FPSB® GLOBAL EDUCATION PROGRAM

RISK AND ESTATE PLANNING SPECIALIST

MODULE

Risk Management

FPSB

FINANCIAL PLANNING STANDARDS BOARD

Risk Management

Table of Contents

Preface

Most financial advice is about gain. Advisors help people gain financially, reach goals, achieve objectives, and live dreams. This course, however, has a different focus. Rather than being about gain, it considers the potential for loss. An important aspect of financial advice includes recognizing the possibility that things may not go as the client desires. Broadly speaking, this type of guidance is known as risk management, and in some ways, it is one of the most important aspects of financial advice.

Adequate and consistent cash flow and sufficient assets are essential elements of financial success. Think about it. While some goals do not require funding, most do require money for clients to achieve their goals and have financial freedom. As a result, financial objectives include making payments from current income, and allocating financial assets, like savings accounts and investments, for goal achievement. The underlying assumption is that cash flows will continue, and assets will remain available and, hopefully, increase.

What happens to financial goals when cash flows stop or assets are depleted or destroyed? In many cases hopes for goal achievement end, or must be modified. This is one reason why we sometimes refer to Maslow's Hierarchy of Needs in the context of financial advice (McLeod, 2014). The lower levels of Maslow's Hierarchy refer to psychological and physiological safety or security needs. The concept is, before an individual can address higher-level needs, he or she must first meet those at the foundational levels. The same concept applies to financial advice. An individual must first address financial security needs before moving to higher-level needs, such as saving for retirement. This is one reason why financial (cash-flow) management is so important.

Risk management is one of the primary financial security needs. While risk management has broad application, when we focus on individuals or businesses, it is primarily concerned with protecting against the financial impact of loss: assets (i.e., property), income, health, and life. We must also address legal liability, as it represents a potentially significant financial concern, and can result in loss of income and assets. This course will consider several risk management techniques, and appropriate application of risk transfer (i.e., insurance) will be a primary focus.

It's unusual to find a client who does not have some form of insurance. In fact, insurance (i.e., risk transfer) is usually the primary risk management tool people use. A client may have existing insurance coverage, but is it the right type of policy with the right amount of coverage? Further, if the coverage is not right, are there implications resulting from making policy changes? This course will emphasize examining insurance coverage characteristics, and how policies can be used to address an individual's risk management concerns.

Course Goal

The material in this course covers risk management and insurance. Upon completion of this course, you should have a good understanding of risk management need areas and ways to address them. You should be able to evaluate existing insurance coverage and how it addresses the client's risk management needs. Finally, you should be able to develop various strategies to protect the client's financial wellbeing through appropriate risk management.

Chapter 1:Principles of Risk Management

Learning Objectives

Upon completion of this section, students should be able to:

1-1 Identify the types of risk clients potentially face (including pure versus speculative)
1-2 Describe principles of insurance

Topics

1.1 Fundamentals
    1.1.1 Meaning and treatment of risk
    1.1.2 Basic risk management assumptions and techniques
1.2 Types of risk
    1.2.1 Pure and speculative risk
    1.2.2 Major types of pure risk
    1.2.3 Major types of speculative risk
    1.2.4 Perils and hazards
1.3 Personal risk tolerance and management
1.4 Principles of insurance
    1.4.1 Characteristics of insurance
        1.4.1.1 Requirements for an insurable risk
        1.4.1.2 The insurance contract

Introduction

As mentioned in the preface, psychologists have suggested that a fundamental need of all people is to satisfy physiological essentials. Some of the foundational areas of concern are having food, protection from the elements, and maintaining security (e.g., protection from criminals, illness, and other threats). Once basic survival and security needs are met, people feel psychologically and physiologically secure enough to focus on other areas, such as financial goals.

Similarly, the financial advice process has foundational aspects that should be addressed prior to concentrating on more advanced needs. Personal risk management is just such a foundational area that should be addressed because it helps to provide security, a safety net so to speak, so people can focus more on their long-term goals.

The reason for this is obvious when you put it in context of a client's situation. For example, let's imagine a client who has done a great job saving for retirement and other investment objectives (long-term goals), but has not adequately managed risk exposures. When an event occurs for which there is no insurance or risk management preparation in place to cover against the loss, savings and investments must be redirected to pay for the damage. The result may be complete loss of necessary money for retirement or other funding needs.

This chapter will provide an overview of risk management and insurance for individuals and business owners. Insurance is not the only risk management tool, but it is one of the major ones. As such, this chapter will introduce and discuss types of insurance, policies and characteristics. Prior to that, it will be important to understand the nature of risk and risk management terminology.

1.1 Fundamentals

1.1.1 Meaning and Treatment of Risk

Risk is the possibility of loss. It represents the uncertainty around whether a loss will occur, and perhaps when and how. People experience low-level risks daily. Is the food in the refrigerator safe to eat? Will I get to work safely and on time? Will a tree branch fall on me or will I step into a hole and twist my ankle? Many questions, all of which represent a level of risk-taking. People often also experience additional, more substantive levels of risk. Will I be harmed in a car accident? Will I outlive my retirement income? Will I become disabled and unable to maintain my current lifestyle? Will my house suffer harm or will someone break in and take my goods? Will I be the target of a lawsuit alleging misconduct or simply seeking to prove liability?

Each of the preceding is one of many significant risk events that people regularly experience. When considering whether a person will experience a loss of some kind, it's likely the better question is not "whether" but "when". Will the individual experience a loss in the near future? If a loss is likely, the person will want to act to avoid or at least minimize the related financial exposure. On the other hand, if a given loss is unlikely to happen soon, but if it were to happen, the loss potential would be financially catastrophic, the individual should not ignore that potential, and take protective action.

Life often presents difficult situations. Whether it's an illness leading to loss of work, significant damage to a home, a recreational accident, or a car crash, each can cause financial loss. Some risks of loss can be addressed without insurance, but others are best addressed by transferring the risk to an insurer. Risks may be relatively simple or complex. Regardless of the nature, risk management begins with an identification of the types of and potential exposures to risk.

1.1.2 Basic Risk Management Assumptions and Techniques

Risk management is the process of addressing concerns related to both insurable and uninsurable risks. It is the identification, analysis, and control of unacceptable risks. Identifying a client's tolerance for risk is part of the data gathering process. By asking the client insightful questions you will determine to what degree the client is comfortable with various risks. Clients aren't always consistent in their attitudes toward risk. For instance, you may find a client who is an avid mountain biker and comfortable taking physical risks, but has low risk tolerance with financial matters.

Once a risk is identified, the techniques used to manage that risk include risk avoidance, risk minimization, risk transfer and risk retention. Some risk management techniques are almost automatic. People make many small decisions in less time than it took to read this section. However, other decisions require more careful thought and deliberation.

Risk Avoidance

Risk avoidance is not doing things that expose one to risk. For example, if someone wants to avoid the risk of death due to hitting a tree while skiing at 50 kilometers per hour, they can

choose to not ski. However, risk avoidance is not always feasible. As an example, if someone wished to avoid the risk of dying in a car accident, giving up driving may not be a reasonable solution if alternative means of transportation are not available or practical.

Risk Minimization

Risk minimization or reduction is employing strategies to reduce the likelihood or the severity of loss caused by a particular risk. Skiing within your ability and wearing appropriate protective gear is an example. Wearing a seat belt while driving and ensuring the brakes work are also examples of risk minimization.

Risk Transfer

Risk transfer occurs when one individual or entity takes on the risk for the benefit of another. When buying a lift ticket at a ski resort, the ticket or receipt states that the skier assumes all risks inherent to skiing, up to and including death. This is an example of the resort transferring the risk of skiing to the skier. Buying car insurance effectively transfers the risk of damaging one's car or someone else's car or person to an insurance company. Insurance is the most common method of risk transfer.

Risk Retention

Risk retention may be intentional or unintentional. To illustrate, an individual with no life insurance might decide that the risks associated with skiing are worth it and does not take steps to avoid, minimize, or transfer the risk. It may also be the case that this same individual doesn't understand the risks of skiing and assumes them unintentionally. Likewise, individuals who drive without car insurance are retaining the property and liability risks associated with driving. More typically, people choose to retain risk when the potential for loss is unlikely or the cost of a loss is small. One of your functions as an advisor is to help clients make proactive choices about retaining risk so they do not retain a risk because they were unaware of their exposure to it. For example, clients may be unaware that insurance exists to replace a portion of their income if they become sick or injured and cannot work. Or they may believe that the odds of such an event happening are so small that protecting against it is not worth the cost. You can educate clients so they can make informed decisions.

To demonstrate how these risk management techniques can work together, let's look at two examples. If Cho does not want her daughter to go mountain climbing, because of potential injury, Cho is practicing risk avoidance. Her daughter An, however, wants to mountain climb, but would reduce potential risk by using a guide and wearing protective clothing. The risk is the same: injury to An. Cho believes that if An does not climb the mountain, she can't get hurt. An thinks that by working with an experienced guide, wearing protective clothing, and keeping fit, she will reduce the possibility and potential severity of injury (risk minimization).

An example of risk transfer would be a young couple, Aden and Jena, purchasing life insurance. In doing so they transfer their risk of not being able to provide financial support for their children to the insurer. In the event of their deaths, the couple's insurer would pay a death benefit to the children (most likely to a guardian or administrator for the children's benefit) to help cover the financial loss.

The Role of Insurance in Risk Management

Insurance is an excellent tool to use when the likelihood of loss is significant and/or when the cost of a loss is substantial and that risk can be transferred for a premium that is relatively affordable. Although insurance is a common solution for managing risk never assume that insurance is the only solution for managing risk. Risk avoidance, risk minimization, or risk retention may be appropriate for a client's unique exposure to a specific risk. Additionally, there

are other financial tools besides insurance, such as an emergency fund, that can help manage the risk of loss.

However, as a practical matter, insurance is commonly used to manage risk. One reason for this is because it is not practical or desirable for most people to avoid most risks and live a satisfying life. Living an active and satisfying life usually means taking calculated risks. Insurance is often available to protect against the resulting exposure to financial losses. Prior to insurance, an individual or family suffered individually for the losses—some people would be lucky and others would not. Insurance allows the loss to be spread across society, so the comparatively small amounts of money spent on insurance by many people reduces individual financial impact. Insurance is used to protect against many pure risks because it is relatively inexpensive compared to the potential losses against which it protects.

Rules of Risk Management

Looking up and down a street before crossing to make sure no cars are coming is risk reduction. Risk avoidance would be making the decision not to cross the street. Risk retention would be to simply cross the street, and allow events to occur naturally.

What about other risk management decisions? Are there rules to use when you are unsure how to proceed? The following rules provide some guidance:

1. Consider the odds
2. Don’t risk a lot for a little
3. Don’t risk more than you can afford to lose

When considering the odds, a person understands that when a financial loss is very likely, insuring such a risk may not make sense. Why? The way insurance usually operates, insurers base premiums, in large measure, on the likelihood of a loss occurring. This means that a high-probability risk will cost quite a bit—perhaps as much as the financial loss—to insure.

A person who does not want to risk a lot for a little would compare the cost of insuring against a possible loss with the potential amount of financial loss. As an example, a person who decides not to insure against a catastrophic loss to his or her home would be risking a lot (loss of the home) for a little (the insurance premium). This could also be a reasonable example of not risking more than you can afford to lose.

1.2 Types of Risk

1.2.1 Pure and Speculative Risk

A speculative risk has the potential for either a gain or a loss. Gambling is an example of speculative risk. As opposed to speculative risk, pure risk only allows for either a loss or no loss. No insurance will cover speculative risk, while coverage is often available for pure risks. As such, we will be addressing various forms of pure risk as it applies to risk management.

Perils and Hazards

Losses (i.e., risks) are caused by perils. Perils such as hail and fire can cause property damage and cancer can lead to disability or death. Perils may be specifically named in an insurance policy to identify what is covered as well as what is not covered.

The term *hazard* is used to describe those things that increase the chance of loss by a peril. Physical hazards could be snow-packed roads, driving while impaired, or other conditions that increase the chance for loss. *Moral hazards* have to do with character flaws in an individual that increase the frequency or severity of a loss. Examples include faking injuries to collect an insurance claim or committing murder in order to collect the life insurance benefits. *Morale hazards* are similar to moral hazards, but have to do with carelessness or indifference to loss. An example would be not locking your car and leaving the keys in it because it's insured.

1.2.2 Major types of Pure Risk

Loss of Income

Losing your income is one of the most common personal financial risks, and losing a job is not the only way to lose income. Sickness, injury, or even death can all cause loss of income (with death producing financial concerns for dependents).

Death and Disability

The death of a wage earner, in addition to causing emotional difficulties, can produce serious financial harm for dependents. Most people count on an ongoing income stream as the funding source for many financial necessities and goals. Death terminates at least some of that income stream, and can create significant financial difficulties as a result.

A disability occurs when sickness or an injury is serious enough that it prevents the individual from being able to work. Thankfully, insurance—either from the government, employer or purchased privately—can help cover at least some of the financial loss. Even a short-term disability can cause financial distress, while long-term disabilities can cause serious lifestyle disruptions.

Catastrophic Losses

Everyone faces the potential of experiencing a catastrophic financial event. Medical expenses have the potential to become financially catastrophic, beyond critical care needs that may cause financial distress. Lengthy recovery or long-term care situations also can strain financial resources.

Natural catastrophes such as floods, earthquakes, fire, volcanic eruptions, and others can destroy property. Thieves can break in and steal. Vandals can destroy. Losses can quickly add up. A risk management plan helps to keep these events from becoming financial catastrophes.

Negligence or recklessness can cause harm to another person, along with liability for the individual who caused the resulting loss. Sometimes, the damages can be significant and require great financial resources to cover. Without adequate insurance, a person can deplete his or her assets completely if a legal judgment is large enough.

Insurance can be a valuable risk management tool. However, few, if any, people have the financial wherewithal to insure against every possibility of financial loss, nor is this a wise risk management approach. As a result, people need to carefully contemplate each insurance purchase. Individuals should cover potential large losses first. Then, if additional funds are available, they should consider other options. Small losses may be upsetting but often do not cause significant financial harm. Large losses, on the other hand, can be financially devastating.

1.2.3 Major Types of Speculative Risk

1.3 Personal Risk Tolerance and Management

Assess Exposure to Financial Risk

Due to the complexity of the risk management process and potential severity of the consequences, it is important for advisors to develop a focused and well-organized process for consistently assessing and addressing risk management issues. The use of a set process and clearly defined methodology reduces the likelihood of being sidetracked or missing important potential risks that may exist in a client’s situation.

In the data gathering step you will identify potential risks the client faces. In your analysis, you will evaluate various options for addressing these risks and present your recommendations to the client. If you sell insurance products, you may personally help implement the product solutions that will aid the client with managing risk. If you are not able to sell insurance, you can monitor the implementation that takes place through a third party. You are a vital part of the process of assessing your clients’ exposure to risk.

Many risks can be managed with the risk management techniques described above. As previously mentioned, some individuals have a higher tolerance for risk-taking and retention than others. Avoiding risky activities or taking precautions to minimize the financial impact of potential losses will help clients reduce the likelihood of suffering significant financial loss. Purchasing appropriate insurance products to transfer the risk to an insurance company allows clients to exchange a known premium that is relatively much smaller than the potential for a

financially devastating loss. Clients may also choose to retain some risks and the financial consequences as a means of managing risk.

The risk management process can be shown in six steps:

1. Identify risk management goals
2. Collect information to identify risk exposures facing the client
3. Analyze and evaluate the information
4. Construct a risk management strategy (i.e., determine appropriate risk treatment methods)
5. Implement the recommendations
6. Monitor the recommendations for any needed changes

Let's look at the steps a little more closely.

Identify Risk Management Goals

First, learn what the client wants from his or her risk management program. Then, define the objectives, often using a formalized risk management policy. This can provide guidance for the advisor and the client as part of evaluating recommendations (similar to an investment policy statement [IPS]). Evaluate all the client's risk exposures and provide guidance in meeting the resulting risk management goals.

Collect Information to Identify Risk Exposures Facing the Client

In an overall risk management program, relevant information includes just about everything you can learn about the client. Potential sources of information include policy checklists, legal documents, risk analysis questionnaires, and financial statements. This information is necessary because all the client's assets and activities are potential sources of risk exposure, and an advisor needs to know the risks a client faces to determine if those risks are adequately covered. Reviewing existing insurance policies allows the advisor to analyze the coverage to see if it is appropriate. You will also want to view tax returns, investment statements, wills, and trust documents.

Analyze and Evaluate the Information

The advisor should evaluate each of the client's assets and activities to look for risk exposures, of which there are three basic types.

1. *Asset-related*; that is, loss of the asset itself, loss of use of the asset, and other associated losses
2. *Liability-related*; based on *contract law* associated with the asset or activity (e.g., acquisition of an asset resulting in liability to a lender, a club membership contract putting certain responsibilities on the client, etc.).
3. *Liability-related;* based on *tort law* (i.e., liability for a loss resulting from the use of an asset or from an activity—a boating accident, practicing one's profession, etc.).

Construct a Risk Management Strategy

After analysis and evaluation, the advisor can develop risk treatment approaches for risk exposures and select appropriate alternatives. When the advisor and client accept appropriate approaches, they should be incorporated into the risk management strategy.

Implement the Recommendations

Implementing recommendations may require restructuring existing insurance policies and risk management plans. It may also mean purchasing new insurance policies. Although the client must ultimately decide whether he or she will implement the strategy you present, you will probably need to help guide the implementation process by recommending action steps.

Monitor the Recommendations for Needed Changes

Monitor recommendations because things change over time. The client's situation will change, as will various options for meeting client needs. By reviewing and updating recommendations, you gain the opportunity to identify new or previously-missed risk exposures, obtain missing information, and modify any previous actions.

As you continue to gather data from the client, it is likely that you will uncover risks that require the client to act. When you share your findings with the client, you will learn how important addressing these risks are to the client. You may also find that the client is unaware of the potential for loss and the extent of the potential financial cost that would result. Property (including liability) and life are two primary risk areas.

Property & Liability

Many clients who do not have adequate liability coverage are exposed to the potentially devastating loss of their savings and investments in addition to having their wages garnished. Clients also may not have their home adequately insured either for the proper value or against potential perils. For example, a client with a home in an earthquake prone area may not have earth movement coverage on the homeowner's insurance policy. Similarly, clients who live in coastal areas should be protected against potential flood and losses from wind damage.

Another often overlooked risk is the potential for loss of high-valued personal property. Jewelry, collectibles, and other such property that may be frequently targeted by thieves should be properly protected. While using security measures like alarm systems and video surveillance is an option to minimize this risk, insurance can also be purchased to transfer this risk.

Life

You probably will meet with clients who do not fully understand the potential financial loss that would result if they die prematurely. The financial difficulties that surviving family members will suffer because of not adequately addressing this risk can cause the loss of the family home and a drastic change in lifestyle.

Insurance, as we have learned, is one of the main risk management tools. In the context of risk management terms, purchasing insurance is risk transfer. In some ways, insurance is simple – pay a premium and transfer the risk of loss to the insurer. However, as you begin to explore insurance more closely, you find it can be a complex financial instrument capable of addressing many risk management needs.

1.4 Principles of Insurance

1.4.1 Characteristics of insurance

Underwriting

Ocean marine insurance first emerged as a precursor to its current form during the 17th century (i.e., 1600s) in England. To take advantage of this insurance coverage, a ship owner would make a list identifying the ship, where it was headed, the cargo, and any additional relevant information. Those who wanted to participate would write their names under the portion of the cargo (or risk) they were willing to accept. They would also include any conditions that might apply to their acceptance of the risk. This process—writing one's name under a given risk—was called underwriting. In today's world, an insurance underwriter essentially does the same thing: he or she determines risks that are acceptable to the insurer, and any related conditions for accepting that risk.

The process of underwriting, then, determines whether a risk is reasonable to accept, at what price, and with what conditions. Applications for insurance coverage are sent to the insurer for underwriting. Upon acceptance of a risk, the insurer issues a policy and completes the underwriting process.

Insurance companies do not accept all risks. In fact, it would be foolish for them to do so. The potential costs for certain risks are greater than the insurer's ability to absorb, regardless of the premium charged. Insurance companies are in business to make a profit. The chosen field is insurance, but the object—or at least one object—is making money. To be profitable, insurers must be selective about risks they are willing to assume.

In some situations it may be possible to insure things that would seem to be uninsurable. When a concert pianist wants to insure her hands, or a singer his voice, where can they turn? While it is true that they almost certainly will not be able to purchase true insurance to cover their hands or voice, they do have an option. This type of protection may be available through Lloyd's of London or similar associations. Lloyd's associations have individuals and firms evaluating each specific risk to determine a premium based on the estimated potential for loss. Normal requirements for an insurer to accept a risk do not necessarily apply; however, most of these associations, and all insurers, do follow certain requirements when assessing acceptable risks.

1.4.1.1 Requirements for an Insurable Risk

Insurers consider four factors before accepting a risk:

1. The law of large numbers must apply
2. The loss must be by chance (i.e., accidental or fortuitous)
3. The loss must be measurable and able to be defined
4. The loss must not be financially catastrophic

A catastrophic loss to an insurer is not the same as a catastrophic loss to an individual. Loss of a house might be financially catastrophic to a family. However, loss of one house would not make much financial difference to an insurer. On the other hand, the loss of 10,000 houses

could definitely be financially catastrophic for an insurer, to the extent that the company might no longer be viable as a business.

This is one of the reasons why it may not be possible to purchase insurance to cover a certain peril. If a business owner wants purchase coverage against robbery in a high-crime area, he or she may be turned down; that, or the coverage premium may be so high as to be prohibitive. The insurer is effectively telling the business owner that the odds of a robbery are so high that the remuneration cost would be too high. As a result, the insurer might choose to cover the peril, but charge an exorbitant premium. More likely, the insurer will determine not to extend coverage.

Law of Large Numbers

The law of large numbers is a foundational insurance principle. The idea is that with enough similar (i.e., homogeneous) risks or exposure units, potential losses for the entire group become somewhat predictable. No one may be able to accurately predict when one house might burn down. However, an insurer that covers 20,000 houses against loss by fire has the statistical information to determine with reasonable accuracy the potential number of homes in that group that may catch fire in a given period.

This knowledge can be applied to assessing anticipated financial losses. The insurer then uses the loss potential as a base for determining appropriate premiums to charge for coverage. The procedure is a bit more involved than this, but that's the basic process for an insurer to determine premiums (along with administrative expenses, and such). Underwriting will also look at home construction quality, location, and claims history for a given area, among other factors.

To accurately determine premiums, an insurer must have enough information to measure potential financial losses. Circumstances surrounding a loss cannot be nebulous; it must be clear a measurable loss actually occurred. These two factors help insurers to remain solvent. While it is tempting to think that we don't really care about an insurer's financial well-being, an individual with insurance wants the insurer to remain viable long enough to pay any claims that may be filed. To do this, the insurer must abide by the preceding insurable risk requirements.

After underwriting completes its work and accepts a risk, the insurer will issue an insurance policy. The policy is a legal contract with specific conditions to be observed.

Structure of Insurance Policies

An insurance policy is an agreement (generally a standard form contract) between the insurer and the policyowner, which determines the claims the insurer is legally required to pay. In exchange for an initial payment, known as the premium or consideration, the insurer promises to pay for losses caused by perils covered under the policy.

Insurance policies are called contracts of adhesion because the insurer has the power to draft the contract (therefore, the insurer is "stuck" with and must abide by contract terms), while the potential policyholder only has the right of refusal and he/she cannot counter the offer, or create a new contract for the insurer to agree to. As a result, it is important that insureds read the contract carefully as all the information and rules have been written by the other party. Related to the concept of adhesion, contracts are unilateral. This means only one party is legally bound to do anything (in most jurisdictions). The insurer is bound by the contract terms, but the insured

is not equally bound by any promise or agreement (other than abiding by the contract terms to continue coverage).

1.4.1.2 The Insurance Contract

Even though a contract in one territory may differ from one in another jurisdiction, to be considered valid, all contracts must satisfy certain legal requirements within a given territory. A legally valid contract must:

1. Pertain to a legal activity
2. Be valid in its given jurisdiction
3. Be between legal parties (i.e., those able to enter into a contract)
4. Have an offer and acceptance, and
5. Provide for some consideration (i.e., payment or performance)

Additionally, there are generally four key insurance concepts that apply to insurance law that affect the operation of the insurance policy:

1. Insurable interest
2. Indemnity
3. Utmost good faith, and
4. Subrogation

Insurable Interest

Insurance contracts require that some insurable interest exists. An insurable interest is the legal or equitable interest that is held by the insured in insured property or a life. In economic terms, it applies where an insured has suffered a monetary or economic loss through the damage or destruction of the subject matter of the insurance. A monetary loss exists if a person is liable to pay or lose money in the event of a loss, i.e., it can be measured in economic terms. For example, in the case of a creditor who insures property owned by a debtor, the insured will not have either a legal or an equitable interest in the property insured, but would stand to suffer a monetary or economic loss if the asset was damaged or destroyed. By applying the same principle, an employer will have an insurable interest in the life of a key employee should that person die or suffer a permanent incapacity. The employer will have an economic loss associated with the cost of replacing and training a replacement.

In common law, the insured must have an insurable interest both when entering a contract of general insurance and at the time of a loss. In some jurisdictions common law has been modified by consumer legislation so that having an insurable interest in the property when entering the contract is no longer required.

Change of Insurable Interest

In some jurisdiction’s insurers require notification if the nature of the insured’s interest changes. However, if the policy does not contain a notification clause, then the policy will remain valid without notification. However, the insured will need to advise the insurer of relevant changes on the renewal of the policy as renewal usually constitutes the creation of a new contract and the disclosure requirements will apply. This means that all material facts that have arisen from the

inception date of the contract to the date of renewal must be disclosed before the policy is renewed.

Principle of Indemnity

Under most circumstances, insurance policies are designed to make the policyowner *whole*. That is, the insured will be restored to the condition he or she was in prior to the loss. However, the insurer will not generally provide enough payment to put the insured in a better financial position than he or she previously held. To indemnify, then, is to be made whole, but not better than whole. The principle of indemnity allows an insured to purchase insurance to protect against loss to the extent of their insurable interest. Under the principle of indemnity, an insured is not able to claim more than their loss. For example, if the owner of a house insured the house for $400,000 against fire and the house was subsequently destroyed by fire, the insured would only be able to recover $400,000, even if the property is actually worth $500,000. If the insured was able to recover $500,000 and so make a profit out of insurance, this would constitute a wager (i.e., speculation), which would be against the true nature of insurance.

In some jurisdictions, it's possible to insure a property for its current replacement value. Since the value of the insured property is calculated at the time of the loss when determining the amount to be recovered, the amount may be less than the replacement value of the property unless regular adjustments are made to the policy addressing the effects of inflation. In addition, the policy conditions may state that underinsurance may result in the policy reverting to an indemnity policy (rather than a replacement policy), which may result in a severe financial loss for the insured.

The principle of indemnity does not apply to life insurance policies, because they are classified as 'contingent' insurance, i.e. a claim arising on the occurrence of contingency of say, death. In addition, indemnity does not apply to valued policies. With these policies, the insurer and insured agree in advance on the value of the insured property (almost always requiring an appraisal), so that in the event of loss or damage this amount will be paid to an insured regardless of the actual value of the property at the time of the loss. For example, if a solid gold pendent is valued at $2,000, and insured for this amount two years ago and was subsequently stolen, the current value of the item could be as high as $3,000 because of the substantial appreciation in the value of gold over the two years. However, the insurance would only pay the agreed value of $2,000. Furthermore, the insurer would still pay $2,000 even if the value of the item actually declined to $1,000.

The Doctrine of Utmost Good Faith

The doctrine of utmost good faith (Latin: *uberrimae fidae)* is an important concept in insurance law, as it applies to potential insureds, current insureds and insurers, and is linked to the duty of disclosure. Utmost good faith refers to the highest degree of honesty and sincerity. The most common indicator of the duty of good faith is in the pre-contractual duty to disclose. It goes without saying that the insured has the greatest knowledge about the risk being proposed to the insurer so the insured should be required to disclose all those facts that might influence the underwriter as to whether to accept the risk, or to do so with altered terms.

There is also a post-contractual duty that continues throughout the policy period. This duty generally arises in relation to claims, either in the way the insured made the claim or in the way the insurer handled the claim. An insurer would not be considered to have acted with due regard

to the insured's interests if the insurer consciously delayed paying a valid claim, speculating that the insured would not contest the delay and give up pursuing the matter.

In some jurisdictions, simple mistakes are not taken to be a breach of the duty of good faith. "Good faith" implies intention. Neither fraudulent claims nor an insurer's delay tactics, as noted above, represent "good faith".

Duty of Disclosure

In common law, each party to the contract is under a duty to voluntarily disclose relevant information to the other during the negotiations leading up to the creation of the contract. The matters that need to be disclosed are any facts the parties are aware of that might be material to the negotiation. A failure to disclose any material fact allows the innocent party to void the contract from the beginning.

The duty of disclosure is important to insurers because the insurer needs accurate information about the risk being proposed to calculate an appropriate premium and apply suitable conditions. This duty falls heavily on the insured because he/she knows all the facts of the risk. Therefore, if one partner signed a proposal for insurance and the other partners were not involved in the negotiations but were aware of facts that would have influenced the insurer's decision to accept the proposed risk, the non-disclosure of these facts will likely allow the insurer to void the policy.

Non-disclosure can be potentially hard on insureds, because of such things as poorly drafted questions from the insurer. These (and similar) can cause real difficulties in disclosing all relevant information. As a result, some jurisdictions have modified common law to require insurers to specifically ask the questions for which they require information, because insurers know better than insureds the information they require.

For general insurance contracts, the duty of disclosure is required when completing a proposal and again on the renewal of the contract. At renewal time, a new contract is crafted so all matters that may have arisen since the commencement of the original contract must be disclosed. This could involve such matters as a drunk driving offence, criminal conviction or as simple as the installation of smoke alarms. In contrast, the duty of disclosure with life insurance only applies during the pre-contractual period, because these policies are issued on a continuing basis and are not subject to the same type of renewal. In some jurisdictions, non-disclosure during the formation of a life insurance contract may only give the insurer the right to void the policy for a limited period, such as two or three years. After the expiration of the two or three years the results of the non-disclosure will not have any effect on future claims.

Material facts may include:

- The name and occupation of the applicant. Occupation may be material particularly where the occupation is hazardous.
- The health status of the applicant. Major illnesses and operations are important especially with life insurance and income protection or personal healthcare insurance.

- Insurance and loss history of the applicant, including previous claims and whether the applicant has been refused insurance or had insurance cancelled.
- Criminal convictions (even if not directly related to the risk under consideration). Criminal convictions generally indicate that a convicted person poses an increase in moral hazard. However, in some jurisdictions, criminal convictions become irrelevant after a period, such as 10 years.
- Matters that indicate an increase in risk for the insurer, such as the storage of flammable liquids on the premises and the type of material used in the construction of the building.

Subrogation

Subrogation is related to the principle of indemnity. You might see a technical definition stating that an insurer will sue the individual who caused covered harm to an insured after it has settled the insured's claim. The insurance company may sue that individual to recover amounts paid to the insured to cover the loss. To some degree, this is an extension of indemnity, because the insurance company is ensuring overall payment does not exceed the claimed loss.

Consideration. A promise from one person to do something or provide a service for another person identifies another contractual component. A simple contract may involve one person agreeing to clean another person's house for a certain sum of money. While quite simple, the transaction is still considered to be contractual. Of course, many contracts are more involved and complex. No matter how simple or complex, a valid contract includes an offer by one party and acceptance by another.

A contract's consideration is simply the amount to be paid for the goods or services involved, or some performance that applies.

Suppose that Saura, a contractor, is willing to help her neighbor, Kadar, find respected suppliers for a remodeling project, in exchange for him agreeing to watch her home while she is on holiday. Here, the consideration for the home watching is information about suppliers, and the consideration for the information is the home watching. Contracts do not always require financial remuneration, but they do require some form of consideration.

With an insurance contract, the insurer makes an offer to provide coverage for a given price (premium). The applicant agrees to coverage terms and pays the required premium (offer and acceptance).

Claims

Claims payment and loss handling is the 'litmus test' of the value of insurance; it is the actual "product" paid for. The procedure for making a claim usually starts with the insured notifying the insurance company, broker or their agent and completing the company's claim form. In some jurisdictions, small claims for damage to a home or contents can be made over the telephone or online without submitting a claim form.

Insurance policies generally require the insured to notify the insurer of a loss within a specified time, such as 'immediately', 'promptly', or within a certain number of days. The notice of loss allows the insurer to begin investigating the insured's loss and to begin proceedings to reduce

their potential loss, such as bringing litigation against negligent parties or arranging salvage. For life claims, doctors' reports, death certificates, etc. need to be obtained before the company will admit liability.

Under common law, insurers have sometimes used the claims notification clause to deny otherwise legitimate claims, thus causing considerable financial distress for their clients. In some jurisdictions insurance law prevents insurers from relying on such clauses, but will allow insurers to reduce the amount of the claim by the amount of the damage they may have suffered, which will generally be the amount of extra costs the insurer has incurred because of the delay.

In addition to the notice of loss clauses, most policies contain further clauses requiring insureds to provide 'satisfactory' proof of their loss. The 'proof of loss' clause may be a conditional requirement for the insured to recover under the policy. Insureds can comply with this requirement by producing valuation certificates or receipts of purchase, wage statements and the like. The insured is also required to show that the loss falls within the terms of the policy. If an insurer does not want to pay the claim, it must prove that the loss is not covered because of an exclusion in the policy.

Proximate Cause

Frequently a chain of events or causes rather than a single cause, leads to a loss. It is necessary to examine this chain to determine the proximate (or immediate) cause and whether it is excluded from cover or not. If an insured peril directly gives rise to the loss, then it will be covered, provided there was no uncovered peril that effectively interrupted the chain of events.

On the other hand, the final loss need not be the direct result of an insured peril, provided the cause of loss was proximately initiated by an insured peril. For example, fire policies generally make no mention of water or smoke damage, but provided that the cause of the fire is not an uncovered peril, all losses resulting from water or smoke following the intervention of the fire services are deemed to be fire damage.

The perils that must be considered can be classified under three headings:

1. ***Insured Perils:*** those named in the policy as insured
2. ***Excepted or Uncovered Perils***: those named in the policy as excluded, either as causes of insured perils or as results or consequences of insured perils
3. ***Other Perils:*** those that are not mentioned at all in the policy but may form part of the chain of events leading to the loss

Once the insured has proven that the cause of loss is covered by the policy, the onus is on the insurer to prove a breach of the policy by the insured. If the insurer has claimed that a breach has occurred, then the onus is on the insured to prove that an act or omission that breaches the warranty or another term of the contract does not cause or contribute to the loss, whether wholly or partially.

Contract Terms and Sections

- ***Aleatory:*** The outcome depends on chance and the financial participation between parties are substantially unequal. Consider that after the insured pays one relatively small premium

for a life insurance policy, the insurer is required to pay a large claim on the death of the insured.

- ***Adhesion:*** The insurer is required to abide by the terms of its contracts. In other words, because the company wrote the contract, it must honor its terms.
- ***Unilateral:*** Only the insurance company can legally be required to honor contractual terms. The insured must abide by any conditions in the contract if he or she wants the policy to pay, but the insurer cannot require insureds to maintain a policy against their will. On the other hand, the insurer is legally bound to abide by policy terms for coverage.
- ***Conditional:*** As previously mentioned, insurance contracts include conditions that must be followed for the policy to pay. For example, an insured may be required to provide an inventory of household items for the insurer to pay a claim for damage to that property.

Insurance Policy Sections

Insurance policies usually contain the same sections.

- ***Duty of Disclosure:*** a statement reminding potential insureds about their obligations to disclose all the information asked for in the proposal form; why honest answers are important in assessing the application and the consequences of making a false declaration
- ***Declarations:*** statements made by the policyowner, often supplied on the application for coverage. This is known as the 'basis clause' and has been discontinued in some jurisdictions
- ***Insuring Agreement:*** what is being insured and the conditions of coverage.
- ***Conditions:*** the process or procedures (or rules) that must be followed for the insurer to be required to pay a claim
- ***Exclusions:*** any related items or instances that will not be covered by the policy

The policy conditions are important and insurance contracts almost always include conditions that must be met for the policy to pay. That is, conditions impose an *obligation* on the policyholder to comply with these requirements. This goes beyond the requirement to pay premiums. As an example, a policyowner may be required to file a claim form within a set period following an insured event, or to take reasonable precautions to protect the insured property. Therefore, if the policyowner does not file a claim form within the required time limits, or the insured leaves the keys in the ignition and the car unlocked while unattended, the insurance company may not pay the claim (e.g., filing a claim months or years after an event might invalidate the claim). Often, insurance companies require evidence of insurable interest. Other conditions usually apply as well, making insurance policies *conditional* contracts.

Insurance policies may also include items known as riders or endorsements. These serve to modify policy coverage or terms and conditions. *Rider* and *endorsement* essentially describe the same thing. Some policies use the term rider, while others use endorsement. Sometimes insurers initiate endorsements. These often make contractual changes to limit coverage or add requirements for continued coverage. Other times the insurer will voluntarily increase coverage or add some other policy benefit. This also would be accomplished through an endorsement. At still other times, the policyowner may wish to add or otherwise modify coverage. As an example, a policyowner may wish to add a family insurance rider to a life insurance policy. This request

would be made in writing, and, if accepted, the policy would be endorsed with the additional coverage.

Exclusion Clauses

Exclusion or exception clauses are important in insurance policies because they define the boundaries (extent of cover) that will apply. Some exclusions are common to most insurance policies, e.g. those excluding cover for claims arising from such events as ‘war, riots, civil commotion and radiation’. Other exclusion clauses will relate specifically to the type of cover provided by the policy.

In some jurisdictions, insurance legislation prevents insurers from relying on an exclusion relating to a pre-existing defect or imperfection in the insured property or a pre-existing illness or disability of the insured, if the insured was not aware of this when the contract was entered into. In addition, if an exclusion clause states that the insurer will not be liable for some act or omission of the insured or third party, the insurer will not be able to refuse to pay a claim if the specific act or omission does not cause or contribute to the loss. For example, cars are expected to be maintained in a roadworthy condition, but if an insured was stopped at a traffic light and was hit in the rear by another vehicle, the insurer will be prevented from denying a claim because the insured vehicle had bald tires. However, if the same vehicle slid off a wet road during a rain storm and suffered damage because of the bald tires then the insurer would be able to rely on the exclusion.

Fraudulent Claims

Insurance fraud is a major problem for insurers. In the insurance industry, the term ‘insurance fraud’ is most often associated with some form of manipulation of an insurance claim. In some cases, this may involve fabricating the entire claim, including deliberately causing damage to the insured property. Unfortunately, the cost of fraudulent claims must be covered so this ultimately results in a cost increase on all insurance premiums.

Loss by Own Act

The basic purpose of insurance is to indemnify insureds for losses caused by fortuitous and unexpected events. Indeed, the very principle of the pooling of losses, the ability of losses to be calculable and the ability of an insurer to strike an economically viable premium relies on the fortuitous presumption.

If an insured causes a loss with the intention of making a claim, then they will be denied the right to recover. For example, if an insured deliberately sets fire to their house to recover from their insurance policy, such a claim will be fraudulent and will not be admissible under the policy.

In some jurisdictions where a policy is issued over jointly owned property, arson by one policyholder does not prevent recovery on the joint policy by an innocent co-insured policyholder for the latter’s share of the joint property. Unfortunately, this does not apply in all jurisdictions so in the instance of an aggrieved spouse burning down the jointly owned property, the innocent co-insured spouse will be denied compensation under the jointly owned policy.

Measurement of the Loss

The principle of indemnity requires the insurer to fully compensate the insured for the loss up to the maximum sum insured during the currency of the policy. This restricts the insurer's maximum liability even if the value of the property or reinstatement costs are greater than the sum insured. The objective is to put the insured back in the position they occupied before the loss occurred. It is not intended that the insured make a profit from the loss. Establishing the actual amount of the loss is the cause of a large number of disputes between insurers and their insureds.

Where the insured suffers a total loss of property or goods, the measurement of the loss will be the market value of the property or goods at the time of the loss. For example, assume a house listed for sale for $300,000 is destroyed by a wind storm. The current value of the house would be the sale price less the value of the land (land is not covered by insurance), assuming the sale price was not overinflated.

In the case of a life policy, the policy face amount or death benefit determines the amount payable under the policy. However, with accident policies the economic loss sustained by the insured is calculated by referring to lost income, medical bills, set amounts detailed in the policy for specified injuries or sicknesses and, in the case of residual injuries, the levels of damages awarded by the courts.

For liability policies, the amount that an insured can recover is the amount of their liability to the third party, but restricted to the limit of liability specified in the policy.

Valued policies, as mention above, are an exception to the principle of indemnity, which allows the insured to claim the sum insured regardless of the actual value of the property at the time of the loss. In most cases, the calculation of agreed value will be based on the value declared by the insured in the contract proposal. This declaration often leads to disputes when cars are insured, and in common law, a breach of a warranty of value will allow an insurer to void the policy if the value is inaccurate at the time. However, in some jurisdictions insurance law prevents insurers from voiding a policy based on a misstatement of value. In these cases insurers are allowed to reduce the amount of the claim by the amount they have been harmed. For example, if a car is purchased for $25,000 and insured for $30,000 an insurer would be required to only pay $25,000 and be prevented from voiding the policy.

Underinsurance

Insurance premiums are based on the belief that insureds will insure for the full value of their property. Therefore, if the property was insured for less than its value (underinsurance) then an insurer is receiving insufficient premium income to maintain the viability of their insurance pool. To overcome this problem most policies contain an 'average' or 'coinsurance' clause to protect insurers from the economic effects of underinsurance.

Under a coinsurance clause, only those insureds whose property has been totally destroyed will be covered for the property's insured value. Where an insured has underinsured the property and the loss is partial, the insured bears a pro-rata proportion of any loss, which is calculated as follows:

$$\frac{Amount\ of\ insurance}{Amount\ of\ insurance\ required} \times Amount\ of\ loss - Deductible$$

For example, if a house that is worth $400,000 (also the required amount of insurance) is only insured for $200,000 and the property suffers damage of $100,000, assuming no deductible, the insured will only be paid $50,000 by their insurer.

$$\frac{\$200{,}000}{\$400{,}000} \times \$100{,}000 = .50 \times \$100{,}000 = \$50{,}000$$

In some jurisdictions, insurance law recognizes that it is difficult to precisely determine the true value of a household property, particularly as inflation and rising property values can lead to underinsurance. Remember, this value will be determined at the time of the loss and not when the insurance was taken out. In these jurisdictions insurers are restricted from applying the average clause to homes and contents unless the sum insured is below a specified amount, such as 80 percent or more of the value. When this is the case, the insured's claim payment will be reduced because of the underinsurance. As an example, assume a house valued at $300,000 is insured only for $200,000 (67 percent of value). If the house suffered damage of $120,000, the claim payment would be based on the 80 percent ($240,000) *coinsurance* requirement for coverage. $200,000 divided by $240,000 is .83. Multiply .83 by the $120,000 loss, and the insurer will pay $100,000, because of the underinsurance amount. This is also known as the coinsurance penalty.

In this chapter we saw an overview of risk and some ways to address it, especially risk transfer or insurance. We will look more closely at insurance products and types in Chapter 3. Next, we will explore some of the risk exposures people face.

Example 1

Question Stem		Which of the following is least likely a technique used to manage risk?
	a	Risk minimization
	b	Risk transfer
	c	Risk affectation
	d	Risk retention
Correct Answer		**c**

Explanation		Risk affectation is not a technique to manage risk. Risk Avoidance is the 4th techqnique.
Distractor #1	**a**	Risk minimization is a technique used to manage risk
Distractor #2	**b**	Risk transfer is a technique used to manage risk
Distractor #3	**d**	Risk retention is a technique used to manage risk

Chapter Review

Discussion Questions

1. As you consider the four basic risk management techniques (avoidance, minimization, transfer and retention), how do they compare and practical or applicable is each as a risk management tool?

2. The risk management rule – consider the odds – may be a little confusing. How would you explain it and why does it (or does it not) make sense?

3. Why do insurers not accept all types of risk and what is the function of underwriting in making this decision?

4. How does the law of large numbers enter into an insurer's coverage decisions?

5. How does the principle of indemnity relate to an individual's risk management plan?

6. Why would you say the insurer is the only party to an insurance contract that is required to abide by and fulfil contract terms?

7. If a person is underinsured he or she may not receive full payment for a claim. Why is this true and is this a fair policy?

Review Questions

1. What are the four primary risk management techniques?

2. What are the three rules of risk management?

3. How would you define risk, peril and hazard?

4. What is underwriting and how does it relate to insurance?

5. What are the requirements for an insurable risk?

6. How does a loss that would be catastrophic for an individual differ from one that is

catastrophic to an insurer?

7. How would you describe insurable interest?
8. What is the principle of indemnity and how does it apply to insurance?
9. What is subrogation and how does it relate to insurance?
10. What are riders and endorsements and how do they differ?
11. Why is underinsurance a problem for insurers, and what is one method they use to compensate?

Chapter 2: Risk Exposures

Learning Outcomes

Upon completion of this chapter, the student will be able to:

2-1 Evaluate a client's personal and general insurance exposures
2-2 Evaluate a client's risk management needs

Topics

2.1 Financial obligations: existing and potential
2.2 Analysis and evaluation of risk exposures

Introduction

As we have seen, people face risks of various types daily. Even eating, going to work, traveling, and crossing the street present the individual with potential risk of loss. Some risks have little long-lasting effect. Others can have a major impact on the individual's life. Of those risks that can have a major impact, those with financial implications are of greatest interest to financial advisors. This category includes lifestyle and health issues, loss to a house, car or other personal property. It also involves liability exposures, some of which do not require any action on the part of the individual to become an issue (e.g., a tree on the property falls onto a neighbor's house). Risk of loss can even extend to loss of life. It is possible to mitigate some risk exposures, especially those that generally do not have a significant impact, by making lifestyle changes. However, many of the more substantive risks require more substantive measures, including the use of insurance to transfer the financial impact to a third party. We will explore many of these risk exposures in this chapter.

2.1 Financial Obligations: Existing and Potential

A person should consider how much financial loss he or she reasonably can sustain. Another way of saying this is to calculate the amount of financial damage a person is capable of incurring, or is willing to incur. When the potential loss gets too high, the rule, "Don't risk more than you can afford to lose" becomes applicable. Any loss that has too high a financial cost is a candidate for risk transfer (i.e., insurance).

Types of Risk and Potential Impact

Some of the risks of which advisors should be aware include:

- Risk of premature death
- Longevity risk (outliving your retirement money)
- Health risk (declining health, including making one uninsurable or requiring a substandard insurance rating)
- Risk of unemployment
- Risk of disability

- Property risks—direct and indirect
- Liability risks

A common thread through these risks is that each holds the potential to be financially devastating to your clients. A premature death or extended period of disability with the accompanying healthcare costs could force clients to drastically change their lifestyle for the worse. Clients could have a lifetime of savings wiped out because of a liability claim for which they are found to be responsible. While some property losses could be minor, the loss of the family home would be devastating.

Lifestyle issues cover a wide array of potential risks. These can range from certain hobbies and habits, alcohol or drug abuse, nutritional issues and eating disorders, and many additional areas. Some of these, like recreational hobbies such as mountain climbing, SCUBA diving, or race-car driving can be positive and enjoyable, but also present potential risks for liability, loss of income due to injury and the like. Others, including alcohol or drug abuse, create risks by their very nature. For our purposes, it is important to identify that a person's life choices can have an impact – sometimes a large impact – on risk management. Consider mountain climbing as we viewed previously. It can be enjoyable to be outdoors in the mountains, but natural hazards, slips and falls can create losses for climbers. Weather can change from pleasant to potentially deadly in a very short period. Rock slides can be severe enough to cause serious injury and disability. If a climber gets caught in an unexpected snow storm he or she could die or be greatly harmed by excess exposure. Lightning strikes in the high mountains cause injury and death.

The preceding perils are common to the mountain climbing experience. As a result, if a climber wants insurance coverage, he or she may have to pay an increased premium because of greater exposure to risk. It's possible the climber may not even be able to purchase some types of insurance cover. With or without coverage, the climber should practice risk reduction by wearing appropriate clothing, using proper gear, climbing with a partner, notifying appropriate authorities about climbing routes and other plans, and generally taking all reasonable precautions. In an extreme, a climber might accidentally dislodge a boulder that falls onto a house and creates a liability exposure.

You can see how such lifestyle choices can have risk management consequences. Those choices that are inherently harmful, such as drug abuse, create even greater problems. Health-related issues can also have significant financial implications.

Health issues often go together with lifestyle issues in the realm of risk management. This is not to say that individuals have the same degree of choice in both areas. Many health concerns are unrelated to choices made by individuals, although there may be a relationship with some. The real concern is how to prepare and how to mitigate potential losses when a health-related issue arises. Without going into detail about good nutrition, proper medical care, exercise, etc., we can summarize by stating the obvious need to maintain one's health. More relevant to this discussion is what happens when a significant health-related event occurs. Some of the answer to that depends on whether the individual had health-related insurance cover prior to the event. As you know, insurance does not prevent such events, just as life insurance does not prevent death. People get coverage because they want to prevent against financial loss in the event of a covered event. We will explore various types of insurance cover in Chapter 3, so for now, we will summarize. Some health-related events can cause hundreds of thousands of dollars' worth of loss. Between actual medical expenses and loss of income due to disability, related expenses

can seriously harm an individual's financial well-being. Appropriate insurance cover, in addition to government-provided benefits, can minimize the damage.

There is one additional area of concern that we should mention at this point. You cannot purchase insurance to cover a loss after it happens. Similarly, an individual cannot get appropriate medical cover to take care of a significant health-related issue once it has been diagnosed. This means people must purchase the insurance prior to the event happening, but they often do not see the value of doing this. To some extent, it's human nature. People don't want an umbrella until it starts to rain. They may not lock the car doors until after personal property has been taken. Unfortunately, after the event, it's too late to take adequate precautions. This is why, as an advisor, you should make sure to discuss these things with clients and do what you can to encourage them to take appropriate action before an event needing insurance coverage happens.

2.2 Analysis and Evaluation of Risk Exposures

To help with the analysis and evaluation process, we will consider the Conway family case.

> James and Mary Conway married following graduation from university 22 years ago. They are both age 45 and have three children – Jamie, Nancy and Barbara. Jamie, age 19, is a first-year medical student. Nancy (age 16) and Barbara (age 14) are in school and living at home. James is an executive with a global firm and Mary, following a successful early career in law, is a stay-at-home mother, focusing on raising the couple's children. Mary also volunteers with a legal aid organization and sits on the board of their neighborhood homeowner's association. Both are active in competitive sports, as are Nancy and Barbara.
>
> James has been successful in the firm and has risen to the level of the firm's chief financial officer. In addition to a strong benefits package, James earns enough to allow the family to live in a beautiful house on a small lake. The family enjoys many hours of boating and other water-oriented activities. James and Mary recently purchased a holiday home, also on a lake, in which the family plans to spend many spring and summer days. The house sits back from the lake's shoreline, but still close enough to provide easy access. James and Mary are a little concerned about potential weather-related damage during the winter months when the family plans to leave the house vacant.
>
> Jamie is a diligent student and has done well in his first year. However, he's also a 19-year old who likes to party from time-to-time. His parents have given Jamie a car, and he has not been quite as careful as he could be about driving after drinking at a party. Many of his student friends do not have vehicles, so Jamie is often the driver of choice. A teacher friend of the family has confided in James and Mary that she is a little concerned about some of Jamie's activities, especially the potential of driving and drinking.
>
> Nancy and Barbara are good students and seem destined for acceptance in their preferred universities. Nancy has just begun working at a job several days after school and on week-ends. She plans to increase her hours during summer break. Barbara plans to follow in her sister's footsteps when she gets old enough. For now, she's just enjoying being with friends and being a teenager. She is also an avid animal lover and relishes the time she spends caring for the family's German Shepherd dog.

James and Mary, both being quite busy, have a part-time household staff of two to help maintain the inside and outside of their primary residence. James, during his global travels, has begun collecting a small, but already valuable, fine art collection. Mary, although generally healthy and having an active lifestyle, recently received a disturbing report from her physician. Nothing to be done for now, but requiring additional tests and monitoring. Jamie has been complaining about an increase in headaches, some of which get so bad that he must rest to recover.

Think about the Conway's and their situation for a moment. What risk exposures does the family have now? What seems to have potential to have an impact in the future? If they were your clients what concerns would you have and what risk management considerations might you recommend?

Without trying to recommend any specific solutions, here are some of the areas of potential concern along with questions you might consider.

- James travels globally. Does he have medical insurance to cover him when he is away from his home country?
- James is reasonably wealthy and a significant member of the firm's upper-management team. Are there any concerns about possible kidnapping and holding for ransom?
- Mary received a troubling medical diagnosis. What are the implications of this?
- James and Mary are active in competetive sports. What is the potential for either to be injured? Is there any increased liability exposure that might come from their activities?
- The family lives on one lake and has a holiday home on another. Both create opportunities for water-related perils and hazards. If any friends or neighbors join the family on the water, and someone gets hurt, do the Conway's have adequate liability cover?
- James' art collection will not be adequately insured by the homeowner's policy. Do they have insurance cover for the collection?
- Mary is an association director, which creates a potential liability situation. Does the association carry adequate cover to protect Mary?
- James and Mary have a small household staff. What are the potential risk implications and are these covered?
- If the family's dog bites or otherwise harms a guest, what are the financial implications?
- Jamie's partying and driving creates both legal and civil liability concerns. What can James and Mary do to address these?

There are other potential areas of concern, but the preceding list should give you an idea of the considerations you should have as a financial advisor. As you evaluate a client's risk exposures, one question you should keep top-of-mind is whether they have adequate insurance cover. This is not to say that other risk management solutions will not be important. Rather, as we have discussed, insurance is often the best solution to mitigate financial losses. Also, are key areas included or excluded, and should coverage be increased. It's also possible that certain areas of coverage might be coordinated, thereby reducing premium cost.

As we have been discussing the use of insurance as a risk management tool, it's time to explore the types of coverage that are available and may be used to address client concerns. We will do this in the next chapter.

Example 2

Question Stem		Which of the following statements is most likely correct:
	a	Risk avoidance occurs when one individual or entity takes on the risk for the benefit of another.
	b	Risk minimization or reduction is employing strategies to reduce the likelihood, or the severity of loss caused by a particular risk.
	c	Risk transfer is not doing things that expose one to risk.
	d	Risk retention is always intentional.
Correct Answer		**b**

Explanation		Risk minimization or reduction is employing strategies to reduce the likelihood, or the severity of loss caused by a particular risk. Skiing within your ability and wearing appropriate protective gear is an example. Wearing a seat belt while driving and ensuring the brakes work are also examples of risk minimization.
Distractor #1	**a**	Risk avoidance is not doing things that expose one to risk.
Distractor #2	**c**	Risk transfer occurs when one individual or entity takes on the risk for the benefit of another.
Distractor #3	**d**	Risk retention may be intentional or unintentional. One of your functions as an advisor is to help clients make proactive choices about retaining risk so they do not retain a risk because they were unaware of their exposure to it. For example, clients may be unaware that insurance exists to replace a portion of their income if they become sick or injured and cannot work.

Chapter Review

Discussion Questions

1. Which type of risk do you think creates the greatest potential for financial loss? Why?
2. Which risks are best addressed by insurance (risk transfer)? Which would be better addressed using a different approach?
3. How might lifestyle choices impact potential risk exposure?
4. How would you approach a risk management plan for the Conways? What different techniques would you suggest using (for which specific exposures)?

Review Questions

1. What are some of the risks people may face about which advisors should be aware?
2. What lifestyle issues might increase a person’s risk?
3. According to the text, why do people purchase insurance?

Chapter 3: Introduction to Insurance

Learning Outcomes

Upon completion of this chapter, the student will be able to:

3-1 Identify types of coverage provided by insurance
3-2 Explain how deductibles and risk assumptions are used

Topics

3.1 General insurance
- 3.1.1 Homeowners
- 3.1.2 Personal property
- 3.1.3 Vehicles

3.2 Liability
- 3.2.1 Personal liability
- 3.2.2 Professional liability
  - 3.2.2.1 Malpractice and errors and omissions

3.3 Life insurance
- 3.3.1 Term life insurance
- 3.3.2 Traditional – whole life and endowment
- 3.3.3 Non-traditional – universal, adjustable, variable, variable universal
- 3.3.4 Joint life policies
- 3.3.5 Amount of life insurance needed
- 3.3.6 Annuities

3.4 Health insurance
- 3.4.1 Types of medical expense insurance
- 3.4.2 Managed health care plans
- 3.4.3 Long-term care (LTC)
  - 3.4.3.1 Common features of LTC insurance policies

3.5 Disability: Personal
- 3.5.1 Common features of disability insurance
  - 3.5.1.1 Definition of disability
  - 3.5.1.2 Common continuation provisions

3.6 Business-related
3.6.1 Key person
3.6.2 Disability: Business
3.6.3 Business overhead expense
3.6.4 Business liability and board member cover

Introduction

Insurance, in its many forms, is perhaps the most common risk management tool. In many ways it provides the most practical, and sometimes only, solution to address a given area of risk. When an individual chooses to purchase an insurance policy, he or she is transferring the risk of loss to the insurer. For a premium payment that is small, relative to the loss being covered, the insurer agrees to bring the policyholder back towards wholeness when there is a covered loss. In some cases, substitute funding simply would not be available to address the loss. Most people cannot provide the hundreds of thousands of dollars required to rebuild a lost home or

replace income lost due to death or extended disability. Liability lawsuits can expose the individual to almost unimaginable financial losses. Insurance, then, can provide a solution to these and similarly pressing concerns.

Not every risk is insurable. Underwriting departments handle much of the decision about whether to insure a risk. Additionally, the insurer may determine that it will not offer cover for a particular risk, under specific circumstances. For example, an insurer may decide not to offer cover for home damage in areas that are prone to severe storms. In their mind, the financial exposure is too great and would violate one of the rules of acceptable risks (i.e., the risk cannot be catastrophic). Other risks do not comply with the law of large numbers. As previously mentioned, Lloyd's associations will often cover singular risks that traditional insurance companies will not. They can do this because they have a network of specialists who work in syndicates and provide funding to cover these specialized risks.

Lloyd's has an interesting history. They were one of the first insurers operating in the city of London, England. According to their website (Society of Lloyd's, 2017), Lloyd's was first mentioned in the year 1688. During that time, it functioned as Edward Lloyd's Coffee House on Tower Street, and was one of the common places of business in that era, specializing in information about shipping. The shipping focus gave rise over time to an early type of insurance covering ships and their cargo – marine insurance. From there, Lloyd's grew and branched out into the organization that exists today.

Marine insurance, both ocean and inland, exists today as business as well as personal cover. Although the insurance industry began by covering specific risks and perils (i.e., monoline cover), and still provides this type of insurance, it has expanded to provide the multi-line and package plans largely available today. In this chapter we will explore various types of insurance, beginning with what is known as general insurance.

3.1 General insurance

General insurance includes cover for many risk exposures including those relating to:

- Property
- Personal property
- Vehicles

Some of the insurance types are quite specialized, covering things like small aircraft, travel, even weddings. When consideration expands to cover provided by Lloyd's associations, the types of insurance covered grow quite lengthy and diverse. Our focus in this section will be on cover for property, vehicles and personal property.

Property Insurance

In this context, property refers to real estate. More specifically, this insurance covers personal residences, outbuildings, warehouses, office buildings, condominiums and town houses, apartment buildings and the like. Insurance covers the buildings, not the land on which they sit. As a rule, you cannot insure land. This is one reason why a residence valued at $500,000 can be considered fully insured with only $400,000 coverage, if the missing $100,000 reflects the value of the land on which the house is built. As is often the case, there is some difference between insurance policies covering commercial buildings (e.g., warehouses, office buildings, apartment buildings) and personal buildings (e.g., homes, condominiums and townhomes). Since commercial property insurance requires specialization not required of most financial

advisors, we will limit our attention to personally-owned properties. Students should also understand that all insurance policies are legal contracts, and legal contracts vary by jurisdiction. In other words, it's unlikely that all the terms and conditions found in a contract from one territory will also be found in one from another territory. In this text we will provide information on standard coverage as it exists in many territories. You may need to adjust the information somewhat to better reflect the situation in your own territory.

3.1.1 Homeowners

The most significant financial investment made by most people is their personal residence—their home. A home's sale price may often equal many times an individual's annual income. As such, conscientious homeowners often carry some form of homeowner insurance coverage. Furthermore, if a loan is used to purchase the home, the lender may require the borrower to maintain homeowner's insurance on the property. As mentioned above, the information that follows represents a composite example of insurance coverages throughout the world (coverage in your area may be different, but generally will include some, or all, of the following).

Homeowner package policies include two sections: *Section I*, which covers property exposures; and *Section II*, which focuses on liability exposures. Section I has four coverage subsections:

1. **Coverage A** insures the main dwelling, including any additions attached to the dwelling, and materials and supplies located on the property for the primary purpose of working on the building.
2. **Coverage B** provides coverage for other structures, such as garages and sheds, which are situated on the property and detached from the dwelling.
3. **Coverage C** covers the insured's personal property.
4. **Coverage D** protects against loss of use, including expenses incurred while the dwelling is damaged, by a covered peril, beyond the point where the dwelling can be occupied.

Section II often includes two areas of coverage:

1. **E** - Comprehensive liability insurance.
2. **F** - Medical payments to others, claims expenses, and damage to property of others.

Section I

Coverage A primarily protects the main dwelling and attached structures. Except for building materials mentioned above, only the buildings are covered; land is not covered.

Coverage B protects buildings that are not attached to the dwelling. Coverage B also covers fences, decks, and swimming pools. Normally, insurance protections are not extended to business use of the other structures.

Most coverage under A and B normally exists on a replacement cost basis. Replacement cost eliminates any depreciation deduction (up to policy limits). However, some policies settle on an actual cash value basis, in which case, depreciation becomes a factor. A policy may sometimes contain an endorsement to provide inflation-based increases to coverage amounts.

Coverage C protects an insured's personal property on or away from the property. This protection extends to any property the insured may use, but does not own, such as a tool borrowed from a neighbor or friend.

Coverage D protects against the loss of use of the dwelling. When insured property is damaged, it may also help pay for expenses related to living somewhere else.

The coverage for sections B, C and D and pricing of a homeowners policy is largely determined by the limit selected for Coverage A on the dwelling. The insured is not asked to determine limits for other coverage under the policy because they are percentages of the Coverage A limit (or Coverage C in the case of renter's insurance or condominium unit owners insurance). Policyowners pay a deductible prior to receiving benefits for a claim under Section I coverage. The amount of any deductible will have an impact on premium cost. Smaller deductibles increase premiums, and larger ones reduce premiums. The difference may be substantial or not, depending on the company and the policy. Remember, a deductible is a form of risk retention. So even when transferring risk via a homeowners insurance policy, the policyowner almost always must retain some of the risk by means of the deductible.

Section II

Coverage E, under Section II, covers personal liability. This section protects the insured (and all family members living in the same house) against losses arising from legal liabilities. The insurance company also will pay for defense in a lawsuit. Insurance companies do not cover intentional injury to another or self-injury. This coverage may be included as part of the homeowners policy or issued as a separate comprehensive personal liability (CPL) policy.

Homeowner policies provide personal, not business or professional, protection. Some policies can be endorsed to provide limited coverage for business or professional activities, but *limited* is the key term. Only specific business or professional insurance provides full protection.

Coverage F covers medical payments to others. This coverage provides that if someone who is not living at the insured's residence is injured there, the company will pay for medical care related to that injury. Negligence is not required. If a friend is helping someone paint the house and falls off a ladder because of their own carelessness, they can submit a claim to the homeowner's insurance company. Although the homeowner did not cause the friend's injury, the homeowner's policy will still pay the claim.

The key word for this coverage is *others*. Household members cannot receive medical payments under this section of the policy. The rationale for this exclusion is logical—insureds cannot be liable to themselves. All household members are considered to be insureds. Therefore, no household member qualifies for medical liability payments.

Additional Coverages

Damage to property of others. This provision is effective even where there is no technical liability. If the insured causes damage to another person's personal property, and it is not covered under Part I of a homeowner's policy, this good neighbor provision of the homeowner's policy will cover it. The maximum claim is relatively low (e.g., $1,000). For example, if someone borrows his neighbor's portable music player for a party and ruins the speakers by increasing the volume too much, this provision will provide payment for new speakers up to policy limits.

Among the exclusions to this provision is intentional damage to the property of others. Intentional damage to others or their property is never covered by insurance. Property that is owned by the insured or rented to the insured is also excluded.

Claim Expense: This provision states that, in addition to any damages a court determines the insured must pay (up to the policy liability limits), the CPL policy will pay for the insured's defense, interest on judgments, and certain related costs.

First Aid: The CPL policy will cover costs that the insured incurs for first aid administered to a visitor who is injured at the insured's residence or due to acts of the insured. These costs are paid in addition to the stated policy limits.

Loss Assessment Coverage: If a member of a condominium or homeowners association is assessed for his or her share of the association's legal liability, the policy will pay that assessment. The basic coverage is limited to $1,000 but generally can be increased.

Covered Perils

Different policies may provide different levels of protection against loss by various perils. Covered perils may be grouped into three categories: *basic coverage*, *broad form coverage*, and *open peril* or *all risks coverage*.

- ***Basic Coverage:*** Includes coverage for 11 perils: fire and lightning, windstorm and hail, explosion, riot and civil commotion, vehicles, aircraft, smoke, vandalism and malicious mischief, breakage of glass, theft, and volcanic eruption.
- ***Broad Form Coverage:*** In addition to the 11 perils listed above, broad form covers falling objects; weight of ice, snow, or sleet; damage resulting from heating or air conditioning systems; accidental discharge or overflow of water; freezing of plumbing; and damage from artificially generated electrical currents. It also expands coverage for some of the basic perils.
- ***Open Peril, or, All Risks Coverage:*** Provides coverage for all perils, unless they are listed and specifically excluded. Some perils always are excluded, so the term all risks is not really appropriate, because the policy will never cover all risks.

How Much is Enough?

When you, as financial advisor, are reviewing a client's homeowner's policy, the question that clients most often ask is "how much coverage should I have?" To help answer this question, the following topics should be addressed during any review of a client's insurance coverage.

One way to look at the worth of a home is that it has three distinct values. First is the market value. This is the value that a willing buyer and willing seller under no compulsion agree to exchange an item at an agreed upon price. The second is the assessed value. This is the value the taxing authority places on the property and on which they base property taxes. Depending on the community, this typically is less than the market value and is usually recalculated at least every three to five years. The third value to consider is the replacement value. This is what it would cost to rebuild the home as it currently exists.

The maxim often heard in real estate is "location, location, location." The location of the property can significantly affect market value; however, the replacement cost is not as easily affected.

For example, in the same city, one property might have a very high market value while another property might have a lower market value and yet the two homes are virtually identical in construction. The replacement value of these similar homes would likely be very similar even though the market value for one is much higher.

Individuals need as much insurance as necessary to provide adequate protection. This probably means replacement-cost coverage in an amount equal to at least 80 percent of the cost to replace/rebuild a dwelling. To provide more thorough coverage, homeowners should insure their home to 100 percent of the replacement value. This will provide coverage the homeowner will need if the home is completely destroyed. Personal property also must be covered, with the amount depending on the value of the specific personal property. Those who do not own a home will still benefit from coverage on their personal property (this type of coverage can easily be purchased separately for those renting or leasing their residence).

Replacement Cost Calculation

Many factors go into determining the level of coverage and the premiums required for a homeowner's policy. The age of the home, construction materials, location, square footage, and number of rooms are all factors that generally play some role in determining amounts of the replacement value of a home. Once the proper level of coverage has been determined, a client should insure the house for *the cost to replace it* (i.e. construction costs).

Most insurance agents or brokers have access to sophisticated tools to assist with estimating the replacement value of the home. Many software packages allow scalability, and will allow minimal to very detailed inputs. At a minimum, the style of home, square footage, and number of bedrooms and bathrooms are entered. On the detailed end of the spectrum, entering the number of fixtures in a bathroom, type of countertops in the kitchen, an elevator, an intercom system, irrigation system, etc., will make the replacement calculation more precise. However, this is only as good as the inputs received.

It is necessary to determine if all additions, improvements, or extra outbuildings have been evaluated to ensure that policy coverage is adequate. Normally, on a base policy, other structures are covered for up to 10 percent of the cost of the dwelling. Detached garages, gazebos with hot tubs, or other expensive structures may require more than 10 percent coverage. Just about all coverage can be expanded beyond what is included in a base policy.

Coinsurance Provision

As we saw in Chapter 1 in the section on underinsurance, when insurance companies price policies, their expectation is that policyholders will insure their home for the full value. Most policies are priced on a per unit of coverage basis (e.g., $3.50 per $1,000 of coverage). Comparatively few people ever suffer a total loss of their home. Most losses are partial, and many claims are for a relatively small percentage of the home's full replacement cost. If most of the insureds determine the likelihood of having a total loss is extremely low and decide to insure their home at 50 percent of the replacement cost, the premiums collected by the insurance company would not be enough to cover all the losses. To that end, the coinsurance provision was added to policies.

For insurance to work properly, everyone in the risk group must participate at a reasonable level. To ensure that premiums received are sufficient to cover claims, insurance companies usually include a coinsurance provision that requires a home to be insured for at least 80

percent of its replacement cost for partial losses to be covered completely. Typically, if an individual does not maintain insurance equal to 80 percent of the replacement cost (at the time of loss), a partial loss will be covered at either the actual cash value (i.e., replacement cost minus depreciation) or per the coinsurance penalty formula, whichever amount is greater. Recall the following formula:

$$\frac{Anount\ of\ insurance}{Amount\ of\ insurance\ required} \times Amount\ of\ loss - Deductible$$

In most cases, the coinsurance penalty formula will provide the higher benefit.

Example: coinsurance penalty formula. Assume the insured's home would cost $400,000 to rebuild. Insurance on the home is $300,000 with a $1,000 deductible. A kitchen fire causes $20,000 in damage.

The first step is to calculate how much insurance is required per the coinsurance requirement. In this example, that would be $320,000 ($400,000 × 80 percent). The second step is to calculate the coinsurance penalty formula as follows: Amount of insurance, $300,000 divided by required amount $320,000 = .9375 × amount of the loss $20,000 = $18,750; $18,750 - $1,000 deductible = $17,750 to be paid by the insurance company. Notice that the deductible is subtracted after doing the initial calculation.

If the loss exceeds the amount of insurance, even if the amount of insurance is more than 80 percent of the replacement cost, the insurance company will not pay more than the actual amount of the insurance cover. The policy limit is the most that would be paid under any circumstance unless the insured has a rider to pay up to a certain amount (e.g., 115 percent or 125 percent) over the replacement value to cover increased rebuilding cost fluctuations. This means a house with $400,000 coverage, but a value of $500,000 meets the 80 percent requirement. However, in the event of a total loss, the insurer will only reimburse $400,000, because that is the amount of cover carried (assuming the policy does not have a provision automatically increasing coverage amounts to meet replacement cost requirements). Any deductible will be subtracted prior to paying the claim.

An important factor to consider is that the replacement value is determined at the time of loss, not at the time the policy was purchased. This is one of the many reasons it is important to have clients regularly review their insurance coverages with their insurance agent. Many companies offer an inflation rider, which adjusts the coverage on an annual basis to keep up with the increased building costs. If this rider is not on the policy and the client does not meet with his or her agent, it is easy to be placed in a coinsurance situation.

Replacement Provisions

Actual Cash Value: The actual cash value is the replacement cost minus depreciation.

Replacement Cost: In the event of a total loss, the policy will reimburse a policyowner the amount required to replace the property up to policy limits.

Guaranteed Replacement Cost: While a homeowner may be adequately covered by having insurance equal to 80 percent of the replacement cost of the home, he or she may have a substantial out-of-pocket expense if the home is destroyed. There also are circumstances where

even 100 percent coverage may not be adequate. When a natural disaster strikes, such as a hurricane, the cost of rebuilding may increase due to the lack of building materials and/or shortage of skilled labor. When this happens, the replacement cost is often higher than the insurance amount. A guaranteed replacement cost benefit takes care of this problem.

Inflation Guard Endorsement: To acknowledge the effects of inflation, insurance companies generally offer an inflation guard endorsement. This endorsement automatically increases the dwelling coverage each year by an amount that is usually tied to an index. Many insurance companies subscribe to services that track costs of construction materials and labor and can even refine the data to account for the specific community where the home is. A periodic review by the insurance agent, the insurance company, or a contractor can be used to confirm the replacement value.

Factors Affecting the Cost of Homeowners Coverage

The cost of a homeowner's policy and its endorsements are affected by the factors mentioned previously, and listed below.

Construction: The way a home is built and maintained — materials, age, upkeep — is important in determining the cost of a homeowner's policy. Brick or stone costs more than siding. A shake shingle roof is more expensive than one made of composite materials and is a greater fire hazard. Heavy landscape growth around a home creates a fire hazard that is greater than that caused by a landscape of well-maintained trees, shrubs, and plants. Older homes have older plumbing and wiring, which are more likely to cause problems than new plumbing or wiring.

Location: In what type of community is the house located? Is it a fire prone area or is there a high vandalism and crime rate in the area? The location of the local fire department, the available water supply, and the accessibility of the home itself also will affect insurance rates.

Deductible: For obvious reasons, the size of the deductible will affect the cost of the policy. The higher the deductible, the lower the premium.

Insurer: The insurer does make a difference. Some insurers offer insurance only to certain groups. When insurance availability is limited, the group's claims may become quite predictable, often resulting in better rates. Some insurance companies offer a discount to those who also have their car insurance with them. Additionally, each insurance company will have unique claims results and this will affect how they price their policies. With all of the various factors that go into determining homeowner's insurance premiums, you should encourage your clients to shop for this coverage every few years to ensure they are receiving the best value for their premium dollar.

General Exclusions

Homeowners forms contain eight general exclusions to the property insuring agreement.

Ordinance or Law: It is common that after a home is built, building codes change. When a partial loss is incurred and the room is being rebuilt, it will need to be brought up to the current code. For example, many cities require that electrical outlets be placed a certain distance from each other. The cost of bringing the room up to code is considered "betterment" and is not covered by the standard insurance policy. With the Ordinance or Law endorsement, the

additional expenses would be covered up to the limit listed in the declarations page. The amount is generally expressed as a percentage of Coverage A (i.e., the dwelling amount).

Earth Movement: This excludes coverage for a loss caused by earth movement, except direct loss by fire, explosion, theft, or breakage of glass. When losses are caused by these other things, the concept of concurrent causation applies. Concurrent causation applies when two actions cause a loss and one of them is a covered peril while the other isn't. The insurer will be liable based on the perils that are covered. Insured's may be able to add this coverage by endorsement or separate policy.

Water Damage: This excludes coverage for a loss caused by flood, water backing up in sewers or drains, water below the ground surface seeping through basement walls, foundation, floors, etc. Damage from backup of sewers and drains may be added by endorsement.

Power Failure: This denies coverage for losses resulting directly from an interruption of power or other utility service, if the interruption takes place away from residence premises (i.e., a neighborhood power outage as opposed to a specific outage at the home).

Neglect: This excludes losses resulting directly or indirectly from neglect of the property by the insured and failure to use reasonable means at or after a loss to save the property.

War: This excludes losses caused by war in all forms (e.g., undeclared war, insurrections, rebellion, revolution, or discharge of a nuclear weapon).

Nuclear Hazard: This excludes losses from nuclear reactions, radiation, and radioactive contamination.

Intentional Loss: This excludes intentional damage to one's own property.

High-Value Property

Getting adequate insurance coverage for high-value or unique property is not always easy. One of the core principles of insurance is known as *the law of large numbers*. Recall, this means that normally, to be insurable, there must be a large number of homogeneous exposure units to make losses reasonably predictable. Translated, this means that an insurer wants lots of units (e.g., houses, cars, etc.) over which to spread its risk exposure. If you think about it, this becomes an underwriting guideline that favors the average or standard (home, car, personal property, etc.). For most people, this works well. However, for owners of very high-value property this can become a problem. Why? There are substantially fewer very high-value homes relative to the number of homes priced more moderately. Fewer homes means fewer homogeneous exposure units over which to spread the risk. At the least, this often means higher premiums. As it turns out, it also means that there are fewer insurers willing to even consider providing coverage on these properties.

Often, to insure such properties, one of the first steps is finding an insurer that specializes in coverage for high-value properties. The type of coverage is also important. Owners of standard homes often must be satisfied with whatever terms an insurer provides. For example, if a wall in the home is damaged, the insurer decides the best way to repair it. If the home has custom plastered walls, most insurers will pay for a basic repair or replacement (e.g., installing drywall and paint), but few will pay to have custom plasterwork redone. This is generally not a satisfactory solution for someone living in a very-high value home. So, the homeowner in this

situation will want to find an insurer that will agree to bring the house back to its original condition. Such insurance coverage is available, but only through a few companies.

It is also possible to obtain coverage for perils that are excluded by typical homeowner's policies. For example, a few insurers are starting to offer private flood insurance for high-value properties. As more insurers begin to explore this area, high-value property owners will likely be able to get—at a price—coverage that more completely meets their specific needs.
Another example should help identify the concerns in this area. It's easy to get insurance for a piece of jewelry that is somewhat over the value of the internal homeowner's policy limit (discussed under personal property below). Simply bring an appraisal to your insurer, pay the premium, and there is a personal property floater/inland marine policy on the jewelry that covers it well. But, multiply the value of the jewelry by ten or twenty times, and the situation changes. That may be too large an exposure for many insurers to take. Consider some individuals may have a collection of jewelry, artwork, antique or custom furniture, and the like worth a great amount of money, and it is easy to understand the potential difficulty of getting all the property adequately insured.

The same insurers that offer enhanced or expanded coverage for high-value properties can also provide coverage for high-value personal property. Coverages may be more easily tailored to specific property owner needs, and some perils that otherwise would not be covered, may be covered.

Other Homeowner's Products

Individuals who rent rather than own their home may wish to insure their personal property. A renter's insurance policy provides all the coverage of a standard homeowner's policy except for Coverages A and B in Section I since there would be no need to insure a dwelling and other structures that the renter does not own. More importantly, renter's insurance policies include the liability protection provided by Section II. This is an important reason for purchasing renter's insurance since a liability claim poses the greatest threat of loss to the insured.

Another type of homeowner's insurance covers condominium unit owners, and is available for people who own a unit in a multi-unit complex. Condominium unit owner's insurance provides all the coverage a renter's policy covers plus limited coverage under coverage A of Section I. This is needed because condominium unit owners own the ceiling, walls, and floors of their unit from the structure frame in and therefore would need coverage for that portion of the building if it should suffer loss.

3.1.2 Personal property

Standard homeowners policies typically cover personal property at 50 percent of the dwelling coverage. With the cost of furniture, rugs, clothes, appliances (not permanently installed), books, etc., this level of coverage may be inadequate. Some companies issue policies with personal property covered at 75 percent to 100 percent of the dwelling coverage.

Most homeowner's policies provide only limited coverage for personal property with higher value. The following items have relatively low limits of coverage (examples of limited coverage in parentheses):

- Money, bank notes, coins, bullion ($200 limit)
- Securities ($1,500 limit)

- Stamp collections ($1,500 limit)
- Watercraft and their trailers (1,500 limit)
- Jewelry, furs, cameras (loss by theft - $1,500)
- Firearms (theft - $2,500 limit)
- Silverware, goldware, etc (by theft - $2,500 limit)
- Business property at home ($2,500 limit)

Actual limits will vary by policy. An inland marine policy (or personal property endorsement—covered below) can be used to provide adequate coverage, however, it is a practical impossibility to increase the personal property coverage within a standard homeowner's policy to the extent that limited coverage items (e.g., jewelry, silverware) will be adequately protected. The only viable method to provide sufficient coverage on these items is to add a personal property endorsement or purchase a separate inland marine policy; both methods provide essentially the same coverage options.

Personal Property Exclusions

Nine classes of property are usually excluded under Coverage C of all homeowner's forms. The classes are:

1. Articles separately described and specifically insured under homeowners or other insurance
2. Animals, birds or fish (the animal itself, not the liability it creates)
3. Motorized land vehicles (with some exceptions)
4. Aircraft and their parts (except model or hobby aircraft)
5. Property of roomers, boarders and other unrelated tenants
6. Property contained in an apartment that is regularly rented or held for rental to others by the insured
7. Property rented or held for rental to others away from the premises
8. Books of account, drawings, paper records, and software media containing business data
9. Credit cards or fund transfer cards, except as provided under the heading of Additional Coverages

Personal Property Endorsement

For high-value items like those listed in the previous section, adequate protection generally is available as an endorsement to the policy. Coverage is in the amount of the item's stated (or appraised) value, not the replacement cost or actual cash value. For this reason, a client may be required to provide appraisals, invoices, photographs, or other evidence of ownership to obtain coverage. This information should be properly filed and stored, most likely in a location not on the main premises (in case of fire or significant destruction). It is important to review the value of items periodically. Occasionally, new appraisals are required.

Coverage of this type may be called a personal property endorsement, personal property floater, or inland marine coverage.

Inland Marine Insurance

Inland marine insurance provides protection for personal property that is in transit or that can be transported. Why call it “inland marine” or “personal property floater” coverage? One of the first types of property insurance covered the cargo of ocean-going ships (i.e., ocean marine). As it developed, this type of coverage was fine, but only while the property was on the ship. There was no coverage for the cargo once it left the ship and moved inland. Typically, the cargo was loaded on barges and floated on a river (i.e., inland marine) to a dock or warehouse. Later, even as barge, train, and truck transport became more prevalent and highways and railways supplanted inland waterways as the transportation of choice for goods on the move, the insurance to cover such cargoes on these conveyances was still known by the previous name, inland marine. This is the origin of the term *inland marine* insurance. Now, the property could be covered while on the ship as well as while it was being *floated* inland. Later still, this insurance coverage evolved to cover anyone’s personal property that was being transported.

While this policy form was originally intended to cover personal property while it was away from the insured’s premises, it now usually covers personal property anywhere in the world, including while at the insured’s home. It is important to remember, though, that property that is installed will not be covered by an inland marine policy. So, an antique rug can be covered by an inland marine policy, but wall-to-wall carpeting will not be covered, except by the homeowner’s policy. This is true because once installed, the wall-to-wall carpeting becomes part of the dwelling, and is considered a fixture.

Inland marine insurance usually is written with open perils coverage. A primary benefit of open perils coverage is that it extends the coverage to theft and loss. Coverage may be written with little or no deductible, or, depending on the insurer and the insured’s wishes, a higher deductible. As is true with other types of insurance, the greater the deductible, the lower the premium.

The insured needs some sort of appraisal or receipt to verify the value of the property being insured. Additionally, coverage usually is for a stated (appraised) value rather than the replacement cost or actual cash value (i.e., depreciated value). However, some policies have built-in inflation coverage, and others do settle either on a replacement cost or actual cash value basis (always look at the policy to determine coverage).

Pair or Sets Settlement

An inland marine policy is one way to overcome problems related to an insurer’s pair or sets settlement option. When one item of a pair (or set) is lost, stolen, and/or damaged, the pair or sets option allows the insurer to only pay for the one item—not the set. This can create problems, as the value of the set is often greater when all the parts are there. As an example, a complete collection of investment-grade figurines is worth more than the sum of the individual pieces in the collection. So, if one figurine is stolen, the actual loss to the collector has a higher value than just the one piece. By using an inland marine policy for the entire collection, it may be possible for the collector to recoup a greater amount of the loss related to the one piece.

What types of items can be covered by inland marine or personal property floaters? Just about anything that fits the category of personal property. Following are some examples: cameras, jewelry, furs, silverware, golf and ski equipment, fine art, antiques, rare stamps or coins, musical instruments, wedding gifts, and more. Coverage may have certain requirements and/or

exclusions, but you can see that this type of insurance can be used to provide coverage for many types of personal property.

3.1.3 Vehicles

The motor vehicle has had a greater impact on global history, as well as the lives of individuals, than almost any other product. Cars impact the lives of nearly everyone in one way or another. A car, while being a beneficial source of private transportation, also has the potential to create great expenses. As such, protecting this expensive asset with adequate insurance coverage makes good sense. In addition to property-related expenses, car owners can incur expenses for personal liability. This, too, is a good reason to maintain adequate insurance coverage.

Specific insurance requirements vary territory-by-territory (and sometimes by state, province, region or other jurisdiction within a given territory). The information that follows is a composite example of various types of third-party car insurance (as with the section on homeowner insurance policies, coverage in your area may be different, but generally will include some, or all, of the coverages in the following section). As with homeowners insurance, if this is not an area where you are able to provide advice because of regulations or lack of experience, an analysis should be referred to a licensed insurance advisor.

Types of Policies

Motor vehicle (car) insurance normally has four main coverage sections: liability, medical payments, physical damage, and uninsured motorists. Car *liability* insurance protects you against legal liability when your car damages another person or another person's property. *Liability* coverage extends to expenses for bodily injury to those injured in an accident (again, not the insured, family members, or other occupants in the insured vehicle). Coverage may be separated out as an amount for each person or as a total for all people injured in a common accident. For example, a policy may cover liability up to $25,000 per injured person, $100,000 for all people injured, and $25,000 for property damage, or it may lump all cover together with a $250,000 limit.

Medical payments resulting from an accident can be covered. Here, though, because coverage does not come under the liability insuring agreement, covered expenses are for the insured, family members, and occupants of the insured vehicle (this is exactly opposite of homeowner coverage, where this protection does come under the liability insuring agreement). This coverage pays for claims due to injury for anyone in or on the vehicle, entering the vehicle, or alighting from the vehicle. For example, a person exiting a car who accidentally slams the door on a finger breaking it would be able to submit the bills for medical care and be reimbursed for costs up to the policy limit.

Coverage also extends to *physical damage* to the insured vehicle. This coverage protects against losses to the insured's car, and has two parts: collision and "other than collision," or comprehensive. Collision coverage is for damage resulting from the insured vehicle hitting something (e.g., another car, fence, tree, wall, etc.). Comprehensive coverage (also known as "other than collision") provides protection when something hits and damages the insured vehicle. Examples include damage from hail, rocks, falling tree limbs, and the like.

Where available, *uninsured motorist* coverage provides protection when the driver of another vehicle does not carry insurance coverage. In an accident situation, up to policy limits, the insured's coverage will pay the amount that should have been paid by the other driver.

Underinsured motorist coverage is similar, except it pays when the other driver has coverage, but not enough (usually just the required minimum coverage level). The two coverage types may be separate or combined into one.

Most territories require drivers to have some level of motor vehicle liability insurance. At times, a driver can post a surety bond guaranteeing to make amends if he or she becomes legally liable for a car-related loss.

Who is Insured?

The car insurance policy makes payments based primarily on the obligation of the insured. The policy defines the insured as being:

- The named insured or any family member (living in the insured's household)
- Any person authorized to use the covered car
- Any person authorized by the insured to drive the covered vehicle

A policy normally covers the insured and any family member (limited to those living in the same household) while using a covered car. This also includes the use of utility (small) trailers, or when borrowing or renting another car. Individuals who rent cars should check coverage prior to renting the vehicle. Coverage usually only applies within the insured's home territory, and may not be applicable at all.

Cost of Insurance

Several factors are used to determine the cost of car insurance. Some of the factors relate to the owner/driver of the vehicle being insured; the others have to do with location of the vehicle, the vehicle itself, and deductibles.

The five primary owner/driver factors are:

1. Age and gender of the driver
2. Use of the vehicle
3. Type of vehicle
4. The driver's record
5. Credit

Age and Gender of Driver: Single male drivers under the age of 25 are put in the highest risk category. All things being equal, their premiums are the highest. After age 25, rates are essentially equal between men and women, again, all other factors being equal. In some areas, when drivers reach older ages, such as age 75, rates may increase again. This reflects the diminished reflexes of older drivers as a group.

Vehicle Use: A car that is driven only for pleasure costs less to insure than one that is driven to work daily. Cars driven less on an annual basis also allow for lower premiums. Longer drives to work and use of the car for business both increase the premium. The geographical location of the car/driver also has a significant impact on premiums (e.g., urban or rural, large city or small).

Type of Vehicle: The type of car will affect rates. High performance cars and sports cars tend to have higher premiums. Sport utility vehicles also tend to have higher than average premiums due to the increased amount of damage they can inflict.

Generally, when an insured purchases insurance on more than one vehicle, the premium per vehicle is lower than if the same vehicles were insured by different companies. This is commonly referred to as a multi-car discount.

Driver's Record: The driving record of an individual directly impacts the rate that will be charged by an insurer to offer auto coverage. In some instances, as in the case of operating while intoxicated or too many speeding tickets, an individual may be denied coverage, and in severe cases even the privilege to drive may be revoked. However, before these extremes occur, a company will often offer coverage with steeper and steeper premiums reflecting the increased risk being taken in insuring these drivers.

Credit: Most insurance companies now use credit/credit score/credit characteristics to determine rates because they have found a significant correlation between credit scores and claims history. Insurers typically use a different model than lenders as they are attempting to predict the propensity for a loss rather than the ability to repay a loan. Those with higher credit scores are considered better risks than those with lower credit scores.

3.2 Liability

The concept of liability varies by jurisdiction, and reflects that jurisdiction's legal code. Most of the world's legal codes are based on one of three systems, or combinations thereof. The three

systems are: civil law (the most widely used), common law, and religious law (e.g., Sharia). Each jurisdiction also modifies and adapts the basic system to its own unique historical and current environment. As a result of the various legal systems, liability, along with its consequences, varies. Generally, when we discuss liability, we are referring to what is called *civil* liability. Civil liability is different than *criminal* liability, and is the result of one individual or entity being held accountable for causing financial loss to another. Criminal liability is the result of violating a jurisdiction's laws, and may result in prosecution and legal penalties (e.g., imprisonment). Actions by an individual may result in both civil and criminal proceedings, and the person may be held both civilly and criminally liable (with penalties assessed from both aspects). Little or no insurance exists to cover criminal actions. Insurance can, however, cover civil actions. It's important to note that car accidents may give rise to both civil and criminal proceedings.

Liability is sometimes misunderstood. Many people think it only comes into effect when an individual does something to cause harm to someone or something else. This can be true, but it goes further. More broadly, liability refers to any situation in which one individual or entity is legally responsible for something such as a financial obligation, responsibility or debt. Liabilities can be personal or professional, with the two requiring different coverage. Businesses can also incur liability, and this is a third type of coverage. We will cover personal liability first, then professional (of which there are two types) and finally business liability. Before doing this, we will identify a few related terms, some of which may or may not be applicable in your territory, but all of which are relevant globally.

Liability Terms

- A *tort* happens when someone causes harm (physical, emotional or financial) to another person. Legally, the person causing harm is called a *tortfeasor*. A tort either may be intentional or unintentional. In almost all cases, the individual intentionally causing harm cannot be protected by insurance. Liability insurance only covers unintentional torts. Torts are civil rather than criminal. This means that torts are not necessarily considered breaking the law. Instead, torts focus on financial damage. However an individual may do something that fits into both the civil and criminal categories, and may be guilty of violating a law in addition to causing financial harm to someone. Intentional acts include things such as assault, battery, false imprisonment, invasion of privacy, slander and libel. Unintentional torts may cover a broader range of activities and frequently involve at least some degree of negligence.
- *Negligence* is not equal to intentional wrong-doing. Negligence does mean, however, that an individual has not exercised a reasonable degree of care. That is, the care expected from a responsible adult. It also can mean that the individual commited a breach of duty. For negligence to result in a tort action, there must be directly-related financial loss or harm. Essentially, no financial loss, no negligence or liability. It's important to remember that a person can be liable without also being negligent. In fact, a person can be liable without having done anything wrong at all. Tort law (in its many forms) simply seeks to determine damages in situations where a loss has occurred. Someone may get harmed on property that another owns and the owner will be deemed to be liable as a result. He or she may not even have been on the property, but as owner, there is liability.

- *Absolute liability* refers to a standard imposed when there is no specific way to show negligence. A person that has a wild animal as a pet may become liable under this

standard if the animal harms a visitor. Employers may be held liabile to an employee by application of absolute liability (also discussed in the business liability section)

- *Vicarious liability* is when one person is held liable for the acts of another person. Parents may be considered liabile for things their children may do that cause financial harm to another person. Vicarious liability may also be applied to employers if one employee harms another.

- *Contributory negligence* may be applied when an individual is deemed to have contributed to his or her own loss. When this is true, it may limit (also known as *comparative negligence*) or negate any financial remuneration from the other person.

- *Assumption of risk* applies in some instances when a person understands the potential risk, but chooses to engage in the activity regardless. Various sports come to mind in this category. In such cases the participant may be said to have assumed the risk of engaging in the activity. This may mitigate the other person's (or entity's) liabilty.

Additional terms are likely to apply in each territory, but they tend to be specific to the jurisdiction. As an example, one territory imposes the standard of negligence per se. This may be employed when an individual violates a statute that is in place to protect people or a class of people. Such might be the case when a child is harmed by a motor vehicle driving recklessly through a safety zone. Penalties will be greater for someone who is guilty of negligence per se than for someone who is merely considered liable, and perhaps also negligent. The concepts are frequently the same from one territory to another, but specific terms and application depend on local jurisdictional law.

3.2.1 Personal Liability

One thing to keep in mind, liability related to a motor vehicle is not the same as other liability, and it requires separate coverage (normally as part of a motor vehicle insurance policy). Adequate protection against personal liability exposures requires regular personal coverage in addition to car-related coverage. We mentioned the liability coverage available as part of a car insurance package policy and now we will look at more general liability exposures.

Most individuals obtain liability insurance through their homeowners and automobile policies. However, in today's litigious world, many people want more protection than the typical homeowners or automobile policy offers. Rather than merely increase the coverage on the other two policies, your clients will be better served if they can obtain an umbrella liability policy. This is sometimes called *catastrophic liability insurance*.

Liability insurance protects against legal liabilities incurred by the insured. Protection is only extended to covered events, and then, only up to policy limits. A normal liability policy, or coverage included with homeowner or auto insurance policies, does a good job, up to a point. That *point* is the financial limit of coverage. Specifically, most standard policies do not have very high coverage limits. Thus, they can leave significant protection gaps, especially for people who have (or are perceived to have) lots of money.

Most homeowner's policies are issued as a package policy, which includes the liability coverage contained in Section II. It is possible to purchase a standalone policy (i.e., monoline), which is a Comprehensive Personal Liability (CPL) policy. Don't be misled by the *comprehensive* terminology. CPL policies cover basic liability. The CPL policy provides coverage for damages payable because of the insured inflicting bodily injury or causing property damage that falls under the covered portion of the policy. Note that slander and libel are not covered under the personal liability portion of this policy because the policy will not cover intentional acts. In addition to paying for damages up to the limits of the policy, the company will pay the legal defense costs as well. The insurance company also generally reserves the right to make an out-of-court settlement at its discretion (without obtaining consent from the insured).

The *insured* is the named insured and usually includes any member of his or her household who are relatives or minors (normally, 21 years or younger) under the care of the insured. It also extends to others who, with the insured's permission, have control of his or her animals or watercraft and who cause damages. Coverage also extends to a child who is at college and who still maintains the insured's residence as his or her weekend and/or vacation home. Under Homeowners Section II, *insured* also means any person or organization legally responsible for the insured's animals or watercraft; any person, while engaged in the policyowner's employment, using a covered vehicle on an insured location with the owner's consent.

Liability Exclusions

The general exclusions include intentional injury and business or professional activities. All forms of personal liability insurance exclude these (because intentional injury is never covered, and business and professional activities are not personal liability exposures) and some additional sources of liability, which are discussed below. Losses covered under homeowners Section I, along with owned and rented property, are also not covered under a CPL policy.

Business Pursuits: Although business pursuits generally are excluded from personal liability policies, certain persons can obtain a Business Pursuits Endorsement. Clerical office employees, salespersons, collectors, messengers, and teachers can get this extension. It is not available to provide coverage for the business pursuits of business owners. There are some other minor exclusions to this coverage. Business-related insurance will be covered below.

Rental of Property: Personal liability policies generally do not cover losses related to the insured's renting his or her property to others. However, occasional rentals of the residence are covered. The insured may also rent out a room or two, if there are no more than two roomers. Additionally, the exclusion doesn't apply to rental of part of the residence used as an office, private garage, school, or studio.

Professional Liability: Liability that may be incurred by a professional such as a CERTIFIED FINANCIAL PLANNER certificant, insurance agent, lawyer, physician, etc., is excluded and must be covered by a professional liability policy. These policies are discussed later.

Motor Vehicles: Since registered motor vehicles typically require their own liability coverage, liability arising out of the use of an automobile is excluded from comprehensive personal liability policies. Some nonregistered motorized vehicles are covered under such policies under certain circumstances. Comprehensive personal liability policies also exclude coverage for negligent entrustment. Negligent entrustment occurs when an insured allows someone known to be

careless to use the insured's property, and the result is damage to another person or another person's property. Remember that there is no coverage to the insured's property under these policies, because they are not property insurance policies, they are liability insurance policies.

Watercraft: Comprehensive personal liability policies also exclude most watercraft from coverage. Certain small watercraft rented to the insured will be covered. Negligent entrustment is also excluded.

Aircraft: Damages inflicted through the ownership, maintenance, or use of an aircraft are also excluded from coverage under CPL policies. This exclusion extends to ultralight aircraft and hang gliders as well.

Communicable Disease: Comprehensive personal liability policies generally exclude coverage for damages claimed because the insured infected someone with a communicable disease. Without this exclusion, transmission of such infection could be considered bodily injury. It would be difficult to know if the insured knowingly transmitted the disease. The exclusion avoids the problem of determining intent.

Other Exclusions: Other exclusions generally are included in personal liability policies. These include war; sexual molestation or abuse; use or sale of controlled substances; contractual liability; damage to property owned by, rented to, or in the care of the insured; workers' compensation; nuclear perils; and injury to insured persons.

Medical Payments to Others

This coverage is identical to the coverage provided under Section II coverage F of a homeowner's insurance policy. It provides for the payment of medical expenses for people who do not live at the insured's residence regardless of fault. The purpose of this coverage is to be able to pay for medical expenses incurred so that potential lawsuits can be avoided.

Umbrella Policy

Most individuals obtain liability insurance through their homeowners and motor vehicle policies. However, in today's litigious world, many people want more protection than the typical homeowners or motor vehicle policy offers. Rather than merely increase the coverage on the other two policies, your clients will often be better served if they can obtain an umbrella liability policy. This is sometimes called *catastrophic liability insurance*.

While a basic liability policy may have low coverage limits, an umbrella policy has very high coverage limits. *Umbrella*, or *excess liability*, policies take over where basic policies stop. Thus, the insured person can get protection against potential liabilities resulting from financial awards that are quite high. Limits and exclusions exist, as is true with all insurance policies, but umbrella liability insurance provides significant protection against liability-related losses.

In most cases, the person seeking coverage will need to carry a minimum level of liability coverage under both homeowners and auto policies. There is no standard policy form. Each company will have its own specific set of requirements and criteria that must be met to issue an umbrella liability policy.

The umbrella liability policy not only increases the coverage that is part of the homeowners and auto policies, but it broadens the coverage as well. Some optional coverages, such as personal injury coverage, are standard under an umbrella liability policy.

If the insured gets sued and the claim falls under the insured's homeowners or auto policy, the appropriate policy will pay first. It is helpful to think of the liability payment that is being made from the car or homeowners insurance as a deductible to be paid prior to the umbrella liability policy being called upon. If the car or homeowner's policy isn't adequate to pay the claim, then the umbrella policy picks up the difference up to its limit of liability. For this reason, it is typically best to have both the umbrella policy as well as the underlying policies with the same insurance company.

Exclusions

Umbrella liability policies do have some exclusions. If watercraft, aircraft, professional services, or business pursuits are covered by endorsements to the homeowners or motor vehicle policy, they usually will be covered by the umbrella policy. If they are not covered by the base policies, they usually will not be covered by the umbrella policy. Following are the normal exclusions (remember, these are liability, rather than property, coverages):

- Owned or leased aircraft excluded under the base policy
- Watercraft of the type excluded under the basic homeowner's policy
- Damage to rented or borrowed aircraft and watercraft
- Business pursuits
- Professional services (unless the underlying insurance program includes coverage for this risk)
- Workers' compensation
- Any act committed by, or at the direction of, the insured with the intent to cause personal injury or property damage

3.2.2 Professional Liability

Personal liability policies do not cover an insured's business activities. Most individuals who are employees are covered for liability by their employer for activities undertaken as employees. However, though personal liability lawsuits are not a common occurrence, professional liability lawsuits take place with significantly greater frequency. Professionals require liability protection for their activities.

Two forms of liability coverage which are available for professionals include:

1. Malpractice insurance
2. Errors and omissions insurance

The cost of professional liability insurance can be high, because people are more likely to sue professionals for failure to use reasonable care in pursuit of their profession.

3.2.2.1 Malpractice and Errors and Omissions

Malpractice

When a medical professional's activities unintentionally cause physical harm to a person, malpractice insurance provides liability protection. Physicians, dentists, surgeons, and hospitals may use this form. Anesthesiologists, chiropractors, hygienists, nurses, opticians, etc., receive coverage using special forms that focus on their particular professional areas.

There is no standard form for malpractice insurance. There are a relatively select group of providers offering this insurance to the medical field; and each of those companies designs its own form. Companies that offer malpractice insurance provide different forms for various specialties rather than using a one-size-fits-all approach. Interestingly, there is technically no exclusion for a medical professional's intentional acts with most malpractice insurance. The reason for this is that what doctors, dentists, etc., do intentionally in their practice is expected, but may have an undesirable outcome. For example, the surgeon intended to cut open the patient (technically assault and battery); he or she just did not intend for the operation to have negative results.

Occurrence versus Claims Made Forms

Insurers use two general approaches to determine which malpractice policy covers a specific claim. In the past, virtually all professional liability policies used an occurrence form. When a claim is made under an occurrence form, the policy that was in place when the alleged mistake was made must pay for the loss. Under this form, if a physician provided care in 2010, and in 2015 the patient developed problems related to the procedure done in 2010, the policy in place in 2010 would be responsible for paying any settlement. This creates what is called a "long tail" of coverage. A major concern with this approach is the insurance company collected premiums in 2010 dollars, but would have to pay a claim in current dollars (this becomes more of an issue when the original policy is many years old).

The occurrence form creates several problems. First, there is no way insurance companies can anticipate claims that might be made 10, 20 or more years in the future. Even if they could, it is not likely they could have charged adequate premiums to cover those claims. Similarly, it can sometimes be difficult—if not impossible—to pinpoint exactly when the damage being referenced occurred. This can become a problem when the professional changed insurers at some point during the period in dispute (i.e., which insurer should pay). An additional problem is that the company that wrote the policy in 2010 may no longer exist or may be out of the professional liability business.

These problems led to the shift toward the *claims made form* of liability insurance. Under this form, the insurance company that issued the policy in place when the claim is made is the insurance company responsible for any required settlement. In the example above, the company providing coverage in 2015 (when the claim was made) would be responsible for paying the claim.

Defense and settlement

In years past, especially in the medical field, the insured had the right to force the insurance company to fight claims in court. This generally was done because of the perception that any

settlement was an admission of guilt. However, perceptions have changed, and many people have come to view liability cases more in terms of economics rather than as a determination of guilt. Under current conditions, if it will cost less to settle a case than to fight it, even if the insured can win the case, the insurer generally will try to settle the case out of court. Few insurance companies and even fewer policies today will allow an insured to prevent an out-of-court settlement.

Errors and Omissions Insurance

When a professional is in a position to cause fiscal (financial) harm (as opposed to physical harm) to a client, those types of liabilities will generally call for the use of *errors and omissions insurance* rather than malpractice insurance. An accountant, lawyer, insurance agent, stockbroker, or financial advisor would use this form of insurance. Very little difference exists between the general structure of this form and malpractice insurance. All the issues discussed above also apply to this form of professional liability insurance.

Life insurance is one of the best known (although not necessarily best understood) insurance types. Further, many people have at least some level of life insurance cover. This is so much so that when people talk about insurance, they often are actually referring to life insurance. There is much to know about life insurance and its annuity counterpart. We will explore this area next.

3.3 Life Insurance

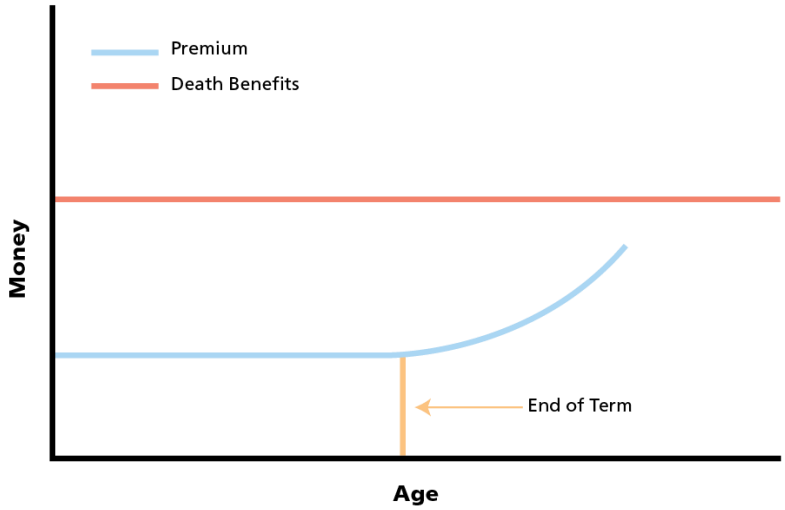
Life insurance is unique among insurance products because everyone will eventually die and so every policy that remains in force when the person dies will pay a death benefit. The reason insurance companies can take on this risk is because the rate at which people die on the aggregate is quite predictable. In short, life insurance companies are very good at predicting how many people will die each year. Consequently, they can develop fair premiums to cover the risk for everyone. Since neither the insurance company nor the policyowner know exactly when the insured will die, both parties are taking some risk. The insurance company is taking the risk that the individual will die shortly after purchasing the policy and that is why they underwrite each individual. The policyowner is taking the risk that the insured will either live beyond the term of the policy (term life insurance) or live a very long time and pay premiums all the while.

3.3.1 Term Life Insurance

Term life insurance, as the name conveys, covers the insured for a specified period, or term. At first, annually renewable term life insurance was the only product life insurance companies sold. The purchaser of the policy paid a premium that provided insurance protection for a single year. These policies were (and are) renewable each successive year, but at a higher premium each year as the insured ages. It should be noted that term policies usually are only renewable to a certain age, usually age 90 or so and in the years prior to that, the annual premium to renew becomes exorbitant relative to the protection provided. That is why most policyowners allow term polices to lapse when they reach their 60s or 70s and beyond. This is not necessarily a problem, because term insurance should be used with the idea in mind that it is only needed for a specific period, to cover a specific need, and should be allowed to lapse when it is no longer needed. For example, a client may wish to purchase a 20-year term policy when children are born to provide for the lost income that would result if the client were to die while the child is still in the household. Once the child reaches adulthood and is living independently, the 20-year term policy has served its purpose and can be allowed to lapse.

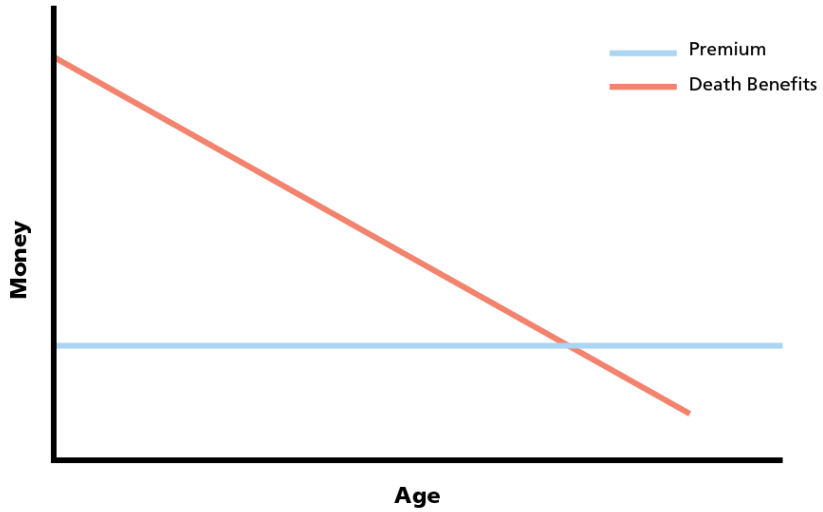
Term products have evolved over the years to include multiyear policies such as 10-year, 20-year or 30-year term policies with level premiums over the entire term. Regular term policies offer a level death benefit and a level premium over the term and typically are renewable each year at increasing rates after the initial term. Because premiums for multiyear policies are averaged over the policy term, premiums paid in the early years are higher than what an annually renewable term policy would cost. However, the premiums would also be lower than annually renewable term in the later years to create a level premium for the entire term. If continued protection is needed beyond the initial period, you may find that it is better for your clients to purchase another multi-year term policy rather than simply pay the annually renewable premium. The basis of this decision would be for how long beyond the initial term protection is needed. For example, if a client's 20-year term policy expires at age 63 and the client needs to continue the coverage for another 10 or 20 years, purchasing another 10-year or 20-year term policy makes sense. However, if the insured only needs to keep the coverage for another three years, simply paying the annual premium could make more sense, assuming the premium was reasonable relative to the amount of coverage being provided.

Figure 1: Multi-Year Term Insurance (Mannaoni, 2016)



Another version of term insurance that seems to be less popular of late is decreasing term. Whereas annually renewable term has increasing premiums over time and a level death benefit, decreasing term has level premiums, but the death benefit reduces each year. Because the amount of insurance protection decreases over time, a decreasing term policy will be less expensive than a level term policy with the same initial death benefit. This type of policy was designed to provide coverage to pay off a mortgage or other debt as the death benefit declines in a manner that roughly approximates the amortization schedule of the loan.

Figure 2: Decreasing Term Insurance (Mannaoni, 2016)



Term policies generally don't build cash value; however, some companies offer term products that can develop some cash value.

3.3.2 Traditional – Whole Life and Endowment

Cash Value (Permanent) Insurance

Some life insurance policies are called "permanent" policies because they are designed to remain in force as long as the person insured is alive. Insurers can accomplish this because these policies retain a portion of the premium in the form of cash value, which helps offset the increasing cost of insurance as the insured ages. To build this cash value, the initial premium for permanent policies is quite a bit higher than what a term policy would cost for the same amount of death benefit protection at the same issue age.

You may be asking yourself, "Why would a person pay more for permanent insurance when lower-cost term policies are available?" The answer lies in the client's time frame for needing coverage. As mentioned above, term policies are ideal when protection is needed for a specific period and purpose. There are some needs for which a client would want death benefit protection regardless of when they die and they don't want to risk the policy lapsing. For example, a client may wish to leave an inheritance for children or a specific bequest to a favorite charity and would use a permanent policy to provide for this even if the client lives to age 100 or more. Another reason for preferring a permanent policy over a term policy is the cash value can be used as the account grows. With many permanent policies, once the cash value grows significantly, it, along with policy dividends (if available) can be used to offset the annual premium. This essentially may allow the policy to pay for itself using the cash value to pay premiums as they come due.

Common types of permanent policies include:

- Whole life (traditional)
- Endowment (traditional)
- Universal life (non-traditional)
- Variable life (non-traditional)

- Variable universal life (non-traditional)
- Joint life—survivorship life or first-to-die

Whole life insurance, as the name implies, is designed to protect the insured for their whole life. To accomplish this, significantly more premium is collected in the early years of the policy relative to what the premium would be for a one-year term policy so that the premium can remain level in later years. It works similarly to the way a 20-year or 30-year term policy works in that premiums are averaged over time.

The big differences are that the policy time frame is generally to age 100 or older and the additional premium paid in the early years collects in the form of cash value after policy expenses are paid. The policy is designed actuarially to guarantee a death benefit and to guarantee a minimum increasing cash value, and will be in force until the death of the insured as long as premiums are paid.

Some whole life policies are designed to endow at a specified age, such as age 100 or earlier. In an *endowment* policy, the cash value will equal the death benefit at the specified age at which the policy endows. When the policy endows, the insurance company normally will send the policyowner a check for the proceeds. In some situations the policyowner can extend the policy for an additional period or convert the endowment to an annuity. Endowment policies used to be popular as savings vehicles in addition to providing a potential death benefit. Over time, they have become less popular as more options are available.

With all whole life policies, the insurance company invests the cash value in the company's general account, which consists primarily of a very conservative real estate and bond portfolio. Consequently, the returns are considered safe, but also relatively low. However, they are guaranteed, which is a key word to remember when it comes to describing the benefits of whole life insurance. If a client mentions that they want to play it safe and be certain of the cash value growth, whole life is likely a good fit. Because the premium, death benefit, and cash value are guaranteed (as long as premiums are paid), life insurance companies can illustrate exactly what the minimum cash value of the policy will be at any point in the future. Furthermore, if the policy pays dividends – and many whole life policies do – the cash value and death benefit can exceed illustrated guaranteed amounts. The cash value or death benefit will never be lower than the guaranteed amount unless the policyowner at some point took out a loan or made a withdrawal.

Limited Pay Whole Life

Limited pay policies are those that provide coverage for the insured's whole life, but allow payments to be made for a shorter period of time. While standard whole life policy premiums continue for the life of the insured, a limited pay policy might only require payments until age 65, or for 20 years (as examples). Depending on the payment period, premiums will be somewhat higher than standard whole life policy premiums. However, the policy will be paid-up much earlier.

Modified whole life policies are different. They often combine a term life policy with a whole life policy. For example, the term element may be in effect for 10 years, after which the whole life policy and premium will begin. Full coverage with initial lower premium payments is the primary rationale for this type of policy. Modified policies are often used to insure children. When the child reaches age 18 (or up to age 25) the policy switches from the term policy and lower premium to a whole life policy with a higher premium. In this way parents can insure children at

a reasonable cost and assure availability of continued coverage as the child enters adulthood, regardless of what happens to the child's insurability.

Insurers often offer additional variations on the basic policy types. You may see hybrid policies, graded premium policies, single premium policies, adjustable life policies and others. The adjustable life variation became the forerunner of universal life insurance, part of what we can call the group of non-traditional policies.

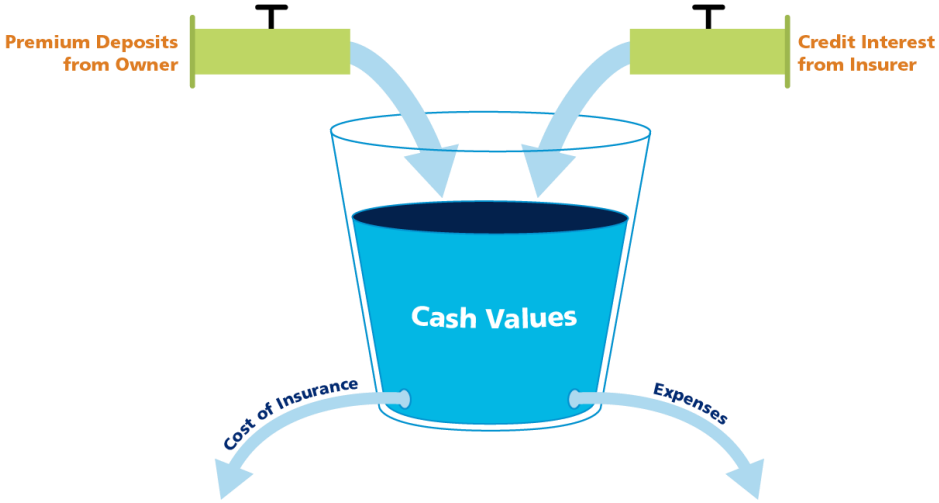
3.3.3 Non-traditional – Universal, adjustable, variable, variable universal

Universal Life

Whole life insurance policies are fixed or bundled. That is, the policy face amount or death benefit, mortality charges, premium and cash value components are all bundled into the policy. As such, they are essentially inseparable. *Universal life (UL)* policies are often referred to on the policy as flexible premium adjustable life. They have the same elements as a whole life policy, but unbundle the components—mortality charges, expense charges, and interest rates—and keep them separate. Rather than the fixed premiums associated with whole life, conventional universal life allows for some flexibility in the amount of premium paid. In fact, flexibility is probably the real distinction of UL. Premiums may even be skipped occasionally as long as the cash value has enough funding to cover the expense and mortality charges to keep the policy in force.

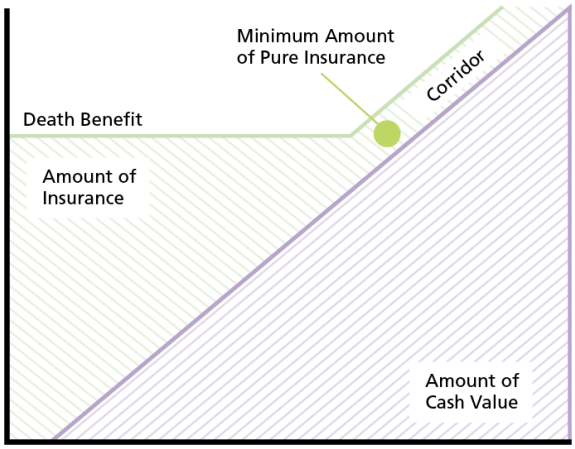
When premiums are paid into the policy, the insurance company deducts a portion for the cost of insurance (mortality expense) and an expense load the company deems it needs for itself. While the company expense load is generally level for the life of the policy, mortality costs increase each year. Note that the risk premium – or term premium – is the cost of providing insurance to cover the net amount at risk at any given time. The balance of the premium remains in the cash value and earns interest. As long as the amount of premiums received and interest earned exceeds the cost of insurance and policy expenses, the cash value will grow. If costs and expenses exceed premiums paid and interest, the cash value will decline.

Figure 3: The UL Bucket Illustration (Mannaoni, 2016)



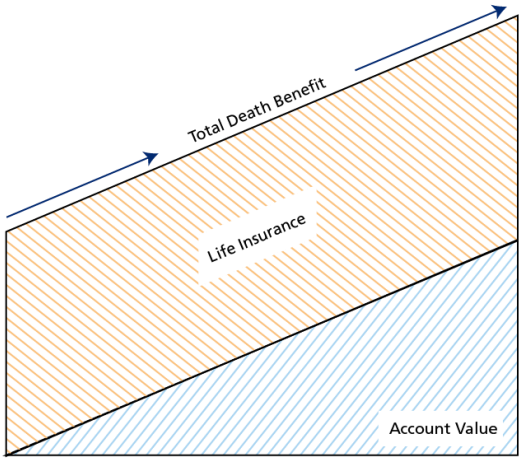
The cash value that builds can be used to offset the amount of one-year term death benefit protection (level death benefit option – type I or A) or it can be used to add to the death benefit protection (increasing death benefit option – type II or B). The level death benefit option will have lower expenses for the pure life insurance protection than the increasing death benefit option because less life insurance is being purchased each year even though the cost per thousand of insurance is increasing. As is true for any permanent product, the policyowner technically is buying an increasing cash value fund and a decreasing amount of term insurance. The net amount at risk for the insurer decreases over time as the cash value component increases. Policies normally are designed to maintain a corridor between the increasing cash value and decreasing (term) death benefit. Many people do not understand that when an insured dies, policies usually do not pay out both the face amount and cash value as a total death benefit. The policy, with few exceptions, only pays the face amount. The nature of permanent life insurance is, in the early policy years the insurer has a greater amount at risk. As the policy ages and the cash value grows, the insurer's amount at risk decreases and the policyowners amount at risk increases. This reflects the aleatory nature of the insurance contracts.

Figure 4: Universal Life (Type I or A) Level Death Benefit (Mannaoni, 2016)



UL policies may also be designed as Type II or B policies where the death benefit increases over time. With the increasing death benefit option, the policyowner is technically purchasing a one-year term policy in the amount of the current cash value. Although the owner likely will not recognize that this is happening, it is the way in which both the face amount plus the cash value amount can be paid as a death benefit (one of the very few situations where this happens). With this option the death benefit increases year-by-year as the cash value amount increases, thus maintaining the insurer's amount at risk. This option is a way to increase the death benefit (within limits) without having to get a medical exam or go through underwriting again. Often, if the policyowner does not increase premium payments each year, the cash value growth will slow, or might stop as the real policy cost increases sufficiently. Remember that as the insured grows older, the mortality costs to insure him or her increase. This is true in all life policies, but is more visible in UL policies.

Figure 5: Universal Life (Type II or B) Increasing Death Benefit Option (Mannaoni, 2016)



Most universal life illustrations state a current interest rate that is presently being paid, as well as a lower minimum interest rate that may be guaranteed. Since the underlying investments are tied to short-term interest rates, they can react to changes in the marketplace more rapidly. Using current interest rate and expense assumptions, insurance companies can illustrate an

estimated premium needed to keep the policy in force. A UL policy normally will have a minimum required premium (necessary to keep the policy in force), a target premium (based on the assumed interest and expense rates) and a maximum premium (the largest amount the insurer will accept for the policy).

Credited interest has four main possibilities.

1. ***Minimum Guaranteed:*** The rate guaranteed in the contract
2. ***Current Rate:*** The interest credited on the current premium deposit, usually guaranteed for one year or less
3. ***Blended Rate:*** Last year's premium payment (or older payments) may receive a different rate than current premiums. These amounts are blended with pools of interest rates that reflect earlier economic conditions (higher or lower than current)
4. ***Loan amounts:*** Interest credited on amounts loaned out may receive current rates or a lower rate

Some companies offer what is called a secondary guarantee universal life product, which is designed to provide a level annual premium throughout the premium-paying years of the contract even though it may not generate any available cash value. In essence, this makes the contract a long-term level-premium term policy.

Early UL policies were based on an assumption of high interest rate crediting that was unrealistic over the long term. As a result, as interest rates reverted to the mean, policy values dropped and some policies lapsed. Realizing this, insurers either stopped offering UL policies or restructured them using more realistic crediting rates. Potential policy lapses are still a concern because of the flexible premium arrangements. A policyowner may pay so little that, as the insured ages and costs increase, there is not enough cash value to pay the higher costs. When this happens, the policyowner must increase premium payments or the policy will lapse.

Initially, no life insurance policy used mutual funds or their equivalent when investing cash values (they were not even available in the earliest years). Money was put in the company's general account. While this practice worked well to support policy security, it was not a good option as an investment. Unfortunately, more than a few life insurance agents had been selling policies as a secure investment that also had a death benefit. True, returns were low, but they were secure.

Over time, as mutual funds and other investment options became more widely available, policyowners began dropping policies and depositing the money in investments that had a higher return. UL policies were among the first to use money-market funds as an alternate investment option. This does not seem radical today, but in the late 1970s and early 1980s when the policies were developed, rates were high and UL policies retained many customers. As mentioned, rates began reverting to the mean and dropping. As they did, insurers felt they had to do something. That something was to use mutual funds or their equivalent (e.g., subaccounts) in new *variable* and *variable universal* life policies.

Variable Life

Variable life was first introduced in the Netherlands, and later became popular in the United Kingdom and other parts of the world. It is estimated that variable life insurance sales account for 15 percent to 30 percent of Europe's new business production. Variable life is essentially built on the same type of platform as traditional whole life, with one main difference. Rather than investing the cash value in the company's general account, money is invested in one of the available sub-accounts. The sub-accounts are similar to pooled / collective investments (e.g., mutual funds or unit trusts). The investment concept is similar to that found in variable universal life policies, but usually not having quite the same amount of variety or opportunity for diversification.

Simply put, variable life combines the traditional protection and savings functions of life insurance with the growth potential of equities. A variable life policy normally includes a guarantee that the death benefit in any year will never be less than the initial face amount. However, the cash value is not guaranteed. Premiums are fixed, like traditional whole life. After deducting policy expenses, the company invests the remaining premium in mutual fund-like separate accounts (or sub-accounts) as directed by the policyowner. Variable insurance products require use of a prospectus that includes all the same types of information usually found in a mutual fund or unit trust prospectus.

Variable life separate accounts are normally invested in equities, bonds, and/or money market instruments. In return for possible improved investment performance, the policyowner must be willing to give up a guaranteed cash value amount. The policyowner also assumes all policy investment risk.

Variable Universal Life

Variable universal life (VUL) policies are similar to universal life policies in the same way variable life policies are similar to whole life policies. The two have a similar structure, with VUL policies also providing the opportunity for the policyowner to invest in several mutual fund-type offerings. The investment risk is transferred from the insurance company to the policyowner, and there is greater potential for better investment returns. The policy also has potential for investment losses. VUL buyers need to be aware of policy investment performance to ensure there are adequate values to sustain the policy for life since the costs for insurance, and possibly administration expenses, increase as the insured ages.

Unlike variable life policies, a VUL usually does not have a guaranteed death. Absent a guarantee, the entire contract can lapse with no residual coverage. Some VUL contracts offer a guaranteed death benefit rider at an additional cost to provide at least some protection if the performance of the subaccounts would result in the policy lapsing.

VUL policies may also be called flexible premium variable life. This recognizes that essentially, VUL combines the flexibility of universal life with the investment aspect of variable life. Keep in mind, unlike variable life, VUL guarantees only mortality charges and the right to keep the policy in force. You can review information on UL policies to get a good idea of how VUL policies are structured (remembering that cash values are handled differently).

Subaccounts versus Mutual Funds

Inside variable products you may find the names of the subaccounts to be exactly the same as or very similar to well-known mutual funds, but it is important to remember that they are not, in fact, mutual funds. Their structure is different and because of this, regulators require them to

carry different identification codes. Taxable mutual funds distribute all capital gains each year, but this is not the case with life insurance policies and annuities whose values typically grow on a tax-deferred basis. Therefore, subaccounts can be managed without regard to tax efficiency. Finally, the fees charged are also different (generally higher with subaccounts), so the performance of subaccount funds will be different from the similarly named mutual funds.

While variable product subaccounts are not mutual funds, they are securities and individuals who wish to sell them need to be properly registered or licensed.

3.3.4 Joint Life Policies

Joint life insurance policies cover more than one insured in a single policy. There are two types of joint life policies—first-to-die and second-to die. These policies may be structured either as whole life or universal life policies. They are designed for specific situations where this feature is important.

First-to-die policies cover two or more individuals and pay the death benefit when the first covered person dies. This makes them ideal tools to fund business buy-sell agreements. For example, if one of four covered business partners die before retiring, the business, as a beneficiary, will have enough money to buy his or her share of the business without impacting current assets. The business can then use the funds to settle with the deceased owner's survivors. These policies can also be used when a couple chooses to leave a bequest upon the first death. It may also be possible to have a contract that gives the survivor the right to purchase a new policy, similar to the original, without evidence of insurability. Premiums are generally higher than the cost to insure either individual, but lower than if two individual policies are purchased.

Second-to-die (or last-to-die) policies cover two people as well, but do not pay a death benefit upon the first death. Instead, these policies pay the death benefit after both individuals pass away. As a result, they are also known as survivorship policies. This unique feature makes the product a good estate management tool when a couple wishes to provide liquidity for estate taxes or to leave a specific bequest upon the second death. Premiums usually are lower than the cost of two separate policies, as is true of first-to-die coverage.

Features & Provisions of Individually-Owned Life Insurance

Standard Provisions

Life insurance policies consistently contain certain normal provisions. Common policy provisions include:

- Entire contract clause
- Ownership rights
- Grace period
- Contestable period
- Misstatement of age
- Reinstatement provision
- Nonforfeiture values
- Policy loans

- Beneficiary
- Suicide/aviation/war
- Dividends
- Conversion clause
- Common disaster clause
- Settlement options
- Common riders
- Installment or annuity table showing direct recognition

Entire Contract Clause

This clause states that the policy, along with the attached application, constitutes the entire contract. Further, this clause states that changes to the contract must be made in writing and must be signed by an officer of the company. This is also known as the waiver clause.

Ownership Rights

Three potential parties exist in a life insurance policy. The policyowner owns the policy. The owner may or may not be the insured. The insured is the individual (or sometimes individuals) covered by the policy. When the insured dies, the policy pays a death benefit. The beneficiary (sometimes more than one) receives payment of the policy proceeds on the death of the insured. All three entities may be involved—owner, insured, beneficiary—or fewer. In fact, there may be only one party involved in a contract, who is owner, insured, and beneficiary (i.e., the estate of the insured).

The owner has all policy rights, including receipt of cash values and dividends and the ability to name beneficiaries, assign the policy, or borrow against the policy. An assignment is a policy transfer. Two basic types of assignments are available to the policyowner. An absolute assignment transfers all ownership rights in the contract from the owner to someone else. A collateral assignment transfers some rights, but not all. Collateral assignments are usually temporary and may be used as security for a loan. When the loan is terminated, policy rights revert to the policyowner.

Grace Period

The grace period is the term, usually 30 or 31 days, after the life insurance premium is due. Technically, if the premium is not paid on the due date, the contract will lapse. However, the grace period allows the contract to remain in full force. The purpose of this provision is to prevent unintentional lapsing of the policy. However, if the individual dies during the grace period, the insurer will subtract any outstanding premium amount from the death benefit proceeds. Also, following the end of the grace period, if the premium remains unpaid, the policy will lapse – either triggering nonforfeiture options (covered below) or terminating if there is no cash value.

Contestable Period

After a life insurance contract has been in effect for a certain period (called the contestable period), the insurer may not deny a claim based on any misstatement or misrepresentation of the insured. The usual contestable period lasts for one or two years. If the insured dies within the time limit, the clock stops, and the insurance company can take any reasonable amount of time required to investigate and determine if there was any material misrepresentation or concealment in the application. Blatant fraud may have no statute of limitations, and in some cases a fraudulent application allows the insurance company to avoid payment of a death claim even beyond the contestable period. This is handled on a case-by-case basis in the courts.

Misstatement of Age

An insured may unintentionally misstate his or her age on the application. When this happens, and the insured is older or younger than indicated, the policy death benefit will be adjusted. The adjustment will be based on the amount the premium would have provided if the correct age was used. Some people believe the insurer will cancel the policy for this misrepresentation, but that is not what typically happens. Another common error is assuming the premium will be adjusted. However, the premium remains the same; the benefit is adjusted.

Reinstatement

This provision allows the policy to be reinstated following lapse. Past due premiums must be paid and the insured normally must provide current evidence of insurability. However, no insurance coverage will have been in place from the date of lapse to the date all reinstatement requirements are submitted, assuming the reinstatement is granted. Upon lapse, and following reinstatement, some companies begin a new, full-term contestable period.

With some companies, the reinstatement clause extends the grace period to some extent. For these companies, there is no requirement to provide proof of insurability if the request is made within 31 days of the lapse date. Many companies allow an application for reinstatement to be made for as long as seven years after lapse. No company will allow reinstatement if a policy has been surrendered for its cash value. Unless otherwise requested, lapse of a whole life policy would result in extended term insurance for a period. This is one of the nonforfeiture options.

Nonforfeiture Options

When you own a cash value insurance policy and decide that you no longer wish to continue to pay premiums on it, you have several options. Over the years of ownership, the policy builds reserves. Since the owner contributed to the reserves that have built up in the cash value account, these options allow the owner to not forfeit those reserves, thus the term nonforfeiture options.

Every cash value of life insurance includes a nonforfeiture table. This table shows the option and amounts available for each policy year. Option amounts are listed as being per thousand of insurance coverage (e.g., values for $100,000 will be listed as 100).

- Cash
- Paid-up reduced amount – cash value used as a single premium to pay for a fully paid-up policy with a face amount (i.e., death benefit) that is reduced from (lower than) the original policy benefit. The policy type remains the same, and continues to build cash values, but the benefit is reduced.

- Extended-term insurance – cash value used to convert the existing policy to term insurance with the same face amount as the original. The nonforfeiture table will show the number of years and days coverage will continue before terminating. The policy will no longer build cash values, and it will only continue as an insurance policy for the term indicated on the table. After this, the policy will laspe without further coverage.

Policy Loan

Depending on the policy, an owner may borrow money from the cash value. The policyowner uses the policy as collateral, and borrows money, at interest, from the insurance company. For example, if someone borrows $1,000 at eight percent for one year, the interest due, if charged in arrears, will be $80 at the end of the year. The present value of $80 due in one year, at eight percent, is $74.07. If another company charges any rate of interest in excess of 7.407 percent in advance, its interest rate is actually higher than eight percent in arrears. This can be an important and somewhat expensive distinction.

The interest rate may be fixed or variable. Participating policies (i.e., those paying dividends) generally use a variable rate. A participating policy that has a fixed interest rate, such as eight percent, generally includes a provision called “direct recognition.” This provision recognizes that the insurance company can earn either more or less than the eight percent being charged for policy loans. If it can earn more, it may compensate by reducing policy when borrowing takes place. If the insurance company cannot earn as much as the eight percent, it may increase dividends. When a variable interest rate is used for borrowing, the dividends are generally the same whether or not borrowing takes place.

When a policy loan is taken from a variable product, an amount of the cash value equal to the amount borrowed is generally moved to a guaranteed interest rate account within the policy. The insurance company is accepting the policy values as collateral for the loan, and as any good business would, it wants those values in a secure investment, not one where the values may fluctuate.
There is no requirement that the loan or interest be repaid. If the loan (and interest) is not repaid prior to the insured’s death, the company deducts any unpaid loan balance from policy proceeds before sending policy proceeds to beneficiaries. In some cases an unpaid policy loan can become large enough, as a result of unpaid interest, to cause the policy to lapse. Depending on the territory, such a policy lapse may also create a tax liability.

Beneficiary

The beneficiary is the entity designated to receive all or a portion of the proceeds of the insurance contract at the insured’s death. The policyowner may name more than one beneficiary. A policy can have primary and contingent (i.e., secondary) beneficiaries. A primary beneficiary is the one who is designated to receive the proceeds first. If the primary beneficiary is unable (e.g., cannot be found or has died) or is unwilling (perhaps due to estate complications) to receive the proceeds, a contingent beneficiary may receive the proceeds. It is possible, and sometimes advisable, to have several layers of contingent beneficiaries (e.g., secondary, tertiary, and so on).

A beneficiary designation can be revocable or irrevocable. Most beneficiary designations are revocable, meaning the owner can change beneficiaries at will. There are times, however, when the owner may choose, or be required, to designate an irrevocable beneficiary (i.e., one who

cannot be changed). An irrevocable beneficiary must approve any contract changes before they can be implemented. The owner may not change beneficiaries, borrow against the policy, surrender the policy, or assign it absolutely or collaterally without the irrevocable beneficiary's written permission. This gives an irrevocable beneficiary a great amount of control over a life insurance policy, so such a designation should only be used with careful consideration. Divorce arrangements often require the policyowner to name the ex-spouse (usually as guardian for the couple's children) as irrevocable beneficiary.

Beneficiary payments, especially when there are both children and grandchildren, may be made either on a per capita or per stirpes basis. When there are grandchildren, the policyowner may inadvertently cause an undesired distribution among beneficiaries. Without proper wording, if one of the beneficiary/children dies before the insured, the deceased child's children (grandchildren) may share equally with any remaining primary beneficiaries. This is a result of a "per capita" or equal distribution. To avoid this, the policyowner must state that multiple beneficiaries in a single class (e.g., children as secondary beneficiaries) are to receive their portion "*per stirpes*" ("by line of descent" or "by right of representation"). If this is done, the children of a deceased child will each receive an equal share of their parent's share, without impacting the share of any remaining primary beneficiaries.

As an example, if the policy lists two primary beneficiaries, both of whom have two children (i.e., four total), and one of the two predeceases the insured, a per capita distribution would divide policy proceeds equally among the remaining primary beneficiary and both children (contingent beneficiaries) of the deceased (total of three; 33.3 percent each). A per stirpes distribution under the same scenario would provide for a 50 percent distribution to the remaining primary beneficiary. The other 50 percent would be equally divided among the two children of the deceased (each getting 25 percent). A per stirpes distribution, therefore, does not dilute the benefit going to any remaining primary beneficiaries.

Suicide/Aviation/War

Death by suicide is normally excluded during a specified period following policy inception. The exclusion period usually is one or two years. This clause provides that if the insured commits suicide within the exclusion period, the insurance company only has to return premiums paid, perhaps with interest. Once the exclusion period passes, suicide is treated as any other death. The exclusion was created to protect insurers against those who deliberately purchase the coverage in advance of a suicide attempt.

Historically, almost all life insurance policies had exclusions for death resulting from aviation accidents. Most current policies cover this eventuality, although coverage for private pilots and pilots and crews of commercial airlines may require an additional premium. During times of declared war, insurance companies may include a clause stating that, in lieu of full payment, premiums will be returned with interest for deaths resulting from war exclusions. Typically, anyone serving in the military is excluded, as is anyone who dies as a direct result of war. For obvious reasons, war exclusions are generally included only during times of war. Also, military personnel are generally offered policies (by the military/government) specifically designed to cover them (even in the event of war).

Dividends

Some life insurance policies pay dividends to policyowners. When a policy pays a dividend to a policyowner, that policy is said to be *participating*. These are usually issued by mutual companies. Mutual companies are owned by policyowners, and stock companies are owned by shareholders. Policies that do not pay dividends to policyowners are called nonparticipating, and are issued by stock companies. When a life insurance company has revenues in excess of expenses, it has a surplus. Some of the surplus is used for contingency reserves, some for working capital, and some is given back to the policyowners or stock holders as dividends. (Stock dividends are not considered part of an insurance policy, and we will not cover them in this course.) Each year, the company's board of directors declares a dividend scale, and the policyowners share in what is called the divisible surplus. Policyowners can use dividends in several ways. These include the following; dividends may be:

- Taken in cash
- Left to accumulate at interest with the insurance company
- Applied toward premium payments
- Used to purchase paid-up additions (PUAs) to the insurance policy
- Used to purchase one-year term insurance (also called the fifth dividend option)

In the early years of a participating policy, the dividends are small. In fact, some companies don't pay a dividend the first policy year or so at all. It may seem like a very minor choice at first, but the dividend choice can have a big impact on the policy in later years. For example, when dividends are left with the company—either to accumulate or as paid-up additions—there may come a time when the policyowner will not need to make any further out-of-pocket premium payments because of the dividend account value. It also is possible that the dividends may allow the policy to become paid up earlier than expected.

Whether from dividends or premium payments, as long as enough accumulated value exists in the policy, the policyowner may not need to make any further out-of-pocket payments. This approach will lower the total cash accumulation that would have been achieved if regular payments had continued, but will also free up cash to use for other purposes.

Conversion Clause

Term insurance policies generally include a provision that permits the policyowner to convert the term insurance into a cash value (permanent) form of insurance. Individuals often purchase term insurance to meet their long-term needs because they can't afford to purchase permanent insurance. Once their income increases, they may want to replace all or part of the term insurance with a policy that more appropriately addresses their long-term needs. This clause often limits conversion to specific forms of cash value insurance, and usually permits conversion only up to the policy anniversary nearest the insured's age Some low-cost term insurance policies further limit the conversion right or exclude it altogether. When the conversion right is restricted, it is often limited to the first five years or so after the issue date of the original term policy.

Common Disaster Clause

This is sometimes called a payment delay clause. Simply stated, if the insured and the primary beneficiary die in a common disaster, even if the deaths occur as much as 30 days apart, the beneficiary is presumed to have died first. This automatically gives the proceeds to the secondary beneficiaries. Think of the complications that would occur if a couple are killed in an

accident and they each have a life insurance policy naming the other as primary beneficiary. It could be impossible to determine who died first and even if that could be determined, it would be disadvantageous to have the death benefit paid to the now-deceased spouse. This clause essentially bypasses the primary beneficiary and allows for the secondary beneficiary, who would receive the benefits eventually anyway, to collect the proceeds faster, with minimal complications.

Settlement Options

When the proceeds of a life insurance policy are paid out as a death benefit, or when the cash values are paid out, a lump-sum payment is the most commonly used method of distribution. Sometimes, however, some other method of distribution is better suited to the needs of the recipient. Policies offer many distribution options. All the proceeds may be distributed using any given option, or several options may be used with different portions of the proceeds.

Annuities and life insurance policies offer the same settlement options. Settlement options are covered in detail when we cover annuities below.

Common Riders

Insurance companies, being creative marketers of their products, are always looking for ways to give their product a competitive advantage. As a result, policies can come with several riders and options that allow for customization of the policy to meet a client's needs and to compete in the marketplace. Riders are the same as endorsements on general insurance policies. They vary by company and policy, but common examples include the following:

- ***Return of Premium:*** Pays the policyowner an amount equal to the premiums paid over the term if the insured survives the term.
- ***Spouse and Children:*** Allows more than one person to purchase term insurance in one policy with a single policy fee versus multiple policies with a policy fee on each.
- ***Waiver of Premium:*** Allows the policyowner to keep the policy in force if the owner becomes disabled. Typically, this rider kicks in when the policyowner is totally disabled for 90 days.
- ***Accidental Death Benefit:*** Typically doubles or triples the death benefit if the insured dies as a result of an accident. These riders sometimes include coverage for dismemberment as well.
- ***Accelerated Death Benefit:*** Provides certain living benefits to insureds with special circumstances.
- ***Terminal Illness:*** Allows an insured who is terminally ill to receive all or a portion of the death benefit while he or she is still alive.
- ***Critical Illness:*** Pays if an insured has suffered certain life-threatening catastrophic illnesses such as kidney failure or certain types of cancer.
- ***Cash Value Policies:*** May also offer two additional riders.

- Guaranteed insurability allows policyowners to insure the insured's ability to buy more life insurance in the future regardless of their health.
- Long-term care pays benefits if the insured requires long-term care in a nursing home or hospital.

3.3.5 Amount of Insurance Needed

There are two basic techniques for dealing with financial risk related to death. You can retain the risk or transfer it. To help make this decision, ask, "When you die, who will suffer economic loss?", and, "Are there enough liquid assets to cover all final expenses, pay off debts and any taxes that are due, and provide sufficient income for the dependents left behind?"

Since every family's situation is unique, time and care need to be taken to conduct a thorough needs analysis that considers these unique situations. The process involves recognizing and evaluating the client's qualitative and quantitative goals and evaluating these variables to determine what amount of insurance is needed. Even then, ultimately, the best solutions are something of an educated guess (another good reason for regular client reviews).

One reason for this is that the word "needs" implies deciding the minimum amount of insurance required. It is also important that a client's "wants" are included in these calculations. For example, be careful not to assume a given client merely wants survivors just to get by. Many people want family lifestyles continued and dreams fulfilled, even if they are unable to participate.

For many people, life insurance is the best option for transferring the risk of financial loss caused by death. There are several good methods for determining the necessary amount of life insurance coverage. This section will consider two basic approaches. The *human life value (income-based) method* puts a value on replacing economic worth. The *needs-based method* analyzes potential needs and, applying a present value to the needs, calculates the required amount of insurance.

One additional note: life insurance is a cash substitute. The economic need at death is for cash to help dependents pay final expenses, settle the estate, and continue their lives—without experiencing adverse financial consequences. This money can come from existing assets or from life insurance proceeds. Unless a person has the required assets, life insurance can provide cash when the need arises. As one's personal estate increases, it may be worth considering the retention of more of the risk, or perhaps completely forgoing the use of life insurance. However, it is unlikely that anyone who has dependents will completely outgrow the need for at least some life insurance.

Human Life Value (Income-Based) Method

With the income-based method, five basic steps determine a person's human life value:

1. Estimate future average annual earnings.
2. From these future earnings, subtract income taxes, insurance premiums, and personal living expenses. This shows how much income the rest of the family actually uses, and becomes the annual payment needed at the beginning of each year (PMT).

3. Estimate the number of productive years (N) the individual has left (i.e., until retirement).
4. Determine an appropriate discount rate (I/YR) for the future earnings.
5. Calculate the present value for the payment stream as an annuity due (PVAD).

Example (Mannaoni, 2016)
Use the income-based, human life value approach to determine a life insurance need. Estimate average annual earnings in the future (assume $50,000 for this example). Deduct personal living expenses, insurance premiums, and taxes (assume $20,000). Determine the number of years prior to retirement (assume 25 years). Determine the discount rate (assume four percent). Now do the calculation. Set the calculator to BEGIN mode. This example would be calculated as follows:

PMT = $50,000 – $20,000 = $30,000
N = 25
I/YR = 4
PVAD = $487,409

For this example, the income-based need for life insurance is $487,409.

The strength of this method is that it accounts for the working life of the deceased, and by inflating the income-producing ability, a more accurate present value can be calculated. The weakness of this approach is that it limits the needs analysis to final expenses and the income-producing ability of the deceased. There is often much more to the client's situation than just these factors. For instance, this method fails to incorporate potential promotions or job changes and the additional income that would accompany these events. Additionally, the amount needed is depleted since this method uses a capital utilization. This will be discussed further below.

Needs-Based Method

The second basic method of determining life insurance needs is much more specific. A personalized needs-based approach allows the advisor and the client to include all the client's needs and wants to determine how much life insurance a client wishes to purchase. This approach is more thorough in that it accounts for much more than just income replacement and final expenses (it also requires more steps and takes longer).

To begin the conversation through this process you can use the acronym LIFE:

- Liabilities
- Income replacement
- Final expenses
- Education funding

Liabilities

Using this as a guide, the first item to determine is whether the client wants enough life insurance to pay off all debt. Most clients can come quite close to the total amount of debt they

have from memory. However, a more precise determination can be calculated by the client's Statement of Financial Position, which includes things like mortgages, education loans, car loans, and credit card balances.

Income Replacement

Income replacement is a bit more complicated to calculate. Using the human life value approach (capital utilization) for this portion of the calculation would certainly be an option. Another option would be to take a capital retention approach to this need. The difference between capital utilization and capital retention is whether the principal used to generate income is gradually depleted or remains intact.

Capital Utilization

For example, let's assume a 45-year-old client named Anna wishes to replace $50,000 of her $80,000 annual income for her spouse's benefit, upon her death. We will further assume that the client expects this salary to increase 3 percent per year and she plans to live to age 90. Since this money is needed to provide for lost income, it may be wise to use a conservative interest (discount) rate assumption in this calculation. For this example we'll use six percent. We will also use the real or inflation-adjusted rate of return in the calculation. The keystrokes on a financial calculator in BEGIN mode are:

- 45, N
- ([1.06/1.03] – 1) = .0291 x 100 = 2.9126, I/YR;
- 50,000, PMT
- Solve for PV = $1,281,305

This indicates that $1,281,305 invested at six percent will generate $50,000 starting tomorrow (when we assume the death will occur) and an increasing amount (i.e., inflation-adjusted) each year thereafter until the Anna would have reached age 90. At that time, the fund would be fully depleted. As long as the surviving spouse dies before that happens, this approach will suffice.

Capital Retention

The capital retention method is a simple capitalization calculation. Using the fact set from the previous example, we would simply divide $50,000 by the inflation-adjusted rate of return. In this example, we divide $50,000 by 2.9126 percent, which results in $1,716,667 as the amount needed to generate $50,000 the first year and an increasing amount hereafter without touching the principal.

This approach requires a greater amount of insurance coverage, along with increased premium cost. However, there are several reasons many clients prefer this method of calculating income replacement:

- It is simple and easy to understand
- While it generates a larger number, and therefore means more life insurance needs to be purchased, few people complain that a death benefit check is too large, and the additional premium is relatively small compared to the additional coverage provided

- When the surviving spouse reaches retirement age, the principal can be used for retirement plans
- If the beneficiary lives beyond the anticipated life expectancy, the principal continues generating income
- When the beneficiary dies, the principal is available for heirs

Final Expenses

The calculation for final expenses is rather straightforward. Final expenses include the costs of funeral arrangements, establishment of an emergency fund, and funds to cover any final medical costs, or to simply provide additional cash for an adjustment period. Additionally, this would be where clients include any specific bequests they may have. For instance, a desire to leave a sum to a charity or a grandchild would be included in the calculation of final expenses.

The primary purpose for this portion of the needs calculation is to provide enough liquidity to have cash to pay for expenses likely to be incurred shortly after death. As an advisor, you should be aware of what funeral costs are in your area. It is generally a good idea to round the amount up for the same reason mentioned in the previous list. Add to this number an amount that would cover the family's expenses for a transition period, perhaps six months' worth. Add an additional amount that the client would like to have just in case there are additional out-of-pocket medical expenses. These added together comprise the total for this portion of the needs calculation.

Education Funding

Education funding can be determined similarly to income replacement. Using the three-step process described below where the current cost of college is inflated, the present value of an annuity due (serial payment) is determined for the college years, and then this sum is discounted to its present value will establish a specific number that can be used for the college funding portion of the needs determination.

Another less complicated option would be to simply take today's cost for college and multiply that by four or five to account for the number of years the student will be in college. Since we always assume death will happen tomorrow when calculating life insurance needs, the assumption under this methodology is the surviving parent can invest the money such that it can keep pace with the rising cost of college.

To illustrate education funding, let's assume the clients have one child who is currently five years old and will be in college for four years, beginning at age 18. We will further assume that a year of college expenses totals $25,000, inflation for college costs is six percent, and our clients can earn seven percent on their investments. We will apply the real/inflation-adjusted rate to reflect how inflation offsets investment return. Using the three-step approach the keystrokes for the first step (inflating the cost of college) would be:

- 13, N
- 6 I/YR;
- 25000, +/-, PV

- Solve for FV = $53,323 – this amount represents the cost of the first year of college in 13 years

The keystrokes for the second step (after setting the calculator to BEG mode since colleges insist on tuition being paid at the beginning of the school year) would be:

- 4, N
- ([1.07/1.06] = 1.094) – 1 = .009434 x 100 = .9434, I/YR
- 53323, +/-, PMT
- Solve for PV = $210,321 – this amount represents the sum needed at the beginning of the first year of college required to cover the costs over four years

The keystrokes for the third step (discounting this lump sum back to today) are:

- 13, N
- 7, I/YR
- 210,321, FV
- Solve for PV = $87,276 – this represents the amount of life insurance needed today to cover the cost of college for the clients' child in 13 years making the usual assumption that the death of the parent occurs tomorrow

By adding the totals calculated in each of the four categories covered using the LIFE acronym, the gross life insurance need is calculated. Subtract existing life insurance amounts from this to arrive at the net life insurance need. Some advisors include other financial assets that could be used by the survivors to further reduce the net amount of life insurance needed. Care should be taken when reallocating savings and investment assets as the survivors may wish to retain these for their intended purpose. The safe option is to leave savings and investment assets alone unless the client insists they be used to reduce the life insurance need.

By using a personalized approach, an individual's situation and attitudes are reflected when determining life insurance needs. The following worksheet illustrates the LIFE approach using a capital retention approach (Mannaoni, 2016).

Liabilities (mortgage, education loans, car loans, credit card balances)	$400,000 +
Income replacement ($50,000 per year in today's dollars assuming 6 percent returns and 3 percent inflation)	$1,716,667 +
Final Expenses (funeral, emergency fund, charitable bequest)	$50,000 +
Education funding (two children for four years each at $25,000 per year)	$200,000 =
Gross death benefit needed	$2,366,667 –
Existing life insurance	$250,000 =
Net new life insurance needed	$2,116,667

It is important to remember that, with married couples, a life insurance needs analysis calculation should be completed for each spouse individually. While the amounts needed to cover liabilities, final expenses, and education may be identical, if the respective wages of each spouse differ, the need for income replacement will be different.

Finally, the life insurance analysis process requires review at various intervals as objectives are achieved or modified and as circumstances change. When working through the life insurance needs determination process, calculations are made as of today (i.e., as if the client were to die tomorrow).

3.3.6 Annuities

Annuities have been called the flip side of life insurance. Life insurance protects against the risk of dying too soon, while annuities protect against the risk of living too long. Insurance companies offer annuities because they have the expertise to provide the annuitant with a guaranteed lifetime income. The only way to do this is to have actuaries include mortality factors into the income calculations. Actuaries work for insurers, so insurance companies offer annuities.

In today's world, annuities are simply another investment option, one that, in some territories, provides tax benefits. However, annuities also offer, as one of their most valuable options, the possibility of a lifetime income. In a time value of money context, an annuity is a stream of payments. We can apply that concept to the annuity product. At its core, it was (and remains) designed to provide a stream of regular payments to the annuitant (i.e., the owner and recipient of the payments). An annuity's function is to spread invested capital and earned interest over a period – such as the life of the annuitant. Actuaries and mortality calculations enter the picture to determine, based on age, and sometimes gender, the amount of each periodic payment to the annuitant. When the capital and interest turns into an income stream, the contract is said to be annuitized.

Annuities do not have to be annuitized over the lifetime of the annuitant. Payments can be structured to last for a specified period, such as 10 or 20 years. In fact, many of today's annuities do not have to be annuitized at all. Unlike with their original iteration, annuity owners may simply make withdrawals at those times when they want to add some income to their cash flow. We should note that some jurisdictions, notably those offering tax-deferred earnings, might require that withdrawals, in specified amounts, begin by a certain age. Further, depending on the contract, either the insurer or the government may assess taxes, surrender charges and penalties against withdrawals.

Definitions

To help with our understanding of annuities, let's review the definition of some terms.

- ***Annuity:*** A contract sold by life insurance companies that guarantees a fixed or variable payment to the annuitant (beneficiary).
- ***Annuitant:*** The owner and individual entitled to receive the annuity's income stream.
- ***Premium Payments:*** May be single (required with an immediate annuity) or flexible (i.e., more than one). Flexible payments allow the owner to deposit money into the annuity at

irregular intervals, or on a fixed plan (e.g., monthly). In some jurisdictions, and depending on the annuity's structure (e.g., in a qualified retirement account), relevant laws may limit the amount and timing of payments.

  - ***Single Premium:*** One payment only.
  - ***Fixed Premium:*** A predetermined amount stated in the contract that is to be paid on each scheduled premium due date.
  - ***Flexible Premium:*** The amount of the premium deposit can be changed, within limits, by the annuity owner at any time.

- ***Immediate Annuity:*** Income payments start shortly after a single premium payment is made.
- ***Deferred Annuity:*** Income payments start at a date in the future.
- ***Joint and Survivor:*** Income payments are made to the primary annuitant while both are alive, and the survivor receives some payment after the death of the primary annuitant.
- ***Pure Life Annuity:*** Income payments last for the lifetime of the annuitant, and then terminate.
- ***Life and Period Certain:*** Income payments last for the lifetime of the annuitant, with a minimum specified payment period (e.g., 10 years) guaranteed.
- ***Refund Annuity:*** If the value of the income payments over the life of the annuitant does not equal the principal value of the annuity at the date of annuitization, the balance is paid to the beneficiary either as continued payments or a lump sum.
- ***Fixed Annuity:*** Payout based on an amount guaranteed in the contract. Payments are normally fixed and level. The insurance company bears investment risk.
- ***Variable Annuity:*** Payout based on the number of units accumulated. Payments are variable and not guaranteed, although contracts may offer minimum guarantees as an option. Unlike a fixed annuity, the owner bears all investment risk. However, many contracts offer minimum earnings levels and other protections as options (these options almost always increase contract expenses).
- ***Annuitize:*** Begin a series of payments from the amount accumulated within the annuity contract. For most contracts, once annuity payments begin, the owner can no longer make contributions into the annuity contract. Technically, the accumulation vehicle has been sold to purchase the income stream. Payments may be fixed or variable, and may begin shortly after the contract is executed (i.e., immediate annuity) or at some point in the future (i.e., deferred annuity).

Immediate Annuities

Immediate annuities are those where a single sum is deposited and payments to the annuitant normally begin one benefit period after the contract is issued. The annuity payments are either a fixed amount (immediate fixed annuity) or an amount that varies with the unit value of the underlying fund (immediate variable annuity). An *immediate annuity* (annuitization) most often is purchased because the buyer wants to begin receiving a stream of regular periodic payments that are guaranteed by the insurer to last for some pre-specified period of time, generally the remaining life of the beneficiary(s) or some other pre-selected time frame.

Two very important considerations exist when contemplating annuitization. First, annuitization is generally irrevocable. Once payment begins, no option exists to reverse the decision and retrieve the principal. The second consideration is the erosive long-term effect of inflation on purchasing power; inflation at four percent per year halves purchasing power in a mere 18 years. This substantial risk cannot be ignored by the advisor; clients should always be alerted to this risk and presented with the option of inflation-adjusted payments.

Deferred Annuities

Deferred annuities allow for payment of either a single sum (*single-premium deferred annuities*) or a series of payments over a period of years (*fixed* or *flexible-premium deferred annuities*). The accumulation period begins once the first premium payment is received and the contract is issued. This period lasts until the time when the funds are removed from the contract under an annuity option.

The policy owner normally has the option of making occasional withdrawals, receiving periodic (i.e., annuity) payments under one of several possible annuity options, or taking a lump-sum cash payment.

Annuity payments begin at the date stated in the contract, although generally the annuity start date can be changed by the policy owner at any time before annuity payments begin. The amount of the payments depends on several variables, including the amount invested, the return earned on that amount, the age of the annuitant when payments begin, and the period for which payments are guaranteed. Payments consist of both principal and interest.
Annuity payments can be based on the life of one person or on the lives of two or more people. An annuity contract issued on two lives, where payments continue in whole or in part until the second person dies, is called a *joint and last survivor annuity*. An annuity issued on more than one life, under which payments stop upon the death of the first person, is called a *joint life annuity*.

While withdrawals may be permitted if funds are needed prior to annuitization, they may be subject to tax or other penalties (depending on the company and jurisdiction). The issuing insurance company may impose penalties (called *surrender charges*) on annuity distributions. Surrender charges normally do not last throughout the entire contract period. Instead, they normally decrease over a period of years until they are eliminated. After the first year, investors usually can withdraw a percentage of the annuity's value without incurring a surrender charge. Because of possible penalties and tax considerations, individuals should consider whether an annuity is the best option for their money.

Once the annuitant selects an annuity income option and payments begin, the annuity account is more or less frozen. At this point the owner has used the amount accumulated in the annuity to purchase an annuity payment stream from the insurance company—so any amount previously accumulated in the annuity no longer belongs to the owner (it was "sold" to the

insurance company for the income stream). When someone says the funds in an annuity are "annuitized," he or she is referring to this purchase. Some companies are making changes to annuities that allow for increased distribution (payout) flexibility.

Fixed Annuities

Annuities may be fixed or variable, and the two options are quite different. In the same way that a whole life insurance contract[1] is fixed, meaning preset premiums, cash values and death benefit, a fixed annuity contract is preset. A fixed annuity payment period may be immediate or deferred, but either way, the amount is fixed in the contract.

Contracts almost always vary by company, so even though we can identify basic or core contract types and benefits, it is highly likely that individual insurers will offer variations. Also, we are talking about base contracts. Insurance contracts and annuities often provide options (i.e., riders or endorsements or additional features) that modify basic coverage. As an example, we may identify that a basic fixed annuity contract provides for level payments throughout the contract period. However, the annuity may also have an option that provides for inflation (e.g., cost-of-living) adjustments. These additional coverage options and guarantees almost always increase a contract's expenses. As such, you should do a careful cost-benefit analysis to determine which options, if any, you should recommend.

Fixed annuities are generally more appropriate for conservative individuals, and those who want a guarantee of future income. The relatively low, guaranteed rate of return paid on a fixed annuity is a potential downside. Remember the basic investing rule: low risk usually results in low returns. This holds true for annuities. In fact, if an advisor sees a fixed annuity offering overly high returns or payouts, he or she should investigate how the high returns are being generated. Chances are good that the insurer is using hedging techniques (not always a bad thing) or increasing risk levels in some way that may not be appropriate for a client. Peace of mind is the biggest value of fixed annuities for many individuals. Some people are willing to forego higher returns and income payments in favor of a guarantee. However, others are not so willing, and for them, a variable contract may be appropriate.

A deferred *fixed annuity* is a savings account that earns a fixed rate of interest for a time specified by the insurer. After that period, the insurer establishes a new rate. A *bailout provision* is an annuity contract provision in which the company agrees that if any new rate established by the company is below the rate specified in the provision, money in the contract can be withdrawn without a company-imposed penalty. Not all contracts offer a bailout provision. The insurance company typically guarantees both principal and interest in a fixed annuity. Assets backing fixed annuities stay in the company's general account and are subject to creditors' claims in the event of insurer financial difficulty.

Variable Annuities

One big problem with fixed annuity payments is that they are *fixed*. The guaranteed payout amounts are a two-edged sword. On the one hand, the annuitant can feel secure (assuming ongoing insurer financial viability) in knowing exactly how much money will be coming in each month. That very security, however, often creates problems. A fixed payment never changes,

[1] No annuity qualifies as life insurance. Some contracts may offer a life insurance rider as an option, and some life insurance policy payouts may be annuitized, but the annuity itself is not life insurance. The two are fundamentally different, even though life insurers offer both.

but cost of living almost always does. As discussed in FPSB's Investment Planning and Asset Management course, market risk is not the only type to note. Especially for those who live long, maintaining purchasing power can be a risk that is as big, or bigger. With any amount of inflation, the cost of an item tomorrow will almost certainly be greater than today's cost. The same is true for all inflation-sensitive expenses, and if all the annuitant's payments are fixed, eventually he or she may begin to struggle.

A variable annuity may provide a solution, in that, depending on investment returns, annuity payments may keep pace with inflation. If we can compare a fixed annuity to a whole life insurance policy (minus the life insurance part), we can compare a variable annuity to a variable (or VUL) life contract. The variable annuity accumulation account invests in owner-chosen mutual funds, or their insurer equivalent. This means that variable annuities are securities, and must be treated as such (including observing all licensing-related requirements).

All annuities, other than those with immediate annuitization, have two primary periods. During the *accumulation phase*, the owner makes deposits into the annuity (or one deposit, with a single-premium annuity). In a fixed annuity, these deposits go into the general fund and earn whatever rate has been contractually guaranteed (plus any excess, if applicable). This is not what happens with a variable annuity. Variable annuity deposits purchase *accumulation units*, and are invested in whatever fund or funds the owner has selected. For example, assume the cost of an accumulation unit is $100 and the owner deposits $100. He or she would have purchased one accumulation unit. If the deposit were $500, the owner would have purchased five units. When the time comes to annuitize, the initial annuity payment amount would be determined based on the number of accumulation units in the contract. From that time on, as the value of each unit (now called an annuity or payment unit) increases or decreases, annuity payments would raise or lower in response (more on this later). The value of each accumulation unit would vary, just as the value of each mutual fund share varies, based on market returns. Some annuities offer minimum earnings guarantees, but such guarantees always come at a price, which must be weighed against the benefit provided.

As is the case with variable life insurance policies, some contracts offer just a few investment alternatives, while others may offer hundreds of options. Investment options have all the same type of expenses as with any mutual fund, including those related to investment management and distribution. Additionally, all annuities have expenses related to the actual annuity contract. These include administrative charges along with mortality-related expenses. Some contracts may have sales charges, and if so, they are usually of the contingent-deferred or surrender variety. That is, if the owner withdraws money from the contract within a set period following the original purchase (e.g., 10 years), the insurer may deduct a percentage from the withdrawal as a way of recapturing sales charges. Some contracts, but not all, allow minimum withdrawals without assessing a sales charge. Typically, surrender charges eventually fall away. A financial advisor should be aware of the period and amount of any surrender charges and advise accordingly. Most contracts allow the owner to move money from one investment option to another, but the number of times this can be done annually may be limited, and fees sometimes accompany the transfers.

If you are getting the idea that at least some variable annuity contracts can have a lot of fees, you are correct. While annuities, like most investment options, can serve a valuable function, advisors must exercise caution to determine whether related fees are excessive. Also, when trying to calculate annuity investment returns, you may see a sizable difference between gross and net returns – especially in the contract's early years. Focus on the need, as is true with any

investment option, to weigh benefits against expenses, and carefully consider whether to use or recommend annuities accordingly.

The *annuity phase* or payout period follows sometime after the accumulation phase. In the case of fixed annuities, payments will be fixed and clearly identified at the beginning of the payout period (remember that some contracts offer inflation adjustments). Variable annuity payments are not fixed, and only the initial payment will be identified. We should mention that it's always possible that the owner will simply want to liquidate the contract and receive all available funds in a lump sum. This payout may or may not be taxable (at least in part), depending on regulations in the jurisdiction, and the type of contract.

Assuming the owner elects to have a payment stream, the insurer would convert accumulation units to annuity or payment units. All the same distribution options apply to variable contracts as are available with fixed annuities (e.g., single life, joint life, period certain, etc.). The owner often has the option to opt for a fixed payout or one that is variable. Sometimes, both options can be applied – to part of the contract's value, of course. Since the variable payout option is a big part of the rationale for variable annuities, most people choose this path. The payment amount of each annuity unit reflects the annuitant's age, and sometimes gender, life expectancy (just as with fixed annuities), payout option (e.g., single life, period certain, etc.), and investment return. That last item is what causes each payment to vary. Sometimes payments are guaranteed for a period, but if not, each payment will rise or fall as the value of the underlying investments does the same. For this reason, annuitants cannot accurately predict the amount of each payment they would receive. At the same time, assuming solid investment performance, the annuitant should be able to count on at least the potential that payments would keep up with inflation. Remember, the number of annuity units does not change, but their value does. This may be re-calculated on a monthly, quarterly, semi-annual or (often) annual basis.

Indexed Annuities

Indexed annuities (IAs) offer some of the growth potential of the stock market with the downside protection of a guaranteed annuity. These products are fairly sophisticated, so both financial advisors and their clients should have a firm understanding of these annuities before adding them to a portfolio. Further, there are several variables in these products, which can make comparisons difficult. Many regulators have issued warnings expressing concern over the complexity of and potential problems associated with IAs.
Indexed annuities have characteristics of both fixed and variable annuities. IAs usually provide a guaranteed minimum interest rate and an interest rate tied to a market index. They typically are linked to a benchmark (such as the S&P 500), which provides the growth potential in these accounts. The *participation rate* determines how much of the underlying index's gain will be applied to the account value. For example, if the participation rate is 90 percent, and the S&P 500 increases by 10 percent in a period of time (called the *index interval*, which can be 1, 5, 7, or even 10 years), the annuity's account value would increase by 9 percent (90 percent of the 10 percent increase). Some annuities may also have a rate cap, which will limit the amount of growth that can be applied to the account value for a given interval.

There are different methods of measuring the change in the underlying index. The *percentage change* method measures the percentage change in the index from the beginning to the end of the index interval. Only the index's starting and ending points matter; market fluctuations in between are ignored. In those intervals when the index declines, no gain is credited to the account. The *ratchet method* (also called point to point) locks in the gain credited to the account each policy year. The index value at the end of one policy year becomes the starting value for

the next policy year. The *spread method* subtracts a fixed percentage (such as two percent or three percent) from the index's percentage change in a given interval. If the index grew by 30 percent over a three-year interval and the insurance company used a two percent spread, the account would be credited with a 28 percent increase in value.

In terms of downside protection, assume the S&P 500 declined 10 percent over a given index interval. In this case, the annuity's account value would remain unchanged from its starting point for that interval. While the annuity owner did not earn any interest or have any gain during this period, neither did the account lose money due to the market's drop. This downside protection can be very appealing to a client who wants to participate in the market's gains (to a limited degree) while avoiding market losses.

The idea is that the account value in an indexed annuity will not decline unless the owner takes a withdrawal. In particular, the timing of a withdrawal can have a significant impact on the participation rate. The ideal situation would be for the annuity owner to *only* take withdrawals immediately after the participation rate (for a given interval) has been credited to the account. Once the participation rate has been credited to the account, the increase in account value is locked in and guaranteed into the next index interval. So you can see that a withdrawal in the middle, or towards the end, of a participation rate interval could minimize the growth potential of the account for that period of time. One final note: as mentioned above, regulators are giving IAs extra scrutiny. They are concerned that these products may be too complex, that IAs are not being adequately described (with adequate disclosures) to potential clients, and that there is too much opportunity for abuse.

Settlement and Payout Options

Annuity payment options are essentially the same as life insurance settlement options. In both cases, lump sum payment is the option most commonly used. This gives the beneficiary all the funds at once. These can then be used for any purposes and serve a valuable cash flow function. When beneficiaries choose to receive regular payments in lieu of a lump sum, the life income option is most frequently chosen. This option will make payments during the life of the beneficiary. At death, all payments stop, regardless of whether money remains in the account or not. As an example, assume an account has $100,000 and the beneficiary has chosen a life income (or single life) payment option. If the beneficiary dies after receiving payments of $20,000, the remaining $80,000 will stay with the insurer. There is no recourse. This is why this option is seldom recommended, except possibly for situations in which only one individual is involved, and he or she does not wish to leave a bequest to anyone.

In addition to life income, annuities (and life policy settlements) also offer other options:

Payout and settlement options:

- ***Joint (and Survivor):*** Payments continue during the lifetimes of both annuitants, after which they terminate. Joint payments may remain level during both lifetimes, or may be reduced (e.g., one-half) following the death of the primary annuitant. If the annuity has a survivor option (certain jurisdictions only) any amount of the basis (i.e., capital plus earnings) that remains after the deaths of the annuitants will be paid to a beneficiary.
- ***Period Certain:*** Annuity payments continue for at least a minimum number of years (e.g., 10). Depending on the contract terms, payments may end once the set number of years has

passed, or may continue for the remaining lifetime of the annuitant. If the annuitant predeceases the period certain, remaining funds go to a beneficiary.

- ***Fixed Amount:*** Annuity payments made in a fixed amount (e.g., 1,000 pesos) for as long as the principal (and earnings) last, after which all payments stop.
- ***Refund:*** Depending on the payout option chosen, the contract may allow for a refund of any remaining money (principal plus earnings) left in the contract at the end of the annuity period (i.e., when the annuitant dies). Where included, the total of payments will be calculated, and if less than the total amount of principal and earnings in the contract, the remainder will be paid to a beneficiary. As an example, if the principal is $100,000, and total payments add up to $80,000, the beneficiary will receive the remainder of $20,000. However, if total payments are more than $100,000 (in this example), the beneficiary will receive nothing, as the original principal has been fully distributed.

Some contracts may allow for variations on the primary options listed above. Further, it may be possible to allocate some of the capital to more than one payout option. Finally, the preceding annuity option list refers to *annuitization*, not periodic withdrawals. Withdrawals, where allowed, enable the owner to receive money from the contract without changing the contract's structure, and keep annuitization options open.

The life insurance and annuity section of this chapter has a lot of content, and much more exists. This is one of the areas of study that can support entire degree programs. We have covered the fundamentals, and now will begin looking at other types of cover, beginning with health insurance.

3.4 Health Insurance

A significant medical claim is one of the most potentially devastating losses an individual can experience. Medical events such as heart attacks, cancer, strokes, and catastrophic injuries, such as those that result in paralysis or permanent brain damage, can leave a person or family devastated with enormous medical bills.

Governments in many territories provide a base-level of healthcare for citizens. Coverage usually comes with limitations and any number of requirements, but it has one strong benefit – it doesn't cost money (other than the taxes that may be required to fund programs). Unfortunately, the benefits provided under these programs sometimes have large coverage gaps. This is especially true when an individual desires a specific type or level of care that is not offered with the base benefits. This situation results in either not getting the desired care or getting it, and having to pay a large amount of money for the services.

Private health insurance is designed to help people manage this risk area. Even with insurance, there can be significant out-of-pocket costs due to deductibles, copayments, coinsurance, and high maximum out-of-pocket limits. In addition to a health insurance plan, individuals and families would be well-advised to have enough cash reserves (i.e., emergency funds) to handle a catastrophic medical event.

While most routine medical issues are relatively inexpensive, the cumulative cost of doctor visits and prescriptions can add up over the course of a year. Most individual health insurance

policies require the insured to pay for a portion of these costs until the deductible amount is reached and then additional costs until a specified maximum out-of-pocket amount is reached.

Having a coordinated plan that includes health insurance and savings is important to managing the cost of healthcare. Even without a significant or catastrophic medical event, healthcare costs can mount up and drain a family's or an individual's savings account. Additionally, the cost to consumers for healthcare continues to increase each year as the cost of healthcare itself rises and many people find that deductibles and out-of-pocket maximums increase.

Coordinating health insurance coverage, which provides protection against large losses with a cash reserve and policies, can help clients manage the out-of-pocket costs health claims will generate. Healthcare plans provide coverage against the risks of sickness and accidents. In addition to government-provided healthcare programs, individuals may be able to obtain coverage from their employers. Clients also may wish to purchase primary or supplemental insurance to cover expenses not covered by government or employer-provided benefits. Different territories may offer different types of coverage.

Two categories of people may need coverage in a given territory: citizens and expatriates. Coverage requirements are likely to vary—sometimes greatly—between these two categories of people. As a result, even if citizens of your territory may not need or use a particular type of healthcare coverage, those in the expatriate community may. Some of these people may be clients, so it is worthwhile to know the types of coverage they may have or need.

The content that follows highlights the major types of coverage that may be available in a territory.

Sources of Coverage

Group Coverage: Some employers are able to offer group health plans at a lower rate than what would be available if employees purchased plans individually because they may offer a large number of potential covered people to a plan provider. Some plans require a waiting period, such as 60 days, before a new employee becomes eligible to join a company's health plan, but some plans provide immediate eligibility. Employers offer a variety of types of plans, some of which will be discussed later.

Privately Purchased Coverage: As with group coverage, a variety of plan types are available. Costs for individual plans (meaning a plan purchased by a single person or by a family) typically are much higher than an equivalent group plan. While employers are sometimes able to negotiate a lower group rate, an individual is not able to leverage group bargaining power. As with most types of insurance, individuals can reduce costs by "self-insuring" as much as possible. When an individual self-insures, he or she assumes a higher deductible, a higher co-payment, or a higher coinsurance provision (terms to be defined later in this unit).

3.4.1 Types of Medical Expense Insurance

Basic Medical Expense Policies: These policies typically cover doctor visits while the insured is in the hospital, as well as office visits, laboratory services, and other care provided outside the hospital. They do not generally cover additional expenses, especially those in the "major" category.

Comprehensive Medical Coverage: Major comprehensive insurance products provide coverage for the large medical expenses associated with a serious injury or long-term illness that could become financially damaging. Relatively few exclusions occur in most comprehensive medical policies (at least insofar as normal medical procedures are concerned), but specific procedures often contain limits (similar to a scheduled benefit), or benefits may be limited to what the carrier considers "usual and customary" or the "prevailing rate." Normal maximum policy limits can range above $1 million (or sometimes offer coverage without an upper limit). With such high coverage limits, comprehensive medical policies may have three cost containment features to help keep costs down: *deductibles*, *coinsurance*, and *copayments.*

The deductible in health insurance works in the same way as a deductible on a homeowners or motor vehicle policy. This is the amount that the insured must pay before the plan pays anything (although homeowner deductibles come off the back end). However, health insurance policies differ in that the deductible doesn't apply to every service. For example, preventive care and wellness benefits, such as mammograms and well-baby care, may be paid 100 percent by the insurance company.

Another difference is that health insurance deductibles are normally annual deductibles, not per incident deductibles. As an example, if a driver has three accidents over the course of a year, the collision deductible would be applied to each claim. If an individual has three health insurance claims in a year, the deductible is not normally applied to each claim, but instead, costs apply cumulatively to the deductible. So, if an insured has a $2,000 deductible and the covered expenses of the first of three claims is more than $2,000, there would be no deductible required on the remaining claim coverage.

Coinsurance is a percentage of the expenses that are paid by the insurance company once the deductible has been met for covered services. A plan might have a deductible of $2,000 and then a coinsurance percentage of 80 percent up to the maximum out-of-pocket limit of $6,350. If a service is provided that costs $5,000, the insured would be responsible for the $2,000 deductible and another $600 due to the coinsurance. The insurance company pays 80 percent of the remaining amount (following the deductible), so the insured pays 20 percent ($3,000 x .2 = $600) and the insurance company would pay the remaining $2,400.

Copayments, or "copays" as they are often called, are easily confused with coinsurance, but they are quite different. A copayment is a set amount that the insured will pay for a service, such as a doctor visit. The copay amount may or may not be applied to the annual deductible or coinsurance percentage depending on the plan. Copayments are another cost-sharing feature that varies among the different plan categories.

Another term with which you need to be familiar when discussing health insurance is *maximum out-of-pocket limit (MOOP limit),* or just *out-of-pocket limit.* The MOOP limit is a set amount that varies among the plans beyond which the insurance company pays 100 percent of the expenses for covered services. This is a stop-loss amount that allows individuals to know exactly the most they might have to pay in any given year for healthcare expenses. For many people, this is a new term and yet very important because it is this dollar amount that they need to make plans to pay in a worst-case scenario.

3.4.2 Managed Healthcare Plans

Managed healthcare plans came about to address the rising costs of medical care and encompass a variety of healthcare programs. First developed in the United States, these plans

have spread to other territories. While there are many variations, not all of which are likely to be offered in every territory, the following identifies the major types of managed healthcare plans and terms.

Capitation: Various managed care plans use capitation to control costs. Capitation is where primary care physicians are paid a fixed fee for every healthcare plan subscriber who names that physician as their primary care physician. The physician then provides whatever services the patient needs. If the patient never visits the doctor, the doctor profits. If the patient visits every week, the doctor loses money on that patient. Managed care plans often use capitation payments for primary care physicians and use negotiated fee reductions for specialists.

HMOs: A health maintenance organization (HMO) provides, through its own or contracted physicians and contracted hospitals, comprehensive healthcare services in return for a set, prepaid premium. The standard HMO is both the financier and the provider of healthcare. When an insurance company offers HMO-style coverage, it is technically called an exclusive provider organization (EPO), although most people won't be able to tell the difference between an EPO and an HMO. With EPOs, the insurer is the financier, but not the service provider. HMOs may be self-run, but there also are many HMOs sponsored by a variety of physician groups, insurance companies, employers, labor unions, hospitals, and consumer groups.

The prepaid monthly premium allows HMOs to provide healthcare at little cost (a *copay*) or no extra cost at the time of service. HMOs encourage subscribers to have regular medical checkups along with other preventive care. Although the monthly premiums for some HMOs may be slightly higher than those of other healthcare coverage providers, the subscriber receives a greater number of services available at a lower cost. One of the primary drawbacks of the HMO system is that the patient must get the required care from an HMO physician. Individuals who prefer to choose their own care providers may see this as a significantly limiting factor.

HMOs normally operate using a gatekeeper concept. The gatekeeper is your primary care physician. Under normal circumstances, when seeking medical care, you first must see your primary care physician. He or she will determine the recommended course of action, including whether you should be referred to a specialist. Since you nearly always must first go through the primary care physician (except in emergencies), he or she has a great deal of control over the healthcare services you receive.

PPOs: Preferred provider organizations (PPOs) are business entities formed by physicians and hospitals that contract with an insurer, a plan administrator, or an employer (if self-insured) to provide healthcare services. The network providers (those participating in the PPO) are promised increased business in return for lower fees. Insureds going to network providers for needed services are subject to lower deductibles and coinsurance percentages, or they may have to pay only a small set fee for office visits. If an insured chooses to use a non-network provider (unlike HMOs, some PPOs offer this choice), deductibles and coinsurance will be higher. PPOs are designed to hold medical costs down by using several cost containment measures.

POS Plans: Like an HMO, point of service (POS) plans may use the gatekeeper mechanism to keep costs down. Like a PPO, the insured chooses where he or she will receive needed care, and the level of benefits received varies, depending on where he or she goes.

Now that you have seen the different type of healthcare options, you need to know that these plans continue to change how they operate and often incorporate characteristics of other plan types. Changes in the regulatory environment are just one of the many factors that can serve as a catalyst for change. As a result, many plans today don't fit neatly under any one definition. It is important to know the basic plan types, but, in practice, each plan must be reviewed for its operation to be fully understood.

How Much and What Type of Coverage is Appropriate?

In many instances, the decision about how much medical coverage to carry is easy. You have whatever amount of coverage the government or your employer's group insurance provides. Some people will supplement their group insurance benefits by purchasing some form of additional coverage, such as an accident plan or a hospital indemnity plan. If group insurance is not available, the decision about how much non-government coverage to carry often comes down to cost.

As with all risk management decisions, the health insurance risk management analysis comes down to this: How much will have to be paid in premiums, deductibles, copays, and coinsurance to obtain a given level of coverage? Better coverage, of course, tends to cost more money. As an advisor, you can help your clients find a balance between the cost savings (for the amount of risk they keep through deductibles and coinsurance) and the amount of risk they transfer to the insurance company.

Choosing Coverage

Sometimes, people find it difficult to choose the type(s) of coverage they need. Aside from the general cost-benefit analysis, a person needs to assess the types of care needed (or might be needed, based on family history, lifestyle, etc.) as well as determine the level of benefits desired. If preventive care is desired, the person may need to use an HMO. If going to your regular personal physician is important, an HMO or a PPO might not work if they are not part of those networks. With children who require frequent, regular visits to the doctor's office, an HMO or a PPO might be a good fit. Individuals who live or travel regularly outside of an HMO network area may need to choose a non-managed healthcare plan or a POS plan. These, along with the premium costs, are among the factors to consider when deciding what type of coverage is appropriate.

As people in most territories are living longer, they often require another level of healthcare. In many places, hospital-based care tends to be somewhat short-term. This works well for addressing the initial problem, but does not fully support the recovery period. Additionally, many older people do not require full hospitalization, but do need ongoing medical care. This may be provided at home, as an outpatient, briefly in a hospital, or in an extended care facility or nursing home. These expenses may or may not be covered under typical healthcare insurance plans. As a result, insurers have developed a type of cover to specifically meet these ongoing and rehabilitation needs: Long-term, or extended, care insurance. We will explore this next.

3.4.3 Long-Term Care

Before we begin coverage of long-term care (LTC) insurance, it is important to distinguish between long-term care and long-term care insurance. *Long-term care* is the skilled, intermediate or custodial level of care that individuals often need when they get older, but is also provided for younger people who have been severely injured or contract a debilitating disease.

Long-term care insurance, on the other hand, is the insurance product specifically designed to help pay for the long-term care needs individuals may have. Oftentimes, long-term care insurance is shortened to simply long-term care, but the two terms mean two different things.

As life expectancies have continued to rise beyond normal retirement age, an increasing number of people find that they need at least some form of critical or ongoing care as they get older. Although nursing homes have existed for many years, the types of care available have expanded to include home-based care, adult day care, and assisted living communities, as well as the skilled nursing care available in nursing homes and hospice (end-of-life) care that can be provided in a facility or at home. Some long-term care providers have developed a continuum of care communities that allow seniors to initially stay in independent living units, then, as their health declines, shift to assisted living, and finally, skilled nursing as the need for care develops—all without having to leave that specific location. Alzheimer's and memory care communities have also developed to provide for the specific needs mental impairment creates.

Consequently, with the increased demand for long-term care, long-term care insurance was developed as a way to help people with the cost of senior care. Because extended periods of healthcare are expensive, long-term care costs can be the greatest risk to retirement security. As is true of other insurance cover, long-term care insurance is a risk transfer technique that transfers much of the cost of care from the individual to the insurance company. The concept is fairly straightforward in that individuals buy the policy while they are healthy and then, if their health deteriorates to the point where care is needed, they have the insurance to help with the cost. Many elderly people tend to get sick or hurt more frequently and for longer periods of time than most young people. Like many insurance policies, there are many options that can be selected that determine the cost of the policy. These will be covered shortly.

Long-term care (LTC) is generally divided into three categories: skilled nursing care, intermediate care, and custodial care. Most LTC is at a custodial care level, and often provided while the recipient is at home. Frequently, once an individual moves from his or her home to an LTC facility, the level of care increases to intermediate or skilled nursing care. This is not always true, but as most people wish to remain at home for as long as possible, the generality is apt. As already mentioned, LTC is not reserved for seniors. Anyone of any age needing extended care is technically receiving LTC. For our purposes, we will focus on the needs of seniors. Most current individual policies cover all levels of care and also offer what is known as respite care (discussed below).

Skilled nursing care is the highest level of care and generally refers to 24-hour-a-day availability of a registered nurse under a doctor's supervision.

Intermediate care refers to less-intensive nursing, or rehabilitative care. This level of care doesn't require 24-hour availability of a registered nurse or physician.

Custodial care generally refers to care that is not medical in nature, but is nonetheless necessary for the health of the individual. This includes such things as assistance with bathing, moving from bed to chair, eating, etc. These activities are known as activities of daily living (ADLs), and will be discussed later.

Assisted living is one of the more recent developments in long-term care. An individual typically pays a basic monthly fee and lives in a private apartment, which may include some limited cooking facilities. The assisted living facility generally provides meals in a common

dining room. Other levels of care are provided as needed, and the individual is charged as services are used.

Home care market forces have created a greater emphasis on home healthcare needs. These may range from 24-hour-a-day care to a few visits a week to help with specific chores. The typical coverage for home care currently has a somewhat limited reimbursement schedule.

In addition, some policies treat adult day care programs and community-based and assisted living facilities as home care. Realizing that many people do better and need less attention at home, some companies provide the money for specialized equipment to be used in the home so that the qualified insured can remain at home. More companies are also paying for a personal care advocate, who provides an objective evaluation of the care being received.

3.4.3.1 Common Features of LTC Insurance Policies

Activities of Daily Living

Insurance companies often use a list of activities of daily living (ADLs) to determine when coverage will be triggered. The typical list of ADLs includes: bathing oneself, feeding oneself, transferring (say, from a chair to a bed or vice versa), dressing oneself, using the bathroom, and maintaining continence.

When it is determined that an individual can no longer perform any two of these ADLs (usually by a physician), they are eligible for benefits under the policy. Mental impairment such as Alzheimer's disease or dementia can trigger benefits if either of these issues alone is diagnosed.

Coverage Amount

The amount of coverage (i.e., benefit) has a significant effect on the cost of long-term care insurance, because the higher the benefit amount, the higher the cost. When selecting a policy, advisors need to be aware of the average costs of care in their client's location so that an appropriate level of coverage is selected.

If you know what the average annual cost for assisted living in your area is per year, then a monthly benefit amount can be more easily determined when alternative sources of funding are taken into consideration. Most policies have minimum and maximum benefit amounts that can be selected, which allow for a great deal of customization.

Individual LTC policies generally pay a set amount per day toward care expenses. Often the average daily cost of care in a nursing home is used as a starting point in determining the daily benefit. A policy might pay a certain amount per day (e.g., $200); the amount is chosen by the insured. Typically, a higher daily benefit means a higher premium. Coverage may also be provided simply as paying expenses rather than stating a daily benefit. This is less common, but it occurs, and when it does, it functions in much the same manner as a regular healthcare benefit plan. It is rare to find insurance policies that cover 100 percent of assessed charges.

Elimination Period

Similar to disability income insurance policies, long-term care policies use an elimination period that substitutes a dollar amount for a time period that functions as a deductible. During this

period, which begins with initial diagnosis and treatment, no benefits will be paid. The most common elimination period is 90 days, which requires the individual to pay expenses for all care during the first 90 days after being diagnosed. Longer elimination periods are often available that can help manage costs because the longer the elimination period, the lower the cost of the policy.

Benefit Period

After the elimination period ends, the insurance company begins paying benefits throughout the policy benefit period while the insured is being cared for. Maximum benefit periods typically range from two years to 10 years, and when combined with the benefit amount, determine the maximum benefit the policy will pay. Some older policies may have offered lifetime benefits.

For example, if a policy pays a $3,000 monthly benefit ($100 daily benefit x 30 days) and has a five-year benefit period, then the policy has a maximum benefit pool of $180,000 ($3,000 x 60 months). If the monthly benefit is not used each month, then the potential benefit period will lengthen. For instance, if the monthly expense is only $2,500, the remaining $500 stays in the pool, which can extend the benefit period. With a lifetime benefit amount, there is technically no ascertainable maximum benefit. To manage costs, the benefit period chosen can be shortened; the shorter the benefit period, the lower the cost of the policy.

Waiver of Premium

As with disability income insurance policies, long-term care policies often include a waiver of premium benefit that states that once the insured qualifies for benefits, he or she no longer needs to pay the premiums while under care. If it is determined that the insured no longer needs long-term care, then the waiver of premium ceases and premiums are once again payable when due.

Respite Care

Many long-term care policies include a provision for respite care. Sometimes, a family member will be the caregiver for an individual who would otherwise need assisted living arrangements or skilled nursing care. The respite care provision provides for the policy to pay for professional care when the family caregiver needs a break. Consider, even shopping for groceries takes the care-giver away from the one being cared for, and this may not be acceptable. Without provision for periods when he or she is not providing care, it’s likely the elderly person will have to move from the home into an extended care facility (or just not get the care they require).

The reason insurance companies include this coverage, typically at no cost, is because when family members provide care for the insured, the policy does not pay benefits. Most policies state that the care received must be from a duly licensed care provider, so unless the family member is approved to provide care, the benefits aren’t payable.

Respite care can be provided for several hours per week or for several weeks per year, depending on the policy language. This allows the caregiver to remain able to provide care and lessens the likelihood of the insured needing to go to a nursing home.

Additional Features

Bed Reservation: In addition to the features already discussed, most long-term care policies include a bed reservation provision that allows the insured to leave the care facility for a period of time without losing his or her place at the care facility. For instance, if the family wants to take the insured on a two-week vacation, this provision would provide for payment to the care facility to hold the insured's spot. This can be valuable if the supply for long-term care can't keep up with demand in the area where the insured lives or if the insured goes back to the hospital for a period.

Spousal Discounts: Many long-term care policies will offer a discounted rate if both a husband and wife obtain coverage. Also, if there is a spouse in the home who does not obtain coverage, there may be a lesser discount available even if the other spouse is not applying or is uninsurable.

Shared Policy Benefits: Some long-term care policies are issued for couples whereby the total benefit amount is available to either spouse. Both spouses are covered by the same policy and benefits may be paid to either or both; however, the total benefit available limits what will be paid. For example, let's say a couple purchases a shared policy benefit that pays a monthly benefit of $3,000 and has a maximum benefit of $210,000. At some point in the future the husband needs care and collects $90,000 in benefits. This leaves $120,000 available for the wife if needed. If the husband's care used all the benefits available—$210,000 in this example—there would be no benefit left for the wife. At the other extreme, if the husband never needs care, then the entire $210,000 would be available for the wife. Some shared care riders provide an additional pool of funds that spouses can share in addition to each individual's benefit.

Common Riders

Inflation Rider

Inflation riders allow for the benefit to increase over time. Older policies that offered this rider used a fixed amount of increase per year stated as a simple percentage of the initial benefit amount. For example, if the inflation rider is 5 percent and the initial benefit amount is $3,000 per month, then the rider will increase monthly coverage by $150 each year.

Compounded rate inflation riders are more common now, as the costs of care have increased dramatically. This version of the rider increases the benefit by, most often, 3 or 5 percent. This produces an ever-increasing daily benefit amount as a result of compounding.

Either version of the rider may be in place for the life of the policy or for a period, such as 10 or 20 years. Regardless of the length of time, there is an additional cost for adding riders.

Return of Premium Rider

As with other insurance products, a return of premium rider states that for an additional premium, an amount equal to the premiums paid will be refunded in the event no benefits are paid or, in some cases, if benefits paid are less than the premium paid. It's important to weight the cost/benefit of adding this nonrefundable rider.

Restoration of Benefits Rider

Some long-term care policies may offer a rider that provides for the total benefit amount available to be restored if the insured recovers from the need for care for a period, such as six months, if prior to the benefit pool being totally exhausted. For example, let's say an insured has been collecting benefits under a policy for eight months after satisfying the elimination period. Let's also assume the policy provides for a benefit of $3,000 per month for up to five years, which would make the total benefit amount $180,000. Over the eight months the insured has

been paid $24,000, which reduces the total benefit available for future use to $156,000. In this example, though, the insured's health improves such that care is no longer needed and remains healthy for at least the six-month period for restoration stated in the rider. The rider would then restore the total benefit amount to the original $180,000.

Nonforfeiture Option Riders

These riders state that if you cancel your policy after a period of time, a minimal amount of paid-up insurance will remain in force in the event of a claim. Typically, this amount is equal to the premiums paid.

How Much and What Type of Coverage is Appropriate?

Costs for long-term care can vary dramatically by location, as well as by institution. The insured can contact local long-term care facilities to get an idea of typical costs in his or her area. In general, the cost of LTC insurance increases with age, so a person buying LTC insurance at age 60 would pay less than if they purchased the same coverage at age 70. In addition to age, other factors such as overall health, gender, and optional benefits (such as inflation protection) will also affect the amount of the premium. As mentioned above, a person can choose the amount of daily benefits that meets his or her financial needs. In general, a higher daily benefit, a shorter elimination period, and a longer benefit period all result in higher policy premiums.

A financial advisor skilled in elder-care advice can be of tremendous benefit to an elderly person or the adult children of an elderly person looking for long-term care. An important part of this is helping clients determine how much coverage is actually needed. Beginning with the cost of nursing home care (which is usually the most costly type of care), subtract income sources the client has that will continue regardless of whether they are in their own home or a care facility. For married clients where only one spouse needs care, it will be important for income sources allocated to elder care to not reduce support for the spouse remaining in the family home.

Additional income sources may come from government pensions, pensions from employers, annuities, or investment income. These additional sources of income can significantly reduce the amount of LTC insurance that should be purchased, thereby reducing the cost of the insurance.

Hybrid Policies

Hybrid Policies can help clients who may be reluctant to purchase long-term care insurance because they believe they will not ever need long-term care. To address this and still provide protection for the possibility that long-term care will be needed, insurers have developed hybrid policies.

A hybrid policy pairs a life insurance or annuity contract with long-term care insurance. The cost for the policy would be more than what it would be for life insurance or long-term care insurance by themselves, but less than buying the two policies individually. The concept is that if the insured dies without needing the long-term care insurance, the death benefit is paid, but if the insured needs long-term care, the insurance can be used for that.

The long-term care insurance portion of a life insurance policy typically pays a percentage of the death benefit each month for a specified period. For example, if the death benefit is $250,000

and the long-term care insurance benefit is 2 percent per month, the benefit would be $5,000 per month payable for perhaps up to 50 months.

When paired with an annuity, a lump sum is deposited with a minimum amount typically being required. The long-term care insurance protection is two or three times the amount deposited and an inflation rider may be available as well. As an example, let's say an individual deposits $100,000 into a deferred annuity paying 3 percent compound interest with a 300 percent long-term care maximum benefit and a five-year benefit period with no inflation rider. The amount available for long-term care expenses would be $300,000. Assuming no withdrawals have been made, in 20 years at 3 percent, the account value of the annuity would grow to $180,611. If this person needs long-term care, then the annuity would have $5,000 per month available ($300,000 / 60 months) for those expenses. If the insured dies without needing long-term care, the account value would be available for the heirs. If the insured needs some long-term care and then dies, the heirs would receive the account value minus what was paid out for long-term care expenses.

A nice feature of hybrid policies is that the premium for the long-term care insurance is guaranteed to never increase beyond a certain amount. Stand-alone long-term care insurance policies can increase premiums if the insurance company determines additional premium is needed to cover claims costs on the aggregate. Insurance companies can guarantee the long-term care insurance premiums in hybrid policies because they pay lower than market interest rates on the cash values. If interest rates rise, they are under no obligation to share the additional earnings with policy owners.

Is LTC Insurance Worth the Money?

This is a question many researchers and end-users are asking. The answer, as is true of many healthcare-related questions, is not simple and not uniformly applicable. Let's look at some of the considerations.
Two general statements can be made up front. First, if your clients are very wealthy (i.e., assets in the multimillions) they probably do not need long-term care insurance (LTCI). They can pay the expenses out-of-pocket. Second, if your clients are on the other end of the financial spectrum, with less assets, LTCI probably does not make sense. The cost of coverage is likely to be too high. Can you dispute both these statements and show situations in which they are wrong or not applicable? Absolutely! However, both statements can stand as reasonable generalizations (realizing that every person and situation is different and requires individual analysis).

People between those two poles have a more difficult time deciding to what degree LTCI makes sense. Among the factors to consider are quality and availability of LTC, maintaining personal choice and freedom, premium cost, and asset and income protection.

In a capitalistic society, whether we like it or not, those who *have* can generally get better care than those who *have not*. This is not to say that it's fair or the best way for things to be done. The implication is, if you have your own funds you can afford to purchase whatever type of care you desire. If you do not have those funds in the bank, LTCI may provide at least a partial solution. With LTCI, insureds can pay for many of the healthcare services they desire.

It may also be true that more services will be made available to them. Those who have neither funds nor coverage may not have access to all possible healthcare options. Beds may not be available. The best doctors may not wish to treat these people. Alternative forms of treatment

will not likely be offered. If someone wants full flexibility in pursuing any and all reasonable forms of treatment, that person will have to have the financial means to do so. In the absence of a large bank account, LTCI can provide all—or at least some—of those funds.

It will do so, however, at a price. Annual premiums for LTCI can be more than $1,000—often quite a bit more. In addition to being impacted by the benefit amount (e.g., $150 per day), the premium can be controlled to some extent by adjusting the waiting (or elimination) period and the benefit term. The waiting/elimination period is the length of time between when LTC services are needed and when the policy begins paying benefits. The longer the period, the lower the policy premium (up to a point). Choosing a longer period must be balanced with the resulting increase in out-of-pocket expenses. However, if funds are available, longer is probably better. Many policies have a maximum elimination period of about 180 days. However, some offer periods of up to 12 months.

How long of a benefit period to choose is another big concern when trying to manage premiums. The average length of time someone over age 65 might need LTC seems to be around three years (women slightly longer, men slightly less). It would seem logical to choose a benefit period of around this length of time. Many people do. Others want a greater margin of error, and prefer a longer benefit period. However, the longer the benefit period, the higher the premium. As a result, people may choose a much shorter benefit period in an attempt to manage LTCI premiums.
Some individuals might combine an extended benefit period with a very long waiting period (e.g., 12 months) in an attempt to keep premiums a little more reasonable. Use of such a plan might be termed a *catastrophic* LTCI policy. Why catastrophic? While the average need for care may only be around two or three years, what happens if an individual needs LTC for longer—say for 10 or 20 years? Had this person chosen a three-year benefit period, he or she would almost certainly be facing the depletion of available financial assets, perhaps even to the point of having to file for bankruptcy. For those with the means to pay for an extended initial period of LTC, being able to increase the benefit period would help protect against the possibility of a much longer need for care (the *catastrophic* need). Certainly, this would not be an appropriate choice for everyone, but it might be worth considering for some people.

3.5 Disability: Personal

While the loss of a loved one is certainly more emotionally devastating to a family, a long-term disability can be more financially devastating. This is because a disability can cause significant medical expenses in addition to the disabled person not being able to fully function or earn an income. As a result, some have referred to disability as “the living death”.

The difference between life insurance and disability income insurance is the difference between mortality and morbidity. Mortality refers to the potential of death; specifically, the number of people who die in a population. Morbidity refers to a condition of unhealthiness or disease. Life insurance protects against the risk of premature death—mortality. Disability insurance (and other health-related insurance products) protect against morbidity risks, which are associated with reduced health.

This difference is also evidenced in the way disability income insurance and life insurance are underwritten. With life insurance, underwriters are concerned with the likelihood of premature death. With disability income insurance, underwriters are concerned with the likelihood of becoming sick or injured. A person who is currently disabled, and therefore unable to buy

disability income insurance, may still qualify for life insurance. Likewise, a person who might not qualify for life insurance may be able to obtain disability income insurance.

Additionally, underwriters either approve or decline life insurance policies and then determine which rate class is appropriate (e.g., preferred, standard, or substandard). With disability insurance, they may agree to insure the individual with one or more exclusions, such as no coverage if the disability is due to an illness or injury to a specific body part. For instance, a person with previous back problems may be able to buy disability insurance, but if a disability is due to a back injury or illness, that would be excluded.

Understanding these differences and knowing intuitively that the likelihood of people getting sick or hurt prior to reaching retirement age is far more likely than dying, puts the need for managing the risk of disability into perspective. Furthermore, unless they have government-provided benefits or purchase coverage through work as an employee benefit, most people don't have adequate protection in place to manage the financial impact of losing their ability to bring home a paycheck. Clearly, loss of income due to a disability is a significant risk management concern.

This risk can be managed by having an adequate emergency fund, disability insurance, or—perhaps best—a combination of the two. An emergency fund that can provide funds to cover the out-of-pocket medical expenses and replace lost income for a period can protect against the financial impact of a short-term disability. If used in conjunction with a long-term disability insurance policy to provide the funds needed until the insurance starts paying, individuals can more easily manage the financial risk a long-term disability creates. Additionally, if the individual has a good source of unearned (i.e., investment) income, the need for other funding may be reduced.

3.5.1 Common Features of Disability Insurance

Three of the most important disability insurance considerations are the:

1. Benefit amount
2. Benefit period (including the elimination period)
3. Definition of disability

An insurer determines the maximum amount of coverage it will write based on the insured's income. Typically, the maximum amount of coverage will be between 60 and 70 percent of earned income at the time the policy is issued. (This amount does not include income from investments or other unearned income; however, the insurer may use unearned income to reduce the amount of coverage it will underwrite.)

The *benefit period* can be short term (generally from six months to two years) or long term (as long as to age 65 or occasionally, for life). Most benefit periods begin with an *elimination or waiting period*, that is, a length of time during which no monthly payment will occur. You might think of the waiting period as a disability policy's deductible. The insurance premium will decrease in direct relation to increases in the elimination or waiting period. Premiums, coverage periods, and benefit limits are also based on the insured's occupation. In a broad disability classification, most office workers (e.g., white collar) are generally offered better coverage at better rates and for longer maximum benefit periods than most non-office workers (e.g., blue collar).

Disability income insurance coverage makes monthly payments to the insured to replace part of lost income. Coverage can be written to make payments only if the disability is the result of an accident or if the disability results from either an accident or sickness (sickness-only coverage almost never occurs). Accident-only disability income insurance will be less expensive than combined accident and sickness plans because disability due to accidents is much less likely than disability due to illness.

In addition to individual coverage from commercial insurers, disability income benefits can be obtained from governments, employers (through group plans, sick days, and self-insurance), and various other organizations (such as service groups and unions) on a specialized basis. Some of these benefits are available at no cost to the disabled individual (other than perhaps taxes or dues), but most involve the payment of a premium. In the absence of an adequate emergency fund, a short-term disability policy would protect the client by replacing a portion of his or her lost income until a long-term disability insurance policy would begin paying benefits. However, there would still be the out-of-pocket medical expenses to consider. While long-term disability insurance policies can be purchased by individuals, short-term disability insurance policies are more difficult to buy individually and are more commonly offered as a group product through employer benefit plans.

A coordinated plan to manage this risk should include cover for unexpected medical expenses and enough income replacement to provide at least basic living expenses. Doing so with an emergency fund plus short- and long-term disability insurance products allows the individual to focus on recovering and not have to worry about how the bills will be paid. With a protection plan in place, individuals will be able to manage a disability whether or not public insurance programs provide any benefits.

Sources of Coverage

Government: In many territories, the government is the primary provider of disability benefits. These may come as a form of workers' compensation or as a separate program providing income. Benefit payments may only continue for a short period or may be provided for life (or any period between the two).

Group Policies: Group disability income insurance is provided in two basic forms: short-term and long-term. *Short-term* plans are characterized by a limited benefit period, frequently no longer than 26 or 52 weeks. Usually plans include a very short or no elimination or waiting period. This is the period between the onset of a disability and when the initial policy payment is made. A short-term disability income policy does not provide long-term protection and needs to be supplemented by a long-term disability income policy. Benefit periods often are tailored to end when long-term disability benefits begin.

Long-Term Group Disability: Income plans provide protection during periods of extended disability. Maximum monthly benefits are typically a percentage (such as 60 or 70 percent) of regular monthly income, and they may have a preset limit (e.g., 60 percent of income up to $4,000 a month). Long-term plans usually have longer elimination periods (such as 90 days, six months, or a year), to help reduce overall premium costs. If a long-term policy is coordinated with a short-term policy, there may be no benefits gap. As an example, a short-term policy that pays for 26 weeks combined with a long-term policy that has a six-month (i.e., 26 week) elimination period, would provide continuous coverage once benefits begin.

Most long-term plans will coordinate benefits with other available sources of disability income. Benefits normally will be reduced under a coordination-of-benefits provision by the amount of any other benefits payable by workers' compensation or other government-sponsored disability benefits, other employer-sponsored disability benefits, or select pension benefits. Not all plans coordinate benefits, however. Employer plans, for example, *do not* normally reduce benefits for payments made from individually owned policies.

An employee's group disability income coverage normally terminates when employment ends. Coverage will also end if the employer decides to terminate the policy or does not pay the premiums.

Individual Policies: Whether you do not have any group disability benefits available or want to augment the benefits you have, an individual disability income policy may be a good addition to your risk management portfolio. Some individual policy provisions are similar to those of group insurance. Coverage will be written for a specified amount of benefits, with an elimination period, for a specific period. Individual disability policies can cover income that is lost due to accidents alone or income lost from accidents or sickness.

The costs of individual policies can vary considerably. Items that affect premium rates include occupation class (e.g., blue collar, white collar, professional), coverage amount, elimination period, maximum benefit period (whether coverage is for both accident and sickness or accident alone), age, definition of disability used, cost-of-living adjustments, and other optional provisions. An insurer may limit the amount of coverage it will write on an individual, based on existing policies from the insurer itself or other insurers. Policies can provide ongoing monthly benefits or a preset number of benefits (e.g., $2,000 per month for three years).

Common Riders

Individual disability policies have riders available that may enhance basic coverage.

Inflation Riders

When an inflation rider is added to a disability income policy, the benefit increases, usually by some fixed amount or percentage, in an attempt to keep pace with inflation. The inflation rider begins increasing benefits *after* there is a claim. The benefit will increase each year, but there may be a maximum amount by which it is allowed to increase. There is an additional cost to this benefit, but it may be less expensive than periodically purchasing additional coverage. Since the benefit can increase over time without additional underwriting, it is a much simpler way of adding coverage as time goes by.

Guaranteed Purchase Option

A *guaranteed purchase option* (GPO) rider states that the insured can purchase additional coverage at specific times in the future without additional evidence of insurability. This option allows the insured to increase benefits coverage *before* there is a claim, by increasing the basic benefit amount. For instance, a disability income policy with a GPO rider might allow the insured to add an additional $500 per month benefit two years after the original issue date and then again two years after that. The insured will have a relatively short period of time in which to decide to purchase the additional coverage and once the opportunity passes, he or she will not be able to exercise the option. The cost of exercising the option is based on the insured's age at exercise.

Return of Premium

A return of premium rider on a disability income insurance policy is very similar to a return of premium rider on a life insurance policy. Basically, if the insured reaches a certain age or the policy has been in force for a certain period and there has been no claim, an amount equal to the premiums paid is returned to the insured. The balance also may be payable if the amount paid in claims is less than the total of premiums paid with some carriers.

Partial Disability

After a period when the insured is totally disabled, he or she may have recovered enough to return to work on a part-time basis. Most policies allow for a reduced benefit to be paid, such as 50 percent of the full benefit amount, if the insured returns to work, but is still unable to work full time. The purpose of this provision is to encourage the worker to return to work rather than simply collect disability benefits.

To collect partial disability benefits, most policies require the insured to have been totally disabled for a specific number of months. There is also a time limit for how long these benefits can be received. For example, the provision may state that partial disability benefits are payable for up to two months after the insured has been totally disabled for a period of three months or more. Partial disability is normally based upon the inability to perform certain duties identified in the policy.

Residual Disability

Similar to a partial disability provision, a *residual disability* provision allows for a lesser amount of benefits to be paid if the insured is able to return to work in some capacity. The difference is that partial disability is generally paid for a shorter period when the insured cannot work full time, whereas residual disability benefits may be payable for the entire benefit period if, as a result of the disability, the insured's income is reduced even when working full time. The reduction in income usually must be greater than a stated percentage of gross earnings, such as 20 percent.

For example, if the insured was earning $5,000 per month prior to the disability, and has a disability income policy that has a $3,000 benefit amount and 25 percent residual disability provision, the insured finds that when he or she can return to work, his or her earnings are only $3,500 per month because of the residual effects of the injury or illness. As a result, the 20 percent reduction in income threshold has been reached and the policy would pay the residual disability benefit amount of $750 (25 percent of the full benefit) making the total income $4,250. Residual disability is based solely on the lost income above a certain percentage.

3.5.1.1 Definition of Disability

A policy's *definition of disability* is critical in determining the level of benefits it will provide. Insurance companies have traditionally used three working definitions of disability. An insured is disabled if he or she cannot work:

- ***At any occupation:*** This definition is the most restrictive and says that, to be considered disabled, the insured must not be able to work in any occupation. For example, under this definition, an electrician or a doctor who is disabled to the point of not being able to do his or her regular job, but is able to work at a fast-food restaurant at a significant loss of income, would not receive any benefits.

- ***In any occupation for which the person might be (or might become) qualified:*** This is a modified any occupation definition and is somewhat less restrictive in that it puts a limit on the types of work a person would be expected to do. This definition may also include terms that take into consideration the insured's prior education, training, or experience.
- ***In his or her own occupation:*** This definition is the most liberal because it says that a person will be considered disabled if he or she is unable to work at his or her own prior occupation. As an example, a surgeon who becomes disabled to the point of not being able to do surgery would be considered disabled even if eventually employed as an instructor at a medical school. This additional provision is sometimes accomplished by the insurer issuing a letter, known as a specialty letter, modifying the terms of the policy. Some companies may issue a policy rider to provide this level of coverage. Changes within the disability income insurance industry have made the own occupation provision less available than it was only a few years ago.
- ***Split definition:*** Many insurance companies, especially in group coverage where there is little or no underwriting, make available a split definition of disability. A split definition typically uses the liberal own occupation definition for a specific time (often the first two to five years of disability), after which a stricter modified own occupation definition or any occupation definition takes effect for the duration of the benefit period.

  A primary purpose of the split definition is to encourage disabled employees to return to productivity. If they become disabled to the extent that they can't do their jobs, they receive benefits for two to five years. In those years, they can learn new skills so that they will be able to earn a living when the own occupation definition ends. If they are capable of working, but choose not to, benefits generally will cease.
- ***Loss-of-income policies:*** These policies pay a benefit if the loss of income is due to illness or injury, even if the insured continues to work. Notice that the insured need not be fully disabled. The duties or occupations in which the insured can engage are not significant factors. If, as a result of injury or sickness, the insured suffers a loss of income, benefits based on that loss are payable regardless of whether the insured returns to work and regardless of the occupation. While this definition may not be as desirable as an own occupation definition, it nonetheless does cover the risk of lost income, generally at a lower cost than the own occupation definition. Loss of income policies are becoming more popular among insurance companies.

When using the loss of income definition, it is important to identify how the policy defines loss. Policies vary both in how they define loss and how and when benefits are paid. No actual definition of disability is used, so the starting point of the period during which income is lost must be identified. It may be the date on which the insured no longer is earning an income due to illness or injury (the income-earned method) or the date on which received income drops (the income-received method). It may include a component for number of hours worked. For an insured with significant receivables (e.g., a business owner), the second definition could delay the beginning of the elimination period by a month or more. Likewise, if benefits end as soon as the insured can return to work full time, regardless of when the income is received, this could create a problem. It is easy to see that substantial differences may exist in the benefits received under the income-earned definition and the income-received definition. Some policies give the insured a choice between the two.

Loss of income policies and residual disability benefits must define average earnings to determine the amount of base income used to identify the percentage reduction in income. Each policy has its own method of calculating this number, which may be the average of the last two

years, the two highest income years among the last five years, or some other variation. Better policies automatically increase the identified average earnings by the consumer price index so that inflation does not further reduce the benefits received by a claimant who already is earning a reduced income due to illness or injury.

The loss of income form of disability income insurance is the only one that will provide progressive benefits to a person who is afflicted with a progressive disease such as multiple sclerosis or muscular dystrophy. As the income of these individuals decreases, benefits start, usually after the insured's income drops by at least 20 percent. Most other policies will not begin paying a benefit until the insured reaches a point where he or she can't work or has a reduction of income that amounts to 80 percent.

Presumptive Disability

Another provision worth noting is the presumptive disability clause. Most policies provide that full disability benefits will be paid if the insured loses his or her sight, hearing, speech, both hands, both feet, or one hand and one foot. Under any of these circumstances the insured is presumed to be disabled—hence the term *presumptive disability*. However, some policies do not cover all of these losses. Some policies require the loss to be total and permanent, while others cover even a temporary loss. Regarding hands and feet, some policies graphically explain that the appendage must be severed to receive benefits, while others simply use the terms *loss of use* and/or *as long as the loss continues*. In other words, the difference is missing feet or hands versus paralysis or even two broken legs from an accident.

Conversion

Group disability income policies generally cannot be converted to individual coverage; thus, leaving one's employer usually will result in loss of coverage. It is important to know, however, that a few carriers do offer group disability coverage with provisions allowing conversion upon termination of employment. Such a provision is, of course, desirable, but generally it is limited to those in a professional occupation category. Typically, there is a very limited time period, such as 30 days, in which the policy can be converted. The policy may also have a built-in rating (i.e., premium expense). Even if there is a rating, if a client has this provision to convert, it is wise to convert the policy initially and apply for coverage with more favorable rates. Therefore, if the client is unable to obtain coverage for some reason, he or she will still be protected. The client can always drop the policy if a better policy is acquired. This factor emphasizes the importance of the portability of individual policies.

Other Common Provisions

Misstatement of age clause. As with life insurance, this clause provides that if the insured files a claim, and it is determined at that time that his or her birth date is different from the one in the application, the benefits will be adjusted to the amount that would have been purchased for the same premium at the correct age.

Grace period. Most policies contain a provision to allow the insured to have a specific number of days from the policy due date in which to pay the premium without fear of a policy lapse. This is generally 30 days, but some policies have shorter grace periods.

Reinstatement. If the policy owner allows the policy to lapse, he or she generally may apply to reinstate the policy. Proof of insurability normally is required.

Relation of earnings clause. This clause protects the insurance company from an insured who may benefit financially by being disabled. If the disability insurance was purchased when the insured was making more money than he or she is now, policy benefits may be higher than current earnings. This might encourage the insured to become, or remain, disabled to collect the high benefits. The relation of earnings clause allows the insurance company to do financial underwriting at the time of claim. If the insured's income is substantially lower than when the insurance was purchased, the company may lower the benefit so that the amount paid in relation to the insured's earnings is appropriate. Excess premiums would be returned to the insured, usually with interest.

Premiums and Benefits

Premiums usually are based on a rate per unit (e.g., $100) of monthly benefit. However, an individual may purchase any amount of disability insurance for which he or she qualifies. If the premium is paid within a given time frame, policy coverage will be continuous. Beyond the grace period, an unpaid premium will result in a policy lapse, and reinstatement normally requires repayment of all back premiums and proof of insurability.
Disability income insurance premiums can be high, but policies provide significant monthly benefits. Remember, too, some degree of disability is fairly common for many people. For example, if a policy has a $550 annual premium for a $1,000 per month benefit, the first thought often is that over every two year-period, one would pay more than one month's benefits in premiums. However, assuming a 90-day elimination period, a one-year disability would provide $9,000 in benefits. It would take 16 years to pay that much in premiums. A five-year disability would result in $57,000 in benefits, and a 20-year disability would result in $237,000 in benefits.

It helps clients to hear these calculations and compare them to the amount they are paying for other protection. Car insurance may just be covering $300,000 in liability and $50,000 in property damage for a total liability of $350,000. It is not uncommon for clients to pay $1,200 a year for this coverage. When compared to homeowners and automobile coverage, clients are insuring a higher value—their income over their working lifetime. If a cost-of-living rider is added to the policy, the amount being covered is most likely more than the individual will accumulate during his or her lifetime. Don't let clients lose sight of the fact that their ability to earn an income is their largest asset.

How Much and What Type of Coverage is Appropriate?

How much disability income insurance should a person have? The simple answer is, as much as he or she can get. The importance of maintaining an income, especially with the potentially crippling expenses of an extended disability, will become apparent during any disability. On a practical level, there are several limits regarding how much coverage a person can or should carry.

The first limitation is the easiest—insurance companies limit the maximum amount of coverage they will write. After a certain point (e.g., 60 to 70 percent of pre-disability income), an insurer will no longer offer to underwrite new coverage.

Cost of coverage is the second limitation. An insurance company can assume a huge potential liability in settling a long-term disability claim, since benefits must be paid as long as the individual qualifies, up to the end of the benefit period. This potential liability, in addition to the

great likelihood of people becoming disabled at some point, contributes to disability insurance being relatively expensive.

The *coordination of benefits* clause is another provision that may reduce benefits below the amount shown in the declarations page. Such provisions, which usually are found in group disability policies and sometimes are found in individual policies, reduce the benefit otherwise payable by amounts received from government benefits, workers' compensation, or other sources of indemnity related to employment. As mentioned, it is rare for a group disability income policy to reduce benefits based on individual disability income policy benefits received.

It may also be possible that employment income is only a small portion of total income. If, for example, the individual has significant investment income or unearned income from some other source, there may be little need to protect employment earnings.

To determine the need for disability income coverage, first determine monthly expenses. To this add any additional expenses that may be caused by the disability (an admittedly difficult job, since you must predict with no concrete frame of reference). Consider that the expenses associated with earning a living (e.g., clothing, transportation) will no longer exist. From this amount, subtract any sources of income, such as income from investments. Also subtract other sources of disability income protection (e.g., from a group disability plan or government benefits). The remaining amount is roughly equal to the amount of coverage that should be carried.

3.5.1.2 Common Continuation Provisions

Policy Durability (Renewal Provisions)

An extremely important consideration in the purchase of disability insurance, and one also directly influenced by the occupational classification of the applicant, is the renewal provision found in each policy. Generally, the better the renewal provisions, the higher the premium. It is important that you understand the terms that relate to policy durability because these terms can be confusing.

Noncancelable: The first term is *noncancelable*. The obvious implication is that this term means the same as guaranteed renewable described below. The confusion is compounded because this type of policy often is called *noncancelable and guaranteed renewable*. Noncancelable means that not only can the insured renew the policy for the full term specified in the policy (the same as under guaranteed renewable), but the company cannot change the premium from what is stated in the contract. Noncancelable is the obvious choice from the insured's point of view, although it should be noted that actuaries have priced into the contract the company's inability to raise the premium. Thus, these are more expensive initially than a guaranteed renewable policy. Noncancelable policies may not be available for all classes of workers. Many disability income insurance companies have stopped selling noncancelable policies because of unfavorable experience, and the difficulty of predicting the future when it comes to determining adequate premiums.

Guaranteed Renewable: This option means that the insured has the right to renew the policy to the age specified in the policy. The company does not have the right to change the premium unless it makes the change for an entire policy class (note the subtle difference between guaranteed renewable and noncancelable: with noncancelable policies, the insurer cannot raise the rates—at all during the policy period. Guaranteed renewable rates may be raised for an

entire class). Thus, the company cannot discriminate against a policyholder based on claims experience. A guaranteed renewable provision is good, but not as good as a noncancelable provision.
Conditionally Renewable: Two different forms of conditionally renewable disability policies are available. The first, and least common, gives the insurance company the right to disallow renewal/continuation of a policy under certain conditions. The second, which is more common, is attached to many policies that provide benefits to age 65. It allows an insured individual who reaches age 65, and who continues to have earned income, to renew his or her policy to provide protection against a disability interrupting those earnings. The premium for the policy after age 65 is based on the attained age of the insured, and benefits are typically provided to age 70.

Nonguaranteed Continuation: Two provisions exist that remove from the insured any security of coverage continuity. One is the *renewable at the option of the company* provision. In this case, the insurance company may choose to renew or not to renew a policy on its anniversary. No reason must be given. The other provision relates to when a policy is cancelable. With this provision, the insurer may give the required notice and cancel the policy at any time. This provision and the following one often may be found in group and association policies.

3.6 Business-related

So far, we have been looking at insurance types targeted primarily to individuals. In some cases, businesses may offer policies to employees such as for healthcare, disability income, even life insurance. However, businesses themselves, along with owners, may also require insurance cover. The policies may be the same as those used by individuals, but terms and beneficiaries are often at least somewhat different. Additionally, businesses may have risk exposures that require specialized policies. In the next section we will explore policies covering business disability and overhead expense, liability and board member cover. We will begin by looking at key person cover – both life insurance and disability.

3.6.1 Key person

For businesses, a key person is one on whom the business depends to remain viable. When considering retirement plans, “key person” has a specific identity as one who is an owner or officer of the organization. We may reasonably extend this to the current discussion. However, a key person may be *key*, but not be in either of those categories. He or she could be an executive, or a sales person, a manager, in some cases, even an administrative support person. Key means vital more than it identifies status. However, you identify a key person, you can be sure the business wants to protect itself and him or her in the event of an adverse event. This often takes the form of one or more life insurance policies and/or a disability income policy often in addition to contractual language describing the company’s intentions upon the death or disability of the key person. Key person insurance is usually thought of first as life insurance. However, it can also include disability income insurance. We will look at life insurance first.

Life Insurance

Key person life insurance is no different from any other life insurance policy. However, in this situation, the business, with the individual’s consent, will apply and pay for a policy on the life of the key person. The business will also name itself as the primary beneficiary. With this policy in place, if the key person dies unexpectedly, the business will receive a policy payout that it can use for one of several purposes. The primary policy function is to provide money to help the

business cope with the loss of the employee. A regular employee (i.e., non-key) may not cause much financial distress for the organization, but a key person is, by definition, vital to the ongoing well-being of the business. The loss may well be more than simply financial, but there will almost certainly be a financial impact. As policy beneficiary, the business will have financial support during the period in which it will attempt to replace the key person, hire temporary replacement(s) or simply continue cash flow that will have been lost due to the key employee's passing.

Taking out a policy like this can be especially important when the key person is also a partner or majority shareholder in a closely held corporation. Technically, this may not be considered key person coverage, but in reality, it fits the criteria. If a partner or majority shareholder dies without having well-crafted documents such as a buy-sell agreement, the future of the company may be in jeopardy. Often, the deceased's share of the business will pass to his or her heirs, often a spouse. This is true whether the spouse or other heir is capable or even desirous of stepping into the position. Regardless, the spouse will likely be counting on money from the business holding to support him or herself and the family. A well-structured buy-sell agreement along with an appropriate life insurance policy to provide necessary funding is one of the best solutions to this problem. The policy can make payment to the business (or other owners) and the owners can pass along the money the spouse in exchange for the deceased's share of the business ownership. In this way both the business and the spouse (heir) receive what each need most. Buy-sell agreements may not exist in all territories or may be called by another name. However, the concept of a business having a life policy that can take care of this type of obligation is a valuable use of life insurance.

Almost as a side note, a key person policy can encourage the key employee to remain employed by the company. If the benefits are properly structured, the employee will want to remain employed to not lose the potential benefits. By itself, this will probably not provide enough incentive if a new offer is strong enough. It can, however, be a part of a package of benefits targeted at keeping key employees on board.

3.6.2 Disability: Business

The problems faced by an organization when a key person dies are replicated when a key person becomes disabled and unable to fulfill some or all previous duties. Additionally, just as with a regular disability situation, the disabled person is not only unable to generate income, he or she is also likely to be incurring increased costs related to healthcare. When addressing concerns about a key person, the organization often would like to keep the person employed and receiving an income. However, many times the company also needs to hire a worker to fulfill the duties the disabled individual can no longer (at least temporarily) fulfill. Adding to the problem is the likelihood that the company is not large. This means that the key person's contributions to the company's well-being probably are significant. A key person disability income plan can help to solve the problem.

A key person disability income insurance policy is designed to provide the business with funding to help the organization deal with the loss of the key person's contribution to the company. The need may be temporary (even if *temporary* is several years) or long-term. Generally, the policy will pay policy funds to the company. Once paid, the company can use the funds to hire a replacement employee to pick up some of the lost work and (perhaps) income generated by the key person. Some of the funds may also be used as additional compensation for the disabled key person, but there is a need for caution to ensure that payments from the company do not interfere with payments to the individual from his or her personal disability income policy.

Sometimes insurance payments can be made as a lump sum benefit, or the claim could be paid monthly. Policies typically have elimination periods between 30 to 180 days, and may have benefit periods up to around two years.

Disability buy-out cover is similar to key person coverage, but targeted to owners. When one of the owners becomes permanently disabled and unable to continue supporting the company, remaining owners may need to act. Small business owners depend on the business to generate income, as well as to build equity. When an owner is disabled, he or she will eventually want and need to sell the business share. The remaining owners will almost certainly want to retain ownership of the company, so they will also want to buy the disabled owner's share. A disability buy-out policy can provide the funds to purchase the disabled owner's share. Such a policy should be part of the organizations business continuation plans. In many ways these disability insurance policies can go a long way to helping the business remain viable and profitable.

3.6.3 Business Overhead Expense

Think about the expenses an organization may have as part of doing business. It is not uncommon for a business to incur regular expenses for things like:

- Employee salaries
- Legal services and accounting
- Professional and trade dues
- Mortgage, rent or lease payments
- Mortgage or other loan interest
- Utilities
- Maintenance services
- Car expenses
- Equipment lease and maintenance expenses
- Insurance premiums
- Taxes

You can probably think of at least a few more expenses businesses might have. In a professional office (or similar), where the key person (e.g., doctor, accountant, financial advisor, etc.) becomes disabled and can no longer generate income, how will the business continue to function? It's likely that the business can continue to generate revenue without the owner if the business can retain the staff and pay bills. Even if the owner has decided to sell the company, it will sell for more with a staff on-board. Additionally, he or she most likely will not want to put all the staff out of work because of a personal disability. It's possible that the professional has enough funds to make necessary payments out-of-pocket, but not likely. Further, if he or she is disabled, there will be a greater need to use assets to provide for living expenses in addition to any personal disability income insurance payments that are made. How will the business get enough income to continue operations until the owner can return to work or decide to sell?

Business overhead expense insurance cover is not a replacement for personal disability income insurance. Instead, it is specifically designed to provide income to the business for a period so it can remain viable and pay salaries and other expenses. Like all disability policies, there is an elimination or waiting period before payment of benefits. Usually, this period lasts for up to 90

days (it's shorter because the business will likely have great need for the payments sooner rather than later). Coverage normally lasts for up to 24 months. As usual, benefit payments begin following the elimination and continue throughout the coverage period. The business owner (policyowner) must select a monthly benefit amount when arranging for the policy. This amount will be based on normal business expenses. This amount may or may not be paid. The policy will pay based on actual e xpenses, up to policy limits. It may be possible to carry unused benefits from one month to the next, but not all policies provide for this. It's even possible for unused benefits to continue being paid beyond the normal benefit period (for as long as the excess lasts). Policies are often written as being noncancelable or guaranteed renewable, with ongoing renewable potentially adjusted as the owner gets to be older than age 65 (or so). Depending on the jurisdiction, premium payments may be tax deductible as a business expense.

3.6.4 Business Liability and Board Member Cover

Business insurance cover often is issued as monoline policies. That is, the policy covers one type of risk, such as plate glass damage, fire, crime, equipment damage and so forth. However, in addition to monoline policies, businesses may also purchase a package of cover, normally including both property and liability cover, in addition to the terms, exclusions and conditions of coverage. Package plans tend to focus either on smaller companies (Business Owner's Policy; BOP) or larger commercial organizations (Commercial Package Policy; CPP). The policies are similar, but focused on the needs of each size organization. Within either package type, a business will get general liability cover. This will provide basic coverage and will almost certainly require purchase of additional coverage with higher limits and protection against a broader array of perils (including business-owned vehicles), in addition to items relevant to a specific business's needs.

Commercial general liability policies, like most other business insurance, provide cover for a company's specific needs. Most policies protect against non-vehicle liability exposures, and do not generally extend coverage to liabilities involving employee injuries (although this can be added). Most policies include cover for crime and some include surety coverage (e.g., guarantees for financial obligations and various contracts). Remember, these policies do not cover personal or professional liabilities. Those require separate cover. These policies cover business liability exposure only. We will look at a few examples.

Employer's Liability: In many territories, employers are liable for any injuries employees receive while working. This is considered a form of absolute liability – the employer is responsible regardless of the cause, even without negligence. On the one hand, this prevents many (but not all) employee lawsuits. However, it also automatically exposes the employer to employee-related liability. Liability is greater if it can be shown that the employer actually was negligent in some way.

Employment Practices Liability: In today's environment, it is becoming more common to individuals to sue employers over what are considered inappropriate employment practices. These may include harassment (sexual or otherwise), discrimination, wrongful termination, and other situations. Territorial governments may issue related fines and penalties, and no insurance will cover this. However, insurers will likely pay for defending against the charges and making payments resulting from civil litigation.

Businesses may also incur liability exposures related to customers, product end-users, as well as employees. Some of these include:

- Thefts and embezzlement
- Injuries (to customers, end-users, or employees)
- Product liability
- Damage to employee or customer property
- Pollution / environmental clean-up
- Motor vehicle related (will require separate cover)
- Directors' and officers' errors and omissions (also board member cover, discussed below)

Remember that we are discussing liability exposures. These may include payment for property that does not belonging to the business, but not business-owned property. That requires property-based coverage, just as is true for individuals.

Commercial Umbrella Liability Coverage: A business may want to purchase umbrella liability coverage, in much the same way as do individuals. Normally, there is no standard form of commercial umbrella liability policy (also called a *blanket catastrophe excess liability policy*). Also, like individual umbrella policies, the commercial form requires substantial underlying liability coverage. Underlying or supporting insurance normally must cover a risk or peril for it to be covered by the umbrella policy (as is true of individual policies).

Board Member Cover: Individuals who sit on nonprofit boards can be held liable for the organization's activities. People may sit on the boards of religious institutions, hospitals or other medical associations, community associations and similar. In most cases, board members' personal liability insurance cover will not protect them for this type of liability. A directors' and officers' liability policy (sometimes known as directors' and officers' errors and omissions insurance) will help to cover this exposure.

In this chapter we have explored many types of insurance cover. While there are many additional policy types, we have covered the major ones: general, including property, vehicles and personal property, liability, both personal and professional, life, health, disability income, long-term (extended) care, and business-related cover for key persons, expenses, and liability, including the special liability of those who sit on boards of directors. We also looked at determining the amount of coverage an individual might need, given their situation and objectives. In the next chapter, we will cover some aspects related to selecting an insurance company and an insurance advisor.

Summary

In this chapter we have explored types of risk coverage that insurance can provide for assets, health, life, liability and business. The extent of insurance cover needed by an individual has been explored based on logical extent, whether the replacement value of asset or liability with provisions of coinsurance, also taking into account factors like deductible and discussing exclusions. Various products of life insurance have been discussed with their respective features and benefits. We learnt aspects of life insurance cover evaluation by capital utilization and capital retention methods. We explored various type of annuities and other aspects of risk like long term care and disability.

EXAMPLE 3		
Module / Topic		Module_5_Risk_Management_and_Insurance_Planning
Subtopic / Chapter		Chapter 3: Introduction to Insurance
Question Stem		There are several good methods for determining the necessary amount of life insurance coverage. The needs-based method is thorough in that it accounts for much more than just income replacement and final expenses. Your client has future annual earnings of $75,000, personal living expenses, insurance premiums, and taxes of $25,000. The number of years prior to retirement is estimated at 20 years. The discount rate is 3.5%. Your client also has liabilities of $400,000 (mortgage, education loans, car loans, credit card balances). Final expenses for funeral, emergency fund is estimated at $50,000. Education funding for three children is estimated at $200,000. Your client has existing life insurance of $250,000. The net new life insurance that your client requires using the needs-based method is most likley closest to:
	a	$1,385,492
	b	$1,135,492
	c	$1,110,920
	d	$1,385,492
Correct Answer		**b**
Explanation		1) L = 400,000. 2) I = Mode = BGN, P/Y = 1, N = 20, I/Y = 3.5, PMT = 75,000 - 25,000 = 50,000, FV = 0, CPT PVAD = -735,492. 3) F = 50,000 4) E = 200.000. Gross death benefit needed = 1,385,492 less

		existing life insurance - 250,000 = 1,135,492
Distractor #1	**a**	Forgot to deduct the exisiting insurance
Distractor #2	**c**	Calculator in END mode for step 2- recall calculate PVAD = BGN mode.
Distractor #3	**d**	Added the exisiting life insurance instead of deduct

Chapter Review

Discussion Questions

1. How does homeowners insurance coverage work in your territory? Are any coverages mentioned in the text different?

2. There are three levels of perils coverage in a homeowners policy. How would you describe the three types to a client and what would you say about the implications of each level?

3. How are actual cash value and replacement cost different? Which would provide better protection for the homeowner?

4. How does insuring high value property potentially violate the law of large numbers? How do insurers address this potential problem?

5. High value personal property is not normally covered adequately under typical homeowners insurance. What types of personal property does this include, how can the problem be addressed and is it really necessary to do so?

6. Which type of personal motor vehicle (car) coverage – liability or property – is most important because of the greatest potential for financial loss?

7. How would you explain to a client the fact that they may be liable to pay someone even when they have not done anything wrong? Under what conditions might this be true?

8. What is the best use for term life insurance?

9. What is the best use for permanent life insurance?

10. How would you explain the purpose of a life policy's cash value account and how it functions

in various policy types?

11. Which life insurance policy types would you recommend for someone with a low risk tolerance who wants stability and security? How would this change with someone who has a higher risk tolerance level?

12. Which of the nonforfeiture options is best used under various circumstances?

13. Why is the choice between having a normal beneficiary designation for someone versus an irrevocable designation so significant?

14. How are the human life value and needs-based methods different? Which is the better approach?

15. Why does an immediate annuity require a single-premium payment?

16. How are annuities and life insurance different? How are they the same?

17. What is the potential problem with a life income settlement or payout option? How would you solve this problem?

18. Even when the government provides healthcare benefits to all citizens, why might it be a good idea for someone to purchase private insurance cover?

19. Under what circumstances would an individual benefit from having a long-term care insurance policy versus a regular healthcare policy?

20. How would you respond to a client who asked you whether LTC insurance is worth the money to purchase it?

21. In what ways does a disability potentially create greater financial exposure than a death?

22. How does the loss-of-income disability definition differ from the other definitions? Which definition is better or worse?

23. If you had to choose between a policy that was noncancelable and one that was guaranteed renewable, which would you choose and why?

24. Why is key person insurance cover (life and disability) so important to a business?

25. How is business overhead expense coverage different from regular disability insurance

coverage? Why might it be necessary?

26. If you are a board member of a charitable organization, what liability exposure might you have?

Review Questions

1. How much land value is included when writing insurance coverage on a home and why?

2. What coverages are normally included in the two sections of a standard homeowners policy?

3. Why are coverages A and B not included on any renter's insurance policy, and what coverage is always included?

4. What perils are included under standard basic, broad form and open peril coverage?

5. How much would an insurance policy reimburse a homeowner who has a house valued at $400,000 insured for $300,000 after experiencing a fire that causes $20,000 in damage? The house has an 80 percent coinsurance provision and a $1,000 deductible,

6. How does actual cash value compare to replacement cost coverage?

7. Why would a homeowner want a policy with a guaranteed replacement cost provision instead of a simple replacement cost provision?

8. What is the problem with basic personal property coverage included in a standard homeowners policy and what can help solve it?

9. On what basis is inland marine insurance usually written?

10. What is the main difference about the medical payments coverage on a motor vehicle insurance policy compared to coverage on a homeowners policy?

11. How does a standard car insurance policy define the insured?

12. How does civil liability compare with criminal liability?

13. What is a tort and how does it relate to liability?

14. What are absolute and vicarious liability and how may they be applied to employers?

15. How does an umbrella liability policy differ from a standard liability policy?

16. What are the two basic types of professional liability coverage and which professionals use either type?

17. What are the two broad divisions in life insurance types?

18. How would you describe the way a regular term life insurance policy works?

19. What does an insurer do to a term life insurance policy so that it can cover an insured for his or her entire life?

20. Where is the cash value invested in a whole life insurance policy; a universal life policy, a variable universal life policy?

21. Why are universal life insurance policies called unbundled and why are they also known as flexible premium adjustable life policies?

22. What is the main difference between universal life type I or A and Type II or B policies?

23. How does variable life (VL) compare with variable universal life (VUL)?

24. What are the two main types of joint life policies and when would you use either one?

25. What three potential parties exist in a life insurance policy?

26. How do the grace period and reinstatement provision of a life insurance policy relate?

27. What are the nonforfeiture options of a standard cash value life insurance policy?

28. Why should a policyowner be careful when thinking about making a beneficiary irrevocable?

29. What are five dividend payment options with a participating life insurance policy?

30. Other than simple rules of thumb, what two methods are used to determine the amount of life insurance an individual may need?

31. Using the capital retention method, and assuming there is no existing life insurance available, how much insurance cover would an individual require who wants beneficiaries to have an additional $75,000 annual income that increases by the rate of inflation each year?

32. How much life insurance must an individual purchase today to fully fund college education costs for a 10-year old child who will enter a four-year university program at age 18? Assume current first-year expenses of $20,000, five percent tuition inflation and a seven percent discount rate, with all funds available at the beginning of college.

33. What is the fundamental difference between annuities and life insurance?

34. Under normal circumstances, how many times may a policyowner change the payment options once a contract is annuitized?

35. How may a variable annuity address inflation-related concerns?

36. What happens to annuity payments under a single (or straight) life annuitization or settlement option when the beneficiary dies, and how can the refund option solve the problem?

37. How is the period certain option different from the fixed amount payout option?

38. In what way are deductibles on homeowners, motor vehicle and health insurance policies different?

39. How are copayments different than coinsurance?

40. In a managed care health plan, what is a gatekeeper?

41. What is the biggest coverage difference between HMOs and PPOs?

42. Why might someone who has good healthcare insurance also benefit from having a long-term care (LTC) insurance policy?

43. What is the highest level of LTC and the second highest level?

44. What are activities of daily living (ADLs) and how do they apply to LTC insurance policies?

45. What is the elimination period found on most LTC and disability income insurance policies?

46. How much benefit will a normal LTC insurance policy pay for expenses incurred when a family member provides LTC care services, and what is one solution?

47. Why do some individuals refer to disability as a living death?

48. What are three of the most important disability insurance considerations?

49. What is the difference between a partial and a residual disability benefit.

50. What are the four primary disability definitions used in a policy?

51. In what way is a loss-of-income policy different from other disability income policies?

52. How is a noncancelable renewal provision different from a guaranteed renewable provision?

53. What is the general purpose of key person insurance, whether life or disability?

54. How is business overhead expense insurance different from standard disability insurance cover on an individual?

55. What type of liability exposure is not covered by either a comprehensive personal liability policy (CPL) or business/commercial liability policy?

56. Why might a person sitting on a non-profit organization board require liability coverage?

Chapter 4: Insurance Company and Advisor Selection

Learning Outcomes

Upon completion of this chapter, the student will be able to:

4-1 Explain the elements to consider when selecting an insurance company

4-2 Explain the elements to consider when selecting an insurance intermediary

4-3 Evaluate the roles and responsibilities of insurance intermediaries

4-4 Discuss the role of insurance industry regulators

Topics

4.1 Company and intermediary selection and due diligence
- 4.1.1 Company evaluation and selection
- 4.1.2 Intermediary selection and responsibilities
- 4.1.3 Choosing an insurance policy

4.2 Legal and financial characteristics of insurance parties involved in an insurance contract
- 4.2.1 Insurance company
- 4.2.2 Policy owner
- 4.2.3 Beneficiary
- 4.2.4 Insured

4.3 Regulation and compliance

Introduction

Insurance policies are complex, as is the insurance industry. Many financial advisors are less familiar with insurance than with investments. As a result, they may have less understanding of insurance companies, related products, and those who market and sell them. It is important for advisors to have a good grasp of these things. Given that many students are likely less familiar with insurance, it may be especially important to understand the parameters around selecting insurers as well as insurance agents with whom to work. Having a more complete understanding of insurance company and insurance advisor (agent) selection will help you to be a more knowledgeable financial advisor and provide better service to clients.

As we have mentioned in this course, insurance is ancient. While modern inland marine and property-related insurance dates back four-hundred years or so, some types of insurance have several thousand years of history. Ancient Babylonians, Chinese, Persians, Greeks and Romans had forms of disability and property-related insurance (especially relating to the military and commerce). Some historians also add forms of life insurance to the list. Regardless of actual insurance cover availability, it's safe to say it's an ancient and diverse industry. Having said that, we can also say that modern insurance companies, policies and agents/advisors are more easily categorized and understood. This is a good thing, because as a financial advisor, you will need to perform appropriate due diligence or due care in helping clients select appropriate policies, insurers and agents. We will begin looking at the process of doing this.

4.1 Company and Advisor (Agent) Selection and Due Diligence

4.1.1 Company Evaluation and Selection

When selecting an insurance company, it's important to choose one that is known for having good customer service. Equally, if not more important, is choosing a company that offers the type of insurance cover your client needs at a competitive price point, having good underwriting processes. Some companies are quite specialized. They only offer a few insurance types. In fact, many companies traditionally have specialized in one type of cover or another. Life insurers often did not offer property-related products. Motor vehicle insurers often did not offer health or disability cover. None of the companies focused on personal products likely would offer business or commercial policies (this remains true in many cases). Much of this comes from starting out offering monoline policies – one type of insurance – to the exclusion of all other policy types. Most insurers began this way, and many continue operating in this general mode, although it's rare to find a company that exclusively offers one type of insurance cover. Given the potential that an insurer may not offer the type of cover your client needs, this should be your first consideration.

When you identify several companies that offer the insurance cover for which your client needs, it's a good idea to price-shop. Prices can vary significantly. Even though the core parameters may be similar (e.g., mortality expenses, underwriting charges, etc.) one company's costs of doing business and desired profit margin can be quite different from another's. The organizational form also can make a difference, with mutual, stock, association and fraternal companies all potentially have different cost structures.

A company's history also must enter the picture. If they offer the type of insurance cover you are researching, is it a new product for them or have they successfully offered it for many years? As you would think, companies develop areas of expertise. You want a company that has expertise in the area of your insurance need.

All these areas are worthy of consideration, but there is another question to ask that may be most important. How financially solvent and stable is the company? When someone buys insurance, they actually are purchasing the insurer's promise to pay a valid claim when it is presented. To do this, the company must be financially sound, and have a history of fiscal strength. The last thing you want is for your client to file a claim only to learn that the company is insolvent and out of business. As a result, it is of utmost importance for financial advisors to investigate and evaluate an insurer's financial stability. Unfortunately, in many cases, this is close to an impossible task. Unless you have an inside track to the information, you most likely will only be able to get a glimpse of an insurance company's true financial status. If so, what can you do? Thankfully, you can tap into resources from several rating agencies.

Rating agencies have been around for many years. According to an article by the BBC (Marston, 2014), the major rating agencies have been in existence since the late 1800s and early 1900s. Many rating agencies exist around the world, but four are primary: Standard and Poor's, Moody's, Fitch and A.M. Best. Of the four, Standard and Poor's is the oldest and largest, closely followed by A.M. Best, Moody's and Fitch which is similar and smaller.

Standard & Poor's (S&P) was begun as *Poor's* in 1860 by Henry Poor. His organization was joined by the *Standard* Statistics Bureau, and almost 80 years later became known as S&P. The

company publishes two separate insurer ratings. The first, a “claims-paying ability rating,” is done by request, and public as well as nonpublic financial information is used. S&P also publishes “qualified solvency ratings.” These are done with public records only and at no charge to the companies being rated. Standard & Poor’s provides ratings via their website at www.standardandpoors.com.

A.M. Best possibly has the greatest coverage of insurers. Founded in 1899 by Alfred M. Best, the company began rating insurers, and currently evaluates around 3,400 companies in more than 80 countries worldwide. According to their website (www.ambest.com), they are recognized as a benchmark for assessing a rated organization’s financial strength as well as the credit quality of its obligations. Advisors can find insurer financial information and related news on the website.

Moody’s was started by John Moody in 1909. Both Moody and Henry Poor began focusing on railroad finances. The company now rates many types of organizations, including insurers. To do so, it uses a similar approach of generally rating a company at its request, but Moody’s rates some companies with public information alone. Moody’s publishes a “financial strength rating.” Ratings can also be accessed by registering on their website at www.moodys.com.

Fitch, started by John Fitch in 1913, provides ratings on around 1,000 insurance entities (and many other entities), along with fixed income security ratings. Fitch provides ratings via their website at www.fitchratings.com.

Using the Information

What can you do with this information? For the most part, the companies whose reputation and business are based on how well they evaluate the financial soundness of the financial services industry believe the insurance industry, as a whole, is quite stable. However, with the thousands of insurance companies, it is easy to understand that many companies have not been rated by any organization. One of the reasons for this is that many companies are considered too small to evaluate, especially when compared to the largest companies, each with assets in the billions. When doing research, it is a good idea to check with more than one rating service. This will help to confirm a company’s rating, or perhaps will point out possible discrepancies between different rating agencies.

There is, however, a problem with depending on rating agency results. Looking back at the global financial crisis beginning in 2007, none of the major agencies correctly identified the financial straits in which several large insurers would find themselves. There may be many reasons for this, but the fact remains, you would have been misled and disappointed by the information you gleaned from the rating agencies. Since then, especially in the U.S. and Europe, governments have increased oversight of the rating agencies and the agencies themselves say they have adjusted their procedures. They may have problems, but given the realities, rating agencies continue to be the most widely available, most reliable source of financial information for insurer evaluation.

NAIC Criteria

There is no truly global organization that oversees insurer solvency. As such, the following information is provided as a guideline for evaluation, but should not be viewed as a model for any territory. In the U.S., each of the 50 states has a commissioner of insurance that oversees the industry in that state. The commissioners meet regularly and as a group – the National

Association of Insurance Commissioners (NAIC) – create model rules to oversee the insurance arena. One of those rules, designed to supervise insurer financial solvency, is called the watchlist. It has twelve financial ratios to help evaluate insurance companies. While the watchlist is not directly applicable outside the U.S., the financial ratios it includes can provide reasonable guidance as an evaluation tool.

According to the NAIC, if a company has 4 of its 12 ratios outside the "usual ranges," it is put on the NAIC Watchlist and selected for *immediate regulatory attention*, *targeted regulatory action*, or *no regulatory action*, depending on the problem ratios and the extent to which they are outside of the "usual ranges." The 12 ratios used in the NAIC Watchlist are as follows:

1. ***Net Change in Capital and Surplus:*** Greater than –10% and less than 50%
2. ***Gross Change in Capital and Surplus:*** Greater than –10% and less than 50%
3. ***Net Gain to Total Income:*** Greater than 0%
4. ***Commissions and Expenses to Premiums and Deposits:*** Less than 60%
5. ***Adequacy of Investment Income:*** Greater than 100%
6. ***Nonadmitted to Admitted Assets:*** Less than 10%
7. ***Real Estate to Capital and Surplus:*** Less than 200% for companies with capital and surplus greater than $5 million; less than 100% for companies with capital and surplus equal to or less than $5 million
8. ***Investments in Affiliates to Capital and Surplus:*** Less than 100%
9. ***Surplus Relief:*** Greater than –99% and less than 39% for companies with capital and surplus greater than $5 million; greater than –10% and less than 10% for companies with capital and surplus equal to or less than $5 million
10. ***Change in Premium:*** Greater than –10% and less than 50%
11. ***Change in Product Mix:*** Less than 5%
12. ***Change in Asset Mix:*** Less than 5%

The NAIC incorporates the preceding financial ratios as part of evaluating risk-based capital. Remember, a primary purpose of insurance companies is to pay valid claims when presented. To do this, they must maintain sufficient capital. Risk-based capital ratios measure the minimum amount of capital an insurer requires to support business operations. There are four main categories of risk that are included in the ratio mix:

1. ***Asset Risk:*** An asset's default of principal or interest or fluctuations in market value because of market changes.
2. ***Credit Risk:*** Default risk on amounts that are due from policyholders, reinsurers or creditors.

3. ***Underwriting Risk:*** Risk arising from underestimating liabilities from existing business or not properly pricing prospective business
4. ***Off-balance Sheet Risk:*** Excessive rates of growth, contingent liabilities or other non-balance sheet items.

Additional Evaluation Items

Beyond financial ratios and rating agencies, an advisor can use several other characteristics to determine whether to work with an insurer. We mentioned a few of these in the introduction, but the following list puts them all together.

Size and Age: How long has a company been in business, and what is its asset base? A client with a $1 million life insurance need might be better served by a company with assets more than $1 billion than by a company with only $90 million in assets. Also, it's likely a better idea to work with an insurer that has a long track record than one of fewer years. Life insurance policies (and others) may be in place for many decades. A newer company may turn out to be very good, but an older company has the history to prove its position.

History: Has the company experienced severe financial problems in the past? What is the dividend or earnings history of the company? Has it consistently met its obligations? Does it have a history of treating all policyholders fairly or does it emphasize making its current products perform at the expense of long-term policyholders? Has the company generally met the illustrated numbers in its policy illustrations, or have the illustrations consistently been more optimistic than their historic performances?

Operating Ratios: The various rating companies provide several financial operating ratios for each of the companies they rate. Taking the time to understand these ratios and how they can show how a given company stands relative to other companies can provide an advisor with valuable insight.

Lapse Ratio: Another indicator of how a company treats its policyholders is its lapse ratio. The lapse ratio represents the percentage of policies that are terminated each year out of all policies in force. This is known as the company's persistency (agents also have persistency ratings). It is important to look at a company's persistency relative to that of the industry. If a company's lapse ratio is high (10% or more), some effort should be made to determine why. It may be an indication of poor results relative to illustrated values or unusually high premiums. It may reflect poor service after the sale of a policy. In the worst case possible, it may indicate that the company is experiencing financial difficulties and policyholders are leaving to protect their policy values.

Average Life Insurance Policy Size: The average policy size by itself may give some indication of the type of business a company is writing. A very large average policy size generally indicates they are primarily selling term insurance. Compare this company's assets and insurance in force with those of other companies. It may show that the company has a substantially smaller number of dollars available to support the average policy size than would a company that has a broader policy mix. A company with a very small average policy size may be selling burial insurance. Its assets will likely be quite high relative to the insurance in force. Most important is to research the amount of insurance in force relative to the assets.

Lines of Business: Obviously, if a company does not offer the kind of policy you want, you will not buy it there. For example, some companies specialize in certain types of business. It may be

homeowners and auto insurance, estate and business planning insurance, the family market, low-cost term products, or variable (investment-oriented) products.

Investment Return: Every company operates in the same world economy and under similar regulations and limitations (at least in a particular territory). Some companies do a little better than average investing their assets. A company's investment return will vary constantly, but it is valuable for the advisor to know how a company's overall investment strategy relates to other companies as well as whether it can support its rate of return assumptions. It does not make much sense that a company earning an average of 4.5 percent on its assets is paying six percent or even 5 percent. If a company seems to be earning much more than the others, either it is very lucky or there is substantially more risk in its investments (or they are exaggerating return statements).

After you have determined one or more insurance companies with which you want to do business, the next step is to identify and advisor or agent with whom you can work.

4.1.2 Intermediary Selection and Responsibilities

In some ways, selecting an insurance advisor or agent is similar to choosing a company with which to work. Although the primary criteria – financial stability – is not typically part of agent selection, several other areas of consideration are the same. Throughout the text we will use the terms insurance agent and insurance advisor to describe the same functions. Technically, an agent is a legal representative of one or more insurers. An insurance advisor is not legally bound to any company, and is sometimes referred to as a broker. Neither option is inherently better or worse, and we will use both terms to refer to these individuals.

A good insurance agent/advisor can provide an educated opinion on an insurance need, alternate approaches to meeting it, guidance as to what kind of insurance is best in the situation, and an estimate of how much insurance is necessary. An agent who represents more than one company can help determine which companies would best provide the coverage.

As with all financial advice areas, if this isn't an area in which a financial advisor specializes, it is wise to seek the opinion of an expert. There is no simple method for selecting a good insurance advisor. However, factors that should be considered include competence, inclination to service, experience, training, education, specialization, and reputation.

Competence and Inclination to Service

An advisor will find that, most often, the quality of an agent has more to do with how inclined he or she is to service than any other factor. If the agent will not listen, make the extra effort to assist, or competently execute what is asked, it is hard to imagine what he or she could do that would compensate for these shortcomings.

Experience, Training, Education and Specialization

These factors are very important. Experience (and where that experience is concentrated) is especially important since much of the knowledge needed to successfully serve a client's needs is not widely taught outside the industry. An agent who specializes in a particular area will have concentrated expertise in that area. If you are dealing with a particularly technical insurance need, an agent with such experience can be a valuable aid. In life and health insurance, areas of specialization might include pensions, tax-sheltered annuities, or estate planning. An agent

with significant experience also may have access to other professionals who can assist in technical areas.

Because the industry is complex and diverse, some insurance offices maintain “advanced underwriting” departments, often staffed by attorneys or others with backgrounds in the more technical areas of the business. Some also maintain pension departments similarly staffed. These people are often available for telephone consultation and sometimes also make “field” visits, allowing them to be personally present to assist.
As to an agent’s specialty, a financial advisor should understand a practical difference between a specialization in the life and health (including pension) areas and a specialization in the property, liability, and surety areas. Most life and health companies make their products available to any insurance producer. If a producer is not an agent with a company, the insurer generally makes the product available through a broker’s contract with the producer. The type of agent with whom you are working will determine product availability. Some agents have contracts with their primary carriers that prevent them from dealing with other insurance companies unless their primary company is unable to fill the need. If an agent specializes in the life and health area, he or she tends acquire more expertise in this area of specialization and usually has a greater awareness of the many products available to meet those specific needs.

On the other hand, the property, liability, and surety areas often operate differently in terms of product availability. These carriers normally will not sell product through anyone except those they have selected and given a contract. This practice can cause the availability of product in these areas to be much more restricted than it would be with life and health insurance. Further, even for a producer who has acquired a contract to distribute product for a certain company, not all that company’s products may be available to the producer. This is not often a problem when trying to fill homeowners or auto coverage needs, but if the advisor has clients with specialized business exposures such as aviation or construction bonding, product availability becomes a major consideration.

One other consideration with property and liability agents is that some have what is known as “draft authority,” and the amount of this authority varies from agent to agent. Draft authority is the authority to handle minor claims in the office, without having to go through a long adjustment process. Service may be quicker on such claims since the agent can settle a claim in the office up to the limit of authority.

Reputation

The agent must be responsible in his or her dealings with the public. It seems likely that the most important area to be investigated here is, once again, service. Incidents of actual fraud or malfeasance are rare. It is far more likely that a financial advisor or client will have a controversy with an agent over a misunderstanding. The complexity of insurance, combined with how easily an expert can be misunderstood by someone not familiar with the area, makes such problems all too common. With this in mind, the advisor can take a few steps that will help avoid misunderstandings.

Steps to Avoid Misunderstandings

The first step is to put key points in writing. The formality of such a step tends to improve everyone’s accuracy. Remember though, an agent does not have authority to change the insurance contract.

The second step is to read and understand the insurance contract. Insurance contracts are complex because they are legal documents addressing real-world situations.

Step three is to understand the insurance company's internal procedures. These are not identified in the insurance contract, but they can directly affect the client.

The fourth step requires realizing the marketplace has an impact on the services an agent can deliver. As a practical matter, it is virtually impossible to know all the detailed information about a large number of companies. Generally, advisors and clients look to the agent to find the best rates or underwriting available. However, with so many companies from which to choose, it can be difficult for either an agent or financial advisor to really get to know all the companies. Concentrating on a few companies helps the agent become more familiar with their policies and capabilities.

Finally, the fifth step: Maintain a professional working relationship. When a financial advisor shops for insurance products, there are two basic options. If it is necessary to review a wide range of proposals from several agents, the financial advisor should personally do the comparison, evaluation, and selection. If, on the other hand, the financial advisor uses one agent extensively to compare many insurance products, the advisor should find an agent who is widely licensed and shop through that agent. An agent used in this manner can provide a comprehensive comparison, effectively pointing out the strengths and weaknesses of each plan.

At this stage, the financial advisor has determined one or more insurers with which to work and selected an agent as an intermediary. The big question now is how to choose an insurance policy. We will consider this next.

4.1.3 Choosing an Insurance Policy

The way to choose a policy may seem self-evident. Pick a company, select an agent, get their recommendation for the product you need and choose the policy. That approach may work sometimes, but often, something else will be needed. It's not that a company or agent will try to misdirect you. Instead, you, as the financial advisor, are in the best position to determine the policy type and contract features that best supports your client's objectives.

Sometimes, financial advisors and clients find it difficult to choose the type of coverage or policy they need. Aside from the general cost-benefit analysis, a person needs to assess the types of care and other cover needed (or might be needed, based on family history, lifestyle, etc.) as well as determine the level of benefits desired. As an example, for healthcare, if preventive care is desired, the person may need to use an HMO. If going to a regular personal physician is important, an HMO or a PPO might not work. With children who require frequent, regular visits to the doctor's office, an HMO or a PPO might be a good fit. Individuals who live or travel regularly outside of an HMO network area may need to choose a non-managed healthcare plan or a POS plan. These, along with the premium costs, are among the factors to consider when deciding what type of healthcare coverage is appropriate. Other types of insurance cover can follow a similar process.

As a financial advisor, it will be helpful for you to be aware of the alternatives for coverage in your area so that you can provide competent advice in a variety of situations.

Let's focus on life insurance to illustrate the policy-selection process. We explored the way to determine coverage amounts in Chapter 3, in the section about how much life insurance do people need. You might want to go back and review that section.

In many situations, the amount of life insurance needed to cover all financial needs is quite high. It is not uncommon for a family to be unable, or unwilling, to purchase sufficient life insurance to cover all the needs. As a result, the client will need to identify priorities and focus on funding them. For example, suppose the parents' primary goal is to have enough money to cover final expenses, and to provide adequate income while the children remain at home. That would become the focus of life insurance coverage. This does not mean the other areas are unimportant. It simply recognizes that not everyone has enough money to cover all financial needs. Prioritization is a key element in providing good financial advice. This is also a reason to explore use of term insurance rather than a permanent product. Coverage will be easier to afford, thereby making it more likely the client will fully cover the need. Type of insurance (i.e., term, permanent) should always be a secondary concern. Having enough coverage should come first.

Choosing the Right Policy

How do you choose which type of life policy to recommend to a client? The following list will provide guidance in items to consider when selecting which type of policy may be most beneficial for a given situation or client.

- ***Level Term:*** Client wants predictable cost with a finite need, and displays good saving and investing habits
- ***Annually Renewable Term:*** Client has substantial need with limited funds or a relatively short-term need and wants to minimize cash flow to insurance
- ***Decreasing Term:*** Client has a need that decreases annually over a predetermined period of time (e.g., mortgage)
- ***Whole Life:*** Can be used when a client wants predictability and guarantees regarding cost, death benefit, and cash accumulations
- ***Limited Payment Life:*** Client wants lifetime coverage and wants assurance that premiums will stop by a certain date (e.g., age 65)
- ***Modified Whole Life:*** Client needs to minimize cash flow now and wants a predictable premium, a death benefit, and cash accumulation for long-term needs; the client also expects income and cash flow to improve within three to five years
- ***Variable Life:*** Client wants the premium and minimum death benefit predictability of whole life, is not risk averse, and wants to participate in the equity/bond market
- ***Universal Life:*** Client wants lifetime coverage, wants flexibility of premiums, does not want to participate in the equity/bond market, and is willing to accept uncertainty about cash values

- ***Variable Universal Life:*** Client is not risk averse, likes the idea of buying term and investing the difference or participating in the equity/bond market, and needs long-term insurance coverage

The question remains, after seeing available options, how do you choose the best policy type to meet a client's need? Here are some thoughts.

If a client can qualify for one type of life insurance policy, he or she generally can qualify for any type of life insurance. The main exception to this guideline is that term products often are not offered to prospective insureds over the age of 65, whereas permanent products may be available at age 70 or 80 (or slightly beyond). Therefore, except when dealing with a client of advanced age, age and health factors do not preclude the availability of any type of product. On the other hand, age and health may influence product selection by making a permanent product more expensive than the client's situation allows.
Original issue rates on any kind of insurance become higher with advancing age. If the client is in poor enough health to require a rating, the insurance premium will increase even further. Nevertheless, if the client can afford the premium, a permanent product still may be quite attractive compared with a rated term product. Since the details of the client's situation will be the determining factor, the financial advisor may need to do some modeling to reach a final decision.

With this in mind, a client typically will have a total life insurance need that will be greater than available money to pay premiums of any permanent product. This probably means the bulk of the need will require using a term policy. When choosing the policy, pick one that is both renewable and convertible to a permanent product throughout the desired policy period. It's unlikely that the total life insurance need will continue for the client's entire life. Any funding specifically targeted to protecting children will end when the children are grown. Amounts focused on meeting those needs may well be met using a term product, because of lower premiums and higher coverage amounts that are temporary (even if *temporary* means 20-25 years or so).

Some of the need, though, will probably be more permanent, making one of the permanent policy types more appropriate. Which type will be best? Try not to assume the client wants to purchase a particular type of permanent product. As already mentioned, having adequate cover is of first importance, and probably will require a term product. Policy type is a secondary consideration. It's worth considering whether a variable product will outperform a more traditional product. The premise always sounds good – take advantage of market-rate returns – but experience shows that real-world results are sometimes less desirable. Increased expenses often offset better market returns, with the result that overall performance between variable and traditional products can be hard to predict.

The client's risk tolerance is one factor to use in making this decision. Conservative clients will probably not do very well with variable products. Even if you choose one of the money market or guaranteed investment options, the increased expenses will make doing so unreasonable. In such cases a more traditional product or perhaps a universal life contract will be better. On the other hand, a client with greater risk tolerance will probably prefer one of the variable contracts.

Price is one of the next major considerations. Simply, how much does a policy from one company cost as compared to a similar policy from another company? If all the features are the same and the companies have similar history and credibility, you will likely want to pick the policy that costs less . . . and there can be quite a bit of cost difference from one company to the

next. Part of the price consideration includes the amount of time the client wants to pay for the policy. It may be that a limited payment option (e.g., 20 years) will be a better choice than a policy that requires payments for life. For traditional policies, check whether the policy pays dividends or not. If so, what is their crediting rate and payment history? For variable products, look through the prospectus to determine the available investment options and related expenses.

Payment options are another consideration. Depending on the holding vehicle, it may make more sense to use a single-premium policy than one requiring periodic payments. One specific use comes to mind – an irrevocable life insurance trust (ILIT). ILITs may not be used in your territory, but the concept may be applicable. With an ILIT, the policyowner places a policy into a trust or holding vehicle with the expectation of removing policy proceeds from his or her estate, as well as potentially exerting some level of additional control over disposition of policy proceeds. With such uses, a single premium payment is often a good choice. Additionally, sometimes individuals simply want to pay “one and done”. Make one payment and be finished. Rather than a single premium policy, a client may be better served using a universal life policy. This will allow for premium payment flexibility – providing for greater or lesser payments made more or less frequently. To get this flexibility requires a universal or adjustable life policy.

From the preceding discussion, you can see how choosing a policy requires knowledge of the client, his or her goals and financial situation. Chances are good that more than one policy type should be used. Choices may be more straightforward with different types of cover (e.g., property, liability, etc.), but the general decision-making framework will remain the same. Meet coverage needs first, then choose on the most cost-effective policy type from the most reputable insurer that satisfies the client the best.

4.2 Legal and Financial Characteristics of Insurance Parties Involved in an Insurance Contract

Insurance policies are legal contracts. Each party to a contract has a legal relationship with the company and vice versa. As a legal contract, there are standard terms and conditions, many of which we have covered in this course. In this section we will look at the legal relationships between insurers, policyowners, insureds and beneficiaries.

4.2.1 Insurance company

We begin with the insurer because it is the major party to any insurance contract. Earlier, we used the terms *aleatory, adhesion* and *unilateral* as descriptions of an insurance contract. The terms are copied below as a reminder.

- ***Aleatory:*** The outcome depends on chance and the financial participation between parties are substantially unequal. Consider that after the insured pays one relatively small premium for a life insurance policy, the insurer is required to pay a large claim on the death of the insured.
- ***Adhesion:*** The insurer is required to abide by the terms of its contracts. In other words, because the company wrote the contract, it must honor its terms.
- ***Unilateral:*** Only the insurance company can legally be required to honor contractual terms. The insured must abide by any conditions in the contract if he or she wants the policy to pay, but the insurer cannot require insureds to maintain a policy against

their will. On the other hand, the insurer is legally bound to abide by policy terms for coverage.

Notice the primacy of the insurer in these contract terms. Contracts are aleatory because the policyowner pays a relatively small premium for a potentially large payment from the insurer. They are contracts of adhesion because the courts have recognized that policyowners seldom have the legal wherewithal that insurers do, and even if they did, they could not change or negotiate insurer contract terms. All the authority rests with the insurer. Partly as a result, it is the insurer alone that can be forced to honor contract terms. This is another way of saying insurance contracts are unilateral. While policyowners may be required to abide by contract conditions, only the insurer will be held accountable in court to uphold the terms of a legally issued contract.

The insurer is represented by its agents. Agents are authorized representatives of the insurer. The insurer, as principal, gives its agents authority to solicit, create, modify or terminate insurance contracts, subject to the limitations of the agency agreement between them, and as modified by laws in each jurisdiction. This is to say that the agent is the face and voice of the insurer. As such, agents have express authority. This authority is identified in the agent's contract with the insurer and typically identifies exactly the scope of activities the agent is authorized to undertake on behalf of the insurer.

The agent also has implied authority. This is not expressly granted, but is authority the agent is assumed to have as he or she does business in the insurer's name. Practically, implied authority relates to areas such as collecting premiums, completing applications, ordering medical exams, and the like. These things are not usually spelled out in the contract, but are a necessary part of doing business.

One final type of authority is not a positive one. This is known as apparent authority, sometimes called ostensible authority, and it is not an authority the agent actually possesses. Instead, it is the appearance of having authority to do something based on the actions of the agent, and perhaps actions of the insurer. An example might be an agent who is licensed to offer health insurance agreeing to write a life insurance policy application. The agent is not authorized to do so, but the client has no way of knowing this. Even though there is no legal authority involved, if the client pays a premium and is given a receipt, and the insured subsequently dies, the insurer will most likely be held responsible for paying the policy claim. This serves as a good example of the relationship between an insurer and its authorized agents. The acts of the agent can (and often do) legally bind the insurer. The insurer may press charges against the agent, but that will not negate its responsibility to honor policy terms (however, it is also likely that the whole situation will result in legal action by insurer and policy owner as one disputes the other).

As we previously identified, insurers may also be represented by brokers. These individuals or entities are not agents, meaning they do not legally represent the insurer. Unlike agents, who are legally bound to support the insurer's interests, brokers represent the client's interests. They technically have no *authority*, but can do most of the things done by agents. Brokers normally work with several insurers and sometimes also have an agency relationship with one or more.

4.2.2 Policyowner

The person who purchases an insurance contract is the policyowner. This person may also be the insured, but not necessarily. The policyowner pays contract premiums to the insurer, sometimes through an agent and sometimes directly. As owner, the individual has all the

contract rights. He or she can apply for more or less coverage, request contract modifications, name beneficiaries, assign the policy, along with any additional contract-related benefits. The policyowner, however, cannot change the insured, alter contract conditions, or modify the premium (with a few exceptions, such as with a universal life policy). All legal rights and responsibilities are transacted between the insurer and the policyowner.

The policyowner is required to have (and show) some level of insurable interest. As a reminder, an insurable interest is the legal or equitable interest that is held by the insured in insured property or a life. In economic terms, it applies where an insured has suffered a monetary or economic loss through the damage or destruction of the subject matter of the insurance. Without some degree of acceptable insurable interest, an individual may not purchase a policy to insure anything or anybody. To do so would move the insurance contract into the realm of speculation, and this is not allowable. As an example, a person can insure their own house, but not one owned by someone else. He or she can purchase a policy to insure a spouse, but not a neighbor. Another aspect of this is that contracts must be for legal activities, and it's not considered legal to purchase insurance where there is no insurable interest.

4.2.3 Beneficiary

It's possible for the policyowner to also be the insured and the beneficiary. However, it is equally likely that the beneficiary is another individual (or entity). The beneficiary is the party who will receive policy benefits resulting from a legal claim. Beneficiaries may be companies or other organizations, and probably most often are individuals. A beneficiary has few responsibilities beyond filing a claim, along with any requested corresponding documentation, and receiving payment. Beneficiaries are sometimes hard to locate, so it is a good idea for them or their representative to maintain current address and contact information with the insurer (often through the policyowner). It's important to recognize that a named beneficiary (i.e., one who is identified in policy documents) has a legal right to receive payment. The insurer must pay the claim as long as it is legitimate and properly filed. It's also important to remember, at least in many jurisdictions, a policy beneficiary designation supersedes a legal will insofar as paying a life insurance (or annuity) claim. As identified in the preceding section, a regular beneficiary may be changed at will by the policyowner. An irrevocable beneficiary cannot be changed without his or her approval. Irrevocable beneficiaries must approve any contract changes before they can be implemented. The policyowner may not change beneficiaries, borrow against the policy, surrender the policy, or assign it absolutely or collaterally without the irrevocable beneficiary's written permission.

4.2.4 Insured

The insured is the focus of an insurance contract. The insured may be a person, property or some other item. Financially, the insured has no responsibility in the contract. If the insured is property, and it's damaged, the policyowner will file a claim to get the property replaced or repaired. If the insured is a person, any of the three parties (policyowner, beneficiary, insured) may initiate a claim. Of course, with a life insurance policy, the insured cannot file a claim. Insurers will often require some degree of investigation into the insured's condition. This means the company might call for a property inspection or require a medical examination for an insured individual. Most often, the company will rely on information on the policy application to determine these requirements. This is one of the writing agent's responsibilities.

4.3 Regulation and Compliance

Securities industry regulators are primarily concerned with investment company solvency. Many of their rules and regulations target requirements designed to enforce prudent company management and disciplines financial operations. Additionally, regulators develop regulations for people who interact with the public to ensure they do so ethically and with compliance on relevant regulations.

Insurance industry regulators have the same concerns and areas of oversight. The insurance industry is vested in the public interest. Individuals purchase insurance to protect themselves against financial loss at some time in the future. Public welfare mandates that the insurer promising to indemnify insureds for future losses fulfills its promises.

Regulation is necessary, in part, to protect the industry (and its customers) from destructive competition. Too much competition cannot be allowed in the insurance industry because price competition directly affects the financial health of insurers and the amount of their reserves. There is a temptation for companies to compete on price by underestimating future losses and subsequently failing. There are three main *global* purposes for regulation: to maintain competition, to prevent abuse of consumers, and to correct market failures. That last one requires a little explanation.

The market failure theory is based on the view that one purpose of regulation is to correct market failures. Market failure occurs when the free market produces too much or too little of a product or service at too high or too low a price, e.g., a monopoly or an unstable competitive process. Translated, this means that an insurance company may find itself in financial difficulty as a result of too much competition and/or unfavorable market forces. While this might not matter too much if you are a candy manufacturer, it can have a significant impact with insurers. When a candy manufacturer has significant financial difficulty, it may stop producing candy. This might be unpleasant for consumers, but not life-changing. When an insurer faces insolvency, its insured's stand to lose their insurance coverage and related financial well-being – which definitely is not a good thing.

Not all territories have dedicated insurance regulators, but most do. Some territories also have state or regional regulators. For example, Canada has regulators at both the federal and provincial (i.e., regional) levels. The international member organization to which most territorial regulatory bodies belong is called the International Association of Insurance Supervisors (IAIS). IAIS is a voluntary membership organization of insurance supervisors and regulators from more than 200 jurisdictions. Its mission, according to the website (http://www.iaisweb.org/home) is to promote effective and globally consistent supervision of the insurance industry in order to develop and maintain fair, safe and stable insurance markets for the benefits and protection of policyholders and to contribute to global financial stability.

While the primary focus of the IAIS is on insurer financial stability, the organization also is concerned with supervision. This includes organizational supervision, again, to promote financial stability. It also includes intermediary (i.e., agents and brokers) supervision to promote best practices and encourage compliance. Each jurisdiction has a unique regulatory environment for agents and brokers, but we can summarize by emphasizing the requirement to operate ethically and in a manner that serves and supports policyowners. As is true in the broader financial services world, the overarching concept is to treat clients in a way that is in their best interest. Compliance with this concept should be automatic with all financial professionals.

Summary

In this chapter we have explored some aspects of insurer and agent selection due diligence (or due care). We have also reviewed legal and financial characteristics of parties involved in contracts. In prior chapters we covered the nature of risk, how it relates to individuals, and methods of addressing various risks. One method, risk transfer, led us to cover various types of insurance as a primary risk management tool. Now, we will turn to investigating ways to develop and implement risk management strategic solutions.

EXAMPLE 4		
Question Stem		In many situations, the amount of life insurance needed to cover all financial needs is quite high. It is not uncommon for a family to be unable, or unwilling, to purchase sufficient life insurance to cover all the needs. Which o the following is most likely a step in the synthesis and

		recommendation stage of risk management and insurance planning:
	a	Prioritize the client's risk management needs
	b	Assess exposure to financial risk
	c	Prioritize action steps to assist the client in implementing risk management recommendations
	d	Assess the implications of changes to insurance coverage
Correct Answer		**c**
Explanation		Prioritize action steps to assist the client in implementing risk management recommendations is the last step in the synthesis and recommendation stage of risk management and insurance planning.
Distractor #1	**a**	Prioritize the client's risk management needs is the last step of the analysis stage of risk management and insurance planning
Distractor #2	**b**	Assess exposure to financial risk is a step in the analysis stage of risk management and insurance planning
Distractor #3	**d**	Assess the implications of changes to insurance coverage is a step in the analysis stage of risk management and insurance planning

Chapter Review

Discussion Questions

1. Some insurers are quite specialized? How does this enter into your selection of a company with which to do business?

2. What are the rating agencies and how can they help you select an insurer? Are there any potential problems that might arise from depending on their services?

3. Why is an insurer's financial condition so important?

4. When you are looking for an insurance advisor/agent with whom to work, what criteria would you use to make your selection?

5. What potential solutions would you recommend to a client who currently has limited financial resources, but needs a large amount of life insurance coverage, and is unsure which policy type to choose and how to make the necessary premium payments.

6. What is the problem with apparent or ostensible authority? Have you ever experienced this?

Review Questions

1. What are the primary factors to include when evaluating an insurance company for possible use?

2. What are the four main rating agencies and what type of rating do they provide?

3. What is a company's lapse ratio and how does it apply to insurer evaluation and selection?

4. What are some of the factors to include when evaluating an insurance agent?

5. What is the difference between express and implied agent authority?

6. Will an insurer usually be liable when an agent abuses apparent or ostensible authority?

7. What is the primary concern of securities industry as well as insurance industry regulators?

Chapter 5: Strategic Solutions

Learning Outcomes

Upon completion of this chapter, the student will be able to:

5-1 Determine potential risk management strategies for a client
5-2 Identify the advantages and disadvantages of risk management strategies
5-3 Optimize risk management strategies to make recommendations
5-4 Prioritize action steps to assist a client in implementing risk management strategies

Topics

Introduction

In this chapter we will try to develop strategies to address clients' risk management needs. To some extent, we have included aspects of this as we explored prior sections and this chapter will serve as a review and summary. Here, we will coordinate what we have learned to develop one or more plans to help clients achieve their goals and objectives.

As a reminder from the course content, the major risk management areas are:

- Property
- Liability
- Life
- Health (including long-term care)
- Disability and Loss of Income

To these we can add the failure of others, in that they might cause loss based on inappropriate action or inaction (that they should have taken). If we accept that we cannot accurately predict losses in any of the areas, we can also accept the need for planning and protection, likely using insurance to some degree. While we cannot accurately predict the likelihood of a loss or when it will occur, we can address whether a client may be affected and if so, the potential financial loss. Doing this, we can decide whether the cost of insurance to protect against a potential loss is reasonable.

As an overly simplified example, consider the potential that an outbuilding might collapse. We built the shed ourselves at nominal cost, using materials that were not very expensive. In fact, the total cost to build the shed was $1,200. Let's say the annual premium cost of insuring the shed against collapse is $600. In two years, we will have paid as much in premiums as the

replacement cost of the shed. In such a case, there is little, if any, reason to purchase insurance against collapse (unless the shed houses valuable content, in which case we might reconsider). On the other hand, if the shed sits behind our home, which has a replacement cost of $1,000,000, it would be wise to carry adequate insurance.

As a general rule, if a client cannot afford to pay for repairs or replacement, either as a result of not having enough money or the negative impact of using available funds for the repair or replacement, he or she should consider purchasing insurance to transfer the risk of loss.

There is, however, another factor to consider. What is the likelihood that a loss will occur? If the shed would simply collapse if there were an earthquake, and the ground on which it sits has not experienced a quake for more than 500 years, it's not likely to experience an earthquake-induced collapse anytime soon. However, if the shed sits in a particularly snowy locale, and we shift the peril (i.e., cause of loss) to snow, or the weight of snow, the potential for collapse increases greatly. The two factors (replacement cost and likelihood), taken together, provide a good rationale for either insuring the property or not purchasing insurance.

Property-related issues seem relatively straightforward, and the same may be true with liability, but what about loss of income areas related to a disability, or medical expenses, or even loss of life? Can we apply the same guidelines to determine the value of purchasing insurance coverage? In many ways, the answer is yes. For example, actuaries can identify the odds of a person becoming disabled, and that information may be available through insurance companies and other resources. Healthcare-related issues are a little more nebulous, in that we don't really know whether someone will develop a significant illness or experience a major accident. However, we do know that such events happen, and that related expenses can be high. Some territories fully cover medical expenses, so this is less of an issue. However, where the individual is wholly or partially responsible to pay healthcare bills, adequate funding can be a concern.

Life insurance is a little different. Actuaries and mortality tables can tell us the odds that someone in a class of people may die at a certain age, but nothing more exact than that exists for an individual. Further, placing a monetary value on a human life is an inexact science. We know that everyone will face death at some point. We also can calculate the relative financial impact of someone's death at various life stages (e.g., the death of a young mother with three dependent children will likely have greater financial impact than that of a single older person with no dependents). Previously in this course, we looked at the process to determine life value (which can be an uncomfortable activity, but is necessary, and beneficial for those who remain). Even in the case of life insurance, though, the amount of coverage must be compared to premium cost. That is, 'I may feel my spouse has immeasurable value, but the cost of insuring "immeasurable" is likely to be prohibitive'.

The general principle is to reduce or avoid the risk of loss whenever it's practical to do so. When impractical, consider risk transfer and the purchase of insurance. As part of the insurance evaluation process, consider both the potential likelihood of loss and its probable cost. Compare the value or cost to the insurance premium required to transfer the risk. If the cost-benefit analysis, as with the $600 shed insurance, shows premiums to be out of line with the insured object's value, skip the insurance. On the other hand, if the cost-benefit analysis leans in favor of insurance, move to the next step of evaluating appropriate insurance coverage.

Assess Exposure to Financial Risk

Risk management requires recognizing the risk areas to which an individual may be exposed. A financial advisor cannot simply say that a client might be exposed to all possible risks, therefore he or she should protect against that possibility. This is neither practical nor possible. Plus, where risk transfer is required, excess amounts of insurance can quickly run through available cash flow. Remember, financial advice is a holistic process, and recommendations a financial advisor makes in one area often have an impact on one or more other areas. If most available cash flow goes to pay insurance premiums, how would the individual accomplish other financial goals?

One can assess risk exposure in several ways. For example, it's not hard to evaluate an individual's healthcare coverage, whether provided by the government, employer, private insurance, or some combination. Once the financial advisor and client review the options, they can discuss areas of over or under coverage, the cost to provide that coverage (or savings from cutting unneeded coverage), and work together to execute that part of the plan. This process would need to be reviewed periodically as government benefits and private insurance coverage changes, and as client needs change.

The process to determine disability income risk exposures is also straightforward. Deciding which coverage to purchase at what price is less clear cut, but determining the exposure level is relatively easy. As with medical expense exposure, first identify the amount of existing benefits from all sources. Remember, those sources may not involve insurance (also true for all other risk management areas). A person may have sufficient financial resources to self-fund a risk exposure area. Assuming insurance is involved, first consider any benefits available from government or employer programs. Add in privately owned insurance, if any. Now determine the amount needed, after factoring in existing assets such as an emergency fund, to protect against financial harm in the event of a disability-related loss of income. To do this part of the analysis, a financial advisor would evaluate cash flow and asset/liability statements, along with available income sources. Is there a point in the future when government-provided or other benefits would begin? If so, are they sufficient to cover the need? If not, you now know the potential risk exposure. Disability income insurance tends to be expensive, so the next step would be to determine how much coverage to purchase, with what kinds of deductibles (waiting periods) and coverage periods (e.g., to age 65, life, etc.). All this information could be included in a cost-benefit analysis to determine potential insurance requirements.

Evaluating long-term care needs is a little more complicated, because it involves a few more unknown factors, and because it can be expensive to purchase. As with the other areas, government or employer-provided benefits may cover all or most of the need. One question to ask is what might be considered long-term care versus regular medical care? In some territories, long-term care refers to just about any medical expense that requires lengthy recuperative periods and what is sometimes called rehabilitative care. This is especially true when the individual is elderly. Other territories include 100 percent of this type of care as part of their regular healthcare benefits. The exposures are different in these two cases, and therefore it's important to learn the situation in your territory.

One of the more difficult parts of long-term care evaluation is trying to anticipate the length of time care may be needed. Some sources identify an average length of long-term care rehabilitation as around two to four years. If the average is valid, the next step is to learn the average annual cost of care. Combine these two, and you have completed part of the analysis. The next step is like evaluating disability income risk exposures. Identify available assets,

including cash reserves and emergency funds, liquid assets, other insurance coverage and the like (and of course, available benefits from the government or employer). Then, determine the length of time an individual could go without any additional coverage and still be financially sound. Remember to include the disability area and others that might have an impact. Existing funds can only cover so many needs. It's sometimes hard to make a single peso work to satisfy multiple needs. As with disability insurance, the amount of coverage, deductible (waiting or elimination period), and length of coverage, are the biggest factors affecting potential premium costs. Optional coverages and additional benefits can also increase premiums.

Long-term care expenses not covered by government or employer-provided programs can have a significant impact on a person's retirement situation. As an example, a person who incurs $50,000 of personally funded expenses would not have that amount to apply to future income needs. For some people, $50,000 represents a large portion of their available funds, and has the potential to significantly lower their retirement standard of living. This is another example of the holistic nature of financial advice. It also illustrates why appropriate advice can be very important, and make a big difference in a person's life.

Property and liability, and life risk exposures require a bit more analysis.

5.1.1 Risk Review and Evaluation: Property and Liability

Most financial advisors would agree that property or liability-related losses can seriously damage an individual's financial wellbeing. It's not hard to envision a scenario where someone could experience a net-worth-decimating loss.

Some questions for your evaluation include:

- Are homeowners and motor vehicle insurance policies in place?
- Are the liability and uninsured/underinsured limits adequate?
- Is there an umbrella or personal excess liability policy in place and is it adequate?
- Is the client involved in any activities that might cause risk to their, or others', life, limb, or property?

The preceding questions represent only the beginning of a good exploration of this risk area, especially with clients who have greater than normal wealth. Affluent individuals can have far more liability and property risks than most people—and far more to lose. These risks include expensive property, property in different geographic areas, employees who maintain their property, assets and interests that create potential liabilities, and valuable collections that are often difficult to value and replace. The complexity of their situations makes crafting a solid personal risk management plan more difficult and considerably more important. All clients are not created equal. Some individuals have unique risk exposures. As a result, they typically should use specialized risk management and insurance tools.

It's also important to coordinate multiple insurance policies. Consider an individual who owns property in several territories. He or she may have purchased separate insurance policies for each property, and may not have checked to see how well the different policies coordinate. You should check whether there are gaps in coverage or overlaps. Also, determine whether there any coordination or tracking mechanism for policy renewal dates. You don't want the client to incur unintended policy lapses.

Some individuals invest in high-value fine arts and collectibles. Most basic property insurance has coverage limits on these types of assets that are quite low. A personal property endorsement or personal property floater may solve the problem, but additional issues may need to be addressed.

- Was a professional appraisal used to establish the item's current value?
- Would the insured be required to replace or repair an item, or would the policy allow for a cash payment option?
- Would items such as antiques be covered for full value, or would they be depreciated?
- Would new items automatically be covered, and if so, for how much and for how long?
- Are items covered when they are outside the home (perhaps on display at a museum or other venue)?
- Would items be covered in full when they are in other residences or in transit?

These are all questions that should be considered when evaluating property coverage. Liability exposures are another important area to consider. Some clients have relatively few assets, but others have many assets. Those with more assets have more to lose, and may be more frequent targets for litigation. A high-coverage-limit umbrella liability policy, coordinated properly with underlying coverage, is a good first step. However, some individuals have other areas of exposure that would not be met by personal liability coverage. If an individual is a director or officer of a nonprofit board, he or she probably has increased liability exposure. A directors' and officers' liability policy would help to cover this exposure. Some people employ household help and personal assistants. Liability exposures from these employees could be covered by a separate policy (and probably would not be covered by homeowners or other personal liability insurance).

Another area worth a brief mention is increased personal safety concerns. Under most circumstances, the average person does not need to be concerned about things like kidnapping, carjacking, abduction, or extortion. This is not always true for some high-profile individuals.

There are two main areas of concern here: maintaining personal safety, and having adequate/appropriate insurance coverage for these exposures. A high-profile individual may require increased personal security services (e.g., hiring a driver trained in evasive maneuvers), and may require things like a more high-tech home security system with increased monitoring. While this is not usually something that falls within a financial advisor's purview, you could encourage the individual to explore solutions to these problems with appropriate professionals. A few insurers offer insurance against these risks (e.g., stalking, kidnapping, abduction, and the like), and it may be a good idea to discuss these risks, as appropriate, with high-profile/affluent clients.

5.1.2 Risk Review and Evaluation: Life

Humans are not property, and human-life risk evaluation differs both quantitatively and qualitatively from similar property-related evaluations. We will not discuss the emotional toll the end of life often produces, focusing instead on things financial. Death often brings financial turmoil, especially when the deceased was a primary income earner with dependents. Financial well-being depends upon adequate cash flow. When that is disrupted, even well-made plans can be upended. Protecting against the potential disruption of income is a major reason for life insurance, and in addition to covering final and estate-distribution expenses, is the major focus of evaluation.

Selecting a life insurance policy can be challenging, in that it requires evaluation of not just the policy, but also the company offering it. As important as it is to make the right policy choice, determining the amount of required coverage is even more important. Covering final expenses is one of the two, and by far the easiest, main tasks for life insurance. Although some estates can be complicated to settle, in most cases, tallying up final expenses is a fairly simple process. As a reminder, final, or postmortem, expenses may include:

- Funeral costs
- Unpaid medical expenses
- Outstanding loans and debts
  - Some debts may be forgiven at death, but many require repayment.
  - Loans in joint names (e.g., husband and wife) may transfer to the remaining joint holder. However, that individual must be financial able to continue repayment.
- Estate-settlement costs
- Adjustment period fund
  - It can be difficult for dependents to quickly adapt to a significant change in income. Further, available funds may sometimes be temporarily tied-up at death, creating an income bottleneck until released. An adjustment period fund can help with this process.
- Miscellaneous
  - This is to cover any additional expenses that may arise.

Once the individual has totaled an estimate of final expenses, he or she should determine the amount of any available liquid assets. Life insurance is, for all practical purposes, a means to provide cash or liquidity at death. Any available liquid assets not earmarked for other purposes may be used to offset final expenses. There may be enough liquid assets to cover all final expenses. If not, the amount needed to pay any uncovered expenses should be identified and included as part of the potential life insurance need.

The process to determine ongoing income needs is more involved. Assuming that a spouse and children survive, you should consider five potential income categories:

- Dependent income for the children until they reach the age at which they are able to live on their own
- Additional income for the surviving spouse while the children remain in the home
- Funds to pay for education expenses (primary, secondary and higher)
- Funds needed to supplement income for the surviving spouse after children have left the home, and before reaching retirement age
- Supplemental retirement income funds

Where there is neither a spouse nor dependent children, the process becomes simpler. In such cases, the individual may not need life insurance, as long has he or she can pay for final expenses. We should point out that every situation is different, and not all individuals will desire (or be able to) fully fund each of the income categories. Part of the “art” of life-needs analysis is to help individuals decide what they do and do not want to fund, and then, the amount they can afford to cover with life insurance. In some cases, there will be the need for compromise.

The first step in determining potential income-related needs is to have an open discussion with the client about how he or she wants to proceed. Such discussions can be difficult, because they involve providing funds for the wellbeing of any surviving dependents. Spouses do not always agree on the amount of income to be provided in the various categories. You should be aware of potential disagreement and stress when discussing end-of-life needs (especially when they involve spouses and children). The economic value of a stay-at-home spouse is one area that can be difficult to determine. It may seem that there is no economic benefit if the spouse is not producing an income, but once you begin to add up all the services provided by that spouse, and the cost to replace them, you begin to recognize that person's significant economic value.

Once the hard work of deciding how much should be provided for the surviving dependents and spouse, the financial advisor can begin to calculate the funding requirements. We covered the process to do this in Chapter 3 in the section on "How much life insurance do people need?" It would be worthwhile to go back and review the information in that section now.

To help make the process a little more concrete, let's look at one example of funding an income-related need.

Faber Case

Frederick and Frieda Faber are working through the steps in a life-needs analysis. Frieda is a stay-at-home mother, taking care of the couple's two children. The Fabers have decided they would like Frieda to continue staying at home until the children leave home. The couple has reached the place in their calculations where they need to decide how much income would be required to provide adequate income to care for the two children: Eva, age 10 and Emma, age 8, until each child reaches age 18.

Step one is determining the amount of cash inflow required to sustain a desirable lifestyle for Frieda, Eva and Emma. This process involves looking at the budget, backing out expenses directly related to Frederick, and settling on the appropriate amount. Calculations would need to factor an acceptable inflation rate so purchasing power would remain relatively constant. We will also need to agree to a discount rate (i.e., return on savings/investments). For our purposes, let's settle on the following:

- Annual income need with Frieda and both girls at home: $20,000
- Annual income need with Frieda and Emma at home: $14,500
- Inflation rate: 3.5 percent
- Discount rate: 5.0 percent
- Years remaining at home
  - Eva: 8
  - Emma: 10

We will first calculate the need while Eva and Emma are both at home, then for the remaining period while Emma remains at home.

Prior to working the calculations, we need to identify the annualized real rate of return (how inflation impacts the nominal rate).

The equation to calculate real rate of return is:

$$\left[\frac{1.05}{1.035} - 1\right] \times 100 = 1.4493$$

We will use the real rate to help maintain purchasing power for Frieda and the girls.

After doing the initial work, the process to determine the funding requirement has three steps:

1. Inflate the current income amount (using only the inflation rate) for the number of years until it will be needed. In this example, no inflation is needed for the first calculation (because the income need begins immediately), but will be required to calculate the amount needed for the two years Emma will remain at home after Eva leaves.
2. Calculate the present value (annuity due – BEGIN mode) of the future income stream using the real rate of return.
3. Discount the amount from Step 1 to determine the lump sum needed to fund that amount (because the income need when Frieda, Eva, and Emma are all at home begins "today" – at the same time the present value annuity due (PVAD) is being calculated, there is no need to apply the discounting step.)

All life insurance-needs calculations have "today" as their starting point, i.e., the day on which the calculations are being worked.

Amount needed while Eva and Emma are both at home:

- 8 N
- 1.4493 I/YR
- 20,000 PMT
- [0 FV]
- PVAD (BEGIN mode) = 152,224 (rounded)

Now that we know the amount required to fund the income stream while both girls are at home, we can move on to calculate the amount needed to fund the additional two years when Frieda and Emma remain in the home. Because this second income stream begins after Eva leaves home, we must add a calculation step to inflate the current $14,500[2] annual income amount for eight years, using the rate of inflation only. This is a simple future value calculation.

Step 1 (inflate the current income amount)

- 8 N
- 3.5 I/YR
- 14,500 PV
- [0 PMT]
- FV = 19,094 (rounded)

In eight years, to maintain the purchasing power of $14,500, Frieda and Emma would need $19,094.

[2] The income amount applicable to Frieda and Emma, without Eva

Step 2 (calculate the sum needed to fund the remaining two years of income while Emma is at home)

- 2 N
- 1.4493 I/YR
- 19,094 PMT
- [0 FV]
- PVAD = 37,915 (rounded)

Step 3 (discount the $37,915 back to today, NOT just back two years to the point where Eva and Emma are both at home. We want to find out how much will be needed today to fund the future need, so we discount back to today)

- 8 N
- 5 I/YR
- [0 PMT]
- 37,915 FV
- PV = 25,663 (rounded)

By adding the two amounts: $152,224 and $25,663, we conclude that $177,887 would be required to fully fund the inflation-adjusted future income stream for Frieda, Eva, and Emma. If no liquid assets or existing insurance is available, $177,887 is the amount of life insurance the Frederick's would need to fund this future income stream.

If we were doing a full life-insurance needs calculation, we would move forward to determine amounts needed to fund Frieda's pre-retirement and retirement-period income (based on what the couple decides that amount should be). If the Fabers want to fund all or part of their daughter's university tuition, we would also work through the amount necessary for that need. The result, after adding all the amounts, is likely to be quite large. This would be true in many situations, and is one reason why term life insurance is often best for providing the necessary death benefit at the most cost-effective (and non-budget busting) premium. In the case of the Fabers, we would probably recommend a 10-year level-term life insurance policy to fund the need while Eva and Emma remain at home.

It may be that a different type of life insurance would make more sense for Frieda's pre-retirement or retirement need, but we would need more information to make that determination. We would need to know about available discretionary income, balanced by the need for other investment funding. Also, we would need to find out whether Frieda would be working outside the home after the girls leave, and if so, what impact that would have on her retirement-funding needs. Finally, whether from investments or other sources, we need to determine Frieda's net financial need during both the pre-retirement and retirement periods. We will not work through these calculations, but you should recognize this as another example of the holistic, inter-related nature of financial advice.

The proper method to assess risk exposures is to conduct a step-by-step audit. If an advisor does a complete risk management plan, he or she would assess each of the risk exposure areas. In some cases, the client may desire a more focused approach, and the advisor should adapt accordingly. As an example, the client may have already addressed all healthcare related risk exposures, and does not want to include that area in a broader risk-assessment audit. At the same time, an advisor should not assume that any area has already been addressed. It's best to assess all potential areas of need and let the client advise otherwise if appropriate.

Part of the process of risk assessment includes evaluating the tools (e.g., insurance) and risk-management approaches being used to address risk areas. The focus is to identify any gaps so they can be closed. We will explore this process next.

5.2 Risk Management Tools Being Used to Address Risk Exposures

We previously identified four primary risk management strategies:

- Avoidance
- Reduction
- Retention
- Transfer

The primary focus when auditing this area is to ensure that risk management tools and strategies are in proper use, and that the individual is aware of the potential financial implications for each option.

Avoidance is perhaps the easiest, and paradoxically, the most difficult, option. It's easy to declare your intention to avoid a risk. However, following through can be difficult. To be sure, some risks are easy to avoid. For example, if you don't want to get hurt playing sports, don't play sports. On the other hand, think of the example of avoiding car-related losses. At the core, this requires not owning a car. While this may not be difficult in a city with good public transportation, it might become quite hard when the individual lives out in the countryside with little or no public transportation.

Retention is also relatively simple to assess, but it can create problems if financial implications from the retained risks mount too high. The advisor should help the client keep a running total of potential out-of-pocket expenses for all retained risks. If potential financial exposure gets too great, the advisor should probably consider risk transfer. A simple spreadsheet is not necessarily the most elegant tracking tool, but serves well for this purpose.

Reduction is perhaps the trickiest strategy, in that it does not seek to eliminate financial exposure, nor does it intend to retain it 100 percent. Instead, reduction intends to retain the risk, but reduce the likelihood of financial impact. So, a person might install an alarm system in a home or office building. He or she might park the car in a guarded or otherwise safe, enclosed space. Any costs for these options would need to be added. At the same time, there is no guarantee that someone would not break into the house, building, or car sanctuary anyway. If that happens, not only did the individual incur the expense of implementing the risk-reduction strategy, he or she suffered the financial loss, too. Perhaps there would be some cost mitigation from, for example, the security service, but perhaps not. As an advisor, you would want to identify these areas and discuss potential outcomes with your client. It's possible that some or all the potential exposure would be best served by including insurance (transfer) in the mix.

Transfer is probably the easiest strategy to quantify in terms of cost and benefit. Assuming the coverage is properly written and maintained, the policy owner would have a good idea of premium cost and the coverage provided by the policy. With this in mind, ask yourself a few questions as you evaluate insurance coverage.

- What risk is the policy intended to cover?
- As written, does the policy provide the desired coverage?

- What is the upper limit of coverage, and is this sufficient? Should it be increased?
- What is the lower limit of coverage? Should it, or any deductibles, be raised?
- For how long is coverage or policy payout expected to last? Is this appropriate or should the term be increased or decreased? For example, is a disability income policy with a five-year benefit period sufficient?
- Are beneficiary arrangements in good order? Do they coordinate with any relevant legal documents, such as wills or trusts?
- If there are different policies addressing the same risk area, is there too much overlap, or are there still gaps in coverage?
- What are the renewal provisions, and does the policy owner need to be aware of any potential renewal premium increases or other problems?
- For healthcare coverage, are the proper health conditions covered, and in sufficient amounts?
- Is the life insurance coverage sufficient, and is the policy type appropriate? Do existing policies need to be modified in any way?
- Do risk exposure gaps exist, and can they (or should they) be addressed through risk transfer? This is especially a concern with liability risk exposures, and when the individual is a professional, or an employer, or a director / officer of a company.
- If household staff is employed in more than one location (and perhaps different territories) are all legal requirements satisfied?
- Is the policy cost effective and issued by a financially sound insurer?

The preceding list is not intended to be all-inclusive. However, it can serve as a guide for the advisor in his or her evaluation. As part of the evaluation process, the financial advisor works with the client to prioritize risk management needs, and then optimize strategies to effectively address those needs. We will look at this next.

5.3 Risk Management Needs

We have identified that few individuals can effectively address all financial needs to the same degree and at the same time. Money is a key issue, but time and energy may also be practical factors. Especially at the start of a financial advice relationship, addressing 100 percent of existing financial needs in all areas can be overwhelming. This is one reason why it's beneficial to work through the process to determine which needs have top priority. This also applies to the area of risk management. Even though risk transfer is not the only available tool, it is often appropriate, and always costs money to implement. In the case of a client with limited funds, risk-management goal prioritization is a valuable activity.

On what basis do you prioritize risk management needs? To start, the advisor must discuss prioritization with the client. While it's true that an advisor will recognize needs to address, the client will often express his or her desire to work on some areas over others. Recognizing the

value in discussion with the client, the advisor will need to understand the criticality of meeting certain needs over others.

Remember, the purpose of risk management is to protect against potential losses that can harm a person financially. An advisor needs to evaluate which risks could cause more financial harm than others, and therein lies the problem. The act of prioritizing a list of roughly equal needs often results in a lack of distinction between them. Consider which is most important:

- Protecting against a total loss of your house or the need to protect against personal liability (auto, home or other)?
- Having the money to pay family medical expenses or protecting against potential long-term care expenses?
- Protecting against financial exposure resulting from an untimely death or protecting against loss of income due to a long-term illness?

As you read through the questions, two things probably came to mind. First, all those needs are important. At the same time, some needs probably seemed more significant than others. When funds to pay insurance premiums are limited, it is important to have a process in place to prioritize needs. From a purely financial standpoint then, with one exception, top risk management priorities should be those areas of risk that can cause the most harm. You must give some consideration to the likelihood of an event happening. If a risk can cause great financial harm, but the likelihood of being affected by that risk is low, the risk probably should not be given the same priority as one where the potential impact is far greater.

Part of the prioritization process should include existing options to address a need. As an example, loss of income due to a disability is potentially quite harmful, but it may not need to be addressed if the individual has enough coverage or benefits (government or employer-provided) to protect against the loss. Further, it may be that the person has enough assets so that purchasing insurance is not necessary. If so, some risk areas might be given lower priority than others, based on the individual's willingness to apply existing assets should the need arise.

With these things in mind, we might be able to agree that having an adequate life insurance portfolio is a top need. However, this is not always true, either. Someone with no dependents may not have much need for life insurance (except perhaps enough to cover final expenses). Therefore, it would be incorrect to arbitrarily place life insurance – or any other need area – as the top priority.

You can see that the only effective way to prioritize risk management needs is to use the same process advisors use to prioritize all other needs. Analyze areas of greatest exposure or need, and in concert with client goals, work through the prioritization on a case-by-case basis.

Having said all that, we can make some generalizations. For people with dependents (e.g., spouse and children), protecting against loss of income due to premature death will normally be one of the top priorities. Having enough insurance coverage to protect against the loss of a primary residence and personal property will also be high on the list. For those who want to drive a car where the law requires adequate liability, and perhaps physical damage coverage, having appropriate coverage will be key. Where the government and/or employer do not provide adequate healthcare coverage, having adequate insurance can make the difference between bankruptcy and financial stability. The same is true for disability-related risk exposures.

If we total the premium cost to provide appropriate insurance coverage for each of the preceding areas, we have the potential for a large percentage of the individual's cash flow to be deployed for premium payments. This is a good reason to find the most cost-effective ways to provide necessary coverage. Even by doing this, though, the individual may have to make some hard choices between the various risks to insure. The individual may choose to provide for partial, rather than total, risk coverage. For example, for life insurance, he or she may decide to cover only half of the income-replacement need while children remain dependents. While not ideal, it may provide enough financial stability to keep the family going.

Risk management prioritization is often a matter of balancing needs with available resources. The process may not always require a choice between total coverage and no coverage. Instead, the advisor may be able to determine levels of coverage that, while not perfectly providing total risk protection, address the client's risk-management needs. Also, don't forget that not all risks require insurance. Some can be addressed by lifestyle changes and choices.

5.4 Risk Management Optimization

Following the prioritization process, the next step is to make optimal strategic risk management recommendations. As we have already discussed, after needs analysis and consideration of goals, the next most important step is to determine available resources. We probably should include assessing which risks might be best managed through avoidance or reduction. We also need to consider the risks a client may decide to retain. Retention includes insurance deductibles, which can add up. More than one person has had their pleasure over low premium payments greatly diminished the first time they submitted a claim and had a large out-of-pocket expense from a high policy deductible.

Risk management recommendations should be based on meeting critical need areas. Then, depending on available resources, a cost-benefit analysis will determine how much of a given risk to cover, as well as the type of insurance to use (e.g., term versus whole life insurance). Finally, as is true with the rest of financial advice, you need to develop a roadmap to help the client reach appropriate coverage levels over time (when adequate funds are not available to meet the whole need).

5.4.1 Risk Management Audit

Conducting a risk management audit is the most appropriate way to begin developing and optimizing a risk management strategy. This will often be done as part of the initial client intake and exploration process. Assuming the financial advisor has a good, in-depth data survey or fact-finding form, he or she will gather a lot of the basic information.

Depending on the client, a risk-management audit can be simple and quick or complex. Either way, begin by talking with the client to gain an understanding of his or her situation and potential risk exposures. Then, collect and review all existing insurance policies. When you do this, be sure to identify any areas where no policy exists, but where coverage might be needed. Also, when reviewing coverage, ensure beneficiary and ownership arrangements are in good order. Make note of deductibles and other coverage limits, along with relevant policy provisions.

When you have completed the audit, compile the information in a report identifying risk areas compared with existing coverage. Also identify any coverage gaps, and provide possible solutions. Following is an example of what an abbreviated audit report might look include:

Risk Management Audit	
Coverage Areas	**Recommendedations**
Inadequate liability coverage: Not enough coverage for car and personal liability relative to the client's net worth	Purchase an umbrella (excess liability) insurance policy to cover car and personal liability exposures. Increase underlying liability limits to coordinate with umbrella policy.
Premature death: Has enough assets to cover final expenses and dependent income needs.	Earmark assets for final expenses. No need for additional life insurance coverage.
Long-term disability: Existing employer-provided insurance plus government benefits should cover one-half current income. Preferred coverage level would provide two-thirds current income with appropriate inflation adjustments.	Purchase individual-owner policy to supplement existing benefits and provide the increased coverage levels. Check with employer-coverage to ensure new policy will not impact existing benefits.
Healthcare expenses: Existing employer-sponsored and government-provided benefits adequately cover potential medical expense exposure.	No additional insurance protection needed.

The preceding chart is an abbreviated sample of what could become an extensive report. The report should highlight areas of coverage the advisor believes should be addressed. An actual report would identify coverage amounts and type of policy. As the advisor and client discuss the report, the advisor would find out which of the areas the client wanted to address now. By the end of the discussion, advisor and client should agree on a strategic course of action. The final step would be to shop for insurance coverage and begin incorporating any lifestyle (or other) changes to address risk management areas not requiring insurance.

Between the audit (and client review) and implementing suggested actions, the advisor and client should agree on the most appropriate strategic risk-management approach. In some cases, the strategy would be as simple as working through the audit list and agreeing or disagreeing on each item. After that, the planner can put together a list of actions and he/she and the client can begin implementation.

Sometimes where needs are straightforward, but far greater than available financial resources, the process will require a little more work. A risk management strategy should include the following steps:

- Identify the risks
- Review (and inspect) current situation
- Analyze the information
- Select the most appropriate risk management technique
- Implement the chosen approaches
- Monitor results

This process is essentially the same as for all financial advice engagements. In this case, with emphasis on risk management. We have already covered the steps, except for implementing the chosen approaches. We will look at that now.

5.4.2 Implement the Chosen Approaches

The implementation process may take some time. New insurance coverage must be underwritten. With life and health-related coverage, this may involve health exams, financial reports, personal interviews and the like. For life policies with high face amounts, the underwriting process can be long and involved. Sometimes, one insurer may reject coverage, which may require applying with another carrier or, perhaps, modifying the plan. Unlike most investment options, insurance policy applications are sometimes rejected. Underwriting is the process an insurer uses to decide whether it wants to accept a risk, and the company always maintains the right of rejection.

Even with an initial rejection, the client may be able to get coverage. Sometimes the insurer just needs more information. Perhaps it needs more financial or medical information. Or, it may be that the amount of coverage requested (e.g., with life or liability insurance) is too high for that insurer to carry. In some cases this may lead the company to decide it will *reinsure* a portion of the coverage. Reinsurance means one company decides to share – or *re*insure part of its risk exposure with another company. An advisor should evaluate a reinsurer in the same way as the original company. Reinsurance would only be an issue when dealing with very high coverage amounts, and should not normally be an area of concern.

If one insurer absolutely rejects an application (i.e., even after new information, etc.), the advisor may decide to try another company. However, before doing so, it's worth determining the odds of getting a policy. Sometimes previously unrevealed information can come to light as a result of inspections and reports. When this is true, it's possible that the advisor may determine that getting a policy at a reasonable price – or at all – is not feasible. In such cases, it's time to explore alternatives. In the worst case, the alternative may be that there is no way, other than retention, to address a risk.

As an advisor, what would you do if you find that, for example, a client simply cannot purchase new life insurance coverage?

The money and the desire are there, but you cannot find any insurer to issue a policy. Assuming the need remains valid, it may be possible to reallocate other resources to substitute for the insurance. For example, money earmarked for retirement may now be targeted to meeting the need that otherwise would have been covered by insurance. To be sure, this may mean that another area (e.g., retirement) would need to be modified, but doing so may provide a solution. It would probably be a less-than-optimal solution, but at least the need will be addressed.

Advantages and Disadvantages

How do you determine the relative advantages or disadvantages of a risk management solution? Simply, ask whether it appropriately addresses the need or not. A big part of determining a strategic approach includes exploring options. Ultimately, the chosen solution should be the one that best meets risk-management needs. The problem, of course, is to determine what is *best*. Best may be the least expensive, but often low cost is not necessarily a good indicator of value. It may, however, be the only way to meet a need. Financial advice, and for discussion purposes, risk management, is often a matter of determining the most reasonable compromise. Sometimes this means deciding not to fully cover all risks. As long as the client

understands the potential results, this may be an acceptable, if less than optimal, solution. At other times, a combination of options may be best. For example, the client may purchase an insurance policy with a higher deductible than the most preferable option. Risk management choices can sometimes be reduced to – some coverage is better than no coverage. However, at other times, such as when satisfying legal requirements, the client may have no option except to purchase full coverage and then modify other risk management goals.

Ultimately, the best solutions will be those that provide the most positive results after doing a cost-benefit analysis. Of course, solutions must fall within the client's implementation ability. This may mean that, rather than implementing the plan all at once, the approach will need to be stepped or staggered. We will explore an option for doing this next.

5.4.3 The Road Map

The road map concept is not unique to risk management. In fact, it's just an analog for an overall financial strategy. The illustration below is an example of how an advisor might construct a risk management roadmap[3].

1. First quarter
    a. Risk management goal determination
    b. Risk management review and analysis
    c. Create risk management strategic plan
2. Second quarter
    a. Goals review
    b. Modify life insurance beneficiary arrangements for existing policies
    c. Submit application to XYZ company for new life insurance policy
    d. Schedule property and liability review with agent
3. Third quarter
    a. Goals review
    b. Monitor life insurance application and issue status
    c. Evaluate property-and-liability-review report from agent
    d. Submit application for new umbrella liability policy
    e. Increase car insurance deductible per agent's report
    f. Get bids to install protective fence around swimming pool
4. Fourth quarter
    a. Goals review
    b. Hire fence contractor
    c. Monitor liability policy issue process
    d. Check status of car-insurance-deductible change
    e. Review newly issued life insurance policy for accuracy and make copy of face page for records

At each step, the advisor can guide the client along the path to implementing all recommendations. Notice, in this example, which covers a year, some solutions are not implemented for six to nine months. Some of this is the result of time required to get policies issued, but some is a recognition that not all solutions can be implemented at the same time. The roadmap serves as a guide as well as a means to evaluate progress. The advisor could easily expand the map to include multiple years. It then would serve as a means by which both financial advisor and client could monitor progress.

---

[3] Based on Russell Investment's Client Engagement Roadmap (now FTSE Russell; www.russell.com)

The optimization process is reasonably clear cut. First, determine the greatest need and work on that. What is the greatest need? The one that will cause the highest level of financial disruption if it is not addressed. This may be satisfying legal requirements. It may be purchasing life insurance on parents' lives to ensure their children are financially secure in the event one or both parents die. Perhaps modifying homeowner coverage will top the list. It's impossible to provide a "one-size-fits-all" approach. What may be most important to one person may be least important to another. The best analytical approach is for advisor and client to determine the greatest need together and address that area first. When financial resources are constrained, the advisor and client should discuss compromise positions, but it's still important to keep first things first. Additional areas can be addressed at later times as appropriate.

Summary

The material in this course covered risk management and insurance. Having completed the course, you should have a good understanding of risk management need areas and ways to address them. You should be able to evaluate existing insurance coverage and how it addresses the client's risk management needs. Finally, you should be able to develop various strategies to protect the client's financial wellbeing through appropriate risk management.

This course explored risk management areas including:

- Risk management principles
- Insurance as a risk management tool
    - Risk-transfer techniques
- Risk exposures
- Primary areas of concern:
    - Property
    - Liability
    - Life
    - Health and long-term care
    - Disability and Loss of Income
    - Business
- Company and advisor selection
- Risk management strategies
- Regulation

Risk Management and Insurance Planning

1. Collection

1.1 Collect Quantitative Information

1. Collect details of the client's existing insurance coverage
2. Identify potential financial obligations of the client

1.2 Collect Quantitative Information

1. Determine the client's risk management objectives and risk exposures
2. Determine the client's tolerance for risk exposure
3. Determine relevant family and lifestyle issues and attitudes
4. Determine health issues
5. Determine the client's willingness to take active steps to manage financial risk, including lifestyle and health issues

2. Analysis

2.1 Assess the Client Situation

1. Determine characteristics of existing insurance coverage
2. Examine current and potential risk management strategies

2.2 Identify and Evaluate Strategies

1. Assess exposure to financial risk
2. Assess the client's risk exposure against current insurance coverage and risk management strategies
3. Assess the implications of changes to insurance coverage
4. Prioritize the client's risk management needs

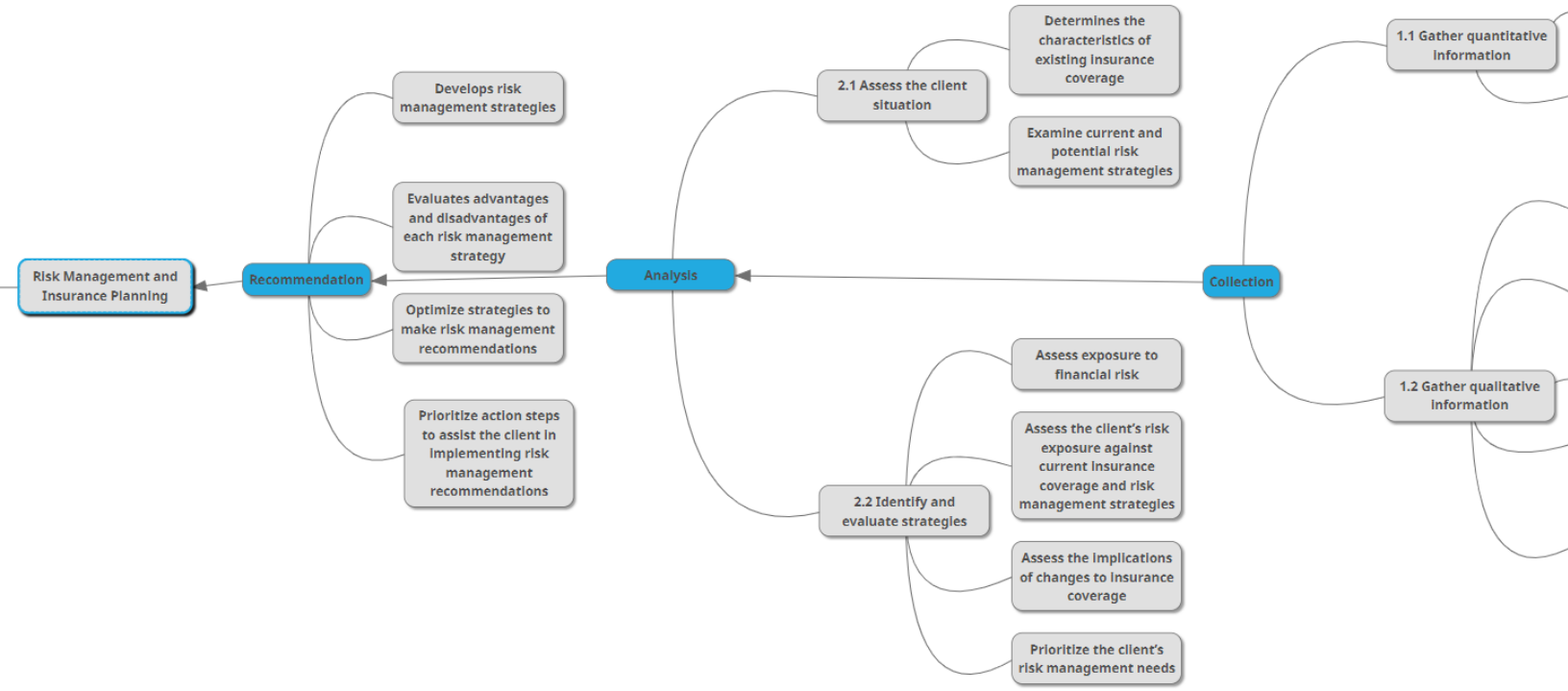
3. Synthesis and Recommendation

1. Develop risk management strategies
2. Evaluate advantages and disadvantages of each risk management strategy
3. Optimize strategies to make risk management recommendations
4. Prioritize action steps to assist the client in implementing risk management recommendations

EXAMPLE 5		
Question Stem		Josh and Susie Rocks are working through the steps in a life-needs analysis. Susie is a stay-at-home mother, taking care of the couple's two children. The Rocks's have decided they would like Susie to continue staying at home until the children leave home. The couple has reached the place in their calculations where they need to decide how much income would be required to provide adequate income to care for the two children: Violet, age 7 and Fred, age 5, until each child reaches age 18. The annual income needs with Susie and both children at home: $17,500. The annual income needs with Susie and Fred at home are estimated to be 70% or $12,250. The inflation rate is 2.0% and assume an 5% investment return. The total amount needed for child care needs for the insurance planning is most likely closest to:
	a	$170,017
	b	$189,057
	c	$167,228
	d	$187,784
Correct Answer		**d**

Explanation		Step 1: Mode = BGN, P/Y = 1, N = 11, I/Y = [1.05/1.02-1] × 100=2.4912, PMT = -17,500, FV = 0, CPT PV = $167,227.69. Step 2: P/Y = 1, N = 11, I/Y = 2.0, PV = -12,250, PMT = 0, CPT FV = 15,231.34. Step 3: Mode = BGN, P/Y = 1, N = 2, I/Y = 2.9412, PMT = -15,23.34, FV = 0, CPT PV = $30,027.49. Step 4: Mode = BGN, P/Y = 1, N = 11, I/Y = 5, PMT = 0, FV = -30,027.49, CPT PV = 17,556.45. Step 5: Child Care Needs = $167,227.69 + $17,556.45 = $184,784.14
Distractor #1	**a**	This uses I/Y = 5 for steps 1,3 and 4
Distractor #2	**b**	This uses I/Y = 2.9412 for step 4
Distractor #3	**c**	This is the amount for just the 2 children at home for 11 years

Risk Management and Insurance Planning



Chapter Review

Discussion Questions

1. How would you make the decision about whether to purchase insurance cover for a particular risk or to choose an alternative method to address the risk?

2. How would you help a wealthy client coordinate property and liability coverage? What questions would you ask? What criteria would you use when deciding whether to recommend coverage changes?

3. What are the potential life-insurance related expenses someone might need to address? How would you help the individual determine which expenses to cover by insurance?

4. How would you apply risk retention, avoidance or reduction, and why might any of these methods be difficult to employ?

5. How would you evaluate a client's insurance coverage to determine the degree to which it is meeting risk management needs?

6. Few people can address all risk management needs in the same way at the same time. How would you help a client prioritize risk management needs and how best to address them?

7. How would you apply a road map to help you and your client address risk management needs over time?

Review Questions

1. Why is it important for a financial advisor to assess an individual's exposure to financial risk?

2. What questions are good to ask when evaluating insurance coverage on high-value fine art collections?

3. What are six final expense areas to address when considering potential life insurance needs?

4. What are five potential income categories to include as part of determining ongoing income needs for a surviving spouse and dependent children?

5. What questions should a financial advisor ask when evaluating existing insurance coverage?

6. What steps should a financial advisor include as part of a risk management strategy?

Chapter Review Answers

Chapter 1 Review Answers

1. What are the four primary risk management techniques?
    - Avoidance
    - Minimization or Reduction
    - Transfer
    - Retention
2. What are the three rules of risk management?
    - Consider the odds, don't risk a lot for a little, don't risk more than you can afford to lose.
3. How would you define risk, peril and hazard?
    - Risk is the possibility for loss, perils are the causes of loss, and hazards increase the chance of loss by a peril.
4. What is underwriting and how does it relate to insurance?
    - The process of underwriting determines whether a risk is reasonable to accept, at what price, and with what conditions. Applications for insurance coverage are sent to the insurer for underwriting. Upon acceptance of a risk, the insurer issues a policy and completes the underwriting process.
5. What are the requirements for an insurable risk?
    - The law of large numbers must apply;
    - The loss must be by chance (i.e., accidental or fortuitous);
    - The loss must be measurable and able to be defined; and
    - The loss must not be financially catastrophic.
6. How does a loss that would be catastrophic for an individual differ from one that is catastrophic to an insurer?
    - A catastrophic loss to an insurer is not the same as a catastrophic loss to an individual. Loss of a house might be financially catastrophic to a family. However, loss of one house would not make much financial difference to an insurer. On the other hand, the loss of 10,000 houses could definitely be financially catastrophic for an insurer, to the extent that the company might no longer be viable as a business.
7. How would you describe insurable interest?
    - Insurance contracts require that some insurable interest exists. An insurable interest is the legal or equitable interest that is held by the insured in insured property or a life. In economic terms, it applies where an insured has suffered a monetary or economic loss

through the damage or destruction of the subject matter of the insurance. A monetary loss exists if a person is liable to pay or lose money in the event of a loss, i.e., it can be measured in economic terms.

8. What is the principle of indemnity and how does it apply to insurance?

    - Under most circumstances, insurance policies are designed to make the policyowner whole. That is, the insured will be restored to the condition he or she was in prior to the loss. However, the insurer will not generally provide enough payment to put the insured in a better financial position than he or she previously held. To indemnify, then, is to be made whole, but not better than whole. The principle of indemnity allows an insured to purchase insurance to protect against loss to the extent of their insurable interest. Under the principle of indemnity, an insured is not able to claim more than their loss.

9. What is subrogation and how does it relate to insurance?

    - Subrogation is related to the principle of indemnity. You might see a technical definition stating that an insurer will sue the individual who caused covered harm to an insured after it has settled the insured's claim. The insurance company may sue that individual to recover amounts paid to the insured to cover the loss. To some degree, this is an extension of indemnity, because the insurance company is ensuring overall payment does not exceed the claimed loss.

10. What are riders and endorsements and how do they differ?

    - Insurance policies may include items known as riders or endorsements. These serve to modify policy coverage or terms and conditions. Rider and endorsement essentially describe the same thing. Some policies use the term rider, while others use endorsement.

11. Why is underinsurance a problem for insurers, and what is one method they use to compensate?

    - Insurance premiums are based on the belief that insureds will insure for the full value of their property. Therefore, if the property was insured for less than its value (underinsurance) then an insurer is receiving insufficient premium income to maintain the viability of their insurance pool. To overcome this problem most policies contain an 'average' or 'coinsurance' clause to protect insurers from the economic effects of underinsurance. Under a coinsurance clause, only those insureds whose property has been totally destroyed will be covered for the property's insured value. Where an insured has underinsured the property and the loss is partial, the insured bears a pro-rata proportion of any loss.

Chapter 2 Review Answers

1. What are some of the risks people may face about which advisors should be aware?
   - Risk of premature death
   - Longevity risk (outliving your retirement money)
   - Health risk (declining health, including making one uninsurable or requiring substandard insurance rating)
   - Risk of unemployment
   - Risk of disability
   - Property risks—direct and indirect
   - Liability risks

2. What lifestyle issues might increase a person's risk?

   - Lifestyle issues cover a wide array of potential risks. These can range from certain hobbies and habits, alcohol or drug abuse, nutritional issues and eating disorders, and many additional areas. Some of these, like recreational hobbies such as mountain climbing, SCUBA diving, or race-car driving can be positive and pleasurable, but also present potential risks for liability, loss of income due to injury and the like. Others, including alcohol or drug abuse, create risks by their very nature.

3. According to the text, why do people purchase insurance?

   - Insurance does not prevent such events, just as life insurance does not prevent death. People get the coverage because they want to prevent against financial loss in the event of a covered event.

Chapter 3 Review Answers

1. How much land value is included when writing insurance coverage on a home and why?

    - A home's insurance coverage does not include any value for land because you cannot insure land.

2. What coverages are normally included in the two sections of a standard homeowners policy?

    - *Section I* has four coverage subsections:
        - **Coverage A** insures the main dwelling, including any additions attached to the dwelling, and materials and supplies located on the property for the primary purpose of working on the building.
        - **Coverage B** provides coverage for other structures, such as garages and sheds, which are situated on the property and detached from the dwelling.
        - **Coverage C** covers the insured's personal property.
        - **Coverage D** protects against loss of use, including expenses incurred while the dwelling is damaged, by a covered peril, beyond the point where the dwelling can be occupied.
    - *Section II* often includes two areas of coverage:
        - E - Comprehensive liability insurance.
        - F - Medical payments to others, claims expenses, and damage to property of others.

3. Why are coverages A and B not included on any renter's insurance policy, and what coverage is always included?

    - Coverages A and B protect against loss to the dwelling (home) and outbuildings. Renters are not responsible for these so the coverage is not included. Renter's insurance always includes personal property coverage C to protect the insured's belongings.

4. What perils are included under standard basic, broad form and open peril coverage?

    - **Basic Coverage:** Includes coverage for 11 perils: fire and lightning, windstorm and hail, explosion, riot and civil commotion, vehicles, aircraft, smoke, vandalism and malicious mischief, breakage of glass, theft, and volcanic eruption.
    - **Broad Form Coverage:** In addition to the 11 perils listed above, broad form covers falling objects; weight of ice, snow, or sleet; damage resulting from heating or air conditioning systems; accidental discharge or overflow of water; freezing of plumbing; and damage from artificially generated electrical currents. It also expands coverage for some of the basic perils.

- **Open Peril, or, All Risks Coverage:** Provides coverage for all perils, unless they are listed and specifically excluded. Some perils always are excluded, so the term all risks is not really appropriate, because the policy will never cover all risks.

5. How much would an insurance policy reimburse a homeowner who has a house valued at $400,000 insured for $300,000 after experiencing a fire that causes $20,000 in damage? The house has an 80 percent coinsurance provision and a $1,000 deductible.

    - Insurance would reimburse the homeowner $17,750 as a result of the coinsurance penalty for being underinsured. Required insurance is 80 percent of replacement value or $320,000, and the house is insured for 93.75 percent of the required amount. To determine the amount that will be reimbursed, divide $300,000 by $320,000 and multiply the loss amount by the result, then subtract the deductible: $300,000 / $320,000 = .93.75 x $20,000 = $18,750 - $1,000 = $17,750.

6. How does actual cash value compare to replacement cost coverage?

    - In the event of a total loss, a replacement cost policy will reimburse a policyowner the amount required to replace the property up to policy limits. Actual cash value is the replacement cost minus depreciation.

7. Why would a homeowner want a policy with a guaranteed replacement cost provision instead of a simple replacement cost provision?

    - While a homeowner may be adequately covered by having insurance equal to 80 percent of the replacement cost of the home, he or she may have a substantial out-of-pocket expense if the home is destroyed. There also are circumstances where even 100 percent coverage may not be adequate. When a natural disaster strikes, such as a hurricane, the cost of rebuilding may increase due to the lack of building materials and/or shortage of skilled labor. When this happens, the replacement cost is often higher than the insurance amount. A guaranteed replacement cost benefit takes care of this problem.

8. What is the problem with basic personal property coverage included in a standard homeowners policy and what can help solve it?

    - Standard homeowners policies typically cover personal property at 50 percent of the dwelling coverage. With the cost of furniture, rugs, clothes, appliances (not permanently installed), books, etc., this level of coverage may be inadequate. Further, most homeowner’s policies provide only limited coverage for personal property with higher value. A personal property endorsement or inland marine policy can help to solve this problem.

9. On what basis is inland marine insurance usually written?

    - Inland marine insurance usually is written with open perils coverage. Coverage may be written with little or no deductible, or, depending on the insurer and the insured's wishes, a higher deductible. Additionally, coverage usually is for a stated (appraised) value rather than the replacement cost or actual cash value (i.e., depreciated value).

10. What is the main difference about the medical payments coverage on a motor vehicle insurance policy compared to coverage on a homeowners policy?

    - On a motor vehicle (car) policy coverage does not come under the liability insuring agreement, covered expenses are for the insured, family members, and occupants of the insured vehicle (this is exactly opposite of homeowner coverage, where this protection does come under the liability insuring agreement, and does not cover any family member).

11. How does a standard car insurance policy define the insured?

    - The policy defines the insured as being:
        - The named insured or any family member (living in the insured's household)
        - Any person authorized to use the covered car
        - Any person authorized by the insured to drive the covered vehicle

12. How does civil liability compare with criminal liability?

    - Civil liability is different than criminal liability, and is the result of one individual or entity being held accountable for causing financial loss to another. Criminal liability is the result of violating a jurisdiction's laws, and may result in prosecution and legal penalties (e.g., imprisonment). Actions by an individual may result in both civil and criminal proceedings, and the person may be held both civilly and criminally liable (with penalties assessed from both aspects).

13. What is a tort and how does it relate to liability?

    - A tort happens when someone causes harm (physical, emotional or financial) to another person. Legally, the person causing harm is called a tortfeasor. A tort either may be intentional or unintentional. In almost all cases, the individual intentionally causing harm cannot be protected by insurance. Liability insurance only covers unintentional torts. Torts are civil rather than criminal. This means that torts are not necessarily considered breaking the law. Instead, torts focus on financial damage.

14. What are absolute and vicarious liability and how may they be applied to employers?

- Absolute liability refers to a standard imposed when there is no specific way to show negligence. Employers may be held liable to an employee by application of absolute liability. Vicarious liability is when one person is held liable for the acts of another person. Parents may be considered liable for things their children may do that cause financial harm to another person. Vicarious liability may also be applied to employers if one employee harms another.

15. How does an umbrella liability policy differ from a standard liability policy?

- Most individuals obtain liability insurance through their homeowners and motor vehicle policies. Many people want more protection than the typical homeowners or motor vehicle policy offers. Rather than merely increase the coverage on the other two policies, an individual might obtain an umbrella liability policy. This is sometimes called catastrophic liability insurance. While a basic liability policy (CPL) may have low coverage limits, an umbrella policy has very high coverage limits. Umbrella, or excess liability, policies take over where basic policies stop. Thus, the insured person can get protection against potential liabilities resulting from financial awards that are quite high.

16. What are the two basic types of professional liability coverage and which professionals use either type?

- Malpractice and errors and omissions insurance are the two forms of professional liability coverage. Medical professionals use malpractice coverage and all others use errors and omissions.

17. What are the two broad divisions in life insurance types?

- Life insurance is offered either as a term policy, which covers the insured for a specified period, or a permanent policy which covers the insured throughout life.

18. How would you describe the way a regular term life insurance policy works?

- Regular term policies offer a level death benefit and a level premium over the policy term and typically are renewable each year at increasing rates after the initial term.

19. What does an insurer do to a term life insurance policy so that it can cover an insured for his or her entire life?

- Insurers can accomplish this because permanent policies retain a portion of the premium in the form of cash value, which helps offset the increasing cost of insurance as the insured ages. To build this cash value, the initial premium for permanent policies is quite a bit higher than what a term policy would cost for the same amount of death benefit protection at the same issue age.

20. Where is the cash value invested in a whole life insurance policy; a universal life policy, a variable universal life policy?

    - With whole life policies, the insurance company invests the cash value in the company's general account, which consists primarily of a very conservative real estate and bond portfolio. Universal life policies invest the cash value in interest-bearing investments, such as money market funds rather than the general account. Variable universal life policies invest the cash value in the equivalent of collective (mutual fund) investments.

21. Why are universal life insurance policies called unbundled and why are they also known as flexible premium adjustable life policies?

    - Universal life (UL) policies are often referred to on the policy as flexible premium adjustable life. They have the same elements as a whole life policy, but unbundle the components—mortality charges, expense charges, and interest rates—and keep them separate. Rather than the fixed premiums associated with whole life, conventional universal life allows for some flexibility in the amount of premium paid. In fact, flexibility is probably the real distinction of UL.

22. What is the main difference between universal life type I or A and Type II or B policies?

    - UL Type I or A policies have a level death benefit. UL Type II or B policies have a death benefit that increases along with the cash value. Technically, the policyowner pays for a one-year term insurance policy in the amount of that year's cash value. At death, both amounts will be paid.

23. How does variable life (VL) compare with variable universal life (VUL)?

    - VL compares to VUL in the same general way as whole life compares to UL. VL policies are bundled and fixed. VUL policies are unbundled and flexible. VL policies invest the cash value in various sub-accounts, while VUL invests in the equivalent of mutual funds.

24. What are the two main types of joint life policies and when would you use either one?

    - First-to-die policies cover two or more individuals and pay the death benefit when the first covered person dies. This makes them ideal tools to fund business buy-sell agreements. Second-to-die (or last-to-die) policies cover two people as well, but do not pay a death benefit upon the first death. Instead, these policies pay the death benefit after both individuals pass away. As a result, they are also known as survivorship policies. This unique feature makes the product a good estate management tool when a couple wishes to provide liquidity for estate taxes or to leave a specific bequest upon the second death.

25. What three potential parties exist in a life insurance policy?

- The policyowner owns the policy. The owner may or may not be the insured. The insured is the individual (or sometimes individuals) covered by the policy. When the insured dies, the policy pays a death benefit. The beneficiary (sometimes more than one) receives payment of the policy proceeds on the death of the insured. All three entities may be involved—owner, insured, beneficiary—or fewer. In fact, there may be only one party involved in a contract, who is owner, insured, and beneficiary (i.e., the estate of the insured).

26. How do the grace period and reinstatement provision of a life insurance policy relate?

- The grace period is the term, usually 30 or 31 days, after the life insurance premium is due. Technically, if the premium is not paid on the due date, the contract will lapse. However, the grace period allows the contract to remain in full force. The reinstatement provision allows the policy to be reinstated following lapse (following the grace period). Past due premiums must be paid and the insured normally must provide current evidence of insurability. However, no insurance coverage will have been in place from the date of lapse to the date all reinstatement requirements are submitted, assuming the reinstatement is granted.

27. What are the nonforfeiture options of a standard cash value life insurance policy?

- When you own a cash value insurance policy and decide that you no longer wish to continue to pay premiums on it, you have several options. Over the years of ownership, the policy builds reserves. Since the owner contributed to the reserves that have built up in the cash value account, these options allow the owner to not forfeit those reserves, thus the term nonforfeiture options. The three options are cash, paid-up reduced amount and extended term insurance.

28. Why should a policyowner be careful when thinking about making a beneficiary irrevocable?

- A beneficiary designation can be revocable or irrevocable. Most beneficiary designations are revocable, meaning the owner can change beneficiaries at will. An irrevocable designation cannot be changed without receiving permission from the beneficiary in writing. An irrevocable beneficiary must approve any contract changes before they can be implemented. The owner may not change beneficiaries, borrow against the policy, surrender the policy, or assign it absolutely or collaterally without the irrevocable beneficiary’s written permission.

29. What are five dividend payment options with a participating life insurance policy?

- Dividends may be:
    - Taken in cash
    - Left to accumulate at interest with the insurance company

- Applied toward premium payments
- Used to purchase paid-up additions (PUAs) to the insurance policy
- Used to purchase one-year term insurance (also called the fifth dividend option)

30. Other than simple rules of thumb, what two methods are used to determine the amount of life insurance an individual may need?

- The human life value and needs-based methods may be used.

31. Using the capital retention method, and assuming there is no existing life insurance available, how much insurance cover would an individual require who wants beneficiaries to have an additional $75,000 annual income that increases by the rate of inflation each year? Assume a real (inflation-adjusted) rate of 2.9126 percent.

- An individual would require $2,575, 019 to provide the inflation-adjusted equivalent of $75,000 annual income for however long it will be needed. To arrive at the amount, divide $75,000 by .029126. The principal will never be diminished.

32. How much life insurance must an individual purchase today to fully fund college education costs for a 10-year old child who will enter a four-year university program at age 18? Assume current first-year expenses of $20,000, five percent tuition inflation and a seven percent discount rate, with all funds available at the beginning of college.

- To fully fund education expenses, the individual will need to purchase life insurance in the amount of $66,887 (rounded). First, inflate $20,000 by five percent for eight years until the child enters university (8N, 5I/YR, 20,000PV, FV = $29,549.11). Next, calculate the real (inflation-adjusted) rate ([1.07/1.05]-1 X 100 = 1.9048). Use this rate to determine the amount required in the future to fund four years of college (4N, 1.9048I/YR, 29,549.11PMT, PVAD = $114,923.62). Finally, solve for the amount of insurance cover needed today to fund the future education need (8N, 7I/YR, 114,923.62FV, PV = $66,886.60).

33. What is the fundamental difference between annuities and life insurance?

- Annuities have been called the flip side of life insurance. Life insurance protects against the risk of dying too soon, while annuities protect against the risk of living too long.

34. Under normal circumstances, how many times may a policyowner change the payment options once a contract is annuitized?

- The policyowner cannot make any changes. Annuitization is generally irrevocable. Once payment begins, no option exists to reverse the decision and retrieve the principal.

35. How may a variable annuity address inflation-related concerns?

- Fixed annuities provide annuity payments that do not change and are therefore subject to purchasing power risk. Variable annuities, because they are invested in securities, may provide a solution because investment returns may keep pace with inflation growth, thereby maintaining purchasing power.

36. What happens to annuity payments under a single (or straight) life annuitization or settlement option when the beneficiary dies, and how can the refund option solve the problem?

- Single life income payments cease when the beneficiary/owner dies and the insurance company retains all remaining payments. Several options can help solve this problem, one of which is the refund option. Under this option, the contract will refund any remaining principal and earning left in the contract at the end of the annuity period (when the annuitant dies).

37. How is the period certain option different from the fixed amount payout option?

- With the period certain option annuity payments continue for at least a minimum number of years based on the sum in the account. The fixed amount options makes payments in a fixed amount for as long as the principal and earnings last.

38. In what way are deductibles on homeowners, motor vehicle and health insurance policies different?

- Deductibles in each policy type have the same function. They are an amount that must be paid prior to receiving policy benefits. Not all benefit payments require a deductible, but where applicable, any deductible also serves as a type of risk retention. Automobile and health insurance deductibles are factored into the claim payment calculation on the front end, before making the remaining benefit calculation. Homeowners policy deductibles are subtracted from the back end of the claim payment calculation. The calculation is determined first and the deductible amount is subtracted from what would have been paid. Finally, a policyowner may satisfy a health insurance policy deductible at some point, and not have to pay any further deductible for the rest of the year, at which point the deductible resets. This is not true for motor vehicle or homeowner insurance policies.

39. How are copayments different than coinsurance?

- Coinsurance is a percentage of the expenses that are paid by the insurance company once the deductible has been met for covered services. The insured is responsible for a percentage of bill payment and the insurer is responsible for its share. When the coinsurance percentage amount has been satisfied, the insurer will pay 100 percent of remaining covered claim amounts. Copayments are set amounts the policyowner will

pay for covered services each time a service is provided, regardless of deductible or coinsurance amounts.

40. In a managed care health plan, what is a gatekeeper?

- The gatekeeper is the primary care physician. Under normal circumstances, when seeking medical care, patients first must see the primary care physician. He or she will determine the recommended course of action, including whether the patient should be referred to a specialist. Since patients nearly always must first go through the primary care physician (except in emergencies), he or she has a great deal of control over the healthcare services received.

41. What is the biggest coverage difference between HMOs and PPOs?

- HMOs do not pay for medical services received outside their network. PPOs also have a network, but also often will pay a reduced amount for out-of-network services.

42. Why might someone who has good healthcare insurance also benefit from having a long-term care (LTC) insurance policy?

- LTC insurance is specifically designed to pay for long-term or extended care needs. Most often, regular health insurance coverage does not apply to or pay for long-term or extended care expenses.

43. What is the highest level of LTC and the second highest level?

- Skilled nursing care is the highest level of care and generally refers to 24-hour-a-day availability of a registered nurse under a doctor's supervision. Intermediate care refers to less-intensive nursing, or rehabilitative care, and is the second highest level of care. This level of care doesn't require 24-hour availability of a registered nurse or physician.

44. What are activities of daily living (ADLs) and how do they apply to LTC insurance policies?

- Insurance companies often use a list of ADLs to determine when coverage will be triggered. The typical list of ADLs includes: bathing oneself, feeding oneself, transferring (say, from a chair to a bed or vice versa), dressing oneself, using the bathroom, and maintaining continence. When it is determined that an individual can no longer perform any two of these ADLs (usually by a physician), they are eligible for benefits under the policy. Mental impairment such as Alzheimer's disease or dementia can trigger benefits if either of these issues alone is diagnosed.

45. What is the elimination period found on most LTC and disability income insurance policies?

- The elimination period has the same function with both policy types. It is the period, following initial diagnosis and treatment, when no benefit payments are available to the

policyowner. A typical elimination period lasts for 90 days, but may be shorter or longer. The elimination period is similar to a policy deductible.

46. How much benefit will a normal LTC insurance policy pay for expenses incurred when a family member provides LTC care services, and what is one solution?

    - Typically, the insurer will pay no amount for services provided by a family member. Some policies include a respite care benefit that allows the caregiver to take a break from caregiving by paying for another caregiver to step in.

47. Why do some individuals refer to disability as a living death?

    - A disability can cause significant medical expenses in addition to the disabled person not being able to fully function or earn an income. As a result, some have referred to disability as a living death.

48. What are three of the most important disability insurance considerations?

    - Benefit amount, benefit period (including the elimination period) and definition of disability.

49. What is the difference between a partial and a residual disability benefit?

    - After a period when the insured is totally disabled, he or she may have recovered enough to return to work on a part-time basis. Most policies allow for a reduced, partial, benefit to be paid, such as 50 percent of the full benefit amount, if the insured returns to work, but is still unable to work full time. Similar to a partial disability provision, a residual disability provision allows for a lesser amount of benefits to be paid if the insured is able to return to work in some capacity. The difference is that partial disability is generally paid for a shorter period when the insured cannot work full time, whereas residual disability benefits may be payable for the entire benefit period if, as a result of the disability, the insured's income is reduced even when working full time. The reduction in income usually must be greater than a stated percentage of gross earnings, such as 20 percent.

50. What are the four primary disability definitions used in a policy?

    - **At any occupation:** This definition is the most restrictive and says that, to be considered disabled, the insured must not be able to work in any occupation. For example, under this definition, an electrician or a doctor who is disabled to the point of not being able to do his or her regular job, but is able to work at a fast-food restaurant at a significant loss of income, would not receive any benefits.
    - **In any occupation for which the person might be (or might become) qualified:** This is a modified any occupation definition and is somewhat less restrictive in that it puts a limit on the types of work a person would be expected to do. This definition may also

include terms that take into consideration the insured's prior education, training, or experience.

- **In his or her own occupation:** This definition is the most liberal because it says that a person will be considered disabled if he or she is unable to work at his or her own prior occupation. As an example, a surgeon who becomes disabled to the point of not being able to do surgery would be considered disabled even if eventually employed as an instructor at a medical school. This additional provision is sometimes accomplished by the insurer issuing a letter, known as a specialty letter, modifying the terms of the policy. Some companies may issue a policy rider to provide this level of coverage. Changes within the disability income insurance industry have made the own occupation provision less available than it was only a few years ago.
- **Split definition:** Many insurance companies, especially in group coverage where there is little or no underwriting, make available a split definition of disability. A split definition typically uses the liberal own occupation definition for a specific time (often the first two to five years of disability), after which a stricter modified own occupation definition or any occupation definition takes effect for the duration of the benefit period.

51. In what way is a loss-of-income policy different from other disability income policies?

- A loss-of-income policy pays a benefit if the loss of income is due to illness or injury, even if the insured continues to work. The insured need not be fully disabled. The duties or occupations in which the insured can engage are not significant factors. If, as a result of injury or sickness, the insured suffers a loss of income, benefits based on that loss are payable regardless of whether the insured returns to work and regardless of the occupation.

52. How is a noncancelable renewal provision different from a guaranteed renewable provision?

- The two are similar, but not identical. Noncancelable means that not only can the insured renew the policy for the full term specified in the policy (the same as under guaranteed renewable), but the company cannot change the premium from what is stated in the contract. A guaranteed renewable provision allows the insurer to increase the premium for an entire policy class, which may include the policyowner.

53. What is the general purpose of key person insurance, whether life or disability?

- A key person is vital to the operation and ongoing success of a business. The business wants to protect itself in case of the key person's death or disability. To do so, and to provide funding to support the business while it adjusts, the business may purchase life and/or disability insurance cover on the key person.

54. How is business overhead expense insurance different from standard disability insurance cover on an individual?

    - Business overhead expense insurance cover is not a replacement for personal disability income insurance. Instead, it is specifically designed to provide income to the business for a period so it can remain viable and pay salaries and other expenses. Like all disability policies, there is an elimination or waiting period before payment of benefits, but it is usually shorter than for personal disability policies. Benefit period usually do not exceed two years.

55. What type of liability exposure is not covered by either a comprehensive personal liability policy (CPL) or business/commercial liability policy?

    - Liability exposure from motor vehicles is not covered by standard liability policies. To get coverage, the individual or business must purchase motor vehicle liability insurance coverage. When umbrella policy underlying coverage includes motor vehicle liability, the umbrella policy will cover motor vehicle liability.

56. Why might a person sitting on a non-profit organization board require liability coverage?

    - Individuals who sit on nonprofit boards can be held liable for the organization's activities. People may sit on the boards of religious institutions, hospitals or other medical associations, community associations and similar. In most cases, board members' personal liability insurance cover will not protect them for this type of liability. A directors' and officers' liability policy (sometimes known as directors' and officers' errors and omissions insurance) will help to cover this exposure.

Chapter 4 Review Answers

1. What are the primary factors to include when evaluating an insurance company for possible use?
    - When selecting an insurance company, it's important to choose one that is known for having good customer service. Equally, if not more important, is choosing a company that offers the type of insurance cover your client needs at a competitive price point, having good underwriting processes. When you identify several companies that offer the insurance cover for which you are looking, it's a good idea to be a wise consumer and price-shop. Prices can vary significantly. A company's history also must enter the picture. How financially solvent and stable is the company is one of the most important factors to consider.

2. What are the four main rating agencies and what type of rating do they provide?
    - The four are Standard and Poor's, Moody's, Fitch, and A.M. Best. Each of these organizations rate insurer's financial stability and well-being.

3. What is a company's lapse ratio and how does it apply to insurer evaluation and selection?
    - Lapse ratio is an indicator of how a company treats its policyholders is its lapse ratio. The lapse ratio represents the percentage of policies that are terminated each year out of all policies in force. This is known as the company's persistency (agents also have persistency ratings). It is important to look at a company's persistency relative to that of the industry. If a company's lapse ratio is high (10% or more), some effort should be made to determine why. It may be an indication of poor results relative to illustrated values or unusually high premiums. It may reflect poor service after the sale of a policy. In the worst case possible, it may indicate that the company is experiencing financial difficulties and policyholders are leaving to protect their policy values.

4. What are some of the factors to include when evaluating an insurance agent?
    - Consider an agent's level of competence and inclination to provide good service. Also learn about experience, training and education. Find out whether the agent has a history with a particular specialization area. Also, learn about an agent's overall reputation.

5. What is the difference between express and implied agent authority?
    - Express authority is identified in the agent's contract with the insurer and typically identifies exactly the scope of activities the agent is authorized to undertake on behalf of the insurer. Implied authority is not expressly granted, but is authority the agent is assumed to have as he or she does business in the insurer's name. Practically, implied authority relates to areas such as collecting premiums, completing applications, ordering

medical exams, and the like. These things are not usually spelled out in the contract, but are a necessary part of doing business.

6. Will an insurer usually be liable when an agent abuses apparent or ostensible authority?

- Yes, the acts of an agent legally bind the insurer. The insurer may press charges against the agent, but that will not negate its responsibility to honor policy terms.

7. What is the primary concern of securities industry as well as insurance industry regulators?

- Securities industry regulators are primarily concerned with investment company solvency. Many of their rules and regulations target requirements designed to enforce prudent company management and disciplines financial operations. Additionally, regulators develop regulations for people who interact with the public to ensure they do so ethically and with compliance on relevant regulations. Insurance industry regulators have the same concerns and areas of oversight. The insurance industry is vested in the public interest. Individuals purchase insurance to protect themselves against financial loss at some time in the future. Public welfare mandates that the insurer promising to indemnify insureds for future losses fulfills its promises.

Chapter 5 Review Answers

1. Why is it important for a financial advisor to assess an individual's exposure to financial risk?

- Risk management requires recognizing the risk areas to which an individual may be exposed. A financial advisor cannot simply say that a client might be exposed to all possible risks, therefore he or she should protect against that possibility. This is neither practical nor possible. Plus, where risk transfer is required, excess amounts of insurance can quickly run through available cash flow.

2. What questions are good to ask when evaluating insurance coverage on high-value fine art collections?

- Was a professional appraisal used to establish the item's current value?
- Would the insured be required to replace or repair an item, or would the policy allow for a cash payment option?
- Would items such as antiques be covered for full value, or would they be depreciated?
- Would new items automatically be covered, and if so, for how much and for how long?
- Are items covered when they are outside the home (perhaps on display at a museum or other venue)?
- Would items be covered in full when they are in other residences or in transit?

3. What are six final expense areas to address when considering potential life insurance needs?

- Funeral costs
- Unpaid medical expenses
- Outstanding loans and debts
    - Some debts may be forgiven at death, but many require repayment.
    - Loans in joint names (e.g., husband and wife) may transfer to the remaining joint holder. However, that individual must be financial able to continue repayment.
- Estate-settlement costs
- Adjustment period fund
    - It can be difficult for dependents to quickly adapt to a significant change in income. Further, available funds may sometimes be temporarily tied-up at death, creating an income bottleneck until released. An adjustment period fund can help with this process.
- Miscellaneous
    - This is to cover any additional expenses that may arise.

4. What are five potential income categories to include as part of determining ongoing income needs for a surviving spouse and dependent children?

- Dependent income for the children until they reach the age at which they are able to live on their own
- Additional income for the surviving spouse while the children remain in the home
- Funds to pay for education expenses (primary, secondary and higher)
- Funds needed to supplement income for the surviving spouse after children have left the home, and before reaching retirement age
- Supplemental retirement income funds

5. What questions should a financial advisor ask when evaluating existing insurance coverage?

- What risk is the policy intended to cover?
- As written, does the policy provide the desired coverage?
- What is the upper limit of coverage, and is this sufficient? Should it be increased?
- What is the lower limit of coverage? Should it, or any deductibles, be raised?
- For how long is coverage or policy payout expected to last? Is this appropriate or should the term be increased or decreased? For example, is a disability income policy with a five-year benefit period sufficient?
- Are beneficiary arrangements in good order? Do they coordinate with any relevant legal documents, such as wills or trusts?
- If there are different policies addressing the same risk area, is there too much overlap, or are there still gaps in coverage?
- What are the renewal provisions, and does the policy owner need to be aware of any potential renewal premium increases or other problems?
- For healthcare coverage, are the proper health conditions covered, and in sufficient amounts?
- Is the life insurance coverage sufficient, and is the policy type appropriate? Do existing policies need to be modified in any way?
- Do risk exposure gaps exist, and can they (or should they) be addressed through risk transfer? This is especially a concern with liability risk exposures, and when the individual is a professional, or an employer, or a director / officer of a company.
- If household staff is employed in more than one location (and perhaps different territories) are all legal requirements satisfied?
- Is the policy cost effective and issued by a financially sound insurer?

6. What steps should a financial advisor include as part of a risk management strategy?

- Identify the risks
- Review (and inspect) current situation
- Analyze the information
- Select the most appropriate risk management technique
- Implement the chosen approaches
- Monitor results

Appendix 1: Provision for Dependents

When determining amounts of life insurance required to provide for dependents – normally children – the best process is to work through a needs analysis approach. This was discussed in chapters three and five. In this section, we will review the approach using algebraic equations rather than a financial calculator. Otherwise, the approach remains the same. This information comes from Australia and reflects that environment. It mirrors the content in this course almost exactly, and will allow students to observe the process in another territory along with the global applicability of the related content (Teale, 2014)[4].

Once it has been determined that life insurance is required as part of a plan to provide for dependents, the next step is to determine how much life insurance is required. This process is important because buying too much life insurance is expensive and diverts funds away from other needed areas, like investments. On the other hand, buying too little life insurance could ultimately prove disastrous. To avoid these problems, a rigorous and accurate method is needed to calculate how much insurance is necessary. The approach used by the financial planning profession is called the 'needs analysis' and this is described next.

Needs Analysis

Needs analysis focuses on the actual income needs that the dependents will have if the income earner dies. A family's needs change over time, so an advisor will need to re-examine the plan periodically to check that the figures are still sufficient. This method involves three steps:

1. Calculate the total economic resources required by the dependents if the main income earner were to die

2. Identify and quantify all financial resources available after death, including existing life insurances and superannuation death benefits

3. Deduct available financial resources from the amount needed to arrive at the additional life insurance required

Step 1: Assessment of Family's Total Economic Needs
This step requires the preparation of a family budget of monthly expenditure required to live a comfortable life. This budget includes items such as expenses for clothing, education, housing, food, utilities, and dental and healthcare. Other items would be insurance costs, rates, recreation and travel. Children's needs change over time, consuming considerable financial resources in the early years but reducing substantially once they have grown up

This step also involves calculating the final expenses and the amount required to liquidate any existing debt and to look after any special needs. If there are elderly dependents, then an allowance may be necessary for the long-term care of disabled or chronically ill dependents. It may also be necessary to establish a special fund for financial emergencies or an education fund for the children's university education.

[4] As drafted and delivered by John Teale, Melbourne, Australia, by permission

Step 2: Determine the Availability of Financial Resources
Once the dependents' financial needs have been estimated, it is then time to list all the available resources that can be applied to meet these needs. These could include money from savings, investments, proceeds from employer-sponsored group life insurance policies, and from superannuation funds. There may also be old whole-of-life policies available that have a term life rider attached to the policy. If the surviving spouse is able to work, their earnings will be an important resource for the family. It may also be possible to liquidate some assets such as jewelry, real estate or other investments in order to meet the financial needs. Once these resources have been identified, it should be possible to assign a reasonable estimate of their value.

Step 3: Calculation of additional life insurance requirements
Finally, the total value of resources available is deducted from the total needed to satisfy the dependents' financial objectives. If the financial value of the resources is greater than the needs, then no further life insurance is needed. However, if the resources are less than the needs, then the difference represents the amount of life insurance needed.

Where there is more than one income earner, a separate calculation needs to be made for each person. The need for cover for each income earner should not be overlooked. The mathematical method used to calculate the amount of life insurance needed to finance future living is called the present value of an annuity.

Present Value of an Annuity Calculation

This calculator is used to determine what a future income stream is worth in today's dollars. This is done by using the following formula:

$$PV = PMT\left(\frac{1-(1+i)^{-n}}{i}\right)$$

Where: PV = present value
PMT = periodic payment amount
n = number of compounding periods
i = interest (or, discount rate)

The PV of an annuity formula is used to calculate how much a stream of payments is worth *currently* where 'currently' does not necessarily mean right now but at some time prior to a specified future date.

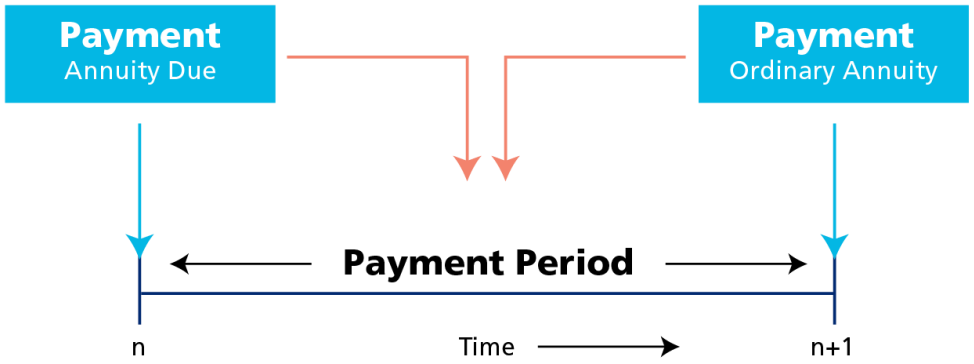
In practice the PV calculation is used as a valuation mechanism. It evaluates a series of payments over a period of time and reduces or consolidates them into a single representative value at a certain date.

Note however that the PV of an annuity formula does not inherently take into account the effect of inflation. The value mechanism for the *current* value of a stream of *future* payments is the time value of money as represented by prevailing market interest rates, not the inflation rate. The PV of the annuity equation above can be rearranged algebraically to solve for the payment amount (PMT) that will amortize (pay off) a loan or equate to a current sales price.

The formula above assumes an ordinary annuity, one in which the payments are made at the *end* of each compounding period. An annuity-due is one in which the payments are made at the *beginning* of the compounding period.

Distinction Between an Ordinary Annuity and an Annuity-due

Each payment of an ordinary annuity belongs to the payment period *preceding* its date, while the payment of an annuity-due refers to a payment period *following* its date.
The meaning of the above statement may not be immediately obvious until it is looked at it graphically (Teale, 2014).



A more simplistic way of expressing the distinction is to say that payments made under an ordinary annuity occur at the end of the period while payments made under an annuity due occur at the beginning of the period.

A third possibility is to define an annuity due in terms of an ordinary annuity: *an annuity-due is an ordinary annuity that has its term beginning and ending* ***one period earlier*** *than an ordinary annuity.* This definition is useful because this is how an annuity due is computed, i.e., in relation to an ordinary annuity (discussed below).

Most annuities are ordinary annuities. Instalment loans and coupon bearing bonds are examples of ordinary annuities. Rent payments, which are typically due on the day commencing with the rental period, are an example of an annuity-due.

Note that an ordinary annuity is sometimes referred to as an immediate annuity, which is unfortunate because it implies that the payments are made immediately (ie, at the beginning of the period, which would be the case with an annuity-due). However, ordinary annuity is the more widely used term.

Calculating the Value of an Annuity Due

An annuity due is calculated in reference to an ordinary annuity. In other words, to calculate either the present value (PV) or future value (FV) of an annuity-due, the value of the comparable *ordinary* annuity is calculated and multiplied by a factor of *(1 + i)* as shown below.

$$Annuity_{Due} = Annuity_{Ordinary} \, x \, (1 + i)$$

This makes sense because if the earlier definitions are considered, it can be seen that the difference between the ordinary annuity and the annuity due is one compounding period. Note also that the above formula implies that *both* the PV and the FV of an annuity due will be greater than their comparable ordinary annuity values.

The following examples illustrate the mechanics of the ordinary annuity calculation and subsequent annuity due calculation.

Present Value of an Annuity

Using the present value of an annuity calculation formula above, the PV of an ordinary annuity of $50 per year over three years at 7% can be expressed as follows

$$PV_{ordinary} = PMT\left(\frac{1-(1+i)^{-n}}{i}\right) = 50.00\left(\frac{1-(1+0.07)^{-3}}{0.07}\right) = 131.22$$

and the present value of an annuity due under the same terms is calculated as

$$PV_{due} = PV_{ordinary}(1+i) = 131.22(1.07) = 140.40$$

In this example, the PV of the annuity due is greater than the PV of the ordinary annuity by 9.18.

Putting it All Together

The application of the needs approach is illustrated in the following example (Teale, 2014).

Illustrated example

The Morrison family has sought advice on the amount of life insurance cover needed to fully protect their family. John Morrison, aged 32, is an architect who has been in his own business for 12 months. His wife, Anna, aged 30, is a full-time homemaker. They have two children: Simon, aged four, and Kathy, aged two. John earned $100,000 in wages in his first year in business, with an after-tax income of approximately $72,000.

The family's living expenses are $5,200 per month. Of this, each parent uses $600 for personal expenses and $2,500 is used for household expenses and a further $1,500 per month in mortgage repayments. The amount owing on credit cards is $6,000. John's car is leased through his business and Anna's car is owned outright.

The Morrisons' house is valued at $500,000 and has a mortgage of $250,000. They want their two children to attend a private school for their high school years and then university. They estimate that schooling will last from age 13 to 25 and cost, on average, $10,000 per year.

If Anna were to die prematurely, it is anticipated that John would need to spend $600 per month on assistance in raising the children. John's only personal insurance is a term life cover for $350,000, while Anna does not have any life insurance. The calculation for the sum insured would be:

Clean-up expenses	
Funeral and other expenses	$15,000
Final medical expenses	$20,000
Mortgage repayment	$250,000
Credit cards	$6,000

Readjustment expenses	$25,000
Taxes	$5,000
Total	$321,000
Plus: dependents' support	

Anna

Anna's life expectancy is approximately 83 years of age, so she will be a dependant for the longest time. Household expenses are $2,500 per month and Anna's personal expenses are included in her calculations. The mortgage repayments will cease, so expenses can be reduced by $1,500. The annual amount required is: [($2,500 + $600) − $1,500] × 12 = $19,200.

Anna is likely to live to age 83, so she will need to be provided for a total of 53 years. Therefore, using the present value of an annuity formula and a discount rate of four per cent, the amount required is $419,955.

Children

The children will need to be provided for until age 25, for which an amount of $600 per month has been allowed. Simon needs to be provided for 21 years and Kathy for 23 years. A separate calculation will need to be made for each child to age 25. Using the present value of an annuity formula and a discount rate of four per cent, the amount required per child is $207,979.

In addition, education expenses of $10,000 per annum per child from 13 to 25 have been allowed. The children's education requirements come to:
$10,000 × 24 = $240,000.

Total insurance requirements

Anna	$419,955
Children's care	$207,979
Children's education	$240,000
Clean-up expenses	$321,000
Total sum insured	$1,188,340
Less: existing insurance	$350,000
Amount of insurance required	$838,934

Term life insurance cover of $838,934 needs to be arranged on the life of John. However, should John already have some life insurance, for example contained in his superannuation (retirement) plan then this needs to be deducted.

Life Insurance for a Non-Income Earner

During this analysis, the value of the homemaker should not be overlooked, especially when there are young children. If the homemaker were to die or become totally disabled, then the family's financial situation could be severely compromised. It may be necessary for the surviving spouse to pay for childcare or for specialist nursing for the disabled spouse. These costs would also have to be considered and life insurance arranged to cover them.

In the previous example, if Anna were to die prematurely, then John's income would be sufficient to meet normal family needs. However, the children would need to be taken care of until age 13 and the amount allowed was $600 per month. This means that Simon would need care for nine years and Kathy for 11 years.

Childcare needs: Using the present value of an ordinary annuity a term life policy for an amount of $116,609 or more likely $120,000 (rounding) should be arranged on the life of Anna.

It is important to realize that life insurance needs do not stay the same forever, because the family situation changes over time. An advisor should conduct regular reviews, particularly when important life events take place, such as a promotion for the breadwinner, a new job, a new baby or an increase in debt.

Effect of Inflation on the Life Insurance Payout

The calculation of the death cover insurance requirements for the Morrisons (see illustrated example) has ignored the eroding effects of inflation. The proceeds from the insurance policies are calculated to meet future needs, but they may prove to be inadequate when ultimately received. For example, the Reserve Bank of Australia indicates that historically the inflation rate from 1951 to 2012 was 5.3 per cent. $100 worth of goods bought in 1997 cost $131.53 at an inflation rate of 5.6 per cent in 2007.

Alternatively, $1,000,000 life insurance cover taken out in 1997 and paid out in 2007 would have a purchasing power of $684,742 at an inflation rate of 5.6 per cent. This is a significant reduction in purchasing power, particularly as this is not a particularly high inflation rate. So the question arises as to how to allow for the effects of inflation when it is not possible to predict what inflation will be over different periods.

The insurance proceeds will not all be needed at once, as only a small portion will be needed each year. Therefore, the balance can be invested and interest earned can be used to supplement the invested funds. The interest earned will help to offset inflation because, while inflation cannot be predicted, interest rates are historically higher than the inflation rate. The interest income will be subject to taxation, but future taxation rates cannot be predicted so it is not possible to allow for this charge. There are other variables to consider, e.g., the dependent spouse may decide to work and so supplement the insurance proceeds.

Using interest to offset the effects of inflation is a reasonable approach given the unpredictable variables that may apply in the future. This approach ensures that the required amount will be available if and when it is needed.

FPSB

FINANCIAL PLANNING STANDARDS BOARD

E info@fpsb.org
W www.fpsb.org

CFP | CERTIFIED FINANCIAL PLANNER | CFP