calls for the prorating of benefits that are payable on any basis other than "expenses incurred."
2. It also provides a return of premiums that exceed the amount needed to pay for the company's portion of prorated benefits.

**FLORIDA LAW****What is the purpose of the "other insurance" provision?**

This provision operates when there is other insurance coverage in force which the insured has failed to give written notice about to the insurance company prior to the time that a claim begins. This clause gives the insurance company the right to prorate benefits and make appropriate premium refunds. The purpose of this clause is to prevent over-insurance through multiple policies. [Sec. 627.622]

**S. #6: Relation of Earnings to Insurance**

1. Suppose disability income benefits from all disability income policies for the same loss exceed the insured's monthly earnings at the time of disability (or the average monthly earnings for two years preceding disability). In that case, the relation of earnings provision states that the insurer is liable only for that proportionate amount of benefits as the insured's earnings bear to the total benefits under all such coverage.
2. Total indemnities payable to the insured may not be reduced below \$500 or the total benefits under all applicable coverage, whichever is less. Any premiums paid for the excess coverage are refunded.

**T. #7: Unpaid Premiums**

1. The unpaid premium is to be deducted from the sum payable to the insured or beneficiary.

**U. #8: Cancellation**

1. If canceled by the insurer, the unearned premium is refunded to the client. If a claim is pending, the claim is not affected by the cancellation.

**V. #9: Conformity to State Statutes**

1. If policy conflicts with the state where the insured lives, it is to be automatically amended to conform to the "minimum state standards/requirements." conform to the Minimum State Requirements when the policy was issued.

**W. #10: Illegal Occupation**

1. The insurer will not pay.

**X. #11: Intoxicants or Narcotics**

1. The insurer will not pay.

**FLORIDA LAW****Can a health insurance policy be cancelled?**

Florida law provides that individual and group health insurance policies and HMO contracts must be renewed at the option of the individual or the policyholder except for:

1. failure to pay or untimely payment of premiums;
2. fraud or intentional misrepresentation of a material fact;
3. failure to meet minimum participation or minimum contribution requirements of a group policy;
4. The insurer ceases offering coverage in a market. If a policy form is no longer issued, the insurer may terminate coverage under current forms if it provides 90 days' notice and offers policyholders any other coverage offered. If all coverages in the individual or group market are discontinued, the insurer must give 180 days' notice and is prohibited from issuing any coverage in Florida for five years; and
5. For network plans, or bona fide associations, no individual or no group enrollee resides or works in the service area, provided this requirement is applied uniformly.

**[Secs. 627.31074, .6425, .6571]**

**Y. Other Health Policy Provisions**

1. Insuring Clause
  - a. Statement on the First Page or Face Page Stating the Benefits, How, and When, They Will Be Paid. It Is the Company's "Promise to Pay."
  - b. However, It Also States Subject to ALL Provisions and Exclusions Listed in the Policy.
2. Consideration Clause
  - a. Consists of the application and payment of the initial premium.
    - i. The consideration clause also lists the effective date of the contract and defines the policy's initial term. In addition, it may specify the insured's right to renew the policy.
3. Conversion Privilege for Dependents
  - a. Health Policies May Include Wife - Husband - Children and Other Dependents of The Insured.
  - b. Generally, children of the insured are eligible for coverage under a family policy until they attain a specified age.
  - c. As of 10/1/2010, the Affordable Health Care Act mandated that dependent coverage be offered until age 26. **Florida Law Requires – To Age 30.**
4. Free Look Provision
  - a. Florida Law Has A 10 Day Free Look on Health Policies
  - b. Medigap = 30 Days.
  - c. Long Term Care = 30 Days.

**FLORIDA LAW****Does Florida law provide for the continuation of coverage for disabled children?**

Both individual and group health insurance policies must continue to provide coverage for a disabled child, covered under a family policy, when that child becomes an adult.

This requirement applies when the child is and continues to be both (1) incapable of self-sustaining employment because of mental retardation or physical handicap and (2) chiefly dependent upon the policyholder for support and maintenance. This rule applies even though the family policy would normally terminate coverage for a child who reaches a specified age. **[Sec. 627.6615]**

**What are the requirements for newborn child coverage under Florida law?**

Both individual and group health insurance policies that provide coverage for a family member of the insured must also provide that the health insurance benefits for children will be payable for a newborn child of the insured from the moment of birth. The law also requires that coverage be provided for a newborn child of a covered family member (e.g., the newborn of a covered daughter or son) for 18 months. **[Sec. 627.6575]**

### III. Common Exclusions

#### A. Common causes of loss that are not covered are:

1. Injuries due to war.
2. Self-inflicted injuries.
3. Non-fare paying passenger of an aircraft (pilot, crewmember, etc.).
4. Suicide.
5. Hernia (Accidental injury only).
6. Riots.
7. Use of drugs or narcotics.
8. Losses sustained while committing a felony.
9. Foreign Travel (limitations apply; extended stays overseas or foreign residence may result in a loss of benefits.)

#### B. Losses sustained from ...

1. Military service
2. Preexisting conditions
3. Cosmetic surgery
4. Treatment of injury or sickness at a VA Hospital
5. Mental disorders.

#### C. Maternity Benefits

1. Treated differently in individual than in group insurance.
2. When available for individuals, it may only provide a fixed amount for childbirth or a specified multiple of the daily room and board benefit.
  - a. Example:  $R\&B = \$200 \times 10 = \text{Maternity benefit of } \$2,000.$

#### D. Preexisting Conditions

1. Individual Preexisting
  - a. Medical Expense and Disability Income Exclude Paying Benefits for Losses Due to Pre-Existing Conditions. For purposes of individual health policies, insurers consider a pre-existing condition as one that the insured contracted (or manifested) before the policy's effective date.
  - b. If policyowner cited the condition, an exclusion waiver or rider would be included. If they did not cite it and the insurer did not expressly exclude it, the "preexisting condition provision" would serve to exclude this condition. However, this is subject to the "time limit on certain defense" provision.

#### E. Waivers for impairments

1. Some people are uninsurable and declined. Most are standard and issued a policy. But what about the in-between cases? A waiver may be used.
2. Example of Waiver Language "This policy does not cover or extend to any disability resulting directly or indirectly from your \_\_\_\_\_."
3. A waiver is dated and bears the signature of an officer of the company and, in many cases, the applicant. This is usually called an "impairment rider."
4. If the insured's condition improves, the company may be willing to remove the waiver.

#### Examples:

Heart condition, liver condition, or female organs, etc.

### IV. Renewability Provisions

#### A. The Most Distinguishing Features of Health Insurance Are the Renewability Provisions.

1. Remember, the more favorable or, the better the definition used in the renewability provision, the higher the premium.

#### B. Cancellable Health Policies (\$)

1. The insurer may cancel or terminate at any time by providing a written notice (45 days).
  - a. Must refund any advance premium that has been paid.
2. Cancelable policies also allow the insurer to increase premiums.

**C. Optionally Renewable Health Policies (\$\$)**

1. The Renewability provision in an optionally renewable policy gives the insurer the option to terminate the policy on a date specified in the contract.
2. Furthermore, this provision allows the insurer to increase the premium for any class of optionally renewable insureds.
  - a. Usually, termination or premium increases take place on policy anniversary dates or premium due dates.

**D. Conditionally Renewable Health Policies (\$\$\$)**

1. A conditionally renewable policy allows an insurer to terminate the coverage, but only in the event of one or more conditions stated in the contract.
  - a. These conditions cannot apply to the insured's health; most frequently, they are related to the insured reaching a certain age or losing gainful employment.
2. Usually, the premium for conditionally renewable policies may be increased if such an increase applies to an entire class of policies.

**E. Guaranteed Renewable Health Policies (\$\$\$\$)**

1. The renewal provision in a guaranteed renewable policy specifies that the policy must be renewed if premiums are paid until the insured reaches a specified age, such as 60 or 65.
2. Premium increases may be applied, but only for the entire class of insureds; they cannot be assessed to individual insureds.

**F. Non-cancellable Health Policies (\$\$\$\$\$)**

1. A Non-cancellable or "Non-can" policy cannot be canceled nor can its premium rates be increased under any circumstances;
2. These rates are specified in the policy.
3. The term of most Non-cancellable policies is to the insured's age 65.
4. Non-can provisions are most commonly found in disability income policies; they are rarely used in medical expense policies.

## UNIT

**23****HEALTH INSURANCE  
UNDERWRITING & PREMIUMS****OVERVIEW**

Health insurers are increasingly finding themselves in a tough position. The high cost of medical care, the high level of health insurance claims, and yet public sentiment and even competition from within the industry pressure companies to keep rates as low as possible. Health insurers are reacting to these conflicting forces by tightening their underwriting requirements and controlling claims through innovative measures. This unit looks at the important topic of health insurance underwriting and covers the related subjects of health insurance premiums and tax treatment of premiums and benefits. In addition, we'll look at the emerging issues of cost control and case management.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Risk Factors in Health Insurance
- Health Insurance Premium Factors
- Tax Treatment of Health Insurance Premiums and Benefits
- Managed Care

**KEY TERMS**

Cost Containment Measures  
Health Insurance Premium Factors  
Health Insurance Risk Factors  
Substandard Risks  
Tax Treatment of Premiums and Benefits

## I. Risk Factors in Health Insurance

### A. Health insurance underwriting is much more complex than in Life insurance.

1. With Life insurance, there is only one claim.
2. With Health insurance, multiple claims are the rule rather than the exception.
3. The degree of risk is highly important.

### B. Physical condition

1. Example: Allergies, sinus, hernia, or back problems would not be a problem in life insurance as they may not kill you, but health claims would be constant.
2. Family health history.

### C. Moral Hazards

1. Alcoholism
2. Drug addiction
3. Dishonesty
4. Poor credit rating

### D. Occupation

1. Has a direct bearing on both the probability of disability and the severity of disability.
2. Disability claims can vary from occupation to occupation.
3. Little risk with non-hazardous occupations. Greater risk with hazardous occupations.
4. Some occupations are uninsurable.
  - a. Steeplejacks, airplane test pilots or stunt flyers.
5. There are five occupational classes. They are  
AAA   AA   A   B   C
6. *Occupation and Renewability Factor*
  - a. "Change of occupation Provision" are all very important.
    - i. Not included in guaranteed renewable policies.
    - ii. If the insured changes to a less hazardous job, the insurer will return any excess unearned premium; however, if the change is to a more hazardous occupation, the benefits are reduced proportionately. The premium remains the same.
    - iii. Non-cancellable policies are sold only to individuals in the higher occupational classes where change of occupation is sold on a factor.

### E. Other Risk Factors



1. Age, Sex, History (family history), and Avocations.
2. **Genetics – Insurers may not require or solicit genetic information, use genetic test results, or consider a person’s decisions or actions relating to genetic testing in any manner for any insurance purpose. [F.S. 627.4301]**

### F. Insurable Interest

1. As with life insurance, insurable interest is a prerequisite for issuing a health insurance policy.

### G. Classification of Applicants

1. Standard Risk
2. Preferred Risk
3. Uninsurable Risk
4. Substandard Risk
  - a. Attach an impairment rider.
  - b. Charge an extra premium.
  - c. Limit the type of policy.

## II. Health Insurance Premium Factors

### A. Rate-making is more complex than for life insurance because:

1. It involves more than one type of benefit.
2. Claims are more frequent.

### B. Primary Premium Factors

1. Morbidity
2. Interest
3. Expense

### C. Morbidity

1. *Morbidity rates indicate the average number at various ages, which can be expected to become disabled each year due to accident or sickness.*
  - a. Also, how long the disability could be expected to last.

### D. Interest

1. A large portion of each premium is invested to earn interest.

### E. Expenses (“Loading”)

1. Every business has expenses. Each policy carries its share.

### F. Secondary Premium Factors

1. *Benefits: the greater the benefits and the better the policy's definition, the higher the costs.*
  - a. *The number and kinds of benefits provided by a policy affect the premium rate.*
2. *Past claims experience:*
  - a. *the age and sex of the insured and the insured's occupation and hobbies.*

### G. Claims Experience

1. The best way to estimate the cost of future claims is to rely on past claims experience tables.
2. Claims experience tables are maintained by insurance companies, hospital expenses, and surgery expenses.

### H. Age and Sex

1. The older the insured, the higher the premium.
2. Women are charged a higher rate in health insurance.
  - a. Disabilities among women under the age of 55 have a greater frequency and longer duration than among men.

### I. Occupation and Hobbies

1. Higher rates for Hazardous Occupations or Hobbies or rider it out completely.

## III. Tax Treatment of Health Insurance Premiums and Benefits

### A. Tax Treatment of Disability Income Insurance

1. Premiums paid for personally owned DI is not tax-deductible, but the benefit is received income tax-free.
  - a. However, with group plans, if the employer pays all, 100% is taxable to the employee in a noncontributory group plan. Premiums paid by the employer are deductible to the employer. However, if contributory and the employee paid any portion, the benefit received will be tax-free only in proportion to the premium paid.

#### **Example:**

Employee pays 40% of the premium -- 40% of the benefit is not taxable  
Employer pays 60% of the premium -- 60% of the benefit is taxable income.

### B. Taxation of Medical Expense Insurance

1. Incurred medical expenses that are not reimbursed by insurance may be deducted if they exceed 10% of the insured's adjusted gross income.
2. Example of these expenses include:

- a. Medical insurance premiums, Prescription drugs, Insulin, Hospital expenses, Physician and Surgeon fees, Dental care, Nursing care, Rehabilitative treatments, Hearing aids, Eyeglasses, etc.

**Example:**

AGI = \$35,000	---TOTAL EXPENSES		\$4,000
X 10%	=		<u>\$3,500</u>
	DEDUCTION		\$ 500

- 3. Self-employed individuals and their families:
  - a. Amounts paid for insurance premiums became fully deductible as of 2003.

**IV. Managed Care — Key strategy for containing rising health care cost**

**A. Policy Design**

- 1. Higher deductible--\$1,000 instead of \$100.
- 2. Coinsurance—75/25 instead of 80/20.
- 3. Shortened benefit periods—5-year benefit period instead of to Age 65.

**B. Medical Cost Management**

- 1. Four general approaches
  - a. Mandatory second opinions
  - b. Pre-certification review
  - c. Ambulatory surgery
  - d. Case management

**C. Mandatory Second Opinions**

- 1. Benefits are reduced if not obtained.

**D. Pre-certification Review**

- 1. Obtain approval on any non-emergency basis.
- 2. Emergency basis, the insurer must be notified within 24 hours.

**E. Ambulatory Surgery---Walk-in / Walkout, etc. Example: Cataract Surgery**

**F. Case Management**

- 1. Case reviewed by the insurance company specialist to try to provide treatment at home.
  - a. The purpose is to hold down the cost of the claim.



UNIT**24****GROUP HEALTH INSURANCE****OVERVIEW**

Group health insurance, like individual health insurance, can be tailored to meet the employer's needs. By its very nature group insurance has several features that set it apart from individual plans, including the nature of the contract, the cost of the plan, the form of premium payments, and eligibility requirements. In this unit, we will examine the characteristics of this type of insurance protection and review the favorable tax treatment given to group plans.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Nature of Group Health Insurance
- Group Health Insurance Coverages
- Tax Treatment of Group Health Plans

**KEY TERMS**

Certificate of Insurance

COBRA

Contributory Versus Noncontributory Plans

Conversion Privilege

Group AD&D

Group Basic Medical Expense

Group Disability Income

Group Health Underwriting

Group Major Medical Expense

HSA

Master Policy

Preexisting Conditions

Taxation of Group Health Insurance

## I. Nature of Group Health Insurance

### A. Master Policy is given to the Employer.

1. Certificate of Insurance and an outline or booklet is given to the Employee.
2. More extensive benefits than under an individual plan.

### B. Characteristics of Group Health Insurance (Similar to Group Life)

1. Group Eligibility
2. Contributory or noncontributory method of premium payments.
  - a. The contributory plan requires the employee to pay part of the premium.
    - i. The premium the employee pays is a qualifying medical expense for determining a medical tax deduction.
3. Lower costs
4. Predetermined benefits
5. Underwriting practices
6. Conversion privileges
7. Preexisting conditions

### C. Eligible Groups (Life or Health)

1. Must be a "natural group." It must have been formed for a reason other than to obtain insurance and must have been in existence for at least two years.

### D. Individual Eligibility

1. Full time.
2. Actively at work.
3. Probationary period.
  - a. One to three months employment service.
2. Enrollment period = 31 days.

### E. Contributory vs. Noncontributory

1. Noncontributory plans require 100% participation of all eligible members.
2. Contributory plans require 75% participation of all eligible members.
3. Florida law; There is no specific minimum percentage participation for employees covered by group health insurance.

### F. Lower cost

1. Administrative and selling expenses are less.

### G. Predetermined Benefits

1. Tailor-made for the employer.

### H. Conversion Privilege

1. A covered group member cannot be denied conversion to an individual plan.
  - a. The individual can be evaluated and rated.
2. Must convert within 31 days of termination.

## II. Underwriting Practices

- The company evaluates the group as a whole rather than individuals within a group.
- Underwriters review a number of factors to determine whether or not a group should be accepted.
- Florida law: insurers of large groups (51 or more persons) must accept the entire group. Florida law does not permit individual risk "carve-outs."

**ILL. 24.1 General Group Underwriting Considerations**

- Despite the many differences between types of groups. There are certain general underwriting considerations applicable to all or most types of groups.
- The reason for the group's existence (purchasing group insurance must be incidental to the group's formation, not the reason for it)
- The stability of the group (underwriters want to see a group of stable workers without an excessive amount of turnover')
- The persistency of the group (groups that change insurers every year do not represent a good risk)
- The method of determining benefits (it must be by a schedule or method that prevents individual selection of benefits)
- How eligibility is determined (insurers want to see a sickness-related probationary period, for example, to reduce adverse selection)
- The source of premium payments, whether contributory or noncontributory (noncontributory plans are preferred because they require 100 percent participation, which helps spread the risk and reduces adverse selection)
- The prior claims experience of the group
- The size and composition of the group
- The industry or business with which the group is associated (hazardous industries are typified by higher-than-standard mortality and morbidity rates)

**A. Preexisting Conditions**

1. ACA plans are not allowed to contain preexisting condition exclusions.
2. Non-ACA limits preexisting conditions to medical advice or treatment recommended or received within six months ending on the enrollment date.

**III. Group Health Insurance Coverages****A. Group Basic Medical Expense**

1. Same basic coverage as in Unit 17

**B. Dental and Vision Care**

1. Dental plans typically have maximum yearly benefit amounts, such as \$1,000 or \$2,000.
2. Vision care pays for eye exams.

**C. Group Major Medical Plans**

1. Like individual major medical plans, group major medical plans may be offered as a single, extensive plan (comprehensive major medical) or superimposed over a group basic plan (supplemental major medical).
2. Participants are usually required to satisfy an initial deductible with comprehensive plans and either a corridor or an integrated deductible with supplemental plans.
  - a. Deductibles are usually lower for group plans
3. Group plans are subject to
  - a. Coordination of benefits provision
  - b. Treatment of maternity benefits

**D. Coordination of Benefits (COB)**

1. Found only in group health plans
2. Used to avoid duplication of benefit payments
3. The provision establishes which plan is the primary plan.
  - a. The primary plan pays the full benefit amounts, and the secondary plan provides for additional benefits.
4. If all the plans that cover an insured for a single claim have coinsurance limits, the insured may not be permitted to receive a higher percentage of claim benefit than either of the plans would have paid separately.

Kevin & Alexandra work for different companies and each company plan covers the employees and dependents. Both plans have a \$100 deductible and an 80/20 coinsurance feature. Kevin had medical bills of \$10,000. They would be paid as follows:

Paid		Kevin owes		Alexandra's Plan
Bills	\$10,000			
Deductible	<u>\$ 100</u>	\$ 100	→	\$ 100
	\$ 9,900	\$ 1,980	→	<u>\$1,980</u>
Coinsurance (80%)	<u>x .80</u>			
Company Paid	<u>\$ 7,920</u>			\$2,080

Subrogation – In most policies, the insurer is given subrogation rights where the insured transfers the “right of recovery against others” to the insurer.

**E. Maternity Benefits**

1. 1979 amendment to the Civil Rights Act requires group plans covering 15 or more to treat pregnancy as any other illness.

**F. COBRA Continuation of Benefits**

1. This law is known as the **Consolidated Omnibus Budget Reconciliation Act** of 1985.
2. Provides for continued group coverage for terminated employees.
3. Employers with 20 or more employees must provide COBRA coverage.
4. Coverage is extended as follows:
  - a. 18 months coverage for Employee -- up to 29 months, if disabled.
  - b. Employee's hours are reduced (resulting in termination from the plan).
    - i. 18 months of continued coverage (or up to 29 months, if disabled).
  - c. Employee dies:
    - i. 36 months coverage for Dependents.
  - d. Dependent child no longer qualifies as "dependent child" under the plan:
    - i. 36 months of continued coverage for affected dependent.
  - e. 36 months if eligible for Medicare; coverage for affected dependent
  - f. 36 months if Divorced or legally separated; coverage for former spouse and affected children.
5. Employers with 20 or more employees must provide COBRA @ 102% of Premiums (paid by employee).
6. **Note: COBRA is not a policy conversion**

**MINI-COBRA (Unit 29) - Florida Health Insurance Coverage Continuation Act**

1. Florida's mini-cobra law for employers with less than 20 employees.
2. Provides for continued group coverage for terminated employees.
3. Coverage is extended as follows:
  - a. 18 months at 115% of the premium
  - b. 29 months if disabled
    - i. Additional 11 months charged at 150% of the premium.
4. May use ASO or TPA.

**B. Group Disability Income Plans (DI)**

1. Group disability income plans differ from individual plans in a number of ways.
  - a. Individual plans usually specify a flat income amount, based on the person's earnings, determined when the policy is purchased.
  - b. Group plans usually specify benefits in terms of a percentage of the individual's earnings.
  - c. Group disability can include short-term plans or long-term plans.
  - d. Group short-term disability' plans: short duration, such as 13 or 26 weeks.
    - i. Benefits are typically paid weekly and range from 50% to 100% of the individual's income.

- e. Group long-term disability plans provide maximum benefit periods of more than two years, occasionally extending to the insured's retirement age.
  - i. Benefit amounts are usually limited to about 60 percent of the participant's income.

**C. Group AD&D**

1. Called voluntary group AD&D
2. Covers Occupational and Non-Occupational
3. No conversion privileges
4. Not necessary—this is an accident policy
5. Principal Sum—Death benefit
6. Capital Sum—dismemberment benefit

**D. Other Types of Group Health Plans**

1. Blanket Health
2. Franchise Health
3. Credit Accident and Health
4. Health Savings Accounts

**E. Blanket Health Plans**

1. Blanket health insurance is issued to cover a group who may be exposed to the same risks, but the composition of the group—the individuals within the group—are constantly changing.
  - a. A blanket health plan may be issued to an airline or a bus company to cover its passengers or a school to cover its students.

**F. Franchise Health**

1. Franchise health plans, sometimes called "wholesale plans," provide health insurance coverage to members of an association or professional society.
  - a. Individual policies are issued to individual members; the association or society simply serves as the "sponsor" for the plan.
  - b. Premium rates are usually discounted for franchise plans

**G. Credit Accident and Health**

1. Designed to help the insured pay off a loan if he or she is disabled due to accident or sickness.
  - a. If the insured becomes disabled, the policy provides for monthly benefit payments equal to the monthly loan payments due.

**H. Health Savings Accounts (HSAs)**

1. The Medicare Prescription Drug and Modernization Act of 2003 established health care savings accounts (HSAs).
2. An HSA is a tax-favored vehicle for accumulating funds to cover medical expenses.
3. Individuals under age 65 are eligible to establish and contribute to HSAs if they have a qualified high-deductible health plan.
4. Annual contributions of up to 100% of an individual's health plan deductible can be made to an HSA.
  - a. After 2010, individuals with HSAs who are age 55 and older can make additional catch-up contributions. (\$1,000 per year)
5. Earnings in HSAs grow tax-free, and account beneficiaries can make tax-free withdrawals to cover current and future qualified health care costs.
6. Qualified health care expenses include amounts paid for:
  - a. doctors' fees;
  - b. prescribed medicine (including prescribed over-the-counter medicine);
  - c. necessary hospital services not paid for by insurance;
  - d. retiree health insurance premiums;
  - e. Medicare expenses (but not Medigap);
  - f. qualified long-term care services; and
  - g. COBRA coverage.

7. Qualified medical expenses are expenses incurred by the HSA owner, the spouse, and dependents.
8. Nonqualified withdrawals are subject to income taxes and a 10% penalty.
9. HSAs are fully portable, and assets can accumulate over the years.
10. Upon death, HSA ownership may be transferred to a spouse tax-free.

### III. Tax Treatment of Group Health Plans

#### A. Taxation of Group Health Premiums

1. Premiums paid by the employer are a deductible business expense to the employer. If the employer pays the whole premium, then benefits are fully taxable to the employee.
2. Generally, premiums paid by an employee to a group health plan are not tax-deductible.
  - a. They can be included in the calculations for out of pocket (unreimbursed) medical expenses.
  - b. Out of pocket expenses that total more than:
  - c. 10% of adjusted gross income would qualify as a tax deduction.

#### B. With Group contributory disability plans, the percentage of the employee's premium is applied to the benefit. That amount is received tax-free.

1. Let us assume the employer paid 2/3 of the premium, and the employee paid 1/3.
2. Review case study "Anne"; (Section 24.3.2)

Percentage of premium paid by:	
Employer	66 $\frac{2}{3}$ % ( $\frac{2}{3}$ )
Anne	33 $\frac{1}{3}$ % ( $\frac{1}{3}$ )
Benefit	
	\$900 x $\frac{1}{3}$ = \$300 tax-free
	\$900 x $\frac{2}{3}$ = \$600 taxable

UNIT**25****USES OF HEALTH INSURANCE****OVERVIEW**

Just as life insurance can be used creatively to meet a variety of needs, so too can the different types of health insurance plans be used in various ways to meet an individual's or business's unique needs. Individuals need to have a comprehensive health insurance plan in place to insure against the financial consequences of illness or disability. Health insurance also is necessary to protect a business against the risks it faces, including losses due to a key employee's death or disability. Businesses also commonly offer health insurance as part of an employee benefits program. In this unit, we will take a closer look at some of the ways in which individuals and businesses use health insurance.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- A proper health insurance plan
- Individual needs for health insurance
- Business needs for health insurance

**KEY TERMS**

Business Overhead Expense Insurance  
Disability Buy-Out Insurance  
Employee Benefit Plans  
Individual Versus Group Health Insurance  
Key Person Disability Insurance

**I. A Proper Health Insurance Program****A. What are its uses? Is the client willing to take some responsibility for his or her own medical in exchange for reduced premiums?**

1. \$1,000 deductible instead of \$500.
2. 75%/25% coinsurance instead of 80%/20%.
3. Longer elimination period
4. Modify the benefits

**II. Individual Needs for Health Insurance****A. Medical Expense Insurance Needs**

1. Due to the high cost of medical care, it would be unwise to be without this type of insurance.
  - a. Even basic medical expenses could use up your savings.
  - b. A catastrophic claim could spell bankruptcy.
2. Most Americans are covered under either:
  - a. A major medical policy
  - b. A service-plan
    - i. A PPO
    - ii. An HMO
3. The ideal policy is the combination plan that consists of a basic plan and a supplementary major medical plan. (Expensive)
  - a. The basic plan provides “first dollar” coverage. (No deductibles—No coinsurance)
  - b. The major medical contains a deductible and coinsurance.
    - i. Electing higher deductibles will result in lower premium costs.

**B. Group vs. Individual Coverage**

1. Group has less out-of-pocket costs than individual plans.
2. Group has lower deductibles.
3. Conversion privilege is built into every group policy.

**C. Disability Income Insurance Needs**

1. Qualifying for Social Security benefits is very strict. Therefore, a personal disability policy or a group disability policy is recommended.
  - a. Premium costs for a personal plan could be lowered by:
    - i. Choosing a longer elimination period.
    - ii. Electing a shorter benefit period.
    - iii. 60% of gross earnings would suffice because:
      - (1) Benefits are received tax-free (Premiums are not deductible).
      - (2) This amount would be about equal to your take-home pay minus expenses (e.g., gas for car, dry-cleaning, etc.).
2. The employee has little choice as to the level of benefits in a group plan.
  - a. The plan will have a schedule of benefits.
  - b. An advantage is that the employer contributes to the premium.
3. If both parents work, then a disability policy must be considered for each.

**III. Business Needs for Health Insurance****A. Employee Benefit Plans**

1. Life Insurance
2. Pensions
3. Profit-Sharing
4. Deferred Compensation
5. Health benefits



**B. Group Health Insurance**

1. Medical
  - a. Basic Medical
  - b. Major Medical
2. AD&D
3. Disability Income (Long and Short Term)

**C. Cafeteria Plan**

1. Known as Section 125 plans.
2. Employees are given an Insurance Menu.
3. Employees are given a dollar amount to spend. If they want more benefits, then they would pay for the additional costs.

**D. Business Continuation Plans**

1. For owner or key employee in the event of sickness or disabling injury.
2. They are the following:

**E. Business Overhead Expense (BOE)**

1. Reimburses a business for overhead expenses if a business owner becomes disabled.
2. Sold on an individual basis to:
  - a. Professionals in private practice.
  - b. Self-employed business owners, partners, and occasionally close corporations.
3. Overhead includes such things as:
  - a. Rent or mortgage payments.
  - b. Utilities, telephones, leased equipment, employees' salaries, etc.
4. No compensation for the business owner.
5. Pays the actual monthly overhead expense up to the policy maximum.
6. The premium is a tax-deductible business expense; the benefits are taxable.

Dr. Miller purchase a BOE with maximum monthly benefits of \$4,500  
He was disabled for the months of July and August. Payments would be:

	<u>July</u>	<u>August</u>
Expenses:	\$3,950	\$4,700
Policy pays	\$3,950	\$4,500 (the policy maximum)

**F. Key-person Disability Insurance**

1. Indemnifies a business for the loss of services of a key employee, partner, or owner due to a disability.
2. Just like Key-Person Life Insurance.

**G. Disability Buy-Outs**

1. Legal Binding Arrangement.
2. Contains a provision allowing LUMP SUM PAYOUT.
3. Characterized by long elimination periods (2 years).
  - a. Rationale: If you are forcing a partner to be bought out, you must be sure he/she cannot return to work. Hence, the two years.
4. Cross-Purchase
5. Entity (Buy-Sell)
6. Key Person, etc.

How many policies would it take to Fund a Cross Purchase Plan Life and Disability Buy-Sell on 3 partners?

Answer: 12 (6 Life Insurance + 6 Disability Income Policies)

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UNIT**4****LICENSURE, ETHICS & THE  
INSURANCE PRODUCER****OVERVIEW**

In addition to information on Florida licensure and appointment, this unit will provide insurance producers with the basic knowledge they need to function ethically in the insurance industry. Producers have ethical duties to insurers, policyowners, clients, and the general public, as well as to the state. Therefore, the state has mandated ethical standards that include specific guidelines on what is considered acceptable and unacceptable ethical behavior.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Ethical Business Practices
- Overview of Ethics and the Insurance Producer
- A view from the Field
- Public Perceptions of the Insurance Industry
- Presenting Recommendations to Clients
- Ethics and the Law

**KEY TERMS**

Compliance  
Credit Report  
Ethics  
Inspection Report  
Market Conduct  
Medical Information Bureau  
Policy Illustrations  
Policy Replacement

## I. Ethical Business Practices

### A. Why should an insurance producer study ethics?

1. Strong ethical behavior is an invaluable characteristic to an insurance producer's success and quickly gain the trust, respect, and loyalty of their clients.
2. Today, most financial services companies have made ethical practices a priority and are teaching their sales representatives how to act ethically in selling insurance and other financial products.

### B. Compliance

1. Compliance means conducting business in accordance with current rules and laws set by government regulatory agencies and the courts.
2. Laws and regulations tell them what they must do.

### C. Ethics

1. Ethics are standards of conduct and moral judgment.
2. An ethical insurance producer is honest, loyal, fair, compassionate, has integrity and respect for others, and a sense of personal responsibility and accountability.

### D. Market Conduct

1. Market conduct is a combination of both ethics and compliance.
  - a. It refers to how insurance companies and producers conduct themselves according to ethical standards and in compliance with rules and laws governing insurance policy sales, marketing and underwriting practices, policy issuance, service, complaints, and terminations.
2. Market conduct is synonymous with professional behavior.
  - a. The ethical insurance producer knows and acts in accordance with ethical principles as well as in compliance with rules and laws governing the sale and servicing of insurance policies.

## II. Overview of Ethics and the Insurance Producer

### A. Ethical behavior helps agents gain professional satisfaction and the respect and loyalty of clients.

1. A code of ethics also helps a producer avoid controversy, misunderstandings, and legal entanglements and increases personal efficiency.
2. Good clients usually refer good clients to ethical producers. Success should be defined not just by financial gain but also by serving insurers and the public.

### B. Under the law, ethical conduct is generally defined as a reasonable person is expected to do under any circumstances.

1. A producer must pay attention to both the legal requirements and the ethical standards of business

### C. Insurance producers have ethical responsibilities to insurers, Policyowners, the public, and the state.

1. The producer owes an insurer honesty, good faith, and loyalty.
2. The producer's day-to-day activities reflect the insurer's image within the community.
3. A producer meets his or her major responsibilities to insured policyowners by filling their insurance needs and providing them with quality service.
4. The producer also owes the policyowner the same degree of loyalty he or she owes to the insurer.
5. He or she has two main ethical responsibilities to the public.
  - a. The first is to inform the public about insurance with the highest level of professional integrity.
  - b. The second is to display a high level of professionalism in all public contacts to convey a strong, positive image of the industry.

A producer must adhere to the ethical standards mandated by their state as marketing practices or **unfair trade practices**.

### **FLORIDA LAW**

#### ***What does Florida Law regard as "unfair claim settlement practices"?***

The following acts are defined as unfair claim settlement practices:

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured.
2. Making a material misrepresentation to an insured or any other person having an interest in the proceeds payable under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy:
  - a. Committing or performing with such frequency as to indicate a general business practice any of the following:
    - b. failing to adopt and implement standards for the proper investigation of claims;
    - c. misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
    - d. failing to acknowledge and act promptly upon communications with respect to claims;
    - e. denying claims without conducting reasonable investigations based upon available information;
    - f. failing to affirm or deny coverage of claims upon the written request of the insured within a reasonable time after proof-of-loss statements have been completed; or
  - g. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement. **[Secs. 626.9541(5), .9541(5)(a), .9541(5)(b), .9541(5)(c)]**

#### **D. Responsibilities of the Principal**

1. The principal must select honest, loyal, and hard-working producers to protect itself from potential liability.
2. A major source of ethical concern for many producers is that they are caught in the middle between two parties who have conflicting interests.
  - a. On the one hand, a producer's primary responsibility is to serve the insurer.
  - b. On the other hand, the consumer is the producer and owes dedication, loyalty, and service.

#### **E. Responsibilities to the Policyowners**

1. A producer must sell the kind of policies that best fit the prospect's needs and affordability. This involves problem analysis, action planning, and product recommendation and plan implementation. The producer has two important commitments.
  - a. A commitment to obtain and maintain the knowledge and skills necessary to carry out those tasks; and
  - b. a commitment to educate the prospect or client about the products and plans that the producer recommends.
2. The policyowner relies on the producer to provide informed options and trusts that the producer's recommendations for insurance are in his or her best interest.
  - a. The producer must keep their base of knowledge and skills current by committing to a continuing education program.
3. Client trust must be earned, nurtured, and constantly reinforced.
  - a. The producer who remembers this basic rule will communicate to the client the reasons why a particular insurance policy or program is being recommended and how it will serve.
  - b. This communication and education continue long after the policy or program is sold.

#### **F. Service and the Sale**

1. Service-during and after the sale is just as important as selling to needs in meeting a producer's ethical responsibilities.
  - a. One of the most important aspects of business ethics is that the characteristics one associates with an ethical person-fairness, honesty, and personal responsiveness-also affect the level of service that a company provides.
  - b. For the purposes of this discussion, service means:

- i. educating the client before, during, and after the sale, ensuring that he or she fully understands the application and underwriting processes, the policy purchased, and any attached rider;
- ii. treating all information with confidentiality,
- iii. disclosing all information so that the policyowner or applicant can make an informed decision;
- iv. Keeping the prospect or client informed of any rejection, exclusion, or cancellation of coverage.
- v. Showing loyalty to prospects and clients.

### G. Service Begins with the Application

1. A producer's primary responsibility in the application process is to the insurer. However, they also have an ethical duty to educate the prospective insured about the application process, including:
  - a. why the information is required;
  - b. how it will be evaluated;
  - c. the need for accuracy and honesty in answering all questions; and
  - d. The meaning of such terms as "waiver of premium," "automatic premium loan," "nonforfeiture options," "policy loans," and "conditional receipt."
2. A conditional receipt is normally given when the applicant pays the initial premium when the application for a policy is signed.
  - a. Also known as a "conditional contract," one contingent upon conditions that existed at the time of application or when a medical examination is completed.
    - i. The applicant is covered immediately from the date of application as long as they pass the insurer's underwriting requirements.
  - b. The producer's ethical responsibility is to explain that the applicant is covered on the condition that he or she proves to be insurable and passes the medical exam, if required.
3. Another ethical responsibility the producer owes the client is to explain the underwriting process that the application will undergo briefly. This explanation should include a description of the checks and balances that apply to underwrite a risk, such as the Medical Information Bureau, the inspection report, and the credit report.
4. Precision and accuracy in completing the application are in the insurer's best interest and the prospective insured.
  - a. Personal information about a client is confidential and should never be released without prior approval from the client.
  - b. In this context, full disclosure means informing the prospect or client of all facts involving a specific policy or plan so that an informed decision can be made.
    - i. Two forms that many producers use as educational tools and in sales presentations are the NAIC Buyer's Guide and the Policy Summary.

### H. Policy Delivery

1. Most policies are issued as applied for. The producer should make prompt delivery of the policy and review its features and benefits.
  - a. Not only does this help solidify the sale, it represents a step toward making the policyowner a lasting client.
2. Unfortunately, some policies will be rated or rejected. When this happens, the producer has two responsibilities:
  - a. Review the rating or rejection.
    - i. Was it medical? Was there an unfavorable medical report?
    - ii. Was something overlooked or not made known to the underwriter? Should additional information be submitted?
    - iii. Is the rating or rejection proper? Should the application be reconsidered?
  - b. The producer should have as much information as possible and explain the rating or rejection to the applicant.
  - c. Assuming the rating or rejection was valid, the producer has the responsibility to notify the applicant promptly.

- i. To withhold this information in an effort to prevent the applicant from seeking insurance elsewhere is a breach of ethics and could actually harm the applicant and his or her family.
- I. Special Situations.** In most cases, an agent needs only common sense to avoid an unethical situation with a policyowner. However, in some specialized areas, such as the sale of estate or business planning insurance, the ethical guidelines are clearly defined by professional organizations chartered to monitor the activities of their practitioners.
1. The insurance producer who works the estate or business planning market needs to work with other professionals, such as lawyers and accountants.
  2. The producer understands that each member of the estate or business planning team serves a specific function.
    - a. The attorney drafts the documents necessary to accomplish the client's objectives and advises the client of any legal consequences
    - b. The accountant determines the accounting and tax implications and procedures.
    - c. The producer recommends specific insurance policies or plans in an appropriate amount and ensures that ownership and beneficiary designations conform to the legal agreements prepared by the attorney.
  3. Once the policy is issued, and an applicant becomes a policyowner and client, service becomes more than the producer's ethical responsibility-service now forms the basis for a lasting relationship. All policyowners should receive periodic reviews to ensure that their insurance programs align with their plans and objectives.
- J. Responsibilities to the Public**
1. The producer has a duty to provide the public with a fair and honest representation of the policies and services they have to offer.
  2. Insurance professionals within the industry have been reexamining and raising their ethical standards since the 1970s.
    - a. As one step in this direction, the National Association of Insurance Commissioners (NAIC) began amending and expanding the model Unfair Trade Practices Act (created in the 1940s) to deal with the inappropriate use of advertising.
    - b. More states adopted all or portions of the model act. At the same time, a number of initiatives were undertaken to assure the proper use of policy illustrations.
- K. Advertising**
1. The potential for deceptive advertising or promotion by insurance companies and producers alike is significant, and the consequences to the consumer can be grave. Accordingly, all states regulate insurance advertising.
    - a. *The basis for many of these state statutes is the NAIC's model Unfair Trade Practices Act, which covers advertising and such acts as coercion, unfair discrimination, and rebating.*
  2. The NAIC created a model regulation directed at advertising called "Advertisement of Life Insurance and Annuities Model Regulation."
    - a. This model regulation defines advertising and attempts to address those actions that have caused trouble in the industry.
    - b. It also mandates the proper identification of insurance professionals and companies, a system of control over its advertisements, a description of the type of policy advertised, and the disclosure of graded or modified benefits over time and so forth.
    - c. The insurer prepares most of the advertising and sales literature a producer uses under its legal staff's careful eye.
    - d. For a producer, then, the ethical issue is not necessarily the material itself, but how the material is used and the deceptive sales presentation that may result.
- L. Deceptive Sales Presentations**
1. Deceptive sales presentations have probably generated more complaints of unethical behavior than any other activity.
    - a. A deceptive sale is any presentation that gives the prospect or client the wrong impression about any aspect of an insurance policy or plan that does not provide

- complete disclosure, or that includes any misleading or inconclusive product comparisons.
- 2. Deceptive sales presentations can be blatant, but even subtle misrepresentations are unethical. Even if the deception is unintentional, the producer has done the client a great disservice.

#### **M. Policy Illustrations**

1. Policy illustrations are based on certain expectations of what will or might happen. When premiums, rates of returns, and death benefits are fixed and guaranteed as in whole life, this is not a large problem.
2. When these things become variable and contingent, the projected numbers are not guaranteed.
3. Insurance companies have redesigned their disclosures to promote better consumer understanding of policy pricing, company and product performance, and illustration assumptions.
4. The most significant initiatives come from the NAIC and the Society of Financial Service Professionals (SFSP, formerly the American Society of CLU & ChFC).
  - a. The NAIC has drafted model legislation on policy illustrations.
  - b. The SFSP has developed illustration questionnaires to help producers understand the assumptions used to design and create sales illustrations.

### **III. A View from the Field**

- ❖ The top ethical concerns producers can be broadly categorized into three areas:

#### **A. Skill and Competence Issues**

1. Many ethical problems producers face or create can be traced to a simple lack of skill and competence.
  - a. Failure to identify prospects' needs and recommend appropriate products is a problem.
    - i. Producers who misrepresent their abilities to provide competent service.
    - ii. A knowledgeable, competent producer would not fail to identify a prospect's needs, nor would he or she have to misrepresent his or her capabilities.
2. Skill and competence are prerequisites to selling insurance. These qualities are how an insurance producer provides informed options and recommendations in the client's best interest. Therefore, a producer has the ethical responsibility to:
  - a. Develop and maintain a high level of knowledge and skill through concentrated study and dedicated work.
    - i. All producers should be committed to a program of continuing education and participate in industry organizations, such as the Florida Association of Insurance and Financial Advisors (FAIFA).
  - b. Acknowledge those cases or situations that are beyond his or her skill level.
    - i. No one can be an expert at everything. When a case is clearly beyond a producer's expertise, the producer should seek help from a more experienced colleague or other professional.

#### **B. Professional Obligations**

- ❖ A lack of professionalism can lead to disparaging the competition, not being objective with others in business dealings, failing to provide prompt and honest answers to clients' questions, and failing to provide products and services of the highest quality in the eyes of the customers. Professionalism requires a producer to:
  1. Place the client's interest beyond one's self-interest.
    - a. They remain independent and objective in their judgment and evaluations and recommend plans or policies that benefit the client and protect their welfare.
    - b. When a policyowner asks for help or advice, the producer is quick to follow up, embracing client service as an important responsibility.
  2. Be dedicated to his or her industry and supportive of all its member companies and representatives.
  3. Offer quality plans and represent quality companies.
    - a. A professional producer represents only those companies with solid financial standings and accurately informs prospects and clients of an insurer's financial position as part of the sales process.



**C. Moral Issues**

1. The 1991 and 1995 surveys identified two problems associated with what is best described as moral issues.
  - a. False or misleading representations of products or services (which producers ranked in both surveys as the number one ethical problem) and
  - b. The temptation between opportunities for financial gain (or other personal benefit) and the proper performance of their responsibilities.
2. While many questionable practices can be condemned outright as being immoral or unethical, maybe the cause of the problem is a lack of knowledge or understanding on the producer's part. The ethical producer:
  - a. Learns very early the difference between right and wrong in the business and practices and acts accordingly. He or she develops high ethical standards through training with experienced professionals and association with industry groups.
  - b. Consistently adheres to his or her values and maintains this integrity throughout his or her sales career. Ethics means emphasizing the interests of clients and companies over one's self. This means that the producer must put service above sales.

**IV. Public Perceptions of the Insurance Industry**

- ❖ A producer's actions help shape the public's perceptions of the insurance industry. A producer's primary ethical duty to the public and each prospective insured is to provide accurate information regarding insurance policies and benefits in a fair and unbiased manner.
- ❖ That information should be complete in every way, providing the prospect with the details of any deductibles, waiting periods, benefit limitations, exclusions, or qualification requirements for the policy.
- ❖ A producer's ethical duties to the public quite demanding. In addition to the responsibilities, the surveys indicated-skill, competence, professionalism, and moral integrity. Let us review other ways in which producers can help (or hinder) the public's perception of insurance and the insurance industry.

**A. Communication**

1. A prospect's lack of understanding of what benefits an insurance policy will and will not usually result from poor communication. Sometimes the source of this problem is that a producer attempts to sell a new product without fully understanding the policy's features and benefits.
2. Attempting to sell any policy without adequate knowledge and training is unethical because it is a producer's responsibility to determine if and how a policy will fit the prospect's needs.

**B. Complete and Honest Representation**

1. A producer has a duty to present each policy with complete honesty and objectivity. This means pointing out any limitations or drawbacks the product may have, along with its features and benefits. In all cases, a simple, straightforward explanation of the policy and how it will help fill the prospect's needs is always the proper ethical course.

**C. Selling to Fit Needs**

1. A prime violation of a producer's ethical duty to a prospect is deliberately selling to fit the producer's needs rather than the needs of the prospect.
2. By committing themselves to professionalism and the needs of the client, insurance producers can act both responsibly and ethically.

**V. Presenting Recommendations to Clients****A. Two principles form the foundation for an effective sales presentation.**

1. First, to uncover the needs of the prospect and eventually show how life insurance satisfies those needs.
  2. Second is to help people solve financial problems. It is likely that many people a producer talks to will not recognize these problems, or, if they do, they will be inclined to ignore them.
- ❖ A producer's role is to isolate these problems and present them to prospects so that they will want to do something about them.

- ❖ These two principles (1) to uncover needs and solve problems (2) are at the heart of all sales presentations.

### **B. The Organized Sales Presentation**

1. In many cases, the entire sales process can be accomplished in one interview. It will also require two or more meetings because the producer will need to spend some time assessing the information received in the initial meeting before recommending the appropriate life insurance solution. The organized sales presentation proceeds according to six steps:
  - a. the approach;
  - b. establishing the general problem;
  - c. establishing the specific problem;
  - d. assessing the need;
  - e. presenting the life insurance solution; and
  - f. the close.

### **C. Informed Decisions**

1. Once facts have been gathered and analyzed, and suitable products have been identified, the next step is the presentation.
  - a. In the past, the prospect was convinced-using virtually any means available-to buy the recommended product and pay the first premium.
    - i. This was often accomplished by scare tactics in which the client was reminded, often with the help of fictitious "motivational stories," that death was inevitable, if not imminent.
2. Hard-sell tactics are not acceptable. The only proper approach is needs-based.
  - a. The objective is to educate clients, so they can make informed decisions about what is best for them, not to sell them, or convince them that the producer's recommendations are best.
  - b. The producer's role is to provide clients with complete and accurate information under the ethical and legal requirements of full disclosure. A client's questions or concerns should be addressed as signs of interest and opportunities to further explain a certain feature or benefit of the policy.
3. This approach to selling involves a partnership between producer and client that enables the client to make informed decisions based on facts. This is one reason many producers present several alternatives, all of which may be suitable.
  - a. The idea is to provide clients with choices that allow them to decide what is best for them.
4. Ethical producers see this method of doing business as liberating. It takes the sales pressure off the clients and the producers. If they have taken the time to establish relationships, conduct quality fact-finding interviews, and select products that reflect genuine needs, this next step, the presentation, is simply the logical progression in the client's decision-making process. It involves discussion and disclosure, not pressure and manipulative selling tactics.

### **D. Overview of the Presentation**

1. The presentation may take a few minutes or an hour, depending on the products' complexity under discussion. Regardless, the presentation will flow through the following four steps:
2. First, the producer reviews and reestablishes the relationship. A week or longer may have elapsed between the fact-finding interview and this next meeting. The producer also should take a few minutes to review his or her credentials. As with the initial meeting, it is important to make sure that all information is accurate.
3. The producer then reviews the client's needs and priorities. Clients are busy. The odds are that the details of a conversation that took place several days ago will be vague at best. It is in everyone's best interests to review the priorities discussed and any decisions made at that first meeting. This step helps ensure that you and the client agree about the facts and that all relevant information has been disclosed.

4. Next, the producer introduces one or more specific product solutions and provides an overview of how the policies work. This usually involves a description of policy features and benefits.  
(Note: There will be occasions when no product should be recommended. At these times, the producer should schedule an appointment, nonetheless, to confirm this with the client. This not only ensures that the client understands and agrees with the decision, but it also leaves the door open for future business.)
5. Finally, if the producer uses a product illustration, they should review and explain the illustration in detail as part of the product presentation process.

The producer is responsible for meeting all disclosure rules.

#### **E. Full Disclosure**

1. Full and accurate disclosure is the cornerstone of the product presentation. The producer also must explain these facts, so the client understands the ramifications of a given decision concerning their particular situation and objectives. The producer is responsible for communicating relevant information in an understandable manner. The goal is to explain and educate, not to sell.
  - a. It is easy for a producer who believes in a company's products to be so positive and motivated that he or she crosses the line to misrepresentation.
2. The producer is a teacher and facilitator. The producer presents the facts; the client makes the decision.
3. When presenting recommendations, many producers prefer to start with a general overview of how a particular product meets identified needs, followed by a detailed explanation of specific features and benefits. This presentation may include the use of policy illustrations, company-approved product brochures, and other support materials. (The use of preprinted materials is recommended because they generally have been reviewed for compliance, so they meet full disclosure and market conduct requirements.)
4. Full disclosure also means discussing a policy's limitations openly. Most consumers welcome being given the complete picture as candidly as possible.
5. The producer can identify the feature clearly, then explain it in terms of its benefits and limitations.
6. Here is an example of possible features of a variable universal life policy, along with a summary of the product's benefits and limitations:

#### **REVIEW EXAMPLES IN THE STATE STUDY MANUAL**

**F. Positioning the Policy with the Client.** With certain policies, it may take some time to provide full and accurate disclosure. Here is one way to position the policy with the client: Henry, based on everything we discussed last week, it is my recommendation that one of my company's variable universal life policies, has the potential to meet your needs. This type of policy, called VUL for short, has some unique features that I want to go over with you. This policy offers life insurance protection, tax-favored accumulation, competitive returns on account values, allocation control of cash value accounts, death benefit flexibility, premium flexibility, access to cash values, and more.

1. At this point, the producer should go through each key feature and its benefits, explaining the potential drawbacks as well. The key is to be accurate and balanced in the presentations.
2. The most important point producers should remember when discussing a product is that while its features and benefits are familiar to the producer, they may confuse the client. The producer must be sure to explain the policy clearly and completely.
3. Producers must respond honestly and straightforwardly to questions and concerns. Questions should be treated as signs of interest. They present producers with the opportunity to further explain a particular feature or benefit to the client.

#### **G. Avoiding Misrepresentation**

Perhaps the biggest market conduct danger producers face during the presentation is that of misrepresentation.

1. What Constitutes a Misrepresentation?

- a. Producers must be sure to avoid creating a false impression about themselves, their companies, their products, or their services.
  - b. A misrepresentation can be a verbal statement, a brochure, or policy illustration that has been altered or some other written communication with a prospect or client.
  - c. Some of the most common examples of misrepresentation follow:
2. Misrepresenting a policy's provisions or benefits or how the policy can be expected to perform over time.
    - a. This includes referring to a policy as anything other than insurance, such as a wealth-building plan or an insured investment.
    - b. Alternatively, it may consist of making inaccurate statements or providing inadequate disclosure.
    - c. It is the producer's job to explain the tax and other consequences of decisions regarding insurance policies.
  3. Overstating promises and guarantees. Sometimes just a few words make the difference between a projection and a guarantee
    - a. When explaining dividends or vanishing premiums to clients, producers should be very clear that they are discussing projections, not guaranteeing the figures.
    - b. There is a big difference between stating that earnings "are guaranteed" and "are possible." Clients must clearly understand that difference.
  4. Giving the impression that policy dividends or cash value projections (other than those that are guaranteed, as stated in the policy) are guaranteed.
    - a. Producers should distinguish between projections and guarantees, and make sure that clients understand the distinction.
  5. Using inaccurate or misleading information or numbers that misrepresent an insurance company's financial condition, a broker-dealer, or another producer.
    - a. The fact that a company is in receivership is public information; however, producers should use caution in explaining the ramifications of a company's financial condition.
    - b. It is equally important not to spread rumors about another producer, agency, or broker-dealer.
  6. Making any statements or giving reassurances of any kind about coverage, the policy, or premiums that are not true or that cannot be supported clearly by the policy.
    - a. One of the most serious examples of this practice would be to tell an applicant that they are insured when this is not the case, or coverage is only conditional.
  7. Engaging in the most serious type of misrepresentation-intentional fraud.
    - a. This criminal act can lead to a fine and loss of license, possibly even criminal proceedings.
    - b. The agency, manager, broker-dealer, and home office may be held liable as well.
    - c. Therefore, producers need to make sure they remain within the legal limits of their state laws and their companies' ethical guidelines.

#### **H. Knowledge - The Key to Avoiding Misrepresentation**

The following two steps can help producers use their knowledge to benefit clients and themselves:

1. Learn the products and the industry.
  - a. Producers should read their policies to make sure they understand them.
  - b. A producer's knowledge and ability to explain policy provisions clearly can help protect clients from costly mistakes.
2. Plan sales presentations carefully.
  - a. Producers must be sure to make complete and accurate sales presentations, disclosing all relevant information about their products to clients.

#### **I. Common Dangers of Misrepresentation**

##### **Vanishing Premiums**

- a. This term should no longer be used.
- b. Vanishing premium is not a contractual provision or part of the policy, and it is not guaranteed.
- c. Under no condition should a producer state or imply that premiums will vanish or that premiums may end on a specific date.

- J. Flexible Premiums.** In many policies, once the initial premium has been paid, the amount of additional premiums is flexible or even optional to some degree for the policyowner.
1. It should never be implied that after the initial premium has been paid, a policy generally will fund itself.
    - a. Present as a financial objective tool
    - b. Clients must be informed of the potential consequences of skipping premiums and how this action may affect policy values.
- K. Insurance Presented as a Savings or Retirement Plan.**
1. While cash value life insurance does have an accumulation element, producers should not give the impression that life insurance is anything other than life insurance.
- L. Guaranteed versus Potential Cash Value Accumulations.**
1. When the cash value growth is guaranteed by the insurance company, as it is in fixed-return policies, it can be stated as such.
  2. In all other cash value policies, however, including universal life and variable universal life, clients should be made aware of how cash values are credited.
- M. Dividend Misrepresentation.**
1. Producers must explain that dividends are a return of premium, which is why they are not taxed. Producers must make sure they never give clients the impression that dividends are guaranteed. Past dividend performance in no way can be interpreted as a projection of future dividends.
- N. Insurance Described as Investments.**
1. If the product is life insurance, producers must not imply that the product is an investment or describe it as such.
    - a. The emphasis should be on life insurance as a means of protection, with accumulation features that receive favorable tax treatment.
    - b. Producers should also not describe cash values as investments, investment returns, equity, savings, or emergency accounts.
- O. Premiums Referred to as Other Than Premiums.**
1. Producers always should refer to premiums as just that—premiums. They should not be described as anything else.
- P. Failure to Distinguish between Tax-Free and Tax-Deferred Accumulations.**
1. Producers should not imply or state that cash value growth is tax-free.
    - a. It is acceptable to remind clients, however, that beneficiaries receive proceeds tax-free in most situations.
- Q. Failure to Divulge Risks.**
1. In addition to the positive aspects, producers must divulge the risks associated with insurance policies, especially when discussing variable-rate products.
  2. Clients must understand that they, not the insurance companies, bear the full risk of loss with the cash values in variable products.
- R. Failure to Explain Product Differences.**
1. Producers should help clients understand the differences between policies under discussion.
    - a. It would be grossly unfair to compare premiums and cash values between a traditional whole life policy and a variable universal life policy without also pointing out the other differences.
- S. Policy Illustrations**
1. One of the best ways to explain policies clearly and completely is to use policy illustrations. Computer-generated life insurance policy illustrations, illustrating policy performance under a handful of possible scenarios, were developed to explain potential policy performance.
    - a. Many producers began to build all their policy presentations around these illustrations.

- b. Although these educational sales tools were intended to help clients better understand guaranteed and projected policy values, they were also the cause for many complaints through misuse.

#### **T. Today's Policy Illustrations**

1. The NAIC's Model Regulation sets the following guidelines:
  - a. Each policy illustration must have a written explanation or policy summary.
  - b. Each policy illustration must show that cash values and coverage will vary depending on changes in insurers' costs and dividends.
  - c. Each policy illustration must be labeled "life insurance illustration" and contain such basic information as the names and addresses of both the insurer and the producer and other relevant identifying information about the source of the illustration.
  - d. Each policy illustration must describe nonguaranteed elements in a straightforward manner and must not give the impression that they are in any way guaranteed.
  - e. Each policy illustration must be complete. The illustration cannot be altered or marked up in any way to highlight any particular area.
  - f. No policy illustration can represent or imply that premium payments are not required, unless that is the case.
  - g. No policy illustration can contain the word "vanish" or "vanishing premium" or similar wording that could mislead the applicant into believing the policy will become paid up through the use of nonguaranteed or projected elements.
  - h. No policy illustration can represent that the policy is anything other than life insurance.
  - i. No policy illustration can show projections of elements (such as reduced expenses or mortality gains) that have not yet occurred.
  - j. Each policy illustration must follow a specific basic illustration format.
2. When using an illustration, producers must obtain a signed and dated statement from the applicant. The wording like the following would suffice as proper notice:

I HAVE RECEIVED A COPY OF THIS ILLUSTRATION AND UNDERSTAND  
THAT ANY NONGUARANTEED ELEMENTS ILLUSTRATED ARE SUBJECT TO  
CHANGE AND COULD BE EITHER HIGHER OR LOWER. THE PRODUCER HAS  
TOLD ME THAT THEY ARE NOT GUARANTEED.

#### **U. When Using Policy Illustrations.** Illustrations cannot stand by themselves; they make little sense unless they are explained. To best use illustrations to help clients make informed buying decisions, producers should take the following nine steps:

1. Become knowledgeable.
  - a. Producers should complete the Society of Financial Service Professionals' Illustration Questionnaire to better understand how illustrations are developed, how they work, and how they should be presented.
  - b. Producers must understand the assumptions underlying illustrations and how those assumptions affect a policy's future performance. Completing the Questionnaire helps to provide that knowledge and avoid errors in communicating illustration information to clients.
2. Make only credible and realistic assumptions when requesting illustrations from insurers or creating original ones from compliance-approved software. For example, introducing 10% projected rates of return in a 4% current environment simply is not ethical.
3. Take time to make sure applicants understand clearly that illustrations are not predictions but simply scenarios that indicate what could take place based on the assumptions used.
4. Make clear distinctions between guaranteed and nonguaranteed cash values.
  - a. Provided the applicant pays all premiums and assumes no policy loans; this is the amount of guaranteed cash value in the policy each year. It often is referred to as the minimum cash value.
  - b. Other values, including dividends and account value increases, are projected based on present assumptions and can change over time based on performance
5. Encourage applicants to ask questions about illustrations; then answer those questions.
6. Review the entire illustration with the applicant, starting with the proposal page.

- a. This page identifies the type of policy, face amount, premiums, and other relevant information. The rest of the illustration consists of columns that show changing values year by year.
7. Point out that total cash value includes nonguaranteed values.
  - a. This number is a projection of how policy values could look over time. It should not be presented as or implied to be a guarantee or prediction of future performance.
8. Be aware of the assumptions used in illustrations.
  - a. No policy loans may be taken against the cash value, and dividends are used to purchase paid-up additions, for example. These affect future values.
9. Ask questions.
  - a. An illustration can be fairly complicated, so the producer should encourage applicants to ask questions if necessary.

#### **V. Policy Replacement**

1. When it is appropriate to replace an existing policy.
  - a. On the one hand, due to the rapid evolution of new and improved products in recent years, a replacement may be in the client's best interests.
  - b. On the other hand, a replacement often exposes the client to undue financial loss and risk.
2. Replacement results from one of two possible motives.
  - a. The producer believes canceling one policy to replace it with another benefit the client.
    - i. This can occur when an existing policy appears to be completely inappropriate or no longer meets client needs, such as in a divorce or the death of beneficiaries.
3. The second motive is the result of a producer's desire to generate new first-year commissions without regard to the client's needs.

#### **w. Definition of Replacement.**

1. Varies from state to state.
2. Replacement, by its broadest definition, may involve:
  - a. An action that eliminates the original policy or diminishes its benefits or values.
3. Examples of this are policy loans, taking reduced paid-up insurance, or withdrawing dividends.
  - a. Traditionally, improper replacement is divided into two categories: twisting and churning:
    - i. Twisting also is referred to as external replacement. It involves illegally inducing a person to drop existing insurance to buy similar coverage with another producer or company.
  - b. Churning also is known as internal replacement. It involves replacing policies within the same company, often by the same producer who sold the original policies.
  - c. When in doubt, producers should never initiate replacement to generate commissions.
    - i. Indeed, it may sometimes be advisable to replace a client's policy with another. However, the litmus test must be how well the action serves the client's best interests, not the producer.
4. In most situations, "the life insurance you already own is your best buy" for the following reasons:
  - a. Changes in health and age. The client may have become uninsurable or insurable only at a higher rate. A whole life policy purchased at age 20 almost always carries a lower premium than one purchased at age 48.
  - b. New contestable period. This may expose the client to the risk of dying without coverage or may subject beneficiaries to legal conflicts.
  - c. New policy fees and expenses. The new policy often comes with new sales loads, policy fees, and other expenses.
  - d. Possible loss of policy upgrades or automatic improvements that may meet the policyowner's objectives. Many companies are introducing unilateral policy improvements to existing policies. These also should be considered before a replacement is initiated.
  - e. Loss of Grandfathered Rights. If the original policy was purchased when tax laws were more favorable, replacement might entail the loss of "grandfathered" income tax benefits.

5. When a Replacement May Be Appropriate.
  - a. The client's health has improved. It might be possible to convince the existing carrier to reconsider the rating and reduce the premium.
  - b. A female client originally was underwritten with unisex rates in compliance with the laws of her state. When she moves to another state, it may be possible that a new policy will reduce her coverage cost.
  - c. A policy issued at a young age and features a small death benefit for an inappropriately large premium no longer meets the client's needs.
  - d. The purpose of the replacement is to undo a bad replacement. For example, a middle-aged client who had whole life insurance was induced to replace this policy with term insurance.
    - i. The recommendation to replace the temporary coverage with a permanent policy may indeed be appropriate.
6. Before Recommending a Replacement.
  - a. Make sure the replacement is legal according to state regulations.
  - b. Conduct a self-check to ensure that the replacement is ethical.
  - c. Give the client a form called a Notice Regarding Replacement, which provides up-to-date information about the client's existing coverage so he or she can compare it with the new proposed policy.
  - d. Provide the client with a completed and signed comparison statement that fairly and accurately allows the client to compare the two policies.
  - e. Notify the existing carrier of the proposed replacement.
    - i. Where external replacement is involved, this enables the policyowner to meet with the original agent.
    - ii. When internal replacement is involved, this also enables the company to ensure that all internal replacement rules are being met.
  - f. Make full and fair disclosure of all facts concerning the new coverage and the existing insurance.
  - g. Give a follow-up letter to the client that summarizes the meeting with the producer.
  - h. Complete all appropriate forms properly. By signing these forms, the insured acknowledges that they are fully aware of which benefits are being given up and which benefits are being accepted.
7. How Replacement Rules Benefit the Producer.
  - a. They assist ethical producers by reducing the incidence of replacements of their policies.
  - b. To avoid inappropriate replacement, producers should do the following:
8. Maintain Close Contact with Clients.
  - a. At the minimum, the producer should conduct an annual review.
9. Educate clients about how the policies they purchase suit their needs.
  - a. The producer should periodically remind clients why they purchased coverage.
10. Ask clients to call if they are ever asked to consider replacing their policies.

## VI. Ethics and the Law

- ❖ Once an insurance producer understands and embraces a personal and professional code of ethics, he or she must also find ways to avoid the temptation to use illegal, unethical, or questionable practices.
- ❖ The States carry the major burden of regulating insurance affairs, including the ethical conduct of agents licensed to conduct business within their borders.

### A. Marketing Ethics

1. All state laws regarding sales and marketing practices are designed to protect consumers' interests by ensuring fair, reasoned, and ethical conduct by a producer.

### B. Unauthorized Insurers

1. By law, only insurers that have been authorized or licensed by a state may issue policies in that state.
2. A producer must ensure that the insurers they represent are licensed to do business where the solicitation is made.
3. Some states will hold the producer personally liable on any insurance contract he or



she places for an unauthorized insurer.

**C. Coercion occurs when someone in the insurance business applies physical or mental force or threats of force in transacting insurances and/or seeks to limit a client's free choice in such transactions**

**D. Unfair Discrimination**

1. Agents should offer insurance products and services without regard to race, gender, age, ethnicity, or any other characteristic that is not a legitimate underwriting distinction.

**E. Misrepresentation**

1. Any written or oral statement that does not accurately describe a policy's features, benefits, or coverage is considered a misrepresentation.
2. The states have enacted laws that penalize producers who engage in this practice.

**FLORIDA LAW**

**What is "misrepresentation"?**

Misrepresentation involves a situation where one fails to clearly bring to mind a fact or condition. Innocence may prevail, or an intent to deceive or be unfair may exist.

An innocent misrepresentation of a material fact is grounds to void a contract-it need not be fraudulent. However, a fraudulent misrepresentation of an immaterial fact would not necessarily void the contract. [Sec. 627.409]

**F. Defamation**

1. Defamation is any false, maliciously critical or derogatory communication-written or oral-that injures another's reputation, fame, or character.
  - a. Unethical producers practice defamation by spreading rumors or falsehoods about a competing producer's character or the financial condition of another insurance company.

**G. Rebating**

1. Rebating occurs if the buyer of an insurance policy receives any part of the producer's commission or anything else of significant value as an inducement to purchase a policy.
  - a. In Florida, rebating is allowed if the agent adheres to the rules on Page 74 in the manual.

**FLORIDA LAW**

**What is "rebating"?**

This is the act of refunding part of the commission, premium, services, or anything of value to the purchaser as an inducement to buy an insurance policy. If not done strictly according to Florida statutes, the act violates the Code of Ethics and Florida law. [Ch. 4-215.220; Sec. 626.9541(l)(h)]

**H. Twisting and Churning**

**I. License Suspension and Termination**

1. A producer's license can be suspended or terminated for violation of unethical actions listed in the state study manual.

❖ Knowledge and calculated awareness can help the honest and ethical producer avoid many of the traps described in this unit.

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# Retirement Planning

## Basic Assumptions

- Retirement at age 65
- Retirement Income of \$50,000 per year in today's dollars using a 2% inflation adjustment
- Retirement Income provided from age 65 to age 85
- Each age category starts with some savings that they have accumulated over the year through IRA's, 401K's, Private savings accounts, etc.

*These assumptions are as follows:*

25-year-old - \$5,000  
 35-year-old - \$15,000  
 45-year-old - \$50,000  
 55-year-old - \$150,000

*Illustration A assumes all current money and new money will earn 9% during your working years and 7% during retirement years.*

*Illustration B assumes all current money and new money will earn 8% during your working years and 6% during retirement years*

### \$50,000 Annual Income Adjusted by 2% Inflation

<u>Age</u>	<u>Illustration A - 9%-7%</u>	<u>Illustration B - 8%-6%</u>
25	(\$110,401 @65) (\$165,051 @85) Need to save \$298.37 per month	Need to save \$442.92 per month
35	(\$90,568 @65) (\$134,579 @85) Need to save \$565.49 per month	Need to save \$787.01 per month
45	(\$74,297 @65) (\$110,401 @85) Need to save \$1,052.91 per month	Need to save \$1,406.27 per month
55	(\$60,949 @65) (\$90,568 @85) Need to save \$2,248.52 per month	Need to save \$2,907.76 per month

# Exhibit “A” Annuities

## Seven (7) Annuity Options Based on a sum of \$300,000\*

Straight Life AKA “Life-Only”	Period Certain 10 or 20 or 30yrs	Joint w/ Survivor and 3/4 or 2/3 or 1/2	Joint with “full Survivor”	Life with “Period Certain”	Installment Refund	Cash Refund	Period Certain 10 or 20 or 30yrs
Cannot outlive Income	<b>Can</b> Outlive Income	Cannot outlive Income	Cannot outlive Income	Cannot outlive Income	Cannot outlive Income	Cannot outlive Income	<b>Can</b> Outlive Income
Pays out the Highest Amount	If Annuitant has elected a guaranteed 30-year payment period	Survivor’s Income reduced to elected 3/4 or 2/3 or 1/2 of original monthly payment		If Annuitant has elected a guaranteed 15 year Payment period			If Annuitant has elected a guaranteed 30-year payment period
\$3,000/month*	\$2,200/month*	\$2,000/month*	\$2,000/month*	\$2,450/month*	\$2,750/month*	\$2,500/month*	\$2,000/month*
Annuitant Dies:  Payment Stops	Annuitant Dies:  Surviving Spouse will continue to receive reduced monthly payments until s/he dies	Annuitant Dies:  Surviving Spouse will continue to receive same monthly payment until s/he dies	Annuitant Dies:  Surviving Spouse will continue to receive same monthly payment until s/he dies	Annuitant Dies after only 5yrs:  Beneficiary will continue to receive same monthly payment for remaining 10yrs Annuitant still alive after 15yrs... Monthly Payments will continue until Annuitant dies.	Annuitant Dies:  Beneficiary will receive unpaid remaining balance of the original \$300,000 in Same Monthly Payment until Entire \$300,000 has been fully refunded	Annuitant Dies:  Beneficiary will receive unpaid remaining balance of the original \$300,000 in One Single Cash Lump Sum	Will Pay Annuitant only for that 30yrs period.  If Annuitant outlives 30-year payment period: Payment stop  Example: Lottery Structured Payment

**UNIT****26****FLORIDA LAWS & RULES:  
LIFE & HEALTH INSURANCE****OVERVIEW**

This unit describes Florida's regulation of the life and health insurance business, its companies, and their marketing practices. Candidates for either the Life and Annuity Insurance Examination or the Health Insurance Examination, or both, will be tested on the various required laws and rules covered in this unit. This content of this unit applies to candidates seeking licensure in Life and Annuity Insurance, Health Insurance, or both. The content found in Units 26 – 30 will comprise of approximately 33% (50 questions) of your state exam

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Financial Services Regulation
- Licensing
- Agent Responsibilities
- Insurance Guaranty Fund
- Marketing Practices
- Rule 69B-215, F.A.C., Code of Ethics NAIFA

**KEY TERMS**

Admitted Versus Non-Admitted Insurers

Agent Responsibilities

Chief Financial Officer

Code of Ethics of the NAIFA

Defamation

Insurance Code

Insurance Regulatory Agencies

Misrepresentation

Office of Insurance Regulation

Rebating

## FLORIDA LAWS AND RULES COMMON TO ALL LINES OF INSURANCE



***This manual contains the most current and up to date material. The video within the course is in the process of being updated. If video content is different than what is in this manual, please utilize the content in this manual.***

### ***Financial Services Regulation***

Effective January 2003, Florida's Department of Insurance, Treasury, State Fire Marshal, and the Department of Banking and Finance were merged into the Department of Financial Services (DFS).

The Department is comprised of 15 divisions and offices with approximately 2,000 employees.

#### ***Chief Financial Officer***

The Department is overseen by an independently elected Chief Financial Officer (CFO), who is also a member of the governor's cabinet. The CFO serves as the head of the DFS and is a member of the Financial Services Commission. Together with the Financial Services Commission, and the Commissioner of the Office of Insurance Regulation (OIR), the CFO administers insurance laws of Florida. [F.S. 20.121]

#### ***Office of Insurance Regulation***

The Director or Commissioner of Insurance Regulation is the head of the OIR. The OIR is responsible for all activities concerning:

- Insurance companies
- Licensing and certificate of authority
- Rates
- Policy forms
- Premium financing
- Claims
- Solvency
- Viatical settlements
- Administrative supervision
- Other provisions of the Insurance Code

#### ***Office of Financial Regulation***

Headed by the Director or Commissioner of Financial Regulation, the Office of Financial Regulation (OFR) is responsible for all activities of the Financial Service Commission relating to the regulation of banks, credit unions, finance companies, and the securities industry. Through the OFR's Bureau of Financial Investigations, the Office investigates suspected wrongdoings and may refer such violations to prosecutorial agencies to aid in its enforcement.

### ***Department of Financial Services***

#### ***General Duties and Powers***

The Department and respective offices have the following powers and duties [F.S. 624.307]

- Enforce the provisions and execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law
- Have the powers and authority expressly conferred upon it by, or reasonably implied from, the provisions of this code
- Conduct such investigations of insurance matters, as it may deem proper to determine whether any person has violated any provision of this code within its respective regulatory. The cost of such investigations shall be borne by the state.

- Collect, propose, publish, and disseminate information relating to the subject matter of any duties imposed upon it by law
- Have such additional powers and duties as may be provided by other laws of this state
- Employ actuaries who shall be at-will employees and serve at the pleasure of the CFO. Actuaries employed pursuant to this paragraph shall be members of the Society of Actuaries or the Casualty Actuarial Society.
- Expend funds for the professional development of their employees to ensure compliance with NAIC regulations and training
- Develop and implement an outreach program for encouraging the entry of additional insurers into the Florida market
- Send legal documents to individuals or to unauthorized carriers by trackable means, including electronic methods
- Receive inquires and complaints from consumers, provide follow-up and consumer assistance, administer penalties, and adopt rules to administer this section
- Florida-licensed insurers must designate the CFO as their attorney to receive service of all legal processes issued against them in any Florida civil action. [F.S. 624.422]

### ***Policyholders' Rights***

The standards conveyed in the list of statements below are to be followed by the Department, Commission, and any other party when dispensing administrative interpretation of the law and adopting rules. [F.S. 626.9641]

Policyholders shall have the right to:

- Competitive pricing practices and marketing methods
- Comprehensive coverage
- Fair and accurate insurance advertising
- Selling approaches that provide accurate and balanced information
- An insurance company that is financially stable
- A competent and honest insurance agent/broker to service their needs
- An insurer that provides an economic delivery of coverage and tries to prevent losses
- A readable insurance policy
- A balanced and positive regulation by the Department, Commission, and Office

### ***Office of Insurance Regulation***

Additional duties and powers of the OIR are provided below.

#### ***Policy Approval Authority, Rates, and Forms***

The following types of policies may not be delivered in Florida unless the form has been filed with and approved by the OIR.

- Basic insurance policy
- Annuity contract application form
- Group insurance
- Riders, endorsements, and renewal certificates

A filing for each item must be completed at least 30 days before any such use or delivery. If a form has been filed and no action has taken place within 30 days, the form is deemed approved.

The Florida health insurance company filing rules state that a company cannot deliver, issue for delivery, or renew in Florida any health insurance policy form until it has filed with the Office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in the rating schedule. [F.S. 624.302, 627.410, F.A.C. 69O-149.002-023]

#### ***Market Conduct Examinations***

The OIR may examine any insurance company as often as may be warranted in the interest of the policyowner or the public. Each domestic company must be examined not less than once every five years.

The Office will examine each insurance company applying for an initial certificate of authority to transact insurance in the state of Florida before granting the initial certificate. An examination must be conducted at least once every year with respect to a domestic insurance company that has held a certificate of authority for less than three years. The examination must cover the preceding fiscal year or the period since the last examination. [F.S. 624.316, F.A.C. 69O-138.0901]

#### *Agency Actions*

The OIR has four major areas of responsibility, including:

- Organizing and licensing insurance companies, including establishing initial financial requirements
- Monitoring unauthorized insurance activities
- Maintaining and overseeing the regulation of company activities, such as policy forms, provisions, and rates (direct rate regulation does not apply to life insurance)
- Monitoring the financial condition of insurers, investment categories, and appropriate methodology for developing liabilities

#### *Investigations*

The DFS or OIR may investigate if it believes any person has violated or is violating a provision of the insurance code. The DFS may investigate the accounts, records, and document transactions pertaining to insurance affairs of any agent, agency, company, representative, or other person subject to its jurisdiction.

During an investigation, the DFS or OIR can administer oaths, subpoena and examine witnesses, and receive evidence. Any person who willfully obstructs the Department, the Office, or the examiner in any examination or investigation may be guilty of a misdemeanor. [F.S. 624.317, .318, .321, 626.601]

### **Office of Financial Regulation**

#### *General Duties and Powers*

The OFR has a supervisory position overall state financial institutions, their subsidiaries, and service corporations. The OFR's purpose is to maintain public confidence and provide for the safe and sound business transactions of the financial institutions it oversees. [F.S. 655.012]

#### *Agency Actions*

When imposing an action, the OFR will consider the appropriateness of the penalty with respect to the financial resources, good faith, gravity of the violation, history of previous violations, and other matters as justice may require.

[F.S. 655.031]

#### Cease and Desist Orders

The OFR may issue and serve **cease and desist orders (CDOs)** upon any state financial institution whenever it has reason to believe that such institution is engaged in conduct that is:

- An unsafe or unsound practice
- A violation of any law relating to the operation of a financial institution
- A violation of any rule of the Commission
- A violation of any order of the OFR
- A breach of any written agreement with the OFR
- A prohibited act or practice pursuant to F.S. 655.032, or
- A willful failure to provide documentation or information to the OFR or any appropriate federal agency, or its representatives, upon written request [F.S. 655.033]

All complaints must include a statement of facts and notice of opportunity for a hearing. If the recipient of the CDO fails to respond to a complaint within the time allotted, the recipient is in default and justifies the entry of the order. If the OFR finds that the conduct of the financial institution is likely to cause insolvency, the OFR may issue an **emergency cease and desist order (ECDO)** requiring the institution to immediately cease and desist from the conduct. An ECDO is effective immediately upon service of the order for a period of 90 days.



### Injunctions

A circuit court has jurisdiction to hear any complaint filed by the OFR. The circuit court may issue an **injunction**, or the granting of another appropriate relief, in the event it feels that the violation of the financial institution will cause substantial injury to a state financial institution. [F.S. 655.034]

### Investigations

The OFR may make **investigations** when it deems necessary. In an investigation, it has the power to administer oaths and affirmations, take testimony and depositions, and issue subpoenas. Non-compliance of a subpoena will result in a contempt of court (circuit court). Florida law permits that reasonable and necessary investigation expenses may be assessed against the person or entity being investigated. [F.S. 655.032]

### **Definitions**

- **Insurance contract.** An insurance contract is *an agreement enforceable by law that binds one or more parties to a certain promise in exchange for a form of consideration.*
- **Insurance transaction.** *An insurance transaction is the selling, soliciting, negotiating, and effectuation of a contract of insurance.*
- **Insurance company.** An insurance company is the party that provides insurance coverage, typically through a contract of insurance.
- **Reinsurance.** When the originating insurance company (the **ceding insurer**) insures itself through another insurer (the **assuming insurer**) on part of an insurance risk, the contract is called reinsurance.
- **Domestic company.** Domestic company is the name given to an insurance company in the state of its incorporation, as a Florida insurance company is domestic (domicile) in the state of Florida, foreign as to all other states and alien as to all other countries.
- **Foreign company.** A foreign company is an insurance company formed under the laws of the United States but operating in a state other than the one in which it has been incorporated.
- **Alien company.** An alien company is an insurance company organized under the laws of a foreign country.
- **Fraternal.** Fraternal are organized under a special section of the insurance code. They must be characterized as nonprofit associations or organizations that have a member-based membership and are operated as lodge systems that include ritualistic work and an elected board.
- **Stock company.** A stock company is a non-participating insurance company owned and organized for the purpose of making a profit for its stockholders, stakeholders, or shareholders.
- **Mutual company.** A mutual company is a participating insurance company owned by its policyholders. Mutual companies generally participate in policy dividends.
- **Authorized/admitted and unauthorized/non-admitted companies.** An authorized/admitted company is duly authorized to transact insurance business in Florida and must have a certificate of authority. An unauthorized/non-admitted company is not authorized to transact insurance business in Florida and does not have a certificate of authority.
- **Unlicensed entities.** No person may directly or indirectly act as an agent for unlicensed entities (any company not authorized to transact insurance business in Florida). If an unauthorized insurance company fails to pay in part or in full any claim or loss, and that party knew, or reasonably should have known that the contract was entered in violation of the insurance code, that insurer is liable to the insured for the full amount of the claim or loss not paid.

- **Certificate of authority.** Issued to a company (carrier, insurer, or insurance company), a certificate of authority is the OIR's permission to engage in insurance activities within the state. Any company, directly or indirectly, acting as an authorized company in the state of Florida without a certificate of authority, is committing a felony of the third degree.
- **Mail-order insurance company.** A mail-order insurance company operates principally by mail without personal agent solicitation of prospects. Florida law prohibits unauthorized mail-order companies from soliciting in Florida. The transaction of insurance, including the application for insurance, must be taken by, and the policy delivered through, a licensed and appointed Florida agent.
- **Penalties for violation.** Any agent licensed in Florida, who knowingly represents or aids an unauthorized company, commits a felony of the third degree. Other penalties may be rendered based on the violation.

## Licensing

### *Purpose*

The purpose of the Florida licensing statute is to provide protection to the general public by requiring minimum levels of insurance knowledge and competence of those licensed to sell, solicit, negotiate, and effect contracts of insurance. As an insurance licensee, one is expected to understand Florida insurance statutes and regulations.

### *License Types*

- **Agent.** The term agent is defined to include general lines agent, life agent, health agent, and title agent. The term specifically does not include a customer representative, limited customer representative, or service representative. [F.S. 626.015]
- **Viatical settlement broker.** A viatical settlement broker is an individual who, on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator resident in this state and one or more viatical settlement providers. A viatical settlement broker must be, at a minimum, a licensed Florida life agent and must self-appoint with the Department and pay the applicable fees.

The term viatical settlement broker does not include an attorney, licensed certified public account (CPA), or investment adviser lawfully registered who is retained to represent the viator and whose compensation is paid directly by or at the direction and on behalf of the viator. [F.S. 626.9911(11), .9916]

- **Public adjuster.** A public adjuster is a properly licensed individual who receives compensation for directly or indirectly preparing, completing, or filing an insurance claim for an insured or third-party claimant. The term public adjuster does not include a licensed health insurance agent who assists an insured with coverage, billing, or claims processing issues. [F.S. 626.854]
- **All-lines adjuster.** An all-lines adjuster is an individual who ascertains or determines the amount of a claim, loss, or damage payable because of an insurance claim on behalf of a public adjuster or an insurer for some form of consideration, directly or indirectly. The term all-lines adjuster does not apply to life insurance or annuity contracts.
- **Insurance agency.** An insurance agency is a location where a licensed insurance business entity transacts insurance business. The term agency does not include an insurer or an adjuster. Note that an insurance agency that is owned and operated by a single licensed agent conducting business in their own name and not employing or otherwise using the services of or appointing other licensees is exempt from the agency licensing requirement. [F.S. 626.015, .112]
- **Unaffiliated agent.** An unaffiliated agent is licensed as an agent but is not appointed by or affiliated with any insurance company. To become an unaffiliated agent, one must **self-appoint**. The agent may act as an independent consultant (for a fee) in the business of analyzing specific

policies, providing insurance advice, or counseling, and making specific recommendations or comparisons. All fees must be established in advance by a written contract signed by both the unaffiliated agent and the client.

Unaffiliated agents are prohibited from being affiliated with an insurer, insurer-appointed insurance agent, or insurance agency that contracts with or employs insurance company appointed agents. An unaffiliated agent can receive commissions on previous sales made prior to the date of their appointment as an unaffiliated insurance agent.

Unaffiliated agents will pay the same appointment fees required of agents who are appointed by companies. This statute applies to limited-lines agents as well.

### *Appointments*

No individual may act as an insurance agent unless they are currently licensed by the Department and appointed by an insurance company or other appropriate appointing entity. Unaffiliated agents must appoint themselves and cannot be appointed by an insurance company. Any producer, who fails to maintain an appointment with an appointing entity during any four-year period, will not be granted an appointment by the Department until they re-qualify as if they were a first-time applicant.

[F.S. 626.112, .311, .381, .431, .471, .511, F.A.C. 69B-211.004]

### *Agents' Additional Appointments*

Upon receipt of an appointment application and payment of fees, the Department may issue an additional appointment. No commissions may be paid by any company to the agent until the additional appointment has been conferred by the Department. [F.S. 626.341]

### *Term of Appointment*

Appointments shall be valid for not less than 24 months and no longer than 36 months. This minimum and maximum number of months are necessary to convert the original issue month to the licensee's birth month or license issue month. Appointments renew every 24 months thereafter unless suspended, revoked, or otherwise terminated at an earlier date. [F.A.C. 69B-221.004]

### *Appointment Termination*

An appointing entity may terminate its appointment of any appointee at any time with at least 60 days' advanced written notice delivered in person, via mail with postage prepaid, or by e-mail. An appointee may terminate their appointment at any time. Within 30 days after terminating an appointment, the appointing entity must file written notice that includes the reasons and facts for termination with the Department. [F.S. 626.471, .511]

### *License Requirements*

For an individual to become a licensed insurance producer in Florida, an applicant must successfully complete a pre-licensing course, complete and sign an application under oath, obtain a background check (fingerprints), and pay all of the applicable fees in advance to the Department. The application must include the applicant's full name, age, Social Security number, residence address, business address, mailing address, contact phone numbers, and e-mail address.

### *Pre-Licensing Education*

Applicants must meet the following knowledge, experience, or instruction requirements within four years immediately preceding the licensing application.

- Life agents (2-14); 40 hours
- Health agents (2-40); 40 hours
- Health, life, and variable contract agents (2-15); 60 hours

These requirements do not apply to candidates who have a chartered life underwriter® (CLU®) designation.

Pre-licensure coursework is not required for an applicant who is a member or veteran of the United States Armed Forces (USAF) or the spouse of such a member or veteran.

### Background Check

Every applicant who applies for a license may be investigated by the Department. The method of investigation may include an application, additional questions that are not on the application, fingerprints, and other means as deemed necessary.

Persons who have committed certain felonies are permanently barred from licensure. Other felonies and certain misdemeanors require the applicant to wait for a disqualifying period to lapse prior to applying for licensure. The Department may not issue a license to an applicant unless all related fines, court costs and fees, and court-ordered restitution have been paid. Florida law states that although an individual may be granted a pardon or restoration of civil rights, this action does not require the Department to award a license.

An applicant who has committed a felony of the first degree, a capital felony, a felony involving money laundering, a felony of embezzlement, or a felony directly related to the financial services business is permanently barred from licensure. This permanent bar applies to convictions, guilty pleas, and nolo contendere pleas, regardless of adjudication, by any applicant.

[F.S. 626.171, .201, .202, .621, .651, 624.34]

An applicant who has been found guilty of or has pleaded guilty or nolo contendere to a crime not included above, regardless of adjudication, is subject to a 15-year disqualifying period for all felonies involving moral turpitude, which are not subject to the permanent bar. The applicant is subject to a seven-year bar for all other felonies not otherwise barred and a seven-year bar for misdemeanors related to the financial services business.

Where an applicant is subject to a seven-year disqualifying period and has served at least half of the disqualifying period, they may reapply for a license if, during that time, they have not been found guilty of or have not pleaded guilty or nolo contendere to a crime.

The department may issue the applicant a license on a probationary basis for the remainder of the disqualifying period. The applicant's probationary period ends at the end of the disqualifying period.

Upon a grant of a pardon or restoration of civil rights, the finding or plea no longer bars or disqualifies the applicant from licensure unless the clemency specifically excludes licensure in the financial services business; however, a pardon or restoration of civil rights does not require the department to award a license.

Aggravating and mitigating factors can affect the true length of the disqualifying period. After the disqualifying period has been met, the burden is on the applicant to demonstrate that they are rehabilitated, do not pose a risk to the insurance-buying public, are fit and trustworthy to engage in the business of insurance, and are otherwise qualified for licensure. [F.S. 626.207(2), (3), (7)]

### License Examination

Applicants must pass an examination that will test their ability, competence, and knowledge. The exam material will cover topics indicated on the current examination outline. A passing grade on the state licensing exam is 70% and is valid for a period of 12 months.

Within 30 days after the applicant passes the state licensing exam, the Department will notify them and issue their producer license. The Department will not issue a license to an applicant based on test results that were earned greater than 12 months prior to an application for licensure.

The state licensing examination is NOT required for:

- An applicant for a renewal license, unless the Department determines that an examination is required to establish competence and or trustworthiness
- An applicant for a limited license: travel insurance, motor vehicle rental insurance, credit insurance, in-transit and storage personal property, and portable electronic insurance
- A reinstatement of a license or appointment as an agent whose license has been suspended within the 48 months prior to the date of application or written request for reinstatement
- An applicant for a temporary license

- An applicant who has been conferred the designation of CLU or chartered property casualty underwriter® (CPCU®); an applicant may be required to take an exam regarding Florida insurance laws and regulations)
- An applicant applying for a non-resident license who holds a comparable license in another state with similar examination requirements as Florida

**Retaking the Examination**

An applicant who does not earn a passing score on the state examination may make additional attempts after filing for a reexamination. (Fees apply.) Applicants may not take an examination for a licensing type more than five times in a 12-month period. [F.S. 626.281]

**Maintaining a License**

**Continuing Education**

A licensee must complete a total of 24 hours of approved continuing education (CE) every two years. Each licensee, except a title insurance agent, must complete at a minimum, a five-hour law and ethics update course every two years specific to the license authority held. A licensee who holds multiple insurance licenses must complete an update course that is specific to at least one of the licenses held. In addition, each licensee must also complete 19 hours of approved elective continuing education courses every two years.

Depending on the number of years licensed and designations an insurance licensee holds, the number of CE credits required may vary. Under each of the following circumstances, the licensee must also complete the required five-hour ethics and law course in at least one of the authorities in which they are licensed.

- A licensee who has been licensed for six or more years must complete a minimum of 15 hours of elective CE every two years.
- A licensee who has been licensed for 25 or more years and is a CLU or CPCU or has a Bachelor of Science degree in risk management must complete a minimum of five hours of elective CE courses every two years.
- An individual who holds a license as a customer representative, limited customer representative, title agent, motor vehicle physical damage and mechanical breakdown insurance agent, an industrial fire insurance, or burglary insurance agent and who is not a licensed life or health agent, must complete a minimum of five hours of approved CE every two years.
- Bail bonds agents must complete the five-hour update course and a minimum of nine hours of elective CE courses every two years.

Active participants of the National Association of Insurance and Financial Advisors (NAIFA), the Florida Association of Insurance Agents (FAIA), the Florida Association of Health Underwriters (FAHU), the Latin American Association of Insurance Agencies (LAAIA), the Florida Association of Public Adjusters (FAPIA), the Florida Bail Agents Association (FBAA), or the Professional Bail Agents of the United States may receive up to two hours of elective CE credit per calendar year, if properly reported, for attending four or more hours of association meetings.

Licensees who are unable to comply with the CE requirements set forth by the state due to active duty in the USAF, may submit a written request for a waiver to the Department.

Excess CE hours accumulated during any two-year compliance period may be carried forward to the next compliance period.

A nonresident licensee must meet the CE requirements set forth in their home state to meet Florida's CE requirements.

Florida Law Regarding Insurance Agents' CE Requirements		
Licensed 1-5 years	24 Credits every 2 years	<ul style="list-style-type: none"> <li>• 5-Hr Law and Ethics Update</li> <li>• 19 Elective Credits</li> </ul>

Licensed 6+ years	20 Credits every 2 years	<ul style="list-style-type: none"> <li>• 5-Hr Law and Ethics Update</li> <li>• 15 Elective Credits</li> </ul>
Licensed 25+ years And CLU, CPCU, Bachelor of Science in Risk Management - OR - 18+ semester hours in insurance-related courses	10 Credits every 2 years	<ul style="list-style-type: none"> <li>• 5-Hr Law and Ethics Update</li> <li>• 5 Elective Credits</li> </ul>

***Insurance Agency Licensing***

An agency owned and operated by a single licensed agent who does business in their own name and does not employ or use other licensees, is not required to obtain an insurance agency license. A branch office under the same name and federal tax identification number as the licensed primary agency and has a designated agent in charge of the branch does not need a license. Agency licenses remain in force until revoked, canceled, terminated by the Department, or they expire by operation of law.

Florida law allows an agency to permit a third party to complete, submit, and sign a licensing application on behalf of the agency. The agency is responsible for ensuring that the application is true and accurate. Additionally, the agency is held accountable for misstatements or misrepresentations.

An agent in charge at a primary location may also be the same person who is in charge at a branch location. An insurance agency, and each branch place of business, must file the name and license number of the agent in charge along with the physical address of the insurance agency location with the Department.

Unlicensed employees shall not engage in insurance activities that require licensure as an insurance agent or customer representative unless a licensed agent is physically present.

***Communicating with the Department***

Insurers have 20 days to respond to the Department once a consumer complaint has been filed. [F.S. 20.121]

***Recordkeeping***

A licensee has 30 days to notify the Department, in writing, of any change of name, address, principal business street address, mailing address, contact telephone number, or email address. Any licensee, who has moved their principal place of residence or business from Florida, will have their license and all appointments immediately terminated by the Department. Failure to notify the Department within the allotted period of 30 days will result in the following fines: first offense, fine up to \$250, and any subsequent offense will incur a fine of at least \$500 or suspension or revocation.

***Administrative Actions***

A licensee must notify the Department within 30 days after the final disposition of an administrative action taken against them. The licensee must submit a copy of the order, consent to order, or other relevant legal documents to the Department. [F.S. 626.536]

***Criminal Actions***

A licensee must report, in writing, to the Department within 30 days of any of the following events: plead guilty or nolo contendere to, has been convicted or has been found guilty of a felony or crime punishable by imprisonment of 12 or more months under any state, federal, or other country law. Florida statute requires this written report even if an agent is or is not convicted by the court having jurisdiction of the case. [F.S. 626.621]

***Prohibited Practices***

***Temporary Suspension for Felony Charge***

The Department may temporarily suspend the license of an agent who has been charged with a felony. The suspension shall continue if the licensee is convicted or if adjudication of guilt is withheld. [F.S. 626.611]

*Denial, Suspension, Revocation, or Refusal to Renew*

The Department may deny an application if it finds that the applicant, licensee, or appointee has engaged in one or more of the following:

- Violation of any provision of the insurance code
- Violation of any lawful order or rule of the Department, Commission, or Office
- Failure to pay to any company any money belonging to them
- Violation of the provision of twisting
- An unfair method of competition or unfair or deceptive act or practice
- Willfully over insuring any property or health risk
- Found guilty of, or plead guilty or nolo contendere to a felony or crime
- Violation of the NAIFA Code of Ethics (Life Agent)
- Cheating on an examination of pre-licensing or state exam
- Failure to notify the Department, in writing, within 30 days after pleading guilty or nolo contendere to, or being convicted or found guilty of any felony or crime
- Knowingly participating in an act that is in violation of the insurance code or any other rule of the Department, Commission, or Office
- Failure to comply with any civil, criminal, or administrative action taken by the child support enforcement program
- Denial, suspension, or revocation of a license to practice or conduct any regulated profession, business in this or any state or district of the United States, or any lawful agency thereof

*Permanent Revocation of License*

If the license of an individual who is eligible to hold a license issued by the DFS has been revoked resulting from the solicitation or sale of an insurance product to a person who is 65 years of age or older, the Department may not thereafter grant or issue any insurance license to such individual. [F.S. 626.641(3)(b)]

**Agent Responsibilities***Fiduciary Capacity*

A **fiduciary** is a person in a position of special trust and confidence. All monies belonging to an insurance company are trust funds received by the licensee in a fiduciary capacity. Agents must keep funds belonging to each company, for which an agent is not appointed (other than surplus lines), in a separate account so that the Department or Office may properly audit such accounts.

Licensees must keep and make available all books, accounts, and records pertaining to a premium payment for at least 36 months after the payment was received. This three-year requirement does not apply to insurance binders when no policy is issued, and no premium is collected.

Any agent or insurance agency that diverts or misappropriates fiduciary funds commits the offense specified in the following:

- If \$300 or less; misdemeanor of the 1<sup>st</sup> degree
- If \$300 or more but less than \$20,000; felony of the 3<sup>rd</sup> degree
- If \$20,000 or more but less than \$100,000; felony of the 2<sup>nd</sup> degree
- If \$100,000 or more; felony of the 1<sup>st</sup> degree

*Record Retention Requirements for Agents*

Every agent who transacts an insurance policy must maintain all records in their office, or have them readily available by digital means, for at least five years after the policy expiration. [F.S. 626.748]

*Compensation*

Florida law specifies that no policy of life or health insurance may be issued for delivery in this state unless the application is taken by, and the policy delivered through a licensed agent who will receive the usual commission. No person other than a licensed and appointed agent may accept any commission or other valuable compensation for soliciting or negotiating insurance.

[F.S. 624.428, 626.572, .581, .794]

### *Commission for Examining Health Insurance*

Health agents can charge a fee for providing advice, counsel, or recommendations regarding both individual and group health insurance. A written agreement between the agent and party being charged is required. The agreement must clearly define that the consulting fee is separate and negotiated from the premium. A copy of the agreement must be retained by the licensed agent for three years after services have been fully performed.

If a commission is earned, it must be returned to the contracting party within 30 days of receipt of the commission paid by the company to the agent.

[F.S. 626.593]

### *Commission Rebates*

An agent or agency may not rebate any portion of a commission except as follows:

- The rebate shall be available to all insureds in the same actuarial class.
- The rebate shall be in accordance with the rebating schedule filed with the insurer issuing the policy to which rebates apply.
- The rebate schedule shall be uniformly applied to all insureds who purchase the same policy through the agent for the same amount of coverage so that they receive the same percentage rebate.
- The rebates shall not be given to an insured if the company prohibits its agents from rebating commissions.
- The rebate schedule is displayed in public view in the agent's office and available for the public's view at their request.
- The rebate available is not subject to discrimination based on an applicant's age, sex, place of residence, nationality, ethnic origin, marital status, occupation, or the location of risk.

When it comes to rebates, rebate schedules, and collateral business, both agents and agencies must maintain copies of all rebate schedules for a period of at least 60 months, from their effective date. No rebate may be withheld or limited based on factors that are unfairly discriminatory, no rebate may be given if it is not reflected on the rebate schedule, and no rebate may be refused or granted based upon the purchase, or failure of the insured or applicant, to purchase collateral business. [F.S. 626.572]

### *Commissions Contingent on Loss Settlements*

Florida law states that when agents of the insurer are acting as an adjuster of claims, it is unlawful for the insurer to enter into any agreement or understanding with its agents in Florida, which bases the agents' commissions on Florida policies contingent upon savings in the settlement of claims. [F.S. 626.581]

### *Ethics*

#### Scope

All agents of all insurers have a common obligation to work together in serving the best interest of the insuring public. Methods of achieving balance include:

- Understanding and observing the laws governing life insurance
- Presenting accurately and completely every fact essential to a client's decisions
- Fair in all relations with colleagues and competitors
- Always placing the policyholder's interests first

#### Use of Designations

To protect consumers from dishonest, deceptive, misleading, and fraudulent trade practices concerning the use of certification and professional designation in the selling, soliciting, negotiating, and effecting of contracts, the Department, Commission, or Office does not endorse any professional designation.

A **designation** is defined as, "any combination of words, any acronyms standing for a combination of words, or job title that implies or indicates a special level of knowledge or training." A designation may not be lawfully used under the insurance code unless it is obtained from an organization that has published standards and procedures for assuring the competency of its certificates or designees on specific subject matters.

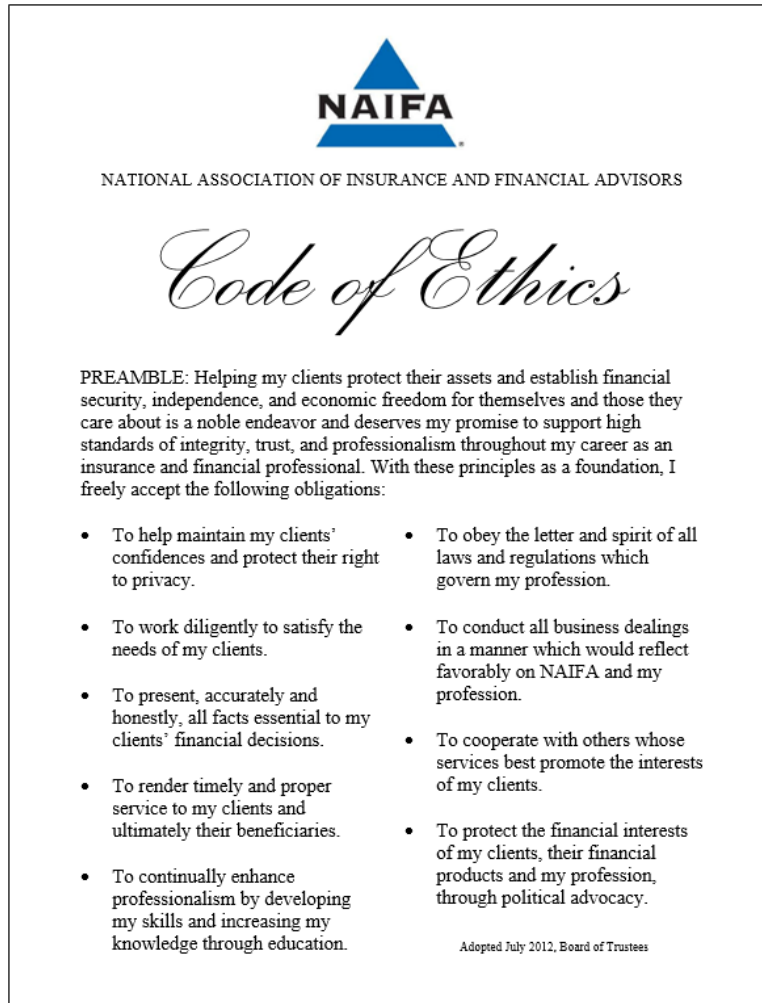


A **certification** is defined as, “any designation that indicates, implies, or recognizes that an individual or organization meets certain established criteria beyond the basic level required for the license held.”

Prohibited uses of a designation include, but are not limited to:

- Use by a person who has not actually earned or is ineligible to use such designation
- Use of a self-conferred or non-existent designation
- Use that indicates or implies a level of occupational qualification obtained through training, experience, or education that the person utilizing the designation does not actually have
- Use of any designation that is not obtained in compliance with Florida law
- Uses that violate the NAIFA Code of Ethics

Code of Ethics for the National Association of Insurance and Financial Advisors (NAIFA)



### ***Insurance Guaranty Fund***

The Florida Life and Health Insurance Guaranty Association is a state-funded non-profit legal entity. All life, health, and annuity companies are members of the association as a condition of their authority to transact insurance business in Florida. The purpose of the association is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of insurance policies and contracts against the failure of a company to perform its contractual obligations due to its impairment or insolvency. [F.S. 631.711, .735]

#### *Scope of Provisions*

Coverage will be provided to residents of Florida and other states only if:

- The insurance company that issues the policy or contract is domiciled in Florida.

- The other state has guaranty associations that are like that of Florida.
- The person is not eligible for coverage by such associations.

Association coverage does not apply to:

- The portion or part of a variable contract (life or annuity) that is not guaranteed by an insurance company
- The portion or part of any policy or contract under which the risk is borne by the policyholder
- Fraternal benefit societies as defined in the code
- Health maintenance insurance
- Dental service plan insurance
- Pharmaceutical service plan insurance
- Optometric service plan insurance
- Ambulance service association insurance
- Funeral (preneed) merchandise or service contract insurance
- Prepaid health clinic insurance
- Any annuity contract not issued to and owned by an individual
- The portion of a policy that exceeds association limits for contracts or policies that provide Medicare Part C (Medicare Advantage Plan) or Medicare Part D (Medicare Prescription coverage)
- A policy or contract that is assumed by the impaired or insolvent insurance company under a contract of reinsurance
- Any federal employees' group policy or contract prohibited from being subject to an assessment

#### *Definitions*

- **Impaired insurer.** An impaired insurer is a member company deemed by the Department to be potentially unable to fulfill its contractual obligations and not an insolvent company
- **Insolvent insurer.** An insolvent insurer is a member insurance company authorized to transact insurance in this state and against which an order of liquidation, with a finding of insolvency, has been entered by a court of competent jurisdiction

#### *Establishment of Association*

The association performs its operation functions through a board of directors. For the purposes of administration and assessment, the association maintains the following three separate accounts:

- The health insurance account
- The life insurance account
- The annuity-account

#### *Board of Directors*

The board of directors of the association must consist of not fewer than nine or more than eleven member insurers and one Florida Health Maintenance Organization Consumer Assistance Plan director. The plan director must not be a member insurer serving on the board, must be confirmed by the Florida Health Maintenance Organization Consumer Assistance Plan's board of directors, and must be a member of the Florida Health Maintenance Organization Consumer Assistance Plan's board of directors.

At all times, the board of directors must consist of at least one member from a domestic insurer. The members of the board who are member insurers will be elected by member insurers subject to the approval of the department.

Members may be reimbursed for expenses incurred by them as members of the board of directors but are not otherwise compensated for their services.

#### *Duties and Powers of Association*

In the event of an insurer's insolvency, the association's liability shall not exceed:

- Life; \$100,000 in net cash surrender and net cash withdrawal values
- Annuity; \$250,000 in net cash surrender and net cash withdrawal values
- Cash value; \$300,000 in benefits with respect to one life, including long-term care policies and cash values
- Effective January 1, 2020, liability shall not exceed \$500,000

The association shall not be liable for any penalties or interest

#### *Assessments Against Member Insurers*

The funds necessary to carry out the powers of the association are the total of all assessments upon the member insurers for each account of insurance. The total of all assessments for each member insurer may not, in any 12-month period, exceed 1% of the sum of the insurance company's premiums written in this state, regarding business covered by the account received during the three years preceding the year in which the assessment is made, divided by three.

#### *Duties and Powers of Department*

The Department shall be appointed as the liquidator or rehabilitator if any domestic insurance company that undergoes liquidation or rehabilitation proceedings. If the insurance company is either an alien or a foreign member, the Department shall be appointed as the conservator.

#### *Use of Membership in Advertising*

No person may make, publish, circulate, disseminate, or place before the public any advertisement that uses the existence of the Florida Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Association.

### **Marketing Practices**

#### *Unfair Methods of Competition*

Unfair methods of competition and unfair or deceptive acts or practices include sliding; boycott, coercion, and intimidation; misrepresentations and false advertising of insurance policies; defamation; false advertising; and unfair discrimination. Each is defined below. [F.S. 626.9541]

- **Sliding.** The sliding definition is divided into three wrongdoings.
  - Indicating that a product (ancillary coverage) is required by law in conjunction with the purchase of another product
  - Representing that a specific ancillary coverage or product is included with the policy for which the applicant applied without an additional premium charge, when such a charge is required
  - Charging an applicant for an ancillary product or coverage without their consent and indicating that the coverage is included in their premium
- **Boycott, coercion, and intimidation.** Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation that results or tends to result in unreasonable restraint or, or a monopoly in, the business of insurance.
- **Misrepresentations and false advertising of insurance policies.** Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, comparison, or property and casualty certificate of insurance altered after being issued that:
  - Misrepresents the benefits, advantages, conditions, or terms of any insurance policy
  - Misrepresents the dividends or shares of the surplus to be received on any insurance policy
  - Makes any false or misleading statement as to the dividends or shares of surplus previously paid on any insurance policy
  - Misleads or misrepresents the financial condition of any person or legal reserve system upon which any life insurer operates
  - Uses any name or title of any insurance policy or class of insurance policy that misrepresents the true nature thereof
  - Misrepresents for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy
  - Misrepresents for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy
  - Misrepresents any insurance policy as being shares of stock or ownership interest in the company
  - Uses any advertisement that would mislead or otherwise cause a reasonable person to mistakenly believe that the state or Federal Government is responsible for the insurance

sales activities of any person, stands behind any person's credit, or that any person, the state or Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person  
[F.S. 626.9541(1)(a)]

- **Defamation.** Making, publishing, disseminating, or circulating (directly or indirectly), or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statements that are false, malicious, or derogatory to the financial condition of an insurance company.
- **False advertising.** Knowingly making, publishing, disseminating, circulating, or placing before the public any representations, assertions, or statements with respect to the business of insurance that are untrue, deceptive, or misleading in a newspaper, magazine, or any other publication, or any radio, television, or electronic transmission.
- **Unfair discrimination.** Insurers may not discriminate based on race, color, creed, marital status, sex, national origin, or any other protected class. No insurance company authorized to transact insurance in Florida shall refuse to issue or charge a higher premium on a life or health insurance policy solely because the person to be insured has the sickle-cell trait. [F.S. 626.9706]

#### *Other Unfair Practices*

- **False statements and entries.** The known filing of any false material statement, false entry, or the omission of a material fact in any book, report, or statement
- **Failure to maintain complaint-handling procedures.** The failure of any person to maintain a complete record of all complaints received since the date of the last examination. A complaint is defined as any written communication expressing a grievance.
- **Advertising gifts permitted.** For advertising, an agent or insurance company may give to a prospective insured, insured, or other person any article of merchandise having a value of not more than \$100.  
[F.S. 626.9541(1)(m)]
- **Travel-based insurance limitations.** An insurer cannot refuse the issuance of a life policy solely on an applicant's response to questions pertaining to their past or future foreign lawful travel experiences unless it is actuarially supported.
- **Limiting insurer choice in credit transactions.** No lender may require, as a condition to lending money or extension of credit, the applicant to purchase a policy through an insurance company, agent, or broker.  
[F.S. 626.9551]

#### *Unfair Claims Practices*

The following are considered unfair claims practices:

- Settling a claim based on an application or any other material document that was altered without knowledge or consent of the insured
- Material misrepresentation made to an insured, or any other person having an interest in the proceeds payable under a contract or policy, for effecting settlement of such claim on less favorable terms than those provided in the contract
- Committing or performing, with such frequency as to indicate a general business practice, any of the following:
  - Failing to adopt and implement standards for the proper investigation of claims
  - Misrepresenting pertinent or material facts relating to policy coverages
  - Misrepresenting insurance policy provisions relating to coverage issues
  - Failing to acknowledge and communicate promptly with respect to claims
  - Denying claims without conducting proper investigations based on information provided
  - Failing to respond to an insured's written request, within 30 days after a proof of loss has been completed, to affirm or deny the full or partial coverage of a claim

- Failing to provide, in writing, a reasonable explanation as to why a claim has been denied or the offer of a compromise settlement
- Failing to notify the insured of any additional information necessary for the processing of a claim

### *Fraud*

A fraudulent insurance act is committed when an individual intentionally conceals a fact of material substance for the purpose of misleading another. Any person who knowingly submits a statement that contains false information for the purpose of defrauding an insurer, broker, or agent is committing insurance fraud.

### *Fraudulent Signatures*

The willful submitting to an insurance company, on behalf of a consumer, an insurance application, or policy-related document that bears a false or fraudulent signature, is considered fraud.

### *Proof of Loss; Fraud Statement*

All proof of loss statements must prominently display the following statement:

“Pursuant to §817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree.”

[F.S. 626.8797]

### *Controlled Business*

The Department will not issue a license or an appointment to any life or health agent who obtains their license for the sole purpose of soliciting, negotiating, or procuring controlled business. [F.S. 626.784, .830]

The term **controlled business** is defined as, “for the life, health, or annuity contract as a policy covering the agent, or agent’s family members, officers, directors, stockholders, partners, or employees of a business in which the agent or family member is engaged; or the debtors of a firm, association, or corporation of which the agent is an officer, director, stockholder, partner, or employee.”

A violation shall be deemed to exist if the Department finds that during a one-year period, the premiums submitted on controlled business are in excess of the premiums submitted, during the same period, by the licensee on life and health insurance contracts to the general public.

### *Twisting*

**Twisting** is knowingly making misleading statements for the purpose of inducing any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, convert, or take out another insurance policy with another carrier.

### *Churning*

**Churning** is the practice where values in an existing insurance policy or annuity contract are used, directly or indirectly, to purchase another policy from the same carrier for the purpose of earning additional premiums, fees, commissions, or other compensation or consideration.

### *Unlawful Rebates*

Except as otherwise expressly provided by law, or in an applicable filing with the office, knowingly:

- Permitting, or offering to make, or making, any contract or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon
- Paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance contract, any unlawful rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract

- Giving, selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the insurance contract.

The following are not considered unfair discrimination or unlawful rebates:

- In the case of any contract of life insurance or life annuity, paying bonuses to all policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any such bonuses or abatement of premiums fair and equitable to all policyholders and for the best interests of the company and its policyholders.
- In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses.
- Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder that may be made retroactive only for such policy year.
- Issuance of life insurance policies or annuity contracts at rates less than the usual rates of premiums for such policies or contracts, as group insurance or employee insurance as defined in this code.
- Issuing life or disability insurance policies on a salary savings, bank draft, preauthorized check, payroll deduction, or other similar plan at a reduced rate reasonably related to the savings made by the use of such plan.  
[F.S. 626.9541(l)(h)]

**General Prohibition and Penalties**

The table below displays fines pertaining to unfair methods of competition. Any person who engages in an unfair method of competition is subject to a fine in an amount not greater than the following: [F.S. 626.9521]

	Willful Violation (Each)	Willful Violation (Aggregate)*	Non-Willful Violation (Each)	Non-Willful Violation (Aggregate)*	Degree
Unfair Method of Competition	\$20,000	\$100,000	\$5,000	\$10,000	---
Twisting	\$75,000	\$250,000	\$5,000	\$50,000	Misdemeanor 1 <sup>st</sup> Degree
Churning	\$75,000	\$250,000	\$5,000	\$50,000	
Fraudulent Signatures	\$75,000	\$250,000	\$5,000	\$50,000	Felony 3 <sup>rd</sup> Degree

\* Arising out of the same claim

**Investigations**

Both the Department and Office shall have powers within their respective regulatory jurisdiction to examine and investigate the affairs of every person involved in the business of insurance to determine if such person has been or is engaged in any unfair method of competition or unfair or deceptive act or practice. [F.S. 626.9561, .9571, .9581, and .9601]

**Misconduct Hearings**

The Department and Office both may conduct a hearing pertaining to a CDO. After a hearing, the Department or Office shall enter a final order in accordance with Florida law.

*Cease and Desist Orders and Other Penalties*

If it is determined that a person has engaged in an unfair or deceptive act, the Department or Office will issue an order to the violator ordering the cease and desist of such a method. Any person who violates a CDO may be subject to one or more of the following penalties:

- Monetary penalty not to exceed \$50,000
- Suspension or revocation of such person's certificate of authority, license, or eligibility to hold such

***Life, Health, and Annuity Advertising****Purpose*

The purpose of the advertising rules is to provide prospective purchasers with clear and unambiguous statements in the advertisements for life and health insurance and annuity contracts. This is accomplished by insurers following the guidelines and standards of conduct in advertising to ensure that product descriptions are presented in a manner that prevents unfair, misleading, and deceptive advertising. [F.A.C. 69O-150.001, .003, .101, .103]

Advertisement includes any method of communication in a publication, such as a magazine or newspaper. It also includes communication in the form of a letter, poster, pamphlet, notice, or circular, and the transmission of such over any airways, including radio, television, or other forms of data transmission.

An advertisement does not include:

- Material to be used solely for the training and education of an insurance company employee, agent, or broker
- Internal communication within an insurer's own organization that is not intended for dissemination to the public
- Individual communication with a current policyholder regarding existing coverage other than material that urges the policyholder to make changes to their coverage
- Communication between a prospective group or blanket policyholder and an insurance company during selling, soliciting, or negotiating a contract

*Disclosure of Required Information*

All disclosures must not be minimized, rendered obscure, or presented in an ambiguous fashion that might cause the applicant or policyholder to be confused or misled. All advertisements must be clear and complete in order to avoid deception or the capacity to mislead or deceive. [F.A.C. 69O-150.004]

*Form and Content of Advertisements*

In its advertisements, an insurer must clearly identify its life and health insurance policies as life and health insurance policies, and its annuity contracts as annuity contracts. The name of any policy must be followed by or include the words "insurance policy," "annuity," or similar words clearly identifying the fact that an insurance policy or annuity is being offered.

**Examples of Properly Named Policies**

- Whole life insurance policy (WL)
- Level term life insurance
- Long-term care insurance policy (LTCi)
- Deferred annuity
- Major medical insurance policy
- Disability insurance policy (DI)

Misleading Content

No advertisement may omit phrases, words, statements, references, etc. if such omissions will have the capacity to mislead purchasers as to the nature and extent of the policy benefits, losses covered, and premiums payable.

[F.A.C. 69O-150.006, .107]

Renewability, Cancellability, and Termination

An advertisement that is an invitation to contract must disclose the provisions relating to renewability. The advertisement must also disclose the provisions relating to termination and modification of benefits, losses covered, or premiums because of age or for other reasons. [F.A.C. 69O-150-007, .108]

Testimonials

Testimonials about an insurance company, used in advertisements, must be genuine and represent the current opinion of the author. The statements must be applicable to the policy advertisement and accurately reproduced.

[F.A.C. 69O-150.008, .110]

Disparaging Comparisons and Statements

Disparaging comparisons and statements in an advertisement must not make an unfair or incomplete comparison of policies, benefits, or contracts.

[F.A.C. 69O-150.011, .112]

Identity of Insurer

The name of the actual insurance company must be stated in all carrier advertisements. In addition, the form number(s) of the policy must be stated. An advertisement must not use a trade name, slogan, or symbol that would be misleading as to the identity of the actual insurer. No advertisement may use symbols, words, or a combination thereof that are used by federal or state government agencies if such use is intended to confuse or mislead the prospective insured into believing that the solicitation is in some manner connected with such agency. Finally, all advertisements used by agents, producers, brokers, or solicitors of an insurer must have prior written approval or prior oral approval with subsequent written confirmation of approval by the insurer. [F.A.C. 69O-150.013, .114, 69B-150.013]

Statements about Insurers

An advertisement must not contain statements that are misleading or untrue with respect to the corporate structure, assets, financial standing, age, or relative position of the insurance company in the insurance business.

[F.A.C. 69O-150.016, .117]

Advertising File

Each insurance company must maintain, in either its home or principal office, a complete file containing the following:

- Every printed, published, or prepared advertisement of its individual policies
- Typical printed, published, or prepared advertisements of its blanket, franchise, and group policies
- A notation attached to each advertisement that indicates the manner and extent of distribution and the form number of any policy advertised

The file must specifically include those advertisements submitted to the insurance carrier by agents, brokers, or others and approved by the insurer for use in Florida. The file must be available for inspection by the Office, and all advertisements must be maintained in the file for a period of four years (48 months) or until the filing of the next regular report or examination by the carrier, whichever is longer. [F.A.C. 69O-150.018, .119]



UNIT

# 27 FLORIDA LAWS AND RULES PERTINENT TO LIFE INSURANCE

**OVERVIEW**

This unit outlines only those marketing practices, policies, and provisions for life insurance that are regulated by the state of Florida. Candidates for the Life Insurance Examination will be tested on their knowledge of the various required laws, rules, and regulations that are covered in this unit.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Marketing Practices
- Policy Replacement
- Individual Contracts
- Group Life
- Annuities

**KEY TERMS**

Annuity Suitability

Buyer's Guide

Florida Replacement Rule

Group Conversion Rights

Group Life Insurance

Lapse Notification and Additional Addresses

Other Policy Provisions

Policy Assignment

Policy Conversion

Policy Summary

## Marketing Methods and Practices

### A. Agent Responsibilities

1. Must inform the prospective buyer
  - a. Before the presentation
    - i. Full name of the insurer that is being represented
2. If using terms such as
  - a. Financial planner
  - b. Investment adviser
  - c. Financial consultant
  - d. Financial counselor

Must **not** be used to imply that an insurance agent is engaged in an advisory business in which they receive compensation unrelated to the sale of a policy or contract; unless that is actually the situation
3. Dividends
  - a. Any reference to a policy dividend must include a statement indicating that it is not guaranteed
4. Time value of money
  - a. If a presentation or system does not recognize the 'time value of money' through the use of appropriate interest adjustments, must not be used for comparing the cost of two or more life insurance policies or contracts
5. Life insurance cost indexes
  - a. Include an explanation to the effect that the indexes are useful only for the comparisons of the relative costs of two (2) or more similar policies
  - b. A life insurance cost index that reflects dividends or an equivalent level annual dividend must be accompanied by a statement that it is based on the insurer's current dividend scale and is not guaranteed **[SEC 626.99]**

### B. Disclosure [Sec. 626.99]

1. "Free Look Period"
  - a. The company shall provide each prospective buyer a "Buyer's Guide" and "Policy Summary" before accepting the applicant's initial premium, unless the policy provides for an unconditional refund for at least 14 days
  - b. If the policy does have a 14 day "Free Look Period," then a "Buyer's Guide" and "Policy Summary" must be delivered either with the policy or before delivery of the policy
2. Buyers Guide
  - a. Purpose
    - i. To improve the buyers understanding of the basic features of the policy that has been or will be purchased
    - ii. Improve the ability of the buyer to evaluate the relative costs of plans of similar types of insurance
    - iii. Improve the buyer's ability to select the most appropriate plan of life insurance for their needs
3. Policy Summary
  - a. A written statement explaining multiple components of a policy; including, but not limited to:
    - i. Title: "STATEMENT OF POLICY COST AND BENEFIT INFORMATION"
    - ii. Name and Address of insurance producer
    - iii. Full name and home office address of the life insurer
    - iv. Where applicable; clearly illustrated premium and benefit patterns
      - (1) Life insurance cost indexes
        - (a) Annual premium for the basic policy Annual premium for each optional rider
        - (b) Guaranteed amount payable upon death
        - (c) Cash dividends payable at the end of the year
          - (i) Values show separately for the basic policy, and each rider
          - (ii) Dividends need not be displayed beyond the 20<sup>th</sup> policy year
        - (d) Effective policy loan annual percentage interest rate
          - (i) Include maximum percentage rate if applicable

- (e) Life insurance cost indexes for 10 and 20 years
  - (i) No beyond the premium-paying period
- v. Participating Policies
  - (1) Equivalent level annual dividend
  - (2) A statement that dividends are based on the insurance company's current dividend scale and are not guaranteed
- vi. Date on which the Policy Summary is prepared

### C. Advertising and Sales [Sec. 626.9531]

When selling, soliciting, or negotiating insurance products, agents must clearly indicate, to the prospective insured, that they are acting as insurance agents with regard to insurance products and identified insurers.

1. Disclosure requirements for indeterminate value life annuity contracts advertisements
  - a. It is prohibited for an advertisement to contain a rate to be earned unless all limitations and conditions are disclosed to the policyholder, certificate holder, or annuitant.
  - b. The disclosure shall include (if applicable)
    - i. Premium expense
    - ii. Administrative charge
    - iii. Full surrender charger (year by year)
    - iv. Market value adjustment
    - v. Participation rates
    - vi. Free withdrawal provisions or bail-outs
    - vii. Guaranteed minimum interest rate during the accumulations period and the annuitization period
  - c. An advertisement must not refer to an annuity as a CD annuity
2. All variable life and annuity advertisements shall disclose whether the insured may realize a positive or negative return on the principal, including potential loss of the original principal contribution **[FAC Rule 690-150.106]** Advertisements of proceeds payable, premiums payable
  - a. Invitations to contract must clearly reflect the following information
    - i. Name of the insurer
    - ii. Agent
    - iii. Policy form number(s)
    - iv. Type of plan
    - v. Premium payable
    - vi. Payment period
    - vii. Changes in the face amounts and premiums (if applicable)
  - b. Life insurance sold by a direct response shall not advertise with the phrase(s)
    - i. "no salesman will call"
    - ii. "no agent will call"
    - iii. "by eliminating the agent and/or commission, we can offer this low-cost plan."
    - iv. Wording similar or in a misleading manner
  - c. Invitations to join an Association, Trust or Discretionary Group
    - i. Must solicit insurance on an application that is separate and distinct and must include separate signatures for each application
    - ii. Membership fee or dues
      - (1) Disclosed on each application
      - (2) Appear separately on the application so that not confused with the premium amounts for insurance coverage
  - d. An advertisement must not refer to a premium as a "deposit."
3. Dividends
  - a. Advertisement cannot be misleading
  - b. Cannot, directly or indirectly, imply that the amount of a dividend or divisible surplus is guaranteed
  - c. Any comparison between participating and non-participating policies or contracts must be true and accurate **[FAC Rule 690-150-109]**

## II. Florida Replacement Rule

### A. Purpose [FAC Rule 69B-151.001, .008; 69O-151.001, .008]

1. Regulate the activities of insurance carriers and agents with respect to the replacement of existing life insurance
2. Protect the interests of life insurance policy owners by establishing minimum standards of conduct to be observed in the replacement of existing life insurance.
  - a. This is accomplished by
    - i. Ensuring the policy owner receives information with which an informed decision can be made in their best interest
    - ii. Reducing the opportunity for misrepresentation or incomplete disclosures

### B. Replacement

1. A transaction in which new life insurance is to be purchased
2. It is known to the proposing agent or company that existing life insurance has been in force or is to be
  - a. Lapsed, surrender, terminated, or forfeited
  - b. Converted to Reduced Paid-up, continued as extended term insurance, or otherwise reduced in value using non-forfeiture benefits or other policy values
  - c. Amended to reflect a reduction in benefit coverage
  - d. Amended to reflect a reduction in term
  - e. Reissued with any reduction in cash value
  - f. Pledged as collateral or subjected to borrowing for an amount in aggregate exceeding 25% of the loan value outlined in the policy

### C. Life Insurance (with regards to replacement includes)

1. Life insurance
2. Annuities
3. Tax-sheltered annuities
4. Life insurance policies that qualify under the definition of a tax-sheltered annuity

### D. Exemptions (Replacement rules do not apply)

1. Industrial insurance
2. Group, franchise, individual credit life insurance
3. Group life and life policies issued in connection with
  - a. Pension
  - b. Profit-sharing
  - c. Other benefit plan qualifying for tax deduction ability of premiums
4. Contractual change or conversion privilege of a policy or contract within an existing company
5. Variable life insurance or annuities under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

### E. Duties of agent

1. Each agent must submit with each application for coverage the following items
  - a. Statement signed by the applicant(s) as to whether or not the new insurance will replace existing life insurance
  - b. Statement signed by the agent(s) as to whether or not the agent knows if the insurance transaction will result in a replacement
2. Whether or not a replacement is being made, the agent(s) must do the following
  - a. Leave with the applicant(s) a copy of all sales proposals used for the presentation of the applicant
  - b. No later than the time of taking the application, have the applicant(s) sign a 'Notice of Applicant Regarding Replacement of Life Insurance' form
    - i. A copy must be submitted to the replacing company
    - ii. A copy must be given to the applicant
    - iii. The form must be signed by both the applicant(s) and agent(s)

**F. Duties of replacing company**

1. Replacing insurance company must inform its field agents of the following requirements
  - a. Require the agent to submit the following with an application for life insurance
    - i. Notice to Applicant Regarding Replacement of Life Insurance
    - ii. Copy of all sales proposals (used in the presentation)
  - b. Send, when requested, a completed Comparative Information Form
    - i. Must be submitted within five (5) working days, from the date of the application and the Notice to the Applicant Regarding Replacement of Life Insurance, to the home or regional office
  - c. Send to the existing insurance company a copy of the replacement notice to their home or regional office
  - d. Provide each prospective purchaser a Buyer's Guide and a Policy Summary before accepting any initial premium or premium deposit, unless the policy contains a provision for an unconditional refund for a period of at least ten (10) days, in which the Buyer's Guide and Policy Summary must be delivered with the policy or before delivery of the policy. **(NOTE: Florida's 14-day Free Look meets this standard).**
  - e. Maintain copies for a period of three (3) years
    - i. Notice of Applicant Regarding Replacement of Life Insurance
    - ii. Requested Comparative Information Forms
    - iii. Sales proposals used
    - iv. Replacement register, cross-indexed by replacing agent and insurer

**G. Surrender recommendation [Sec. 627.4553]**

1. "Insurance agents that recommend the surrender of an annuity or life insurance policy containing a cash value and do not recommend that the proceeds from the surrender be used to fund or purchase another annuity or life insurance policy, before execution of the surrender, the agent must provide written information relating to the annuity or policy to be surrendered. Such information must include, but is not limited to:
  - a. the amount of any estimated surrender charge
  - b. the loss of any minimum interest rate guarantees
  - c. the possibility of tax consequences
  - d. the amount of any forfeited death benefit; and
  - e. a description of any other investment performance guarantees being forfeited as a result of the transaction.
2. "Surrender" means "voluntary surrender, by the owner's request, of the annuity or life insurance policy before its maturity date, in exchange for the policy's current cash surrender value."

**III. Individual Contracts****A. Standard provisions**

1. Protection of beneficiaries from creditors **[Sec. 222.13, .14]**
  - a. At the death of the insured, the insurer will pay the life insurance death benefit exclusively to the beneficiary(ies) designated in the contract
  - b. Whenever the insurance is payable to the insured's estate, the insurance proceeds will become a part of the insured's estate. They will be administered in accordance with the probate laws of the state.
2. Proceeds exempt from attachment **[Sec. 222.14]**
  - a. Cash surrender values issued upon the lives of citizens or residents of the State of Florida;
  - b. Proceeds of annuity contracts issued to citizens or residents of the State of Florida Shall not be liable to attachment, garnishment, or legal process in favor of any creditor unless the insurance policy or annuity contract was affected for the benefit of such creditor
3. Prohibited provisions
  - a. Policy loan **[Sec. 627.4585]**
    - i. A fixed-rate not to exceed 10% annual interest (subject to restrictions) is permissible for a policy loan
    - ii. An Adjustable-rate of interest, with limits based on the average monthly published interest rate determined by Moody's Corporate Bond Index
  - b. Free Look **[Sec. 626.99]**

- i. Unconditional refund of premiums
  - ii. Available for a period of at least 14 days
  - iii. Fixed annuity contracts
    - (1) Includes contract fees or charges
    - (2) Available for a period of 21 days
    - (3) Refund shall be equal to the cash surrender value provided in the annuity contract, plus any fees or charges deducted from the premiums or imposed under the contract; or a refund of all premiums paid
  - c. Grace Period (individual) **[Sec. 627.453]**
    - i. Not less than 30 days within which payment of any premiums may be made
    - ii. If a policy becomes a claim, during the grace period and the premium due has not been paid, the amount owed may be deducted from the death benefit payment
  - d. Designation of beneficiary
    - i. The policy owner has the right, at all times unless the beneficiary designation is name irrevocable, to change a beneficiary
  - e. Life agents as beneficiaries **[Sec. 626.798]**
    - i. A life insurance agent or a family member of the life agent is not permitted to be named as a beneficiary of a life insurance policy covering the life of a person who is not a family member of the agent; unless the agent has an insurable interest in the life of such person
    - ii. Insurable Interest is defined to include
      - (1) Family member (father, mother, son, daughter, brother, sister, grandfather, grandmother, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister)
  - f. Effects of divorce on death proceeds **[Sec. 732.703]**
    - i. A beneficiary designation naming a former spouse is void at the time the policyholder's marriage is judicially dissolved, so long as the beneficiary designation was made before the court order
    - ii. Additional lapse notice and secondary addressee
    - iii. Life insurance contract, issued for delivery in Florida covering a person 64 years of age or older and has been in force for at least 12 months, may not be lapsed for non-payment of premiums unless, after the expiration of the grace period, and at least 21 days before the effective date of any impending lapse, a notification has been mailed to the policy owner and a specified secondary addressee
- B. Non-forfeiture options [Sec. 627.476]**
- 1. Life insurance policies delivered in Florida must contain the following benefits
    - a. Surrender Cash Value
    - b. Reduced Paid-Up Life Insurance
    - c. Extended Term Life Insurance
- C. Policy settlement**
- 1. When a policy becomes a claim, the contract indicates that the death benefit must be paid according to the agreement in such a contract.
  - 2. When the policy provides a payment of its proceeds in a lump sum, the payment must include interest from the date the insurance company received written proof of loss (death) of the insured.
  - 3. If payments of death benefit proceeds are to be paid in installments, a table showing the amounts and periods of payments must be included in the policy

#### IV. Group Life

##### Standard Provision/Required provision

- 1. Grace Period (Group)
  - a. Grace period of 31 days.
  - b. If the insured dies during the grace period, the death benefit will be paid
- 2. Incontestability

- a. A group life insurance policy shall provide that the validity of the policy shall not be contested, except for non-payment of premium, after it has been in force for 24 months from its date of issuance
- 3. Attachment of application to policy; representations in the application
  - a. A copy of the application is attached to the back of the contract when the policy is issued.
  - b. All statements made by the applicant that are believed to be true to the best of the applicant's ability are considered to be representations
- 4. Misstatement of age
  - a. A clearly stated provision stating that in the event an age is misstated in an application, a specific method of adjustment will be used
  - b. Misstatement of age is not subject to the incontestability period
- 5. Individual Certificates
  - a. A group life insurance carrier must issue to each member a certificate containing the following information
    - i. Group number
    - ii. Person insured
    - iii. Insurance protection being provided
    - iv. Whom the insurance benefits are payable to
    - v. Dependent's coverage included
    - vi. Rights and conditions
    - vii. Person to whom the insurance benefits are payable
  - b. Alternative statement  
 "This certificate provides life insurance for the employees and dependents, if applicable, of (employer's name and address) under (group contract number). The employee shall be given a copy of the group enrollment application. The benefits are payable to the beneficiaries of record designated by the employee."
  - c. Notification of termination [**Sec. 627.5725**]
    - i. The company shall notify each certificate holder when the master policy has expired or been canceled.
    - ii. The policy owner shall advise the certificate holder as soon as practicable upon notice of expiration or cancellation

## **B. Conversion rights**

- 1. Conversion on termination of group eligibility
  - a. Upon severance of an employer/employee relationship, a person is entitled to purchase an individual life insurance policy, without proof of insurability, within 31 days of separation
  - b. Premium for the individual policy will be based on the applicant's attained age on the effective date of the individual policy
- 2. Death pending conversion [**Sec. 637.566 - .568**]
  - a. If a person dies during a conversion period, the insurer will pay the contract as if the insured's coverage was in effect

## **C. Types of groups/eligible groups**

- 1. Employer-Employee group
  - a. Full-time employees of a single employer
- 2. Labor Union Group
  - a. Members of a particular union
  - b. Policy is held by the union
- 3. Trustee Group
  - a. Group of employees (2 or more employers)
  - b. The trustee holds the policy for the members
- 4. Debtor Group
  - a. Debtors of a single creditor
  - b. The amount of credit insurance issued cannot exceed the indebtedness of the amount owed

5. Association Group
  - a. Any association of professionals, licensed by the State of Florida, can obtain an association group life insurance contract.
  - b. Requirements
    - i. Association must have been in existence for at least two years
    - ii. Formed for the purpose other than obtaining insurance
    - iii. Hold regular meetings at least on an annual basis
    - iv. Contributory Plans; must have at least 100 members participate.
    - v. Non-Contributory plans; all members must be covered
6. Credit Union Members
  - a. Available to credit unions and their members
  - b. Provides equal coverage to the amount of share balance held by the member

#### **D. Employee life**

1. Eligibility
  - a. In order to be eligible for a group insurance policy, there must be an employee/employer (EE/ER) relationship
  - b. The EE/ER relationship must not be discriminatory
    - i. All employees of the employer
    - ii. All employees of a specific class of employees
2. Employee
  - a. Must meet the definition of employee
    - i. Employees of one or more subsidiary corporations
    - ii. Employees, individual proprietors, and partners if the employer is an individual proprietor or a partnership.
    - iii. Directors of a corporation, former employees, or retired employees

#### **E. Assignment of proceeds [Sec. 627.552 - .571]**

- a. A person insured under a group life insurance policy is allowed to make an assignment of all or part of their incidents of ownership under that policy

### **V. Annuities**

#### **A. Suitability**

1. Purpose [**Sec. 627.4554; FAC Rule 69B-162.001**]
  - a. Require insurance companies to establish a standard and procedure for making recommendations to consumers interested in transactions involving annuity products.
2. Recommendation
  - a. Advice provided by an insurer or its agent to a consumer that may result in the purchase, exchange, or replacement of an annuity contract
3. Replacement
  - a.
  - b. Means a transaction in which a new policy or contract is to be purchased and an existing policy or contract will be
    - i. Lapsed, forfeited, surrender, assigned, terminated
    - ii. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value due to the use of non-forfeiture benefits
    - iii. Used in a financial purchase
    - iv. Amended to affect a reduction in benefits or cash value

#### **B. Suitability information**

1. Means information related to the consumer that is reasonably appropriate to determine the suitability of a recommendation made to the consumer; including the following
  - a. Intended use of the annuity
  - b. Liquidity needs
  - c. Liquid net worth
  - d. Financial objectives
  - e. Risk tolerance
  - f. Tax Status



- g. Financial time horizons
  - h. Annual income
  - i. Financial experiences
  - j. Financial situation and needs, including the financial resources used for funding the annuity
  - k. Age
  - l. Existing assets, including investment and life insurance holdings
2. Duties of insurers and insurance representatives
- a. When recommending the purchase or exchange of an annuity, the agent and insurance company must have reasonable grounds for believing that the recommendation is suitable for the consumer and that there is a reasonable basis to believe all the following
    - i. The particular annuity as a whole is suitable
    - ii. The consumer has been reasonably informed of various features of the annuity; such as
      - (1) Potential surrender charge
      - (2) Potential tax penalties
      - (3) Other fees
    - iii. The consumer will benefit from certain features of the annuity; such as
      - (1) Tax-deferred growth
      - (2) Annuitization
      - (3) Death or living benefit
    - iv. In case of exchange or replacement of annuity, the exchange or replacement is suitable whether the consumer
      - (1) Will incur a surrender charge
      - (2) Be subject to the commencement of a new surrender period
      - (3) Lose existing benefits
        - (a) Death, living, contractual benefits
        - (b) Subject to fees
          - (i) Investment advisory
          - (ii) Riders; product enhancements
          - (iii) General increases
      - (4) Would benefit from the product enhancement or improvement
      - (5) Has had another annuity exchange or replacement (within the past three (3) years).
    - v. Before executing a purchase, exchange, or replacement of an annuity (resulting from a recommendation), the insurance carrier and its appointed agent must make reasonable efforts to obtain the consumer's suitability.
3. Recordkeeping
- a. Companies and agents must maintain records containing information collected from the consumer, as well as other information used in making the recommendations for the basis of the transaction, for five (5) years
  - b. A company may maintain the documentation instead of an agent
4. Prohibited charges
- a. An annuity contract issued to a senior consumer age 65 or older may not contain a surrender or deferred sales charge for a withdrawal of money from an annuity exceeding 10% of the amount withdrawn.

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UNIT**29****FLORIDA LAWS & RULES:  
HEALTH INSURANCE****OVERVIEW**

This unit outlines only those marketing practices, policies, and provisions of health insurance that are regulated by the state of Florida. Candidates for the Health Insurance Examination will be tested on the various required laws and rules covered in this unit.

**OBJECTIVES**

After completing this chapter, you should be able to understand:

- Standard Policy Provisions and Clauses
- Group Health
- Disclosure
- Medicare Supplements
- Long-Term Care Policies
- Requirements for Small Employers
- Florida Health Kids Corporation
- Requirements relating to HIV/AIDs
- Plan Types
- Dread Disease Policy

**KEY TERMS**

Community Health Purchasing

EPOs (Exclusive Provider Organizations)

Florida Employer Health Care Access Act

Florida Health Insurance Coverage Continuation Act

Free-Look Privilege

Grandfathered Plans

Group Health Insurance

Guarantee-Issue Basis

HMOs

Long-Term Care

Medicare Supplements

PLHSOs

Portability

Preexisting Coverages

Required Contract Provisions

Required Coverages

Small Employer

## I. Standard Policy Provisions and Clauses (Individual & Group)

### A. Minimum benefit standards

1. Free-look
  - a. Health insurance policy may be returned within ten days of delivery and have a full refund of the premium paid if the purchaser is not satisfied with the policy for any reason
2. Nongrandfathered health plan
  - a. Coverage provided by a group health plan in which an individual was enrolled on March 23, 2010, and has continuously covered someone since March 23, 2010
  - b. Plans may not have to meet all the requirements contained in PPACA
  - c. The following situations could cause a plan to lose grandfathered status [**Sec. 627.402**]
    - i. Elimination of benefits
      - (1) Elimination of all or substantially all benefits to diagnose or treat a particular condition
      - (2) Increase in percentage cost-sharing requirements
        - (a) Any increasing percentage cost-sharing requirement
      - (3) Increase in a fixed-amount cost-sharing requirement other than a copayment
        - (a) If the total percentage increase in the cost-sharing requirement exceeds the maximum percentage increase allowed by federal regulation
      - (4) Increase in a fixed-amount copayment
        - (a) If the total increase in the copayment exceeds amounts permitted by federal regulation
      - (5) Decrease in contribution rate by employers and employee organizations
        - (a) Contribution rate based on cost of coverage
        - (b) Contribution rate based on a formula
      - (6) Changes in annual limits
        - (a) Addition of an annual limit
        - (b) Decrease in limit for a plan or coverage with only a lifetime limit
        - (c) Decrease in limit for a plan or coverage with an annual limit
    - d. A group health plan that provided coverage on March 23, 2010, and has retained its status as a grandfathered health plan is a grandfathered health plan for new employees (whether hired or newly enrolled) and their families enrolling in the plan after March 23, 2010
3. Patient Protection and Affordable Care Act (PPACA) provisions applicable to grandfathered health plans
  - a. Group health plans and group and individual health insurance coverage:
    - i. May not establish lifetime limits for essential benefits (annual limits may apply)
    - ii. May not establish annual limits for essential benefits (annual limits may apply)
    - iii. Dependent coverage for adult children
      - (1) Must be continued until the child turns age 26
    - iv. Waiting periods (elimination period)
      - (1) Definition
        - (a) Delay before benefits are paid
        - (b) The insured self-insurers for this period
        - (c) The purpose of the waiting period is to control overutilization of the policy
      - (2) Provision
        - (a) May not establish waiting periods greater than 90 days
    - v. May not contain any pre-existing conditions exclusions
4. PPACA provisions NOT applicable to grandfathered health plans
  - a. Do not provide free preventative care
  - b. Do not have to provide “essential health benefits.”
    - i. A minimum set of benefits that must be covered by a health plan in order to be considered “real” health insurance coverage.

### B. Required and optional coverages

1. Medical Provider (physicians and medical doctor) [**Sec. 627.419**]
  - a. Also includes

- i. Dentist; when policy covers surgical procedures performed in an accredited hospital with a licensed physician and within the scope of a dentist's professional license
  - ii. Medical expense policies must also provide for payment for
    - (1) Optometrist
    - (2) Chiropractor
    - (3) Podiatrist
- 2. Diabetes coverage: equipment, supplies, and outpatient self-management training [**Sec. 627.6408**]
  - a. Florida law requires Health Maintenance Organizations (HMOs) and health insurance contracts to provide coverage for all medically necessary equipment, supplies, and services to treat diabetes. Certification from a licensed physician is required for proof of condition. This law also includes coverage for outpatient self-management training and education services, if medically necessary
- 3. Osteoporosis coverage
  - a. Bone-thinning disease that increases the risk of bone fractures
  - b. Florida health plans and HMOs are required to provide coverage and treatment for high-risk individuals
  - c. Excluded
    - i. "Specified accident, specified disease, hospital indemnity, Medicare supplement, long-term care health insurance, and Florida state employee health program."
- 4. Coverage for newborn children
  - a. Florida law requires coverage for newborn child(ren) of a covered family for a period of eighteen (18) months
  - b. Coverage will consist of
    - i. Injury
    - ii. Sickness (including)
      - (1) Diagnosed congenital defects and disabilities
      - (2) Birth abnormalities
      - (3) Prematurity
      - (4) Transportation costs (nearest hospital equipped to handle the newborn's condition)
  - c. Insured may be required to notify the carrier upon birth of a child. Failure to notify the carrier within 30 days after the birth may result in denial of coverage for the newborn
  - d. This section does not apply to disability income, hospital indemnity policies, or normal maternity policy provisions applicable to the birthing mother [**Sec. 627.641**]
- 5. Coverage for adopted, foster, custodial care, and natural-born children
  - i. Provides coverage for children of the insured who are
    - (1) Natural-born
    - (2) Adopted
    - (3) Placed by foster care
  - ii. Coverage applies from the moment of placement to the child's 18<sup>th</sup> birthday
  - iii. Exception
    - (1) In the case of a foster child, the policy may not exclude coverage for any preexisting condition of the child [**Sec. 627-6415**].
  - b. Children's Health Supervision Services
    - i. All expense-incurred basis health policies that provide coverage for a family member of the insured must provide benefits applicable for children from the moment of birth to age sixteen (16) for the following
      - (1) Medical history
      - (2) Physical examination
      - (3) Developmental assessment and anticipatory guidance
      - (4) Appropriate immunizations and laboratory tests
  - c. Children with disabilities [**Sec. 627.6615, .0641**]
    - i. Individual and group health insurance policies must continue to provide coverage for a child while the child continues to
      - (1) Be incapable of self-sustaining employment because of intellectual or physical disability

- (2) Be chiefly dependent upon the employee (member, subscriber) for support and maintenance
- 6. Coverage for mastectomies
  - a. Coverage for prosthetic devices and reconstructive surgery for a mastectomy is required by Florida law
  - b. Florida law also
    - i. Mandates coverage for all surgeries necessary to reestablish symmetry between breasts
    - ii. Prohibits inpatient hospital coverage for mastectomies from being limited
    - iii. Prohibits a person from being denied or excluded from coverage for breast cancer (1) If the person remains cancer-free for two (2) years
    - iv. Requires that both outpatient and inpatient postsurgical care coverage for mastectomies be comparable to each other
    - v. Prohibits breast cancer follow-up care from being considered an evaluation for a preexisting condition; unless breast cancer is found **[Sec. 627.6417, .64171, .64172]**
- 7. Coverage for mammograms
  - a. Policies delivered in Florida must include coverage for at least the following
    - i. Baseline mammogram for any woman age 35 to 39
    - ii. Mammogram every two (2) years for any woman age 40 to 49 (1) More frequently, if based on the patient's physician recommendation
    - iii. Mammogram every year for any woman age 50 or older
    - iv. One or more mammograms a year for any woman at risk for breast cancer because of a personal or family history or breast cancer **[Sec. 627.6418]**
- 8. Exclusions for fibrocystic condition prohibited
  - a. Unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer, an insurance carrier may not deny the issuance or renewal of a policy of health insurance because the insured has been diagnosed as having a fibrocystic condition, a nonmalignant lesion, family history related to breast cancer, or any combination of these factors **[Sec. 627.6419]**
- 9. Coverage for cleft lip and cleft palate of children **[Sec. 627.64193]**
  - a. Health insurance policy covering a child under the age of eighteen (18) years of age must provide coverage for treating a cleft lip or palate.
  - b. Coverage must also include
    - i. Medical
    - ii. Dental
    - iii. Speech therapy
    - iv. Audiology
    - v. Nutrition service
  - c. Coverage does not apply to
    - i. Specified-accident
    - ii. Specified-disease
    - iii. Hospital indemnity
    - iv. Limited benefit disability income
    - v. Long Term Care insurance (LTCi)
- 10. Rebates for participation in wellness program **[Sec. 627.6402]**
  - a. Rebate may be based on premiums paid in the last calendar year or the last policy year.
  - b. Individual must provide evidence of maintenance or improvement of the individual's health status
  - c. Rebate not to exceed ten percent (10%) of paid premiums
- 11. Experimental Treatment for Terminal Conditions
  - a. Coverage for the cost of or the cost of services related to the use of an investigational drug, biological product, or device.
  - b. An insurance company is **not** required, under the Florida Insurance Code, to provide this coverage. **[Sec. 627.605-.617]**
- 12. Emergency Services
  - a. Coverage must be provided without prior authorization regardless of whether services are provided by participating or non-participating providers.

- b. Insurer may only impose a coinsurance, copayment, or limitation of benefits requirement to a non-participating provider if the same applies to a participating provider.
- 13. Autism Spectrum Disorder and Down Syndrome
  - a. Health insurance plan or health maintenance contract shall provide coverage for treatment of autism spectrum disorder and down syndrome
  - b. Treatment shall include:
    - i. Speech therapy
    - ii. Occupational therapy
    - iii. Physical therapy
    - iv. Applied behavior analysis
- 14. Opioids
  - a. Prior authorization requirements may be imposed as long as the policy imposes the same requirement for each occurrence without labeling the claim as an abuse – deterrence. [Sec. 627.64194]
- 15. Balance Billing Restriction
  - a. Florida statutes prohibit the practice of balance billing when an insured receive non-emergency health care services in an in-network facility.
  - b. Balance billing is prohibited when an insured receives emergency health care services in either an in-network or out-of-network facility.

**C. Required health insurance policy provisions [Sec. 627.605 - .617]**

Policies issued for delivery in Florida must contain the following provision

*“An insurer may substitute one or more corresponding provisions of different wording if approved by the Commissioner, and they are not less favorable in any respect to the insured or the beneficiary.”*

- 1. Entire contract clause
  - a. The policy, its endorsements, and attached materials, including the application, constitute the entire contract
  - b. No change in the policy will be effective until approved by an officer of the insurance company and attached to the policy
  - c. No agent may change the policy or waive any of its provisions
- 2. Time limit on defenses (Time limit on certain defenses)
  - a. This provision states that after two (2) years, no misstatements, except fraudulent ones, made by the application on the application, shall be used to void the policy or deny a claim for a loss incurred commencing after the end of such two-year period.
  - b. Cannot deny a claim not specifically excluded by name that had existed before the policy inception date (preexisting)
- 3. Grace Period
  - a. Period after the premiums due during which the policy remains in effect.
    - i. 7 days; weekly premium
    - ii. 10 days; monthly premium
    - iii. 31 days; all other modes
  - b. Protects the insured from an unintentional lapse in the policy
- 4. Reinstatement
  - a. A provision that allows the insured to reinstate a lapsed policy by paying 60 days back premium due plus interest and providing insurability.
  - b. If the carrier takes no action within 45 days following a conditional receipt, the policy is reinstated.
  - c. Coverage for accidents become effective immediately upon reinstatement
  - d. Coverage for sickness does not become effective until the conclusion of a 10-day probationary/incubation period
- 5. Claim Provisions
  - a. Notice of claim (20 days)
  - b. Claim forms (15 days)
  - c. Proof of loss/Completed claim forms (90 days)
  - d. Time of payment of claims (00/30 – immediate/monthly)
  - e. Payment of claims
  - f. Physical Examination and Autopsy

6. Legal Action (60 x 5) 5-year Statute of Limitations
  - (1) Payment of claims
    - (a) Indemnities (benefits) for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment
    - (b) If no designation is provided, it will be payable to the insured's estate
  - (2) Physical examination and autopsy
    - (a) The company, at its own expense, shall have the right and opportunity to examine the insured as often as reasonably necessary while a claim is pending
    - (b) Unless prohibited, by law (not custom or religion), in case of death, may do an autopsy
  - (3) Change of beneficiary
    - (a) Unless the beneficiary is designated as irrevocable, the policy owner may make changes to the beneficiary, surrender or assign the policy without the consent of any beneficiary

#### **D. Optional health insurance provisions [Sec. 627.619 - .629]**

1. Change of occupation
  - a. If an insured changes their occupation to a more hazardous occupation than what is stated in the policy, the insurer will pay only such portion of the benefits provided in the policy as the premium paid would have purchased; at the rates and within limits fixed by the carrier for such more hazardous occupation
  - b. If an insured changes their occupation to a less hazardous occupation than what is stated in the policy, the insurer, upon proof of a change of occupation, will reduce the premium rate accordingly and will return the excess pro-rata unearned premium from the date of change of occupation
2. Misstatement of age or sex
  - a. If age or sex is misstated, all amounts payable under the policy will be adjusted according to the correct age or sex
  - b. Misstatement of age or sex are not subject to the incontestability clause
3. Other insurance with insurer
4. Insurance with other insurers; expense-incurred basis
5. Insurance with other insurers; other than expense incurred basis
6. Unpaid premium
  - a. Upon payment of a claim, any premium then due may be deducted from the claim payment
7. Prohibited cancellation for HIV or AIDS
  - a. No insurer shall cancel or non-renew the health insurance policy of an insured because of a diagnosis or treatment for the Human Immunodeficiency Virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS)
8. Conformity with state statutes
  - a. If a provision on the policy conflicts with the state of the state in which the insured resides, the policy will amend itself to conform to the minimum requirements of such a statute
9. Illegal occupations
  - a. The insurance company shall not be liable for any loss to which a contributing cause was the insured's attempt to commit a felony or to which a contributing cause was the insured's engaging in an illegal occupation
10. Intoxicants and narcotics
  - a. The insurance company shall not be liable for any loss sustained or contracted due to the insured's being intoxicated or under the influence of any narcotic unless prescribed by a physician.

## **II. Group Health Insurance**

Group health insurance may be issued to eligible groups in Florida insurance more than one individual [Sec. 627.651 - .6699]

### **A. Eligible groups (employer-based, fraternal, association, blanket) [Sec. 627.6516-.656]**

1. Trustee group policy
  - a. Issued to the trustees of a fund
  - b. Consists of:



- i. Groups of employees of employers or members of labor unions
  - ii. Insured for the benefit of persons other than the employers or unions
- c. The trustees are the policyholders
- d. Premiums may be paid by
  - i. Policyholder
  - ii. Employer(s)
  - iii. Union(s)
  - iv. Insured person
- e. Policy must cover at least five persons.
- f. The amount of insurance under the policy must be based upon some plan precluding individual selection
- 2. Employee group policy
  - a. The employer is the policyholder
  - b. Master policy is issued to the employer
  - c. Insured for the benefit of persons other than the employer, under a master policy, issued to the employer
  - d. Employees can consist of any of the following
    - i. Directors of a corporate employer, former and retired employees
    - ii. Individual proprietor or partners (sole proprietor/partnership)
    - iii. Elected or appointed officials if the policy is issued to insure employees of a public body
    - iv. Employees of one or more entities under common control
  - e. All persons within the classification specified in the policy are eligible.
    - i. Classifications must not be determined to exclude those in a more hazardous employment
      - a. "Full-Time Employee"
        - i. Defined as an employee who has a normal workweek of twenty-five (25) or more hours
- 3. Associations, labor unions, and small employer health alliances
  - a. Made up of groups of individuals insured under a policy issued to an association, including labor unions, as long as
    - i. The association has a constitution and bylaws
    - ii. The association has at least twenty-five (25) members
    - iii. The association has been organized and has been maintained in good faith for at least twelve (12) months for other than the purpose of obtaining insurance
    - iv. The association is the policyholder
    - v. The association has, at a minimum, 15 members enroll in the plan
    - vi. Plans are fully insured by an authorized insurer.
  - b. A single master policy is issued to the association
  - c. Enrollment in the plan cannot be subject to discrimination
- 4. Debtor group policy
  - a. The creditor is the policyholder
  - b. The debtors are indemnified in connection with a specific loan or credit transition
  - c. Two types
    - i. Credit Disability
      - (1) May only be issued if the group is to receive entrants at the rate of at least 100 persons annually, or
      - (2) may reasonably be expected to receive at least 100 new entrants during the first policy year
      - (3) Company has a right to require evidence of insurability if less than 75% of the new entrants enroll
    - ii. Mortgage Insurance
      - (1) Used for all the debtors of the creditor, or all of any class or classes of debtors of the creditor
      - (2) Debtor includes the following terms
        - (a) Borrowers of money in connection with an indebtedness of more than 10 years' duration, and is secured by a first real estate mortgage
- 5. Blanket health insurance

- a. A form of health insurance that covers special groups of individuals, including policies owned by and issued to the following:
  - i. Any common carrier, operator owner, or lessee of a means of transportation covering passengers on that common carrier
  - ii. Employer, covering any group of employees or the employee's or the employee's dependents or guests defined by reference to activities or operations of the policyholder.
  - iii. A school, district school system, college, university, or other institution of learning insuring all or any of its students, teachers, and employees.
  - iv. Any volunteer fire department, emergency services, first aid group, local emergency management agency, or other first responder groups covering members or employees of the policyholder or covering participants in an activity or operation of the policyholder.
  - v. An organization, or branch thereof, such as the Boy Scouts of America, the Future Farmers of America, religious or education bodies.
  - vi. A Newspaper is covering independent contractor newspaper delivery persons.
  - vii. A health care provider is covering patients, donors, recipients, or surrogates.
    - (1) Plan may not be made a condition of receiving care
    - (2) Benefits provided must not be assignable to any health care provider.
  - viii. A sports team, camp, or sponsor covering members, campers, participants, employees, etc.
  - ix. Travel agent that provides travel-related services to cover any or all persons for whom travel and travel-related services are provided.
  - x. An association (25 individual members or more) and has been organized and maintained in good faith for at least one year for the purposes other than obtaining insurance.

## B. Continuation (Mini-COBRA)

1. Purpose and intent [**Sec. 627.6692**]
  - a. to ensure continued access to affordable health insurance coverage for employees of small employers and their dependents and other qualified beneficiaries not currently protected by the Consolidated Omnibus Budget Reconciliation Act (COBRA), Title X of 1985
  - b. This section does not apply if continuation of coverage is available to covered employees or other qualified beneficiaries of COBRA
2. Definitions
  - a. Small employer
    - i. A business who employs less than 20 employees
  - b. Group health plan
    - i. Small employer health benefit plan, which provides health care benefits to the employer's employees, former employees, or the dependents of such employees or former employees
  - c. Qualified beneficiary
    - i. Any individual who is a beneficiary under the group health plan by virtue of the individual being
      - (1) Spouse of the covered employee
      - (2) Dependent child of the covered employee
      - (3) The covered employee
        - (a) Except when the employee is terminated for gross misconduct
    - ii. Qualifying event for continuation (Triggers)
      - (1) Death of a covered employee
      - (2) Divorce or legal separation of the covered employee from the covered employee's spouse
      - (3) Termination or reduction of hours of the covered employee's employment
      - (4) Dependent child ceasing to be a dependent child under the generally accepted requirements of the group health plan
3. Continuation of coverage under group health plans

- a. A health plan issued to a small employer must have a provision that provides an offering of coverage to an affected insured, because of a qualifying event or trigger, within the election period, to continue coverage under the employer's group plan
  - i. Qualifying beneficiary must give written notice to the insurer within sixty-three (63) days after the occurrence of a qualifying event.
  - ii. Within fourteen (14) days after the receipt of the qualified beneficiary's written note, the carrier shall send each qualified beneficiary, by an approved method (certified mail) and election and premium notice form
  - iii. A covered employee must pay the initial premium and elect such continuation within 30 days after receiving notice from the insurance company.
  - iv. The insurer will process all selections promptly
  - v. Coverage and premium due will be retroactive to the date coverage would otherwise have terminated
  - vi. Carrier must bill the qualified beneficiary monthly, with a due date on the first of the month and allowing a thirty (30) day grace period
  - vii. Premium paid for continuation of coverage may not exceed 115% of the applicable group premium
  - viii. The ending date for continuation of coverage is not earlier than the earliest of the following
    - (1) 18 months after the qualifying event/trigger
    - (2) Qualified beneficiary who is determined to have been disabled at the time of a qualifying event (11-month extension)
    - (3) The date on which coverage ceases due to non-payment of a premium
    - (4) The date a qualified beneficiary is entitled to benefits under Medicare Part A or Part B
    - (5) The date on which the employer terminates coverage under the group health plan for all employees

### C. Conversions / "Converted Policy"

1. An insured who has continuously been insured under a group policy at a minimum of three (3) months, immediately before termination, is entitled to have issued to them by the insurance company, a policy or certificate of health insurance, referred to as a "converted policy."
2. The employee or member will not be issued a "converted policy" if
  - a. Termination of the group insurance occurred because of a failure to make a premium payment
  - b. Because the discontinued group coverage was replaced by similar group coverage within thirty-one (31) days after discontinuance
3. A written application for a "Converted policy" must be submitted, with the initial premium paid to the insurer, no later than 64 days after termination of the group policy
4. Proof of insurability is not required for issuance of a "converted policy."
5. The premium for a "converted policy" may not exceed 200% of the standard risk rate (established by the Florida OIR)
6. The effective date of the "converted policy" will be the day following the termination of the insurance under the group policy

### D. Coordination of Benefits (COB)

1. Policy must contain a provision for coordination of benefits
2. If a claim is submitted and the policy includes a COB provision, and the claim involves another insurance policy or plan that also has a COB provision, the following rules apply to determine the settlement of the claim
  - a. The benefits of a policy or plan that covers the person as an employee, member, or subscriber, other than as a dependent, are determined before those of the policy or plan that covers the person as a dependent
  - b. If the person is also a Medicare beneficiary, and based on the Medicare Secondary Rule, Medicare benefits are secondary, then the person as a dependent of an active employee, the order of benefits is determined as such
    - i. 1<sup>st</sup>; benefits of a plan covering a person as an employee, member, or subscriber
    - ii. 2<sup>nd</sup>; benefits of a plan of an active worker covering a person as a dependent

- iii. 3<sup>rd</sup>; Medicare benefits
  - iv. The rule for the order of benefits for a dependent child when the parents are not separated or divorced are as follows
    - (1) The benefits of the plan of the parent whose birthday falls earlier in a year shall be determined before those of the plan of the parent whose birthday falls later in that year
    - (2) If both parents have the same birthday, the benefits of the plan which covered the parent longer shall be determined before those of the plan which covered the other parent for a shorter period
    - (3) The word “birthday” refers only to month and day in a calendar year and not the year in which the person was born
  - v. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child shall be determined as follows
    - (1) The plan of the parent with custody of the child shall have its benefits determined first
    - (2) The plan of the spouse of the parent with the custody of the child shall have its benefits determined next
    - (3) The plan of the parent not having custody of the child shall have its benefits determined last
  - c. Coordination of benefits (COB) is not permitted against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy [**Sec. 627.4235**]
- E. ERISA preemption and state insurance regulation**
1. Employee Retirement Income Security Act of 1974 (ERISA)  
Students should review the State Study Manual for more details.

### III. Disclosure

#### A. Outline of coverage

1. Rule
  - a. No policy may be delivered or issued for delivery in Florida, unless it is accompanied by an appropriate “outline of coverage.”
  - b. “Outline of Coverage” must be completed and delivered to the applicant at the time of application and is receipt or certificate of delivery of such an outline must be prepared and signed.
  - c. The “outline of coverage” must include the following information
    - i. Statement identifying the applicable category of coverage provided in the policy
    - ii. Brief description of the principal benefits and coverage provided by the policy
    - iii. When home health care coverage is provided, a statement that such benefits are provided in the policy [**Sec. 627.642**]
    - iv. A summary statement:
      - (1) of the principal exclusions, limitations, or reductions confined in the policy, pertaining to but not limited to
        - (a) Preexisting conditions
        - (b) Probationary periods
        - (c) Elimination periods
        - (d) Deductibles
        - (e) Coinsurance
        - (f) Age limitations and reductions
      - (2) of the renewal and cancellation provisions
        - (a) including any reservations of the insurance company of a right to change premiums
      - (3) that the outline contains a summary only and that the issued policy should be referred to for the actual provisions

#### B. Renewal Agreements / Nonrenewal and Cancellation

*“Except as provided in this section, an insurer that provides individual or group health insurance coverage must renew the coverage at the option of the individual, or group policyholder”* [**627.6425, .6571, .636.028, 641.31074**]

1. Individual health insurance

- a. A company may non-renew or discontinue an individual health insurance policy for one or more of the following reasons
    - i. Nonpayment of premium
    - ii. An act or practice that constitutes fraud or made an intentional misrepresentation of material facts under the terms of the policy
    - iii. Company ceases to offer coverage in the individual market
    - iv. Individual no longer resides, lives, or works in the service area
    - v. Individual no longer resides, lives, or works in an area where the insurance company is authorized to do business
    - vi. Individual ceases to be a member of a bona fide association
  - b. If the insurance company decides to discontinue offering a particular health insurance policy form, the insurer must provide notice to each covered individual at least ninety (90) days before the date of non-renewal
  - c. The company must offer each discontinued individual an option to purchase another individual health insurance coverage currently being offered by the company
  - d. If the insurer elects to discontinue offering all health insurance coverage in the individual market in the State of Florida, they must provide notice to the Office and each individual at least 180 days before the date of non-renewal
  - e. When the insurer discontinues all individual health insurance policies in the state, the company may not write individual health insurance coverage in the State of Florida during the next five (5) year period beginning on the date the last health insurance coverage did not renew
2. Group health insurance
- a. An insurance company may non-renew a group health insurance policy for one or more of the following reasons
    - i. Nonpayment of a premium
    - ii. An act or practice that constitutes fraud or made an intentional misrepresentation of material facts under the terms of the policy
    - iii. Company ceases to offer a particular type of coverage in the group market
    - iv. Policyholder has failed to comply with a material provision of the plan that relates to rules for employer contributions or group participation
    - v. There is no longer any enrollee in connection with the plan who lives, resides, or works in the service areas of the insurer
    - vi. Employer ceases to be a member of a bona fide association
  - b. If the insurance company decides to discontinue offering a particular health insurance policy form, the insurer must provide notice to each covered individuals at least ninety (90) days before the date of non-renewal
  - c. The company must offer each discontinued individual an option to purchase another individual health insurance coverage currently being offered by the company
  - d. If the insurer elects to discontinue offering all health insurance coverage in the individual market in the State of Florida, the must provide notice to the Office and each individual at least 180 days before the date of non-renewal
  - e. When the insurer discontinues all individual health insurance policies in the state, the company may not write individual health insurance coverage in the State of Florida during the next five (5) year period beginning on the date the last health insurance coverage did not renew

### C. Advertising

1. All advertisements and communications developed by the insurers regarding insurance products must clearly state that their communications relate to insurance products
2. When selling or soliciting insurance products, agents must clearly indicate to the prospective insured that they are acting as insurance agents with regard to insurance products and identified insurers [**Sec. 626.9531; Rule 690-150.001-.021**]
3. Advertisements of benefits payable, losses covered, or premiums payable
  - a. No advertisement may use words or phrases such as “all,” “full,” “complete,” “comprehensive,” “unlimited,” “up to,” or similar words and phrases in a manner that exaggerates any benefits beyond the terms of the policy
  - b. An advertisement that acts as an invitation to join an association must distinctly solicit insurance coverage on a separate application

- i. Application and invitation must have separate signature sections as to appear they are not part of the same document
- c. Membership fees must be disclosed on each application and must appear separately so as not to construe that they are part of the insurance coverage premium. No advertisement of benefits for which a payment is conditional upon conferment in a hospital or similar setting may use words or phrases such as “tax-free,” “extra cash,” “extra income,” “extra pay” in a manner that would have the capacity or tendency to mislead or deceive the public in any way, so that it would enable them to profit from being hospitalized or disabled
- d. An advertisement for a policy providing benefits for specialized illness (such as cancer and specified accident, nursing home coverage only) must clearly state in a language identical to, or substantially similar to the following:
  - i. “THIS IS A LIMITED POLICY,” “THIS IS A CANCER ONLY POLICY”, “THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY”, THIS IS A NURSING HOME COVERAGE ONLY POLICY”.
- e. An advertisement must disclose exceptions, reductions, and limitations affecting the basic provisions of the policy
- f. Advertisements must disclose the existence of waiting/elimination periods or probationary/incubation periods

#### **D. Certificate of Coverage [Sec. 627.657]**

- a. The insurance company must provide to the policyholder a certificate containing the group number and the essential features of the insurance coverage and to whom the benefits are payable to

#### **E. Group blanket health [Sec. 627.660]**

- a. Covers a number of individuals exposed to the same hazards, such as members of an athletic team, college, school or other institution of learning, passengers in the same plane, volunteer fire departments, etc.
- b. No certificates or individual policies are issued
- c. An individual application is not required from a person covered under a blanket health insurance policy

### **IV. Medicare Supplement Insurance**

- 1. “Preexisting condition.”
  - a. May not limit or preclude liability under a policy for a period greater than six (6) months
  - b. A condition in which medical advice was given or treatment was recommended within six (6) months before the policy effective date
  - c. A Medicare supplement policy may not exclude benefits based on a preexisting condition if the individual has had a continuous period of creditable coverage for at least six (6) months before the date of application for coverage
- 2. “Free look.”
  - a. Medicare supplement policies and certificates must have a statement on the front page of the policy or certificate stating the applicant has thirty (30) days from the date of delivery to have the premium refunded if the applicant is not satisfied for any reason.
  - b. An insurer may not advertise, solicit, or issue for delivery in Florida a Medicare supplement policy or certificate unless it has been filed with and approved by the Office.
  - c. Policy must be written in simplified language and be easily understood by the purchaser **[Sec. 627.674; 690-156.003, .014]**

#### **B. Open enrollment periods**

- 1. Age 65 and over
  - a. Medicare supplement insurance company may not deny any application for Medicare supplement policy of an applicant if the application is submitted before or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B
- 2. Underage 65

- a. Medicare supplement insurance company must offer the opportunity of enrolling a Medicare supplement policy to any Florida resident who is under age 65 and is eligible for Medicare by reason of disability or end-stage renal disease
  - b. High-pressure tactics & Cold lead advertising is prohibited [**Sec. 627.6743; FAC Rule 690-156.017**]
3. Permitted compensation arrangements [**Sec. 627.6742; FAC Rule 690-156.013**]
- a. An agent may receive compensation for the sale of a Medicare supplement policy or certificate only if the first-year compensation does not exceed 200% of the compensation paid for selling or servicing the policy in the second year or period
  - b. If a company elects to restrict first agent commission or compensation to 15% or less of the policy premium, the company may elect not to pay any commission or other compensation to an agent or other representative for the renewal or replacement of such policy
4. Multiple policies
- a. Medicare supplement insurance may not be issued or sold to an individual if such individual already has in force a Medicare supplement policy
  - b. Exception to rule
    - i. If the applicant indicates, in writing, that the intent of the new policy is to replace their current policy,
    - ii. the insurance company providing the replacement policy forwards the statement to the insurer whose policy is being replaced [**Sec. 627.6744**]

### C. Disclosure

1. Buyer's Guide
  - a. Must be delivered at the time of application and acknowledged by a receipt
  - b. Medicare Supplement Buyer's Guide is developed by the NAIC and Health Care Financing Administration of the US Department of Health and Human Services [**Sec. 627.674**]
2. Outline of coverage
  - a. Medicare supplement outline of coverage must be delivered to the applicant at the time the application is made.
  - b. The following language must be printed on or attached to the first page of the Outline of Coverage [**Sec. 627.764**]
    - i. *"This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."*

### D. Replacement/Replacement Forms

1. Are when any transaction wherein new Medicare supplement insurance is to be purchased, and it is known to the producer (agent, broker) or insurer at the time of application
2. Application forms must include statements and questions designed to elicit information about whether the applicant is currently enrolled in a current Medicare supplement, Medicare Advantage, or Medicaid plan.
3. Notice Regarding Replacement of Medicare Supplement Coverage must be completed
  - a. Signed copies to be given to
    - i. Agent
    - ii. Applicant
    - iii. Insurer
  - b. Within five (5) working days from the receipt of application, the replacing carrier must furnish a copy of such note to the incumbent carrier, whose policy is being replaced

### E. Duplication of benefits

1. No Medicare supplement policy or certificate in force in the state of Florida must contain benefits that duplicate benefits provided by Medicare [**FAC Rule 690-156.005**]

### F. Standardized policy benefits (A-N)

1. ***Specific coverage by the plan are discussed in Unit 21, Private Insurance Plans for Seniors***

- a. Applicable to all 2020 Standardized Medicare Supplement policies or certificates delivered or issued in the State of Florida with an effective date of January 1, 2020, or later
  - i. Medicare supplement policies must be guaranteed renewable
  - ii. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state unless it complies with the standards of this section
  - iii. Must not indemnify losses resulting from sickness on a different basis than losses resulting from an accident
  - iv. A Medicare supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005

## V. Long Term Care (LTC) Policies

### A. Disclosure

- 1. Outline of coverage
  - a. Must be delivered to an applicant for individual LTCi at the time of application
  - b. The outline must include
    - i. Description of the principal benefits and coverage provided in the policy
    - ii. Statement of the principal exclusions, reduction, and limitations
    - iii. Statement of the renewal provisions, including any reservation in the policy of a right to change premiums
    - iv. Statement indicating that the outline of coverage is a summary of the policy and that the policy should be consulted to determine contractual provision
    - v. Must show benefit levels for at least twenty (20) years
    - vi. Premium increases and additional premiums must be disclosed for applicants at the age of 75 and 85 years of age [**Sec. 627.9407; 69O-157.120**]
- 2. Buyer's Guide
  - a. Must be delivered before the presentation of an application or enrollment form
  - b. Must be in a format developed by the NAIC (2001)
  - c. Life insurance policies or riders containing accelerated LTC benefits are not required to furnish an LTC Buyer's Guide [**69O-157.121**]

### B. Advertising and Marketing

- 1. An insurance company must file with the Office any LTCi advertising material intended for use in Florida for review or approval.
- 2. Carriers may immediately begin using material upon filing; however, they must immediately cease if the Office issues notice of disapproval or withdrawal of approval
- 3. A qualified LTCi policy must include a disclosure statement within the policy and within the outline of coverage that indicates the policy is intended to be qualified as a long-term contract
 

*"This long-term care insurance policy is not intended to be a qualified long-term care insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about such potential income tax consequences."*
- 4. Prohibition against post-claims underwriting
  - a. The following language, or language substantially similar to the following, must be set out conspicuously on the LTCi policy or certificate at the time of delivery
 

*"Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained] by you when you applied]. If your answers are incorrect or untrue, the company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! IF, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]."*
- 5. Requirements for replacement
  - a. A Notice Regarding Replacement of Accident and Sickness or Long-Term Care Coverage is required
  - b. Sign and executed copies of the notice must be given to
    - i. Agent
    - ii. Insurer
    - iii. Applicant



- c. A copy of the notice must be given to the incumbent company within five (5) working days from the date of the application
- 6. Producer training
  - a. Carriers providing LTCi must maintain records that before their appointed producers sell, solicit, negotiate, or effect any LTCi policy, that they receive necessary and sufficient training to understand partnership policies and their relationship to public and private coverage for LTC
- 7. Suitability
  - a. Every company marketing LTCi must develop and maintain suitability standards to determine whether the purchase or replacement of such policy is appropriate for the needs of the prospective applicant
  - b. Both the agent and the insurer must make reasonable efforts to obtain suitability information
  - c. A completed personal worksheet must be sent to the insurer before the insurer considers the application for coverage
  - d. The personal worksheet is provided to the applicant.
  - e. If the insurer determines that the applicant does not meet its financial suitability standard, the insurer may reject the application [**Sec. 627.9407; FAC Rule 690-157.109, .110, .115-.116**]

### C. Policy standards

- 1. Free-look
  - a. Individual LTCi policies provide for 30 days after delivery of the policy, whereas the insured may return the policy and receive a full refund if they are not fully satisfied with the policy
  - b. A policy issued to an individual must not contain renewal provisions other than “guaranteed renewable” or “noncancelable.”
- 2. Preexisting conditions
  - a. LTCi definition
    - i. “a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.”
    - ii. The definition does not prohibit an insurance company from using an application form designed to elicit the complete health history of an applicant; in accordance with company underwriting standards
- 3. Limitations and exclusions
  - a. Mental or nervous disorders
    - i. This shall not permit exclusion or limitation of benefits based on Alzheimer’s disease or any other organic brain disease such as senile dementia
    - ii. Preexisting conditions or disease
    - iii. Illness, treatment, or medical conditions arising out of
      - (1) War, or act of war
      - (2) Participation in a felony, riot, or insurrection
      - (3) Service in the armed forces or units’ auxiliary thereto
      - (4) Suicide (same or insane), attempted suicide, or intentionally self-inflicted injury
      - (5) Aviation (this exclusion applies only to non-fare paying passengers)
      - (6) Treatment provided in a government facility
      - (7) Treatment provided for alcoholism and drug addiction
      - (8) Services for which benefits are available under Medicare or other government programs (excluding Medicaid)
      - (9) Services provided by a member of the covered person’s immediate family
      - (10) Any state or federal workers’ compensation, employer’s liability or occupational disease law, or any motor vehicle no-fault law
      - (11) Services for which no charge is normally made in the absence of insurance
  - b. LTCi policy may not do the following
    - i. Be canceled, non-renewed, or otherwise terminated on the grounds of
      - (1) Age

- (2) Deterioration of the mental or physical health of the insured individual or certificate holder
        - ii. Restrict its coverage to care only in a licensed nursing home
        - iii. Condition eligibility for benefits on a prior hospitalization requirement
        - iv. Contain an elimination period in excess of 180 days
      - c. The premium rate schedule must be based on the issue age of the insured
      - d. An LTCi policy may not be issued if the premiums are calculated to increase based solely on the age of the insured
4. Home care coverage
  - a. An LTCi policy, certificate, or rider that contains a home health care benefit must meet or exceed the minimum standards outlined in **[Sec. 627.94071]**
    - i. Home health care cannot be covered unless the insured would, without the home health care, require skilled care in a skilled nursing facility
    - ii. The insured first or simultaneously receive nursing or therapeutic services in a home setting or community setting before home health care services are covered
    - iii. Exclude coverage for personal care services provided by a home health aide
    - iv. The home health care services must be at a level of certification of licensure greater than that required by the eligible services
    - v. The insured/claimant have an acute condition before home health services are covered
    - vi. Limiting benefits to services provided by Medicare-certified agencies or providers
    - vii. Excluding coverage for adult day care services
5. Inflation protection **[Sec. 627.94072]**
  - a. The option to purchase a policy that provides that benefit levels increase with benefit maximums or reasonable durations, to account for reasonably anticipated increases in the cost of services covered by the policy
  - b. Provisions that increases benefits annually at a rate not less than five percent (5%) compounded annually
6. Non-forfeiture benefits
  - a. An insurance company that offers a long-term care insurance policy must offer a non-forfeiture protection provision if all or part of a premium is not paid.
  - b. In addition to the standard nonforfeiture options, a protection provision may be offered in the form of a return of premium upon the death of the insured or upon the complete surrender or cancellation of the policy or contract
  - c. The standard non-forfeiture credit must be equal to 100% of the sum of all premiums paid.
  - d. The minimum non-forfeiture credit must not be less than thirty (30) times the daily nursing home benefit at the time of the lapse
  - e. At the time of the lapse, the carrier must disclose to the insured the insured's then-accrued non-forfeiture values
  - f. When the policy is issued, the insurance company must provide the policyholder a schedule demonstrating the values of non-forfeiture benefits. However, the schedule must indicate that the values are estimated and are not to be construed as being guaranteed **[Sec. 627.94072]**
7. Contingent benefit on lapse **[FAC Rule 690-157.118]**
  - a. If the offer to purchase non-forfeiture benefits is rejected, for individual and group policies without non-forfeiture benefits, the insurer must include in the policy, or as a rider or endorsement to the policy, the contingent benefit upon lapse
8. Grace period and unintentional lapse **[Sec. 627.94073]**
  - a. Grace period of not less than 30 days
  - b. If the policy becomes a claim during the grace period (before the premium is paid), the amount of such premium may be deducted from the claim
    - i. Interest, not to exceed 8% may be imposed
  - c. Unintentional lapse
    - i. "Secondary Addressee" is defined as an individual, other than the applicant, to whom receives a notice of lapse or termination of the policy for nonpayment of premiums

- ii. If a policy is canceled for nonpayment of a premium, the policyholder is entitled to have the policy reinstated, within not less than five (5) months after the date of cancellation if the policyholder or any other “secondary addresses” can demonstrate that the reason for the failure to pay the premium was unintentional and due to the policyholder’s cognitive impairment, loss of functional capacity, or continuous confinement in a hospital, skilled nursing facility or assisted living facility for a period greater than sixty (60) days
  - iii. Reinstatement must be subject to payment of overdue premiums
9. Conditions for determination of benefit payments
- a. Failure to be able to perform any three (3) of the six (6) activities of daily living (ADLs) will trigger the benefits of a long-term care policy
    - i. Activities of Daily Living (ADLs)
      - (1) Bathing
      - (2) Continence
      - (3) Dressing
      - (4) Eating
      - (5) Toileting
      - (6) Transferring
      - (7)

**D. Required provisions (Minimum standards)**

1. All LTC policies must provide coverage for at least one type of lower-level form of care.
2. An LTC policy must not provide more coverage for care in a nursing home than coverage for a lower level of care
  - a. Different forms of “lower level(s) of care” include
  - b. Home Health Services
  - c. Assisted Living Facility
  - d. Nursing Services
  - e. Adult Day Care Center
  - f. Personal Care and Social Services
  - g. Adult Foster home
  - h. Community Care for the Elderly

**E. Terminology**

1. Long Term Care Insurance Policy
2. Chronically ill
3. Cognitive impairment
4. Qualified long-term care services
5. Adult daycare center
6. Assisted living facility
7. Home health services
8. Nursing home facility
9. Personal care
10. Waiting period or probationary period

**F. Long-Term Care Partnership (LTCi-P)**

1. Florida’s LTCi-P program is a partnership program between Medicaid and private LTC insurers.
2. LTCi-P provides dollar-for-dollar asset protection in the event the policyholder needs to apply for LTC Medicaid assistance
3. A policy or certificate marketed as an approved LTC-P program policy must meet the following criteria
  - a. Be a qualified long-term care insurance policy
  - b. Have a statement of the principal exclusions, reductions, and limitations
  - c. Be issued to a Florida resident or another state that had entered into a reciprocal agreement with Florida when coverage first became effective under the policy
  - d. Policies or certificates issued to an individual who has attained age 61 but has not attained age 76 must contain annual inflation coverage **[FAC Rule 69O-157.201]**

## VI. Requirements for Small Employers

Purpose and intent

### A. Florida Employee Health Care Access Act

1. "To promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status, to establish rules regarding renewability of that coverage, to establish limitations on the use of exclusions for preexisting conditions, to provide for the establishment of a reinsurance program for coverage of small employers, and to improve the overall fairness and efficiency of the small-group health insurance market." **[Sec. 627.6699]**

### B. Definitions

1. Dependent
  - a. The spouse or child of an eligible employee
2. Eligible employee
  - a. An employee who works full-time
  - b. Normal workweek of 25 or more hours
  - c. Has met any applicable waiting period requirement
3. Guaranteed-Issue basis
  - a. An insurance policy that must be offered to an employer, employee, or dependent of the employee, regardless of health status, preexisting condition, or claims history
4. Small Employer
  - a. An employer that is actively engaged in business
  - b. Has its principal place of business in Florida
  - c. Employed an average of at least one but not more than 50 eligible employees
5. Small Employer carrier
  - a. A carrier that offers health benefit plans covering employees of one or more small employees

### C. Special Provisions

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by credible coverage continually to a date not more than 63 days before the effective date of his or her new coverage
2. An initial enrollment period of at least 30 days must be provided.
3. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents
4. A small employer carrier must provide a special enrollment period if an eligible employee or dependent was previously covered by other health insurance coverage, and the:
  - a. Employee's or dependent's COBRA coverage terminated;
  - b. Previous coverage was terminated as a result of loss of eligibility due to legal separation, divorce, death, termination of employment, or reduction in hours of employment;
  - c. Coverage was terminated as a result of termination of the employer contributions towards such coverage; or
  - d. The employee must request such special enrollment not later than 30 days after the coverage termination date.

### D. Denial / Termination / Nonrenewal

1. Small employer carriers do not need to offer coverage or accept application to
  - a. A small employer not physically located in an established geographic service area
  - b. An employee if the employee does not work or reside within an established geographic service area

### E. Fair Market Standards

1. Each small employer insurance company shall actively market health benefit plans coverage to eligible small employers in the state.
2. Small employer carriers must offer, and issue all plans on a guaranteed-issue basis
3. No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience,

occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in unfair marketing practices.

**F. Benefit Plans Offered**

1. A small employer carrier must file with the Office, at a minimum, the following types of plans
  - a. Standard health care plan
  - b. High deductible plan (that meets Federal guidelines)
  - c. Basic health care plan
2. The small carrier may not use any policy until the insurer has filed it with the Office and has subsequently been approved
3. Standard health benefit plan must include coverage for
  - a. Inpatient hospitalization
  - b. Outpatient services
  - c. Newborn children
  - d. Childcare supervision services
  - e. Adopted children upon placement in the residence
  - f. Mammograms
  - g. Handicapped or disabled children
  - h. Emergency and urgent care out of the geographic area
  - i. Hospice case
    - i. When appropriate and the most cost-effective method of treatment

**G. Small Employer Rating, Renewability, and Portability Act**

1. Rating factors related to age, gender, tobacco use, family composition, or geographic location may be developed by each carrier to reflect the carrier's experience
2. The factors used by insurance companies are subject to Office review and approval.

**H. Guaranteed Issue**

1. Florida law states that every small employer carrier must offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer. That elects to be covered under such a plan.
2. Option rider that provides additional, medically underwritten, benefits may be offered for an additional premium.

**I. Small Employer Access Program**

1. This plan is intended to provide small employers the option and ability to provide health care benefits to their employees through the creation of a purchasing pool
2. Eligibility to this access plan includes employees of
  - a. Employers with up to 25 employees
  - b. Municipality
  - c. County
  - d. School district
  - e. Hospital employers nursing home employers (regardless of the number of employees)

**J. Stop-Loss insurance**

1. An insurance policy issued to a small employer covers the small employer's obligation for the excess cost of medical care on an equivalent basis per employee provided under a self-insurance health benefits plan.
2. A stop-loss insurance policy is considered a health insurance policy if
  - a. it has an aggregate attachment point lower than the greater of \$2,000 multiplied by the number of employees;
  - b. 120% of expected claims; or
  - c. \$20,000.
3. Once the plan reached the aggregate attachment point, the stop-loss policy must cover 100% of all claims that exceed the aggregate attachment point.

## VII. Florida Healthy Kids Corporation

### A. Florida Healthy Kids Corporation (1990)

1. Purpose
  - a. Participation in the program is voluntarily
  - b. Uninsured children can obtain affordable health care coverage
  - c. Funds are collected at the local, state, federal, and family level
  - d. Coverage can insure services ranging from preventative care to major surgery
2. One of several providers of services for children eligible for medical assistance under Title XXI of the Social Security Act
3. Recipients of this service are school-age children with a family income below 200% of the federal poverty level, who do not qualify for Medicaid

## VIII. Requirements Related To HIV/AIDS

### A. HIV testing; AIDS exclusion clauses

1. The company must disclose its intent to test the person for HIV
2. Must obtain the person's written informed consent to administer the test
3. Informed consent must include
  - a. The purpose, potential use, and limitations of the results
4. If the applicant is to test 'POSITIVE' for the HIV infection
  - a. Results will be transmitted to a physician designated by the applicant or Department of Health
5. If the applicant is to test 'NEGATIVE,' notification will not be provided
6. Sexual orientation may not be used in the underwriting process
7. The following may not be used to establish an applicant's sexual orientation
  - a. Marital status
  - b. Living arrangements
  - c. Occupation
  - d. Gender beneficiary designation
  - e. Postal code (zip code)
  - f. Other territorial classifications
8. The company must maintain strict confidentiality regarding medical test results with respect to exposure to the HIV infection or a specific sickness or medical condition derived from such exposure [**Sec. 627.429**]

### B. Restrictions on Coverage Exclusions and Limitations

1. No health insurance policy may contain exclusions or limitation with respect to coverage for exposure to the HIV infection, except as provided in a preexisting condition clause

### C. Prohibited Cancellation for HIV or AIDS [**Sec. 627.6265, 6646**]

1. No insurance carrier shall cancel or non-renew the insured's health insurance policy because of the diagnosis or treatment of HIV or AIDS.

## IX. Plan Types

### A. Health Maintenance Organization (HMO)

1. Employer pays a fixed periodic contribution in advance for the services of participating physicians and cooperating hospitals
2. HMO provides direct medical service in return for a periodic premium (capitation payment).
3. Co-Payment is required
4. HMO Characteristics
  - a. Must provide certain basic benefits as set by State Statute
  - b. Must provide comprehensive care
  - c. Cost control through emphasis on
    - i. Preventive care
    - ii. Outpatient treatment
    - iii. Use of salaried doctors
  - d. Typically enrolled on a group basis by their employer

**B. Preferred Provider Organization (PPO)**

1. Network-based form of managed care providers
2. Provide medical care services at a reduced rate
3. Allows plan members to seek medical care and treatment both within and outside of the network
4. If a patient uses a provider within the network, the provider will get paid for the services directly from the insurer
5. A PPO provider is prohibited from “balance billing” or charging any additional amount to the patient above what the provider is paid from the carrier
6. If a patient uses an out-of-network provider, the company must also pay the provider directly for the services. However, the provider can charge the patient any difference between what is paid by the carrier and the amount the provider charges for services (Balance Billing). **[Sec. 627.6471, F.S]**
7. A policy issued must include the disclosures indicating
  - a. Limited benefits will be paid when non-participating providers are used, and
  - b. Nonparticipating providers may require you to pay more than the coinsurance or copayment amount

**C. Exclusive Provider Organization (EPO)**

1. A provider that has entered into a written agreement with a health insurance carrier to provide health care services for certain insured.
2. Services are offered through
  - a. Its own facilities of network health care professionals
  - b. Contracted other facilities, such as HMO or PPO
3. Agreement provides reasonable access to these services in the service area
4. Strict criteria are established under law
5. EPO agreements must be approved, inspected, and monitored by the Office
6. Not required to be licensed as insurance agents **[Sec. 636.202, .204, .210]**

**X. Dread Disease Policy****A. Limited risk, Critical illness**

1. Policies that provide medical expense coverage for specific kinds of illness
2. Policy benefits are typically paid as
  - a. Lump-sum
  - b. Scheduled benefits
    - i. Benefits are used to help defray medical costs associated with a specific medical diagnosis
3. The plans are sometimes known as supplemental plans.