LOMA 280

Principles of Insurance

MODULE 1

Basic Principles of Insurance

List of chapters

(click on chapter number/title below)

25 24 23 22 21 20 19 18 17 10 9 8 7 6 5 4 3 2 1

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Contents

(click on chapter number/title or chapter headings)

Module 1: Basic Principles of Insurance (Chapters 1–4)

Chapter 1

Introduction to Risk and Insurance

Objectives

After studying this chapter, you should be able to

1A Distinguish between speculative risk and pure risk

1B Describe four methods used to manage financial risk

1C Identify the five characteristics of insurable risks

1D Define antiselection and give examples of two factors that can increase or decrease the likelihood that an individual will suffer a loss

1E Identify four risk classes for proposed insureds

1F Define insurable interest and determine in a given situation whether the insurable interest requirement is met

Outline

The Concept of Risk

Risk Management

- Avoiding Risk
- Controlling Risk
- Transferring Risk
- Accepting Risk

Insurance

Managing Risks through Insurance

- Characteristics of Insurable Risks
- Insurance Underwriting
- Insurable Interest Requirement

Life is full of risk. You take risks when you travel, when you engage in recreational activities, even when you breathe. Some risks are significant; others are not. When you decide to leave your umbrella at home, you are taking the risk that you might get wet in a rain shower. Such a risk is insignificant and will probably not cause you a financial loss. Other risks, however, such as the risk of a severe illness or the destruction of your home, may result in substantial—even ruinous—financial loss. ***Risk*** is the chance or possibility of an unexpected result, either a gain or a loss. To understand insurance and how it works, you first need to understand the concept of risk.

The Concept of Risk

Risk exists whenever there is uncertainty about the future. Individuals and businesses experience two kinds of risk—speculative risk and pure risk. ***Speculative risk*** involves three possible outcomes: loss, gain, or no change. For example, when you purchase shares of stock, you are speculating that the value of the stock will rise and that you will earn a profit on your investment. At the same time, you know that the value of the stock could fall and you could lose some or all of the money you invested. Finally, you know that the value of the stock could remain the same—you might not lose money, but you might not make a profit.

Pure risk involves no possibility of gain; either a loss occurs or no loss occurs. An example of pure risk is the possibility that you may become disabled. If you do become disabled, you are likely to experience a financial loss due to lost income and the costs incurred for your medical care. If, on the other hand, you never become disabled, then you will incur no loss from that risk. This possibility of financial loss without the possibility of gain—pure risk—is the only kind of risk that can be insured. The purpose of insurance is to compensate for financial loss, not to provide an opportunity for financial gain.

LEARNING AID

Risk Management

Because the effects of an unexpected financial loss can be severe, individuals and businesses usually seek to minimize their exposure to risk whenever possible. ***Risk management*** is the process in which individuals and businesses identify and assess the risks they face and determine how to deal with their exposure to these risks. Four general methods can be used to manage risk: (1) avoiding the risk, (2) controlling the risk, (3) transferring the risk, and (4) accepting the risk.

Avoiding Risk

The first, and perhaps most obvious, method of managing risk is simply to avoid it altogether. We can avoid the risk of personal injury that may result from a motorcycle accident by not riding a motorcycle, and we can avoid the risk of financial loss in the stock market by not investing in stocks. Sometimes, however, avoiding risk is not practical.

Controlling Risk

We can try to control risk by taking steps to prevent or reduce potential losses. For example, people can reduce the likelihood of contracting certain diseases by exercising regularly, eating a healthy diet, and not smoking. People who become ill can often reduce the severity of the illness by taking proper medication or following a prescribed course of medical treatment. Similarly, a business can install smoke detectors and sprinkler systems in its office buildings to reduce the likelihood of fire damage and lessen the severity of any damage that might occur.

Transferring Risk

Another method of managing risk is to transfer it. When you transfer risk to another party, you are shifting the liability associated with that risk to the other party, usually through financial products that involve a fee for the transfer. As we shall see, the most common way for individuals, families, and businesses to transfer risk is to purchase insurance coverage.

Accepting Risk

The final method of managing risk is to accept, or retain, risk. Simply stated, to accept a risk is to assume all financial responsibility for that risk. Sometimes, as in the case of an insignificant risk—such as losing an umbrella—the financial loss is not great enough to warrant much concern. We assume the cost of replacing the umbrella ourselves.

Some people consciously choose to accept more significant risks. For example, a couple may decide not to purchase disability income insurance because they believe they can reduce their standard of living if one of them becomes disabled.

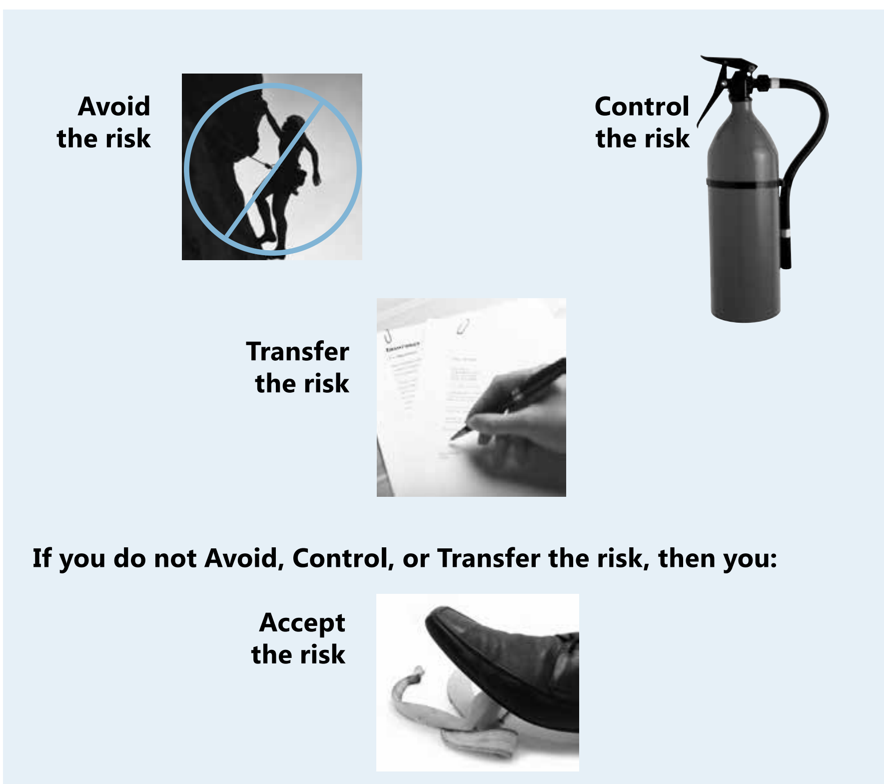
Alternatively, accepting a risk can be an unconscious decision. Any risk you face that is not managed by other methods is always accepted, whether you are aware of it or not. For example, for a number of years, many people and businesses were unaware that hackers could gain access to the data on their computers. Because they were unaware of this risk and therefore took no steps to manage it, they often suffered significant financial losses if their information systems were hacked. People and businesses can prevent the inadvertent acceptance of potentially disastrous risks through risk management, which requires *identifying* all significant potential risks and then determining the methods to use to manage them.

Note that individuals and businesses often use several risk management methods in combination. For example, to reduce the risk of an accidental injury, many people *avoid* certain hazardous activities, such as sky diving. People also use safety devices, such as automobile seat belts, to help *control* the risk of accidental injuries. Finally, people purchase insurance to *transfer* the risk of financial loss resulting from any injuries they do receive. Figure 1.1 illustrates the four methods of risk management.

Insurance

In simple terms, insurance is a method in which an individual or entity transfers to another party the risk of financial loss from events such as accident, illness, property damage, or death. A company that accepts risk and makes a promise to pay a policy benefit if a covered loss occurs is an ***insurer*** or an *insurance company*. A ***policy benefit*** is a specific amount of money the insurer agrees to pay under an insurance policy when a covered loss occurs. An ***insurance policy***, also known as a *policy* or *insurance contract*, is a written document that contains the terms of the agreement between the insurer and the owner of the policy. The ***premium*** is the specified amount of money an insurer charges in exchange for agreeing to pay a policy benefit when a covered loss occurs.

Figure 1.1 Risk Management Techniques



In general, individuals and businesses can purchase insurance policies to cover three types of risk:

- ***Personal risk*** is the risk of economic loss associated with death, poor health, injury, and outliving one's economic resources. ***Life and health insurance companies*** issue and sell products that insure against the financial losses that result from personal risks. Figure 1.2 presents some of the products that life and health insurers issue and sell and that we describe in the text.

- *Property damage risk* is the risk of economic loss resulting from damage to or loss of a person's property. *Property insurance* provides a benefit if insured items are damaged, destroyed, or lost because of various specific risks described in the policy, such as fire, theft, or accident.

- *Liability risk* is the risk of economic loss that results when a person is held legally responsible for harming others or their property. For example, you can be held liable for damage you cause to another person's vehicle in an automobile accident. A business can be held liable for injury to an individual who slips and falls while walking through the building. *Liability insurance* provides a benefit payable on behalf of a covered party who is legally responsible for unintentionally harming others or their property. Property insurance and liability insurance (also referred to as *property and casualty insurance*) are commonly marketed together in one policy. In the United States, insurers that issue and sell insurance policies to provide financial security from property damage risk and liability risk are known as ***property/casualty (P&C) insurance companies*** or *property and liability insurers*.

A number of terms are commonly used to describe the people who are involved in the creation and operation of an insurance policy. The ***applicant*** is the person or business that applies for an insurance policy. Once an insurer issues a policy, the person or business that owns the insurance policy is known as the ***policyowner***. In most cases, the applicant is also the policyowner. The ***insured*** is the person whose life, health, or property is insured under the policy. In some countries, the term *assured* is used to refer to the person insured.

The policyowner and the insured of a particular policy are often the same person. If, for example, you purchase an insurance policy on your life, you are both the policyowner and the insured (sometimes called the *policyowner-insured*). In contrast, if your spouse purchases a policy on your life, then she is the policyowner and you are the insured. A ***third-party policy*** is a policy purchased by one person or business on the life of another person.

If the person insured by a life insurance policy dies while the policy is in force, the insurer usually pays the policy benefit to the beneficiary. The ***beneficiary*** is the person or party the policyowner names to receive the life insurance policy benefit. A request for payment under the terms of an insurance policy is called a ***claim***.

Figure 1.2 Types of Life and Health Insurance Products

The focus of this text is on the following life and health insurance products:

Life insurance: Insurance that provides protection against the economic loss caused by the death of the person whose life is insured.

Important forms of life insurance are as follows:

- ***Term life insurance*** provides a policy benefit only if the insured dies during the period specified in the policy.
- ***Cash value life insurance***, also known as *permanent life insurance*, provides life insurance coverage throughout the insured's lifetime and also provides a savings element. As premiums are paid for these policies, an accumulated savings amount—known as the policy's ***cash value***—gradually builds. A policy's cash value is a valuable asset that the policyowner can use in a number of ways.
- ***Endowment insurance*** provides a policy benefit that is paid either when the insured dies or on a stated date if the insured is still alive on that date.

Annuity contract: A contract under which an insurer promises to make a series of periodic payments to a named individual in exchange for a premium or series of premiums.

Health insurance: Insurance that provides protection against the risk of financial loss resulting from illness, injury, or disability.

Three important forms of health insurance coverage are as follows:

- ***Medical expense insurance*** provides benefits to pay for the treatment of an insured person's illnesses and injuries and some preventive care.
- ***Disability income coverage*** provides income replacement benefits if an insured is unable to work because of illness or injury.
- ***Long-term care insurance (LTCI)*** pays benefits for medical or other health-related services needed by an individual who, because of his advanced age or the effects of a serious illness or injury, needs care in his own home or a qualified facility.

All of the above products can be issued as either an individual insurance policy or a group insurance policy:

- An ***individual insurance policy*** is a policy that insures the life or health of a named person. Some individual policies also insure the named person's immediate family or a second named person.
- A ***group insurance policy*** is a policy that insures the lives or health of a specific group of people, such as a group of employees.

Example:

Matthew Byrne applied to the Reliable Insurance Company for a $100,000 life insurance policy covering his wife, Nancy. Reliable issued the policy as applied for. If Nancy dies while the policy is in force, Reliable will pay $100,000 to the Byrnes' son, Stephen.

Analysis:

In this situation, Matthew is the *applicant* and *policyowner* of this policy, Reliable is the *insurer*, Nancy is the *insured*, and Stephen is the *beneficiary*. The policy is a *third-party policy*, because the policyowner, Matthew, and the insured, Nancy, are two different people. After Nancy's death, Stephen can file a *claim* with Reliable for the policy benefit of $100,000.

Managing Risks through Insurance

You may wonder how an insurance company can afford to be financially responsible for the economic risks of its insureds. Insurers use a concept known as *risk pooling*. With risk pooling, individuals who face the uncertainty of a particular loss—for example, the loss of income due to a disability—transfer this risk to an insurance company. Insurance companies know that not everyone who is issued a disability income policy will suffer a disability. In reality, only a small percentage of the individuals insured by this type of policy will actually become disabled. By collecting premiums from all individuals and businesses that wish to transfer the risk of disability, insurers spread the cost of the relatively few losses that are expected to occur among all the insured persons.

Insurance thus protects against the risk of economic loss by applying a simple principle:

If the economic losses that actually result from a given peril, such as disability, can be spread across a large pool (or number) of people who are all subject to the risk of such losses *and* the probability of loss is relatively small for each person, then the cost to each person will be relatively small.

Characteristics of Insurable Risks

Insurance products are designed in accordance with some basic principles that define which risks are insurable. In general, for a risk—a potential loss—to be considered insurable, it must have the following characteristics:

- The loss must occur by *chance*.
- The loss must be *definite*.
- The loss must be *significant*.
- The loss rate must be *predictable*.
- The loss must *not* be *catastrophic* to the insurer.

A loss without these characteristics generally is not considered an insurable risk.

The Loss Must Occur by Chance

For a potential loss to be insurable, the element of chance must be present. The loss must result either from an unexpected event or from an event that the insured person did not intentionally cause. For example, people generally cannot control whether they become seriously ill. As a result, insurers can offer medical expense insurance policies to protect against the financial losses caused by the chance event that an insured person will become ill and incur medical expenses.

When this principle of loss is applied in its strictest sense to life insurance, an apparent problem arises: death is certain to occur. The *timing* of an individual's death, however, is usually out of the individual's control. Therefore, although the event being insured against—death—is a certain event rather than a chance event, the timing of that event usually occurs by chance.

The Loss Must Be Definite

For most types of insurance, an insurable loss must be definite in terms of *time* and *amount*. In other words, the insurer must be able to determine *when* to pay policy benefits and *how much* these benefits should be. Death, illness, disability, and old age are generally identifiable conditions. The amount of the financial loss resulting from these conditions, however, can be subject to interpretation.

One of the important terms of the contractual agreement between an insurance company and the policyowner is the amount of the policy benefit that will be payable if a covered loss occurs while the policy is in force. Depending on the way in which a policy states the amount of the policy benefit, every insurance policy can be classified as being either a contract of indemnity or a valued contract. A ***contract of indemnity*** is an insurance policy under which the amount of the policy benefit payable for a covered loss is based on the actual amount of the financial loss that results from the covered event, as determined at the time of the event. For example, some types of health insurance policies pay benefits based on the amount of the insured's covered financial loss or a maximum amount stated in the contract, whichever is *less*.

A ***valued contract*** specifies the amount of the policy benefit that will be payable when a covered loss occurs, regardless of the actual amount of the loss that was incurred. Life insurance policies are valued contracts because they specify the benefit that the insurer will pay when the insured dies while the policy is in force. Some life insurance policies, such as decreasing term life insurance policies, provide that the amount of the benefit may change over the life of the policy. These policies are still considered valued contracts because the changes in the amount of the benefit are based on factors that are not directly related to the amount of the actual loss that will result from the insured's death.

The Loss Must Be Significant

As described earlier, insignificant losses, such as the loss of an umbrella, are not normally insured. The administrative expenses of paying benefits when a very small loss occurs would drive the cost for such insurance protection so high in relation to the amount of the potential loss that most people would find the protection unaffordable.

On the other hand, some losses would cause financial hardship to most people and are considered to be insurable. For example, a person injured in an accident may lose a significant amount of income if she is unable to work. Disability income insurance coverage is available to protect against such a potential loss.

The Loss Rate Must Be Predictable

No one can predict the losses that a specific person will experience. We do not know when a specific person will die or whether a person will become disabled or need hospitalization, let alone how much these events may cost. However, insurers must have some way of predicting future losses so that they can determine the proper premium amounts to charge policyowners.

Although individual losses cannot be predicted, insurers can provide a specific type of insurance coverage if they can predict the *loss rate*—the frequency of losses—that the insureds are likely to experience. To predict the loss rate for a given group of insureds, the insurer must be able to predict the number and timing of covered losses that will occur in that group of insureds.

Insurers can predict with a fairly high degree of accuracy the number of people in a given large group who will die, become disabled, or require hospitalization during a given period of time. These predictions are based on observations of past events and a concept known as the *law of large numbers*.

> The ***law of large numbers*** states that, typically, the more times we observe a particular event, the more likely that our observed results will approximate the true ***probability***—or likelihood—that the event will occur in the future.

A classic example of the law of large numbers is the coin toss. If you toss a "fair" coin—one that has not been altered to influence outcomes—there is a 50-50 probability that the coin will land with the head side up. If you toss the coin 10 times, you might not get an equal number of heads and tails. However, if you toss the coin 10,000 times, in approximately 50 percent of the tosses, the coin will land with the head side up and the other 50 percent of the tosses will land on tails. The more often you toss the coin, the more likely you will observe an approximately equal proportion of heads and tails.

Insurance companies rely on the law of large numbers when they make predictions about the covered losses that a given group of insureds is likely to experience during a given time period. Insurers collect specific information about large numbers of people so that they can identify the pattern of losses that those people experienced. For many years, for example, U.S. life insurance companies have recorded how many of their insureds of each sex have died and how old they were when they died.

Using these statistical records, insurance companies have been able to develop charts—called ***mortality tables***—that indicate with great accuracy the number of people in a large group (100,000 people or more) who are likely to die at each age. A ***mortality rate*** is the rate at which death occurs among a specified group of people during a specified period, typically one year. Mortality tables show the mortality rates that are *expected* to occur in a group of people at a given age.

Insurance companies have developed similar charts, called ***morbidity tables***, which display ***morbidity rates***, or the incidence of sickness and accidents, by age, occurring among a given group of people. By using accurate mortality and morbidity tables, life and health insurers can predict the probable loss rates for given groups of insureds. Insurers use those predicted loss rates to establish premium rates that will be adequate to pay claims.

The Loss Must Not Be Catastrophic to the Insurer

A potential loss is not considered insurable if its occurrence is likely to cause or contribute to catastrophic financial damage to the insurer. Such a loss is not insurable because the insurer could not responsibly promise to pay benefits for the loss and still meet its other obligations.

To prevent the possibility of catastrophic loss and ensure that losses occur independently of each other, insurers spread the risks they choose to insure. For example, major natural disasters such as hurricanes or earthquakes can damage or destroy a large number of properties in a concentrated area. In the past, some insurers failed because they were unable to pay claims following a disaster. For this reason, property insurance companies today usually limit the number of properties they will insure in any particular geographic area.

Alternatively, by purchasing reinsurance, an insurer can reduce the possibility that it will suffer catastrophic losses. ***Reinsurance*** is insurance that one insurance company—known as the ***direct writer*** or *ceding company*—purchases from another insurance company—known as the ***reinsurer*** or *assuming company*—to transfer all or part of the risk on insurance policies that the direct writer issued. For example, if Alpha Life Insurance Company (the direct writer) purchases reinsurance from Celtic Reinsurance Company (the reinsurer), then Celtic accepts some or all of the risk on the insurance policies Alpha has issued. By entering into a reinsurance agreement with a reinsurer, an insurer can provide relatively large amounts of coverage without exposing itself to an excessive amount of risk.

Figure 1.3 summarizes the characteristics of insurable risks.

Insurance Underwriting

Mortality and morbidity tables provide insurers with broad general statistics to help them estimate how many people of a certain age and sex will die or become ill in the future. However, not all individuals of the same sex and age have an equal likelihood of suffering a loss. Individual insurance is sold on a case-by-case basis, and insurers cannot presume that each proposed insured represents an average likelihood of loss.

When an insurer receives an application for insurance, the company must assess the degree of risk it will be accepting if it issues the policy. The process of assessing and classifying the degree of risk represented by a proposed insured and making a decision to accept or decline that risk is called ***underwriting*** or *risk selection*. Insurance company employees who are responsible for evaluating proposed risks are called ***underwriters***.

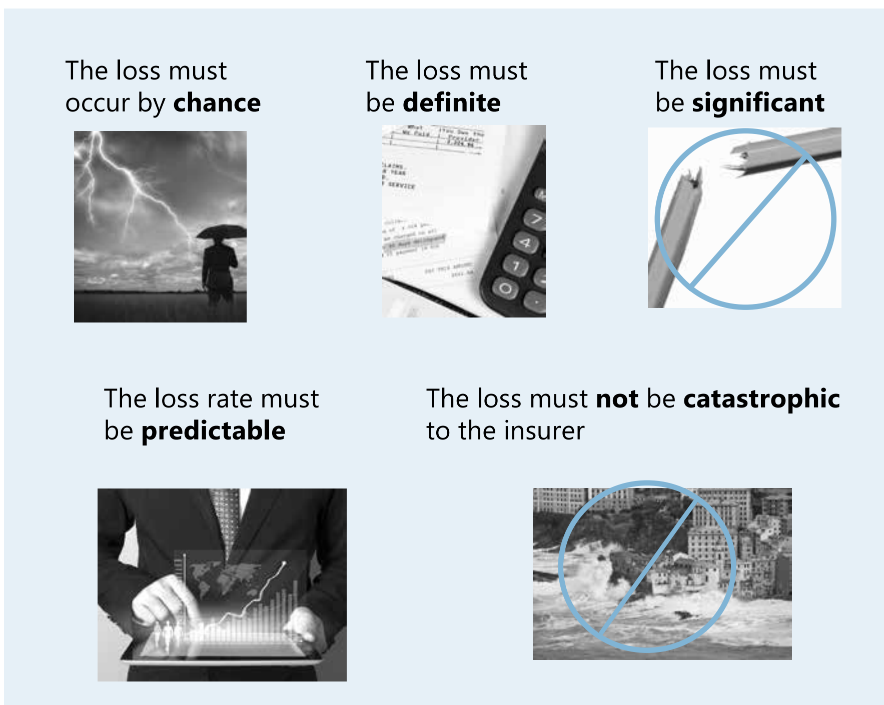
Proper underwriting is vital for an insurer's success and even its survival. The premium rates that an insurance company establishes are based in large part on the amount of risk the company is assuming for the policies it issues. The greater the risk an insured represents, the higher the premium rate the insurer must charge. If the insurer consistently underestimates the risks that it assumes, its premium rates will be inadequate to provide the benefits promised to all its policyowners. On the other hand, if the insurer overestimates the risks it will be assuming, its premium rates may be considerably higher than those of its competitors, and potential customers will purchase insurance elsewhere.

Underwriting becomes more difficult because of antiselection, also known as *adverse selection* or *selection against the insurer*. ***Antiselection*** is the tendency of individuals who believe they have a greater-than-average likelihood of loss to seek insurance protection to a greater extent than do other individuals. For example, people who believe they are in poor health are more likely to apply for life and health insurance—and also to apply for larger amounts of coverage—than people who believe they are in average or good health. The possibility of antiselection requires an insurer to carefully review each application to assess the degree of risk the company will be assuming if it issues the requested policy.

Underwriting consists of two primary stages: (1) identifying the risks that a proposed insured presents and (2) placing the proposed insured into an appropriate risk class.

Figure 1.3 Characteristics of Insurable Risks

For a risk to be insurable:



Identifying Risks

Although predicting when a specific individual will die, become injured, or suffer from an illness is impossible, insurers have identified a number of factors that can increase or decrease the likelihood that an individual will incur a loss. The most important of these factors are physical hazards and moral hazards. A ***physical hazard*** is a physical characteristic that may increase the likelihood of loss. For example, a person with a history of heart disease possesses a physical hazard that increases the likelihood that the person will die sooner than a person of the same age and sex who does not have a similar medical history. A person's activities or lifestyle can also present a physical hazard. Tobacco use and alcohol or substance abuse are known to contribute to health problems, and those health problems may result in higher-than-average medical expenses and a lower-than-average life expectancy. Similarly, an occupation such as coal mining, which exposes a person to a significantly greater-than-average risk of health problems or accidental injury, can present a physical hazard. Underwriters must carefully evaluate proposed insureds to detect the presence of such physical hazards.

Moral hazard is a characteristic that exists when the reputation, financial position, or criminal record of an applicant or a proposed insured indicates that the person may act dishonestly in the insurance transaction. For example, an individual who has a confirmed record of illegal or unethical behavior is more likely than an individual without this type of background to act dishonestly in an insurance transaction. The person may be seeking insurance for financial gain rather than as protection against a financial loss. Therefore, an insurer must carefully consider that fact when evaluating the individual's application for insurance. Underwriters also evaluate the moral hazards presented by individuals who provide false information on their applications for insurance. In these cases, the applicants may be trying to obtain coverage that they might not otherwise be able to obtain. When underwriters evaluate applications, they take a variety of steps to identify proposed insureds who present moral hazards.[1]

Classifying Risks

After identifying the risks that a proposed insured presents, the underwriter places the proposed insured into an appropriate risk class. A ***risk class*** is a grouping of insureds who represent a similar level of risk to the insurer. Assigning proposed insureds to risk classes enables the insurer to establish equitable premium rates to charge for the requested coverage. People in different risk classes are charged different premium rates, much the same as people of different ages are charged different rates. Without these premium rate variations, some policyowners would be charged too much for their coverage, while others would be paying less than the actual cost of their coverage.

Each insurer has its own ***underwriting guidelines***, which are the general rules it uses when assigning proposed insureds to an appropriate risk class. Individual life insurers' underwriting guidelines usually identify at least four risk classes for proposed insureds: standard risks, preferred risks, substandard risks, and declined risks.

- Proposed insureds who have a likelihood of loss that is not significantly greater than average are classified as ***standard risks***, and the premium rates they are charged are called ***standard premium rates***. Traditionally, most individual life and health insurance policies have been issued at standard premium rates.

- Proposed insureds who present a significantly lower-than-average likelihood of loss are classified as ***preferred risks*** and are charged lower-than-standard premium rates known as ***preferred premium rates***. Insurance company practices vary widely as to what qualifies a proposed insured as a preferred risk or a standard risk.

- Proposed insureds who have a significantly greater-than-average likelihood of loss but are still found to be insurable are classified as ***substandard risks*** or *special class risks*. For example, a proposed insured may have been diagnosed with a disease such as diabetes, which can lead to a shorter life expectancy. For individual life insurance, insurers typically charge substandard risks a higher-than-standard premium rate, called a ***substandard premium rate*** or *special class rate*.

- The ***declined risk*** category consists of those proposed insureds who present a risk that is too great for the insurer to cover. In addition to proposed insureds with a poor health history, those who engage in exceptionally risky activities, such as sky diving or mountain climbing, are sometimes classified as declined risks.

Because tobacco use represents a major health hazard, almost all insurers today take a proposed insured's tobacco use into account in their underwriting guidelines. Some insurers have established separate rate classes for tobacco users and tobacco nonusers, such as "standard tobacco user" and "standard tobacco nonuser." Other insurers place proposed insureds who use tobacco in a less favorable risk class than tobacco nonusers. For example, a tobacco user who might otherwise be classified as a preferred risk is instead classified as a standard risk.

Insurable Interest Requirement

As noted earlier, insurance is intended to compensate an individual or a business for a financial loss, not to provide an opportunity for gain. At one time, however, people used insurance policies as a means of wagering. In eighteenth-century England, for example, people frequently purchased life insurance on the lives of famous people, especially those who were reportedly ill, hoping to make a profit if the insured person died.

The practice of purchasing insurance as a wager is now considered against public policy. As a result, laws in the United States and many other countries require that a policyowner have an insurable interest in the risk that is insured at the time the policy is issued. An ***insurable interest*** means that the policyowner must be likely to suffer a genuine loss or detriment should the event insured against occur.

To understand how insurable interest requirements are met, we need to consider two possible situations: (1) an individual purchases insurance on her own life and (2) an individual purchases insurance on another's life. In both cases, the applicant for life insurance must name a beneficiary.

All persons are considered to have an insurable interest in their own lives. A person is always considered to have more to gain by living than by dying. Therefore, an insurable interest between the policyowner and the insured is presumed when a person seeks to purchase insurance on her own life.

Insurable interest laws do not require that the beneficiary have an insurable interest in the policyowner-insured's life. In other words, the laws allow a policyowner-insured to name anyone as beneficiary. Most insurance company underwriting guidelines, however, require that the beneficiary also have an insurable interest in the life of the insured when a policy is issued. As a result, life insurers typically inquire into the beneficiary's relationship to the proposed insured and may refuse to issue the coverage if the beneficiary does not possess an insurable interest in the proposed insured's life.

In the case of a third-party policy, laws in many countries and in most states in the United States require only that the policyowner have an insurable interest in the insured's life when the policy is issued. Most insurance company underwriting guidelines and the laws in some states, however, require both the policyowner and the beneficiary of a third-party policy to have an insurable interest in the insured's life when the policy is issued.

Certain family relationships are assumed by law to create an insurable interest between an insured and a policyowner or beneficiary. In these cases, even if the policyowner or beneficiary has no financial interest in the insured's life, the bonds of love and affection alone are sufficient to create an insurable interest. According to the laws in most jurisdictions, the insured's spouse, mother, father, child, grandparent, grandchild, brother, and sister are deemed to have an insurable interest in the life of the insured. Figure 1.4 illustrates the family relationships that create an insurable interest.

An insurable interest is *not* presumed when the policyowner or beneficiary is more distantly related to the insured than the relatives previously described. In these cases, a financial interest in the continued life of the insured must be demonstrated to satisfy the insurable interest requirement.

Example:

Mary Mulhouse obtained a $50,000 personal loan from the Lone Star Bank.

Analysis:

If Mary dies before repaying the loan, Lone Star could lose some or all of the money it lent her. Therefore, Lone Star has a financial interest and, consequently, an insurable interest in Mary's life, in the amount of the outstanding loan.

Similar examples of financial interest can be found in other business relationships.

The insurable interest requirement must be met before a life insurance policy will be issued. After the life insurance policy is in force, the presence or absence of insurable interest is no longer relevant. Therefore, a beneficiary need not provide evidence of insurable interest to receive the benefits of a life insurance policy.

The insurable interest requirement also must be met when a health insurance policy is issued. For a health insurance policy, the insurable interest requirement is met if the applicant can demonstrate a genuine risk of economic loss should the proposed insured require medical care or become disabled. Typically, people seek health insurance for themselves and for their dependents. In both of these cases, the applicant has an insurable interest in the continued health of the proposed insured. Additionally, for disability income insurance purposes, businesses have an insurable interest in the health of their key employees.

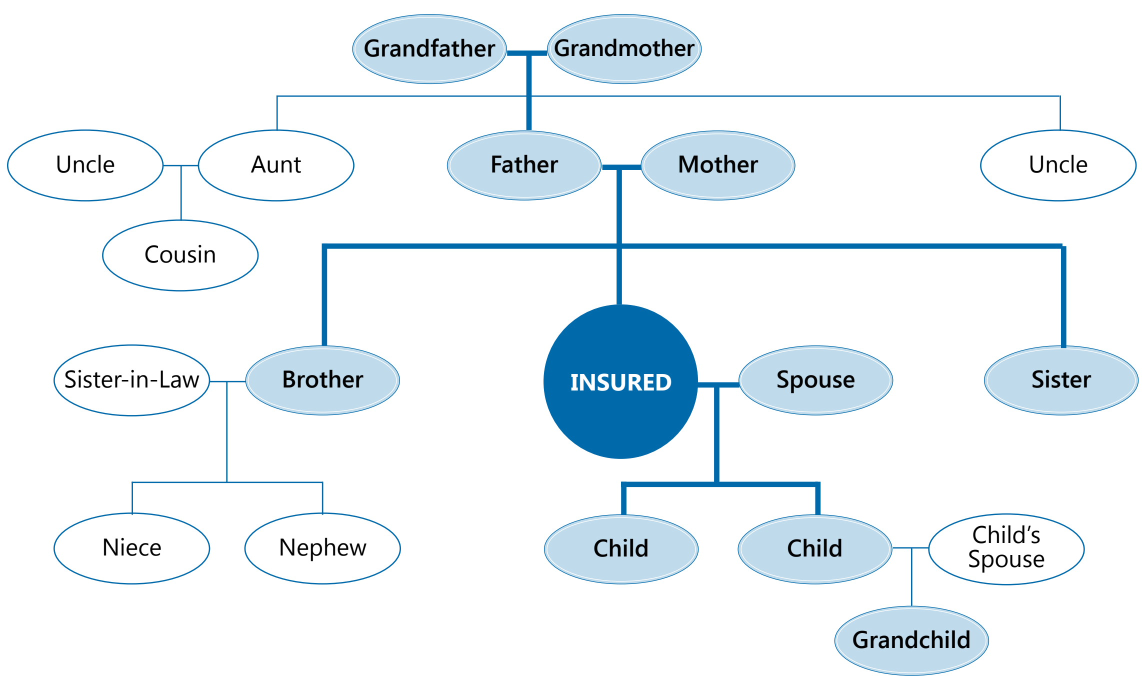
Example:

Didactic Training is a small company that contracts with other companies to conduct seminars for their management staffs. Shilpa Gouda works for Didactic as its primary seminar leader. Because Shilpa's expertise and teaching skills are essential to the success of the business, Didactic has applied for disability income coverage on Shilpa and has named itself as the beneficiary of this coverage.

Analysis:

Didactic would be unable to meet its scheduled seminar commitments if Shilpa were ill or injured and, thus, unable to conduct seminars. Therefore, Didactic has a financial interest in Shilpa's continued good health. This financial interest creates the necessary insurable interest for Didactic to purchase disability income coverage on Shilpa.

Figure 1.4 Family Relationships that Create an Insurable Interest



Key Terms

risk
speculative risk
pure risk
risk management
insurer
policy benefit
insurance policy
premium
personal risk
life and health insurance company
life insurance
term life insurance
cash value life insurance
cash value
endowment insurance
annuity contract
health insurance
medical expense insurance
disability income coverage
long-term care insurance (LTCI)
individual insurance policy
group insurance policy
property/casualty (P&C) insurance company
applicant
policyowner
insured
third-party policy
beneficiary
claim
contract of indemnity
valued contract
law of large numbers
probability
mortality tables
mortality rate
morbidity tables
morbidity rate
reinsurance
direct writer
reinsurer
underwriting
underwriter
antiselection
physical hazard
moral hazard
risk class
underwriting guidelines
standard risk
standard premium rate
preferred risk
preferred premium rate
substandard risk
substandard premium rate
declined risk
insurable interest

Endnote

1. The term *moral hazard* is also used in the insurance industry to refer to the tendency of individuals to alter their behavior because they have insurance. This tendency is typically of more concern with health insurance than life insurance. For example, an injured person who has a disability income policy with generous benefits may feel disinclined to follow a prescribed rehabilitation regime and get back to work, and an individual in poor health who has medical expense insurance may be more likely to pursue treatment for her medical conditions than if she had no medical expense insurance.

Chapter 2

The Life and Health Insurance Industry

Objectives

After studying this chapter, you should be able to

2A Distinguish among the three types of business organizations and explain why insurance companies must be organized as corporations

2B Distinguish among stock insurers, mutual insurers, and fraternal benefit societies

2C Describe the financial services industry and explain how insurance companies function within that industry

2D Describe the roles that the federal and state governments play in U.S. insurance regulation

2E Identify the two primary types of insurance regulation in most countries

Outline

Insurance Company Organization
- Types of Business Organizations
- Types of Insurance Company Organizations

Insurance Companies as Financial Institutions
- Financial Intermediaries
- Evolution of the Financial Services Industry

Role of Government in Insurance
- Social Insurance Programs
- Regulation of Insurance
- Taxation

In some ways, a life insurance company functions just like any other business. The company determines the needs of its customers, creates products that meet those needs, and pursues *profits* to ensure its survival. ***Profit*** is the money, or revenue, that a business receives for its products *minus* the expenses it incurs to create and support the products.

What sets insurance companies apart, however, is the nature of the products that they sell. The products of a typical life insurance company represent promises of future payments, which may not be called upon for 20, 30, or even 50 or more years into the future. This characteristic of a life insurance company greatly influences the way that the company is organized.

Insurance Company Organization

In many countries, including the United States, three primary types of business organizations are sole proprietorships, partnerships, and corporations. Insurers are organized as corporations. Let's explore each type to find out why.

Types of Business Organizations

A ***sole proprietorship*** is owned and operated by one person. The owner receives all the profits and is personally responsible for all the debts of the business. If the business fails, the owner's personal property may be used to pay the debts of the business. If the owner becomes disabled or dies, the business often cannot continue to operate.

A ***partnership*** is a business that is owned by two or more people, who are known as the *partners*. The partners divide the profits, and generally each of them is personally responsible for all the debts of the business.

Example:

George Everett and Andrew Carter formed an equal partnership. At first, the business was successful, and George and Andrew each received one-half of the profits. However, the business eventually failed, and George was unable to pay his share of the losses.

Analysis:

Because George and Andrew formed their business as an equal partnership, Andrew was personally responsible for *all* the partnership's debts.

If one of the partners dies or withdraws from the business, the partnership generally dissolves, although the remaining partners may form a new partnership and continue to operate the business.

In most countries, insurance companies and most other major businesses are organized as corporations. A ***corporation*** is a legal entity that is created by the authority of a governmental unit (through a process known as *incorporation*) and that is separate and distinct from its owners.

A corporation has two major characteristics that set it apart from a sole proprietorship and a partnership:

- As a legal entity that is separate from its owners, a corporation can sue or be sued, enter into contracts, and own property. In addition, the corporation's debts belong to the corporation itself and not to its owners. The owners are not personally responsible for the corporation's debts.

- The corporation continues beyond the death of any or all of its owners. This characteristic of the corporation provides an element of stability and permanence that a sole proprietorship and partnership cannot guarantee. Because an insurer's contractual obligations extend many years into the future, the corporation is the ideal form of business organization for an insurance company. Recognizing the importance of such stability and permanence, laws in the United States and many other countries require insurance companies to operate as corporations.

Types of Insurance Company Organizations

Even though they must be corporations, life and health insurance companies have some flexibility in how they are organized to do business. Typically, an insurer is organized as a stock insurance company, a mutual insurance company, or a fraternal benefit society.

Stock Insurance Companies

Most corporations, including most life and health insurers, are stock corporations. A ***stock corporation*** is a corporation whose ownership is divided into units known as ***shares*** or *shares of stock*. A ***stockholder***, or *shareholder*, is a person or organization that owns shares of stock in a corporation. The corporation's stockholders collectively are its owners. Insurers organized as stock corporations are known as ***stock insurance companies***.

If a stock insurance company has profits, the stockholders may receive a ***stockholder dividend***, which is a portion of the corporation's earnings paid to the owners of its stock. Many companies pay dividends quarterly or annually.

Mutual Insurance Companies

A ***mutual insurance company*** is an insurance company that is owned by its policyowners. Because a mutual insurance company does not have stockholders, it does not pay stockholder dividends. Instead, a portion of the company's operating profits may be distributed to its policyowners in the form of *policy dividends*. We discuss policy dividends in more detail in Chapter 9.

Although stock insurers greatly outnumber mutual insurers in the United States, mutual insurers historically have been older and larger than stock insurers and thus provide a significant amount of the life insurance in force.

Fraternal Benefit Societies

A ***fraternal benefit society***, also known as a *fraternal insurer*, is a nonprofit organization that is operated solely for the benefit of its members and that provides social, as well as insurance, benefits to its members. The members of such societies often share a common ethnic, religious, or vocational background, although membership in some societies is open to the general public. One of the legal requirements of being a fraternal benefit society is that the fraternal society must have a representative form of government—that is, the members must elect the officers of the fraternal society. In addition, fraternal societies must operate through a lodge system, in which only lodge members and their families are permitted to own the fraternal society's insurance. Applicants for insurance automatically become members once the society issues them a policy.

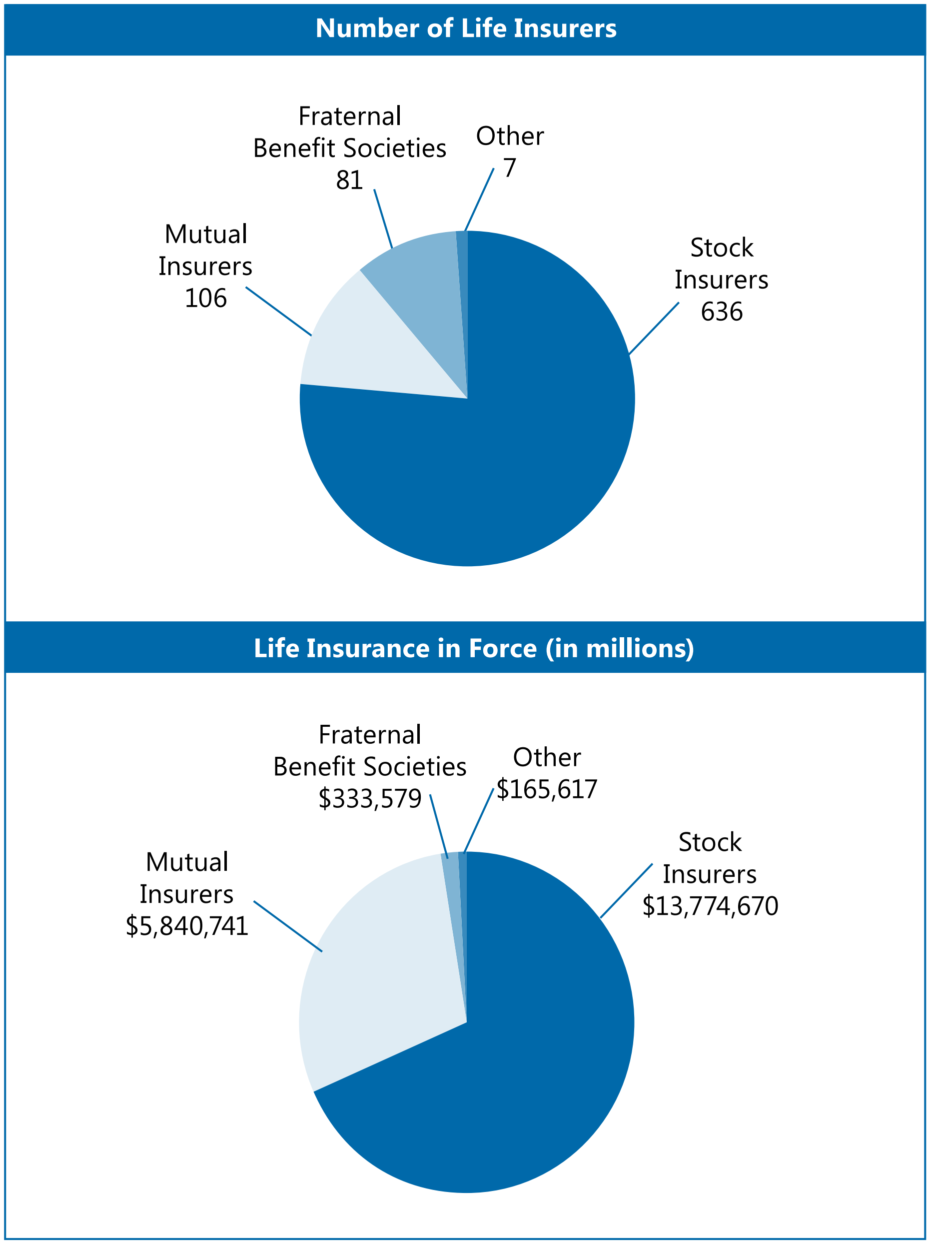
Figure 2.1 depicts the total number of stock insurers, mutual insurers, and fraternal benefit societies operating in the United States in 2014, as well as the life insurance in force for each type of insurance company.

Insurance Companies as Financial Institutions

Insurance companies are financial institutions that function in the economy as part of the financial services industry. A ***financial institution*** is a business that owns primarily financial assets, such as stocks and bonds, rather than fixed assets, such as equipment and raw materials. The ***financial services industry*** is an industry that offers financial products and services to help individuals, businesses, and governments meet their financial goals of protecting against financial losses, accumulating and investing money and other assets, and managing debt and payments. In addition to insurance companies, financial institutions include

- **Depository institutions**, which specialize in accepting deposits from and making loans to people, businesses, and government agencies. Commercial banks, savings and loan associations, and credit unions are examples of depository institutions.
- **Finance companies**, which specialize in making short- and medium-term loans to people and businesses.
- **Securities firms**, which specialize in the purchase and sale of securities. A ***security*** is a financial asset that represents either (1) an obligation of indebtedness owed by a business, a government, or an agency, which is known as a *debt security*, or (2) an ownership interest, which is known as an *equity security*.
- **Mutual fund companies**, which operate mutual funds. A *mutual fund* is an investment vehicle that pools the funds of investors and uses the funds to buy a variety of stocks, bonds, and other securities.

Figure 2.1 Comparison of Stock Insurers, Mutual Insurers, and Fraternal Benefit Societies in the United States, 2014



Source: Adapted from ACLI, *Life Insurers Fact Book 2015*, Copyright © 2015 American Council of Life Insurers, Washington, DC, (November 2015, 19,) 2–3 https://www.acli.com/Tools/Industry%20Facts/Life%20Insurers%20Fact%20Book/Documents/FB15_All.pdf (15 February 2016). Used with permission.

Financial Intermediaries

Financial institutions, including insurance companies, serve as financial intermediaries. A ***financial intermediary*** is an organization that collects funds from one group of people, businesses, and governments, known as *suppliers*, and channels them to another group, known as *users*. Insurers, for example, collect premiums from policyowners and pay claims to beneficiaries. In the process of moving funds from suppliers to users, financial intermediaries generate income for themselves.

As financial intermediaries, insurance companies take a substantial portion of the money that their customers pay for insurance and invest that money in other businesses and industries, primarily through the purchase of bonds issued by corporations. The investments that insurers make provide funds that these businesses need to operate and expand. For example, life insurance companies in the United States have been the largest institutional holders of corporate bond financing since the 1930s.[1]

Evolution of the Financial Services Industry

The financial services industry has undergone profound changes in the past few decades. The evolution of the financial services industry is characterized by convergence, consolidation, and globalization.

Convergence

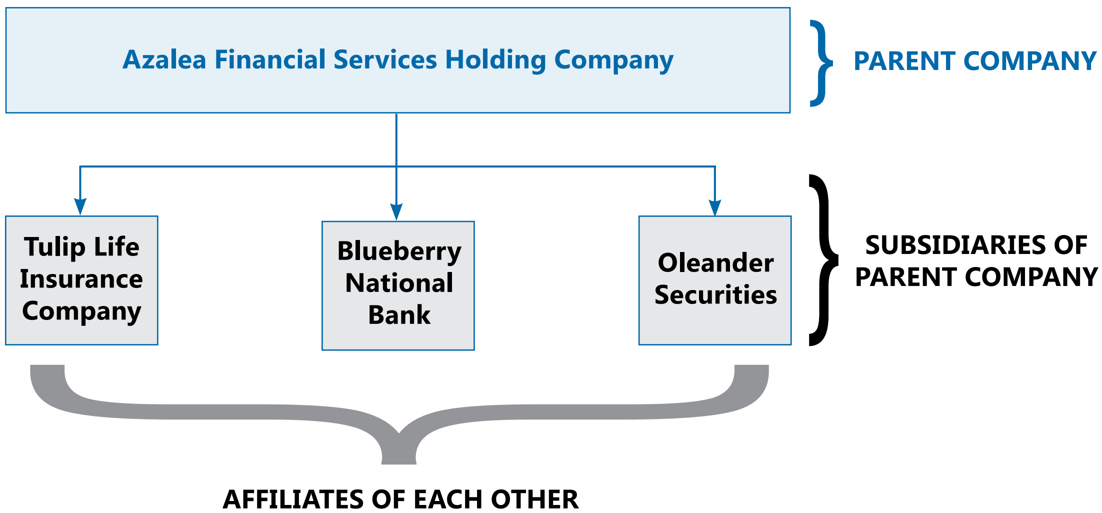
Historically, the financial services industry was divided into distinct sectors, often as a result of regulatory requirements in various countries. Banks provided banking services such as checking accounts, savings accounts, and loans. Securities firms and mutual fund companies handled investments. Insurance companies issued and sold insurance products.

Today, however, the financial services industry is characterized by ***convergence***, which is a movement toward a single financial institution being able to serve a customer's banking, insurance, and securities needs. Financial services companies have entered into each other's traditional businesses, either through expansion of operations or affiliations. Thus, the distinctions among financial institutions based on the products they offer have blurred.

In the United States, financial services companies may affiliate by means of a financial holding company. A *holding company*, also known as a *parent company*, is a company that owns and controls another company or companies, which are referred to as *subsidiaries* or *operating units*. The various subsidiaries that are under the common control of the holding company are known as *affiliates* of each other because they are affiliated within a holding company system, often operating under a single brand name. A *financial holding company* is a holding company that conducts activities that are financial in nature or incidental to financial activities, such as insurance activities, securities activities, banking, and investment and advisory services. Figure 2.2 illustrates a financial holding company structure.

Affiliation in a financial holding company system allows companies to sell one another's products. For example, although banks in the United States still cannot issue—that is, accept the risk on—insurance products, an insurance company can design a product according to a bank's specifications and issue a product that the bank can sell. Such affiliations also increase the ability of insurance companies to offer a wider variety of noninsurance products, such as mutual funds.

Figure 2.2 Financial Holding Company



Consolidation

In the financial services industry, the term ***consolidation*** typically refers to the combination of financial institutions within or across sectors. This consolidation occurs primarily through mergers and acquisitions:

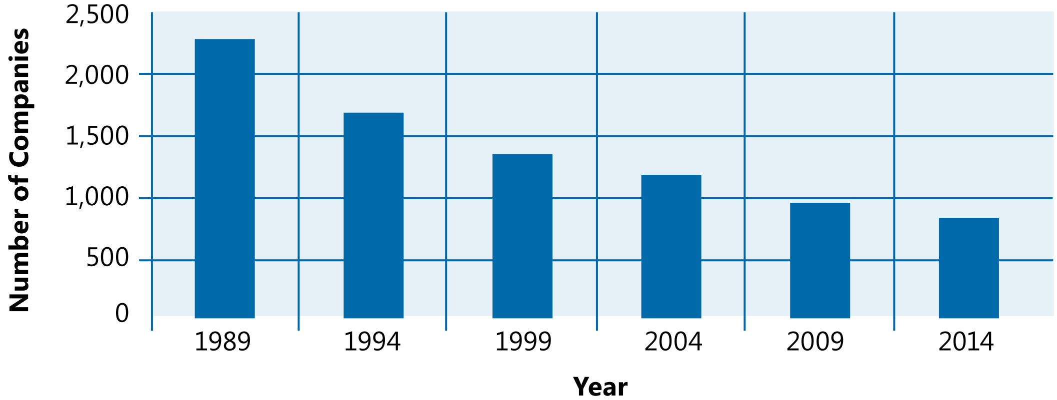
- A *merger* is a transaction in which the assets and liabilities of two companies are combined into one company. One of the companies survives as a legal entity, and the other company ceases to exist.
- An *acquisition* is a transaction in which one corporation purchases a controlling interest in another corporation, resulting in an ownership link between two formerly independent corporations. After the transaction, both corporations survive as separate legal entities.

Consolidation has decreased the number of traditional financial institutions within each sector of the financial services industry. As the number of financial institutions has decreased, many of the remaining institutions have grown in size. Figure 2.3 illustrates how the number of life insurance companies in the United States has decreased steadily since 1989.

Globalization

Financial institutions operate in a global environment. Large financial services enterprises, particularly those from Western Europe and North America, increasingly are expanding their customer bases worldwide. For example, Canadian life and health insurers generated 41 percent of their premiums abroad in 2014.[2] In addition, the proportion of life insurance companies operating in the United States that are foreign-owned was 11 percent in 2014.[3]

Figure 2.3 Number of U.S. Life Insurance Companies 1989–2014



Source: Adapted from ACLI, *Life Insurers Fact Book 2015*, Copyright © 2015 American Council of Life Insurers, Washington, DC, (November 2015, 19,) 5 https://www.acli.com/Tools/Industry%20Facts/Life%20Insurers%20Fact%20Book/Documents/FB15_All.pdf (15 February 2016). Used with permission.

Role of Government in Insurance

Governments around the world perform a variety of functions, such as providing social insurance programs, acting as regulators, and influencing spending and saving through taxation. In performing these functions, governments affect the supply and demand for insurance in the private sector.

Social Insurance Programs

A ***social insurance program*** is a welfare plan that is established by law and administered by a government and that provides assistance to specified groups of the population, such as the elderly, disabled, and unemployed. Social insurance may provide cash payments to replace income lost because of old age, disability, death, occupational injuries, and unemployment. Social insurance also may provide services such as medical care.

In most countries, insurance companies cannot provide products that duplicate the coverage of social insurance programs. Instead, insurers create and sell products that fill in the gaps not covered by social insurance and that supplement the coverage that social insurance provides.

Example:

In the United States, one important social insurance program is *Medicare*, which pays certain health care expenses for the elderly and people with qualifying disabilities. Most Americans age 65 and older receive Medicare coverage. Medicare doesn't cover all of an individual's medical expenses, however. To complement Medicare coverage, private insurance companies created *Medigap policies*, also known as *Medicare supplement insurance policies*, which pay for many medical expenses not covered by Medicare.

Regulation of Insurance

Insurance companies protect millions of individuals against economic loss and offer them opportunities to save and invest money. Because the financial health of insurance providers is of such importance to so many people, insurers occupy a special position of public trust. As a result, the insurance industry is subject to regulation designed specifically to safeguard the public trust in insurance companies.

Although insurance laws vary from one country to another, many insurance laws are similar in principle throughout the world. For example, to operate as an insurer, a company must incorporate in one particular jurisdiction. The jurisdiction in which a company incorporates becomes the company's ***domicile***. The company must then obtain a certificate of authority from each jurisdiction in which it plans to conduct business. A ***certificate of authority***, or *license*, grants an insurer the right to conduct an insurance business and sell insurance products in the jurisdiction that grants the certificate. An insurer must comply with all applicable laws in each jurisdiction in which it is licensed.

Example:

The New Englander Insurance Company, a U.S. insurer, is incorporated in the state of Connecticut. New Englander conducts business in Connecticut, Massachusetts, and New Hampshire.

Analysis:

Connecticut is New Englander's domicile. New Englander must have a certificate of authority from each state in which it conducts business—Connecticut, Massachusetts, and New Hampshire. New Englander must also comply with all applicable laws in each of these three states.

Insurance regulatory systems also vary from country to country. In many countries, insurance regulation is centralized and under the supervision of the national government. For example, in India, authority over insurance regulation rests solely with the national Insurance Regulatory and Development Authority (IRDA). Some countries, including the United States and Canada, have ***federal systems*** of government, in which a *federal government* and a number of lower-level governments, known as *state governments* in the United States and *provincial governments* in Canada, share governmental powers, including the power to regulate insurance.

Insurance Regulation in the United States

Although the power to regulate insurance in the United States is shared by the state governments and the federal government, the states have the primary authority to regulate the business of insurance. This authority was established through the ***McCarran-Ferguson Act***, a federal law in which the U.S. Congress agreed to leave insurance regulation to the states, as long as Congress considers this regulation to be adequate.

Each state has its own laws, usually referred to as the ***state insurance code***, which regulate insurance in that state. Each state also has an administrative agency, typically known as the ***state insurance department***, which is responsible for making sure that companies operating in the state comply with applicable regulatory requirements. Each state insurance department is under the direction of an ***insurance commissioner***, known in some states as the *superintendent of insurance* or *director of insurance*.

Although each state has its own set of laws and regulations governing insurance, these laws and regulations are often similar across the various states because they are based on models developed by the National Association of Insurance Commissioners. The ***National Association of Insurance Commissioners (NAIC)*** is a nongovernmental association of the insurance commissioners of all the states. The NAIC's primary function is to promote uniformity of state insurance regulation by developing model laws and regulations as guidelines for the states. States are not required to adopt model laws and regulations as written; instead, states may either modify the models or choose not to adopt them at all.

In the United States, the federal government has long regulated certain aspects of the insurance industry. For example, certain investment-linked insurance products, such as variable life insurance and variable annuities, are considered securities. Therefore, these products are subject to oversight by the *Securities and Exchange Commission (SEC)*, a federal agency that administers federal laws governing securities. In addition, individuals who sell variable products or provide investment advice to owners of variable products must be registered with the *Financial Industry Regulatory Authority (FINRA)*, a nongovernmental organization authorized by the SEC to regulate all securities firms doing business in the United States.

Figure 2.4 describes the growing role of the federal government in insurance regulation since the passage of the Dodd-Frank Act in 2010.

In some countries, insurance companies may also be regulated by *self-regulatory organizations (SROs)*, which are nongovernmental organizations that exercise regulatory authority over an industry or profession. In the United States, FINRA is an influential SRO for the life insurance industry. In Canada, an important SRO for life insurance companies is the *Canadian Life and Health Insurance Association (CLHIA)*, which is a voluntary association whose member companies include 99 percent of Canada's life and health insurance business. Among other directives, the CLHIA establishes guidelines for member companies that apply to a broad range of business activities.

Two Primary Goals of Insurance Regulation

Throughout the world, insurance regulation has two primary goals:

- To ensure that insurers remain ***solvent***—that is, able to meet their debts and pay policy benefits when they come due. Solvency regulation is known as *prudential regulation* in many countries.
- To ensure that insurance companies conduct their businesses fairly and ethically. Such regulation is referred to as *market conduct regulation*.

Solvency Regulation

To ensure the solvency of insurance companies, most countries impose minimum financial requirements that an insurance company must meet before it obtains a license to transact insurance; a company that is financially unsound cannot obtain a license. In addition, governments have the authority to act to protect the public interest if an insurance company becomes financially unsound.

Figure 2.4 The Dodd-Frank Act

As a result of the financial crisis of 2007–2010, the U.S. Congress enacted the ***Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank)***, which is designed to (1) promote the financial stability of the United States by improving accountability and transparency in the financial system and (2) protect consumers from abusive financial services practices.

Dodd-Frank created several agencies, including the

- ***Federal Insurance Office (FIO)***, which is a federal agency authorized to monitor the insurance industry, identify areas with inadequate state regulation, and handle international insurance issues.
- ***Financial Stability Oversight Council (FSOC)***, which is an independent agency responsible for monitoring the safety and stability of the nation's financial system, identifying threats to the system, and coordinating regulatory responses to any such threats. The FSOC is empowered to identify ***systemically important financial institutions (SIFIs)***, which are institutions—including insurance companies—whose failure could potentially pose a risk to the financial system. Financial institutions that are identified as SIFIs will be subject to more stringent regulatory standards than other institutions.

A company's solvency is evaluated by applying the *basic accounting equation*, which states:

LEARNING AID

Assets = Liabilities + Owners' Equity

In the basic accounting equation,

- ***Assets***, such as cash and investments, are all items of value owned by a company.
- ***Liabilities*** are the company's debts and future obligations. A large portion of an insurer's liabilities consist of the company's *policy reserves*, which represent the amount the insurer estimates it will need to pay policy benefits as they come due.
- ***Owners' equity***, which represents the owners' financial interest in the company, is the difference between the amount of the company's assets (what it owns) and its liabilities (what it owes). For a stock insurer, owners' equity has two components: capital and surplus. ***Capital*** is the amount of money that the company's owners have invested in the insurer, usually through the purchase of company stock. ***Surplus*** is the amount by which the company's assets exceed its liabilities and capital.

  Because a mutual insurer does not issue stock, it has no capital. Therefore, owners' equity for a mutual insurer consists entirely of the company's surplus. Figure 2.5 illustrates the calculation of owners' equity for stock and mutual insurers.

Figure 2.5 Calculations of Owners' Equity

Stock Insurance Company

Friendly Insurance Company has assets of $12 million and liabilities of $8 million. The stockholders of Friendly have invested $3 million in the company.

Basic Accounting Equation:

$12 million (Assets) = $8 million (Liabilities) + Owners' Equity (Capital + Surplus)

Owners' Equity = $12 million (Assets) – $8 million (Liabilities)
= $4 million

$4 million (Owners' Equity) = $3 million (Capital) + Surplus

Surplus = $4 million (Owners' Equity) – $3 million (Capital)
= $1 million

Therefore, owners' equity is $4 million, consisting of $3 million in capital and $1 million in surplus.

Mutual Insurance Company

Pleasant Mutual Insurance Company has assets of $10 million and liabilities of $4 million.

Basic Accounting Equation:

$10 million (Assets) = $4 million (Liabilities) + Owners' Equity (Surplus)

Owners' Equity = $10 million (Assets) – $4 million (Liabilities)
= $6 million

Therefore, owners' equity is $6 million, all of which is surplus.

Governments have established methods to oversee the financial condition of insurance companies operating within their jurisdiction. In the United States, the states oversee the financial condition of insurance companies by reviewing an accounting report, known as the ***Annual Statement***, which every insurer prepares each calendar year and files with the insurance department in each state in which it operates. The NAIC has developed an Annual Statement form that all states accept, so an insurer can file the same Annual Statement form in all the states in which it operates. In addition, state regulators conduct an on-site financial condition examination of each insurance company every three to five years. In this examination, state regulators physically check the insurer's business records. State regulators may conduct more frequent examinations of companies that appear most likely to have financial difficulties.

As a general rule, when an insurer is experiencing financial difficulties, regulators are authorized to intervene in the insurer's operations to protect policyowner interests. The specific actions that regulators are permitted to take when an insurer's solvency is in question vary from country to country. In extreme cases where an insurer's solvency cannot be restored, countries typically have established procedures to liquidate the company. In each case, the protection of policyowner interests is the primary regulatory goal.

Market Conduct Regulation

Market conduct laws are designed to make sure that insurance companies conduct their businesses fairly and ethically. These laws regulate most of the nonfinancial operations of insurers, including sales practices, advertising, underwriting, policyowner service, complaint handling, and claims.

In the United States, each state regulates the market conduct of insurers operating in the state. Many market conduct laws are designed to ensure that customers are presented with fair and accurate information before they buy insurance. For example, laws require insurers to disclose specific information about a policy to a potential customer before selling the policy. Other laws regulate the form and content of insurance advertisements to make sure that consumers are not misled about the features or limitations in advertised insurance policies.

In the United States, the state insurance departments perform periodic market conduct examinations of insurers to ensure that the companies are complying with the state's market conduct laws. If the department determines that an insurer has violated market conduct laws, it may impose sanctions against the insurer, including fines and, in severe cases, suspending or revoking the insurer's certificate of authority.

In addition to regulating insurance companies, the states regulate the conduct of the individuals who market and sell insurance. These individuals, typically known as *insurance producers* or *insurance agents*, must be licensed by each state in which they conduct business. The licensing process helps ensure that insurance producers are reputable and knowledgeable about the insurance products they sell. In conducting business, insurance producers must comply with all applicable state and federal laws. A state insurance department may revoke or suspend the license of a producer who engages in behavior that violates the state's laws.

Taxation

Many governments use taxation as a mechanism for accomplishing social, in addition to economic, goals. Through taxation, governments can influence people to act or refrain from acting in certain ways. For example, some governments tax tobacco heavily not only to raise revenue, but to discourage tobacco use. Governments also offer taxpayers reductions in taxable income for contributions made to qualified charities to encourage charitable giving.

Many governments also use tax policies to encourage people to purchase various types of private insurance and financial products. Governments, for example, provide tax incentives to encourage people to contribute to, and employers to provide, group retirement plans. Such tax incentives can be quite effective, and they have benefitted insurers and other financial institutions by increasing the demand for their products.

Key Terms

profit
sole proprietorship
partnership
corporation
stock corporation
share
stockholder
stock insurance company
stockholder dividend
mutual insurance company
fraternal benefit society
financial institution
financial services industry
security
financial intermediary
convergence
consolidation
social insurance program
domicile
certificate of authority
federal system
McCarran-Ferguson Act
state insurance code
state insurance department
insurance commissioner
National Association of Insurance Commissioners (NAIC)
Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank)
Federal Insurance Office (FIO)
Financial Stability Oversight Council (FSOC)
systemically important financial institution (SIFI)
solvent
assets
liabilities
owners' equity
capital
surplus
Annual Statement
market conduct law

Endnotes

1. ACLI, *Life Insurers Fact Book 2015* (Washington, DC: American Council of Life Insurers, 2015), 8, https://www.acli.com/Tools/Industry%20Facts/Life%20Insurers%20Fact%20Book/Pages/RP15-010.aspx (27 January 2016).
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Chapter 3

The Insurance Contract

Objectives

After studying this chapter, you should be able to

3A Distinguish between formal and informal contracts, bilateral and unilateral contracts, commutative and aleatory contracts, and contracts of adhesion and bargaining contracts, and identify which types characterize an insurance contract

3B Explain the difference between a valid contract, a void contract, and a voidable contract

3C Identify the four general requirements for the creation of a valid informal contract and describe how each of these requirements can be met in the formation of an insurance contract

3D Identify the property rights that a policyowner has in the insurance policy he owns

Outline

Fundamentals of Contract Law

- Types of Contracts
- General Requirements for a Contract

The Policy as Property

- Right to Use and Enjoy Property
- Right to Dispose of Property

Remember our point that life and health insurance products represent promises—promises that, in some cases, could extend over decades? This characteristic influences the form that such a product takes: in return for an initial payment, an applicant typically receives an insurance policy, which is a written record of the promise that the insurance company is making.

Recall that an *individual insurance policy* is an insurance policy that insures the life or health of a named person. Some individual policies also insure the person's immediate family or a second named person. A *group insurance policy* insures the lives or health of a specific group of people. For example, most group insurance policies are purchased by employers to provide life or health insurance coverage to their employees and, sometimes, to the dependents of covered employees.

Unless otherwise noted, the information presented in this chapter applies to both individual and group insurance policies.

Fundamentals of Contract Law

Before an insurance policy is purchased, the applicant for insurance and the insurance company must reach an agreement: the applicant must agree to buy the insurance coverage from the company at the stipulated rate, and the company must agree to issue that coverage under the offered terms. The insurance policy describes the terms of their agreement.

An insurance policy represents a special kind of agreement known as a contract. A ***contract*** is a legally enforceable agreement between two or more parties. The two parties to an individual life or health insurance contract are the insurance company that issued the policy and the individual who owns the policy, known as the *policyowner.* The parties to a group insurance contract are the insurer that issued the policy and the ***group policyholder***, which refers to the person or organization that decides what types of group insurance coverage to purchase for the group members, negotiates the terms of the insurance contract, and purchases the group insurance coverage.

The fact that a contract is legally enforceable means that the parties are bound to carry out the promises they made when entering into the contract. If a party does not carry out its promise, then that party has breached the contract. Laws provide innocent parties with remedies they can pursue to recoup losses resulting from a breach of contract.

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Types of Contracts

In Chapter 1, we described contracts of indemnity and valued contracts. As noted in that chapter, health insurance policies typically are contracts of indemnity, and life insurance policies are valued contracts. Contracts may be categorized in other ways—for example as either

- Formal or informal contracts
- Bilateral or unilateral contracts
- Commutative or aleatory contracts
- Bargaining contracts or contracts of adhesion

Formal and Informal Contracts

Contracts are either formal or informal. A ***formal contract*** is a written contract that is enforceable because the parties met certain formalities concerning the form of the agreement. Historically, a formal contract had to be stamped with a seal, but that is no longer a requirement.

Life and health insurance contracts are informal contracts. An ***informal contract*** is an oral or a written contract that is enforceable because the parties met requirements concerning the substance of the agreement rather than requirements concerning the form of the agreement.

As informal contracts, life and health insurance contracts could theoretically be made in either written or oral form. However, laws in some jurisdictions require insurance contracts to be in writing. Life and health insurance contracts typically are expressed in written form—whether required by law or not—for practical reasons. For example, a written contract provides a permanent record of the agreement. Life insurance policies often remain in effect for many years. The memory of someone's oral promises made many years in the past may not be reliable, even under the best circumstances. Putting the contract in writing helps prevent misunderstandings between the parties as to the terms and conditions of their agreement.

Bilateral and Unilateral Contracts

A contract between two parties may be either bilateral or unilateral. A ***bilateral contract*** is one in which both parties make legally enforceable promises when they enter into the contract.

Example:

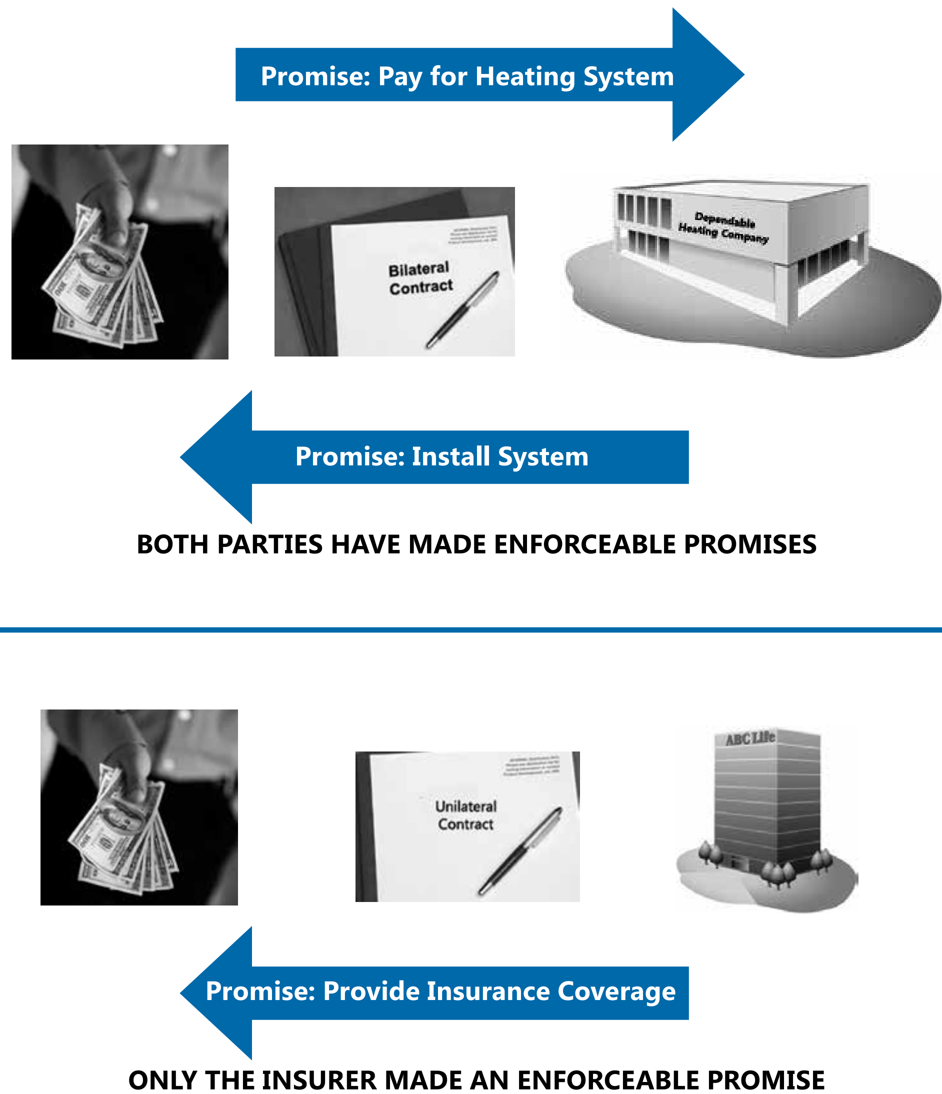
Shi-Fay Cheng contracts with the Dependable Heating Company to have the company install a heating system in her home for a mutually agreed-upon price. Dependable promises to perform the work, and Shi-Fay promises to pay a stated amount in exchange for the work.

Analysis:

This contract is bilateral—both Shi-Fay and Dependable have made legally enforceable promises. If either Shi-Fay or Dependable fails to perform its promise, the other party can take legal action to enforce the contract.

In contrast to a bilateral contract, a ***unilateral contract*** is one in which only one of the parties makes a legally enforceable promise when entering into the contract. Life and health insurance policies are unilateral contracts. The insurer promises to pay a policy benefit if the insured dies, gets sick, or is injured. As long as the premiums are paid, the insurer is legally bound by its contractual promises. The purchaser of the policy, on the other hand, does not promise to pay the premiums and cannot be compelled by law to pay them. In fact, the policyowner has the right to stop paying premiums and cancel the policy at any time. Figure 3.1 illustrates the difference between a bilateral and a unilateral contract.

Figure 3.1 Bilateral vs. Unilateral Contracts



Commutative and Aleatory Contracts

Contracts may also be classified as either commutative or aleatory. A ***commutative contract*** is an agreement in which the parties specify in advance the values that they will exchange. Moreover, the parties generally exchange items or services that they think are of relatively equal value. In the case of Shi-Fay Cheng and the Dependable Heating Company, both parties essentially agreed that the installation of the heating system and the price to be paid were of equal value. Contracts for the sale of goods or services usually are commutative contracts.

In an ***aleatory contract***, one party provides something of value to another party in exchange for a conditional promise. A ***conditional promise*** is a promise to perform a stated act if a specified, uncertain event occurs. If the event does not occur, the promise will not be performed. Also, under an aleatory contract, if the specified event occurs, one party may receive something of greater value than that party gave.

Life and health insurance policies are aleatory contracts. A life insurance policy is an aleatory contract because the insurer's promise to pay the policy benefit is contingent upon the death of the insured while the policy is in force. The insured's death is an uncertain event because no one can say with certainty when the insured will die.

A life insurance policy is also an aleatory contract because one of the parties may receive something of greater value than that party gave. For example, a policy may terminate prior to the death of the insured, and the insurer's promise to pay the policy benefit will never be performed—even if the insurer has received a number of premiums. Conversely, death may occur soon after an insurer issues a life insurance policy. In this case, the insurer must pay the policy benefit, which will be more than the premiums the insurer received for the policy.

Bargaining Contracts and Contracts of Adhesion

Contracts may be further classified as either bargaining contracts or contracts of adhesion. Suppose two individuals, Jean and Dylan, had the following conversation:

Jean: I will sell you my car for $3,000.

Dylan: I would like to buy your car but not for $3,000. How about $2,000?

Jean: I can't sell you the car for $2,000; how about $2,500?

Dylan: Okay, I will buy your car for $2,500.

Jean and Dylan have entered into a ***bargaining contract***, one in which both parties, as equals, set the terms and conditions of the contract.

In contrast, life and health insurance policies are contracts of adhesion. A ***contract of adhesion*** is a contract that one party prepares and that the other party must accept or reject as a whole, generally without any bargaining between the parties to the agreement. Although the applicant for individual life or health insurance has choices about some of the contract provisions, generally he must accept or reject the contract as the insurance company has written it. As a result, if any policy provision is ambiguous, the courts usually interpret the provision in whatever manner would be more favorable to the policyowner or beneficiary. In contrast to individual insurance policies, group insurance agreements often are subject to some negotiation between the parties. Nevertheless, group insurance contracts are contracts of adhesion. Figure 3.2 lists the various types of contracts and identifies which types characterize life and health insurance contracts.

LEARNING AID

General Requirements for a Contract

According to the laws in most states in the United States and many other countries, an agreement must meet the following four general requirements to be a valid informal contract:

1. The parties to the contract must express mutual assent, or agreement, to the terms of the contract.
2. The parties to the contract must have contractual capacity.
3. The parties to the contract must exchange legally adequate consideration.
4. The contract must be for a lawful purpose.

Figure 3.2 Types of Contracts

Type of Contract	Characterizes Life and Health Insurance Contracts
Contract is based on the form of the agreement (Formal contract)	No
Contract is based on the substance of the agreement (Informal contract)	Yes
Both parties make legally enforceable promises (Bilateral contract)	No
Only one party makes a legally enforceable promise (Unilateral contract)	Yes
The parties exchange things of equal value (Commutative contract)	No
One party provides something of value in exchange for a conditional promise (Aleatory contract)	Yes
Both parties set the terms (Bargaining contract)	No
One party sets the terms that the other party accepts or rejects (Contract of adhesion)	Yes

In describing the legal status of a contract, the words *valid*, *void*, and *voidable* are often used:

- **Valid.** A ***valid contract*** is one that is enforceable by law. Valid contracts satisfy all legal requirements.
- **Void.** The term void is used in law to describe something that was never valid. A ***void contract*** is one that does not satisfy one or more of the legal requirements to create a valid contract and, thus, is never enforceable.
- **Voidable.** At times, one of the parties to an otherwise valid contract may have grounds to reject, or avoid, it. A ***voidable contract*** is one in which a party has the right to avoid her obligations under the contract.

Let's look at the four requirements in more detail.

Mutual Assent

Whether a contract is made when the parties sign a written agreement or shake hands, the parties involved have agreed to do something. The requirement of ***mutual assent*** is met when the parties reach a meeting of the minds about the terms of their agreement.

For life and health insurance policies, as well as for other contracts, mutual assent is expressed through a process of *offer and acceptance*. An ***offer*** is a proposal to enter into a binding contract with another party. The party that makes the offer is the *offeror*, and the party to whom the offer is made is the *offeree*. An ***acceptance*** of the offer is the offeree's unqualified agreement to be bound to the terms of the offer. If an offer is accepted according to its terms, mutual assent has occurred.

Example:

Denise Chung said to her neighbor, Graham Spader, "I will sell you my old lawn mower for $100." Graham replied, "I like your lawn mower, so I will buy it for $100."

Analysis:

Denise's statement to Graham was an *offer*, and Denise was the *offeror*. Graham was the *offeree*. Graham's reply was an *acceptance* of the offer. Through their offer and acceptance, Denise and Graham expressed their *mutual assent* to the terms of the contract.

Contractual Capacity

For an informal contract to be binding on the parties, the parties must have ***contractual capacity***—that is, they each must have the legal capacity to make a contract. Individuals and insurance companies can enter into binding contracts, but the criteria for determining contractual capacity are somewhat different for individuals than for insurers and other corporations.

Contractual Capacity of Individuals

Every individual is presumed to have the legal capacity to enter into a valid contract. The law, however, has established some exceptions to this general rule to protect certain individuals who may not understand the consequences of their actions. In most jurisdictions, these individuals include (1) minors and (2) people with diminished mental capacity.

Minors. The laws in nearly all jurisdictions establish a particular age, referred to as the *age of majority* or *age of maturity*, at which people are considered adults who are capable of managing their own affairs and accepting the legal obligations created by their actions. A ***minor*** is a person who has not attained the age of majority. In most countries and most states in the United States, the age of majority is 18.

Generally, a contract entered into by a minor is voidable by the minor.[1] A minor is usually permitted to reject a contract before reaching the age of majority or within a reasonable time afterward.

Many jurisdictions have, by law, lowered the age of majority for the purpose of entering into life insurance contracts. These laws permit younger people—generally those who are at least age 15 or 16—to purchase life insurance and to exercise some of a policy's ownership rights as though they were adults. In most such situations, the beneficiary of the life insurance policy must be a member of the minor's immediate family.

If an insurance company sells an insurance policy to a person who is younger than the permissible age to purchase insurance, then the company is required to provide the promised insurance protection as long as the premiums are paid. The minor, however, could sue to avoid the policy, and the insurance company would have to return the premiums the minor paid for the policy.

Example:

Caridad Mendoza, age 17, purchased a life insurance policy from Totem Life Insurance Company and paid the initial premium. The minimum permissible age to purchase life insurance in the jurisdiction in which Caridad lives is 18 years.

Analysis:

Because Caridad is younger than the permissible age, this life insurance policy is voidable by Caridad. She can reject the contract before she turns 18 or within a reasonable time afterward, and Totem must refund any premiums she has paid. In contrast, as long as Caridad pays the premiums for the policy, Totem is bound by the contract.

Mental Capacity. Two situations arise in which a person's lack of mental capacity affects her contractual capacity:

- A court declares the person to be insane or mentally incompetent. A contract entered into by such a person is usually *void*.

- The person's mental competence is impaired, but a court has not declared her to be insane or mentally incompetent. For example, the person can be mentally impaired as a result of being intoxicated or mentally ill. Contracts entered into by such a person are generally *voidable* by that person. If the person later regains mental competence, she may either reject the contract or require that it be carried out. In contrast, the other party to the contract does not have the right to reject the contract and must carry out its terms if required to do so.

Contractual Capacity of Organizations

Corporations are generally presumed to have the contractual capacity of a mentally competent adult. Therefore, a corporation that was created in accordance with the laws of the applicable jurisdiction has the contractual capacity to enter into a contract, including a contract to purchase insurance.

An insurer acquires the legal capacity to issue an insurance contract by being licensed or authorized to do business as an insurer by the proper regulatory authority. A company that is neither licensed nor authorized as an insurance company does not have the legal capacity to issue an insurance contract. Should an unauthorized insurer issue a policy to a person who is unaware of the insurer's lack of legal capacity, the policy may be enforceable against the insurer. The legal effect of such a contract depends on the laws of the particular jurisdiction. In some jurisdictions, the contract is *void*; in others, the contract is *voidable* by the policyowner.

Legally Adequate Consideration

For an informal contract to be valid, the parties to the contract must exchange ***consideration***, which means that each party must give or promise something that is of value to the other party. In addition, the consideration exchanged must be legally adequate. In general, consideration is legally adequate as long as it has some value to the parties.

An applicant submits the application and the ***initial premium***—the first premium paid for an insurance policy—as consideration for a life or health insurance policy. The applicant gives this consideration in return for the insurer's promise to pay the policy benefit if the conditions stated in the policy occur. If the applicant does not pay the initial premium, then no contract is formed, because the applicant has not provided the required consideration. ***Renewal premiums***, which are premiums payable after the initial premium, are a condition for continuance of the policy and are not consideration for the policy.

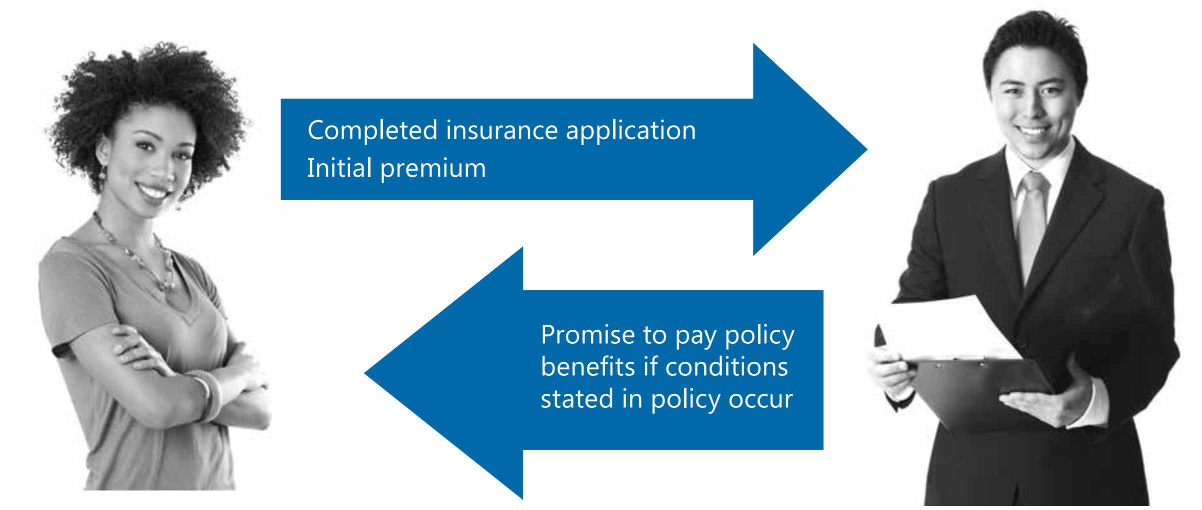
Figure 3.3 illustrates legally adequate consideration for an insurance policy.

Lawful Purpose

No contract can be made for a purpose that is illegal or against the public interest—a contract is valid only if it is made for a lawful purpose. For example, all jurisdictions have laws that make certain acts punishable as crimes. An agreement between two parties to commit a criminal act, such as an agreement to kill an individual in exchange for money, is not legally enforceable.

As we mentioned in Chapter 1, early life insurance policies were sometimes used to gamble on an individual's life. As a result, many jurisdictions enacted

Figure 3.3 Legally Adequate Consideration for Insurance



insurable interest laws as a matter of public policy to prevent such wagering. The requirement that an insurable interest be present when a policy is issued provides assurance that a life insurance contract is being made for the lawful purpose of providing protection against financial loss rather than for an unlawful purpose, such as speculating on another person's life in hopes of making a profit.

The requirement of lawful purpose in making an individual life insurance contract is met if an insurable interest is present when the policy is issued. After issuance, a continuing insurable interest is not required for the contract to remain valid.

Example:

Harvey Atkinson purchased a life insurance policy insuring his wife, Lily. Harvey and Lily divorced several years later.

Analysis:

As Lily's spouse, Harvey had an insurable interest in her life when the policy was issued. Therefore, the policy remains valid and in effect as long as premiums continue to be paid even if Harvey no longer has an insurable interest in Lily's life.

An insurable interest usually is not required in a group insurance contract because the group policyholder's interest in the contract does not encourage wagering as does a policyowner's interest in an individual insurance contract. For a group insurance contract, the lawful purpose requirement is met when the group policyholder enters into the contract to provide benefits to covered group members.

Figure 3.4 summarizes the requirements for a valid informal contract.

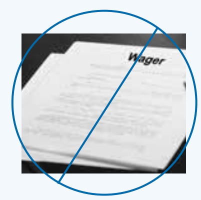
Figure 3.4 Requirements for a Valid Informal Contract

Mutual Assent

Contractual Capacity

Legally Adequate Consideration

Lawful Purpose



The Policy as Property

In addition to being governed by contract law, insurance policies are a type of property and, thus, are also subject to the principles of property law. In legal terminology, ***property*** is defined as a bundle of rights a person has with respect to something. In most countries including the United States, property is characterized as either real property or personal property. ***Real property*** is land and whatever is growing on or attached to the land. All property other than real property is characterized as ***personal property*** and includes tangible goods such as clothing, furniture, and automobiles, as well as intangible goods such as contractual rights. An insurance policy is intangible personal property—it represents intangible legal rights that have value and that can be enforced by the courts. The owner of an insurance policy—rather than the insured or beneficiary—holds these ownership rights in an insurance policy.

Ownership of property is the sum of all the legal rights that exist in that property. The legal rights an owner has in property include the right to use and enjoy the property and the right to dispose of the property.

Right to Use and Enjoy Property

The right to use and enjoy property that one owns is an inherent feature of property ownership. The owner of an insurance policy has the right to deal with the policy in a number of ways. For example, the owner of an individual life insurance policy has the right to name the policy beneficiary. The policyowner also usually has the right to change the beneficiary designation at any time while the policy is in force. We describe naming and changing the beneficiary of an individual life insurance policy in Chapter 9. We describe the right to name the beneficiary of a group life insurance policy in Chapter 13.

Right to Dispose of Property

The owner of property generally has the right to dispose of the property. For example, if you own an automobile, you have the right to give it away or sell it. Similarly, the owner of an insurance policy can dispose of it. The policyowner may transfer ownership of the policy by making a gift of the policy to someone else. We describe some of these aspects of policy ownership in later chapters. For now, just remember that, as property, an insurance policy consists of a bundle of ownership rights.

Key Terms

contract
group policyholder
formal contract
informal contract
bilateral contract
unilateral contract
commutative contract
aleatory contract
conditional promise
bargaining contract
contract of adhesion
valid contract
void contract
voidable contract
mutual assent
offer
acceptance
contractual capacity
minor
consideration
initial premium
renewal premium
property
real property
personal property
ownership of property

Endnote

1. The general rule that a minor's contract is voidable by the minor has some exceptions. One important exception is that a minor's contract for *necessaries*, which are goods and services that a minor requires for her well-being, is valid and binding on both parties.

Chapter 4

Life Insurance Premiums

Objectives

After studying this chapter, you should be able to

- **4A** Define policy reserves and explain the premises of the legal reserve system
- **4B** Define premium rate and calculate the annual premium amount for a given life insurance policy
- **4C** Explain how actuaries account for the cost of benefits, operating expenses, and investment earnings in developing premium rates
- **4D** Explain how insurers use mortality tables in pricing products and describe the effect that mortality rates have on the cost of benefits and the premium rate for a block of policies
- **4E** Describe the effect of compound interest on investment earnings and calculate the amount of interest earned on a given sum of money
- **4F** Explain the purpose of using conservative values in financial models
- **4G** Explain how the level premium system operates

Outline

The Legal Reserve System

Establishing Premium Rates
- Cost of Benefits
- Operating Expenses
- Investment Earnings
- Financial Models

The Level Premium System

Suppose you have just purchased a life insurance policy and made your initial premium payment. How did the insurance company decide what the policy's premium would be? And assuming that your policy has renewal premiums, how did the company come up with an amount for those as well?

To determine the proper premiums to charge, insurers employ specialists known as actuaries. An ***actuary*** is an expert in financial risk management and the mathematics and modeling of insurance, annuities, and financial instruments. In insurance companies, actuaries are responsible for ensuring that products are financially sound and profitable. Actuaries accomplish this dual objective by establishing for every product a premium rate that will enable the company to both cover its costs of developing and administering the product and generate a reasonable profit for the company and its owners.

Unlike previous chapters, which applied to a broader spectrum of life and health insurance products, this chapter focuses on life insurance products.

The Legal Reserve System

The system that insurers use to set financial values for life insurance products is generally known as the ***legal reserve system***. The legal reserve system derives its name from legal requirements that apply to insurers in the United States and many other jurisdictions. Insurers are required by law to establish ***policy reserves***, sometimes referred to as *contractual reserves*, *legal reserves*, or *statutory reserves*. These reserves represent the amount an insurer estimates it needs to pay future benefits.

Of all the terms used in the insurance industry, *reserves* is one of the most important and also one of the most easily misunderstood. In our everyday lives, we use the term *reserves* to mean something extra, something that is available in addition to our usual supply. For example, in a broad sense, people use the term *reserves* to refer to a sum of additional money that is put aside in case a special need arises. Used in this sense, a reserve fund is an asset.

In the insurance industry, however, reserves are not assets. Rather, they are liabilities representing the amount of money an insurer estimates it will need to pay its future obligations. Policy reserves represent the largest portion of an insurer's total liabilities. By law, the insurer is required to maintain assets that are at least equal to the amount of its policy reserve liabilities. Accordingly, the insurer must price its life insurance products so that it can meet its policy reserve requirements at all times.

The legal reserve system is based on the following premises:

- The amount of benefits payable should be specified or calculable in advance of the insured event.
- Companies should collect in advance the money needed to fund a policy reserve so that they will have sufficient funds available to pay claims and expenses as they occur.
- The premium an individual pays for a life insurance policy should be directly related to the amount of risk the insurance company assumes for the policy.

Establishing Premium Rates

In pricing life insurance products, actuaries do not determine the exact *premium amount* that each policyowner pays. Rather, they establish *premium rates* for blocks of policies. A ***block of policies*** is a group of policies issued to insureds who are all the same age and sex and in the same risk classification.

Example:

An insurer may classify into one block all term life insurance policies to be issued to male tobacco nonusers, age 35, with no significant medical history.

A ***premium rate*** is a charge per unit of insurance coverage. In most cases, premium rates for a block of policies are based on a $1,000 life insurance coverage amount, known as a *coverage unit*. Thus, the premium rate for an individual life insurance policy is typically expressed as the rate per thousand per year. An annual premium amount for a policy is calculated by multiplying the premium rate by the number of coverage units.

Example:

The annual premium rate for a $500,000 life insurance policy is expressed as $4 per $1,000 of coverage.

Analysis:

The annual premium amount for the policy is $2,000, which is calculated as follows:

Premium Rate (Payment per Unit per Year)	×	**Number of Units** ($1,000 of Coverage)	=	**Annual Premium Amount** (Customer's Annual Payment)
$4	×	500, found as ($500,000 ÷ $1,000)	=	$2,000

LEARNING AID

Note that other factors, such as the application of policy fees and policy dividends, may affect the premium amount actually charged to a policyowner.

Actuaries consider many variables as they perform the calculations necessary to establish premium rates. In performing these calculations, actuaries seek to ensure that premium rates are

- **Adequate.** Adequate premium rates are high enough so that the insurer will have enough money to pay policy benefits as well as operating expenses. Because most insurance companies operate for a profit, their premium rates should be high enough to provide a reasonable profit as well.

- **Equitable.** Equitable premium rates ensure that each policyowner is charged a premium that reflects the degree of risk the insurer assumes in providing the coverage. Insureds who represent similar degrees of risk to the company should be charged similar rates.

- **Not excessive.** If an insurer's premium rates are too high, potential customers may instead purchase policies from competitors that offer lower premium rates. In addition, sales producers may prefer to represent other insurers that offer lower premium rates.

The three most important factors that actuaries consider in the calculation of life insurance premium rates are (1) the cost of benefits, (2) operating expenses, and (3) investment earnings.

Cost of Benefits

The ***cost of benefits***, sometimes known as the *cost of insurance*, is the value of all the contractually required benefits a product promises to pay. For a given life insurance product, the projected cost of benefits generally equals the sum of all the potential benefit payments under the product multiplied by the probability that each benefit will be payable. We can express the projected cost of a given benefit as follows:

Projected cost of a given benefit = Potential benefit amount payable × Probability that the benefit will be payable

The primary policy benefit payable by an insurer when an insured dies while the policy is in force is the ***death benefit***. Insurers determine the probability that death benefits will be payable in a given year by referring to mortality tables, which estimate the mortality rate for a given group of insureds.

The cost of benefits for a group of insureds depends in part on the mortality rate:

- In general, the higher the mortality rate for a group of insureds of the same age and sex, the higher the cost of benefits and, thus, the higher the premium rate.

- Conversely, the lower the mortality rate for a group of insureds of the same age and sex, the lower the cost of benefits and the lower the premium rate.

Because life expectancy and mortality rates vary widely from one country to another, insurers usually rely on mortality tables developed for use in a particular country. Figure 4.1 illustrates a portion of a mortality table.

Figure 4.1 Sample Mortality Table—Male

Age	Number Living	Number Dying	Mortality Rate per 1,000
59	100,000	1,100	11
60	98,900	1,200	12
61	97,700	1,300	13

The group of males age 59 begins the year with 100,000 members. During the year, 1,100 of the men are expected to die. The mortality rate during the year is 11 per 1,000, calculated by dividing the number dying at age 59 by the number living at age 59 at the beginning of the year.

$$1{,}100 \div 100{,}000 = 0.011$$

According to this mortality table, 11 out of every 1,000 men are expected to die after attaining age 59 but before attaining age 60.

We can check this number—the 1,100 dying during their 59th year—by subtracting it from 100,000, the number of men expected to be alive at the beginning of their 59th year. This calculation should give us the number of men expected to be alive at the beginning of their 60th year:

$$100{,}000 - 1{,}100 = 98{,}900$$

Most mortality tables are known as *sex-distinct mortality tables* because they contain separate statistics for males and females. In contrast, other mortality tables, known as *unisex mortality tables*, show a single set of mortality rates to be used for both males and females.

Mortality statistics show that, at nearly all ages, females have lower mortality rates than males of the same age. To reflect this difference, most insurers set lower life insurance premium rates for equivalent coverage for women than for men of the same age and underwriting risk. Figure 4.2 shows the differences in average life expectancies at birth by country and by sex, as of 2013.

Most mortality tables that insurers use to price products divide the mortality rates into two additional categories: tobacco users and tobacco nonusers. In other words, sex-distinct mortality tables often show mortality rates for four categories of people: male tobacco users, male tobacco nonusers, female tobacco users, and female tobacco nonusers. A mortality table that does *not* show separate mortality rates for tobacco users and tobacco nonusers is referred to as a *composite mortality table*. For the purpose of setting premium rates, mortality tables in some countries, such as the United States and Canada, are also divided into even more categories, such as preferred, standard, and substandard risk classifications.

Figure 4.2 Average Life Expectancy by Country, 2013

	Male Life Expectancy at Birth	Female Life Expectancy at Birth
Australia	80	85
Brazil	72	79
Canada	80	84
China	74	77
Indonesia	69	73
Japan	80	87
Mexico	73	78
Spain	80	86
United States	76	81

Source: From Global Health Observatory Data Repository: Life expectancy—Data by country. http://apps.who.int/gho/data/node.main.688?lang=en Chapter 4. Figure 4.2. displayed as a chart showing Male and Female Life expectancy at Birth for countries Australia, Brazil, Canada, China, Indonesia, Japan, Mexico, Spain, United States

Operating Expenses

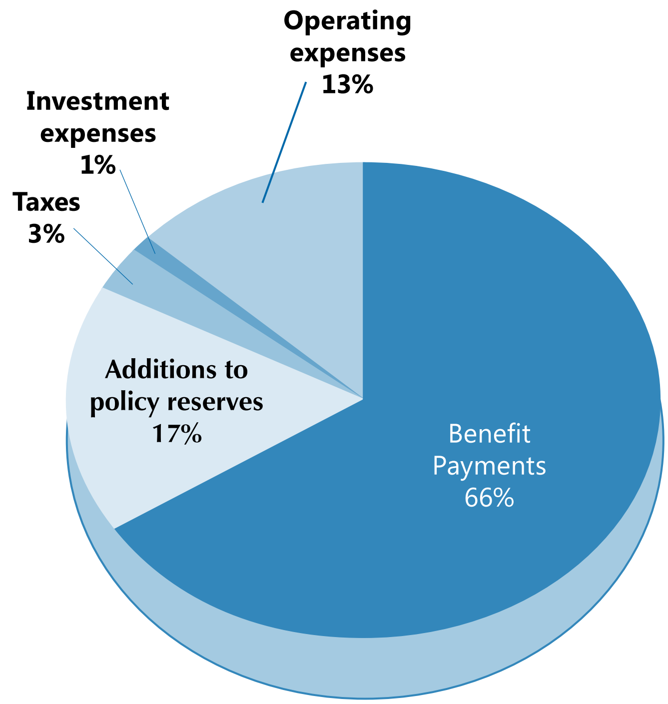
For life insurance companies, ***operating expenses*** are the costs of operations other than expenses for contractual benefits, or the cost of benefits. In setting a premium rate for a product, the insurer must estimate the expenses associated with developing the product, selling it, and supporting it over the years it is expected to remain in force. Examples of these expenses include

- Product development costs
- Distribution and promotion costs
- Payroll costs for staff, as well as employee benefit costs
- The costs of providing customer service to policyowners, such as producing and mailing account statements and answering customer service phone calls
- The costs associated with maintaining the company's offices and its computer systems

In general, insurers spend considerably more on benefit payments to customers than on their operating expenses. Figure 4.3 shows the typical portion of insurance company expenses that was attributable to paying benefits and the portion that was attributable to operating expenses.

A significant risk associated with an insurer's operating expenses is that customers will terminate or reduce the value of a life insurance policy before the policy becomes profitable. During the policy's early years, the insurer incurs substantial product expenses. Underwriting expenses and other expenses are incurred when an insurer issues a policy. For example, insurers often pay a substantial portion of a policy's initial premium as a commission to the producer who sold the policy. Thus, a policy generally must remain in force for several years for it to be profitable.

Figure 4.3 Distribution of U.S. Life Insurance Company Expenditures, 2014



Source: Adapted from ACLI, *Life Insurers Fact Book 2015*, Copyright © 2015 American Council of Life Insurers, Washington, DC, (November 2015, 19,) 50 https://www.acli.com/Tools/Industry%20Facts/Life%20Insurers%20Fact%20Book/Documents/FB15_All.pdf (15 February 2016). Used with permission.

An example of a situation in which an insurer may lose money on a product is when the product's actual *lapse rate* exceeds the rate built into the product's premium rate. The termination of an insurance policy for nonpayment of premium is known as a ***lapse***. Therefore, the ***lapse rate*** is the percentage of a specified group of policies in force at the beginning of a specified period, such as a year, that are terminated by the end of that period for reasons other than the death of the insured.

Example:

The Reliable Insurance Company had a block of 10,000 life insurance policies in force at the beginning of last year. During the year, 1,000 of the policies lapsed.

Analysis:

For last year, the actual lapse rate for this block of policies was 10%, found as follows:

1,000 lapses ÷ 10,000 policies in force = 10% lapse rate

If this 10% lapse rate exceeded the rate that Reliable's actuaries built into the product's premium rate, Reliable may have lost money on this product.

Investment Earnings

In setting a product's premium rate, an insurer must take into account ***investment earnings***—the money the insurer earns from investing the funds it receives from customers. Many life insurance policies remain in force for a number of years before benefits become payable. During that time, the funds paid for these policies are available for the insurer to invest. The earnings on these investments allow insurance companies to charge policyowners less than if companies relied solely on the premiums and charges that policyowners paid.

As financial intermediaries, insurance companies invest the funds received from customers in many different ways—in government and corporate bonds, mortgages, real estate, and corporate stock. In fact, insurance companies can place money in any safe investment that is likely to provide good earnings and is not prohibited by government regulation.

How Investments Create Earnings

Many investments earn money in the form of interest payments. ***Interest*** is a payment for the use of money. The rate of interest is expressed in terms of a percentage, such as 10 percent. The ***principal*** is the sum of money originally invested, loaned, or borrowed.

Simple interest is interest on the principal only. Consider an example of a simple-interest loan. In such a transaction, the lender is considered to be the investor. A 10 percent interest rate on a loan indicates that the borrower must pay the lender the amount originally borrowed, plus an additional 10 percent of that amount each year.

Example:

Casper O'Hare loaned Riley Nugent $1,000 for two years at an annual interest rate of 10%. Riley did not repay any of the principal or interest on the loan for two years.

Analysis:

At the end of one year, Riley owed Casper $1,100, calculated as

$1,000 principal + ($1,000 principal × 0.10)

At the end of two years, Riley owed Casper another $100 in interest, calculated as

$1,000 principal × 0.10 = $100

Therefore, at the end of the second year, Riley owed Casper a total of $1,200, calculated as

$1,100 + $100

Calculating interest on both the principal and the accrued interest is called ***compounding***, and the interest in this case is called ***compound interest***. Today, the interest on most loans and investments is compound interest. When interest is compounded, the interest earned each investment period is equal to the accumulated balance at the beginning of the period multiplied by the interest rate. The amount of interest earned that period is then added to the accumulated balance to determine the beginning balance on which interest will be paid during the next period. In this way, interest is earned on both the original principal and on all accumulated interest.

Example:

Olivia Sandoval loaned Shu-Ling Lee $1,000 at an interest rate of 10%, compounded annually. Shu-Ling did not repay any of the principal or interest on the loan for two years.

Analysis:

At the end of the first year, Shu-Ling owed Olivia $1,100, calculated as

$1,000 principal + ($1,000 principal × 0.10)

At the end of the second year, Shu-Ling owed Olivia $110 in interest, calculated as

($1,100 accumulated balance) × 0.10

Therefore, at the end of the second year, Shu-Ling owed Olivia a total of $1,210, calculated as

$1,100 + $110

The interest in this example was compounded annually. However, interest can be compounded with any frequency—quarterly, monthly, or daily, for example.

Although the additional $10 earned by compounding interest in the previous example may seem small, over a long period of time, compounding interest has a dramatic effect on the total amount of interest that is earned.

Example:

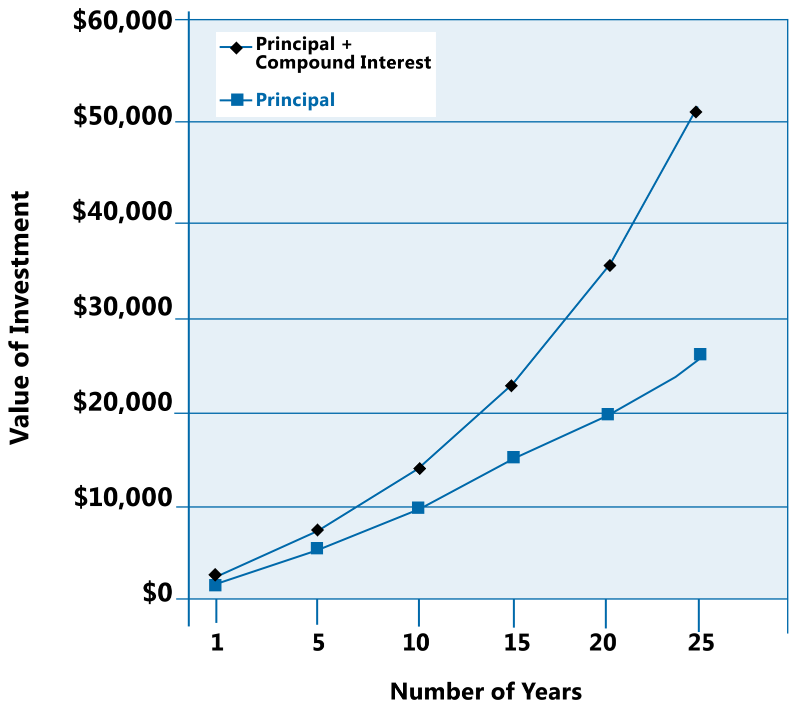
Kalinda Patel deposited $1,000 in a bank account that pays 5% simple interest. She made no other deposits for the next 25 years.

Analysis:

After 25 years, Kalinda's account earned $1,250 in simple interest ($50 × 25). Had her account paid compound rather than simple interest, she would have earned a total of $2,386 in compound interest at the end of the 25-year period.

The example of the bank account shows how much money a single amount can earn over time. Many insurance policies require annual premium payments, which usually allow the insurer to invest an additional amount from premiums every year the policy remains in effect. Figure 4.4 shows the amount of money that can be earned over various periods of time by investing $1,000 a year at 5 percent interest, compounded annually.

Figure 4.4 Value of $1,000 Annual Investment at 5% Interest, Compounded Annually



Value of Investment							
1 year	Principal	$1,000	Interest	$50	Total	$1,050
5 years	Principal	$5,000	Interest	$802	Total	$5,802
10 years	Principal	$10,000	Interest	$3,207	Total	$13,207
15 years	Principal	$15,000	Interest	$7,657	Total	$22,657
20 years	Principal	$20,000	Interest	$14,719	Total	$34,719
25 years	Principal	$25,000	Interest	$25,113	Total	$50,113

For the sake of simplicity, we illustrated investment earnings in terms of an interest rate earned on a loan and on a bank account. However, companies can receive investment earnings from many other types of investments. For example, insurance companies invest money by buying stock in other companies. While an insurance company owns the stock, the company may collect dividend payments on that stock. In addition, the insurer might be able to sell the stock for more than it paid. In both instances, the insurer's investment earnings can be expressed as a ***rate of return***, which is the investment earnings expressed as a percentage of the principal.

Example:

Reliable Insurance Company purchased stock in the Mimosa Corporation for $100,000. One year later, Reliable sold the Mimosa stock for $120,000.

Analysis:

Reliable earned a return of $20,000 on its investment ($120,000 - $100,000). The percentage rate of return on the investment was 20% ($20,000 return ÷ $100,000 = 0.20 or 20%).

Financial Models

Actuaries need to be able to establish premium rates for products that will satisfy the company's objectives over the many years that the products are expected to be in force. Product outcomes can vary, however, based on economic conditions, the insurer's claim experience, policy terminations, and other factors. Companies can evaluate the potential effects of various future conditions on a product's financial values by using financial models. In general, a ***financial model*** is a computer-based mathematical model that approximates the operation of real-world financial processes. Companies use product development software that simulates the potential financial processes likely to occur over the time that a product is expected to remain in force.

Examples of financial values that insurers use in modeling are values for interest rates, mortality rates, expenses, and lapses. A typical financial model runs hundreds or even thousands of scenarios, with each scenario representing a different set of financial values that the product is likely to experience.

Insurers build into their financial models the risk that they will face unexpected outcomes. One way they do this is by using projections that are designed to be more than adequate; such projections are said to be *conservative*.

Conservative values for specific life insurance product elements generally take the form of

- Mortality rates that are higher than expected
- Investment earnings that are lower than expected
- Operating expenses that are higher than expected

Example:

An insurer may project mortality rates that are 10% higher than expected to ensure that the premium rate for a product will be more than adequate.

In calculating premium rates, actuaries use conservative values to provide a buffer against adverse product results.

LEARNING AID

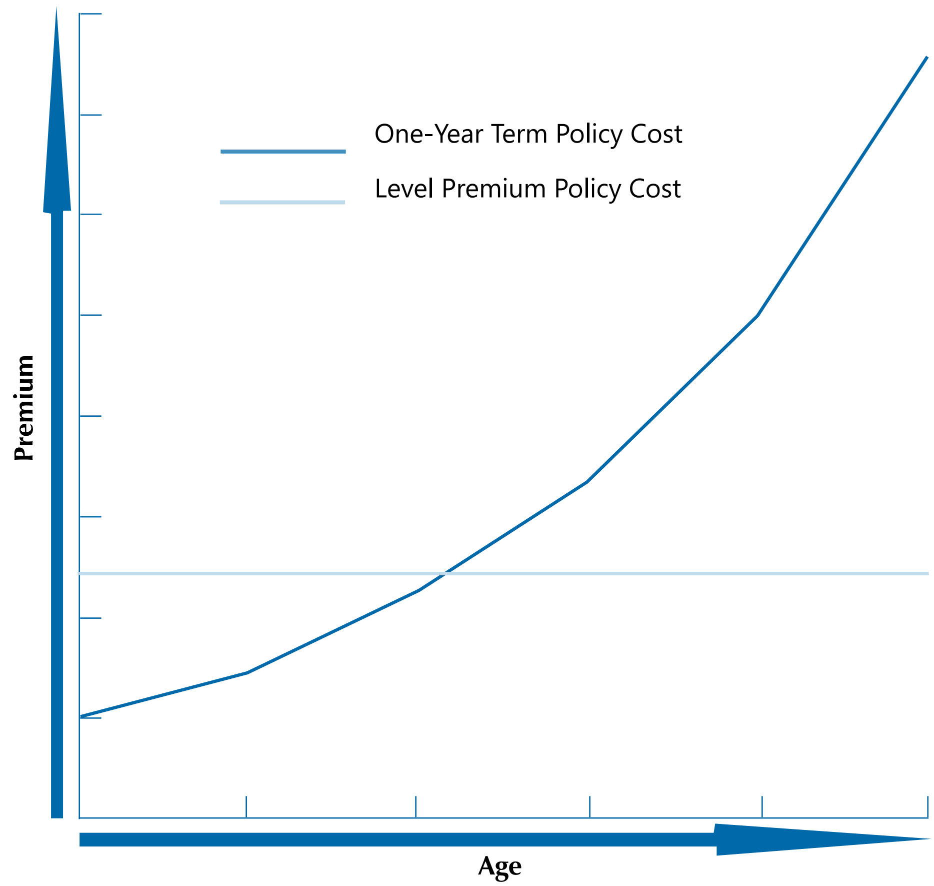
The Level Premium System

If insurers always charged policyowners the amount it cost to provide coverage at the insured's current age, the mortality expense would be low when the insured was young and increase as the insured grew older. Most people would not be able to afford the cost of insurance in their later years when mortality rates and expenses are high. Therefore, insurers developed the ***level premium system***, which is a life insurance premium system that allows a policyowner to pay the same premium amount each year a policy is in force. Insurers use the level premium system to price many types of cash value life insurance, term life insurance that provides coverage for more than one year, and endowment insurance.

Level premiums are possible because, in the early policy years, premium rates for level premium policies are higher than needed to pay claims and expenses. Relatively few insureds will die during those early policy years, and few claims will be payable. The insurer can invest the premium dollars that are not needed to pay claims and expenses in those years.

As people insured under a block of level premium policies grow older, the insurer expects to receive an increasing number of death claims each year. Under a level premium system, the insurer uses premium dollars from the early policy years, plus the investment earnings, to help pay the increased number of death claims in the later years. Thus, the premium rate on any of these policies can remain level throughout the duration of the policy. Figure 4.5 illustrates the difference between the premiums required for a level premium policy and those required for a series of similar one-year term life policies. We discuss term life insurance in Chapter 5.

Figure 4.5 Level Premiums Contrasted with One-Year Term Life Premiums



Key Terms

actuary
legal reserve system
policy reserves
block of policies
premium rate
cost of benefits
death benefit
operating expenses
lapse
lapse rate
investment earnings
interest
principal
simple interest
compounding
compound interest
rate of return
financial model
level premium system

Glossary

401(k) plan. A type of qualified retirement plan that employers establish for the benefit of employees and that allows both employers and employees to make specified contributions to the plan that reduce current taxable income. [14]

403(b) plan. A tax-advantaged retirement plan available only to tax-exempt organizations established for religious, charitable, and educational purposes and public schools. [14]

457(b) plan. A deferred compensation plan established by a state or local government or a tax-exempt organization. [14]

absolute assignment. An irrevocable assignment of a life insurance policy under which a policyowner transfers all of his policy ownership rights to the assignee. *Contrast with* **collateral assignment**. [9]

ACA. *See* **Patient Protection and Affordable Care Act.**

accelerated death benefit. A supplemental life insurance policy benefit that typically provides that a policyowner may elect to receive all or part of the policy's death benefit before the insured's death, if certain conditions are met. Also known as a *living benefit.* [7]

acceptance. The offeree's unqualified agreement to be bound to the terms of the offer. [3]

accidental death and dismemberment (AD&D) benefit. A supplemental life insurance policy benefit that provides an accidental death benefit and also provides a dismemberment benefit payable if an accident causes the insured to lose any two limbs or sight in both eyes. [7]

accidental death benefit. A supplemental life insurance policy benefit that requires the insurer to pay a specified amount of money in addition to the policy's basic death benefit if the insured dies as a result of an accident. [7]

account value. *See* **accumulated value.**

accumulated value. For a deferred annuity, the amount paid for the annuity, plus the interest earned, minus the amount of any withdrawals and fees. Also known as the *accumulation value*, *contract value*, or *account value*. [10]

accumulation at interest dividend option. A policy dividend option under which the policy dividends are left on deposit with the insurer to accumulate at interest. Sometimes called *dividends on deposit option*. [9]

accumulation period. The period between the contract owner's purchase of a deferred annuity and either the date when the annuity's payout period begins or the date when the annuity is terminated. [10]

accumulation unit. An ownership share in a selected subaccount held during the accumulation period of a variable deferred annuity. [10]

accumulation value. *See* **accumulated value.**

actively-at-work provision. A group insurance policy provision that states that, to be eligible for coverage, an employee must be actively at work—rather than ill or on leave—on the day the insurance coverage is to take effect. [13]

activities of daily living (ADLs). Activities used to measure a person's functional status, such as eating, bathing, dressing, continence, toileting, and transferring into or out of a bed, chair, or wheelchair. *Contrast with* **instrumental activities of daily living**. [12]

actuary. An expert in financial risk management and the mathematics and modeling of insurance, annuities, and financial instruments. [4]

AD&D benefit. *See* **accidental death and dismemberment benefit.**

additional insured rider. *See* **second insured rider.**

additional term insurance dividend option. A policy dividend option under which the insurer uses each policy dividend to purchase one-year term insurance on the insured's life. [9]

ADLs. *See* **activities of daily living.**

advanced life deferred annuity. *See* **longevity annuity.**

adverse selection. *See* **antiselection.**

Affordable Care Act. *See* **Patient Protection and Affordable Care Act.**

aleatory contract. A contract in which one party provides something of value to another party in exchange for a conditional promise. *Contrast with* **commutative contract**. [3]

annually renewable term insurance. *See* **yearly renewable term insurance.**

Annual Statement. An accounting statement that every U.S. insurer prepares each calendar year and files with the insurance department in each state in which it operates. [2]

annuitant. The person whose lifetime the insurer uses to determine the amount and duration of annuity payments under an annuity contract. [10]

annuity. A series of periodic payments. [10]

annuity benefit payments. *See* **annuity payments.**

annuity certain. *See* **fixed period annuity.**

annuity commencement date. *See* **annuity start date.**

annuity contract. A contract under which an insurer promises to make a series of periodic payments to a named individual in exchange for a premium or series of premiums. [1]

annuity income payments. *See* **annuity payments.**

annuity options. The choices a contract owner has as to how the insurer will distribute the annuity payments. Also known as *payout options*. [11]

annuity payments. The monthly, quarterly, semiannual, or yearly payments that the insurer promises to make under an annuity contract. Also known as *annuity benefit payments*, *annuity income payments*, and *periodic income payments*. [10]

annuity period. For an annuity, the time span between each of the annuity payments. [10]

annuity start date. The date when the insurer is required to begin making annuity payments under the contract. Also known as the *annuity commencement date*, *income date*, or *maturity date*. [10]

annuity unit. A share in an insurer's subaccount that is used in the calculation of variable annuity payments. [11]

antiselection. The tendency of individuals who believe they have a greater-than-average likelihood of loss to seek insurance protection to a greater extent than do other individuals. Also known as *adverse selection* or *selection against the insurer*. [1]

APL option. *See* **automatic premium loan option.**

applicant. The person or business that applies for an insurance policy. [1]

assets. Items of value, such as cash, buildings, and investments, that a company owns. [2]

assignee. The party to whom life insurance property rights are transferred. [9]

assignment. An agreement under which the policyowner transfers some or all of his ownership rights in a life insurance policy to another party. [9]

assignment provision. A life insurance policy provision that describes the roles of the insurer and the policyowner when the policy is assigned. [9]

assignor. The policyowner who makes an assignment of a life insurance policy. [9]

assuming company. *See* **reinsurer.**

attained age. The age the insured has reached (attained) on a specified date. [5]

attained age conversion. A conversion of a term life insurance policy to a cash value insurance policy in which the premium rate for the cash value policy is based on the insured's age at the time the policy is converted. [5]

automatic dividend option. A specified policy dividend option that the insurer will apply if the owner of a participating policy does not choose an option. [9]

automatic nonforfeiture benefit. A specific nonforfeiture benefit that becomes effective automatically when a renewal premium for a cash value life insurance policy is not paid by the end of the grace period *and* the policyowner has not elected another nonforfeiture option. [8]

automatic premium loan (APL) option. A cash value life insurance policy nonforfeiture option under which the insurer will automatically pay an overdue premium for the policyowner by making a loan against the policy's cash value as long as the cash value equals or exceeds the amount of the premium due. [8]

bargaining contract. A contract in which both parties, as equals, set the terms and conditions of the contract. *Contrast with* **contract of adhesion**. [3]

basic medical expense coverage. Medical expense insurance coverage that provides separate benefits for each type of covered medical care cost: hospital expenses, surgical expenses, and physicians' expenses. [12]

beneficiary. (1) For a life insurance policy, the person or party the policyowner names to receive the policy benefit. [1] (2) For an annuity, the person or legal entity who may receive benefits accrued or values remaining in an annuity contract upon the death of the contract owner or annuitant. [10]

benefit formula. A formula that describes the calculation of a plan's financial obligation to participants in a retirement plan. [14]

benefit period. In a disability income insurance policy, the time period during which the insurer agrees to pay income benefits to the insured. [12]

benefit schedule. A schedule included in group life insurance policies to define the amount of life insurance the policy provides for each group insured. [13]

benefit trigger. A long-term care insurance policy feature specifying the conditions that establish an insured's eligibility to receive long-term care benefits. [12]

benefit waiting period. *See* **elimination period.**

bilateral contract. A contract in which both parties make legally enforceable promises when they enter into the contract. *Contrast with* **unilateral contract**. [3]

blended rating. A method of setting group insurance premium rates in which the insurer uses a combination of manual rating and experience rating. *Contrast with* **manual rating** and **experience rating**. [13]

block of policies. A group of policies issued to insureds who are all the same age, the same sex, and in the same risk classification. [4]

business continuation insurance plan. An insurance plan designed to ensure the continued financial viability of a business when faced with the death or disability of the business owner or other key person. [5]

buy-sell agreement. An agreement in which (1) one party agrees to purchase the financial interest that a second party has in a business following the second party's death, and (2) the second party agrees to direct his estate to sell his interest in the business to the purchasing party. [5]

calendar-year deductible. In medical expense insurance, a deductible that applies to the total of all allowable expenses an insured incurs during a given calendar year. [12]

capital. The amount of money that a company's owners have invested in the company, usually through the purchase of company stock. [2]

cash dividend option. A policy dividend option under which the insurance company sends the policyowner a check in the amount of the policy dividend that was declared. [9]

cash payment nonforfeiture option. A cash value life insurance policy nonforfeiture option under which the policyowner discontinues premium payments, surrenders the policy, and receives the policy's cash surrender value in a lump-sum payment. [8]

cash surrender value. The amount that a policyowner is entitled to receive upon surrendering a cash value life insurance policy, before adjustments for factors such as policy loans and applicable charges. Also known as the *surrender value* or the *surrender benefit*. [6]

cash value. The savings element of a cash value life insurance policy. [1]

cash value life insurance. Life insurance that provides coverage throughout the insured's lifetime and also provides a savings element, known as the cash value. Also known as *permanent life insurance*. *Contrast with* **term life insurance**. [1]

CDHP. *See* **consumer-driven health plan.**

ceding company. *See* **direct writer.**

certificate holder. An individual who is insured under a group insurance plan and who has received a certificate of insurance. [13]

certificate of authority. A document that grants an insurer the right to conduct an insurance business and sell insurance products in the jurisdiction that grants the certificate. Also known as a *license*. [2]

certificate of insurance. A document that is provided to each person insured by a group insurance plan that describes (1) the coverage that the master group insurance contract provides and (2) the group insured's rights under the contract. [13]

children's insurance rider. A supplemental life insurance policy benefit that provides term life insurance coverage on the insured's children. [7]

claim. A request for payment under the terms of an insurance policy. [1]

class designation. A life insurance beneficiary designation that identifies a certain group of people rather than naming each person individually. [9]

closed contract. A contract for which only those terms and conditions that are printed in—or attached to—the contract are considered to be part of the contract. *Contrast with* **open contract**. [8]

cognitive impairment. A reduction in a person's ability to think, reason, or remember. *Contrast with* **physical impairment**. [12]

coinsurance. In medical expense insurance, an expense participation requirement in which the insured must pay a specified percentage of all allowable expenses that remain after he has paid the deductible. [12]

COLA benefit. *See* **cost-of-living-adjustment benefit.**

collateral assignment. A temporary assignment of the monetary value of a life insurance policy as collateral—or security—for a loan. *Contrast with* **absolute assignment**. [9]

commutative contract. A contract in which the parties specify in advance the values that they will exchange, and the parties generally exchange items or services that they think are of relatively equal value. *Contrast with* **aleatory contract**. [3]

compounding. Calculating interest on both the principal and the accrued interest. [4]

compound interest. Interest on both the principal and accrued interest. *Contrast with* **simple interest**. [4]

conditional promise. A promise to perform a stated act if a specified, uncertain event occurs. [3]

consideration. A requirement for the formation of a valid informal contract that is met when each party gives or promises something that is of value to the other party. [3]

consolidation. In the financial services industry, typically refers to the combination of financial institutions within or across sectors. [2]

consumer-driven health plan (CDHP). An employer-sponsored health benefit plan that gives individuals the freedom to choose health care providers and benefits, but also requires them to assume the financial risk for their choices. [12]

contingent beneficiary. The party named to receive the policy proceeds only if all designated primary beneficiaries have predeceased the insured. Also called a *secondary beneficiary* or *successor beneficiary*. [9]

contingent deferred sales charge. *See* **surrender charge.**

contingent payee. For a life insurance policy, the person or party who will receive any proceeds still payable at the time of the payee's death. Also known as the *successor payee*. [9]

continuous-premium whole life insurance policy. A whole life insurance policy under which premiums are payable until the death of the insured. Also called a *straight life insurance policy* or *ordinary life insurance policy*. [6]

contract. A legally enforceable agreement between two or more parties. [3]

contract fee. For fixed deferred annuities, a periodic charge that an insurer assesses to cover the general expenses of administering the contract, such as the preparation of account statements. [11]

contract maintenance fee. For variable deferred annuities, a periodic charge that an insurer assesses to cover the general expenses of administering the contract, such as the preparation of account statements. [11]

contract of adhesion. A contract that one party prepares and that the other party must accept or reject as a whole, generally without any bargaining between the parties to the agreement. *Contrast with* **bargaining contract**. [3]

contract of indemnity. An insurance policy under which the amount of the policy benefit payable for a covered loss is based on the actual amount of the financial loss that results from the covered event, as determined at the time of the event. [1]

contract owner. The person or other entity who owns and exercises all the rights and privileges of an annuity contract. [10]

contract value. *See* **accumulated value.**

contractual capacity. The legal capacity to make a contract. [3]

contractual reserves. *See* **policy reserves.**

contributory plan. A group insurance plan in which group members are required to pay part or all of the premium for their coverage. *Contrast with* **noncontributory plan**. [13]

convergence. A movement toward a single financial institution being able to serve a customer's banking, insurance, and securities needs. [2]

conversion privilege. (1) For individual life insurance, a term life insurance provision that gives the policyowner the option to change—or convert—the term insurance policy to a cash value policy without providing evidence of insurability. [5] (2) In group life insurance, a policy provision that allows a group insured whose coverage terminates for certain reasons to convert her group life insurance coverage to an individual life insurance policy, usually without presenting evidence of insurability. [14]

convertible term insurance policy. A term insurance policy that gives the policyowner the option to convert the term policy to a cash value life insurance policy without providing evidence of insurability. [5]

cooling-off provision. *See* **free-look provision.**

copayment. In managed care plans, a specified, fixed amount that a plan member must pay to a network provider for certain medical services at the time the services are received. [12]

corporation. A legal entity that is created by the authority of a governmental unit, through a process known as *incorporation*, and that is separate and distinct from its owners. [2]

cost of benefits. The value of all the contractually required benefits a product promises to pay. Sometimes known as the *cost of insurance*. [4]

cost of insurance. *See* **cost of benefits.**

cost-of-living-adjustment (COLA) benefit. In disability income insurance policies, a benefit that provides for periodic increases in the disability income benefit amount that the insurer will pay to a disabled insured. [12]

credit life insurance. A type of term life insurance designed to pay the balance due on a loan other than a mortgage if the borrower dies before the loan is repaid. [5]

critical illness benefit. *See* **dread disease (DD) benefit.**

current interest-crediting rate. (1) For universal life (UL) insurance policies, the rate of interest that an insurer declares and pays on the policy's cash value for a specified period of time. [6] (2) For fixed deferred annuities, the rate of interest that an insurer declares and pays on the annuity's accumulated value for a specified period of time. [10]

DD benefit. *See* **dread disease benefit.**

death benefit. (1) For a life insurance policy, the primary policy benefit payable by an insurer when an insured dies while the policy is in force. [4] (2) For a deferred annuity, an amount of money payable to a beneficiary designated by the contract owner if the contract owner or annuitant (depending on the contract) dies before the annuity payments begin. Also known as a *survivor benefit*. [10]

declined risk. A proposed insured who presents a risk that is too great for the insurer to cover. [1]

decreasing term life insurance. Term life insurance that provides a death benefit that decreases in amount over the policy term. [5]

deductible. In medical expense insurance, a flat dollar amount of eligible medical expenses that an insured must pay before the insurer begins making any benefit payments under the policy. [12]

deferred annuity. An annuity under which the annuity payments are postponed for at least one year after the annuity is purchased. *Contrast with* **immediate annuity**. [10]

deferred income annuity (DIA). A fixed annuity that an individual typically buys in the years nearing retirement that locks in a guaranteed stream of income when it is purchased, although the annuity payments do not begin until a specified future date. [10]

defined benefit formula. A retirement plan benefit formula that specifies the amount of the retirement benefit a plan sponsor agrees to provide to each plan participant. *Contrast with* **defined contribution formula**. [14]

defined benefit pension plan. A type of qualified retirement plan that provides plan participants with a lifetime monthly income benefit at retirement. [14]

defined benefit plan. A retirement plan that specifies the amount of the benefit that each plan participant will receive at retirement. *Contrast with* **defined contribution plan**. [14]

defined contribution formula. A retirement plan benefit formula that specifies the contributions that the plan sponsor agrees to make to the plan. *Contrast with* **defined benefit formula**. [14]

defined contribution plan. A retirement plan that describes the annual contribution that the plan sponsor will deposit into the plan on behalf of each plan participant. *Contrast with* **defined benefit plan**. [14]

dental expense coverage. A type of medical expense coverage that provides benefits for routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the tooth and jaw. [12]

DIA. *See* **deferred income annuity.**

director of insurance. *See* **insurance commissioner.**

direct writer. In a reinsurance transaction, the insurance company that purchases reinsurance to transfer all or part of the risks on insurance policies the company issued. Also known as a *ceding company*. *Contrast with* **reinsurer**. [1]

disability buyout coverage. A type of disability income insurance coverage that provides benefits designed to fund the buyout of a partner's or owner's interest in a business should he become disabled. [12]

disability income benefit. A supplemental life insurance policy benefit that provides a monthly income benefit to the insured if she becomes totally disabled while the policy is in force. [7]

disability income coverage. A type of health insurance coverage that provides income replacement benefits if an insured is unable to work because of illness or injury. [1]

distribution period. *See* **payout period.**

dividend options. Specified methods by which the owner of a participating life insurance policy or the contract owner of a participating annuity may receive dividends. [9, 10]

dividends on deposit option. *See* **accumulation at interest dividend option.**

divisible surplus. A portion of an insurance company's surplus set aside specifically for distribution to owners of participating policies. [9]

Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank). A U.S. federal law designed to (1) promote the financial stability of the United States by improving accountability and transparency in the financial system and (2) protect consumers from abusive financial services practices. [2]

Dodd-Frank. *See* **Dodd-Frank Wall Street Reform and Consumer Protection Act.**

domicile. The jurisdiction in which a company incorporates. [2]

dread disease (DD) benefit. An accelerated death benefit under which the insurer agrees to pay a portion of the policy's death benefit to the policyowner if the insured suffers from one of a number of specified diseases. Also known as a *critical illness benefit*. [7]

eligibility period. In contributory group insurance plans, the period of time—usually 31 days—during which a new group member may first enroll for contributory group insurance coverage without providing evidence of insurability. Also called the *enrollment period*. [13]

elimination period. (1) In a disability income insurance policy, the specific amount of time that the insured must be disabled before becoming eligible to receive policy benefits. Also known as a *waiting period* or a *benefit waiting period*. [12] (2) In a long-term care insurance policy, the number of days that the insured must receive care before becoming eligible to receive benefits. [12]

Employee Retirement Income Security Act (ERISA). A U.S. federal law designed to protect covered employees and their beneficiaries by ensuring that employee benefit plans, such as retirement plans, meet specified requirements. [14]

employee stock ownership plan (ESOP). A type of qualified retirement plan in which employer contributions are invested primarily in the employer's stock. [14]

endorsement. *See* **policy rider.**

endowment insurance. Life insurance that provides a policy benefit payable either when the insured dies or on a stated date if the insured is still alive on that date. [1]

enrollment period. *See* **eligibility period.**

entire contract provision. An insurance policy or annuity contract provision that defines the documents that constitute the contract between the insurance company and the policyowner or contract owner. [8, 10]

equity indexed universal life insurance. *See* **indexed universal life insurance.**

ERISA. *See* **Employee Retirement Income Security Act.**

ESOP. *See* **employee stock ownership plan.**

estate. The accumulated assets that an individual owns when he dies. [5]

estate plan. A plan that considers the amount of assets and debts that a person is likely to have when he dies and how best to preserve those assets so that they can be distributed as he desires. [5]

evidence of insurability. Proof that a given person is an insurable risk. [5]

exchange. *See* **health insurance exchange.**

exclusion. An insurance policy provision that describes circumstances under which the insurer will not pay the policy benefit following an otherwise covered loss. [8]

experience rating. A method of setting group insurance premium rates in which the insurer considers the particular group's prior claims and expense experience. *Contrast with* **manual rating** and **blended rating**. [13]

extended term insurance nonforfeiture option. A cash value life insurance policy nonforfeiture option under which the policyowner discontinues paying premiums and uses the policy's net cash surrender value as a net single premium to purchase term insurance for the full coverage amount provided under the original policy, for as long a term as the net cash surrender value can provide. [8]

face amount. The amount of life insurance policy benefits for which an individual applies and that the insurer approves. [5]

family income coverage. A plan of decreasing term life insurance that pays the beneficiary a stated monthly income benefit amount if the insured dies during the policy term. [5]

family income policy. A cash value life insurance policy with a decreasing term insurance benefit that usually pays the death benefit as a lump sum when the insured dies and provides a stated monthly income benefit amount for a predetermined period to the insured's beneficiary—typically the surviving spouse. [5]

family insurance rider. *See* **spouse and children's insurance rider.**

family policy. A whole life insurance policy that includes term life insurance coverage on the primary insured's spouse and children. [6]

Federal Insurance Office (FIO). Created by Dodd-Frank, a U.S. federal agency authorized to monitor the insurance industry, identify areas with inadequate state regulation, and handle international insurance issues. [2]

federal system. A system of government in which a federal government and a number of lower-level governments share governmental powers. [2]

FIA. *See* **fixed indexed annuity.**

financial institution. A business that owns primarily financial assets, such as stocks and bonds, rather than fixed assets, such as equipment and raw materials. [2]

financial intermediary. An organization that collects funds from one group of people, businesses, and governments, known as *suppliers*, and channels them to another group, known as *users*. [2]

financial model. A computer-based mathematical model that approximates the operation of real-world financial processes. [4]

financial services industry. The industry that offers financial products and services to help individuals, businesses, and governments meet their financial goals of protecting against financial losses, accumulating and investing money and other assets, and managing debt and payments. [2]

Financial Stability Oversight Council (FSOC). Created by Dodd-Frank, a U.S. independent agency responsible for monitoring the safety and stability of the nation's financial system, identifying threats to the system, and coordinating regulatory responses to any such threats. [2]

FIO. *See* **Federal Insurance Office.**

first beneficiary. *See* **primary beneficiary.**

first-dollar coverage. Medical expense coverage under which the insurer begins to reimburse the insured for eligible medical expenses without first requiring an out-of-pocket contribution from the insured. [12]

first-to-die life insurance. *See* **joint whole life insurance.**

fixed account. For variable annuities, an account that guarantees payment of a fixed rate of interest for a specified period of time. [10]

fixed amount annuity. An annuity option in which the insurer provides annuity payments of a specified amount. *Contrast with* **fixed period annuity**. [11]

fixed amount option. A life insurance policy settlement option under which the insurance company pays equal installments of a stated amount until the policy proceeds, plus the interest earned, are exhausted. [9]

fixed annuity. An annuity contract under which the insurer guarantees (1) the minimum interest rate that it will apply to any accumulated value and (2) the minimum amount of the annuity payments that it will make. *Contrast with* **variable annuity**. [10]

fixed indexed annuity (FIA). A fixed deferred annuity that offers principal and interest rate guarantees as well as the possibility of additional earnings based on changes in an index. Also known as an *indexed annuity*. [10]

fixed period annuity. An annuity option in which the insurer provides annuity payments for a specified period of time. Also known as a *period certain annuity* or *annuity certain*. *Contrast with* **fixed amount annuity**. [11]

fixed period option. A life insurance policy settlement option under which the insurance company agrees to pay policy proceeds in equal installments to the payee for a specified period of time. [9]

fixed-premium universal life insurance policy. A universal life insurance policy that requires a series of scheduled premium payments of a specified amount for a specified length of time (typically 8 to 10 years) or until the insured's death, whichever comes first. [6]

flexible-premium annuity. An annuity that allows the contract owner to make additional premium payments after the contract is purchased. *Contrast with* **single-premium annuity**. [10]

flexible-premium variable life insurance. *See* **variable universal life (VUL) insurance.**

flexible-premium universal life insurance policy. A universal life insurance policy that allows the policyowner to alter the amount and frequency of premium payments, within specified limits. [6]

formal contract. A written contract that is enforceable because the parties met certain formalities concerning the form of the agreement. *Contrast with* **informal contract**. [3]

fraternal benefit society. A nonprofit organization that is operated solely for the benefit of its members and that provides social, as well as insurance, benefits to its members. Also known as a *fraternal insurer*. [2]

fraternal insurer. *See* **fraternal benefit society.**

fraudulent misrepresentation. A misrepresentation that was made with the intent to induce another party to enter into a contract that results in the giving up of something of value or a legal right and that did induce the innocent party to enter the contract. [8]

free-examination provision. *See* **free-look provision.**

free-look provision. An insurance policy or annuity contract provision that gives the policyowner or contract owner a stated period of time—usually at least 10 days—after the policy is delivered within which to cancel the policy. For an insurance policy, the policyowner receives a refund, and for an annuity contract, the contract owner receives a refund of the premiums paid or the contract's accumulated value. Also called a *free-examination provision* or *cooling-off provision*. [8, 10]

front-end load. For deferred annuities, a charge that an insurer imposes when a contract owner pays an initial premium and any additional premiums to help cover the costs of selling the annuity. [11]

FSOC. *See* **Financial Stability Oversight Council.**

fund operating expense charge. For variable deferred annuities, an annual charge that each investment fund underlying a subaccount assesses to cover the advisory and administrative expenses of the fund. [11]

funding instrument. *See* **funding vehicle.**

funding vehicle. An arrangement for investing a retirement plan's assets as the assets are accumulated. Also known as an *investment vehicle* or a *funding instrument*. [14]

future purchase option benefit. In certain disability income policies that specify a flat benefit amount, an option that grants the insured the right to increase the benefit amount in accordance with increases in the insured's earnings. [12]

general account. An asset account in which an insurer maintains funds that support its contractual obligations to pay benefits under its guaranteed insurance products, such as whole life insurance, fixed annuities, and other nonvariable products. [6]

GI benefit. *See* **guaranteed insurability benefit.**

GLBs. *See* **guaranteed living benefit riders.**

GLWB. *See* **guaranteed lifetime withdrawal benefit.**

GMAB. *See* **guaranteed minimum accumulation benefit.**

GMDB. *See* **guaranteed minimum death benefit rider.**

GMIB. *See* **guaranteed minimum income benefit.**

GMWB. *See* **guaranteed minimum withdrawal benefit.**

grace period. A specified time (often 31 days) following each premium due date during which the contract remains in effect regardless of whether the premium is paid. [8]

grace period provision. An insurance policy provision that specifies a length of time following each renewal premium due date within which the premium may be paid without loss of coverage. [8]

group annuity. In a retirement plan, an annuity that is purchased by a plan sponsor to provide annuity payments to plan participants at retirement. *Contrast with* **individual annuity**. [10]

group creditor life insurance. Group life insurance issued to a creditor, such as a bank, to insure the lives of the creditor's current and future debtors. [14]

group insurance. A method of providing life or health insurance coverage for a group of people under one contract. [13]

group insurance policy. A policy that insures the lives or health of a specific group of people, such as a group of employees. [1]

group insured. In most jurisdictions, an individual covered by a group insurance policy. Also known simply as the *insured*. [13]

group policyholder. The person or organization that decides what types of group insurance coverage to purchase for a specific group, negotiates the terms of the group insurance contract, and purchases the group insurance coverage. [3]

guaranteed insurability (GI) benefit. A supplemental life insurance policy benefit that gives the policyowner the right to purchase additional insurance of the same type as the basic life insurance policy—for an additional premium amount—on specified option dates (typically every three years) during the life of the policy without supplying evidence of the insured's insurability. Also known as a *guaranteed insurability option*. [7]

guaranteed insurability option. *See* **guaranteed insurability (GI) benefit.**

guaranteed lifetime withdrawal benefit (GLWB). A guaranteed living benefit rider that allows the contract owner to take withdrawals for life without annuitizing the contract, even if the accumulated value is completely depleted. [11]

guaranteed living benefit riders (GLBs). For many variable annuities and some fixed indexed annuities, riders that offer contract owners protection from downturns in the market by guaranteeing certain income, withdrawal, or accumulation amounts. [11]

guaranteed minimum accumulation benefit (GMAB). A guaranteed living benefit rider that offers the contract owner a minimum protected amount if the annuity stays in force for a specified period of time, regardless of the investment performance of the accumulated value. [11]

guaranteed minimum death benefit rider (GMDB). A variable deferred annuity rider that guarantees that, if the annuitant dies before the annuity payments begin, the beneficiary will receive a stated minimum amount, regardless of the contract's accumulated value at the time. [11]

guaranteed minimum income benefit (GMIB). A guaranteed living benefit rider that offers a lifetime minimum annuity payment amount when the benefit base is annuitized, regardless of the investment performance of the accumulated value. [11]

guaranteed minimum interest-crediting rate. (1) For universal life (UL) insurance policies, the minimum interest rate that an insurer must pay on the policy's cash value. [6] (2) For fixed deferred annuities, the minimum interest rate that an insurer must pay on the annuity's accumulated value. [10]

guaranteed minimum withdrawal benefit (GMWB). A guaranteed living benefit rider that allows the contract owner to withdraw a specified percentage of the benefit base annually—but not for life—regardless of the investment performance of the accumulated value. [11]

HCFSA. *See* **health care flexible spending account.**

HDHP. *See* **high-deductible health plan.**

health care flexible spending account (HCFSA). An employer-sponsored health plan that allows employees to set aside a predetermined amount of their pre-tax wages to pay for qualified medical expenses. [12]

health insurance. Insurance that provides protection against the risk of financial loss resulting from illness, injury, or disability. [1]

health insurance exchange. Created as a result of the Patient Protection and Affordable Care Act, an online insurance marketplace in which individuals and small businesses can purchase medical expense insurance coverage. Also known as an *insurance marketplace* or an *exchange*. [12]

health maintenance organization (HMO). In the United States, a health care financing and delivery system that provides comprehensive health care services to plan members, often referred to as *subscribers*, in a particular geographic area. [12]

health reimbursement arrangement (HRA). An employer-sponsored health plan that is used to pay for qualified medical expenses and that allows contributions only by the employer. [12]

health savings account (HSA). A tax-advantaged account in which an individual can accumulate money to pay for qualified medical expenses. [12]

high-deductible health plan (HDHP). A medical expense insurance plan that has a high deductible (usually at least $1,300 or more) and typically costs less than traditional medical expense insurance. [12]

HMO. *See* **health maintenance organization.**

hospital expenses. Medical expenses that include charges for specific inpatient and outpatient hospital services, such as room and board, medications, laboratory services, and other fees associated with a hospital stay. [12]

HRA. *See* **health reimbursement arrangement.**

HSA. *See* **health savings account.**

IADLs. *See* **instrumental activities of daily living.**

immediate annuity. An annuity that provides annuity payments that begin no later than one year after the annuity is purchased. *Contrast with* **deferred annuity**. [10]

income date. *See* **annuity start date.**

incontestability provision. A life insurance policy or annuity contract provision that denies the insurer the right to rescind—or cancel—the contract on the grounds of a material misrepresentation in the application after the contract has been in force for a specified period of time. [8, 10]

increasing term life insurance. Term life insurance that provides a death benefit that starts at one amount and increases by some specified amount or percentage at stated intervals over the policy term. [5]

indemnity benefit method. In long-term care insurance policies, a benefit payment method in which the insurer pays a stated benefit amount to the insured, regardless of the amount of expenses incurred. Also known as the *per diem method*. [12]

indemnity benefits. Contractual benefits that are based on the actual amount of the insured's financial loss. Also known as *reimbursement benefits*. [12]

index account. The portion of the cash value of an indexed universal life insurance policy for which the crediting rate is determined by changes in an index. [6]

indexed annuity. *See* **fixed indexed annuity.**

indexed universal life (IUL) insurance. A type of universal life insurance that offers the same features as universal life insurance, but also offers the possibility of additional earnings based on changes in a published index. Also called *equity indexed universal life (EIUL) insurance*. [6]

individual annuity. An annuity that is purchased and owned by a person or purchased by a legal entity, such as a trust, on behalf of a person. *Contrast with* **group annuity**. [10]

individual insurance policy. A policy that insures the life or health of a named person. [1]

individual retirement account. An individual retirement arrangement that takes the form of a trust or custodial account created in the United States for the exclusive benefit of a taxpayer or a taxpayer's beneficiaries. *Contrast with* **individual retirement annuity**. [11]

individual retirement annuity. An individual retirement arrangement that takes the form of an annuity issued by an insurance company. *Contrast with* **individual retirement account**. [11]

individual retirement arrangement (IRA). In the United States, a tax-favored retirement savings vehicle that allows a person with taxable compensation to deposit a stated amount of that compensation into the vehicle. [11]

informal contract. An oral or a written contract that is enforceable because the parties met requirements concerning the substance of the agreement rather than requirements concerning the form of the agreement. *Contrast with* **formal contract.** [3]

initial premium. The first premium paid for an insurance policy. [3]

instrumental activities of daily living (IADLs). Activities that are necessary for an individual to live independently but that are not essential to daily functioning, such as managing finances, cooking, doing laundry, shopping for food and clothing, using transportation, taking medications, and using the telephone. *Contrast with* **activities of daily living**. [12]

insurable interest. The interest an insurance policyowner has in the risk that is insured. A policyowner has an insurable interest if he is likely to suffer a genuine loss or detriment should the event insured against occur. [1]

insurance commissioner. The individual who is responsible for directing the operations of the state insurance department. Also known as the *superintendent of insurance or director of insurance*. [2]

insurance company. *See* **insurer.**

insurance contract. *See* **insurance policy.**

insurance marketplace. *See* **health insurance exchange.**

insurance policy. A written document that contains the terms of the agreement between the insurer and the owner of the policy. Also known as a *policy* or an *insurance contract*. [1]

insured. (1) The person whose life, health, or property is insured under an insurance policy. [1] (2) In group insurance plans, an alternate term for a group insured. [13]

insurer. A company that accepts risk and makes a promise to pay a policy benefit if a covered loss occurs. Also known as an *insurance company*. [1]

insurer-administered group plan. A group insurance plan in which the insurer is responsible for handling the administrative and recordkeeping aspects of the plan. *Contrast with* **self-administered group plan**. [13]

interest. A payment for the use of money. [4]

interest option. A life insurance policy settlement option under which the insurance company invests the policy proceeds and periodically pays interest on those proceeds to the payee. [9]

investment earnings. The money an insurer earns from investing the funds it receives from customers. [4]

investment vehicle. *See* **funding vehicle.**

IRA. *See* **individual retirement arrangement.**

IUL insurance. *See* **indexed universal life insurance.**

irrevocable beneficiary. A life insurance policy beneficiary whose designation as beneficiary cannot be changed by the policyowner unless the beneficiary gives written consent. *Contrast with* **revocable beneficiary.** [9]

joint and survivor annuity. An annuity option in which the insurer provides a series of annuity payments based on the life expectancies of two or more annuitants, with payments continuing until the last annuitant dies. [11]

joint mortgage life insurance. A variation of mortgage life insurance that provides the same benefit as a mortgage life insurance policy except the joint policy insures the lives of two people. [5]

joint whole life insurance. A plan of whole life insurance that has the same features and benefits as individual whole life insurance, except that it insures two people under the same policy. Often referred to as *first-to-die life insurance*. [6]

juvenile insurance policy. An insurance policy that is issued on the life of a child but is owned and paid for by an adult, usually the child's parent or legal guardian. [7]

key employee life insurance. *See* **key person life insurance.**

key person. For insurance purposes, any person or employee whose continued participation in a business is vital to the success of the business and whose death or disability would cause the business to incur a significant financial loss. [5]

key person disability coverage. A type of disability income insurance coverage that provides benefit payments to the business if an insured key person becomes disabled. [12]

key person life insurance. Individual life insurance that a business purchases on the life of a key person. Also known as *key employee life insurance*. [5]

lapse. The termination of an insurance policy for nonpayment of premium. [4]

lapse rate. The percentage of a specified group of policies in force at the beginning of a specified period, such as a year, that are terminated by the end of that period for reasons other than the death of the insured. [4]

last survivor life insurance. A variation of joint whole life insurance under which the death benefit is paid only after both people insured by the policy have died. Also known as *second-to-die life insurance* or *survivorship life insurance*. [6]

law of large numbers. A concept that states that, typically, the more times we observe a particular event, the more likely that our observed results will approximate the true probability that the event will occur in the future. [1]

legal reserves. *See* **policy reserves.**

legal reserve system. The system insurers use to set financial values for life insurance products. [4]

level premium system. A life insurance premium system that allows a policyowner to pay the same premium amount each year a policy is in force. [4]

level term life insurance. Term life insurance that provides a death benefit that remains the same over the policy term. [5]

liabilities. A company's debts and future obligations. [2]

license. *See* **certificate of authority.**

life and health insurance company. A company that issues and sells products that insure against financial losses that result from personal risks. [1]

life annuity. An annuity that provides annuity payments for *at least* the lifetime of a named individual. [9]

life income option. A life insurance policy settlement option under which the insurance company agrees to pay the policy proceeds in periodic installments over the payee's lifetime. [9]

life income with period certain annuity. An annuity option that guarantees that the insurer will make annuity payments throughout the annuitant's life and for at least a specified period, even if the annuitant dies before the end of that period. [11]

life income with refund annuity. An annuity option that provides annuity payments throughout the annuitant's lifetime and guarantees that at least the purchase price of the annuity will be paid out. Also known as a *refund annuity.* [11]

life insurance. Insurance that provides protection against the economic loss caused by the death of the person whose life is insured. [1]

life only annuity. An annuity option in which the insurer provides annuity payments for only as long as the annuitant lives. Also known as a *single life annuity* or a *straight life annuity.* [11]

limited-payment whole life insurance policy. A whole life insurance policy for which premiums are payable only for a stated period of time or until the insured's death, whichever occurs first. [6]

liquidation period. *See* **payout period.**

living benefit. *See* **accelerated death benefit.**

longevity annuity. A fixed annuity that an individual at or near retirement purchases with a lump sum that at the time of purchase locks in a guaranteed stream of income to begin at a specified advanced age—typically age 80 or 85. Also known as an *advanced life deferred annuity* or *longevity insurance*. [10]

longevity insurance. *See* **longevity annuity.**

longevity risk. The risk that a person will live longer than expected and will exhaust her assets. [10]

long-term care insurance (LTCI). A type of health insurance that pays benefits for medical or other health-related services needed by an individual who, because of his advanced age or the effects of a serious illness or injury, needs care in his own home or a qualified facility. [1]

long-term care (LTC) insurance benefit. An accelerated death benefit under which the insurer agrees to pay a monthly benefit to a policyowner if the insured requires constant care for a medical condition. [7]

long-term group disability income coverage. Group disability income coverage that provides a maximum benefit period of more than one year. *Contrast with* **short-term group disability income coverage**. [12]

long-term individual disability income coverage. Individual disability income coverage that provides a maximum benefit period of five years or more. *Contrast with* **short-term individual disability income coverage**. [12]

LTC insurance benefit. *See* **long-term care insurance benefit.**

LTCI. *See* **long-term care insurance.**

lump-sum distribution. For deferred annuities, an annuity option in which the contract owner chooses to have the accumulated value of the annuity distributed in a single payment. [11]

M&E charge. *See* **mortality and expense risks (M&E) charge.**

major medical expense coverage. Medical expense insurance that provides substantial benefits for (1) basic hospital expenses, surgical expenses, and physicians' expenses; (2) additional medical services related to illness or injuries; and (3) preventive care. [12]

managed care plan. An arrangement that integrates the financing and management of health care with the delivery of health care services to a group of individuals who have enrolled in the plan. [12]

manual rating. A method of setting group insurance premium rates in which the insurer establishes rates for very broad classifications of group insureds using its own experience with a product and information collected by various governmental and trade associations rather than the experience of one particular group. *Contrast with* **experience rating** and **blended rating**. [13]

market conduct law. A law designed to make sure that insurance companies conduct their businesses fairly and ethically. [2]

market-value-adjusted (MVA) annuity. A type of fixed deferred annuity that adjusts withdrawal and surrender values based on changes in market interest rates. [10]

master group insurance contract. A contract that describes the relationship between an insurer and a group policyholder and specifies the benefits provided by the contract to the insured group members. [13]

material misrepresentation. A statement made in an application for insurance that is not true and that caused the insurer to enter into a contract it would not have agreed to if it had known the truth. [8]

maturity date. (1) The date on which the insurer will pay an endowment policy's face amount to the policyowner if the insured is still living. [6] (2) For annuities, an alternate term for **annuity start date**. [10]

maximum out-of-pocket provision. A major medical expense insurance policy provision that states that the policy will cover 100 percent of allowable medical expenses after the insured has paid a specified amount out of pocket to satisfy the deductible and coinsurance requirements. Also known as a *stop-loss provision*. [12]

McCarran-Ferguson Act. A U.S. federal law under which Congress left insurance regulation to the state governments, as long as Congress considers this regulation to be adequate. [2]

Medicaid. In the United States, a joint federal and state program that provides basic medical expense and nursing home coverage to low-income individuals and to certain elderly and disabled individuals. [12]

medical expense insurance. A type of health insurance coverage that provides benefits to pay for the treatment of an insured's illnesses and injuries and some preventive care. [1]

Medicare. In the United States, a federal government program that provides medical expense benefits to people age 65 and older and those with certain disabilities. [12]

minor. A person who has not attained the age of majority. [3]

misrepresentation. A false or misleading statement in an application for insurance. [8]

misstatement of age or sex provision. An insurance policy or annuity contract provision that describes the action the insurer will take in the event that the age or sex of the insured or annuitant is incorrectly stated. [8, 10]

modified coverage whole life insurance policy. A whole life insurance policy under which the amount of insurance provided decreases by specific percentages or amounts either when the insured reaches certain stated ages or at the end of stated time periods. [6]

modified-premium whole life insurance policy. A whole life insurance policy for which the annual premium amount changes after a specified initial period (typically 5 or 10 years). [6]

moral hazard. A characteristic that exists when the reputation, financial position, or criminal record of an applicant or a proposed insured indicates that the person may act dishonestly in the insurance transaction. *Contrast with* **physical hazard**. [1]

morbidity rate. The incidence of sickness and accidents, by age, occurring among a given group of people. *Contrast with* **mortality rate**. [1]

morbidity tables. Charts that show the incidence of sickness and accidents, by age, occurring among a given group of people. *Contrast with* **mortality tables**. [1]

mortality and expense risks (M&E) charge. For variable deferred annuities, a charge that covers various risks and expenses assumed by the insurer, such as the risk of providing the death benefit and certain other guarantees. [11]

mortality charge. The insurer's cost to cover the mortality risk assumed in issuing a life insurance policy. [6]

mortality rate. The rate at which death occurs among a specified group of people during a specified period, typically one year. *Contrast with* **morbidity rate**. [1]

mortality tables. Charts that indicate the number of people in a large group who are likely to die at each age. *Contrast with* **morbidity tables**. [1]

mortgage life insurance. A plan of decreasing term insurance designed to provide a benefit amount that corresponds to the decreasing amount owed on a mortgage loan. Also known as *mortgage redemption insurance*. [5]

mortgage redemption insurance. *See* **mortgage life insurance.**

mutual assent. A meeting of the minds about the terms of an agreement. [3]

mutual insurance company. An insurance company that is owned by its policyowners. *Contrast with* **stock insurance company**. [2]

MVA annuity. *See* **market-value-adjusted annuity.**

NAIC. *See* **National Association of Insurance Commissioners.**

National Association of Insurance Commissioners (NAIC). In the United States, a nongovernmental association of the insurance commissioners of all the states whose primary function is to promote the uniformity of state insurance regulation by developing model laws and regulations as guidelines for the states. [2]

net cash surrender value. The amount the policyowner actually receives—after the insurer makes any additions or subtractions to the cash surrender value—upon surrendering the policy. [8]

network. A group of physicians, hospitals, and ancillary service providers that a specific managed care plan has contracted with to deliver health care services to plan members. [12]

noncontributory plan. A group insurance plan in which group members are not required to pay any part of the premium for their coverage. *Contrast with* **contributory plan**. [13]

nonforfeiture provision. A cash value life insurance policy provision that sets forth the options available to the owner of a cash value policy if the policy lapses or if the policyowner decides to surrender—or terminate—the policy. [8]

nonpar policy. *See* **nonparticipating policy.**

nonparticipating policy. A type of insurance policy under which the policyowner does not share in the insurance company's divisible surplus. Also called a *nonpar policy*. [9]

nonqualified annuity. An annuity that is purchased outside of a tax-advantaged retirement plan or individual retirement arrangement. *Contrast with* **qualified annuity**. [11]

offer. A proposal to enter into a binding contract with another party. [3]

open contract. A contract that identifies the documents that constitute the contract between the parties, but all the enumerated documents are not necessarily attached to the contract. *Contrast with* **closed contract**. [8]

open enrollment period. In group insurance, a period of time—typically a specified 30 or 31 days per year—during which eligible people who did not join the group insurance plan at the first opportunity may join the plan without providing evidence of insurability. [13]

operating expenses. The costs of operations other than expenses for contractual benefits, or the cost of benefits. [4]

Option 1 plan. *See* **Option A plan.**

Option 2 plan. *See* **Option B plan.**

Option A plan. A universal life insurance policy under which the amount of the death benefit at any given time is level; the death benefit payable is always equal to the policy's face amount. Also known as an *Option 1 plan*. [6]

Option B plan. A universal life insurance policy under which the amount of the death benefit at any given time is equal to the policy's face amount plus the amount of the policy's cash value. Also known as an *Option 2 plan*. [6]

optional insured rider. *See* **second insured rider.**

optional modes of settlement. *See* **settlement options.**

ordinary life insurance policy. *See* **continuous-premium whole life insurance policy.**

original age conversion. A conversion of a term life insurance policy to a cash value insurance policy in which the premium rate for the cash value policy is based on the insured's age when the original term policy was issued. [5]

other insured rider. *See* **second insured rider.**

owners' equity. The owners' financial interest in a company, which is the difference between the amount of the company's assets (what it owns) and the amount of its liabilities (what it owes). [2]

ownership of property. The sum of all the legal rights that exist in a piece of property. [3]

P&C insurance company. *See* **property/casualty insurance company.**

paid-up additional insurance dividend option. A policy dividend option under which the insurer uses any declared policy dividend to purchase paid-up additional insurance on the insured's life. [9]

paid-up additions option benefit. A supplemental life insurance policy benefit offered in connection with a whole life insurance policy that allows the policyowner to purchase single-premium paid-up additions to the policy on stated dates in the future without providing evidence of the insured's insurability. [7]

paid-up policy. A life insurance policy that requires no further premium payments but continues to provide coverage. [6]

par policy. *See* **participating policy.**

partial disability. A disability that prevents the insured either from performing some of the duties of his usual occupation or from engaging in that occupation on a full-time basis. [12]

partial surrender provision. *See* **policy withdrawal provision.**

participating policy. A type of insurance policy under which the policyowner shares in the insurance company's divisible surplus. Also called a *par policy*. [9]

partnership. A business that is owned by two or more people, who are known as the partners. [2]

Patient Protection and Affordable Care Act. Enacted by the U.S. Congress in 2010, legislation intended to make health insurance more affordable for and accessible to Americans. Also known as the *Affordable Care Act* or the *ACA*. [12]

payee. (1) For a life insurance policy, the person or party who is to receive the policy proceeds under a settlement option. [9] (2) For an annuity, the person or entity designated by an annuity contract owner to receive the annuity payments. [10]

payout factor. The amount of each annuity payment per thousand dollars of premium (for an immediate annuity) or accumulated value (for a deferred annuity). [11]

payout options. *See* **annuity options.**

payout period. For an annuity, the period during which the insurer makes annuity payments. Also known as the *liquidation period* or the *distribution period*. [10]

PCP. *See* **primary care provider.**

pension. A lifetime monthly income benefit paid to a person upon her retirement. [14]

per diem method. *See* **indemnity benefit method.**

period certain. For a fixed period annuity, the stated period over which the insurer will make the annuity payments. *See* **fixed period annuity**. [11]

period certain annuity. *See* **fixed period annuity.**

periodic income payments. *See* **annuity payments.**

permanent life insurance. *See* **cash value life insurance.**

personal property. All property other than real property. *Contrast with* **real property**. [3]

personal risk. The risk of economic loss associated with death, poor health, injury, and outliving one's economic resources. [1]

physical hazard. A physical characteristic that may increase the likelihood of loss. *Contrast with* **moral hazard**. [1]

physical impairment. A treatable, but generally incurable, chronic condition such as arthritis, emphysema, heart disease, diabetes, and hypertension. *Contrast with* **cognitive impairment**. [12]

physicians' expenses. Medical expenses that include charges associated with physicians' visits both in and out of the hospital. [12]

plan administrator. The party responsible for handling the administrative aspects of a retirement plan. [14]

plan document. A detailed legal agreement that establishes the existence of a retirement plan and specifies the rights and obligations of the various parties to the plan. [14]

plan participant. A member of a covered group who is eligible to participate in a retirement plan and who actually chooses to take part in the plan or whose participation is automatic. [14]

plan sponsor. A business, government entity, educational institution, nonprofit organization, or other group that establishes a retirement plan for the benefit of its members. [14]

point-of-service (POS) plan. A managed care plan that offers incentives for plan members to use providers who belong to the plan's network of providers, but allows plan members to choose, at the point of service, whether to seek medical care from inside or outside the network. [12]

policy. *See* **insurance policy.**

policy anniversary. The anniversary of the date on which coverage under an insurance policy became effective. [5]

policy benefit. A specific amount of money an insurer agrees to pay under an insurance policy when a covered loss occurs. [1]

policy dividend. An amount of money that an insurer pays to the owner of a participating policy from the insurer's divisible surplus. [9]

policy loan. A loan a policyowner receives from an insurer using the cash value of a life insurance policy as security. [6]

policy loan provision. A cash value life insurance policy provision that specifies the terms under which the policyowner of a cash value insurance policy can obtain a loan from the insurer against the policy's cash value. [8]

policy loan repayment dividend option. A policy dividend option under which the insurer applies policy dividends toward the repayment of an outstanding policy loan. [9]

policyowner. The person or business that owns an insurance policy. [1]

policy proceeds. The total monetary amount paid by an insurer if the insured dies while the policy is in force. [9]

policy reserves. Liabilities that represent the amount an insurer estimates it needs to pay future benefits. Sometimes referred to as *contractual reserves*, *legal reserves*, or *statutory reserves*. [4]

policy rider. An amendment to an insurance policy that becomes part of the insurance contract and changes its terms. Also known as an *endorsement*. [5]

policy term. The specified period of time during which a term life insurance policy provides coverage. [5]

policy withdrawal provision. A universal life insurance policy provision that permits the policyowner to reduce the amount of the policy's cash value by withdrawing up to the amount of the cash value in cash. Also called a *partial surrender provision*. [8]

portability provision. A provision in a group insurance policy that allows a group insured whose coverage terminates for certain reasons to continue her coverage under the group plan. [14]

portable coverage. Group insurance coverage that can be continued if an insured employee leaves the group. [14]

POS plan. *See* **point-of-service plan.**

PPO. *See* **preferred provider organization.**

preference beneficiary clause. A provision included in some life insurance policies that states that if the policyowner does not name a beneficiary, then the insurer will pay the policy proceeds in a stated order of preference. Also called a *succession beneficiary clause*. [9]

preferred premium rate. A lower-than-standard premium rate charged to insureds who are classified as preferred risks. [1]

preferred provider organization (PPO). A managed health care plan that arranges with providers for the delivery of health care at a discounted cost and that provides incentives for PPO members to use the providers who have contracted with the PPO, but also provides some coverage for services rendered by providers who are not part of the PPO network. [12]

preferred risk. A proposed insured who presents a significantly lower-than-average likelihood of loss. [1]

premium. A specified amount of money an insurer charges in exchange for agreeing to pay a policy benefit when a covered loss occurs. [1]

premium payment mode. The frequency at which an insurance policy's renewal premiums are payable. [9]

premium rate. The amount an insurer charges per unit of insurance coverage. [4]

premium reduction dividend option. A policy dividend option under which the insurer applies policy dividends toward the payment of renewal premiums. [9]

prescription drug coverage. A type of medical expense coverage that provides benefits for the purchase of drugs and medicines that are prescribed by a physician and are not available over the counter. [12]

presumptive disability. According to the terms of some disability income policies, a stated condition that, if present, automatically causes an insured to be considered totally disabled and thus eligible to receive disability income benefits. [12]

primary beneficiary. The party designated to receive a life insurance policy's proceeds following the death of the insured. Also known as a *first beneficiary*. [9]

primary care physician. *See* **primary care provider.**

primary care provider (PCP). In a managed care plan, a network member selected by a plan member who coordinates the plan member's medical care and treatment. Also known as a *primary care physician*. [12]

principal. The sum of money originally invested, loaned, or borrowed. [4]

probability. The likelihood that a given event will occur in the future. [1]

probationary period. In group insurance, the length of time—typically, from one to six months—that a new group member must wait before becoming eligible to enroll in a group insurance plan. [13]

profit. The money or revenue that a business receives for its products minus the expenses it incurs to create and support the products. [2]

profit sharing plan. A type of qualified retirement plan that allows the plan sponsor to make discretionary contributions funded primarily from its profits. [14]

property. A bundle of rights that a person has with respect to something. *See* **real property** and **personal property**. [3]

property and liability insurer. *See* **property/casualty (P&C) insurance company.**

property/casualty (P&C) insurance company. An insurer that issues and sells insurance policies that cover property damage risk and liability risk. Also known as a *property and liability insurer*. [1]

pure risk. A risk that involves no possibility of gain; either a loss occurs or no loss occurs. [1]

qualified annuity. An annuity that is purchased to fund or distribute funds from a tax-advantaged retirement plan or individual retirement arrangement. *Contrast with* **nonqualified annuity**. [11]

rate of return. The investment earnings expressed as a percentage of the principal. [4]

real property. Land and whatever is growing on or attached to the land. *Contrast with* **personal property**. [3]

reduced paid-up insurance nonforfeiture option. A cash value life insurance policy nonforfeiture option under which the policyowner discontinues paying premiums and uses the policy's net cash surrender value as a net single premium to purchase paid-up life insurance of the same plan as the original policy. [8]

refund annuity. *See* **life income with refund annuity.**

regular individual retirement arrangement. *See* **traditional individual retirement arrangement.**

reimbursement benefits. *See* **indemnity benefits.**

reimbursement method. In long-term care insurance policies, a benefit payment method in which the insurer reimburses eligible expenses that are incurred by the insured, up to the policy's daily or monthly benefit amount. [12]

reinstatement. The process by which an insurer puts back into force an insurance policy that either has been terminated because of nonpayment of renewal premiums or has been continued under the extended term or reduced paid-up insurance nonforfeiture option. [8]

reinstatement provision. An individual life insurance policy provision that describes the conditions that the policyowner must meet for the insurer to reinstate a policy. [8]

reinsurance. Insurance that one insurance company, known as the *direct writer* or *ceding company*, purchases from another insurance company, known as the *reinsurer* or *assuming company*, to transfer all or part of the risk on insurance policies that the direct writer issued. [1]

reinsurer. An insurance company that accepts risks transferred from another insurer in a reinsurance transaction. Also known as an *assuming company*. *Contrast with* **direct writer**. [1]

renewable term insurance policy. A term life insurance policy that gives the policyowner the option to continue the coverage at the end of the specified term without presenting evidence of insurability, although typically at a higher premium because the premium amount is based on the insured's attained age. [5]

renewal premium. An insurance policy premium payable after the initial premium. [3]

renewal provision. A term life insurance policy provision that gives the policyowner the option to continue the coverage for an additional policy term without providing evidence of insurability. [5]

return of premium (ROP) term insurance. A form of term life insurance that provides a death benefit if the insured dies during the policy term and promises a return of all or a portion of the premiums paid for the policy if the insured does not die during the policy term. [5]

revocable beneficiary. A life insurance policy beneficiary whose designation as beneficiary can be changed by the policyowner at any time before the insured's death. *Contrast with* **irrevocable beneficiary**. [9]

right of revocation. A life insurance policyowner's right to change the beneficiary designation at any time during the insured's lifetime. [9]

risk. The chance or possibility of an unexpected result, either a gain or a loss. [1]

risk class. A grouping of insureds who represent a similar level of risk to an insurer. [1]

risk management. The process in which individuals and businesses identify and assess the risks they face and determine how to deal with their exposure to these risks. [1]

risk selection. *See* **underwriting.**

ROP term insurance. *See* **return of premium term insurance.**

Roth individual retirement arrangement (Roth IRA). A type of individual retirement arrangement that permits people within certain income limits to make nondeductible contributions and to withdraw money on a tax-free basis, provided certain requirements are met. *Contrast with* **traditional individual retirement arrangement (IRA)**. [11]

Roth IRA. *See* **Roth individual retirement arrangement.**

savings incentive match plan for employees (SIMPLE) IRA. For small businesses with 100 or fewer employers, a tax-advantaged retirement plan that offers retirement benefits through employee salary reductions and employer contributions. [14]

secondary beneficiary. *See* **contingent beneficiary.**

second insured rider. A supplemental life insurance policy benefit that provides term insurance coverage on the life of a person other than the policy's insured. Also known as an *optional insured rider*, *other insured rider*, or *additional insured rider*. [7]

second-to-die life insurance. *See* **last survivor life insurance.**

security. A financial asset that represents either (1) an obligation of indebtedness owed by a business, a government, or an agency, which is known as a *debt security*, or (2) an ownership interest, which is known as an *equity security*. [2]

segregated account. *See* **separate account.**

selection against the insurer. *See* **antiselection.**

self-administered group plan. A group insurance plan in which the group policyholder is responsible for handling the administrative and recordkeeping aspects of the plan. *Contrast with* **insurer-administered group plan**. [13]

SEP. *See* **simplified employee pension.**

separate account. An asset account the insurer maintains separately from its general account to isolate and help manage the funds placed in its variable products. Also called a *segregated account*. [6]

service fee. For deferred annuities, a fee that is charged for specific services or transactions requested by the contract owner. [11]

settlement options. Alternative methods that the owner or beneficiary of a life insurance policy can elect for receiving payment of the policy proceeds. Also known as *optional modes of settlement*. [9]

settlement options provision. A life insurance policy provision that grants a policyowner or a beneficiary several choices as to how the insurance company will distribute the proceeds of a life insurance policy. [9]

share. A unit of ownership in a stock corporation. Also known as a *share of stock*. [2]

shareholder. *See* **stockholder.**

share of stock. *See* **share.**

short-term group disability income coverage. Group disability income coverage that provides a maximum benefit period of one year or less. *Contrast with* **long-term group disability income coverage**. [12]

short-term individual disability income coverage. Individual disability income coverage that provides a maximum benefit period of one to five years. *Contrast with* **long-term individual disability income coverage**. [12]

SIFI. *See* **systemically important financial institution.**

simple interest. Interest on the principal only. *Contrast with* **compound interest**. [4]

SIMPLE IRA. *See* **savings incentive match plan for employees IRA.**

simplified employee pension (SEP). A written arrangement that allows a plan sponsor to make deductible contributions to a traditional IRA—referred to as a *SEP IRA*—set up for each plan participant. [14]

simultaneous death act. A law in many jurisdictions that governs how insurance companies evaluate common-disaster situations. [9]

single life annuity. *See* **life only annuity.**

single-premium annuity. An annuity that is purchased with the payment of a single, lump-sum premium amount. *Contrast with* **flexible-premium annuity**. [10]

single-premium deferred annuity (SPDA). An annuity that is purchased with a lump-sum premium payment and provides annuity payments that are postponed for at least one year after the annuity is purchased. [10]

single-premium immediate annuity (SPIA). An annuity that is purchased with a lump-sum premium payment and provides annuity payments that begin no later than one year after the annuity is purchased. [10]

single-premium whole life insurance policy. A type of limited-payment whole life insurance policy that requires only one premium payment. [6]

social insurance program. A welfare plan that is established by law and administered by a government and that provides assistance to specified groups of the population, such as the elderly, disabled, and unemployed. [2]

Social Security. A U.S. federal insurance program that provides specified benefits—such as monthly retirement income benefits—to eligible individuals. [14]

sole proprietorship. A business that is owned and operated by one person. [2]

solvent. A term used to describe an insurance company that is able to meet its debts and pay policy benefits when they come due. [2]

SPDA. *See* **single-premium deferred annuity.**

special class rate. *See* **substandard premium rate.**

special class risk. *See* **substandard risk.**

speculative risk. A risk that involves three possible outcomes: loss, gain, or no change. [1]

SPIA. *See* **single-premium immediate annuity.**

spouse and children's insurance rider. A supplemental life insurance policy benefit offered by some insurers that provides term life insurance coverage on the insured's spouse and children. Also known as a *family insurance rider*. [7]

spouse insurance rider. A supplemental life insurance policy benefit that provides term life insurance coverage on the insured's spouse. [7]

standard premium rate. A premium rate charged to insureds who are classified as standard risks. [1]

standard risk. A proposed insured who has a likelihood of loss that is not significantly greater than average. [1]

state insurance code. A set of laws in each state that regulates insurance in that state. [2]

state insurance department. An administrative agency in each state that is responsible for making sure that companies operating in the state comply with applicable regulatory requirements. [2]

statutory reserves. *See* **policy reserves.**

stock corporation. A corporation whose ownership is divided into units known as *shares* or *shares of stock*. [2]

stockholder. A person or organization that owns shares of stock in a corporation. Also known as a *shareholder*. [2]

stockholder dividend. A portion of a corporation's earnings paid to the owners of its stock. *Contrast with* **policy dividend**. [2]

stock insurance company. An insurance company that is owned by the people and organizations that own shares of the company's stock. *Contrast with* **mutual insurance company**. [2]

stop-loss provision. *See* **maximum out-of-pocket provision.**

straight life annuity. *See* **life only annuity.**

straight life insurance policy. *See* **continuous-premium whole life insurance policy.**

subaccount. (1) One of several investment funds to which a variable life insurance policyowner allocates the premiums she has paid and the cash values that have accumulated under her policy. [6] (2) An investment fund within an insurance company's separate account; used with variable life insurance policies and variable annuities. [6, 10]

substandard premium rate. A higher-than-standard premium rate charged to insureds who are classified as substandard risks. Also known as a *special class rate*. [1]

substandard risk. A proposed insured who has a significantly greater-than-average likelihood of loss but is still found to be insurable. Also known as a *special class risk*. [1]

succession beneficiary clause. *See* **preference beneficiary clause.**

successor beneficiary. *See* **contingent beneficiary.**

successor payee. *See* **contingent payee.**

suicide exclusion provision. A life insurance policy provision that states that the insurance company does not have to pay the death benefit if the insured dies as the result of suicide as defined by the policy within a specified period following the date of policy issue. [8]

superintendent of insurance. *See* **insurance commissioner.**

surgical expenses. Medical expenses that include charges for inpatient and outpatient surgical procedures. [12]

surplus. The amount by which a company's assets exceed its liabilities and capital. [2]

surrender benefit. *See* **cash surrender value.**

surrender charge. (1) For a cash value life insurance policy, a specific charge imposed if the owner surrenders the policy for its cash surrender value. [8] (2) For a deferred annuity, a fee an insurer imposes if the contract owner makes excess withdrawals as defined in the contract or fully surrenders the contract before the surrender period is over. Also known as a *contingent deferred sales charge*. [10]

surrender value. (1) For cash value life insurance, an alternate term for **cash surrender value**. [6] (2) For deferred annuities, the amount of the annuity's accumulated value, less any surrender charges, that the contract owner is entitled to receive if the contract is surrendered during its accumulation period. [10]

survivor benefit. For annuities, an alternate term for **death benefit**. [10]

survivorship clause. A provision included in some life insurance policies that states that the beneficiary must survive the insured by a specified period, usually 30 or 60 days, to be entitled to receive the policy proceeds. [9]

survivorship life insurance. *See* **last survivor life insurance.**

systemically important financial institution (SIFI). As identified by the Financial Stability Oversight Council, a financial institution whose failure could potentially pose a risk to the U.S. financial system and that is therefore subject to more stringent regulatory standards than other institutions. [2]

terminal illness (TI) benefit. A supplemental life insurance policy benefit under which the insurer typically pays a portion of the policy's death benefit to a policyowner if the insured suffers from a terminal illness and has a physician-certified life expectancy of less than a stated time, generally 12 or 24 months. [7]

term life insurance. Life insurance that provides a policy benefit only if the insured dies during the period specified in the policy. *Contrast with* **cash value life insurance**. [1]

third-party policy. A policy purchased by one person or business on the life of another person. [1]

TI benefit. *See* **terminal illness benefit.**

total disability. A disability that meets the requirements of a disability benefit provision in an insurance policy or policy rider and that qualifies a covered person to receive disability income benefits. [12]

traditional individual retirement arrangement (IRA). A type of individual retirement arrangement into which a person with taxable compensation can make annual contributions, which may be tax deductible. Also known as a *regular individual retirement arrangement*. *Contrast with* **Roth individual retirement arrangement (IRA)**. [11]

traditional IRA. *See* **traditional individual retirement arrangement.**

UCR fee. *See* **usual, customary, and reasonable fee.**

UL insurance. *See* **universal life insurance.**

underwriter. An insurance company employee who is responsible for evaluating proposed risks. [1]

underwriting. The process of assessing and classifying the degree of risk represented by a proposed insured and making a decision to accept or decline that risk. Also known as *risk selection*. [1]

underwriting guidelines. The general rules that an insurer uses when assigning proposed insureds to an appropriate risk class. [1]

unilateral contract. A contract in which only one of the parties makes a legally enforceable promise when entering into the contract. *Contrast with* **bilateral contract**. [3]

universal life (UL) insurance. A form of cash value life insurance that is characterized by its separation of the three primary policy elements and its flexible face amount, death benefit amount, and premiums. [6]

usual, customary, and reasonable (UCR) fee. The amount that medical care providers within a particular geographic region commonly charge for a particular medical service. [12]

valid contract. A contract that is enforceable at law. *Contrast with* **void contract** and **voidable contract**. [3]

valued contract. An insurance policy that specifies the amount of the policy benefit that will be payable when a covered loss occurs, regardless of the actual amount of the loss that was incurred. [1]

variable annuity. An annuity under which the amount of any accumulated value and the amount of the annuity payments fluctuate in accordance with the performance of one or more specified investment funds. *Contrast with* **fixed annuity**. [10]

variable life (VL) insurance. A form of cash value life insurance in which premiums are fixed, but the death benefit and other values may vary, reflecting the performance of the investment subaccounts that the policyowner selects. [6]

variable universal life (VUL) insurance. Cash value life insurance that combines the premium and death benefit flexibility of universal life insurance with the investment flexibility and risk of variable life insurance. Also called *flexible-premium variable life insurance*. [6]

vested interest. A property right that has taken effect and cannot be altered or changed without the consent of the person who owns the right. [9]

vesting requirements. For a retirement plan, requirements that define when a plan participant is entitled to receive partial or full benefits under the plan even if he terminates employment prior to retirement. [14]

vision care coverage. A type of medical expense coverage that provides the insured with benefits for expenses incurred in obtaining eye examinations and corrective lenses. [12]

VL insurance. *See* **variable life insurance.**

voidable contract. A contract under which one party has the right to avoid his obligations under the contract. *Contrast with* **valid contract** and **void contract**. [3]

void contract. A contract that does not meet one or more of the legal requirements to create a valid contract and, thus, is never enforceable. *Contrast with* **valid contract** and **voidable contract**. [3]

VUL insurance. *See* **variable universal life insurance.**

waiting period. *See* **elimination period.**

waiver of premium for disability (WP) benefit. A supplemental life insurance policy benefit under which the insurer promises to give up—to waive—its right to collect premiums that become due when the insured is totally disabled according to the policy or rider's definition of disability. [7]

waiver of premium for payor benefit. A supplemental life insurance policy benefit that provides that the insurer will waive its right to collect a renewal premium if the payor—the person who pays the policy premiums—dies or becomes totally disabled. [7]

whole life insurance. A type of cash value life insurance that provides lifetime insurance coverage, usually at a level premium rate that does not increase as the insured ages. [6]

will. A legal document that directs how an individual's property is to be distributed after her death. [5]

withdrawal provision. For deferred annuities, a provision that gives the contract owner the right to receive a portion of the contract's accumulated value during the accumulation period. [10]

WP benefit. *See* **waiver of premium for disability benefit.**

yearly renewable term (YRT) insurance. A one-year term insurance policy or rider that is renewable for a stated number of years. Also known as *annually renewable term (ART) insurance*. [5]

YRT insurance. *See* **yearly renewable term insurance.**

Index

Numbers in *italics* indicate figures

———

A

D

G

H

I

J

K

L

M

Y

End of Module