Principles of Insurance

Second Edition

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LOMA®

Principles of Insurance

Second Edition

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Principles of Insurance

Second Edition

LOMA Education and Training
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The LOMA 280 Principles of Insurance course is the result of the dedicated efforts of a project team of LOMA staff members and consultants who were responsible for writing and editing the text's content, developing learning aids and study materials to accompany the textbook, and overseeing the production of the text and the Course Portal.

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Preface

Principles of Insurance, Second Edition is designed to give readers an understanding of the basic principles that underlie the operation of life and health insurance companies throughout the world. The text describes the products that are most widely marketed by life and health insurance companies, and it explains the features of those products. The text is divided into five modules:

- Module 1: Basic Principles of Insurance (Chapters 1–4)
- Module 2: Individual Life Insurance (Chapters 5–7)
- Module 3: Individual Life Insurance Policy Provisions and Ownership Rights (Chapters 8–9)
- Module 4: Annuities, Individual Retirement Arrangements, and Health Insurance (Chapters 10–12)
- Module 5: Group Life Insurance and Group Retirement Plans (Chapters 13–14)

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LOMA 280 Text Review Panel

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Introduction

The purpose of *Principles of Insurance,* Second Edition is to provide an overview of the basic products and principles of life insurance, annuities, and health insurance. Enrollment in the course includes access to an online Course Portal via LOMA's learning system. The Course Portal gives learners access to everything they need to study and prepare for the course examination. The Course Portal organizes the assigned text material into convenient Modules—chapter clusters that help to focus the learning process by breaking up the course content into meaningful sections. In addition to the assigned study materials, the Course Portal provides access to an array of blended learning resources, including multimedia features designed to enhance the learning experience. The Course Portal provides access to

- PDFs of the assigned text and Test Preparation Guide, which can be printed or read online
- An interactive version of the Test Preparation Guide's Practice Questions and Sample Exam
- Review tools, including Learning Aids—animations of important concepts—and a "Top Ten Tough Topics" tutorial
- Recommended study plans to help you set goals and manage your learning experience
- Related links which help you apply the course instruction to the real world

Students preparing to take the examination for this course will find that the assigned study materials include many features designed to help learners more easily understand the course content, organize their study, and prepare for the examination. As we describe each of these features, we give you suggestions for studying the material.

- **Learning Objectives.** Each chapter lists the chapter's learning objectives to help you focus your studies. Before reading each chapter, review these learning objectives. Then, as you read the chapter, look for material that will help you meet the learning objectives. The interactive version of the Test Preparation Guide's Practice Questions and Sample Exam questions (accessible from the Course Portal) is linked to the learning objectives to give you an idea of how each learning objective might be measured on an examination, as well as to help you assess your mastery of the learning objectives.
- **Chapter Outline.** Each chapter contains an outline of the chapter. Review this outline to gain an overview of the major topics that will be covered; then scan through the chapter to become familiar with how the information is presented. By looking at the headings, you can gain a preview of how various subjects in each chapter relate to each other.
- **Figures.** We include figures throughout the text to illustrate and bring a real world perspective to the text's discussion of selected topics. Information contained in figures may be tested on the examination for the course.

- **Learning Aids.** Learning Aids enhance your learning experience by helping you to visualize concepts described in the text and allowing you to see those concepts in action. This icon in the margin of the text indicates that there is a Learning Aid on the Course Portal that relates to the topic in the text. If you are reading the text in PDF format, click on the Learning Aid icon to go to that Module's Learning Aid collection. If you are reading a printed copy of the text, use the Learning Aid icon as a visual cue that the Course Portal holds more information on the topic. Information contained in Learning Aids may be tested on the examination for the course.
- **Glossary and Key Terms.** This text explains key terms that apply to the text material and, where appropriate, reviews key terms previously presented in LOMA courses. Each key term is highlighted with bold italic type when the term is defined and is included in a list of key terms at the end of each chapter. All key terms also appear in a comprehensive glossary at the end of the PDF of the text. As you read each chapter, pay special attention to the key terms.
- **Top Ten Tough Topics.** The Top Ten Tough Topics tutorial, found on the Course Portal, contains animations and study tips for topics that learners often find difficult when answering questions on the examination. This tutorial enhances the learning experience, appeals to a variety of learning styles, and offers a great way for learners to advance their understanding and retention of course content.

LOMA may periodically revise the assigned study materials for this course. To ensure that you are studying from the correct materials, check the current LOMA *Education and Training Catalog* **available at www.loma.org. Also be sure to visit the Announcements page on the Course Portal to learn about important updates or corrections to the assigned study materials.**

Using the Test Preparation Guide

LOMA's *Test Preparation Guide for LOMA 280* (TPG) is assigned reading for students preparing for the LOMA 280 examination. It contains Practice Questions organized by chapter and a full-scale Sample Exam. The TPG is available in two versions, both accessible from the Course Portal: (1) a printable PDF that includes answer keys for all questions, and (2) an interactive version that can be used online or downloaded for offline use. The interactive version has the added advantage of answer-choice explanations for all Practice Questions and Sample Exam questions. The TPG is designed to help you learn the course content and prepare for the examination. Used along with the assigned text, the TPG will help you master the course material. **Studies indicate that students who use LOMA TPGs consistently perform significantly better on LOMA examinations than students who do not use TPGs.**

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.

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.

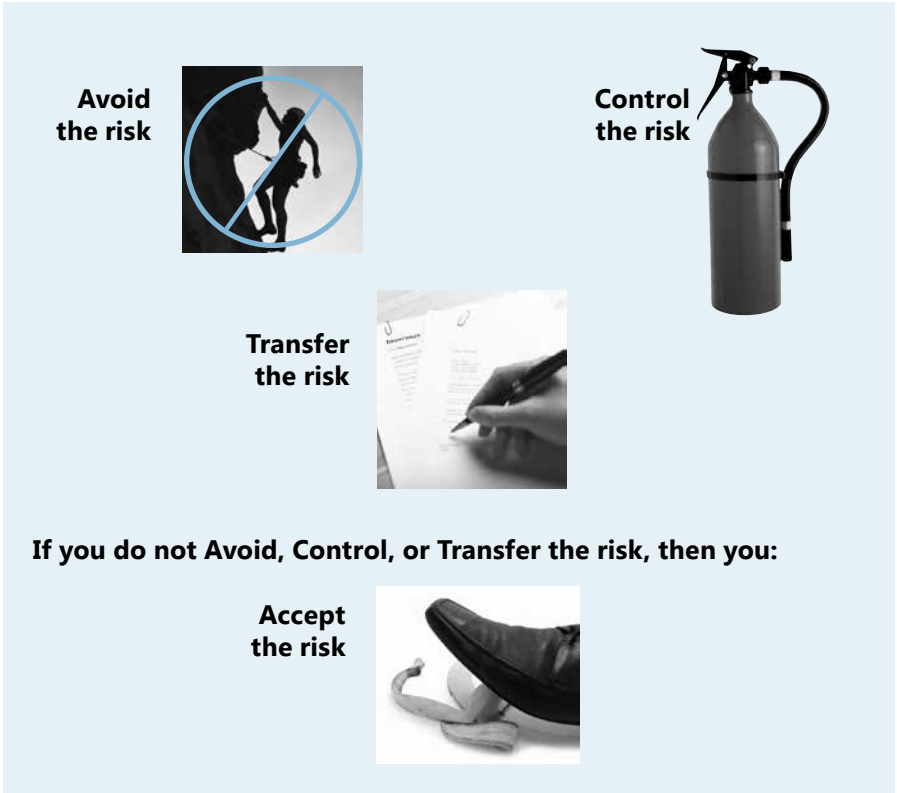
Alternatively, accepting a risk can be an unconscious decision. Any risk you face that is not managed by other methods is always accepted, whether you are aware of it or not. For example, for a number of years, many people and businesses were unaware that hackers could gain access to the data on their 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

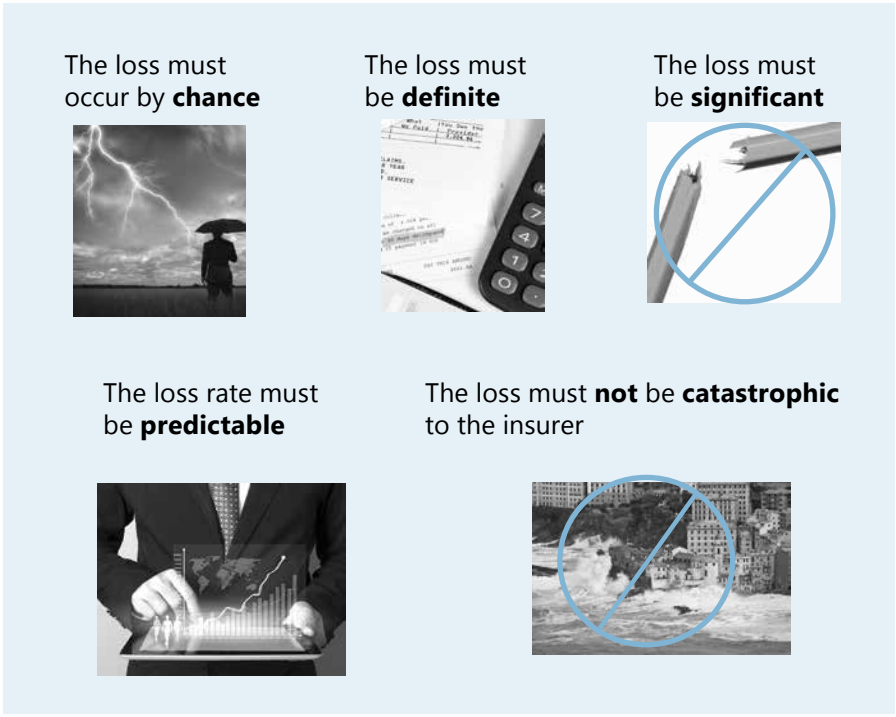
risk an insured represents, the higher the premium rate the insurer must charge. If the insurer consistently underestimates the risks that it assumes, its premium rates will be inadequate to provide the benefits promised to all its policyowners. On the other hand, if the insurer overestimates the risks 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.

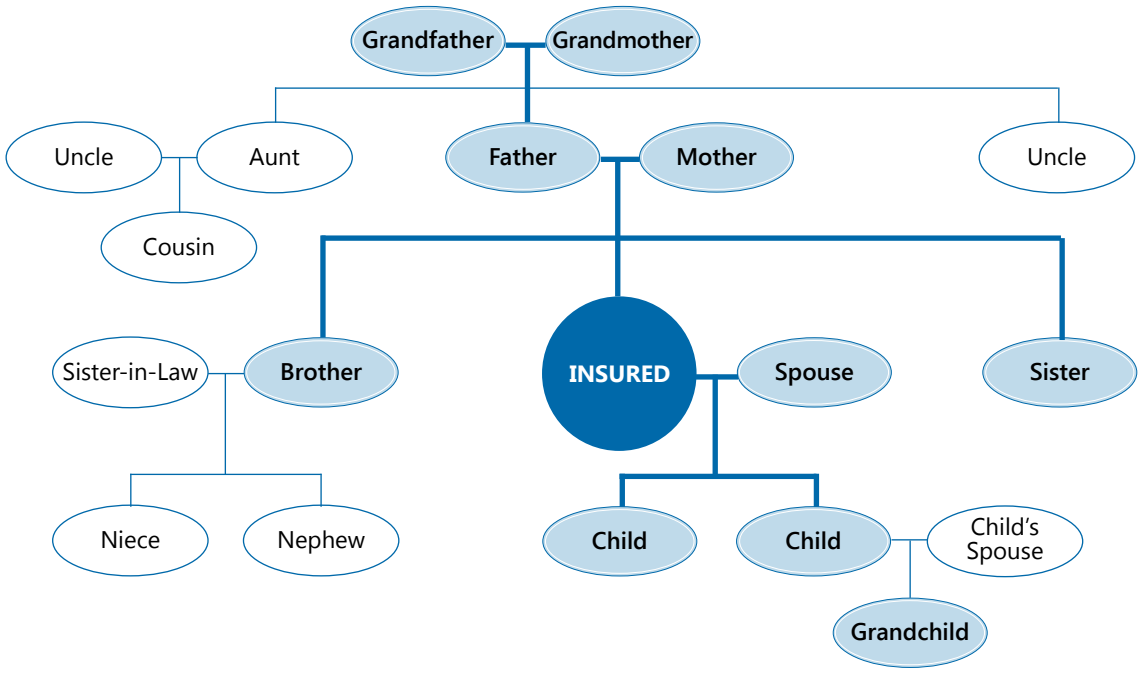
Example:

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.

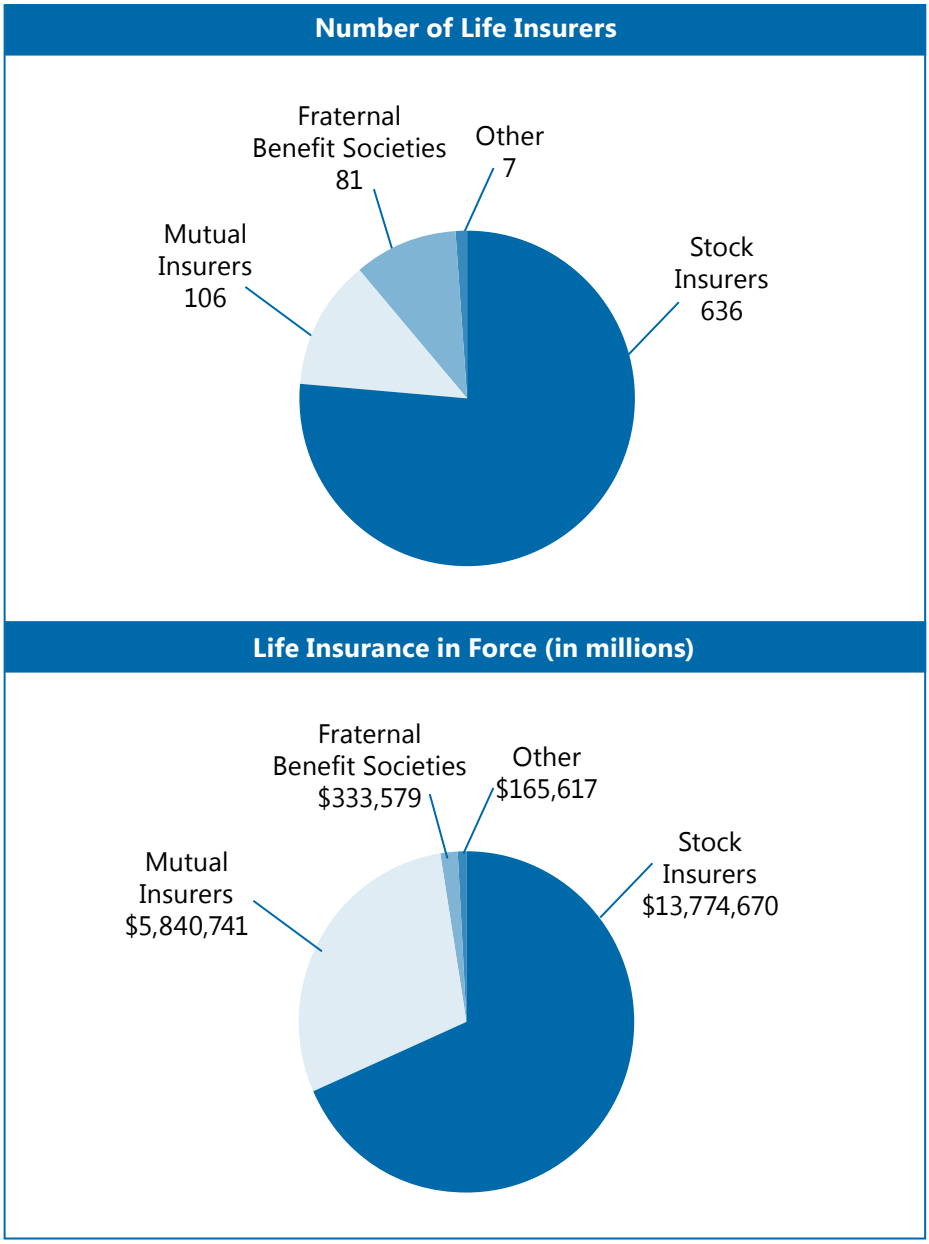
Figure 2.1 depicts the total number of stock insurers, mutual insurers, and fraternal benefit societies operating in the United States in 2014, as well as the life insurance in force for each type of insurance company.

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

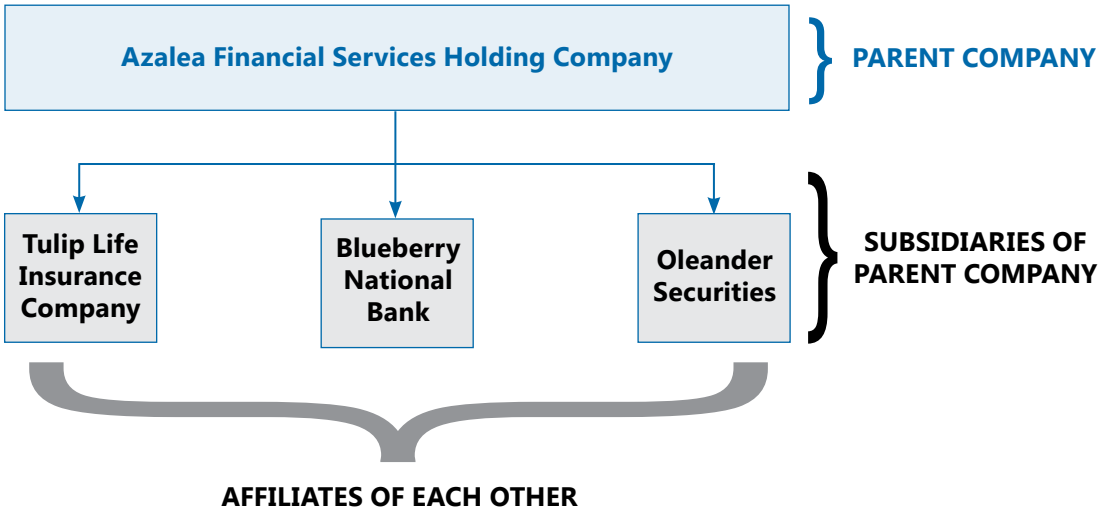
Historically, the financial services industry was divided into distinct sectors, often as a result of regulatory requirements in various countries. Banks provided banking services such as checking accounts, savings accounts, and loans. Securities firms and mutual fund companies handled investments. Insurance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

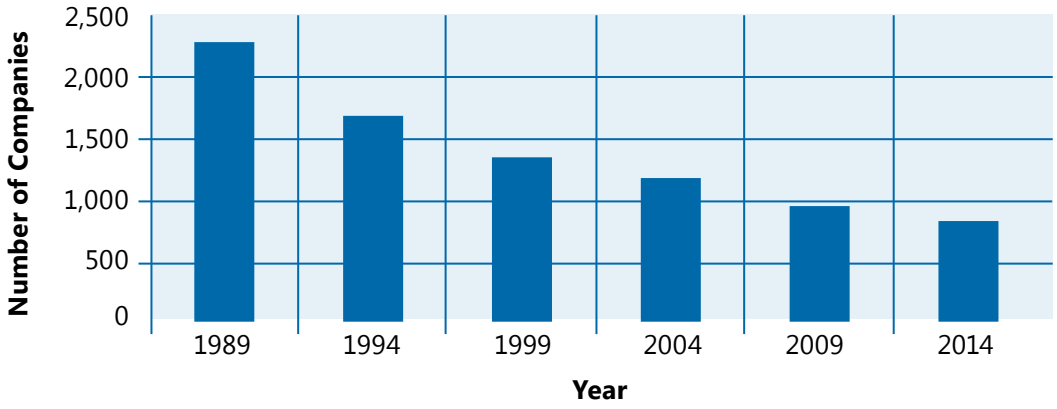
- A *merger* is a transaction in which the assets and liabilities of two companies are combined into one company. One of the companies survives as a legal entity, and the other company ceases to exist.
- An *acquisition* is a transaction in which one corporation purchases a controlling interest in another 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:

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

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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.

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:

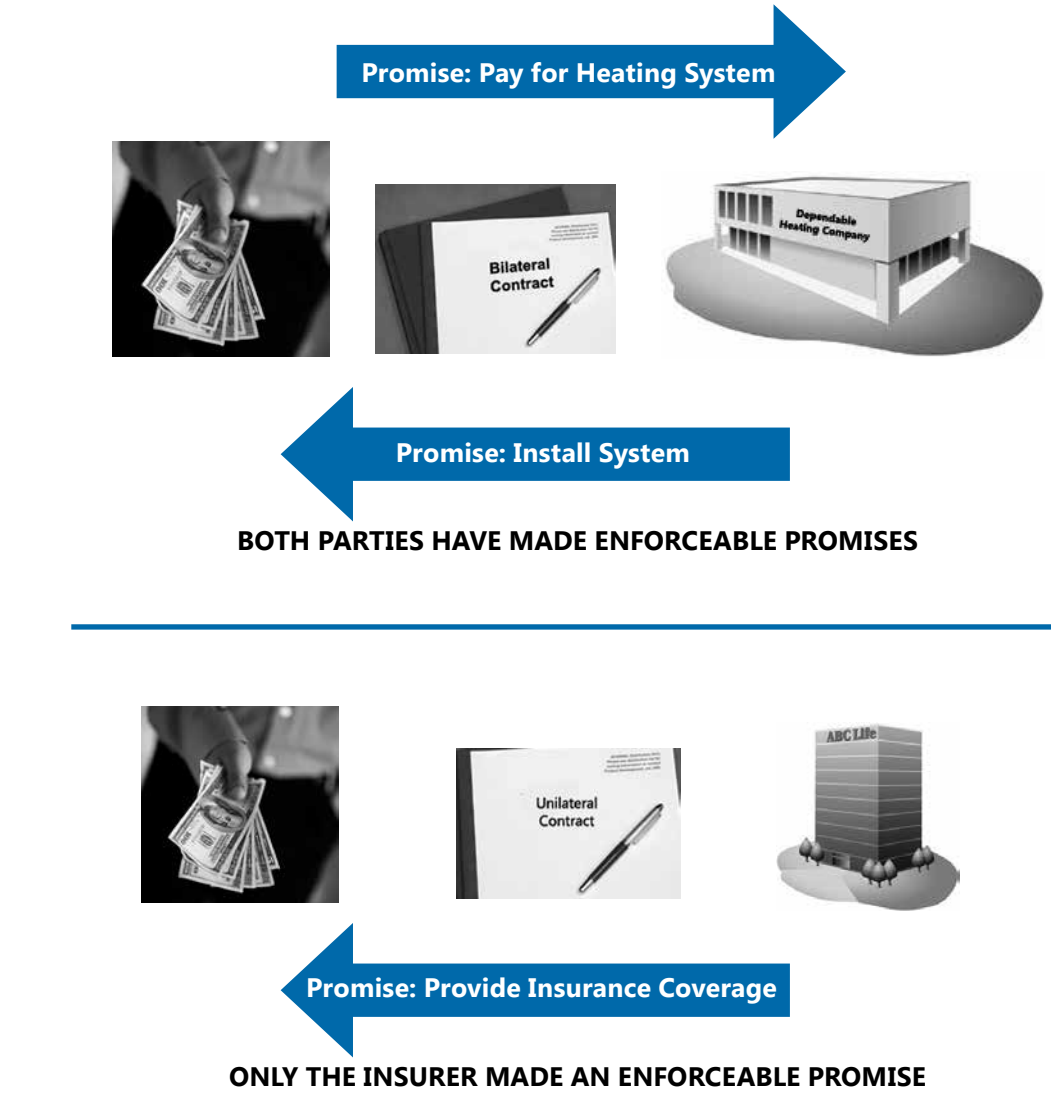
Shi-Fay Cheng contracts with the Dependable Heating Company to have the company install a heating system in her home for a mutually agreed-upon price. Dependable promises to perform the work, and Shi-Fay promises to pay a stated amount in exchange for the work.

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.

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.

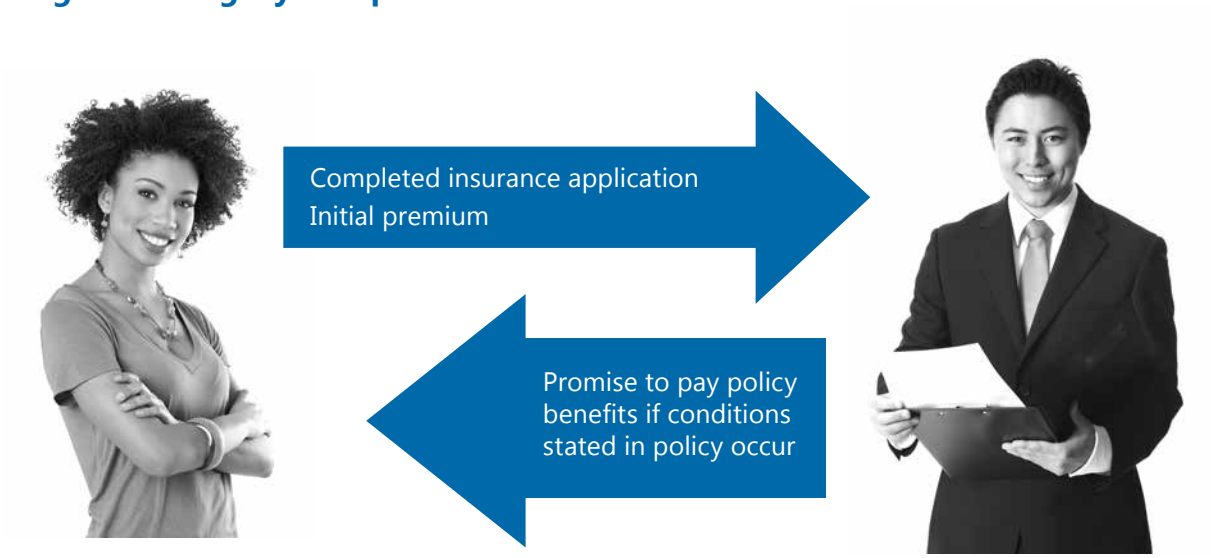
Figure 3.3 illustrates legally adequate consideration for an insurance policy.

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.

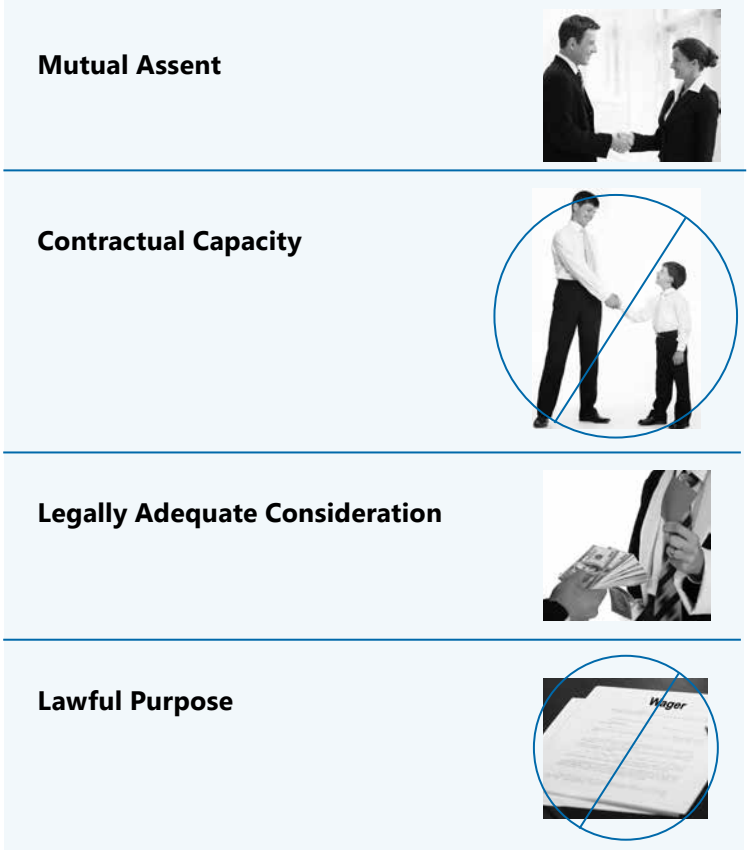
Analysis:

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



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

The Level Premium System

Establishing Premium Rates

- Cost of Benefits
- Operating Expenses
- Investment Earnings
- Financial Models

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

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

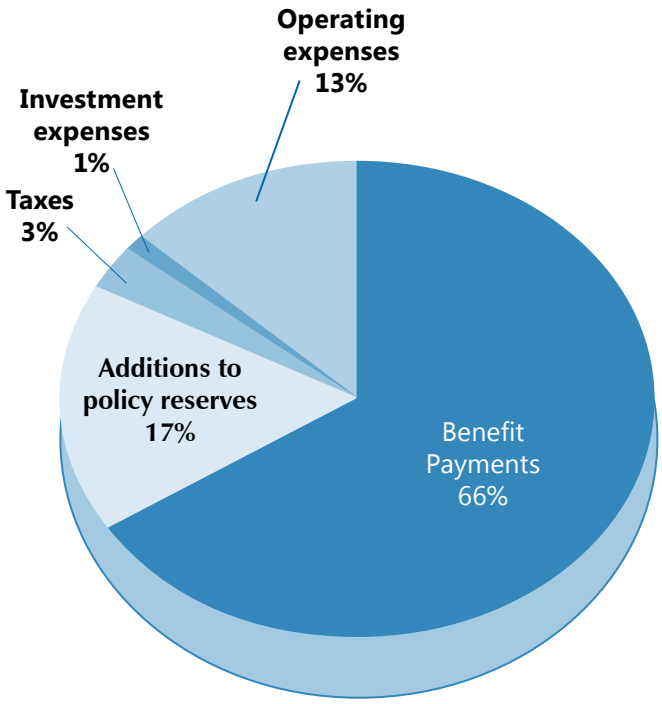
For life insurance companies, ***operating expenses*** are the costs of operations other than expenses for contractual benefits, or the cost of benefits. In setting a premium rate for a product, the insurer must estimate the expenses associated with developing the product, selling it, and supporting 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:

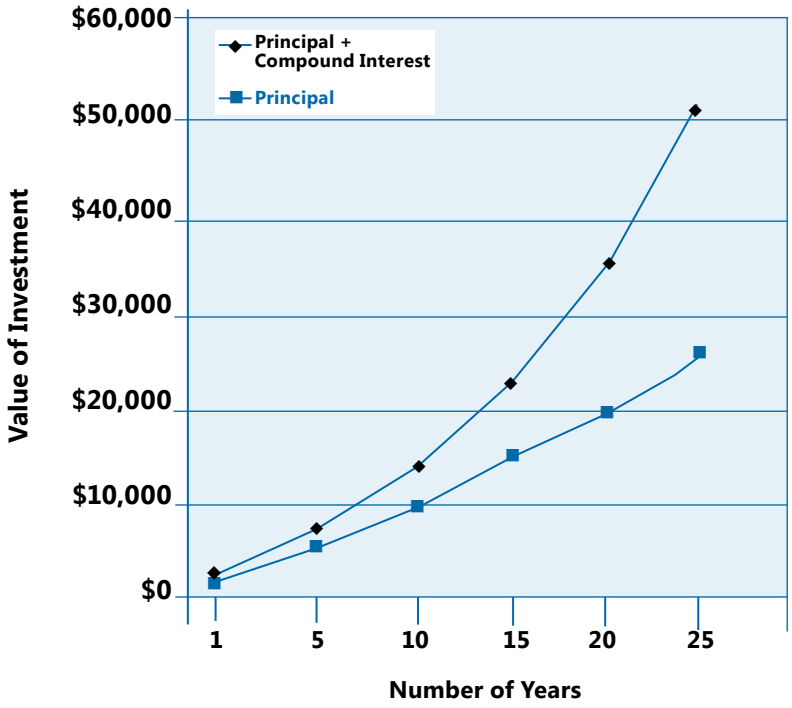
Kalinda Patel deposited $1,000 in a bank account that pays 5% simple interest. She made no other deposits for the next 25 years.

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.

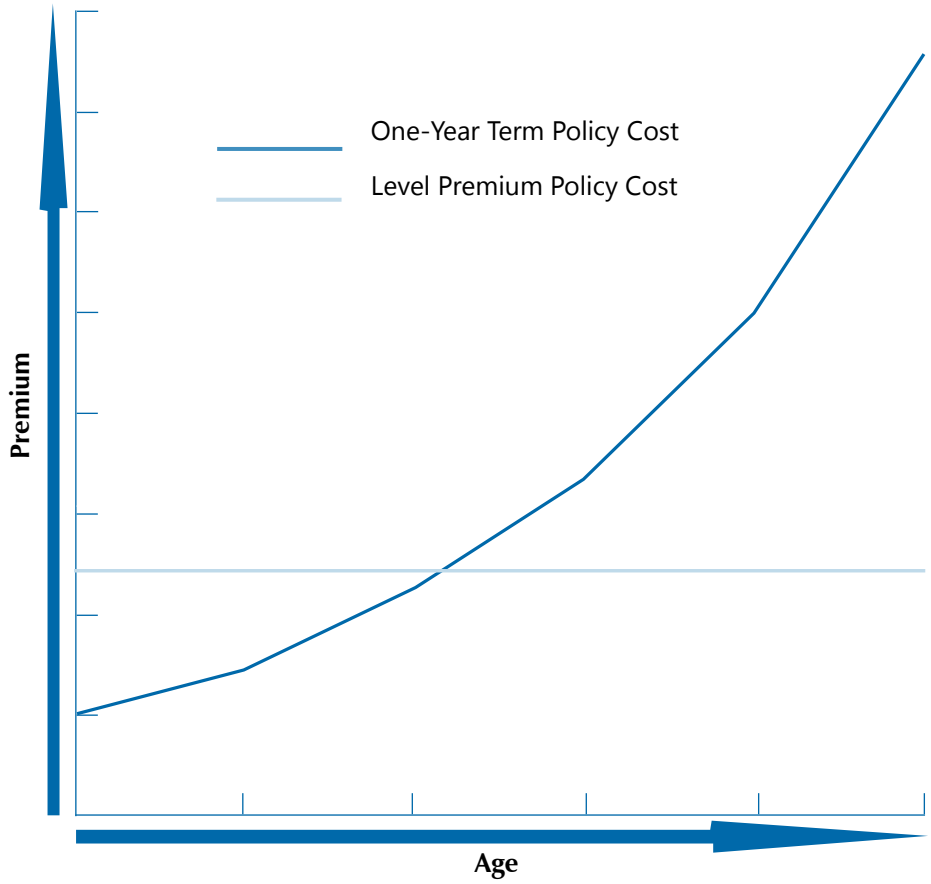
The Level Premium System

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

Chapter 5

Term Life Insurance

Objectives

After studying this chapter, you should be able to

5A Identify the common personal and business needs that life insurance can meet

5B Describe the coverage provided by level term, decreasing term, and increasing term life insurance policies, and explain when the premium charged for term life insurance coverage may increase

5C Describe renewable term life insurance and convertible term life insurance

5D Describe the operation of a return of premium (ROP) term policy

Outline

Needs Met by Life Insurance
- Personal Needs
- Business Needs

Term Life Insurance
- Characteristics of Term Life Insurance Products
- Plans of Term Life Insurance Coverage
- Features of Term Life Insurance Policies

In this chapter, we describe various types of term life insurance products. Term life insurance is distinct in that it remains in force for a specific period of time, rather than for the entire life of the insured. Why would a person choose to be covered for only a portion of her life? It depends on what her needs are.

Many products, life insurance included, meet different needs for different people. One clear example is the automobile. One person might purchase a vehicle with four-wheel drive and high ground clearance to carry heavy loads over dirt roads. Another may need a small, fuel-efficient vehicle for an urban commute—until she starts a family, when she decides a larger vehicle with comprehensive safety features is more important. Financial products such as life insurance also cover a wide variety of needs. A person's financial needs can be very different from his neighbor's. They can even be very different from what his needs were when he was younger, or what his needs will be in the future.

Needs Met by Life Insurance

Recall that life insurance policies pay a policy benefit following the death of the insured. The beneficiary can use this benefit for a variety of purposes, including both pre-existing needs and needs that arise upon a person's death. Individuals and businesses both have needs life insurance can meet.

Personal Needs

People's needs for life insurance coverage vary greatly, but most buyers share a number of common reasons to purchase life insurance. Among the most common of these needs are dependents' support, paying debts and final expenses, and estate planning.

Dependents' Support

If a person who supports or helps support a family dies, the surviving dependents may face serious problems after the person's death. Household expenses persist; rent or mortgage payments still come due; utility bills continue to arrive; food and clothing remain necessities. The death may create additional expenses, such as the need to provide child care or household upkeep. To make matters worse, surviving family members often must make difficult financial decisions while they are still coping with the emotional effects of the loss of a loved one.

Many people save money for unexpected expenses. But relatively few have sufficient funds to pay their usual expenses for an extended period of time if the regular family income is reduced substantially or ceases altogether. Even those who possess sufficient savings may worry that using those savings to pay household expenses will make it more difficult for them to meet future financial needs, such as providing for retirement.

Life insurance can provide funds to support dependents until they obtain new methods of support or adjust to living on a lower income. It also can fund the education of the insured's dependents.

Example:

Derek Chau purchased a $250,000 life insurance policy. At the time of his death, he had a wife, Kelly—the policy beneficiary—and two teenage children.

Analysis:

The policy was in force upon Derek's death, so the insurer paid $250,000 to Kelly. Kelly used $15,000 of the proceeds to pay Derek's final expenses and put $100,000 toward college funds for the children. She placed the remaining $135,000 in the bank to help her make mortgage payments and cover household expenses for the next few years.

In many jurisdictions, when an insurer pays the death benefit of a life insurance policy in a lump sum to a beneficiary following the death of the insured, that benefit usually is not considered taxable income to the beneficiary. Regulators provide this tax benefit to encourage people to protect their dependents with life insurance. By doing so, they hope to lessen potential reliance on government aid.

Debts and Final Expenses

When a person dies, he often leaves a variety of debts, such as mortgage loans, educational loans, personal loans, credit accounts, and automobile loans. Some expenses arise as a result of the person's death itself, such as doctor and hospital bills that are not covered by insurance, and of course funeral expenses. Furthermore, various taxes may come due. Balanced against these debts and taxes are the individual's assets. These assets may include cash, bank and investment accounts, real estate, personal possessions, and possibly ownership interests in a business. The accumulated assets that an individual owns when she dies are referred to as that person's ***estate***. When the individual dies, her estate is distributed in an orderly manner according to the law.

In general, an individual can determine who will receive the assets in her estate by executing a ***will***, which is a legal document that directs how the individual's property is to be distributed after her death. If an individual does not execute a valid will during her lifetime, the law determines how the property is to be distributed.

When a person dies, a personal representative typically is appointed to settle the deceased person's estate. The personal representative is known as the *executor* if the person died with a valid will, or the *administrator* if the person died without a valid will. The responsibilities of settling an estate include identifying and collecting the deceased's property, filing any required tax forms, collecting all debts owed to the deceased, and paying all outstanding debts that the deceased owed. The personal representative then distributes the remaining property according to the deceased person's will or the applicable law.

To ensure that her estate is distributed properly, a person should have an ***estate plan***, which is a plan that considers the amount of assets and debts that a person is likely to have when she dies and how best to preserve those assets so that they can be distributed as she desires. An estate plan is particularly important because a person's death generally does not extinguish her debts. Instead, the debts must be paid from the deceased's estate before her heirs can receive any assets from the estate.

Example:

Monica LeBeau died with a will in place and an estate worth $600,000, including a home worth $200,000. She also had $120,000 in final expenses, mortgage debt, and credit card debt. Her will specified that her oldest child, Reba, would receive the family home, and the remainder of her estate would be divided between her two younger children, Ben and Luke.

Analysis:

Monica's executor paid off her debts from her estate. After the debts were settled, the remaining estate was worth $480,000, including the home. Reba received the home, and Ben and Luke divided the remaining $280,000 worth of Monica's estate between them.

If Monica's final expenses and debt had been $420,000, the executor would not have been able to pay them out of her estate without selling the family home, and Monica would not have been able to leave the home to Reba.

However, if a life insurance policy is included in the deceased's estate plan, the proceeds can help pay those remaining debts. The personal representative then can distribute the deceased's assets in accordance with the deceased's wishes.

In some cases, other people, such as a spouse or parent, may be personally liable for a particular debt of the deceased. For example, a spouse or parent may have co-signed a loan with the deceased and be jointly liable with the deceased for its repayment. Insurance benefits can help pay off any such debts, easing the burden on the deceased's loved ones.

Figure 5.1 describes some methods for determining how much life insurance an individual should purchase.

Business Needs

Businesses also have needs that life insurance can meet. Two common reasons for a business—or an individual who owns a business—to purchase life insurance are (1) to provide funds to ensure that the business continues in the event of the death or disability of an owner, partner, or other key person, and (2) to provide benefits for its employees.

Figure 5.1 How Much Life Insurance Is Enough?

Without the ability to predict the future, it's impossible to know exactly how much life insurance a person will need. But life insurance companies are specialists at making educated estimates. They also try to teach customers how to make informed estimates on their own. A very simple method is to use a formula based on the person's current income. For example, an insurer's formula might recommend that people purchase at least five times their current income in life insurance. Thus, a person who earns $60,000 a year would be advised to purchase at least $300,000 of life insurance. These multiples vary widely, depending on the person or institution making the recommendation, and of course are very general estimates.

A more exacting method requires the person to develop a comprehensive picture of her financial situation and future financial needs by evaluating her debts, savings, expenses, and family situation. Insurance companies and financial advisors make this task easier by offering various software programs and mobile applications designed to help organize the required information. These programs, usually called *life insurance needs calculators* or simply *life insurance calculators*, are generally available at no charge on an insurer or financial publication's website. Some non-profit organizations, such as Life Happens (www.lifehappens.org), were founded with the intention of educating the public on the benefits of owning life insurance and related products. Providing free access to life insurance needs calculators is an integral part of this strategy.

Business Continuation Insurance

A ***business continuation insurance plan*** is 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. A ***key person*** is any person or employee whose continued participation in the business is vital to the success of the business and whose death or disability would cause the business to incur a significant financial loss. A business continuation insurance plan often includes key person life insurance or a buy-sell agreement.

Key Person Life Insurance

Key person life insurance, or *key employee life insurance*, is individual life insurance that a business purchases on the life of a key person. When a business purchases key person life insurance, the business owns, pays the premiums on, and is the beneficiary of the insurance policy. If the key person dies, the business receives the death benefit.

Key persons typically include a company's owners, executives, and managers—those who have the knowledge, experience, and expertise to manage the company successfully. However, other people also may be vitally important to the continued success of the business. For example, a top salesperson or an employee with important business contacts may be responsible for a large portion of the company's income. Similarly, a lead engineer might be the only person with enough technical expertise and familiarity with the company's equipment to maximize manufacturing efficiency.

The loss of a key person's expertise and services may seriously affect the company's earnings. During the period following the death of a key person, sales may drop off, and morale and productivity can decline. Creditors, customers, and suppliers may become uneasy. The business almost certainly incurs the cost of finding or training a replacement for the key person. Key person life insurance helps offset those costs. In addition, if the company's creditors, customers, and suppliers know that the business has protected itself by insuring the lives of its key employees, they may be more confident about the company's future.

Example:

Electric Galaxy Software Solutions considers its owners and executives to be key persons. It also identifies its lead software engineer, Rebecca Sloe, as a key person. Rebecca is well-known in the industry for her innovative work. The business purchases key person life insurance on Rebecca as well as on its owners and executives.

Analysis:

If Rebecca were to die, the proceeds from her policy would provide a source of cash to supplement the company's earnings while it searches for and trains a replacement for her. In addition, if Electric Galaxy's customers and suppliers know about the key person life insurance, they may be more confident about the company's future and may agree to continue their business relationships with Electric Galaxy on the same basis as before Rebecca's death.

Buy-Sell Agreements

The owner of a small business may want to ensure that the business can continue to operate under new ownership after his death. A ***buy-sell agreement*** is 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. One or more of the parties to a buy-sell agreement often purchase life insurance to fund the buy-sell agreement. Life insurance can be used to fund buy-sell agreements for sole proprietorships, partnerships, or corporations with a small number of shareholders.

Example:

Emmett Jackson is the sole owner of Reliable & Timely Services. Emmett entered into a buy-sell agreement with one of his employees, Kareena Singh. Under the agreement's terms, Kareena agreed to buy the business for $1,000,000 in the event of Emmett's death. She purchased a $1,000,000 life insurance policy on Emmett's life, naming herself as the beneficiary.

Analysis:

Should Emmett die, the proceeds of the life insurance policy would be paid to Kareena. Kareena could use the proceeds to purchase Reliable & Timely Services from Emmett's estate, which has been directed to sell the business to Kareena in this situation.

Employee Benefits

Many businesses provide various financial products, including life insurance, for their employees as an employee benefit. These compensation packages enable businesses to attract and retain qualified personnel. Many employers provide health insurance and retirement plans, which we'll explore later in the text; group term life insurance is also very common, as we'll discuss below.

Term Life Insurance

All life insurance policies provide for the payment of a benefit upon the death of the insured while the policy is in force. Therefore, all life insurance policies help individuals and businesses meet the needs we discussed earlier. But the more features a policy has, and the more needs it meets, the more expensive it tends to be. Term life insurance is usually the least expensive plan of life insurance available. Therefore, individuals and businesses often choose term life insurance to meet their needs. In 2014, 39 percent of new individual life insurance policies purchased in the United States were term life policies, for a total face amount of $1.1 trillion.[1] A life insurance policy's ***face amount*** is the amount of life insurance benefits for which an individual applies and that the insurer approves. Group term life policies are also the most common form of group life insurance purchased.

Characteristics of Term Life Insurance Products

Term life insurance is life insurance that provides coverage only if the insured dies during the period specified in the policy; that specified period is known as the ***policy term***. The death benefit is payable *only* if (1) the insured dies during the policy term, *and* (2) the policy is in force when the insured dies. If the insured lives until the end of the specified term, the policy may give the policyowner the right to continue some form of life insurance coverage. If the policyowner does not continue the coverage, then the policy expires and the insurer has no obligation to provide further insurance coverage.

The length of the policy term varies considerably from one policy to another. For example, some insurers issue travel insurance policies that provide a policy benefit only if the insured dies during a specified trip. Insurers also sell policies that cover a term of a specified number of years, such as 1 year, 5 years, 10 years, 20 years, or 30 years.

When term life policies were first introduced in the United States, the vast majority purchased were for a one-year term. Over time, longer terms have grown more popular, to the point that now 20-year term policies are the favorite choice with customers. Figure 5.2 shows how this change has occurred over time.

Term life policyowners typically must pay annual renewal premiums on the policy anniversary to keep the coverage in force. The ***policy anniversary*** generally is the anniversary of the date on which coverage under the policy became effective. Both the *policy date*—the date on which the policy's coverage begins—and the *expiration date*—the date on which the policy's coverage ends—are usually stated on the face page of the policy.

Figure 5.2 Term Insurance Sales Over Time

	1990	1995	1999	2001	2005	2008	2010	2012	2014	2015
1 Year	62	37	13	9	5	7	6	7	6	6
10 Year	9	14	21	23	20	18	16	19	20	21
20 Year	1	3	18	35	38	41	36	39	37	38
Other	28	46	48	33	37	34	42	35	37	35
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: LIMRA's U.S. Individual Life Buyer Study and Quarterly Individual Life Sales Survey.

Another common type of term insurance policy covers the insured until she reaches a specified age, usually age 65 or 70. For example, a term insurance policy that covers an insured until age 65 is referred to as *term to age 65*. However, the policy does not expire on the actual date when the insured reaches the specific age. Instead, the policy's coverage expires on the policy anniversary that falls either closest to, or immediately after, the insured person's 65th birthday, depending on the terms of the policy.

Example:

Twin brothers Alex and Byron Freeman were born on September 4, 1980. Both purchased term to age 65 policies, effective on the same day, July 7, 2011. Alex's coverage expires on the policy anniversary *closest to* his 65th birthday, while Byron's expires on the policy anniversary *immediately after* his 65th birthday. Both plan to pay all renewal premiums as they come due.

Analysis:

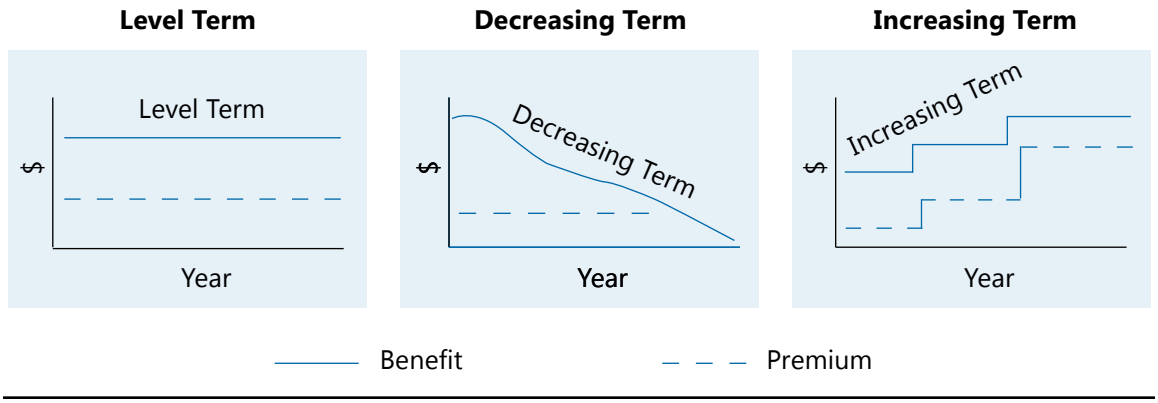
Alex's policy will expire on July 7, 2045, the anniversary date closest to his 65th birthday of September 4, 2045. Byron's policy will expire on July 7, 2046, the first policy anniversary immediately after his 65th birthday.

Another distinctive characteristic of term life is that it does not accumulate a cash value. We discuss cash value insurance in more detail in the next chapter.

Plans of Term Life Insurance Coverage

The amount of the benefit payable under a term life insurance policy usually remains the same throughout the term of the policy. To meet specific customer needs, term life policies are also available with benefits that either increase or decrease over the policy's term. Figure 5.3 illustrates the differences in these plans.

Figure 5.3 Term Life Insurance Plans



Level Term Life Insurance

By far, the most common plan of term insurance is ***level term life insurance***, which provides a death benefit that remains the same over the policy term. Level term policies also usually feature *level premiums*, where the amount of the initial premium and each renewal premium remains the same throughout the stated policy term. However, some level term policies provide for renewal premiums that may increase during the policy term, although the death benefit remains the same.

Example:

Andrea Kovachev owns a 10-year level term policy that provides $250,000 of coverage. The initial premium was $500, and the policy features level premiums.

Analysis:

The insurer agrees to pay $250,000 if Andrea dies at any time during the 10-year period that the policy is in force. Each renewal premium also will be $500 throughout the policy term.

Decreasing Term Life Insurance

Decreasing term life insurance provides a death benefit that decreases in amount over the policy term. The death benefit begins at a specific amount and then decreases over the policy term according to a method described in the policy. For example, assume that the benefit during the first year of coverage for a 10-year decreasing term policy is $100,000 and that the benefit then decreases by $10,000 on each policy anniversary. The coverage is $90,000 for the second policy year, $80,000 for the third year, and so forth, down to $10,000 for the tenth year. At the end of the 10th policy year, the coverage expires.

The renewal premiums for a decreasing term policy usually remain the same throughout the policy term. However, they are usually less than the renewal premiums for a comparable level term policy.

Decreasing term policies are typically designed to meet specific needs that decrease over a period of time. For example, many people borrow money to purchase houses or cars, and as they repay those loans, their liabilities decrease. Similarly, a family's expenses decrease as children grow up and move away from home. A decreasing term policy usually is specifically intended to shield dependents from inherited debts such as a mortgage, car payments, or credit card debts.

Three common plans of decreasing term insurance are mortgage life insurance, credit life insurance, and family income insurance.

Mortgage Life Insurance

The largest debt that many people owe is the mortgage loan on their homes. Under the terms of a typical home mortgage loan, a borrower makes equal monthly payments for a period of time, usually either 15 or 30 years. Each payment the borrower makes on a mortgage loan consists of both principal and interest on the loan. The amount of the outstanding principal balance owed on the mortgage loan gradually decreases over the term of a mortgage, although initially the decrease is fairly slow.

Mortgage life insurance, sometimes referred to as *mortgage redemption insurance*, is a plan of decreasing term insurance designed to provide a benefit amount that corresponds to the decreasing amount owed on a mortgage loan.[2] If the borrower purchases mortgage life insurance, the amount of the death benefit payable at any given time generally equals the amount the borrower owes on the mortgage loan at this time. The term of a mortgage life policy is based on the length of the mortgage. Renewal premiums payable for mortgage life insurance are generally level throughout the term.

Often, the beneficiary of a mortgage life policy is a family member of the insured, and the beneficiary uses the death benefit to pay off the mortgage. Typically, however, the beneficiary is not required to pay off the mortgage; she may choose to invest the benefit instead, or use it for other purposes. Because the insurance policy usually is independent of the mortgage, the mortgage lender is not a party to the insurance contract.

In some cases, a mortgage lender may require the borrower to purchase mortgage life insurance as a condition for obtaining a mortgage loan. The policy names the lender as beneficiary, and the lender requires the borrower to maintain the coverage throughout the mortgage term. If the borrower dies during the mortgage term, the lender receives a benefit equal to the remainder due under the mortgage loan. The insurance company is not a party to the mortgage loan contract. Its only obligation is to carry out its duties under the mortgage life policy. In Canada, the beneficiary of a mortgage life policy is automatically the mortgage lender.

Example:

When Hector Ruiz purchased his home, he also bought a mortgage life insurance policy from Enduring Life Insurance Company. Hector named his wife, Alisa, as beneficiary.

Anna Zolkozky purchased a house at the same time and applied for a mortgage loan from Grandiose Banking. As a condition of the loan, Grandiose required Anna to purchase a mortgage life insurance policy naming Grandiose as the beneficiary, and to maintain the coverage during the mortgage term. Anna purchased her policy from Enduring Life.

Seven years later, both Hector and Anna died, and the death benefit on each of their mortgage life insurance policies was $120,000.

Analysis:

In both cases, Enduring Life was obligated to pay the $120,000 to the beneficiary. In Hector's case, his beneficiary, Alisa, could use the benefit to pay off the remaining balance on the mortgage loan or put it toward another purpose, such as a college fund for their children. As the beneficiary of Anna's policy, Grandiose used the benefit to pay off her mortgage.

Many mortgage loans are obtained jointly by two people, both of whose incomes are required to make the monthly mortgage payments. For that reason, insurers offer ***joint mortgage life insurance***, which provides the same benefit as a mortgage life insurance policy except the joint policy insures the lives of two people. If both insureds survive until the end of the policy term, the joint mortgage life policy expires. But if one of the insureds dies while the policy is in force, the insurer pays the death benefit to the beneficiary, who typically is the surviving insured. Again, the beneficiary is not required to use the benefit to pay off the mortgage.

Example:

Kofi and Jenna Morant purchased a joint mortgage life policy soon after buying their house. Kofi named Jenna as his beneficiary, and Jenna named Kofi as hers.

Analysis:

If Kofi dies while the policy is in force, the insurer will pay an amount equal to the mortgage loan's balance to Jenna. If Jenna dies instead, the insurer pays the amount to Kofi. Either one would be free to use the benefit amount to pay off the remaining balance on the mortgage loan or to use it for other purposes.

Credit Life Insurance

Life insurance also is available to ensure the repayment of other types of loans besides mortgages. ***Credit life insurance*** is 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. Like mortgage life insurance, credit life insurance usually is decreasing term insurance. Unlike mortgage life insurance policies, credit life insurance policies *always* provide that the death benefit is payable directly to the lender, or creditor, if the insured borrower dies during the policy's term. Credit life insurance guarantees the lender that the insured's outstanding debt will be paid if the insured borrower dies before the loan is repaid. Generally, the loan must be a type of loan that can be repaid in 10 years or less.

Credit life insurance is available for automobile loans, furniture loans, and other personal loans. Insurers typically issue credit life policies through lenders such as banks, finance companies, credit unions, and retailers. As with mortgage life insurance, the amount of the benefit payable under a credit life insurance policy is usually equal to the amount of the unpaid debt. Thus, as the amount of the loan decreases, the amount of credit life insurance provided decreases. In addition, some credit card holders are covered by credit life insurance for the amounts they owe on their accounts. In such cases, the amount of life insurance coverage in force at any given time may increase or decrease depending on the amount of the outstanding debt.

Premiums for credit life insurance may be level over the duration of the loan or, in cases in which the amount of the loan varies, may increase or decrease as the amount of the outstanding loan balance increases or decreases. In most cases, the insured pays the premium to the lender, and the lender then remits the premium to the insurer.

Family Income Coverage

Family income coverage (called *survivor income benefit* in Canada) is 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. Monthly income benefits continue until the end of the term specified when the coverage was purchased. Family income coverage is a form of decreasing term life insurance because the longer the insured remains alive during the term of coverage, the shorter the length of time over which the insurer is required to pay monthly income benefits and the smaller the total amount of benefits the insurer will pay out. The beneficiary of family income coverage typically is the insured's surviving spouse. This form of term insurance can meet the need of providing for a family until the children can support themselves.

Under some family income coverages, the insurer promises to pay the income benefit amount for at least a stated minimum number of years if the insured dies during the policy's term.

Example:

Arnold Kim purchased 10-year family income coverage that provides for a $1,000 monthly income benefit payable to his wife, Nari. His coverage specifies that the income benefit will be paid for at least 3 years if he dies during the 10-year term of coverage.

Analysis:

If Arnold dies 2 years after buying the family income coverage, the insurer will pay to Nari a total of $96,000 in monthly income benefits ($1,000 x 8 years x 12 months). If he dies 8 years after buying the coverage, the insurer will pay the monthly income benefit for 3 years, for a total of $36,000 ($1,000 x 3 years x 12 months). If he dies 11 years after purchasing the coverage, no monthly income benefit would be paid because the coverage expired a year before his death.

Family income coverage is most commonly purchased as a policy rider to a cash value life insurance policy, a type of policy that we describe in the next chapter. A ***policy rider***, also known as an *endorsement*, is an amendment to an insurance policy that becomes part of the insurance contract and changes its terms. A policy rider is as legally effective as any other part of the insurance contract. Riders commonly provide some type of supplementary benefit or increase the amount of a policy's death benefit.

When a family income coverage rider is added to a life insurance policy, the beneficiary is entitled to receive the death benefit of the policy if the insured dies while the policy is in force. If the insured dies within the term of the family income rider, the beneficiary will receive both the death benefit and the monthly income benefit for as long a period as the rider provides. A cash value life insurance policy with a family income coverage rider is referred to as a ***family income policy***.[3]

Increasing Term Life Insurance

Increasing term life insurance provides a death benefit that starts at one amount and increases by some specified amount or percentage at stated intervals over the policy term. For example, a policy may provide coverage that starts at $100,000 and then increases by 5 percent on each policy anniversary date throughout the policy term. Alternatively, the death benefit may increase according to increases in the cost of living, as measured by a standard index such as the Consumer Price Index (CPI).[4] If the CPI has increased by 2 percent since the last policy anniversary date, for example, the death benefit also would increase by 2 percent.

People often purchase increasing term insurance as a rider to a life insurance policy, and usually just for a limited time to meet a specific need, such as providing funds for a child's education.

Features of Term Life Insurance Policies

Term life insurance provides only temporary protection; at the end of the stated term, the policy expires. A policyowner who wants to maintain insurance coverage after the policy expires must apply for a new policy. However, the new policy must be underwritten, and the premium will be higher to take into account the increased age of the insured. If the insured's health has declined during the policy term, the insured may now be a substandard risk—raising premiums even higher—or even no longer insurable. To meet this customer need to continue life insurance coverage, insurers include renewability and convertibility features in some term life insurance policies.

Renewable Term Insurance

A ***renewable term insurance policy*** is 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***—proof that the insured person continues to be an insurable risk. The provision in the policy that gives the insured the option to continue coverage for an additional policy term without presenting evidence of insurability is called the ***renewal provision***. In order to continue coverage at the end of the specified term, the insured is not generally required to undergo a medical examination or to provide the insurer with an updated health history. Often, all the policyowner must do to renew the policy is pay the renewal premium.

Example:

Ten years ago, Maria Donato purchased a ten-year renewable term policy from Wellbeing First Insurance Company. Eight years ago, she began smoking again, and three years ago she was placed under observation for cardiac arrhythmia.

Analysis:

Maria may renew her term insurance policy by paying the required renewal premium. Ordinarily, Wellbeing First would have declined an application for insurance from an applicant with Maria's health history at the time of renewal. But the renewal provision of Maria's policy gives her the right to renew without proof that she continues to be an insurable risk.

According to the provisions of a typical renewable term insurance policy, the policyowner has the right to renew the coverage for the same term and face amount that the policy originally provided. For example, a policyowner usually can renew a $250,000 10-year renewable term policy for another 10-year period and for $250,000 in coverage. Most insurers also allow the policyowner to renew the policy for a *smaller* face amount or a *shorter* period than provided by the original contract, but not for a larger face amount or a longer period.

Many renewable term policies place limits on the policyowner's right to renew. The most common limitations are that the coverage may be renewed only (1) until the insured reaches a stated age or (2) a stated maximum number of times. For example, the renewal provision of a policy may specify that the coverage is not renewable after the insured has reached the age of 75. Another policy may state that the coverage is renewable no more than three times. Such restrictions exist to minimize antiselection.

When a policyowner renews a term life insurance policy, the policy's premium rate increases because the insured is older than when the policy was issued. The renewal premium rate is based on the insured person's ***attained age***—the age the insured has reached (attained) on a specified date, which in this case is the renewal date. Usually, the renewal premium rate remains level throughout the new policy term.

Example:

Douglas Woo purchased a 10-year renewable term life insurance policy on his wife Ellen, age 36. The policy states that coverage is not renewable after the insured has reached the age of 65. The policy's annual premium is $260.

Analysis:

On the policy anniversary at the end of the first 10-year term, Douglas has the right to renew Ellen's coverage without Ellen having to provide evidence of insurability. The coverage will be for the same face amount as the original policy and for the same 10-year term. The new premium amount, however, will increase to reflect Ellen's attained age at the *time of renewal*—age 46. Douglas will pay this higher premium each year during the 10-year renewal period. At the end of the second 10-year period, he will have the option to renew the policy again, but the premiums will increase a second time to reflect Ellen's attained age of 56. At the end of the third 10-year period, he will no longer be able to renew this policy, as it will be the policy anniversary date after her 65th birthday.

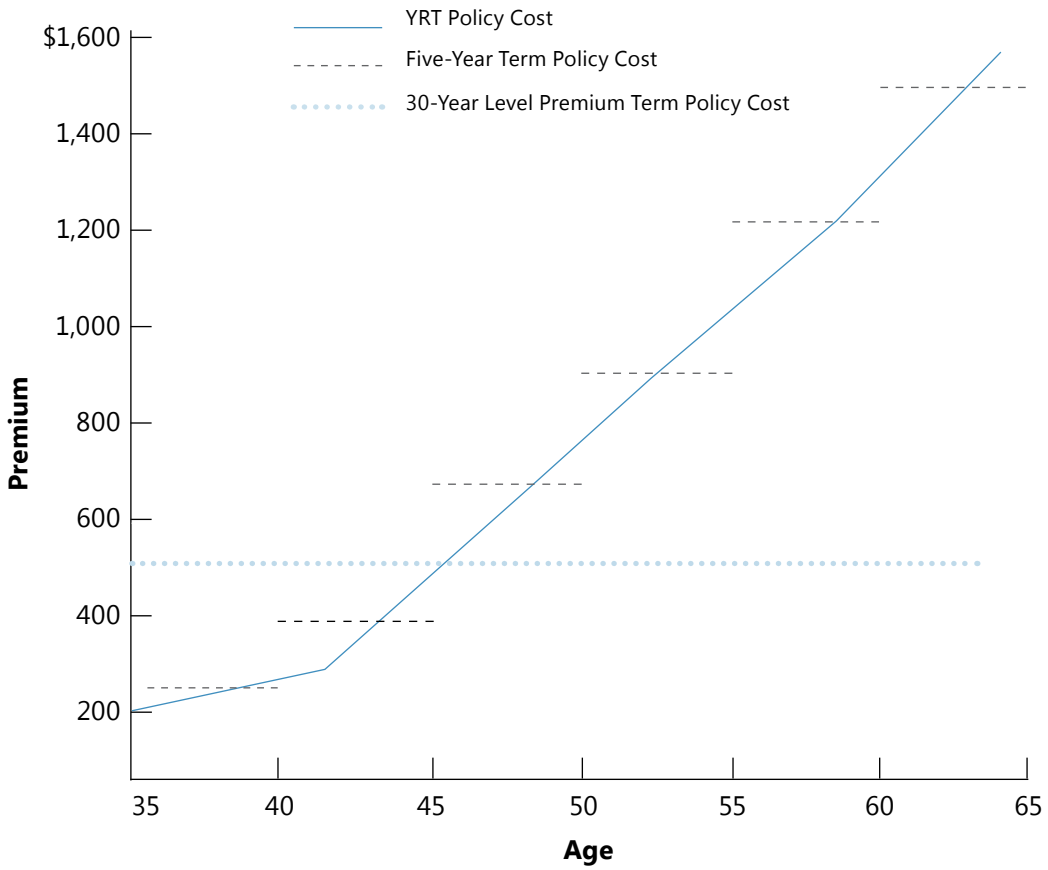
The renewal feature can lead to some antiselection; insureds in poor health are more likely to renew their policies because they may not be able to obtain other life insurance. Because of this risk, the premium for a renewable term life insurance policy usually is slightly higher than the premium for a comparable nonrenewable term life insurance policy.

Most one-year term insurance policies and riders are ***yearly renewable term (YRT) insurance*** or *annually renewable term (ART) insurance*, which means they are renewable each year for a stated number of years. Yearly renewable term policies typically are renewable for periods of 10 to 30 years, depending on the age of the insured. As the insured ages, however, the renewal premiums for YRT coverage can become considerably more expensive than premiums for comparable 5- or 10-year level premium policies. For that reason, most renewable term insurance policies sold today have policy terms of from 5 to 30 years. Figure 5.4 illustrates the difference in premium costs between a YRT policy, a 5-year term policy, and a 30-year term policy as an insured ages.

Convertible Term Insurance

Younger people often purchase term insurance because of the lower premium cost, but they may want cash value insurance later, when they can afford it. A ***convertible term insurance policy*** gives the policyowner the option to convert the term policy to a cash value life insurance policy without providing evidence of insurability. Convertible term insurance policies contain a ***conversion privilege***, which allows the policyowner to change—convert—the term insurance policy to a cash value policy without providing evidence of insurability. Some policies, known as *renewable/convertible term insurance policies*, are both renewable and convertible.

Figure 5.4 Relative Premium Costs of a YRT Policy, a 5-Year Term Policy, and a 30-Year Term Policy



When a term insurance policy is converted to a cash value policy, the new premium rate is higher than the premium rate the policyowner paid for the term insurance policy. This increase is required because the premium charged for a cash value life insurance policy is higher than the premium charged for a comparable term insurance policy. However, the premium a policyowner is charged for the cash value policy cannot be based on any increase in the insured's mortality risk, except with regard to an increase in the insured's age.

Insurers can use two different types of conversions. The more common conversion is known as an ***attained age conversion***, in which the premium rate for the cash value policy is based on the insured's age at the time the policy is converted. Alternately, under an ***original age conversion***, the premium rate for the cash value policy is based on the insured's age when the original term policy was issued.

The renewal premium rate charged for cash value insurance is lower under an original age conversion than under an attained age conversion. This difference occurs because the premium rate is based on a younger age. For that reason, you would think that a policyowner would always prefer an original age conversion to

an attained age conversion. However, under an original age conversion, the policyowner also must pay an additional lump sum at the time a policy is converted. The lump sum is based on the difference between the lower premiums the policyowner actually paid for the term insurance policy and the higher premiums that he would have paid if he had purchased a cash value policy originally. This lump sum can be substantial, and as a result, attained age conversion is much more common than original age conversion.

Example:

Henrik Swenson bought a convertible term life policy at age 35 and converted it to a cash value policy at age 39, using an attained age conversion. Constance Braddock also bought a convertible term life policy at age 35, and converted it to a cash value policy at age 39, but her policy used an original age conversion.

Analysis:

At conversion, the insurer charges Henrik the same premium it would charge a 39-year-old man for a comparable cash value policy. Constance's insurer charges her the same premium rate it would charge for a comparable cash value policy issued to a 35-year-old woman. However, her insurer also requires a lump sum payment based on the difference between the premiums she paid for the last four years and the premiums she would have paid if she had purchased a cash value policy.

Like the renewal feature, the conversion privilege can lead to some antiselection. Insureds in poor health are more likely to convert their coverage because they may not be able to obtain other life insurance, or the premium rate for a new policy would be prohibitively expensive. As a result, insurers usually charge a higher premium rate for a convertible term policy than they charge for a comparable nonconvertible term policy. In addition, insurers usually limit the conversion privilege in some way. For instance, some policies do not permit conversion after the insured has attained a specific age, such as 55 or 65, or after the term policy has been in force for a specified time. For example, a 10-year term policy may permit conversion only during the first 7 or 8 years of the term. In many cases, insurers place additional limits on original age conversions. Under a 20-year term policy, an insurer might permit an attained age conversion for the first 10 years of the policy term, but permit an original age conversion only during the first 5 years of the policy term.

Return of Premium Term Insurance

Some people are reluctant to purchase term insurance because they see it as a financial risk. If they are alive when the policy expires, they will receive no monetary benefits from the insurer despite having paid premiums for a number of years. Some insurers now offer ***return of premium (ROP) term insurance***, which is a form of term life insurance that provides a death benefit if the insured dies during the policy term and promises a return of premiums if the insured does not die during the policy term.

Example:

Helene Nikos, age 38, is the policyowner-insured of a $500,000 30-year ROP term policy from Azure Insurance. Helene paid all the required annual premiums of $1,150 and was alive when the policy expired.

Analysis:

Azure would return to Helene the premiums she has paid for the coverage, a total of $34,500 ($1,150 x 30 years).

Some ROP term policies provide a partial return of premiums if the policy is kept in force for a stated period of time but then canceled before the end of the term. The longer these policies are kept in force, the greater the percentage of the premium that is returned. Under such a policy, if the insured dies during the policy term, the beneficiary receives the death benefit only; there is no additional partial return of premiums.

Most insurers offer ROP term policies for terms of only 15 years or longer. The premium for an ROP term policy varies by insurer. The premium is usually more than 25 percent higher than for a comparable term policy without a return of premium feature, and sometimes as much as three times as high.

Renewability, convertibility, and return of premium features are of obvious potential value to the policyowner, but they also are of value to the insurance company. Most policyowners who renew or convert their term life insurance policies do so not because they are in poor health, but because they want to continue their insurance protection. Regulatory changes have led to fewer insurers in the United States carrying the return of premium feature, but this feature also gives policyowners substantial motivation to keep a policy in effect.

Key Terms

estate
will
estate plan
business continuation insurance plan
key person
key person life insurance
buy-sell agreement
face amount
policy term
policy anniversary
level term life insurance
decreasing term life insurance
mortgage life insurance
joint mortgage life insurance
credit life insurance
family income coverage
policy rider
family income policy
increasing term life insurance
renewable term insurance policy
evidence of insurability
renewal provision
attained age
yearly renewable term (YRT) insurance
convertible term insurance policy
conversion privilege
attained age conversion
original age conversion
return of premium (ROP) term insurance

Endnotes

1. ACLI, *Life Insurers Factbook 2015* (Washington, DC: American Council of Life Insurers, 2015), 64, https://www.acli.com/Tools/Industry%20Facts/Life%20Insurers%20Fact%20Book/Pages/RP15-010.aspx (30 August 2016).
2. The term "mortgage insurance" is sometimes used to refer to a type of property/casualty insurance more commonly referred to as *private mortgage insurance (PMI)* or *lenders mortgage insurance (LMI)*. PMI is insurance that pays the lender if the borrower fails to make mortgage payments as required. PMI is **not** a form of life insurance.
3. Some insurers offer an alternative to the family income policy called a *family maintenance policy*, which is a cash value life insurance policy that contains a level-term monthly income benefit rider. If the insured dies during the term of the monthly income benefit rider, the beneficiary receives monthly income payments for a fixed number of years. For example, assume that an insured purchased a family maintenance policy with a 10-year term that provides for $1,000 monthly payments. If the insured dies during that 10-year term, the beneficiary would receive both the death benefit and a $1,000 monthly benefit for a total of 10 years, regardless of whether the insured dies in the first year or the 10th year of the policy. If the insured dies after the 10-year term expires, no monthly benefits are payable, but the beneficiary still receives the death benefit, as long as the policy remains in force.
4. The Consumer Price Index (CPI) measures the change in the price of a fixed list of items (a "basket of goods") bought by a typical consumer. The goods included in the CPI include food, transportation, housing, utilities, clothing, and medical care.

Chapter 6

Cash Value Life Insurance and Endowment Insurance

Objectives

After studying this chapter, you should be able to

6A Define cash value life insurance and distinguish it from term life insurance

6B Identify the common characteristics of whole life insurance, modified whole life insurance, and joint whole life insurance, and describe the features that differentiate these types of whole life insurance

6C Explain how universal life insurance differs from whole life insurance in terms of its separate policy elements and its flexible face amount, death benefit, and premiums

6D Explain how indexed universal life insurance differs from universal life insurance

6E Describe how variable life insurance allows policyowners to decide how their premiums and cash values are invested

6F Describe the features that variable universal life insurance products share with universal life insurance and variable life insurance products

6G Describe the characteristics of endowment insurance

Outline

Whole Life Insurance
- Premium Payment Periods
- Modified Whole Life Insurance
- Whole Life Insurance Covering More Than One Insured

Universal Life Insurance
- Separation of Policy Elements
- Operation of a Universal Life Insurance Policy
- Flexibility Features
- Periodic Statements
- Indexed Universal Life Insurance

Variable Life Insurance

Variable Universal Life Insurance

Endowment Insurance

While term life insurance policies meet many specific financial needs, they are limited in their ability to meet other needs, such as contributing to long-term savings. Therefore, insurance companies also offer cash value life insurance products. As you may recall from Chapter 1, *cash value life insurance* has two characteristics that distinguish it from term life insurance. First, cash value life insurance provides insurance coverage for the *entire* lifetime of the insured, as long as the policy remains in force. Second, cash value life insurance provides a savings element, known as the *cash value*, that a policyowner can use to meet financial needs during the insured's lifetime.

The various types of cash value life insurance accounted for nearly two-thirds of individual life insurance policies sold in the United States in 2014.[1] Figure 6.1 shows the trends in recent years in U.S. life insurance sales among the various types of insurance by premium dollars.

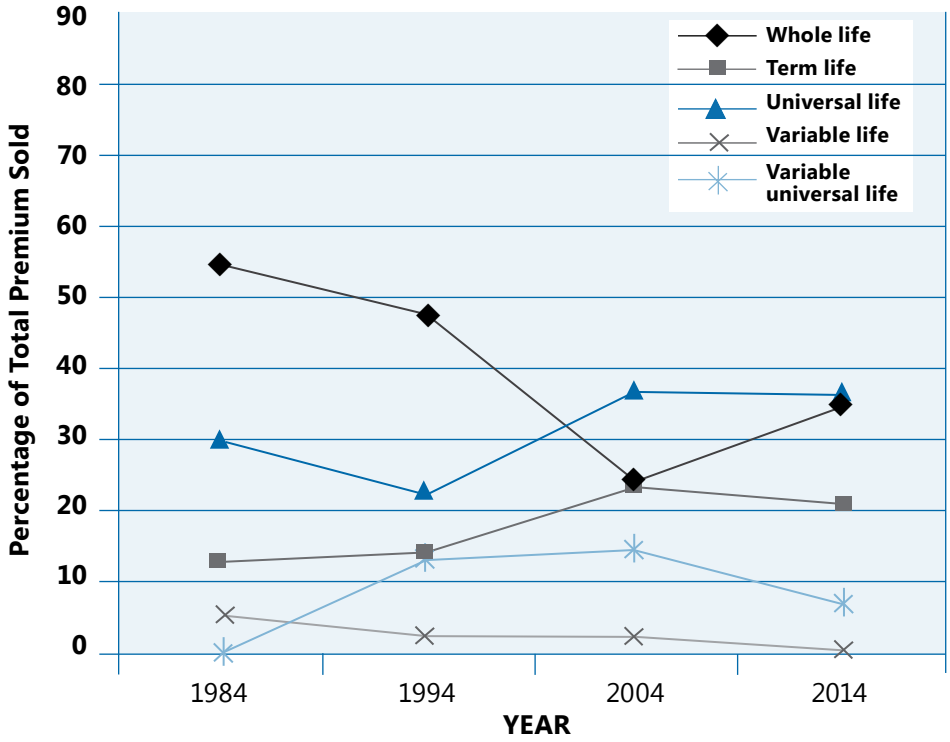
While cash value life insurance is designed for long-term financial needs, it can also be useful in the short term. The owner of a policy that has accumulated a cash value can use the cash value as security for a ***policy loan*** from the insurer. If the insured dies before a policy loan is repaid, however, the unpaid amount of the loan—plus any interest outstanding—is subtracted from the death benefit. Alternatively, the policyowner can use the cash value as collateral for a loan from another financial institution.

A policyowner can also *surrender*—or terminate—a cash value policy for its cash value during the insured's lifetime. If a policyowner chooses not to keep a cash value life insurance policy in force until the insured's death, the insurer agrees to pay the cash surrender value to the policyowner. The ***cash surrender value*** is the amount that a policyowner is entitled to receive upon surrendering the policy, before adjustments for factors such as policy loans and applicable charges. Other terms for the cash surrender value are the *surrender value* or *surrender benefit*.

Cash surrender values and policy loans are discussed in more detail in Chapter 8.

As you can see, the savings element of a cash value policy can offer useful financial options. In addition, in the United States, while the policy remains in force, the government does not collect income tax on interest or other earnings credited to the policy's cash value, nor does it collect income tax on funds borrowed from the cash value through a policy loan.[2] Further financial advantages of a cash value policy depend on the type of cash value life insurance a person owns.

Figure 6.1 U.S. Individual Life Insurance Sales, 1984–2014



- 1984: Whole life 55%, Term life 12%, Universal life 30%, Variable life 3%, Variable universal life 0%.
- 1994: Whole life 48%, Term life 14%, Universal life 22%, Variable Life 3%, Variable universal life 13%.
- 2004: Whole life 24%, Term life 23%, Universal life 37%, Variable Life 1%, Variable universal life 15%.
- 2014: Whole life 35%, Term life 21%, Universal life 37%, Variable Life <½%, Variable universal life 7%.

Source: Adapted from Ashley V. Durham and Benjamin Baldwin, *U.S. Individual Life Insurance Sales Trends, 1975–2014* (Windsor, CT: LL Global, Inc., © 2015). Used with permission; all rights reserved.

Whole Life Insurance

Whole life insurance is 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. As we noted in Chapter 4, life insurers use the level premium pricing system so that premium rates remain level even as an insured's mortality risk increases.

Note that the term *whole life* is not used consistently in the insurance industry. Sometimes, *whole life* refers to the broad classification of insurance products that are considered to be cash value life insurance. However, this text uses *whole life* to refer to a specific type of cash value life insurance product.

The size of a whole life insurance policy's cash value at any given time depends on a number of factors, such as the policy's face amount, the length of time the policy has been in force, and the length of the policy's premium payment period. Depending on factors that we discuss later in this chapter, a life insurance policy's face amount may or may not be the same as its death benefit.

Most whole life policies do not accumulate a cash value until the policy has been in effect for a minimum length of time, typically two or three years. The cash value then increases throughout the life of the policy, slowly at first, and then more rapidly in later years. During the policy's early years, the cash value is less than the policy's reserve, which is also increasing over time. Eventually, at the last year of the mortality table used to calculate premiums for that policy, both the reserve and the cash value equal the face amount of the policy. At that point, the insurer typically pays the face amount of the policy to the policyowner, even if the insured is still living.

A whole life insurance policy includes a table that illustrates how the policy's cash value grows over time. Figure 6.2 provides an example of a table of cash values.

Premium Payment Periods

Although whole life insurance policies provide insurance coverage for the entire lifetime of the insured, the time period over which policyowners pay premiums can vary. The length of a policy's premium payment period directly affects both the amount of the premium required for the policy and the pace at which the policy's cash value builds.

Continuous-Premium Policies

Most whole life insurance policies sold today are continuous-premium whole life policies. Under a ***continuous-premium whole life insurance policy*** (sometimes referred to as a *straight life insurance policy* or an *ordinary life insurance policy*), premiums are payable until the death of the insured. Because premiums are payable over the life of the policy, the amount of each premium payment required for a continuous-premium whole life policy is lower than the premium amount required under any other premium payment schedule for a whole life policy.

Limited-Payment Policies

A ***limited-payment whole life insurance policy*** is a whole life policy for which premiums are payable only for a stated period of time or until the insured's death, whichever occurs first. Many limited-payment policies provide for premiums to be payable for a specific number of years. For example, a 20-payment whole life insurance policy is a policy for which premiums are payable for 20 years. Other limited-payment policies provide for premiums to be payable until the insured reaches a specified age. For instance, a paid-up-at-age-65 whole life insurance policy provides that premiums are payable until the insured reaches the policy

anniversary either closest to or immediately following her 65th birthday, depending on the terms of the policy.

If the insured is still alive at the end of the premium payment period, premium payments cease but the coverage continues. A policy that requires no further premium payments but continues to provide coverage is said to be a ***paid-up policy***.

Limited-payment policies are designed to meet a policyowner's need for life insurance coverage that continues throughout the policyowner's lifetime and that is funded over a limited time. The policyowner, for example, may expect that her income will drop considerably when she retires, and yet she expects that she will continue to need life insurance coverage after retirement.

Figure 6.2 Growth of Cash Value in a $100,000 Whole Life Insurance Policy Issued to a Male, Age 37

End of Policy Year	Age	Cash Value
1	38	————
2	39	————
3	40	————
4	41	————
5	42	$1,258.32
6	43	1,354.60
7	44	2,367.70
8	45	3,145.79
9	46	3,386.51
10	47	4,735.39
11	48	6,291.59
12	49	8,058.71
13	50	10,038.25
14	51	12,233.41
15	52	14,644.65
16	53	17,274.78
17	54	20,128.95
18	55	23,210.96
19	56	26,521.53
20	57	30,062.42
23	60	35,066.89
28	65	43,492.52
33	70	51,731.25

*This table assumes premiums have been paid to the end of the policy year shown. These values do not include any dividend accumulations, paid-up additions, or policy loans.

Example:

Ellen Yelk, who was born on January 6, 1973, purchased a paid-up-at-age-65 whole life policy with a policy date of February 1, 2015. According to the terms of Ellen's policy, premiums are payable until she reaches the policy anniversary nearest her 65th birthday.

Analysis:

Ellen's last premium payment will be on February 1, 2038, the policy anniversary nearest her 65th birthday. At that time, if Ellen has made all required premium payments, she will have a paid-up policy that requires no further premium payments and will provide life insurance coverage for the rest of her life.

An insurer must collect sufficient premiums during the payment period of a limited-payment policy to keep the policy in force for the rest of the insured's lifetime. If the insured survives until the end of the payment period, she will have paid fewer annual premiums under a limited-payment policy than under a comparable continuous-premium policy. Therefore, the annual premium for a limited-payment policy is greater than the annual premium for an equivalent continuous-premium policy. In addition, cash values generally build more rapidly under limited-payment policies than they do under continuous-premium policies.

Single-Premium Policies

A ***single-premium whole life insurance policy*** is a type of limited-payment policy that requires only one premium payment. The single premium is substantially larger than premiums for most limited-payment policies, and a sizable cash value is available immediately on any single-premium policy.

Example:

Ahmad Brooks, a 50-year-old male, purchases a whole life policy insuring his own life with a single premium of $50,000. The insurer calculates his death benefit to be $200,000.

Analysis:

Ahmad's policy will be in force until his death, and no other premiums are required to prevent the policy from lapsing. In addition, Ahmad's policy has a cash value that is available immediately, allowing him to take out policy loans or withdraw a portion of the cash value without waiting for the cash value to build over time.

Modified Whole Life Insurance

The traditional whole life insurance products we have described provide a constant face amount of life insurance coverage in exchange for a series of level premiums or a single premium. Some insurers offer whole life insurance policies

under which either (1) the amount of the premium payments required changes at some point during the life of the policy or (2) the face amount of the coverage changes during the life of the policy.

Modified Premiums

A ***modified-premium whole life insurance policy*** is a policy for which the annual premium amount changes after a specified initial period (typically 5 or 10 years). The initial annual premium for a modified-premium policy is less than the initial annual premium for a similar continuous-premium whole life policy. After the specified period, the annual premium for a modified-premium policy increases to an amount that is somewhat higher than the usual (nonmodified) premium would have been. This new increased annual premium is then payable for as long as the policy remains in force.

The face amount of a modified-premium whole life policy remains level throughout the life of the policy. For example, a $100,000 continuous-premium whole life policy issued on the life of a 25-year-old man might have an annual premium of $700. The annual premium for a modified-premium whole life policy for the same face amount could be $420 for the first five years, with the premium increasing to $900 per year thereafter for the rest of the life of the policy. Figure 6.3 illustrates this example.

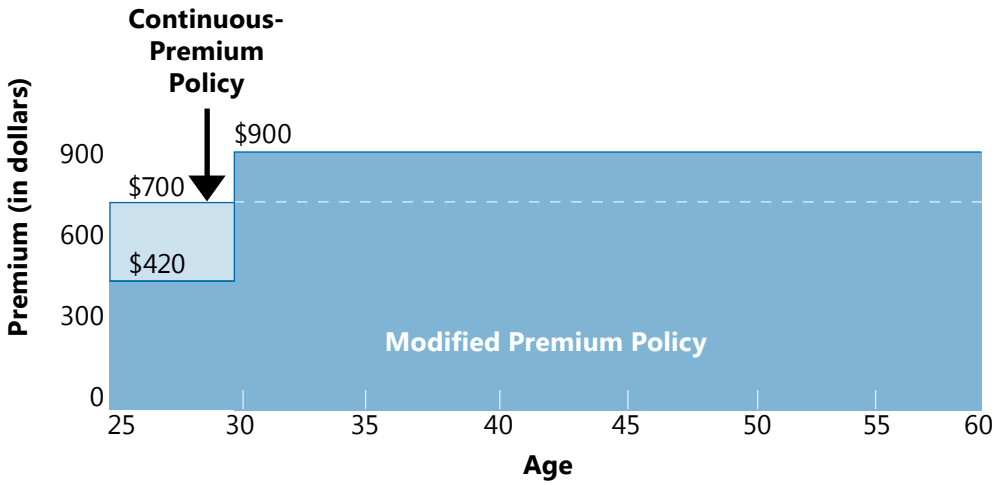
So why would a person choose a modified-premium policy over a continuous-premium policy of the same face amount? The primary advantage of a modified-premium policy is that it allows a person to purchase a larger amount of life insurance than he otherwise could afford. The premium payments become larger later, presumably when the policyowner's earnings have also increased. The chief disadvantage of a modified-premium whole life policy is that the cash value builds more slowly under this type of policy than it would under a continuous-premium whole life policy.

Modified Coverage

Many people find that the amount of life insurance they need decreases as they grow older. As a person grows older, she may pay off debts and mortgages, her children may leave home, and her financial obligations may decrease. In addition, she may have accumulated substantial savings and other assets over the years, making it even less likely she needs the same amount of life insurance. A ***modified coverage whole life insurance policy*** is a whole life 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. For example, the face amount of a modified coverage whole life policy may begin at $250,000, decrease to $150,000 when the insured reaches age 60, decrease further to $100,000 at age 70, and then remain level for the rest of the insured's lifetime.

The annual premium for a modified coverage whole life policy is lower than for a continuous-premium whole life policy having the same initial face amount. The reason for the lower premium is that during the period of the greatest risk of death—the period when the insured is at an advanced age—the face amount of the policy will be at its lowest level.

Figure 6.3 Comparison of Premiums for a Continuous-Premium and a Modified-Premium Whole Life Policy of the Same Face Amount Purchased at Age 25



Whole Life Insurance Covering More Than One Insured

The whole life insurance policies we've discussed so far provide insurance coverage on the life of only one person. However, insurers also offer whole life insurance policies that provide coverage on the lives of more than one person.[3] Some common types of such policies are joint whole life insurance, last survivor life insurance, and family policies.

Joint Whole Life Insurance

Joint whole life insurance has the same features and benefits as individual whole life insurance, except that it insures two people under the same policy. Joint whole life insurance is sometimes referred to as *first-to-die life insurance* because, upon the death of one of the insureds, the death benefit is paid to the beneficiary, who typically is the surviving insured.

Because coverage under a joint whole life policy ends once the death benefit is paid, the surviving insured may be left uninsured. To give the surviving insured the ability to obtain life insurance coverage, joint whole life policies usually provide a specified period—frequently 60 or 90 days—following the first insured's death within which the surviving insured may purchase an individual whole life policy of the same face amount without providing evidence of insurability. Some joint whole life policies provide the surviving insured with temporary term insurance coverage during this specified period. If both insureds die simultaneously, the insurer pays a death benefit for each insured.

Last Survivor Life Insurance

Last survivor life insurance—also known as *second-to-die life insurance* or *survivorship life insurance*—is a variation of joint whole life insurance under which the death benefit is paid only after both people insured by the policy have died. Premiums for last survivor life insurance coverage may be payable only until the first insured dies, or premiums may be payable until the death of both insureds. In either case, two people can obtain insurance on both of their lives for an annual premium that is usually less than the cost of either (1) two individual whole life insurance policies or (2) a joint whole life insurance policy.

Last survivor life insurance was designed primarily to insure married couples who want to provide funds to pay estate taxes that may be levied after their deaths. Joint whole life, by comparison, was designed primarily for a surviving spouse who will need a death benefit to cover continued living expenses, but won't need to leave a death benefit to a beneficiary.

Family Policies

Some insurers market a ***family policy***, which is a whole life insurance policy that includes term life insurance coverage on the insured's spouse and children. The amount of term insurance coverage provided on the insured's spouse and children is a fraction—generally one-fourth or one-fifth—of the amount of the insured's whole life insurance coverage.

Example:

Simon Park purchases a family policy with Flashstone Insurance to cover himself, his wife Linda, and their two children. Simon is the primary insured, and the family policy provides $100,000 of whole life coverage for Simon.

Analysis:

Assuming the policy remains in force, it will pay out $100,000 in the event of Simon's death. As the primary insured's spouse, Linda has $25,000 of term insurance coverage (one-fourth of the amount of the coverage on the primary insured). Each child also has $20,000 of term insurance coverage (one-fifth of the amount of coverage on the primary insured). Thus, this one family policy provides the Parks with $165,000 of life insurance coverage.

Typically, the applicant for a family policy must provide evidence that all family members are insurable. Once the policy is issued, however, each child born to or adopted by the family thereafter is automatically covered by the policy, although the additional term life coverage often is not effective until the child reaches age 15 days. Some insurers charge an additional premium for the additional coverage. However, because mortality rates are low for children older than 15 days, some family policies provide automatic coverage for additional children without any additional premium charge.

Universal Life Insurance

Universal life (UL) insurance is a form of cash value insurance that is characterized by its separation of the three primary policy elements and its flexible face amount, death benefit amount, and premiums. Universal life insurance appeals to policyowners who are interested in the flexibility and transparency that such insurance offers.

Separation of Policy Elements

Each universal life policy specifies the following policy elements: (1) the mortality charges that the insurer will apply, (2) the interest rate that the insurer will credit to the policy's cash value, and (3) the expense charges that the insurer will apply.

Mortality Charges

The insurer periodically deducts a mortality charge from a universal life insurance policy's cash value. The ***mortality charge*** is the amount needed to cover the mortality risk the insurer has assumed in issuing the policy. In other words, the mortality charge is the actual cost of the life insurance coverage.[4] For this reason, some universal life policies refer to the mortality charge as the *cost of insurance*.

The amount of the mortality charge usually is based on the insured's age, sex, and risk classification, and this charge typically increases each year as the insured ages. Universal life policies guarantee that the mortality charge will never exceed a stated maximum amount. In addition, these policies usually provide that the mortality charge will be less than the specified maximum if the insurance company's mortality experience is more favorable than expected.

Universal life policies express the mortality charge as a charge per thousand dollars of net amount at risk. A life insurance policy's *net amount at risk* is the amount of the insurer's funds that would be required at any given time to pay the policy death benefit. Although the net amount at risk for most life insurance policies at any given time is equal to the policy's face amount minus its reserve, the net amount at risk for a universal life insurance policy depends on whether the death benefit payable is level or varies with changes in the policy's cash value or premiums paid. We discuss this topic in more detail later in this section.

Interest Rate

In the United States, universal life policies incorporate a ***guaranteed minimum interest-crediting rate***, which is the minimum interest rate that an insurer must pay on a universal life policy's cash value. The policy also provides that the insurer will pay a higher interest rate if economic and competitive conditions warrant. This rate, known as the ***current interest-crediting rate***, is the rate of interest that an insurer declares and pays on a universal life insurance policy's cash value for a specified period of time. Usually, the insurer bases the current interest rate on the return that its own investments are earning. However, some policies state that the current interest rate will be tied to the rate paid on a standard investment, such as a specific type of government bond. The current interest-crediting rate is declared annually, and guaranteed to never be below the guaranteed minimum interest-crediting rate.

Expenses

Each universal life insurance policy lists the expense charges that the insurance company will impose to cover the costs it incurs in connection with the policy. Insurers commonly impose the following types of expense charges:

- A percentage of each premium (such as 4 percent) to cover expenses
- An administrative (management) fee, usually charged on a monthly basis; sometimes referred to as a *policy fee*
- A charge if the owner surrenders the policy for its cash surrender value
- Specific charges for other services such as duplicate policy copies, coverage changes, or policy withdrawals

Operation of a Universal Life Insurance Policy

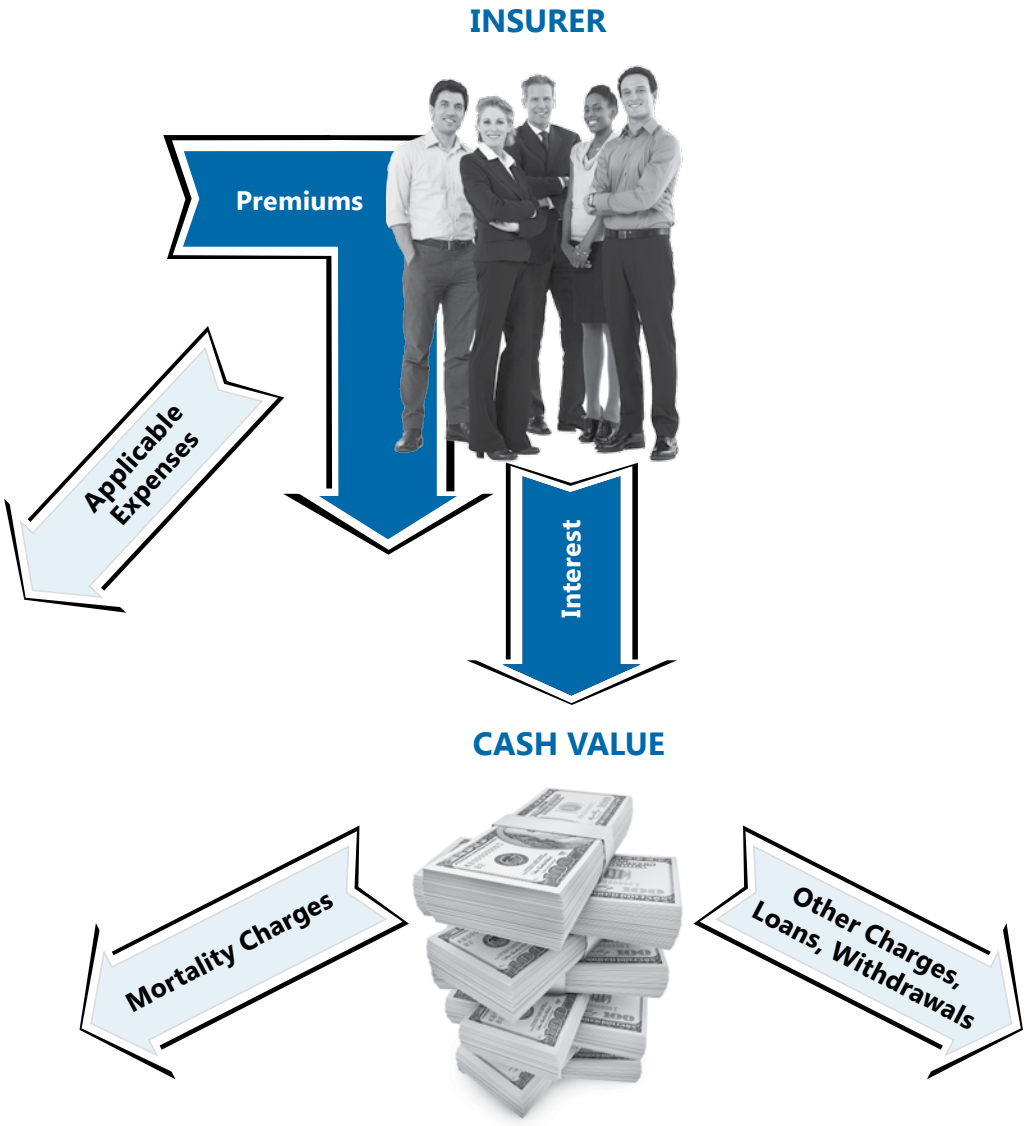
When an insurer receives a premium payment for a universal life insurance policy, it first deducts the amount of any applicable expense charges. The insurer then credits the remainder of the premium to the policy's cash value. Each month the policy remains in force, the insurer deducts the periodic mortality charges from the cash value and credits the cash value with interest. The insurer may deduct additional expense charges from the policy's cash value as well. The more a policyowner pays in premiums above the amount needed to pay the policy's mortality and expense charges, the greater the policy's cash value will be. Figure 6.4 illustrates the operation of a universal life policy.

The policyowner can increase the cash value of a universal life policy by making additional or larger-than-required premium payments, as we discuss in more detail later in this section. The policyowner usually can decrease the cash value of the policy as well by withdrawing funds from the cash value. In such a withdrawal, the cash value is reduced by the amount withdrawn plus any applicable withdrawal charges. The policy remains in force as long as the cash value is sufficient to pay the applicable mortality and expense charges. The owner of a universal life policy also can receive a policy loan, which operates in much the same way as a policy loan under a whole life insurance policy. We describe universal life policy withdrawal provisions in more detail in Chapter 8.

If the cash value of a universal life policy is not sufficient to pay the periodic mortality and expense charges, the policy will lapse unless the policyowner takes action within a stated period of time—usually 60 days—to keep the policy in force. To prevent a policy from lapsing, the policyowner must either (1) pay additional premiums or (2) reduce the policy's face amount.

Some universal life insurance policies include a *no-lapse guarantee*, which provides that the insurance coverage will remain in effect for a stated period of time, such as 20 years, or until the insured reaches a particular age. As long as the policyowner has made at least the stated minimum premium payments, the coverage continues regardless of the policy's cash value or any changes in the credited interest rate or mortality and expense charges.

Figure 6.4 The Operation of a Universal Life Insurance Policy



Flexibility Features

A universal life insurance policy gives the policyowner a great deal of flexibility, both at the time of purchase and over the life of the policy. When he purchases the policy, the policyowner decides, within certain limits, what the policy's face amount will be, the amount of the death benefit payable, and the amount of the premiums he will pay for that coverage. The policyowner can change these amounts during the life of the policy, but the insurer must approve certain types of changes.

Face Amount and Death Benefit

When a person buys a universal life policy, he specifies the policy's face amount. After the policy has been in force for a specified minimum time—often one year—the policyowner can request an increase or decrease in the policy's face amount. The insurer typically requires the policyowner to provide evidence of the insured's continued insurability when a proposed increase in the policy's face amount exceeds a certain amount. Before approving a decrease in a policy's face amount, the insurer must make sure that the decrease would not cause the policy to lose its status as an insurance contract and instead be classified as an investment contract. Later in this section we describe the Internal Revenue Code Section 7702 requirements that a life insurance policy must meet to be classified as an insurance product rather than an investment product.

The policyowner also decides whether the amount of the death benefit payable will remain equal to the face amount (as with most traditional whole life policies) or will vary with changes in the policy's cash value or premiums paid. Under an ***Option A plan*** (also known as an *Option 1 plan*), 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. Under an ***Option B plan*** (also known as an *Option 2 plan*), 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. Note that the net amount at risk for an Option A plan decreases as the amount of the cash value increases. The net amount at risk for an Option B plan, however, is always equal to the policy's face amount. Figure 6.5 illustrates the operation of these two plans. Some insurers also offer an Option C plan, where the death benefit payable is equal to the policy's face amount plus premiums paid; this option is less common than Option A and Option B.

Premiums

A universal life policy may feature either flexible premiums or fixed premiums. A ***flexible-premium universal life insurance policy*** allows the policyowner to alter the amount and frequency of premium payments, within specified limits. Within these limits, the policyowner can determine how much to pay for the initial premium and for each renewal premium. The insurer requires payment of at least a stated minimum initial premium, and for administrative purposes, the insurer may also impose a minimum limit on the size of any renewal premium payment. One of the main advantages to flexible premiums is the ability to pay a larger premium than required and directly add to the policy's cash value. However, the insurer must impose maximum limits on the amounts of the initial and renewal premiums to ensure the policy meets the regulatory requirements described later in this section. The policyowner has great flexibility in deciding when to pay renewal premiums. As long as the policy's cash value is large enough to pay the periodic mortality and expense charges the insurer imposes, the policy remains in force even if the policyowner does not pay renewal premiums.

A ***fixed-premium universal life insurance policy*** 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. However, the owner of a fixed-premium universal life policy does not have a paid-up policy

at the end of the premium payment period. Sometimes, a product's actual experience is less favorable than the insurer projected when it designed the product. For example, the insurer's investments may earn a lower rate of return than the insurer projected, which reduces the current interest rate the insurer pays on the product's cash values. If that occurs, a fixed-premium universal life policy's cash value will be lower than projected and may not be large enough to pay the periodic mortality and expense charges. If the cash value is not large enough to pay the periodic charges, the policyowner must take action or the policy will lapse.

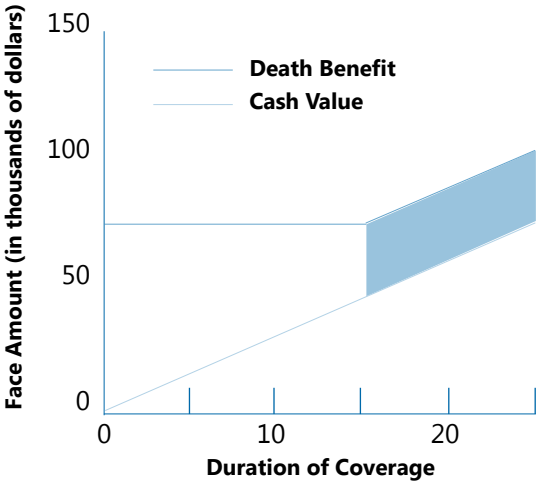
Figure 6.5 Relationship Between a Policy's Cash Value and Face Amount Under an Option A and an Option B Plan

OPTION A PLAN

Death benefit = Face amount

Net amount at risk = (Death benefit) − (Cash value)

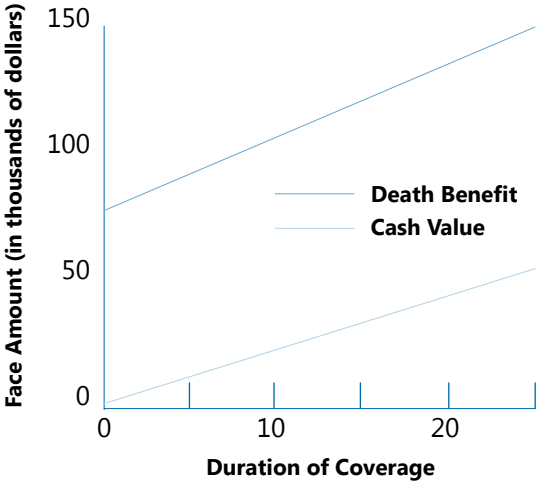
Automatic face amount increase to comply with regulatory requirements



OPTION B PLAN

Death benefit = (Face amount) + (Cash value)

Net amount at risk = Face amount



Effects of Regulation on Universal Life Policies

Because a universal life policyowner can pay much more in premiums than is needed to fund the cost of insurance, the amount of the policy's cash value can be much greater in relation to the death benefit of the policy than is possible with a whole life insurance policy. The larger the cash value is in relation to the policy's death benefit, the more a policy resembles an investment product rather than an insurance product.

To ensure that favorable income tax treatment is available only to life insurance products, U.S. federal tax laws set limits on the size of a life insurance policy's cash value in relation to the policy's death benefit. The difference between the policy's death benefit and cash value is called the *Section 7702 corridor*. If the relationship of the policy's cash value to its death benefit exceeds the regulatory limits, then the policy is treated for tax purposes as an investment product rather than as an insurance policy. Insurance companies generally do not allow a policyowner to pay a premium amount that would result in the death benefit exceeding the legislatively specified percentage of the cash value. In addition, most universal life policies provide that if the cash value exceeds the specified percentage of the death benefit, then the insurer will increase the death benefit to an amount that meets the regulatory requirements.

Periodic Statements

Because so many aspects of a universal life insurance policy change over the course of a year, insurers send each policyowner an annual, semiannual, or quarterly statement containing the policy's current values and benefits. Examples of the values and benefits that typically appear in this report are the amount of the death benefit, the amount of the policy's cash value, the amount and type of any charges deducted, and the amount of the premiums paid during the period.

Indexed Universal Life Insurance

Indexed universal life (IUL) insurance, also called *equity indexed universal life (EIUL) insurance*, offers the same features as universal life insurance, but also offers the possibility of additional earnings based on changes in a published index. Commonly used indexes are the S&P 500 or Nasdaq 100.

An IUL policy's cash value is backed by the insurer's general account assets. The ***general account*** is 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. The insurer places funds in the general account in relatively secure investments, so that it can be certain of having funds available to pay the benefits it has guaranteed to pay policyowners. An IUL policy generally divides the cash value into two policy accounts:

- A *fixed account*, which is the portion of the cash value for which the crediting rate is the same as on the insurer's traditional UL products
- An ***index account***, which is the portion of the cash value for which the crediting rate is determined by changes in an index

The policyowner decides how to allocate premium payments between the two types of accounts.

The crediting rate for the index account—known as the *index crediting rate*—is subject to a guaranteed minimum crediting rate, typically called the *floor* or the *growth floor*, and a maximum crediting rate, typically called the *cap* or the *growth cap*. For IUL insurance, the floor limits the product's investment risk, whereas the cap limits the product's growth potential.

The *index performance rate* is the change in the index's value over the policy's index term. Most index terms are one year, though some insurers offer two-year, three-year, or five-year terms. To determine the index crediting rate, the index performance rate is multiplied by the *participation rate*, which is the percentage of the index performance rate that is counted in calculating the crediting rate. For example, a participation rate of 80 percent means that 80 percent of the index performance rate is considered.

Example:

Joseph Madaki purchased an indexed universal life policy from Begemot Insurance with a starting cash value of $10,000 in the index account. The policy's terms include a participation rate of 90%, a cap of 12%, and a floor of 0%. Over the first index term of the policy, the index's value rose by 20%. Over the second index term, the index's value fell by 10%.

Analysis:

At the end of the first index term, the index crediting rate was 12% (20% index performance rate × 90% participation rate = 18%, which is subject to the cap of 12%). Begemot applied this 12% index crediting rate to the portion of the cash value in the index account. Therefore, this value rose by $1,200 ($10,000 × 0.12).

At the end of the second index term, the index crediting rate was 0% (–10% index performance rate × 90% participation rate = –9%, which is subject to the floor of 0%). The portion of the cash value in the index account did not increase in value. Thanks to the policy's floor, neither did it lose any value from index losses, though the cash value could still decrease due to fees and charges.

The main attraction of indexed universal life insurance is that it offers additional gains in the cash value when the market is strong, with relatively little risk. The guaranteed minimum interest-crediting rate on the fixed account and the growth floor on the index account both protect the policy from losses when the market is weak. Thus, indexed universal life insurance has a fairly conservative risk-reward structure; those interested in comparably higher risks and higher potential rewards may look into variable life insurance, as we'll see below.

Variable Life Insurance

Variable life (VL) insurance is 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. A ***subaccount*** is 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.

The subaccounts in which variable insurance premiums and cash values are invested are part of an insurer's separate account. The ***separate account***, also known as a *segregated account*, is an asset account the insurer maintains separately from its general account to isolate and help manage the funds placed in its variable products.

Most variable life insurance policies permit the policyowner to allocate premium payments among a selection of subaccounts. The subaccounts have different investment strategies. For example, some subaccounts concentrate on investing in high-growth stocks, other subaccounts concentrate on investing in stocks that pay high dividends, and still other subaccounts may concentrate on investing in bonds.

Most variable life insurance policies also allow the policyowner to invest a portion of the premium payments in a fixed account, which provides a minimum guaranteed rate of return. Such a fixed account is part of the insurer's general account.

The amount of both the variable life policy's death benefit and cash value depends on how well the subaccounts perform. If the subaccounts perform well, then the amount of the death benefit and the cash value of the policy will increase as the insurer credits the investment returns to the policy's cash value. If the investment performance is poor, then the amount of the death benefit and the cash value will decline. Although the policy's death benefit may change from time to time, most variable life policies provide a minimum guaranteed death benefit, regardless of the subaccounts' performance. This minimum guaranteed death benefit often is the face amount of the policy. Variable life policies, however, do not guarantee either investment earnings (other than the fixed account) or a minimum cash value.

Because a variable life insurance policyowner assumes the investment risk that the cash value and death benefit of the policy may decline, variable life insurance policies are considered securities under U.S. law. Variable life policies, therefore, must comply with federal securities laws as well as state insurance laws.

Although new variable life insurance policies are rare, you need a basic understanding of them before you learn about a more popular product: variable universal life insurance.

Variable Universal Life Insurance

Variable universal life (VUL) insurance, which is also called *flexible-premium variable life insurance* (or simply *universal life* in Canada), combines the premium and death benefit flexibility of universal life insurance with the investment flexibility and risk of variable life insurance. Like a universal life policy, a variable universal life policy allows the policyowner to choose the premium amount and face amount. As with a variable life policy, the policyowner chooses to allocate premiums among several subaccounts and may change the chosen options periodically, depending on the terms of the policy. The investment returns that the insurer credits to the policy's cash value reflect the investment earnings of the subaccounts.

Most insurers allow the policyowner to choose whether a variable universal policy's death benefit will remain level or will vary along with changes in the investment earnings of the subaccounts. Like variable life policies, variable universal policies do not guarantee investment earnings or cash values. Therefore, variable universal life insurance products are considered securities under U.S. laws and must comply with federal securities laws.

Example:

Rachid Othmani is considering purchasing one of several life insurance policies. Rachid is a seasoned investor who enjoys following financial markets. He is interested in accepting additional risk in exchange for the possibility of increased rewards, but he also wants to have the flexibility to use extra income to increase his policy's cash value in pay periods when his finances are particularly strong.

Analysis:

Rachid picks a variable universal life policy to suit his needs. A universal life policy would not give him the potential investment return he's interested in, and a variable life policy would have fixed premiums, which would not give him the flexibility he requires.

Figure 6.6 compares different types of universal and variable life insurance.

Endowment Insurance

You may recall from Chapter 1 that *endowment insurance* provides a policy benefit payable either when the insured dies or on a stated date if the insured is still alive on that date. Each endowment policy specifies a ***maturity date***, which is the date on which the insurer will pay the policy's face amount to the policyowner if the insured is still living. The maturity date is reached either (1) at the end of a stated term, such as 20 years, or (2) when the insured reaches a specified age. If the insured dies before the maturity date, then the insurer pays the policy's face amount to the designated beneficiary. Thus, an endowment insurance policy pays a fixed benefit whether the insured *survives* to the policy's maturity date or *dies* before that maturity date.

Figure 6.6 Universal and Variable Life Insurance Policy Features By Product

	Universal life	Indexed universal life	Variable life	Variable universal life
Flexible premiums	Yes	Yes	———	Yes
Fixed premiums	———	———	Yes	———
Separate policy elements	Yes	Yes	———	Yes
Policyowner assumes investment risk	———	———	Yes	Yes
Death benefit can remain level or vary with changes to cash value	Yes	Yes	———	Yes
Death benefit varies according to investment performance	———	———	Yes	Yes

Endowment policies share many of the features of cash value life insurance policies. For example, premiums usually are level throughout the term of an endowment policy, although a policyowner can purchase an endowment policy with a single premium or with a series of premiums over a limited period of time. Like cash value life insurance policies, endowment policies steadily build cash values. Recall that the reserve and the cash value of a whole life policy eventually equal the policy's face amount—but not until the insured reaches the age at the end of the mortality table used to calculate premiums for that policy. By contrast, the reserve and cash value of an endowment policy usually equal the policy's face amount on the policy's maturity date, which typically is much sooner than when the insured reaches the last age found in the mortality table. As a result, an endowment policy's cash value builds much more rapidly than does the cash value of a comparable whole life insurance policy.

Because endowment policies build cash values rapidly and the cash value of an endowment policy is quite large in relationship to the face amount of the policy, these policies generally do not satisfy the requirements to receive the same favorable federal income tax treatment in the United States as do most other life insurance policies. Given this increased tax liability, very few insurers in the United States still offer endowment insurance. Endowment insurance remains a popular product in insurance markets in many other countries, however.

Key Terms

policy loan
cash surrender value
whole life insurance
continuous-premium whole life insurance policy
limited-payment whole life insurance policy
paid-up policy
single-premium whole life insurance policy
modified-premium whole life insurance policy
modified coverage whole life insurance policy
joint whole life insurance
last survivor life insurance
family policy
universal life (UL) insurance
mortality charge
guaranteed minimum interest-crediting rate
current interest-crediting rate
Option A plan
Option B plan
flexible-premium universal life insurance policy
fixed-premium universal life insurance policy
indexed universal life (IUL) insurance
general account
index account
variable life (VL) insurance
subaccount
separate account
variable universal life (VUL) insurance
maturity date

Endnotes

1. Ashley V. Durham and Benjamin Baldwin, *U.S. Individual Life Insurance Sales Trends, 1975–2014* (Windsor, CT: LL Global, Inc., © 2015). Used with permission; all rights reserved.
2. In Canada, tax is paid on accrual income from an insurance policy. With some exceptions, the taxpayer must report accrued investment income on a life insurance policy or annuity on an annual basis.
3. Some insurers also offer joint term life insurance and last survivor term life insurance.
4. The primary risk the insurer assumes is the risk of the insured's dying while the policy is in force, which is referred to as the *mortality risk*. However, as we shall see in Chapter 7, many life insurance policies offer supplemental benefits in addition to the death benefit. The mortality charge covers the cost of providing all benefits that may be payable under a particular policy.

Chapter 7

Supplemental Benefits

Objectives

After studying this chapter, you should be able to

7A Identify and describe three types of supplemental disability benefits that life insurance policies may provide

7B Explain the coverage that an accidental death benefit rider provides and give examples of common exclusions

7C Identify three types of accelerated death benefit riders and describe the differences between these riders

7D Describe three types of insurance riders that expand a life insurance policy's coverage to insure more than one individual

7E Identify two types of insurability benefit riders and explain how they allow a life insurance policyowner to purchase additional insurance coverage

Outline

Supplemental Disability Benefits
- Waiver of Premium for Disability Benefit
- Waiver of Premium for Payor Benefit
- Disability Income Benefit

Accident Benefits
- Accidental Death Benefit
- Accidental Death and Dismemberment Benefit

Accelerated Death Benefits
- Terminal Illness Benefit
- Dread Disease Benefit
- Long-Term Care Insurance Benefit

Benefits for Additional Insureds
- Spouse Insurance Rider
- Children's Insurance Rider
- Second Insured Rider

Insurability Benefits
- Guaranteed Insurability Benefit
- Paid-Up Additions Option Benefit

Although their features may vary, all life insurance policies provide a benefit if the insured dies while the policy is in force. Life insurance policies may also offer other benefits, which we refer to as *supplemental benefits*. The insurer usually charges an additional premium amount for each supplemental benefit that is added to a policy; the additional premium charge typically ends when the supplemental benefit expires or is cancelled.

In some situations, insurers offer life insurance policies that include supplemental benefits as standard features, but these benefits are usually added as riders to a life insurance policy. Policy riders benefit both the policyowner and the insurer because they give both parties flexibility. When an insurance company issues a policy, it can include riders to customize a basic plan of insurance for the policyowner. If the policyowner later wants to adapt the policy to better meet her needs, the insurer can drop or add riders. Thus, the policyowner and the insurer don't have to enter into a new contract when the policyowner desires customized or additional coverage.

The most common supplemental life insurance benefits are supplemental disability benefits, accident benefits, accelerated death benefits, benefits for additional insureds, and insurability benefits.

Supplemental Disability Benefits

Because disability benefits cover financial losses that result from sickness or injury, they are generally classified as a type of health insurance. However, some disability benefits can be added to a life insurance policy. In this section, we describe three types of disability benefits:

- The waiver of premium for disability benefit
- The waiver of premium for payor benefit
- The disability income benefit

Waiver of Premium for Disability Benefit

One of the most common supplemental life insurance policy benefits is the ***waiver of premium for disability (WP) benefit***. (Note that in Canada, the abbreviation is "WOP.") Under a WP benefit, the insurer promises to give up—to waive—its right to collect premiums that become due while the insured is totally disabled according to the policy or rider's definition of disability. If the policy is one that builds a cash value, the cash value continues to increase just as if the policyowner paid the premiums. In the case of a participating policy, the insurer also continues to pay policy dividends as if the policyowner were paying premiums.

To receive WP benefits, the policyowner must notify the insurance company in writing of a claim and must provide proof that the insured is totally disabled as defined by the WP benefit. Most WP benefits define *total disability* as the insured's inability to perform the essential duties of her own occupation or any other occupation for which she is reasonably suited by education, training, or experience. The insurer generally reserves the right to require periodic submission of proof that the insured continues to be totally disabled. Premiums are generally waived throughout the life of the policy as long as the insured remains totally disabled.

Disabilities resulting from intentionally self-inflicted injuries and injuries the insured suffered while committing a crime are typically excluded. In addition, most WP benefits stipulate a three- to six-month waiting period, which means that the insured must be totally disabled for three to six months before the insurer will begin waiving premium payments. By specifying a waiting period, the insurer can substantially reduce the expenses involved in processing WP benefits for disabilities that last for only a very short time. The policyowner must continue to pay premiums that come due during the waiting period, although some WP benefits provide that these premiums will be refunded if the insured is still disabled when the waiting period ends.

Example:

Edward Stern purchased a whole life insurance policy from the Reliable Insurance Company. Edward's policy included a waiver of premium for disability (WP) benefit rider with a six-month waiting period. One month before his first semiannual renewal premium was due, Edward became totally disabled.

Analysis:

To qualify for the WP benefit, Edward must notify Reliable and provide proof of his disability. Because the renewal premium was due during the waiting period, Edward must pay that premium. Once the waiting period ends, Reliable will waive all future premiums as long as Edward remains totally disabled, during which time his policy will continue to build a cash value.

Because universal life insurance policies and variable universal life insurance policies typically have variable premiums, the standard WP benefit usually is not offered. Instead, these types of policies may have a *waiver of cost of*

insurance benefit, sometimes referred to as a *monthly deduction waiver benefit*, which waives most of the periodic charges of the policy if the insured meets the policy's definition of disabled. The exact charges that are waived vary depending on the terms of the rider.

Waiver of Premium for Payor Benefit

In contrast to the WP benefit, which waives the premium if the insured becomes totally disabled, the ***waiver of premium for payor benefit*** waives the insurer's right to collect a policy's renewal premiums if the *payor*—the person who pays the policy premiums—dies or becomes totally disabled. The payor, who is typically the policyowner, generally must provide satisfactory evidence of his own insurability—in addition to supplying evidence of the insured's insurability—before the insurer will add this benefit to a life insurance policy.

A waiver of premium for payor benefit is often included as a rider to a ***juvenile insurance policy***, which is a 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. When this benefit is added to a juvenile life insurance policy, the policy or rider usually states that the insurer will waive premium payments only until the insured reaches a specified age, such as 18 or 21, when ownership and control of the policy typically pass to the insured.

Waiver of premium for payor benefits generally include a two-part definition of total disability. During the first two years of disability, the payor is considered totally disabled if she is unable to perform the essential duties of her own occupation. After the two-year period, the payor is considered totally disabled if she is unable to perform the essential duties of any occupation for which she is reasonably suited by education, training, or experience.

Figure 7.1 compares the features of the waiver of premium for disability benefit and the waiver of premium for payor benefit.

Disability Income Benefit

Another benefit that may be added to a life insurance policy is the ***disability income benefit***, which promises the insurer will pay a monthly income benefit to the insured if he becomes totally disabled while the policy is in force. Like WP benefits, disability income benefits typically define *total disability* as the insured's inability to perform the essential duties of his own occupation or any other occupation for which he is reasonably suited by education, training, or experience. Also like WP benefits, disability income benefits usually include a three- to six-month waiting period before benefits will begin.

Typically, the amount of the monthly disability income benefit is a stated percentage of the policy's face amount. For example, a disability income rider might provide a monthly disability income benefit of 1 percent of the face amount. In this case, if an insured owned a $100,000 life insurance policy, he would receive a monthly payment of $1,000 ($100,000 × 0.01) if he became totally disabled. Some disability insurance riders also state a maximum monthly benefit amount payable, a maximum benefit period, or both.

When a disability income benefit is activated, the life insurance coverage under the policy continues, and if the insured dies before recovering from the disability, the insurer pays the policy's death benefit to the beneficiary.

Figure 7.1 Comparison of Waiver of Premium for Disability Benefit and Waiver of Premium for Payor Benefit

Waiver of Premium for Disability Benefit	Waiver of Premium for Payor Benefit
Premiums are waived if the *insured* becomes totally disabled.	Premiums are waived if the payor, who is typically the *policyowner*, dies or becomes totally disabled.
Designed for policies where: Policyowner = Insured	Designed for third-party policies where: Policyowner ≠ Insured
Total disability defined as the insured's inability to perform the essential duties of her own occupation or any other occupation for which she is reasonably suited by education, training, or experience.	During the first two years of disability, the payor is considered totally disabled if she is unable to perform the essential duties of her own occupation. After the two-year period, the payor is considered totally disabled if she is unable to perform the essential duties of any occupation for which she is reasonably suited by education, training, or experience.

Example:

Paxton Haynes was the policyowner-insured of a $200,000 life insurance policy that included a disability income benefit rider. According to the terms of this rider, if Paxton became totally disabled, the insurer would pay him a monthly income benefit of 1% of his policy's face amount during the period of disability; the rider also stipulated a three-month waiting period. While the policy was in force, Paxton became disabled as defined in the disability income benefit rider. Two years later, he died as a result of his disability.

Analysis:

Three months after he became disabled, Paxton became eligible to receive a disability income benefit of $2,000 a month, found as $200,000 × 0.01. This monthly income benefit was payable as long as Paxton remained disabled. Upon Paxton's death, the policy's death benefit became payable to the beneficiary.

Life insurance policies that are issued with a disability income benefit generally include a WP benefit as well. In this case, the renewal premiums charged for the life insurance policy and the additional premiums charged for the disability income benefit are both waived during the total disability of the insured.

Accident Benefits

Accident benefits may be added to any type of life insurance policy. The two most commonly offered accident benefits are (1) accidental death benefits and (2) accidental death and dismemberment (AD&D) benefits.

Accidental Death Benefit

An ***accidental death benefit*** is 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. For example, a policy might provide a basic death benefit of $100,000 and a supplemental accidental death benefit of $100,000. If the insured dies as a result of an accident while the coverage is in force, the beneficiary would receive a total benefit of $200,000.

In the example above, the amount of the accidental death benefit is equal to the face amount of the life insurance policy. In this situation, where the total death benefit payable if the insured dies in an accident is double the policy's face amount, the benefit is often referred to as a *double indemnity benefit*. However, the additional sum payable if the insured dies accidentally may be some other multiple of the policy's face amount—such as three times the face amount—or it may be an amount that is unrelated to the policy's face amount. Most accidental death benefit riders expire when the insured reaches age 65 or 70.

Generally, the accidental death benefit is payable if the insured's death was caused, directly and independently of all other causes, by an accidental bodily injury. Determining the precise cause of an insured's death, however, can sometimes be difficult.

Example:

An insured with a history of heart disease died in an automobile accident. Her policy provides a $250,000 death benefit and includes an accidental death benefit rider that provides an accidental death benefit of $250,000.

Analysis:

If the accident itself caused the insured's death, then the insurer would pay the $250,000 accidental death benefit in addition to the policy's basic death benefit of $250,000. On the other hand, if the insured died from a heart attack while driving, causing her to lose control of the automobile, then her death did not result from an accident. In this case, the insurer would pay only the policy's basic death benefit of $250,000 to the beneficiary.

Accidental death benefit riders usually contain several exclusions and limitations. For example, these riders typically exclude payment of the accidental death benefit if the insured's death results from certain stated causes, including

- Self-inflicted injuries (suicide)
- War-related accidents
- Aviation-related accidents, if the insured acted in a capacity other than as a passenger during a commercial flight
- Accidents resulting from the insured's commission of a crime

In addition, some riders require that the insured's death occur within a specified time period after the accident, such as within 90 days of the date of the accident, in order for the benefit to be payable.

Keep in mind that these exclusions and limitations relate only to the accidental death benefit. With a few exceptions, which we describe later in the text, the basic death benefit provided by the life insurance policy is payable regardless of the cause of the insured's death.

Accidental Death and Dismemberment Benefit

An ***accidental death and dismemberment (AD&D) benefit*** is a supplemental benefit that provides two benefits: (1) an accidental death benefit and (2) a dismemberment benefit payable if an accident causes the insured to lose any two limbs or sight in both eyes. The amount of the dismemberment benefit is usually equal to the amount of the accidental death benefit. In many cases, however, a smaller amount—such as one-half the amount of the accidental death benefit—will be payable if the insured loses one limb or sight in one eye as the result of an accident. The loss of a limb may be defined either as the actual physical loss of the limb or as the loss of the use of the limb. Usually, AD&D benefits state that the insurer will not pay both accidental death benefits and dismemberment benefits for injuries suffered in the same accident.

Accelerated Death Benefits

Partly as a result of medical advances, people today live longer than ever before and often require costly medical care late in their lives. However, traditional life insurance benefits typically are payable only after the insured's death. An ***accelerated death benefit***, also known as a *living benefit*, typically provides that the policyowner may elect to receive all or part of the policy's death benefit before the insured's death if certain conditions are met. (Remember that the policyowner and insured are often the same person.) The payment of an accelerated death benefit usually reduces the death benefit that will be paid to the beneficiary at the insured's death by the amount of the accelerated death benefit paid.

To keep administrative costs down, life insurers usually offer accelerated death benefit coverage only on policies with larger face amounts, such as $100,000 and above. Some insurers also require that before they pay an accelerated death benefit, the beneficiary must sign a release acknowledging that the policy's death benefit will be reduced by the amount paid to the policyowner under the accelerated death benefit rider.

The policyowner can use the accelerated death benefit funds for any purpose. Figure 7.2 provides some common examples of how policyowners have used such funds.

The specific amount of the accelerated death benefit that is payable under a policy and the conditions for payment depend on the wording of the benefit rider or provision. We describe three commonly offered types of accelerated death benefits: (1) the terminal illness benefit, (2) the dread disease benefit, and (3) the long-term care benefit.

Figure 7.2 Using Accelerated Death Benefits

A policyowner might use money received as an accelerated death benefit to pay the insured's

- Medical expenses
- Outstanding debts and living expenses
- Home health care costs
- Travel expenses (or those of the insured's family)

Terminal Illness Benefit

The most common type of accelerated death benefit is the terminal illness benefit. The ***terminal illness (TI) benefit*** is a 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. A statement by an attending physician establishes evidence of the terminal illness and certifies that the insured is likely to die within the time period specified in the rider.

The amount of the TI benefit that is payable varies from insurer to insurer. Some policies permit payment of the full face amount prior to the insured's death. Generally, however, the maximum TI benefit payable is a stated percentage—usually between 25 and 75 percent—of the policy's face amount up to a stated maximum amount. The benefit usually is paid in a lump sum to the policyowner. The remainder of the death benefit is paid to the beneficiary following the insured's death.

Unlike other supplemental benefits, for which insurers impose an additional premium charge, the terminal illness benefit typically is paid for by an administrative charge that the insurer assesses when a policyowner elects to exercise the TI benefit.

Dread Disease Benefit

A ***dread disease (DD) benefit***, also known as a *critical illness benefit*, is 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. Most insurers provide DD coverage only to insureds who are under the age of 70 and who have no serious health problems. Although the DD benefit is usually paid in a lump sum, some insurers pay the benefit in monthly installments over a period of 6 to 12 months. The remainder of the death benefit is paid to the beneficiary following the insured's death. The DD benefit may be paid for by an administrative charge that the insurer assesses when a policyowner elects to exercise the DD benefit. However, a more popular approach is to apply a

discount factor to the death benefit accelerated. For example, if the discount factor is 60 percent for every $10,000 of death benefit accelerated, then a $100,000 policy would yield a benefit of $40,000.

An insured becomes eligible for DD benefits when she has a certain disease or event or undergoes certain medical procedures specified in the rider. These specified diseases, events, or medical procedures are known as *insurable events* and usually include

- Life-threatening cancer
- Coronary artery bypass surgery
- Myocardial infarction (heart attack)
- Stroke

The above four insurable events are the most common. Other less common insurable events include end-stage renal (kidney) failure, vital organ transplants, and Alzheimer's disease.

In many countries, considerably more diseases and medical procedures—sometimes more than 30 in total—are included as insurable events. In these countries, insurers offer a number of DD benefit options, such as a less expensive basic rider, which covers a limited number of diseases and procedures, and a more expensive comprehensive rider, which covers a greater number of diseases and procedures.

Policyowners can purchase another form of dread disease coverage as supplemental medical expense coverage. We discuss medical expense coverage in a later chapter.

Long-Term Care Insurance Benefit

A ***long-term care (LTC) insurance benefit*** is an accelerated death benefit under which the insurer agrees to pay a monthly benefit to the policyowner if the insured requires constant care for a medical condition. The types of care given and the medical condition required to qualify for the LTC benefit are specified in the LTC policy rider or provision. Insurers generally waive premiums on both the LTC benefit and the basic life insurance policy during the period when the policyowner receives LTC benefits.

The amount of each monthly LTC benefit payable generally is equal to a stated percentage of the policy's face amount. For example, the benefit may state that 2 percent of the policy's face amount will be paid each month if the insured qualifies for LTC benefits. In this case, if the policy has a $100,000 face amount, the policyowner would receive a monthly LTC benefit of $2,000 ($100,000 × 0.02). The insurer usually pays monthly benefits until a specified percentage of the policy's face amount has been paid out. Any remaining death benefit is paid to the beneficiary after the insured's death.

Most LTC benefits impose a waiting period, typically 90 days, before the benefits are payable. Under such a provision, the insurer pays the benefits 90 days following the date on which the insured becomes eligible for benefits. Some LTC benefits also require that the LTC coverage must be in force for a given period of time, usually one year or more, before the insured will qualify for LTC benefits.

Benefits for Additional Insureds

Insurers offer riders that provide benefits if someone other than the policy's insured dies. The most common of these riders are the spouse insurance rider, the children's insurance rider, and the second insured rider.

Spouse Insurance Rider

A ***spouse insurance rider*** is a supplemental life insurance policy benefit that provides term life insurance coverage on the insured's spouse. The coverage provided by this type of rider typically is sold on the basis of coverage units. Usually, each coverage unit of a spouse insurance rider provides $5,000 of term insurance coverage on the spouse. Therefore, an insured who purchases 5 units of coverage on his spouse would be purchasing $25,000 of term life insurance coverage. Most insurance companies do not offer more than 5 or 10 coverage units.

Children's Insurance Rider

A ***children's insurance rider*** is a supplemental life insurance policy benefit that provides term life insurance on the insured's children. Like the spouse insurance rider, coverage is sold on the basis of coverage units, although the amount of insurance coverage per unit typically is only $1,000 or $2,000. A married insured with children may purchase a spouse insurance rider, a children's insurance rider, or both.

The premium charged for each coverage unit is a stated amount, regardless of the number of children covered or the ages of those children. For example, a single mother of three children could purchase a $1,000 children's insurance rider for the same amount that would be charged to a single father of two children. Therefore, the insurer does not have to revise the premium for a children's insurance rider if additional children are born or adopted after the coverage is purchased. The additional children are covered automatically at no extra premium charge, although the coverage typically does not take effect until the child is 15 days old.

The term insurance coverage on each child expires when that child reaches a stated age, typically 21 or 25. Such riders, however, usually include a conversion privilege that allows the child to convert the term insurance coverage to an individual life insurance policy. For example, the rider may permit each child to convert up to five times the amount of the term insurance coverage to an individual cash value insurance policy without providing evidence of insurability.

Some insurers combine spouse and children's insurance coverage into one rider, which is referred to as a ***spouse and children's insurance rider*** or a *family insurance rider.*

Second Insured Rider

A ***second insured rider***, also called an *optional insured rider*, *other insured rider*, or *additional insured rider*, is a supplemental life insurance policy benefit that provides term insurance coverage on the life of a person other than the policy's insured. The person insured under the rider is known as the *second insured* and

may be the spouse of the insured, another relative, or an unrelated person, such as a business partner of the insured. The amount of coverage a second insured rider provides typically is greater than what is available under a spouse's insurance rider, although some insurers limit the maximum coverage to the face amount of the primary insurance policy. The premium rate charged for the second insured rider is based on the risk characteristics of the second insured, and not on the risk characteristics of the person insured under the basic policy.

Some advantages of the second insured rider are its convenience—as more than one life can be insured under a single policy—and the fact that it typically provides coverage on the second person at a lower cost than would a separate policy on that person.

Insurability Benefits

A policyowner may anticipate that she will need additional coverage in the future but will become uninsurable as she ages. Insurers offer two types of supplemental benefits that allow policyowners to purchase additional insurance without the insured having to provide evidence of insurability at the time of purchase: the guaranteed insurability benefit and the paid-up additions option benefit.

Guaranteed Insurability Benefit

The ***guaranteed insurability (GI) benefit***—sometimes referred to as a *guaranteed insurability option (GIO)*—is 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. The GI rider also may permit the purchase of additional life insurance coverage when certain events occur, such as when the insured marries or at the birth of a child. Thus, the GI rider guarantees that the policyowner will be able to purchase additional life insurance even though the insured may no longer be in good health. The premium for the additional coverage is based on the insured's attained age when the additional insurance is purchased.

Typically, the amount of coverage the policyowner may purchase on an option date is limited to the policy's face amount or to an amount specified in the GI rider, whichever is less. For example, a GI rider attached to a $100,000 whole life policy may give the owner the right to purchase an additional $25,000 of whole life insurance coverage on certain stated dates. Most GI riders, however, limit the benefit by permitting the policyowner to exercise the GI option only until the insured reaches age 40.

Although the right to purchase the additional coverage is automatic, the actual purchase is not. A policyowner who desires the extra coverage must take specific actions—such as submitting an appropriate application form—to purchase the new coverage. Most GI riders specify that if the policyowner does not exercise the option on one of the specified dates, then that option is lost forever, although the policyowner is permitted to exercise the next option when it becomes available.

Paid-Up Additions Option Benefit

The ***paid-up additions option benefit*** is 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. For example, many paid-up additions option riders allow the policyowner to purchase paid-up additional whole life insurance on each policy anniversary. Because the paid-up additions are whole life insurance, they have their own cash values.

Premiums for paid-up additions are based on the insured's attained age at the time the paid-up additions are purchased. Most riders state that if the policyowner does not exercise the option for a stated number of years, then the rider will terminate. At that time, the paid-up additions already purchased remain in force, but the policyowner can no longer exercise the option to purchase new paid-up additions.

Key Terms

waiver of premium for disability (WP) benefit
waiver of premium for payor benefit
juvenile insurance policy
disability income benefit
accidental death benefit
accidental death and dismemberment (AD&D) benefit
accelerated death benefit
terminal illness (TI) benefit
dread disease (DD) benefit
long-term care (LTC) insurance benefit
spouse insurance rider
children's insurance rider
spouse and children's insurance rider
second insured rider
guaranteed insurability (GI) benefit
paid-up additions option benefit

Chapter 8

Individual Life Insurance Policy Provisions

Objectives

After studying this chapter, you should be able to

8A Describe the free-look provision of an insurance policy

8B Identify the documents that make up the entire contract between the owner of a life insurance policy and the insurer

8C Explain the purpose and operation of the incontestability provision

8D Apply the terms of the standard grace period provision in a given situation to determine whether a life insurance policy has lapsed for nonpayment of premium

8E Identify situations in which a life insurance policy can be reinstated and the conditions the policyowner must meet to reinstate the policy

8F Determine the action an insurer likely will take if it discovers a misstatement of the age or sex of the person insured by a life insurance policy

8G Describe the rights provided by a policy loan provision and a policy withdrawal provision, and explain the differences between a policy loan and a commercial loan

8H Identify and describe the nonforfeiture options typically included in cash value life insurance policies

8I Identify the exclusions that insurers sometimes include in individual life insurance policies

Outline

Standard Policy Provisions
- Free-Look Provision
- Entire Contract Provision
- Incontestability Provision
- Grace Period Provision
- Reinstatement Provision
- Misstatement of Age or Sex Provision

Provisions Unique to Cash Value Policies
- Policy Loans and Policy Withdrawals
- Nonforfeiture Provision

Life Insurance Policy Exclusions

As we saw in Chapter 3, an individual insurance policy is a contract between the insurance company and the policyowner. Every contract must anticipate the needs of both parties involved, and therefore like other contracts, an insurance policy relies heavily on its provisions to address possible circumstances that might arise. The provisions included in the written policy (1) set forth the terms of the agreement between the two parties, (2) describe the operation and effect of the contract, and (3) define the rights and obligations of the parties to the insurance contract.

Standard Policy Provisions

To protect policyowners and beneficiaries, insurance laws in many jurisdictions require insurers to include certain standard provisions in individual life insurance policies. Some standard provisions are found in all types of such policies, whereas others are unique to cash value policies. Examples of provisions required in all individual life insurance policies are the free-look provision, entire contract provision, incontestability provision, grace period provision, reinstatement provision, and misstatement of age or sex provision. Although the specific wording of these provisions may vary from policy to policy, from insurer to insurer, and from jurisdiction to jurisdiction, they are similar in principle. Even in jurisdictions that do not require these provisions, insurers tend to include them in policies. Note that insurers generally have the right to include provisions that are more favorable to policyowners than those required by law.

Free-Look Provision

An individual life insurance policy typically includes a ***free-look provision***, sometimes referred to as a *free-examination provision* or a *cooling-off provision*, which gives the policyowner a stated period of time—usually at least 10 days—after the policy is delivered within which to cancel the policy and receive a refund. In most jurisdictions, this period of time ranges from 10 to 30 days. The free-look period begins on the date the policy is delivered to the policyowner, not on the date of issue. Insurance coverage is in effect throughout the free-look period or until the policyowner rejects the policy, whichever occurs first.

Example:

Claude Juneau applied for an individual insurance policy on his life and paid the initial premium. The insurer issued the policy, which contained a 10-day free-look period, and delivered it to Claude on October 6. On October 8, Claude changed his mind about purchasing the policy. Before he could contact the insurer to cancel the policy, Claude died in an accident.

Analysis:

During the free-look period, Claude had the right to cancel the policy and receive a refund. However, because the policy was in force when Claude died, the insurer is obligated to pay the death benefit to Claude's beneficiary.

Entire Contract Provision

The ***entire contract provision*** defines the documents that constitute the contract between the insurance company and the policyowner. The entire contract provision limits the terms of the contract to specific written documents, thereby preventing oral statements from altering the terms of the policy. The provision thus helps policyowners and insurers avoid misunderstandings regarding the terms of the contractual agreement.

The specific wording of the entire contract provision varies depending on whether the policy is a closed contract or an open contract. A ***closed contract*** is 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. Most individual life insurance policies are closed contracts. The entire contract provision in these policies typically states that the entire contract consists of (1) the policy, (2) any attached riders, and (3) the attached copy of the application for insurance. The entire contract provision ensures that policyowners have access to all of the terms of the contractual agreement.

An ***open contract*** is 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. Fraternal benefit societies usually are the only insurers to issue life insurance policies as open contracts. The entire contract provision in such a policy typically states that the entire contract consists of the policy and any attached riders; the fraternal society's charter, constitution, and bylaws; the policyowner's attached application for membership in the society; and the attached application for insurance or declaration of insurability, if any, signed by the applicant. A *declaration of insurability* is a form in which a proposed insured answers specific questions about his medical history. Fraternal insurers are permitted to issue open contracts because membership in the fraternal society is a requirement for purchasing insurance through the society. When a person becomes a member of the fraternal society, he receives—and can examine—a copy of the society's charter, constitution, and bylaws. For that reason, when a fraternal insurer issues a policy, it does not attach a copy of those documents to the policy.

In addition to defining the documents that make up the contract, the entire contract provision usually states that (1) only specified individuals—such as certain officers of the insurer—can change the contract, (2) no change is effective unless made in writing, and (3) no change will be made unless the policyowner agrees to it in writing.

Incontestability Provision

Applications for life insurance policies contain questions designed to provide the insurance company with relevant information so that it can decide whether the proposed insured is an insurable risk. Under the general rules of contract law, an insurance company has the right to rescind—or cancel—an otherwise enforceable insurance contract if the applicant misrepresented certain facts in the application for insurance.

Insurance laws in many jurisdictions, however, impose two important limits on an insurer's right to rescind an insurance contract on the basis of misrepresentation. First, only *material misrepresentations* give the insurer the right to rescind an insurance contract. Second, the insurer has only a limited amount of time in which to rescind an insurance contract. As a result, life insurance policies contain an ***incontestability provision***, which denies the insurer the right to rescind 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. This provision is designed to give the insurer sufficient time in which to evaluate the information in an application.

Material Misrepresentation

A false or misleading statement in an application for insurance is known as a ***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 is called a ***material misrepresentation***. A misrepresentation is considered material if, had the truth been known, the insurer would not have issued the policy or would have issued the policy on a different basis, such as with a higher premium or a lower face amount. A misrepresentation in an application for life insurance gives the insurer grounds to rescind the contract only if it was a material misrepresentation.

Example:

Ivana Gradenko's application for life insurance contained the statement that she had recently visited a doctor for a fractured wrist, when the injury had actually been a badly sprained wrist.

Analysis:

The insurer's decision as to whether Ivana is an insurable risk would not have changed as a result of the misstatement of Ivana's injury. Ivana's misstatement is not a material misrepresentation, and the insurer could not use it to rescind the contract.

Example:

Edward Honda's application for life insurance contained the statement that he had visited a doctor on November 12 for a routine physical examination, when in fact the reason for the visit was that he was being treated for kidney disease.

Analysis:

To evaluate Edward's application properly, the insurance company needed to know that he suffered from kidney disease. Therefore, the misrepresentation regarding this doctor visit is a material misrepresentation, and the insurer could rescind the contract. Alternately, the insurer could revise the terms of the policy—such as by changing the required premiums or the face amount—based on the corrected application.

Operation of the Incontestability Provision

If an insurance company issues a life insurance policy and later discovers a material misrepresentation in the application, the terms of the incontestability provision usually determine whether the insurer can rescind the contract. In the United States, a typical incontestability provision states that the policy is incontestable after it has been in force during the lifetime of the insured for two years from the date the policy was issued. The two-year contestable period is the maximum contestable period permitted by law in most states.[1] A period shorter than two years is permitted because a shorter contestable period would be more favorable to the policyowner; some states even limit the contestable period to one year. A sample incontestability provision reads as follows:

> We will not contest this policy after it has been in force during the lifetime of the insured for two years from the date of issue.

As a general rule, after a policy's contestable period has ended, the insurer cannot rescind the contract. Laws in many jurisdictions, however, contain an exception: an insurer may contest a policy at any time if the application for insurance contained a fraudulent misrepresentation. A ***fraudulent misrepresentation*** is 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 into the contract. When an application contains a fraudulent misrepresentation, the contract is not made for a lawful purpose—and recall that a contract not made for a lawful purpose is void at inception. In reality, insurers seldom exercise their right to contest a policy in this situation because they are unable to prove that a misrepresentation was fraudulent.

The phrase *during the lifetime of the insured* is an important part of the incontestability provision. This phrase, in effect, makes the policy contestable forever if the insured dies during the contestable period. As a result, the insurance company will have the opportunity to investigate for material misrepresentation whenever a claim arises within the contestable period of a life insurance policy. If the phrase *during the lifetime of the insured* were not included in the incontestability provision and the insured died during the contestable period, the beneficiary could possibly delay making a claim until after the contestable period expired. The insurer might then be prevented from contesting the policy and, thus, would be required to pay the death benefit even if the application contained a material misrepresentation.

The purpose of the incontestability provision is to assure policyowners and beneficiaries that, after the contestable period has ended, the insurer cannot rescind the policy on the basis of a material misrepresentation in the application for insurance.

Example:

In the previous example, Edward Honda did not disclose the true reason for his visit to the doctor. Edward died four years after the policy was issued. In evaluating the claim, the insurer discovered the material misrepresentation.

Analysis:

Because the policy's two-year contestable period had expired by the time the insurer discovered the misstatement, the insurer does not have the right to contest the validity of the contract. As a result, the insurer must pay the death benefit to the beneficiary.

Grace Period Provision

The ***grace period provision*** specifies a length of time following each renewal premium due date within which the premium may be paid without loss of coverage. The specified time (often 31 days) following each premium due date during which the contract remains in effect regardless of whether the premium is paid is known as the ***grace period***. If the insured dies during the grace period, then the insurer will pay the death benefit to the beneficiary. The insurer, however, usually deducts the amount of any unpaid renewal premium from the amount of the death benefit.

If a required renewal premium is not paid by the end of the grace period, a life insurance policy typically lapses. However, cash value life insurance policies contain a *nonforfeiture provision*, which typically allows a policyowner to continue coverage under specific circumstances even if a renewal premium is not paid by the end of the grace period. We discuss the operation of the nonforfeiture provision later in this chapter.

Example:

Joanna Hark was the policyowner-insured of a $150,000 term life insurance policy. The policy's annual renewal premium of $600 was due on July 6 of each year. Her policy contained a typical 31-day grace period provision. Joanna died on August 3, 2015, without having paid the renewal premium then due.

Analysis:

Because Joanna died during her policy's grace period, the insurer was liable to pay the death benefit to the beneficiary. The insurer deducted the unpaid premium from the death benefit and paid the policy beneficiary $149,400 ($150,000 - $600). If Joanna had died a week later on August 10, without having paid the renewal premium then due, the policy's grace period would have expired, and the insurer would not be obligated to pay the death benefit.

Some types of life insurance policies, such as universal life insurance policies, do not require scheduled premium payments. If the cash value of the policy is sufficient, the insurer uses it to pay the policy's monthly mortality and expense charges. If the cash value is not sufficient, the insurer applies the grace period provision. The date on which the grace period begins can vary by policy, and the grace period's length varies based on this date. For example, some universal life insurance policies state that the grace period begins on the date on which the policy's cash value is insufficient to cover the policy's monthly mortality and expense charges. For those policies, the grace period will continue for 61 or 62 days after that date. Other universal life policies provide that the grace period begins on the date that the cash value is zero and continues for 30 or 31 days after that date. The grace period provision in these policies also requires the insurer to notify the policyowner that if the policyowner does not make a premium payment large enough to cover the policy charges, then coverage will terminate. This notification must be issued at least 30 or 31 days before the coverage expires. If the insured dies during the policy's grace period, then the insurer will pay the death benefit less the amount required to pay the overdue mortality and expense charges.

Example:

Hideo Tanaka is the policyowner-insured of a universal life insurance policy. Hideo has not made a premium payment in several years, during which time the insurer has used the policy's cash value to pay the monthly mortality and expense charges. Currently, the policy's remaining cash value is insufficient to cover the mortality and expense charges.

Analysis:

The insurer will send Hideo a notice that his policy will continue under the grace period provision for 61 days, during which time he must make a premium payment sufficient to cover the overdue mortality and expense charges to keep the policy from lapsing. If Hideo should die during the 61-day grace period, the insurer would pay the beneficiary the death benefit, less the amount of any overdue mortality and expense charges.

Reinstatement Provision

Individual life insurance policies typically include a ***reinstatement provision***, which describes the conditions that the policyowner must meet for the insurer to reinstate a policy. ***Reinstatement*** is 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. (We discuss these nonforfeiture options later in this chapter.) Most insurers do not permit reinstatement if the policyowner has surrendered the policy for its cash surrender value. When an insurer reinstates a policy, the original policy is again in effect; the insurer does not issue a new policy.

To reinstate a life insurance policy, the policyowner must fulfill the conditions stated in the policy's reinstatement provision. The following conditions typically must be met to reinstate a policy:

- The policyowner must complete a reinstatement application within the time frame stated in the reinstatement provision (usually two to five years).
- The policyowner must provide the insurance company with satisfactory evidence of the insured's continued insurability.
- The policyowner must pay a specified amount of money; the amount required depends on the type of policy being reinstated. We describe this amount later in this section of the chapter.
- The policyowner may be required to either pay any outstanding policy loan or have the policy loan, including any additional accrued interest, reinstated with the policy.

Perhaps the most significant of these conditions concerns the required evidence of insurability. This condition is necessary to help prevent antiselection. If no evidence of insurability were required, those people who were unable to obtain insurance elsewhere because of poor health would be more likely to apply for reinstatement than would those who were in good health.

The specific amount of money required to reinstate a policy depends on the type of policy. For a fixed-premium policy, such as a whole life policy, the policyowner must pay all back premiums plus interest on those premiums. The insurer charges interest at the rate specified in the reinstatement provision. Payment of back premiums with interest is needed to bring the policy reserve to the same level as the reserve for a similar policy that has been kept in force without a lapse in premium payments.

For a flexible-premium policy, such as a universal life policy, the policyowner usually must pay an amount sufficient to cover the policy's mortality and expense charges for at least two months. In addition, some universal life policies require that the policyowner pay mortality and expense charges for the period between the date of lapse and the date of reinstatement.

Because reinstating a life insurance policy may require the policyowner to pay a sizable sum of money, each policyowner must decide whether reinstating the original policy or purchasing a new policy is more advantageous. One advantage to reinstating a fixed-premium policy is that the premium rate for the original policy is based on the insured's *issue age*, or age at the time the policy was purchased. A comparable new policy usually calls for a higher premium rate,

because it is based on the insured's attained age. Another advantage of reinstatement is that the original policy's cash value is also reinstated.

Typically, a new contestable period begins on the date on which the policy is reinstated. During this new contestable period, the insurer may rescind the policy on the basis of material misrepresentations made in the application for reinstatement. The insurer may not rescind the policy on the basis of material misrepresentations made in the original application unless the original contestable period has not yet expired.

Example:

Marisol Velasquez took out a life insurance policy on her father Jorge; the policy was issued on February 16, 2012. When she was laid off in 2013, she let the policy lapse. Marisol got a new job not long afterward and submitted an application to reinstate the lapsed policy. The insurer reinstated the policy on May 4, 2014. On September 9, 2015, the insurer discovered that Jorge had been admitted to the hospital for a heart attack in 2011, and that Marisol had not stated this incident on either her initial application for insurance or her application for reinstatement.

Analysis:

The contestable period on the original policy expired on February 16, 2014, so the insurer could not rescind the policy based on the original application. However, a new contestable period began on May 4, 2014, when the policy was reinstated. The insurer could choose to rescind the policy based on the material misrepresentation submitted on Marisol's application for reinstatement.

Misstatement of Age or Sex Provision

An insurer or policyowner may discover that the age or sex of the insured is incorrect as stated in the life insurance policy. Because the age and sex of the insured are significant factors in determining the premium rate charged for a policy, a misstatement of the insured's age or sex is a significant error. However, misstatements of the insured's age or sex are not treated as material misrepresentations in an application for a life insurance policy.

Most life insurance policies include a ***misstatement of age or sex provision***, which describes the action the insurer will take if the age or sex of the insured is incorrectly stated. A typical provision states that if the age or sex of the insured is misstated and the misstatement resulted in an incorrect premium amount for the amount of insurance purchased, then the insurer will adjust the face amount of the policy to the amount the premiums actually paid would have purchased if the insured's age or sex had been stated correctly.

Insurers adjust the face amount of the policy when they discover a misstatement of age or sex *after* the death of the insured. If the insured's actual age is younger than listed, or the insured is female but misstated as male, then the face amount increases. If the insured's actual age is older than stated, or the insured is male but misstated as female, then the face amount decreases. If the misstatement is discovered *before* the death of the insured, however, the insurer may give the

policyowner the option to pay—or receive as a refund—any premium amount difference caused by the misstatement instead of adjusting the policy's face amount.

When an insurance company adjusts the amount of the death benefit payable under a life insurance policy because of a misstatement of age or sex, the insurer is not contesting the validity of the contract. Rather, the insurer is enforcing the misstatement of age or sex provision. Therefore, the policy's incontestability provision does not prohibit the insurance company from making such an adjustment at any time.

Example:

On Inga Henriksson's 35th birthday, her brother Michael purchased an insurance policy on her life from Presidency Life Insurance. Inga died seven years later, after the policy's contestable period had expired. While Presidency was processing the claim, they discovered that Michael had mistakenly listed her as both 33 years old and male.

Analysis:

Presidency will adjust the policy's death benefit to the amount that the premiums paid would have purchased for Inga as a 35-year-old woman. The amount will adjust upward for the misstatement of sex, but downward for the misstatement of age; Presidency will apply the difference between the two adjustments to the death benefit and pay the modified amount to the beneficiary.

Provisions Unique to Cash Value Policies

The provisions we've just described are common to all individual life insurance policies. Cash value life insurance policies also contain provisions related to policy loans, withdrawals, and nonforfeiture options.

Policy Loans and Policy Withdrawals

Cash value life insurance policies typically include a ***policy loan provision***, which specifies the terms under which the policyowner can obtain a loan from the insurer against the policy's cash value. Some policy loan provisions allow the policyowner to take out a loan in an amount that does not exceed the policy's cash value less one year's interest on the loan. Other policy loan provisions allow a stated maximum loan amount or a maximum loan of a certain percentage—such as 75 to 90 percent—of the policy's cash value. A policy loan is actually an advance payment of part of the amount that the insurer eventually must pay out under the policy.

A policy loan differs from a commercial loan from a lending institution, such as a bank, in two respects. First, a commercial loan creates a debtor-creditor relationship between the borrower and the lender, which means that the borrower is legally obligated to repay a commercial loan. In contrast, the policyowner is not legally obligated to repay a policy loan, as he is technically borrowing from his own funds. The policyowner, however, may choose to repay part or all of the loan at any time. If a policy loan has not been repaid when the insured dies, the insurer deducts the amount of the unpaid loan, including any unpaid interest on the loan, from the death benefit payable.

Example:

At the time of his death, Marco Grimaldi was insured under a $350,000 whole life insurance policy. The policy had an unpaid policy loan in the amount of $15,000.

Analysis:

The insurance company will deduct the amount of the unpaid policy loan from the death benefit. As a result, the beneficiary will receive $335,000 ($350,000 - $15,000).

A policy loan also differs from a commercial loan in that the insurance company does not perform a credit check on a policyowner who requests a policy loan. The policyowner's request is evaluated only in terms of the amount of the net cash value available.

Insurers charge interest on each policy loan, usually on an annual basis. Although the policyowner may pay policy loan interest at any time, she is not required to pay the interest. Any unpaid interest charges become part of the policy loan. Therefore, when we speak of the amount of the policy loan outstanding, that amount includes the unpaid amount of the loan plus any unpaid interest. If this amount increases to the point at which the total indebtedness exceeds the policy's cash value, then the policy terminates without further value. Typically, the insurer must notify the policyowner at least 30 days in advance of such a policy termination.

Universal life insurance policies typically include a policy loan provision and a policy withdrawal provision. A ***policy withdrawal provision***, which is often called a *partial surrender provision*, 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. Insurers do not charge interest or expect repayment on policy withdrawals; the amount of the cash value is simply reduced by the amount of the withdrawal. However, many policies impose an administrative fee for each withdrawal and limit the number of withdrawals allowed within a one-year period. Withdrawals may also reduce the amount of the policy's death benefit.

Nonforfeiture Provision

The ***nonforfeiture provision*** 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. Most nonforfeiture provisions give the policyowner the right to select from among several nonforfeiture options if a renewal premium is unpaid when the grace period expires. These nonforfeiture options include the cash payment nonforfeiture option, two continued insurance coverage options—reduced paid-up insurance and extended term insurance—and the automatic premium loan option. Most policies include an ***automatic nonforfeiture benefit***, which is 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. The most typical automatic nonforfeiture benefit is the extended term insurance benefit.

Cash Payment Nonforfeiture Option

The ***cash payment nonforfeiture option*** states that a policyowner who discontinues premium payments can elect to surrender the policy and receive the policy's cash surrender value in a lump-sum payment. When a policyowner decides to surrender a cash value policy, the insurer first subtracts any ***surrender charges***, which are specific charges imposed if the owner of a cash value insurance policy surrenders the policy for its cash surrender value.

Cash value policies include a chart that lists cash surrender values at various times, and these policies describe the method used to compute those values. Laws in many jurisdictions require that these cash values meet or exceed the amount that would be provided to the policyowner on the basis of an actuarial formula stated in the laws. In most cases, applying this formula requires the policy to provide a cash surrender value by the end of the second or third policy year. Insurance companies often issue policies that provide a cash surrender value sooner than required by law and that provide a larger cash surrender value than that required by law.

The amount of the cash value actually available to a policyowner upon surrender of a policy may not be the exact cash surrender value amount described in the policy. For example, the insurer subtracts the amount of any outstanding policy loan, plus any interest on the loan, from the cash surrender value in determining the amount payable to the policyowner. We discuss other additions and subtractions to the cash surrender value in the next chapter. The amount the policyowner actually receives—after the insurer makes any additions or subtractions to the cash surrender value—upon surrendering the policy is called the ***net cash surrender value***.

When the insurer pays a policyowner the net cash surrender value, the policy—and all coverage under the policy—terminates. Typically, the policyowner returns (surrenders) the policy to the insurer at this time.

Continued Insurance Coverage Nonforfeiture Options

Many policies that build a cash value provide the policyowner with the option of discontinuing premium payments and continuing insurance coverage as either reduced paid-up insurance or extended term insurance.

Reduced Paid-Up Insurance

Under the ***reduced paid-up insurance nonforfeiture option***, 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. The insurer bases this premium on the insured's attained age when the option goes into effect. The amount of paid-up insurance that can be purchased under this option is smaller than the face amount of the original policy—thus the name *reduced* paid-up insurance. For example, if the policyowner of a $500,000 whole life insurance policy exercises this option, he can purchase a paid-up whole life policy with a face amount lower than $500,000.

Policies that include this option typically contain a chart listing the amount of reduced paid-up insurance that is available each year for the first 20 years the policy is in force. The amount of reduced paid-up insurance listed for each year is based on the cash value listed in the policy for that year.

The coverage issued under this option continues to have and to build a cash value, and the policyowner retains the rights available to the owner of any life insurance policy. Thus, the policyowner has the right to surrender the policy for its cash value. Any supplemental benefits that were available on the original policy, such as accidental death benefits, are usually not available when the policy is continued as reduced paid-up insurance.

Extended Term Insurance

Under the ***extended term insurance nonforfeiture option***, the policyowner discontinues paying premiums and uses the policy's net cash surrender value as a single net 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. For example, if the owner of a $500,000 whole life insurance policy exercises this option, she can purchase $500,000 of term life insurance for as long a term as the net cash surrender value can provide. As with reduced paid-up insurance, the premium charge for the extended term insurance is based on the insured's attained age when the option goes into effect.

Life insurance policies that offer the extended term insurance option typically contain a chart showing the length of time the original face amount of the policy will be continued in force under the extended term option for each of the first 20 policy years. Figure 8.1 shows a sample table of guaranteed values for a whole life policy, including the amount of reduced paid-up insurance available and the duration of the extended term insurance available at the end of specified policy years.

According to the terms of most policies, a policyowner who has elected the extended term nonforfeiture option can no longer exercise the policy loan privilege or receive policy dividends. The policyowner, however, does have the right to cancel the extended term insurance and surrender the policy for its remaining cash value. As with the reduced paid-up option, any supplemental benefits that were available under the original policy usually are not available when the policy is continued under the extended term insurance option.

Because of the way in which they operate, universal life insurance policies typically do not include an extended term insurance nonforfeiture option. Recall that the insurer periodically deducts mortality and expense charges from the universal life policy's cash value. Thus, even if the owner of a universal life policy pays no premium, the policy continues in force until the cash value is exhausted by the routine monthly deductions.

Automatic Premium Loan Option

Under the ***automatic premium loan (APL) option***, 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. The use of the automatic premium loan keeps the original policy in force for the full amount of coverage, including all supplemental benefits. Some jurisdictions require that cash value life insurance policies contain an automatic premium loan provision, and it is widely used in policies issued in many other jurisdictions.

Universal life insurance policies usually do not include an automatic premium loan provision because a similar benefit is already provided in these policies as part of their monthly cash value deduction mechanism.

Figure 8.1 Sample Table of Guaranteed Nonforfeiture Values

Table of Guaranteed Values
Plan: Whole Life
Face Amount: $100,000
Sex of Insured: Male
Age of Insured at Issue: 35

		Alternatives to Cash Value			
End of Policy Year	Cash Value	Paid-Up Insurance	or Extended Insurance		End of Policy Year
			Years	Days	
1	___	___	___	___	1
2	$ 100	___	0	276	2
3	800	$ 3,421	5	95	3
4	1,800	7,436	9	245	4
5	2,900	11,574	13	142	5
6	4,100	15,809	16	68	6
7	5,200	19,376	17	337	7
8	6,500	23,410	19	214	8
9	7,700	26,812	20	213	9
10	9,000	30,309	21	260	10
11	10,200	33,233	21	349	11
12	11,600	36,574	22	201	12
13	12,900	39,369	22	328	13
14	14,300	42,246	23	71	14
15	15,800	45,183	23	159	15
16	17,300	47,896	23	202	16
17	18,800	50,400	23	207	17
18	20,400	52,974	23	211	18
19	22,000	55,355	23	185	19
20	23,600	57,564	23	133	20
Age 60	32,100	67,500	22	53	Age 60
Age 65	41,100	75,379	20	93	Age 65

Life Insurance Policy Exclusions

Insurance policies sometimes contain ***exclusions***—provisions that describe circumstances under which the insurer will not pay the policy benefit following an otherwise covered loss. For example, individual life insurance policies typically include a ***suicide exclusion provision***, which 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. Laws in many jurisdictions specify the maximum allowable length of a suicide exclusion period, which is usually one or two years. A typical suicide exclusion provision follows.

> **Suicide Exclusion.** Suicide of the insured, while sane or insane, within two years of the date of issue, is not covered by the policy. In that event, this policy will end, and the only amount payable will be the premiums paid to us, less any loan.

In some policies, the suicide exclusion provision states that, if the insured commits suicide during the suicide exclusion period, the insurer will pay the larger of (1) the cash surrender value or (2) the premiums paid for the policy.

Insurance companies include the suicide exclusion provision in policies to protect themselves against the possibility of antiselection. Otherwise, a person who is planning to commit suicide would be more likely to apply for life insurance than would other people. For the same reason, when a policy is reinstated, a new suicide exclusion period generally begins to run from the date of reinstatement. Death benefits are not payable if the insured dies as the result of suicide within the suicide exclusion period following the date of policy reinstatement.

Insurers may also include other exclusions in life insurance policies. These exclusions, which vary from insurer to insurer and from country to country, include

- A *war exclusion clause*, which states that the insurer will not pay the death benefit if the insured's death results from war or an act of war. The policy defines the terms "war" and "act of war." Similarly, some policies include a *military service exclusion clause*, which states that the insurer will not pay the death benefit if the insured's death results from his military service during a time of war. Policies containing these clauses typically are issued only during periods of war or threats of war.

- A *hazardous activities exclusion provision*, which states that the insurer will not pay the death benefit if the insured's death results from specified dangerous activities such as mountain climbing, sky diving, or scuba diving. This exclusion is usually included only when the application indicates that the insured engages in such hazardous activities.

- An *aviation exclusion provision*, which states that the insurer will not pay the death benefit if the insured's death results from aviation-related activities. Some aviation exclusions apply only to activities connected with military or experimental aircraft. Other aviation exclusion provisions apply to pilots and crew members of privately owned aircraft. A few aviation exclusion provisions apply to any aviation-related death unless the insured was a passenger on a regularly scheduled commercial airline.

Some insurers offer policyowners the option of (1) excluding certain hazardous or aviation-related activities from coverage or (2) paying an additional premium for such coverage.

Key Terms

free-look provision
entire contract provision
closed contract
open contract
incontestability provision
misrepresentation
material misrepresentation
fraudulent misrepresentation
grace period provision
grace period
reinstatement provision
reinstatement
misstatement of age or sex provision
policy loan provision
policy withdrawal provision
nonforfeiture provision
automatic nonforfeiture benefit
cash payment nonforfeiture option
surrender charge
net cash surrender value
reduced paid-up insurance nonforfeiture option
extended term insurance nonforfeiture option
automatic premium loan (APL) option
exclusion
suicide exclusion provision

Endnote

1. A one-year contestable period is the maximum allowed by law in some states and countries. Most other countries allow a maximum two-year contestable period, but some extend the maximum allowable period to three years or even more.

Chapter 9

Life Insurance Policy Ownership Rights

Objectives

After studying this chapter, you should be able to

9A Distinguish between primary and contingent beneficiaries and between revocable and irrevocable beneficiaries

9B Describe the premium payment modes that insurers typically offer on individual life insurance policies

9C Identify the policy dividend options that most commonly are included in participating life insurance policies and describe the characteristics of each option

9D Identify the methods by which ownership of a life insurance policy can be transferred

9E Identify the person in a given situation who is entitled to receive the proceeds of a life insurance policy following the insured's death

9F Describe the general rule stated in a simultaneous death act and explain how that rule is affected if a policy contains a survivorship clause

9G Calculate the proceeds payable under a given life insurance policy following the death of the insured

9H Identify the settlement options that typically are included in life insurance policies and describe the features of each option

Outline

Naming the Beneficiary
- Primary and Contingent Beneficiaries
- Changing the Beneficiary

Mode of Premium Payment

Policy Dividends
- Cash Dividend Option
- Premium Reduction Dividend Option
- Policy Loan Repayment Dividend Option
- Accumulation at Interest Dividend Option
- Paid-Up Additional Insurance Dividend Option
- Additional Term Insurance Dividend Option

Transfer of Policy Ownership
- Transfer of Ownership by Assignment
- Transfer of Ownership by Endorsement

Death of the Policyowner

Right to Receive Policy Proceeds
- Identifying Who Is Entitled to Policy Proceeds
- Calculating the Amount of the Policy Proceeds
- Paying Policy Proceeds under a Settlement Option

We've already seen in Chapter 3 that an insurance policy is a contract and therefore is personal, intangible property. When a life insurance policy is issued, the policy's ownership rights vest in the policyowner. If a policy has no living owners, including contingent owners or joint owners, then ownership typically passes to the estate of the policyowner.

Ownership rights are spelled out in the policy, and some vary depending on the type of policy. One of the most important ownership rights in a life insurance policy is the right to name the beneficiary who will receive the ***policy proceeds***, which is the total monetary amount paid by an insurer if the insured dies while the policy is in force. Other important rights concern premium payments, policy dividends, and settlement options. The owner of a policy can also transfer her ownership rights to another party.

Naming the Beneficiary

For many people, the most important ownership right of a life insurance policy is the right to name the beneficiary. The beneficiary of a life insurance policy may be a named individual, or it may be any other entity recognized by the laws of the jurisdiction, including the executor of an estate, a corporation, or a charitable organization. A policyowner also can designate a group of persons as a beneficiary. A beneficiary designation that identifies a certain group of people rather than naming each person individually is called a ***class designation***. The beneficiary designation "my children" is a common example of a class designation.

Primary and Contingent Beneficiaries

The ***primary beneficiary***, or *first beneficiary*, is the party designated to receive a life insurance policy's proceeds following the death of the insured. To receive

policy proceeds, the primary beneficiary must survive the insured; the beneficiary's estate has no claim to the policy proceeds if the beneficiary dies before the insured does. If more than one party is named as primary beneficiary, the policyowner may indicate how the proceeds are to be divided among the parties. If the policyowner does not make such an indication, then the insurer divides the proceeds evenly among the primary beneficiaries who survived the insured.

Example:

At the time of his death, Jason Kilpatrick owned an insurance policy on his life. Jason named his three children—Amos, Kiley, and Rebecca—as the policy beneficiaries. All three children survived Jason.

Analysis:

Unless Jason indicated otherwise, the policy proceeds would be divided evenly among Amos, Kiley, and Rebecca.

The policyowner also may designate a ***contingent beneficiary***, sometimes referred to as a *secondary beneficiary* or *successor beneficiary*, who receives the policy proceeds only if all designated primary beneficiaries have predeceased the insured. The policyowner can name any number of contingent beneficiaries and may specify how the proceeds are to be divided among the contingent beneficiaries. The designation of contingent beneficiaries can be especially important in cases in which the primary beneficiary dies and the policyowner is unable to designate a new beneficiary before the policy proceeds become payable.

Example:

Sophie Katsaros took out an insurance policy on her life and named her children, Mia and Zoe, as equal primary beneficiaries. She also named her husband, Basil, as contingent beneficiary. When Sophie died, she was survived only by Mia and Basil, as Zoe had died in an accident two years earlier.

Analysis:

The policy proceeds are payable to the sole surviving primary beneficiary, Mia.

Example:

Juliet Chau owned an insurance policy on her life and named her husband, Stephen, as primary beneficiary and her children, Sam and May, as equal contingent beneficiaries. Both Stephen and May predeceased Juliet.

Analysis:

Because the primary beneficiary (Stephen) is deceased, the policy proceeds go to any surviving contingent beneficiaries—Sam, in this case.

Insurers usually prefer that policyowners name at least a primary and a contingent beneficiary. Naming additional levels of contingent beneficiaries ensures that the proceeds are paid to the desired party.

Example:

Javad Kashani owned an insurance policy on his life. He named his wife, Maria, primary beneficiary; their daughter, Azra, first contingent beneficiary; and his brother, Mahmud, second contingent beneficiary. Javad and Maria died in an accident.

Analysis:

Azra is entitled to receive the policy proceeds. Mahmud would be entitled to receive the policy proceeds only if Maria and Azra had both predeceased Javad.

A minor named as beneficiary generally cannot receive policy proceeds directly. In most U.S. jurisdictions, the law requires that a guardian be appointed to administer the proceeds payable to a beneficiary who is a minor. Other options include a trust set up for the beneficiary or an account set up via the Uniform Transfers to Minors Act (UTMA), both of which allow a policyowner to dictate the means of managing the proceeds until a beneficiary who is a minor attains the age of majority.

Changing the Beneficiary

Life insurance policies usually give the policyowner the right to change the beneficiary designation at any time during the insured's lifetime. This right to change the beneficiary designation is known as the ***right of revocation***. A beneficiary designation is said to be *revocable* if the policyowner has the unrestricted right to change the designation during the life of the insured. In contrast, a beneficiary designation is said to be *irrevocable* if the policyowner has the right to change the beneficiary designation only after obtaining the beneficiary's consent. As a general rule, a beneficiary designation is revocable unless the policyowner voluntarily gives up the right to change the beneficiary and makes the designation irrevocable.

Revocable Beneficiary

The vast majority of life insurance policy beneficiaries are revocable beneficiaries. A ***revocable beneficiary*** is a life insurance beneficiary whose designation as beneficiary can be changed by the policyowner at any time before the insured's death. During the insured's lifetime, the revocable beneficiary has no legal interest in the policy proceeds and cannot prohibit the policyowner from exercising any policy ownership rights, including the right to change the beneficiary. A revocable beneficiary's interest in a life insurance policy during the insured's lifetime is referred to as a "mere expectancy" of receiving the policy proceeds.

Note that a beneficiary change can be made only during the insured's lifetime. After the insured dies, the beneficiary has a vested interest in the policy

proceeds, and the policyowner cannot deprive the beneficiary of that interest. A ***vested interest*** is a property right that has taken effect and cannot be altered or changed without the consent of the person who owns the right.

Irrevocable Beneficiary

An ***irrevocable beneficiary*** is a life insurance policy beneficiary whose designation as beneficiary cannot be changed by the policyowner unless the beneficiary gives written consent. An irrevocable beneficiary has a vested interest in the proceeds of the life insurance policy even during the lifetime of the insured. A policyowner usually designates an irrevocable beneficiary as a contractual promise to meet obligations, such as in some divorce cases.

Most insurers do not permit a policyowner who has designated an irrevocable beneficiary to exercise all of his ownership rights in the contract without the irrevocable beneficiary's consent. For example, the policyowner cannot obtain a policy loan, surrender the policy for cash, or assign ownership of the policy to another party without the written consent of the irrevocable beneficiary. (We discuss assignments later in this chapter.)

Most life insurance policies also contain a provision stating that the rights of any beneficiary, including an irrevocable beneficiary, will terminate if the beneficiary should die before the insured dies. This provision prevents the payment of the proceeds to the estate of the irrevocable beneficiary and permits the policyowner to designate a new beneficiary following the death of an irrevocable beneficiary.

Example:

Aimie Brodeur purchased an insurance policy on her own life and named her mother, Yvette, as irrevocable beneficiary. Several years later, while the policy was still in effect, Yvette died.

Analysis:

Upon Yvette's death, Aimie is permitted to designate a new beneficiary—revocable or irrevocable—without having to obtain anyone's consent.

Mode of Premium Payment

Most individual life insurance policyowners pay periodic renewal premiums to keep their policies in force. A policy's ***premium payment mode*** is the frequency at which renewal premiums are payable. Each insurance company determines which premium payment modes it will make available to its policyowners. Typical premium payment modes are on an annual, semiannual, quarterly, or monthly basis. The applicant selects a premium payment mode—most commonly annual—during the application process, and typically can change the mode of premium payment after the policy has taken effect.

The more frequent the renewal premium payments, the greater the insurer's administrative costs to receive and process premiums. In addition, insurers can

more effectively accumulate interest on larger, more infrequent premiums. To cover some of those costs and to offset the difference in interest, an insurer usually charges more than the annual premium amount when a policyowner chooses to pay premiums more frequently than once a year. For example, suppose the annual renewal premium for a particular policy is $1,200 a year. If the policyowner elects to pay on a monthly basis, the insurer probably will increase the monthly renewal premium payable from $100 ($1,200 annual premium ÷ 12 monthly payments) to a greater amount, such as $108, to cover the insurer's additional administrative costs.

Policy Dividends

Insurance policies may be issued on either a participating or nonparticipating basis. A ***participating policy***, sometimes referred to as a *par policy*, is a type of policy under which the policyowner shares in the insurance company's divisible surplus. A ***nonparticipating policy***, also known as a *nonpar policy*, is a type of policy in which the policyowner does not share in the insurer's divisible surplus. Recall that a company's surplus is the amount by which its assets exceed its liabilities plus its capital. ***Divisible surplus*** is the portion of surplus that insurance companies set aside specifically for distribution to owners of participating policies. An amount of money that an insurer pays to the owner of a participating policy from the insurer's divisible surplus is called a ***policy dividend***.

Stock insurance companies as well as many mutuals offer both participating and nonparticipating policies. In 2014, approximately 73 percent of the individual life insurance policies issued in the United States were nonparticipating policies.[1]

Although policy dividends are not guaranteed, most insurers periodically pay dividends on participating life insurance policies that are expected to remain in force over a long time period. The insurance company's board of directors annually determines the amount payable as dividends. Any policy dividend declared for a policy is payable on the policy's anniversary date, and the terms of some life insurance policies state that the policy must be in force for two years before any policy dividends are payable. Generally, dividend amounts increase substantially with the age of the policy, as they are based on the cash surrender value, which grows over time.

The owner of a participating life insurance policy may receive policy dividends by a number of specified methods, called ***dividend options***. Common dividend options for participating life insurance policies include

- The cash dividend option
- The premium reduction dividend option
- The policy loan repayment dividend option
- The accumulation at interest dividend option
- The paid-up additional insurance dividend option
- The additional term insurance dividend option

An applicant for a participating policy usually selects a dividend option during the application process. Over the life of a participating policy, the policyowner may change the dividend option at any time, although, as we will soon discuss,

some changes are subject to certain restrictions. Each participating life insurance policy also specifies an ***automatic dividend option***, which is the dividend option that the insurer will apply if the policyowner does not choose an option. Most cash value policies specify the paid-up additional insurance option as the automatic dividend option. Most term insurance policies specify the accumulation at interest option as the automatic dividend option.

Cash Dividend Option

Under the ***cash dividend option***, the insurance company sends the policyowner a check in the amount of the policy dividend that was declared. In many jurisdictions, insurers are required by law to offer the cash dividend option to all owners of participating life insurance policies.

Premium Reduction Dividend Option

Under the ***premium reduction dividend option***, the insurer applies policy dividends toward the payment of renewal premiums. The insurer notifies the policyowner of the amount of the policy dividend and bills the policyowner for the difference, if any, between the premium amount due and the amount of the policy dividend. If the amount of an annual policy dividend exceeds the amount of the annual renewal premium, the policyowner can select another dividend option to receive the remainder of the dividend, or the insurer will apply the automatic dividend option.

Policy Loan Repayment Dividend Option

Under the ***policy loan repayment dividend option***, the insurer applies policy dividends toward the repayment of an outstanding policy loan. The amount of the policy dividend usually is applied first to repay any outstanding interest on the loan and then to repay the loan principal. If the amount of the annual policy dividend exceeds the amount of the policy loan and any outstanding interest, the policyowner can select another dividend option to receive the remainder of the dividend, or the insurer will apply the automatic dividend option.

Accumulation at Interest Dividend Option

Participating life insurance policies usually contain an ***accumulation at interest dividend option***, sometimes called the *dividends on deposit option*, under which the policy dividends are left on deposit with the insurer to accumulate at interest. The insurer specifies the interest rate annually based on current economic conditions. However, the policy usually guarantees that the insurer will pay at least a stated minimum interest rate.

During the life of the policy, the policyowner typically has the right to withdraw part or all of these dividends and the accumulated interest at any time. If the policyowner surrenders the policy, the amount the insurer pays the policyowner includes the accumulated value of the policy dividends. In cases where the policyowner is not the insured, any policy dividends that are on deposit with the insurer when the insured dies usually are payable to the beneficiary rather than to the policyowner.

Paid-Up Additional Insurance Dividend Option

Under the ***paid-up additional insurance dividend option***, the insurer uses any declared policy dividend to purchase paid-up additional insurance on the insured's life. The paid-up additional insurance is issued on the same plan as the basic policy and in whatever face amount the dividend can provide at the insured's attained age. Because the premium charged for paid-up additions does not include an amount to cover the insurer's expenses, the cost of paid-up additions is less than the cost of comparable coverage provided by a new life insurance policy.

For cash value policies, the paid-up additions purchased with policy dividends build cash values, and the policyowner has the right to surrender those additions for their cash value at any time while the policy is in force. Insurers generally do not offer the paid-up additional insurance dividend option with term life insurance policies.

Although the face amount of the paid-up additions purchased each year under this option can be relatively small, over the life of a policy, the total additional insurance available can be substantial. Figure 9.1 illustrates how the paid-up additional insurance option increases the total death benefit payable under a policy.

Additional Term Insurance Dividend Option

Under the ***additional term insurance dividend option***, the insurer uses each policy dividend to purchase one-year term insurance on the insured's life. The additional term insurance option is not offered by as many insurance companies as are the other dividend options.

The policyowner's right to purchase one-year term insurance under this option is limited in two respects:

- Insurers often limit the maximum amount of one-year term insurance that can be purchased each year to the amount of the policy's cash value. If the annual policy dividend is larger than the premium required to purchase the maximum amount of one-year term insurance permitted, then the insurer applies the remaining amount under one of the other dividend options.

- Before a policyowner is permitted to change from another dividend option to the additional term insurance option, insurers usually require evidence of the insured's insurability. This requirement is designed to prevent antiselection because a policyowner is more likely to change to this dividend option if the insured is in poor health rather than to apply dividends to purchase the more expensive paid-up option.

Transfer of Policy Ownership

The owner of a life insurance policy has the right to transfer ownership of some or all of her rights in the policy. However, a policyowner cannot transfer ownership merely by handing someone else the policy. The two ways in which a policyowner may transfer ownership rights are by assignment and by endorsement.

Figure 9.1 Illustration of Paid-Up Additional Insurance Option

Insured's Age	Dividend Declared	Paid-Up Dividend Additions Current Year	Total Paid-Up Dividend Additions to Date	Total Death Benefit
40	$ 0	$ 0	$ 0	$ 100,000
42	5	16	16	100,016
43	21	65	81	100,081
––	––	––	––	––
50	229	598	1,905	101,905
––	––	––	––	––
60	1,664	3,342	22,280	122,280
––	––	––	––	––
65	2,771	5,042	49,357	149,357

As you can see, after the policy had been in force for two years, the insurer declared a dividend of $5. The insurer automatically applied the $5 dividend to purchase a paid-up whole life addition of $16, the amount of paid-up whole life insurance that the $5 premium would purchase at the insured's attained age of 42. As a result, the total death benefit payable under the policy increased to $100,016.

The next year, the insurer used the $21 policy dividend to purchase another paid-up whole life addition—this time for $65—and the total death benefit payable under the policy increased to $100,081.

By the time the insured reached age 65, the total amount of paid-up additions purchased with policy dividends totaled $49,357, thus increasing the total death benefit payable under the policy to $149,357. Although the dividends were relatively modest at first, the policy death benefit increased to almost 150% of its original value over time.

Transfer of Ownership by Assignment

An ***assignment*** of a life insurance policy is an agreement under which the policyowner transfers some or all of his ownership rights in the policy to another party. The policyowner who makes an assignment is known as the ***assignor***; the party to whom the property rights are transferred is known as the ***assignee***.

The right to assign a life insurance policy is subject to the following restrictions:

- To make a valid assignment of an insurance policy, the policyowner must have contractual capacity. As a result, if the policyowner is a minor or, for some other reason, lacks contractual capacity, any attempt by the policyowner to assign the policy is invalid.

- The assignment of a life insurance policy may not infringe on the vested rights of an irrevocable beneficiary. An assignment made without such a beneficiary's consent is invalid. Note that when the beneficiary is a revocable beneficiary, the policyowner has an unlimited right to assign the policy without obtaining the beneficiary's consent.

- An assignment that is made for illegal purposes, such as speculating on a life, is invalid.

Types of Assignment

An assignment may take one of two forms: an absolute assignment or a collateral assignment. Whether an assignment is absolute or collateral depends on whether the assignee has received complete ownership of the policy or only certain specified ownership rights in the policy.

Absolute Assignment

An ***absolute assignment*** of a life insurance policy is an irrevocable assignment under which a policyowner transfers all of his policy ownership rights to the assignee. The policyowner-assignor has no further rights under the contract, and the assignee becomes the policyowner. In general, a policyowner can absolutely assign a policy to anyone, regardless of whether the assignee has an insurable interest in the life of the insured.

A policyowner can make a gift of a life insurance policy by absolutely assigning the policy to the assignee without receiving any payment in exchange. For example, parents who purchase insurance on their child's life often transfer ownership of the policy—as a gift—to the child when she reaches the age of majority. A policyowner also can sell a life insurance policy by absolutely assigning the policy to the assignee in exchange for financial compensation. For example, a business that owns an insurance policy on the life of a key person may sell the policy to the key person in exchange for the policy's accumulated cash value when that key person leaves employment.

Collateral Assignment

A ***collateral assignment*** of a life insurance policy is a temporary assignment of the monetary value of a life insurance policy as collateral—or security—for a loan. For example, if a person takes out a personal loan from a bank, that person may collaterally assign a life insurance policy to the bank as security for the loan. A collateral assignment differs from an absolute assignment in three general respects.

1. **The collateral assignee's rights are limited to those ownership rights that directly concern the monetary value of the policy.** The policyowner retains all ownership rights that do not affect the policy's value. For example, the right to name the policy beneficiary and the right to select a settlement option remain with the policyowner. The policyowner-assignor, however, is not permitted to take out a policy loan or surrender the policy for its cash surrender value while a collateral assignment is in effect unless the assignee consents. This limitation protects the assignee's right to the policy's value because a policy loan and a policy surrender both diminish that value.

2. **The collateral assignee has a vested right to the policy's monetary values, but that right is limited.** The assignee's rights to the policy's values are limited to the amount of the assignor's debt to the assignee. Consequently, if the policy proceeds become payable, the assignee is entitled to receive only the amount of the indebtedness; any remaining amount must be paid to the policy's beneficiary. The assignee can receive this amount only in a lump sum and cannot select a settlement option.

Example:

Mark Tetley was the policyowner-insured of a $100,000 life insurance policy. Mark collaterally assigned the policy to Enlightened Bank as security for a loan he received from Enlightened. When Mark died, he owed Enlightened $30,000.

Analysis:

The insurer paid Enlightened $30,000. The policy beneficiary received the remaining $70,000 of the policy proceeds.

3. **The collateral assignee's rights to the policy values are temporary.** If the policyowner repays the amount owed to the collateral assignee during the insured's lifetime, the assignment terminates, and all of the policy's ownership rights revert to the policyowner. Once the loan is repaid, the policyowner usually secures from the assignee a release of the assignee's claim to the policy proceeds.

Assignment Provision

Most life insurance policies include an ***assignment provision***, which describes the roles of the insurer and the policyowner when the policy is assigned. An example of a life insurance policy's assignment provision follows.

Assignment. While the insured is living, you can assign this policy or any interest in it. As owner, you still have the rights of ownership that have not been assigned. We must have a copy of any assignment. We will not be responsible for the validity of an assignment. An assignment will be subject to any payment we make or other action we take before we record it.

An assignment is an agreement between the assignor and the assignee. The insurance company is not a party to the agreement. Therefore, the policy's assignment provision states that the insurer is not responsible for the validity of any assignment. When an insurance company receives written notice of an assignment, the company presumes that the assignment is valid. An insurer usually cannot be held liable for having acted in accordance with an assignment that is later determined to be invalid.

The insurance company is not obligated to act in accordance with the terms of an assignment unless it has received written notice of the assignment. The following example illustrates what can happen if an insurer is not notified of a collateral assignment.

Example:

Eileen Shelton collaterally assigned the insurance policy she owned on her life to Enlightened Bank as security for a loan. When Eileen died, the insurance company had not been notified of the assignment, and, thus, it paid the policy proceeds to the beneficiary. Enlightened later claimed its share of the policy proceeds.

Analysis:

Because the insurer was not notified of the assignment before it paid the death benefit, it has no liability to pay any part of the proceeds to Enlightened.

Because the assignee wants to protect its own interests, the assignee typically assumes responsibility for notifying the insurance company, in writing, of the assignment. Similarly, when the policyowner repays the debt, the policyowner usually assumes responsibility for notifying the insurance company that the assignment is no longer in effect.

Transfer of Ownership by Endorsement

Many life insurance policies issued today specify a simple, direct method of transferring all the policy's ownership rights. Under this method, known as the *endorsement method*, the policyowner does not need to enter into a separate assignment agreement to transfer policy ownership. The endorsement method is commonly used when a policy is given as a gift, such as the gift of a policy from a parent to a child.

The right to change the policy's owner is generally specified in the *change of ownership provision* in the policy. Typically, to change the ownership of the policy, the policyowner must notify the insurer, in writing, of the change. However, the insurer usually has the right to require that the ownership change be endorsed in the policy. In such a case, the policyowner sends the policy to the insurance company, and the insurer adds to the policy an endorsement that states the name of the new owner. The change of ownership provision usually states that the insurance company is not responsible for any payments it made to the owner of record before it received written notice of an ownership change and recorded that change. This provision prevents the new owner from contesting the insurer's actions in the event that the insurer had granted a loan or made benefit payments between the date the policyowner signed the notification and the date the insurance company recorded the change.

Death of the Policyowner

The policyowner and the insured are often the same person, but this isn't true for third-party policies, where the policyowner and insured are different people. In

such a policy, a policyowner might die while the insured is still alive, raising the question of who owns the policy. For example, a person might take out an insurance policy on his father, while retaining ownership of the policy, only to die in an accident before his father does.

To cover these situations, an insurance policy may name a *contingent owner*. This person becomes the new owner of the policy if the original policyowner dies while the insured is still living. Rather than name a contingent owner, some policies name multiple people as the joint owners of the policy.

If a policy has no living owners, including contingent owners or joint owners, then ownership typically passes to the estate of the policyowner.

Right to Receive Policy Proceeds

Upon an insured's death, the beneficiary has a vested right to receive the policy proceeds. The insurer pays the proceeds in accordance with the provisions of the policy. In addition to establishing the rightful recipient of the policy proceeds, the policy's provisions specify how the total amount of the policy proceeds is calculated and how the proceeds are to be paid.

Identifying Who Is Entitled to Policy Proceeds

Typically, the beneficiary survives the insured, and the insurance company pays the policy proceeds to that beneficiary. Sometimes, however, identifying the person or party entitled to receive the proceeds is not that easy.

No Surviving Beneficiary

If no beneficiary has been named or none of the beneficiaries are living when the insured dies, then the policy proceeds typically are paid to the policyowner, if the policyowner is living. If the policyowner is deceased, then the proceeds are paid to the policyowner's estate.

Example:

Mark Palakiko was the policyowner-insured of a life insurance policy that named his wife as the primary beneficiary and their two children as contingent beneficiaries. Mark's wife and children all predeceased him.

Analysis:

If Mark did not name a new beneficiary prior to his death, the policy proceeds are payable to the policyowner's—in this case, Mark's—estate.

Some policies contain a ***preference beneficiary clause***, or *succession beneficiary clause*, which states that if the policyowner does not name a beneficiary, then the insurer will pay the policy proceeds in a stated order of preference. For example, a preference beneficiary clause might list the beneficiaries in the following order: the spouse of the insured, if living; then the children of the insured, if living; and then the parents of the insured, if living. If no living recipients are available from that list, then the policy proceeds are payable to the estate of the

insured. The preference beneficiary clause is found more often in group life insurance policies than in individual life insurance policies.

Insured and Beneficiary Die in a Common Disaster

A beneficiary is entitled to receive the policy proceeds only if he survives the insured. Sometimes, however, the insured and the beneficiary die in the same accident. This situation is referred to as a *common disaster*, because the accident or disaster was common to more than one person. Under such circumstances, the insurer may be unable to determine whether the insured or the beneficiary died first. This ambiguity can make it difficult to act according to the policyowner's wishes, specifically in cases where the death benefit would go to the deceased beneficiary's estate rather than to a contingent beneficiary.

Many jurisdictions have enacted a ***simultaneous death act***, which governs how insurance companies evaluate common-disaster situations. A typical simultaneous death act states the following general rule:

> If the insured and the beneficiary die at the same time or under circumstances that make it impossible to determine which of them died first, the insured is deemed to have survived the beneficiary, and policy proceeds are payable as if the insured outlived the beneficiary, unless the policy provides otherwise.

The following example illustrates how this rule of law affects the payment of life insurance policy proceeds.

> **Example:**
>
> Amy Leong and her husband, James, died in an automobile crash, and the evidence did not clearly indicate which of them died first. Amy owned a policy on her life that named James as the primary beneficiary and Amy's sister, Gemma, as the contingent beneficiary. Gemma was still living at the time of the accident.
>
> **Analysis:**
>
> If the insurer is located in a jurisdiction that has a typical simultaneous death act, the insurer will assume that Amy survived the primary beneficiary, James. Therefore, the policy proceeds are payable to the contingent beneficiary, Gemma.

A simultaneous death act generally does not affect how policy proceeds are paid in cases in which the beneficiary survives the insured.[2] If the beneficiary survives the insured by any length of time—even if only for a few minutes—then the beneficiary usually is entitled to receive the policy proceeds. Therefore, if the beneficiary survives the insured but dies before receiving the policy proceeds, then the proceeds are payable to the beneficiary's estate.

The policyowner, however, may prefer that the proceeds be paid to someone other than the beneficiary's estate if the beneficiary survives the insured by only a short time. Some life insurance policies include a survivorship clause to address this potential problem. A ***survivorship clause*** 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. If the beneficiary does not survive the insured by the stated amount of time, then the policy proceeds are paid as if the beneficiary predeceased the insured. As a result of the survivorship clause, the policy proceeds are more likely to be distributed as the policyowner had intended. The survivorship clause is not limited to cases involving a common disaster. It applies in all situations in which the beneficiary dies within the stated period of time after the insured's death.

Example:

Lars Klunder was insured under a life insurance policy that included a survivorship clause requiring the beneficiary to survive the insured by 30 days. His son, Nils, was the policy's primary beneficiary, and his wife, Hanna, was the contingent beneficiary. Lars and Nils were involved in a boating accident; Lars died immediately, and Nils died five days later.

Analysis:

Because Nils died only 5 days after Lars died, he did not survive his father by the required 30 days. Therefore, the proceeds are payable to the contingent beneficiary, Hanna.

Beneficiary Wrongfully Kills the Insured

Laws in many countries exist to prevent individuals from benefiting from a criminal act. According to these laws, a beneficiary would be disqualified from receiving the policy proceeds if the beneficiary is convicted of wrongfully and intentionally killing the insured.[3] In most cases in which a beneficiary is disqualified from receiving policy proceeds, the life insurance contract is valid, and the insurer is liable to pay the policy proceeds to someone, such as the contingent beneficiary. If, however, the policy was purchased with the intention to profit from the insured's death, then the life insurance contract is void because the lawful purpose requirement was not met when the contract was created.

Calculating the Amount of the Policy Proceeds

For most individual life insurance policies, the insurer calculates the amount of the proceeds payable following the insured's death by adding together a number of items and deducting other items. The insurer first adds together the following items:

- The amount of the **death benefit payable**.
- The amount of any **accidental death benefits payable**.
- The amount of any **declared but unpaid policy dividends**.
- The amount of any **accumulated policy dividends**, including interest, left on deposit with the insurer.
- The face amount of any **paid-up additions**.

- The amount of any **unearned premiums paid in advance**. Policyowners sometimes pay premiums before they are due. For example, a policyowner might pay a renewal premium a month before the premium due date. If the insured dies shortly before the renewal premium is payable, the insurer usually refunds the amount of the renewal premium because the insurer has not earned that premium.

After totaling the amount of the foregoing items, the insurer then subtracts the following items from that total:

- The amount of any **outstanding policy loans**, including any unpaid interest.
- The amount of any **premium due and unpaid** at the time of the insured's death. This situation occurs when the insured dies during the policy's grace period before the premium due has been paid.

The result of this calculation is the total policy proceeds payable.

Example:

When Teemu Pulkkenin died in an accident, he was insured under a $200,000 life insurance policy with a $100,000 accidental death benefit. At the time of his death, $350 in accumulated policy dividends were on deposit with the insurer, and Teemu had paid $450 in advance premiums. Teemu also had an outstanding policy loan of $6,200.

Analysis:

The insurer was liable to pay the beneficiary a total benefit of $294,600. That amount was calculated as follows:

$200,000	Death benefit of policy
+100,000	Accidental death benefit
+350	Accumulated policy dividends
+450	Premium paid in advance
–6,200	Outstanding policy loan
$294,600	Total benefit amount payable

Paying Policy Proceeds under a Settlement Option

In most cases, the insurer pays the proceeds of a life insurance policy in a lump sum following the insured's death. Typically, the insurer pays the lump sum directly to the beneficiary. In addition to lump-sum settlements of policy proceeds, insurance companies provide several alternative methods that the owner or beneficiary can elect for receiving payment of the policy proceeds. These alternative methods are called ***settlement options*** or *optional modes of settlement*, and insurers that provide such options include a settlement options provision in their life insurance policies. The ***settlement options provision*** grants a policyowner or a beneficiary several choices as to how the insurance company will distribute the proceeds of a life insurance policy.

The policyowner may select a settlement option at the time of application or at any time while the policy is in force. The policyowner also has a right to change to another settlement option at any time during the insured's lifetime. A policyowner

who selects a settlement option for the beneficiary may choose to make the settlement mode *irrevocable*, in which case the beneficiary will not be able to change to another option when the policy proceeds become payable. For example, the policyowner might not feel that the beneficiary would handle a single lump sum responsibly, and would prefer that the death benefit take the form of a series of payments. In contrast, the settlement mode is considered to be *revocable* when the beneficiary has the right to select another settlement option when the proceeds become payable. Further, if the policyowner has not chosen a settlement option when the policy proceeds become payable, then the beneficiary has the right to choose a settlement option.

The person or party who is to receive the policy proceeds under a settlement option is referred to as the ***payee***. The party who elects an optional mode of settlement—either the policyowner or the beneficiary—also has the right to designate a ***contingent payee***, or *successor payee*, who will receive any proceeds still payable at the time of the payee's death.

Insurers commonly offer four optional modes of settlement in their individual life insurance policies. These settlement options are the interest option, the fixed period option, the fixed amount option, and the life income option.

Interest Option

The ***interest option*** is a settlement option under which the insurance company invests the policy proceeds and periodically pays interest on those proceeds to the payee. The policy usually guarantees that the insurer will pay at least a stated minimum interest rate, but the insurer may pay a higher rate if its investment earnings are better than expected.

The payee generally has the right to withdraw all or part of the policy proceeds at any time or to place all of the proceeds—including any interest that the insurer is holding—under another settlement option. However, a policyowner who selects the interest option may place restrictions on the payee's right to withdraw the policy proceeds. For example, the policyowner might specify that the payee is not permitted to withdraw more than 10 percent of the policy proceeds per year for the first 10 years after proceeds are payable.

Fixed Period Option

The ***fixed period option*** is a settlement option under which the insurance company agrees to pay policy proceeds in equal installments to the payee for a specified period of time. Each payment will consist partly of the policy proceeds being held by the company and partly of the interest earned on the proceeds. As with the interest option, the policy states the minimum guaranteed interest rate that will be earned on the proceeds and states that the rate may be higher if the insurer's investment returns are better than expected.

The amount of each installment paid under the fixed period option depends primarily on the amount of the policy proceeds, the interest rate, and the length of the payment period that the policyowner or beneficiary chooses. Installments may be paid annually or more frequently—even monthly if the amount of each installment is large enough to meet the company's minimum requirements. For example, the policyowner might elect for the insurer to pay the policy proceeds in equal monthly installments for a five-year period.

If the policyowner has not designated the fixed period option as irrevocable, many policies permit the payee to cancel the option at any time and to collect all of the remaining policy proceeds and unpaid interest in a lump sum. The payee, however, usually does not have the right to withdraw only a part of the funds during the payment period. Such a partial withdrawal would reduce the amount of the remaining funds and would require the insurer to recalculate the entire schedule of benefit payments.

Fixed Amount Option

The ***fixed amount option*** is a settlement option under which the insurance company pays equal installments of a stated amount until the policy proceeds, plus the interest earned, are exhausted. For example, the policyowner might elect for the insurer to pay $1,000 a month to the payee until the policy proceeds are exhausted.

The number of installments that the insurer will pay depends on the amount of the policy proceeds, the interest rate, and the fixed amount selected. As with the fixed period option, the fixed amount option states the minimum guaranteed interest rate that the insurer will pay on the policy proceeds it holds. The larger the amount of the proceeds and all other factors remaining equal, the longer the period for which the insurer will make installment payments of the fixed amount.

The payee receiving the policy proceeds under the fixed amount option generally has the right to withdraw part or all of the remaining policy proceeds at any time. If the payee makes a partial withdrawal, then the insurer will continue making installment payments of the selected amount but will reduce the number of installments it pays. In many cases, the payee also has the right to increase or decrease the amount of each installment payment. Increasing the amount of each payment means that the proceeds will be exhausted more rapidly and fewer payments will be made. Alternatively, reducing the amount of each installment means that the proceeds will be paid over a longer period of time.

Life Income Option

The ***life income option*** is a settlement option under which the insurance company agrees to pay the policy proceeds in periodic installments over the payee's lifetime. As we have seen, both the fixed amount and fixed period options provide installment payments for only a limited time. On the other hand, the life income option provides a permanent source of income for the payee, even though this method of settlement typically results in smaller installment payments than would be available under the fixed amount or fixed period options.

Under the life income option, the insurance company agrees to use the policy proceeds to purchase a life annuity for the payee. Recall that an *annuity* is a series of periodic payments. A ***life annuity*** is an annuity that provides annuity payments for *at least* the lifetime of a named individual. In other words, the payee is entitled to receive annuity payments throughout his lifetime.

Insurance companies offer several types of life annuities. Therefore, insurance companies also give a policyowner or beneficiary who chooses the life income option the right to select from among several types of life annuities. In Chapter 11, we discuss the various types of life annuities that insurers offer.

The settlement options provision also guarantees that each annuity payment will be at least as large as a stated amount. Policies typically contain charts that list the amount of the guaranteed minimum annuity payments that will be available under each of the life income options. If the insurer's payout factors in effect at the time of settlement would result in larger payment amounts, then the insurer typically provides the larger amounts, rather than the guaranteed amounts. We'll go into greater detail about annuities in the next two chapters.

Key Terms

policy proceeds
class designation
primary beneficiary
contingent beneficiary
right of revocation
revocable beneficiary
vested interest
irrevocable beneficiary
premium payment mode
participating policy
nonparticipating policy
divisible surplus
policy dividend
dividend options
automatic dividend option
cash dividend option
premium reduction dividend option
policy loan repayment dividend option
accumulation at interest dividend option
paid-up additional insurance dividend option
additional term insurance dividend option
assignment
assignor
assignee
absolute assignment
collateral assignment
assignment provision
preference beneficiary clause
simultaneous death act
survivorship clause
settlement options
settlement options provision
payee
contingent payee
interest option
fixed period option
fixed amount option
life income option
life annuity

Endnotes

1. *ACLI Life Insurers Fact Book 2015* (Washington, DC: American Council of Life Insurers, 2015), 68, https://www.acli.com/Tools/Industry%20Facts/Life%20Insurers%20Fact%20Book/Pages/RP15-010.aspx (30 August 2016).
2. In some jurisdictions, the simultaneous death act applies if the insured and beneficiary die within a stated amount of time—often 120 hours—of each other. Under such a law, if the beneficiary dies within 120 hours of the insured, then the insured is deemed to have survived the beneficiary, unless the policy provides otherwise.
3. In many jurisdictions, the beneficiary's unintentional wrongful killing of the insured also disqualifies her from receiving the policy proceeds. For example, the beneficiary might have driven a car while intoxicated and unintentionally caused an accident that resulted in the death of the insured, who was a passenger in the car.

Chapter 10

Introduction to Annuities

Objectives

After studying this chapter, you should be able to

10A Define longevity risk and important annuity terms, such as annuity, annuity payment, contract owner, individual annuity, group annuity, annuitant, payee, beneficiary, annuity start date, payout period, and annuity period

10B Distinguish between immediate and deferred annuity contracts, single-premium and flexible-premium annuity contracts, and fixed and variable annuity contracts

10C Describe the features of the deferred income annuity (DIA), the longevity annuity, and the fixed indexed annuity (FIA)

10D Explain standard contract provisions included in individual annuity contracts

Outline

Important Annuity Terms

Types of Annuity Contracts
- Immediate and Deferred Annuities
- Single-Premium and Flexible-Premium Annuities
- Fixed and Variable Annuities
- Other Types of Fixed Annuities

Annuity Contract Provisions
- Standard Annuity Contract Provisions
- Standard Deferred Annuity Contract Provisions

According to a recent study, most Americans rank death as their second-greatest fear. What could be scarier than dying? Coming in at first place: running out of money before you die.[1]

The life insurance products we have discussed so far in this text can provide protection against the financial consequences of premature death. However, living too long is also a risk. As a result of increasing life expectancies, many people now live for a number of years or even decades longer than they planned. These people face ***longevity risk***, which is the risk that a person will live longer than expected and will exhaust her assets.

In the United States, life insurers offer annuities as a means of protection against longevity risk. As Figure 10.1 demonstrates, policy reserves for annuities significantly exceed those for life and health insurance in the United States.

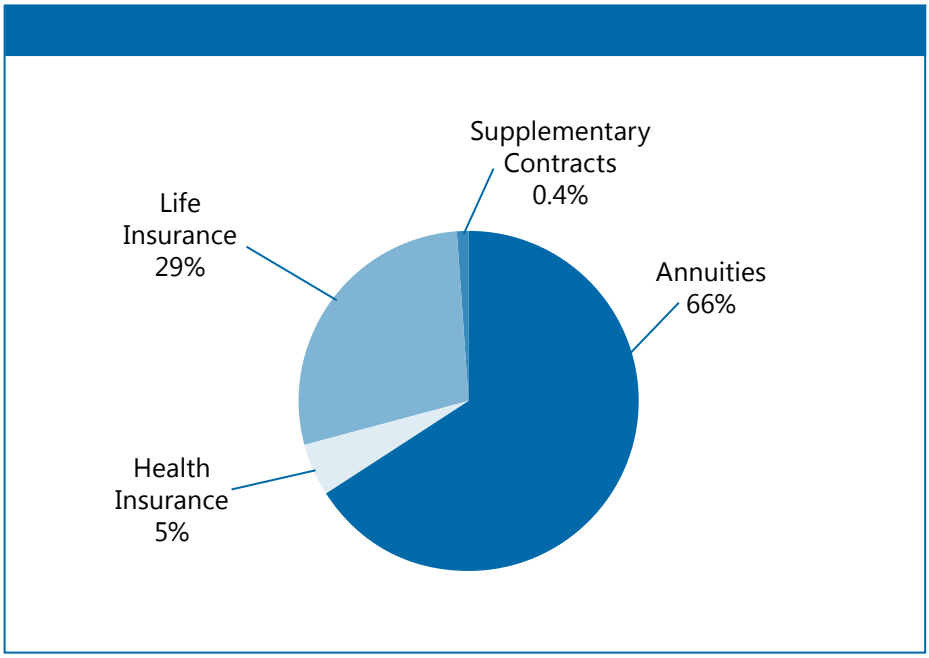
In some countries, such as Argentina, companies that issue life insurance policies and annuity contracts must be different legal entities. In the United States, annuities are considered to be life insurance products, and only life insurance companies are permitted to issue annuities. Thus, annuities must comply with state insurance laws and regulations. Although only insurers may issue annuities, many types of financial institutions, including depository institutions and broker-dealers, may market and distribute annuities.

Important Annuity Terms

In the most general terms, an ***annuity*** is a series of periodic payments. In an annuity contract, these periodic payments are commonly referred to as ***annuity payments***. (Other terms are *annuity benefit payments*, *annuity income payments*, or *periodic income payments*.) As noted in Chapter 1, an *annuity contract* is a legally enforceable agreement under which an insurer promises to make a series of periodic payments to a named individual in exchange for one or more premium payments. In this text, we use both terms—*annuity* and *annuity contract*—interchangeably to refer to annuity contracts.

The terms of an annuity contract govern the rights and duties of the contracting parties. The parties to an annuity contract are (1) the insurer that issued the contract and (2) the person or other entity, known as the ***contract owner***, who owns and exercises all the rights and privileges of the annuity contract. As with a life insurance policy, the insurer provides the contract owner with a written agreement that contains all the terms and provisions of the annuity contract.

Figure 10.1 Distribution of Life Insurers' Policy Reserves, 2014



Source: Adapted from ACLI, *Life Insurers Fact Book 2015*, Copyright © 2015 American Council of Life Insurers, Washington, DC, (November 2015, 19,) 28 https://www.acli.com/Tools/Industry%20Facts/Life%20Insurers%20Fact%20Book/Documents/FB15_All.pdf (15 February 2016). Used with permission.

Insurers issue both individual and group annuities:

- An ***individual annuity*** is purchased and owned by a person or purchased by a legal entity, such as a trust, on behalf of a person. We describe individual annuities in this chapter and the next chapter.
- In a retirement plan, a ***group annuity*** is purchased by a plan sponsor to provide annuity payments to plan participants at retirement.

Insurers use a number of terms that specify the roles of certain individuals or entities under an annuity contract:

- The ***annuitant*** is the person whose lifetime the insurer uses to determine the amount and duration of annuity payments under the contract.
- The ***payee*** is the person or entity that the contract owner names to receive the annuity payments. Typically, annuity contracts state that the insurer pays the annuity payments to the annuitant.
- The ***beneficiary*** is 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.

In most cases, the contract owner, annuitant, and payee are the same person. Important dates and time periods for annuities include the

- ***Annuity start date***, also known as the *annuity commencement date*, *income date*, or *maturity date*, which is the date when the insurer is required to begin making annuity payments under the contract.
- ***Payout period***, also known as the *liquidation period* or the *distribution period*, which is the period during which the insurer makes annuity payments.
- ***Annuity period***, which is the time span between each of the annuity payments. The annuity period is typically either one month or one year, although quarterly or semiannual payments are also available.

Example:

Jocelyn Picard used a lump sum of money to purchase an annuity from the Reliable Insurance Company. According to the terms of this annuity, Reliable will begin making annuity payments to Jocelyn beginning next month on March 1, and it will continue making monthly annuity payments to her for a 10-year period. If Jocelyn should die during this 10-year period, Reliable will make the remaining annuity payments to her son, Grant.

Analysis:

Jocelyn is the *contract owner* and *annuitant* of this annuity. Her son, Grant, is the *beneficiary*. The *annuity start date* is March 1, and the 10-year period during which Reliable makes the annuity payments is the *payout period*. The *annuity period* is one month, making her annuity a monthly annuity.

Types of Annuity Contracts

As noted earlier, annuity contracts may be issued as either individual or group annuities. Annuity contracts can be categorized in other ways, based on

- When annuity payments begin
- How often premiums are paid
- What guarantees the insurer offers

As we will show, these categories overlap one another.

Immediate and Deferred Annuities

An annuity can be classified as either an immediate annuity or a deferred annuity, depending on when the insurer begins making annuity payments. An ***immediate annuity*** is an annuity that provides annuity payments that begin no later than one year after the annuity is purchased. The owner of an immediate annuity selects the annuity start date when she applies for the annuity.

Example:

Abigail Choate purchased an immediate annuity on September 1, 2016. She selected an annuity start date of February 1, 2017, and annual annuity payments.

Analysis:

Abigail will begin receiving annual annuity payments on her annuity's start date of February 1, 2017.

A contract owner often uses an immediate annuity to convert a lump-sum payment into an income stream. For example, a person who is retiring might take a portion of her savings and use it to purchase an immediate annuity that will provide her with monthly payments during her retirement. Note that an annuity is the only financial product that an individual can purchase that can guarantee a lifetime income stream.

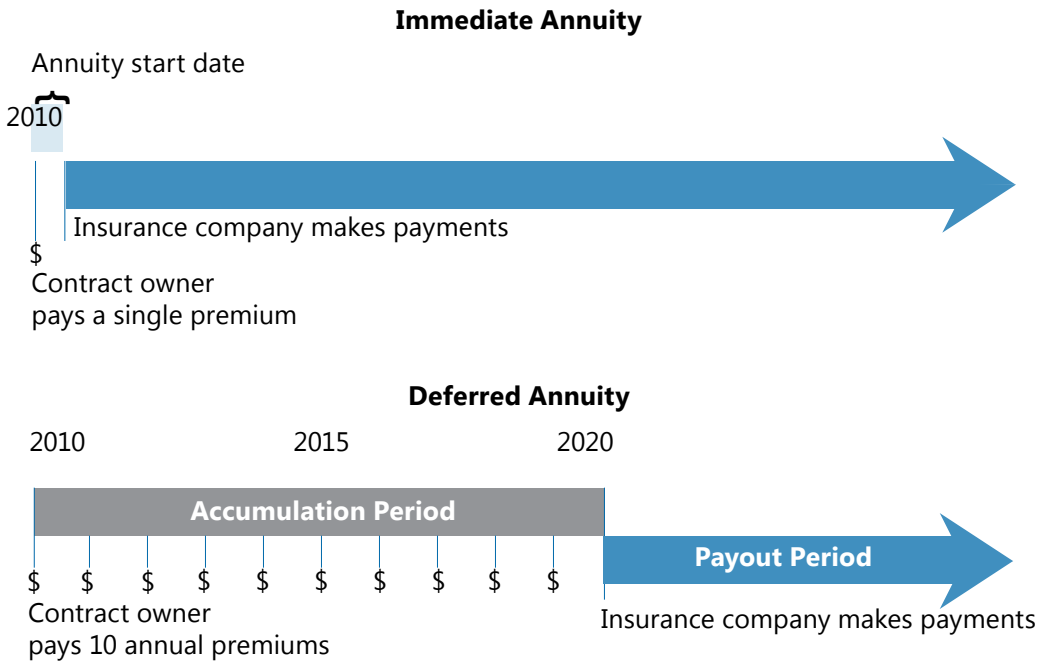
A ***deferred annuity*** is an annuity under which the annuity payments are postponed for at least one year after the annuity is purchased. The period between the contract owner's purchase of a deferred annuity and either the date when the annuity's payout period begins or the date when the annuity is terminated is known as the ***accumulation period***. During the accumulation period, the insurer invests the premiums paid by the contract owner, and the annuity builds an accumulated value. A deferred annuity's ***accumulated value***, also known as the *accumulation value*, *contract value*, or *account value*, is equal to the amount paid for the annuity, *plus* the interest earned, *minus* the amount of any withdrawals and fees. The accumulated value can be expressed in equation form as:

Accumulated value of a deferred annuity =
(Premiums) + (Interest earned) – (Withdrawals and fees)

People often purchase deferred annuities during their working years to accumulate savings for retirement. At retirement, deferred annuity contract owners may then convert the contract to payout status and begin receiving annuity payments. A deferred annuity contract that has been converted to payout status—whether over the course of the annuitant's life or a specific time period—is said to be *annuitized*.

Figure 10.2 illustrates the difference between an immediate annuity and a deferred annuity.

Figure 10.2. Immediate vs. Deferred Annuities



Single-Premium and Flexible-Premium Annuities

Annuity contracts can be categorized as either single-premium annuities or flexible-premium annuities based on how often premiums are paid. A ***single-premium annuity*** is an annuity that is purchased with the payment of a single, lump-sum premium amount. A single-premium annuity can be either an immediate annuity or a deferred annuity:

- A ***single-premium immediate annuity (SPIA) contract*** is purchased with a lump-sum premium payment and provides annuity payments that begin no later than one year after the annuity is purchased. All immediate annuities are single-premium annuities.
- A ***single-premium deferred annuity (SPDA) contract*** 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.

A ***flexible-premium annuity*** is an annuity that allows the contract owner to make additional premium payments after the contract is purchased. Because every annuity purchased with flexible premiums is a deferred annuity, most insurers refer to the flexible-premium annuities they issue as *flexible-premium deferred annuity (FPDA) contracts*.

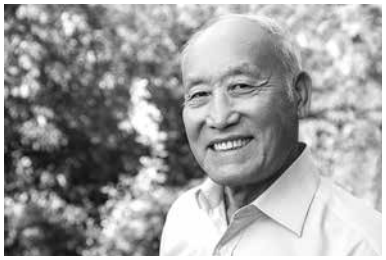
Typically, the minimum amount required for the initial premium of an FPDA is larger than the minimum amount allowed for subsequent premiums. For example, an FPDA might require the contract owner to pay an initial premium of at least $2,000 and then allow the contract owner to pay subsequent premiums of at least $100 each year. The contract owner can also choose not to pay any premium in a given year; the only requirement is that any premium amount paid each year must fall within the stated minimum and maximum amounts

Figure 10.3 illustrates some of the different ways that people can use annuities.

Fixed and Variable Annuities

People who purchase annuities have different goals in mind for the funds they place in an annuity. Annuity contract owners also differ in the amount of risk they are willing to assume when they place money in their annuities. Thus, many insurers offer two general options for annuity purchasers: fixed annuities and variable annuities.

Figure 10.3. How People Can Use Annuities



Example 1. Wei-Chao Chen, age 65, is retiring. He sold his home for $250,000 and moved into an apartment. Wei-Chao used some of the proceeds from the sale of his home to purchase a *single-premium immediate annuity* that will provide monthly annuity payments beginning one month after purchase.

Example 2. Marisela Linares, age 45, is employed and plans to retire at age 65. Marisela's mother died, and Marisela received $100,000 as the beneficiary of her mother's life insurance policy. Marisela used this money to purchase a *single-premium deferred annuity.* Later, she can request that annuity payments begin at age 65.

Example 3. Francis Moran, age 30, is employed and wants to save money for his retirement. Francis purchased a *flexible-premium deferred annuity.* He paid an initial premium of $2,000 and paid subsequent monthly premiums of $100 for three months, when he experienced a financial emergency. Six months later, after resolving the emergency, Francis resumed making monthly premium payments.

Fixed Annuities

A ***fixed annuity*** is 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 pay. Most fixed annuities state that after the insurer begins making annuity payments, the amount of each payment will not change.

If the fixed annuity is an *immediate annuity*, then it has no accumulated value and the amount of each annuity payment is known when the insurer issues the contract.

If the fixed annuity is a *deferred annuity*, then the accumulated value earns interest throughout the accumulation period. Fixed deferred annuities (FDAs) typically specify two types of interest rates that apply to the accumulated value:

- The ***guaranteed minimum interest-crediting rate*** is the minimum interest rate an insurer must pay on an FDA's accumulated value. Guaranteed minimum interest rates ensure that the value of an FDA will increase over time and that the contract owner will not lose any of the premiums—or *principal*—paid into the annuity, unless he terminates the contract within a specified time period.

- The ***current interest-crediting rate*** is the rate of interest that an insurer declares and pays on an FDA's accumulated value for a specified period of time. Insurers typically offer FDAs with current interest-crediting rates that are good for one, three, and even five years. After this initial period, the insurer will set a new interest rate that is good for one year at a time.

Example:

The Reliable Insurance Company offers a guaranteed minimum interest-crediting rate of 1% on its FDAs. Reliable also offers the following current interest rates:

1 year	3 years	5 years
1.10%	1.20%	1.25%

The new current interest-crediting rate can be higher or lower than the previous current rate, but it can't drop below the guaranteed minimum interest-crediting rate stated in the contract.

When an insurer provides interest-rate guarantees in a fixed deferred annuity contract, the insurer agrees to assume the investment risk of the contract. The insurer places the funds in relatively secure investments as part of its general account. If the insurer's general account performs well, the insurer can pay interest rates that are higher than the minimum rates guaranteed in its contracts while still achieving profits from the general account. The insurer, however, faces the risk that its investments will perform poorly. If investment returns are less than the minimum guaranteed in its contracts, the insurer will lose money.

Variable Annuities

A ***variable annuity*** is 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. In general, insurers make no guarantees regarding the principal or the interest rate. The contract owner benefits from any gains that result from profitable investments and bears most or all of the risk of any losses from unprofitable investments. Because the investment risk is assumed by the contract owner, variable annuities in the United States are considered securities and must comply with federal securities laws.

Subaccounts and Fixed Accounts for Variable Deferred Annuities

Premiums for variable deferred annuities are generally deposited in the insurer's separate account. These premiums are used to purchase investments in one or more subaccounts chosen by the contract owner. The owner may allocate premiums among a number of subaccounts and has the right to (1) transfer money among subaccounts, (2) change the percentage of money allocated to specific subaccounts, and (3) change the subaccounts in which future premiums are invested.

Typically, variable deferred annuities offer a wide variety of subaccounts. In addition, contract owners usually can place a portion of their premiums in a ***fixed account***, which guarantees payment of a fixed rate of interest for a specified period of time. Unlike money invested in subaccounts, money invested in a fixed account is held in the insurer's general account. The insurer bears the investment risk for the fixed account.

During a variable deferred annuity's accumulation period, the annuity's accumulated value will fluctuate directly with the investment performance of the chosen subaccounts.

Accumulation Units for Variable Deferred Annuities

Premiums paid into subaccounts, minus certain expense charges, buy ***accumulation units***, which are ownership shares in a selected subaccount held during the accumulation period of a variable deferred annuity. The value of an accumulation unit changes over time. The lower the value of an accumulation unit, the more units a contract owner can purchase, given the same premium amount.

The contract owner's subaccount value is equal to the current value of an accumulation unit multiplied by the total number of units the contract owner holds in the subaccount. The contract's total accumulated value is equal to the total of all the contract owner's subaccount values plus any fixed account value.

These relationships can be expressed in equation form as follows:

Subaccount value = Current value of accumulation unit × Total number of units

Total accumulated value of a variable annuity	=	Total value of subaccounts	+	Total value of fixed account

Example:

On January 15, Trisha Hart paid a $100,000 single premium for a variable deferred annuity from the Reliable Insurance Company. She chose to invest her premium payments in two subaccounts, as follows:

25% of $100,000 in Subaccount A, or $25,000
75% of $100,000 in Subaccount B, or $75,000

At the time of purchase, accumulation units in
Subaccount A were valued at $20 per unit
Subaccount B were valued at $15 per unit

Therefore, Trisha purchased
1,250 accumulation units in Subaccount A ($25,000 ÷ $20)
5,000 accumulation units in Subaccount B ($75,000 ÷ $15)

By August 1, the value of the accumulation units in
Subaccount A had increased to $25 per unit
Subaccount B had decreased to $12 per unit

Analysis:

As of August 1, the value of Trisha's investment in

- Subaccount A was equal to $31,250, found as $25 × 1,250. Thus, Subaccount A increased in value by $6,250, found as $31,250 − $25,000.
- Subaccount B was equal to $60,000, found as $12 × 5,000. Thus, Subaccount B decreased in value by $15,000, found as $75,000 − $60,000.

The accumulated value of her account was equal to $91,250 ($31,250 + $60,000), so overall her subaccount investments declined in value during the period.

Figure 10.4 summarizes the major classifications of annuities.

Figure 10.4. Major Classifications of Annuity Contracts

	Immediate Annuity	Deferred Annuity
Fixed Annuity	Single-premium	Single-premium OR Flexible-premium
Variable Annuity	Single-premium	Single-premium OR Flexible-premium

Other Types of Fixed Annuities

In addition to traditional fixed annuities, insurers offer three other types of fixed annuities: the deferred income annuity (DIA), the longevity annuity, and the fixed indexed annuity (FIA).

Deferred Income Annuities and Longevity Annuities

Insurers created deferred income annuities and longevity annuities for individuals who desire a guaranteed stream of income during retirement. A ***deferred income annuity (DIA)*** is 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. Contract owners typically purchase DIAs sometime in their 50s to mid-60s. They usually schedule their annuity payments to begin in approximately seven or eight years to replace income when they retire.

A ***longevity annuity***, also known as an *advanced life deferred annuity* or *longevity insurance*, is 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. Technically, a longevity annuity is a type of DIA. Note that a longevity annuity was not designed to provide income throughout retirement. Rather, it covers the long-tail risk of outliving one's assets and frees the individual from the worry that she will run out of money should she live longer than expected.

Deferred income annuities and longevity annuities possess features of both immediate and deferred annuities:

- Like immediate annuities, DIAs and longevity annuities have no accumulation period.
- Like deferred annuities, the annuity start date for a DIA and a longevity annuity can be anywhere from 12 months to 40 years or more after purchase.

Fixed Indexed Annuities

An increasingly popular type of annuity in the United States is the fixed indexed annuity. A ***fixed indexed annuity (FIA)***, also known as an *indexed annuity*, is 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. An *index* is a means of measuring the performance of a group of similar investments. For FIAs, a commonly used index is the Standard & Poor's (S&P) 500 composite stock price index. FIAs are classified as fixed annuities because of the guarantees they offer. However, like variable annuities, FIAs offer the potential for higher returns.

Figure 10.5 illustrates the sales of annuities by product type in the United States from 2009 to 2014.

Figure 10.5. Sales by Annuity Product Type (Dollars in Billions)

	2009	2010	2011	2012	2013	2014	Percentage Change 2014/2013
Variable							
Deferred	$127.9	$140.5	$157.9	$147.4	$145.4	$140.0	-4%
Immediate	0.10	0.03	0.03	0.03	0.05	0.13	151%
Total Variable	$128.0	$140.5	$157.9	$147.4	$145.4	$140.1	-4%
Fixed							
Book Value[1]	$53.2	$30.3	$29.7	$20.2	$22.2	$20.9	-6%
Market-Value Adjusted	14.4	6.1	5.2	4.5	7.1	9.9	39%
Indexed	29.9	32.1	32.2	33.9	39.3	48.2	23%
Total Deferred	$97.5	$68.5	$67.1	$58.6	$68.6	$70.0	15%
Immediate	7.5	7.6	8.1	7.7	8.3	9.7	17%
Deferred Income (DIA)	*	*	0.20	1.0	2.2	2.7	22%
Structured Settlements	5.6	5.8	5.1	5.0	5.3	5.4	3%
Total Fixed	$110.6	$81.9	$80.5	$72.3	$84.4	$96.8	15%
TOTAL	$238.6	$222.4	$238.4	$219.7	$229.8	$236.9	3%

•[1]Book Value = Traditional Fixed Deferred *Less than $50 Million

Source: Adapted from Todd Giesing, *U.S. Individual Annuity Yearbook—2014* (Windsor, CT: LL Global, Inc., ©2015), 14. Used with permission; all rights reserved.

Annuity Contract Provisions

As we mentioned earlier, an annuity is a contract between an insurance company and a contract owner. Annuity contracts typically contain standard annuity contract provisions. Insurers include some of these standard provisions in all annuities, whereas others apply specifically to deferred annuities.

Standard Annuity Contract Provisions

Many of the provisions that insurers include in individual life insurance policies are also included in individual annuity contracts. The following provisions are generally required by law to be included in all types of individual annuity contracts:

- An *entire contract provision*, which states that the entire contract consists of the annuity contract, the application if it is attached to the contract, and any attached riders.
- A *free-look provision* or *free-examination provision*, which gives the contract owner a stated period of time—usually 10 to 30 days—after the contract is delivered in which to examine it. During the free-look period, the contract owner has the right to cancel the contract and receive a refund of the premiums paid or the contract's accumulated value.

- An *incontestability provision*, which describes the insurer's right to contest the validity of the annuity contract. In general, the application for an annuity does not contain questions relating to the insurability of the applicant, and the applicant does not make representations on which the insurer bases its decision to issue the annuity. As a result, the incontestability provision in an annuity contract typically states that, after the contract becomes effective, the insurer may not contest the validity of the contract. However, some insurers offer supplemental benefit riders, such as a waiver of premium for disability benefit rider. In this case, the applicant generally must provide evidence of insurability, and the annuity's incontestability provision gives the insurer a specified period, usually one to two years, in which to contest the validity of the coverage provided by the rider based on a material misrepresentation in the application. The annuity contract itself remains in force.
- A *misstatement of age or sex provision*, which states that if the annuitant's age or sex was misstated in the application, then the annuity payments will be adjusted to the amount that the premiums paid would have purchased for the correct age or sex.
- Like participating individual life insurance policies, participating individual annuity contracts must include a *dividends provision*, which describes the contract owner's right to share in the insurer's divisible surplus, if any, and the dividend payment options available to the contract owner.

Standard Deferred Annuity Contract Provisions

Deferred annuity contracts generally include a number of provisions that govern the rights of the contract owner during the annuity's accumulation period. For example, the ***withdrawal provision*** gives the contract owner the right to receive a portion of the contract's accumulated value during the accumulation period. Most contracts allow the owner to withdraw up to a stated percentage of the accumulated value each year without charge. For example, fixed deferred annuities typically allow contract owners to withdraw up to 10 percent of the accumulated value per year, without penalty. If the contract owner makes excess withdrawals as defined in the contract, the insurer generally imposes a fee, known as a ***surrender charge*** or a *contingent deferred sales charge*.

Example:

Imran Kahn owns a fixed deferred annuity from the Reliable Insurance Company. Imran's annuity allows him to withdraw up to 10% of the accumulated value each year without incurring a surrender charge. Last year, Imran chose to have $400 per month deducted from his annuity's accumulated value and deposited into his bank account. Therefore, his scheduled withdrawals for the year totaled $4,800 ($400 per month × 12 months). The accumulated value of Imran's annuity on the most recent contract anniversary date was $40,000.

Analysis:

Reliable determined that Imran's free withdrawal amount for the contract year was $4,000, found as $40,000 × 0.10. Because Imran withdrew $800 more than this amount ($4,800 – $4,000), he was required to pay a surrender charge on the $800.

Insurers also impose a surrender charge if the contract owner fully surrenders the contract within a stated number of years after it was purchased (the surrender period). In this case, the contract owner receives the annuity's ***surrender value***—the accumulated value less any surrender charges included in the policy. The amount of any surrender charge that is imposed usually declines over time. An insurer typically imposes a surrender charge during the early years of a deferred annuity contract to recover the costs it incurred in issuing the contract.

Example:

Cynthia Quincy purchased a single-premium fixed deferred annuity contract from the Reliable Insurance Company. Her annuity contract contained the following surrender charge schedule:

Contract Year	Surrender Charge Percentage
Year 1	7%
Year 2	6%
Year 3	5%
Year 4	4%
Year 5	3%
Year 6	2%
Year 7	1%
Year 8	0%

Cynthia surrendered the contract 18 months after she purchased it. At that time, the contract had an accumulated value of $100,000.

Analysis:

The insurer imposed a surrender charge of 6% of $100,000, or $6,000, and paid Cynthia the surrender value of $94,000, found as $100,000 – $6,000.

A special type of fixed deferred annuity, known as a ***market-value-adjusted (MVA) annuity***, adjusts withdrawal or surrender values based on changes in market interest rates. In other words, the insurer imposes a *market value adjustment* if a contract owner makes withdrawals in excess of the permissible limits or surrenders the contract prior to the end of the surrender period. This adjustment is in addition to the surrender charge, and it can result in an increase, a decrease, or no change in the withdrawal amount, depending on current interest rates. MVA annuities must meet certain requirements to be issued as fixed annuities in the United States.

If either the annuitant or the contract owner of a deferred annuity (depending on the contract) dies before the annuity payments begin, the contract usually provides a ***death benefit***, also known as a *survivor benefit*, which is an amount of money payable to a beneficiary designated by the contract owner. The death benefit usually equals at least the amount of the annuity's accumulated value at the date of death. Insurers typically do not impose surrender charges on the payment of death benefits.

Key Terms

longevity risk
annuity
annuity payments
contract owner
individual annuity
group annuity
annuitant
payee
beneficiary
annuity start date
payout period
annuity period
immediate annuity
deferred annuity
accumulation period
accumulated value
single-premium annuity
single-premium immediate annuity (SPIA)
single-premium deferred annuity (SPDA)
flexible-premium annuity
fixed annuity
guaranteed minimum interest-crediting rate
current interest-crediting rate
variable annuity
fixed account
accumulation unit
deferred income annuity (DIA)
longevity annuity
fixed indexed annuity (FIA)
withdrawal provision
surrender charge
surrender value
market-value-adjusted (MVA) annuity
death benefit

Endnote

1. Allianz Life Insurance Company, *Reclaiming the Future*, http://www.thepg.com/resources/allianz_brochure.pdf (9 October 2015).

Chapter 11

Annuities and Individual Retirement Arrangements

Objectives

After studying this chapter, you should be able to

11A Identify and distinguish among the types of annuity options available under annuity contracts

11B Describe the guaranteed benefits offered as riders on certain annuity contracts

11C Explain how insurers determine the amount of each annuity payment for a fixed single premium immediate annuity (SPIA) and describe the effect of various factors on the amount of each annuity payment

11D Explain how insurers determine the amount of each annuity payment for a fixed deferred annuity (FDA) and for a variable annuity

11E Explain the fees and charges typically paid by annuity contract owners

11F Differentiate between qualified and nonqualified annuities and describe the income tax treatment of annuities

11G Differentiate between an individual retirement account and an individual retirement annuity and between a traditional and a Roth individual retirement arrangement

Outline

Annuity Features
- Annuity Options
- Annuity Guarantee Riders

Financial Aspects of Annuities
- Determining Annuity Payment Amounts
- Fees and Charges for Annuities

Taxation of Annuities

Individual Retirement Arrangements

In this chapter, we continue our discussion of annuities by describing important annuity features, such as annuity options and guarantee riders. We then examine some of the financial aspects of annuities by explaining how insurers determine annuity payment amounts and describing the kinds of fees and charges they assess for annuities.

We then present another product in the United States that can offer protection against longevity risk: the individual retirement arrangement. U.S. life insurers offer one type of individual retirement arrangement—the individual retirement annuity. Individual retirement arrangements (IRAs) have become the largest component of private-sector retirement assets in the United States. According to the Federal Reserve, as of the end of 2014, IRAs contained $7.4 trillion in assets, accounting for 30 percent of all retirement assets.[1]

Annuity Features

Important annuity features include the options for distributing the annuity's funds and riders that give contract owners certain guaranteed benefits.

Annuity Options

Every annuity contract includes a list of ***annuity options***, also known as *payout options*, which are the choices a contract owner has as to how the insurer will distribute the annuity payments. In the case of an immediate annuity, the applicant chooses an annuity option when she applies for the annuity. For a deferred annuity, the contract owner must choose an annuity option if she decides to annuitize the contract.

All but one of the options described below apply to immediate annuities and to deferred annuities that have been annuitized. The exception is the lump-sum distribution, which applies only to deferred annuities.

For all of the examples of annuity options in this chapter, we are assuming that the contract owner and annuitant are the same person.

Lump-Sum Distribution

A deferred annuity contract owner may choose to have the accumulated value of the annuity distributed in a single payment, known as a ***lump-sum distribution***. Once the insurer makes a lump-sum distribution, the annuity contract terminates, and the insurer has no further obligation to the contract owner.

Fixed Period Annuity

With a ***fixed period annuity***, also known as a *period certain annuity* or *annuity certain*, the insurer provides annuity payments for a specified period of time. The stated period over which the insurer will make the annuity payments is called the ***period certain***. At the end of the period, annuity payments cease. If the annuitant dies before the end of the period certain, the beneficiary becomes entitled to receive the remaining annuity payments.

The fixed period annuity is useful when a person needs an income for a specified period of time. For example, a person might purchase a fixed period annuity to provide income for a specified period until some other source of income, such as a retirement plan benefit, becomes payable.

Example:

Miko Yamata plans to retire at age 60. However, she will not receive benefits from her employer-sponsored retirement plan until she reaches age 65. Miko purchased a five-year fixed period deferred annuity with an annuity start date of when she reaches age 60.

Analysis:

When Miko reaches age 60, she will begin receiving annuity payments from her annuity for five years. At the end of the five-year period, the payments will cease, but at this time Miko will begin receiving benefits from her employer-sponsored retirement plan.

Fixed Amount Annuity

With a ***fixed amount annuity***, the insurer provides annuity payments of a specified amount. The contract owner tells the insurer the amount of the annuity payment she wants, and the insurer calculates how long the premiums (for an immediate annuity) or the accumulated value (for a deferred annuity) can provide annuity payments of the specified amount. Some retirees use fixed amount annuities to provide extra income at some point during retirement.

Example:

Isabel Loyola, age 60, purchased a fixed amount annuity of $1,000 a month with her husband, Clyde, as the beneficiary. She paid the insurer a premium of $55,000.

Analysis:

The insurer will inform Isabel of how long she will receive monthly annuity payments of $1,000, as well as the amount of the last payment, which will be less than $1,000. If Isabel dies before the annuity payments have all been made, Clyde will receive the remaining annuity payments.

Life Annuities

As noted in Chapter 9, a *life annuity* is an annuity that provides annuity payments for *at least* the lifetime of the annuitant. Insurers offer various forms of life annuities as annuity options.

The most basic form of life annuity is the ***life only annuity***, also known as a *single life annuity* or a *straight life annuity*, which provides annuity payments for only as long as the annuitant lives. Upon the death of the annuitant, the insurer has no further liability under the contract.

With a life only annuity, if the annuitant lives a very long time, he might receive more in annuity payments than he paid in premiums. (Remember that we're assuming the contract owner and annuitant are the same person.) On the other hand, if the annuitant dies shortly after annuity payments begin, he could end up paying a great deal more in premiums than he receives in annuity payments. The possibility of experiencing this second scenario makes many people unwilling to purchase life only annuities. Instead, they purchase other forms of life annuities that contain more guarantees than a life only annuity.

Example:

When Gabriel Long retired at age 65, he used a lump sum of $500,000 to purchase a life only annuity. The annuity began making monthly payments of $2,955 to Gabriel one month later.

Analysis:

Assume that Gabriel beats the odds by living to the age of 97. Gabriel would receive a total of $1,134,720 in annuity payments from his life only annuity—more than double what he paid for the annuity.

Now assume instead that Gabriel dies five years after purchasing his annuity. At that time, he would have received $177,300 in total payments from his annuity, an amount considerably less than his premium payment of $500,000.

A ***joint and survivor annuity*** provides a series of annuity payments based on the life expectancies of two or more annuitants, with payments continuing until the last annuitant dies. Most joint and survivor annuities cover two lives. The terms of the contract determine whether, after the death of one of the annuitants, the amount of each annuity payment remains the same or decreases by a stated amount, such as 50 percent. A married couple might purchase a joint and survivor annuity to provide income for the rest of both of their lives.

Example:

When Lawrence and Natasha Raymond retired at age 66, they purchased a joint and survivor annuity that specified a monthly payment of $2,000, beginning in one month and continuing until one of them died. In this event, the insurer would reduce the monthly payments by 50% for the rest of the survivor's life.

Analysis:

When Lawrence died 15 years later, the annuity continued to make payments in the amount of $1,000 a month. The annuity payments continued until Natasha died at age 88.

A ***life income with period certain annuity*** 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. The contract owner selects the guaranteed period, which is often 5 or 10 years. If the annuitant dies before the period certain has expired, then the beneficiary becomes entitled to receive the annuity payments for the rest of the period certain. If the annuitant dies after the period certain has expired, annuity payments cease.

Example:

Blanche Bessett purchased a life income annuity with a 10-year period certain. She named herself as the annuitant. She named her daughter, Elaine, as the beneficiary. Blanche died 7 years after annuity payments began.

Analysis:

Elaine received annuity payments for the rest of the 10-year period certain—which was 3 more years. After the 10-year period expired, no more payments were made. If Blanche had lived 15 years after annuity payments began, she would have received the payments until she died, and Elaine would have received no payments after her death.

The ***life income with refund annuity***, also known as a *refund annuity*, provides annuity payments throughout the annuitant's lifetime and guarantees that at least the purchase price of the annuity will be paid out. Therefore, if the annuitant dies before the purchase price of the annuity has been paid out, the insurer will pay the beneficiary an amount equal to the difference between the purchase price and the amount that has already been paid out.

Example:

Harry Benedict paid a single premium of $150,000 for a life income with refund annuity that provided an annuity payment of $10,000 per year. He named his wife, Dorothy, as the beneficiary. Harry died 6 years after annuity payments began; at the time of his death, he had received annuity payments totaling $60,000.

Analysis:

Dorothy was entitled to a refund of $90,000, which was the difference between the $150,000 purchase price and the $60,000 in annuity payments made during Harry's lifetime. If Harry had died 20 years after annuity payments began, he would have received more in annuity payments than he paid for the annuity (20 years × $10,000 = $200,000). In that case, Dorothy would not have received a refund following Harry's death.

Annuity Guarantee Riders

Some annuities give contract owners the option of purchasing riders that offer various guarantees. The most common of these riders are *guaranteed minimum death benefit riders (GMDBs)* and *guaranteed living benefit riders (GLBs)*. Because these guarantees increase risk for the insurer, insurers generally charge contract owners extra for these riders.

These riders apply only to deferred annuities in the accumulation period. If a deferred annuity is annuitized, the riders can no longer be activated.

Guaranteed Minimum Death Benefit Riders

A ***guaranteed minimum death benefit rider (GMDB)*** is 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. Most GMDBs specify a minimum amount equal to the greater of (1) all premiums paid, adjusted for withdrawals, or (2) the contract's accumulated value at the time of death.

Example:

Kishan Halwai purchased a variable deferred annuity with a single premium payment of $500,000. Kishan's variable annuity has a GMDB that specifies a death benefit equal to the greater of (1) all premiums paid, adjusted for withdrawals, or (2) the accumulated value at the time of his death. When Kishan died, he had taken no withdrawals from his annuity, and its accumulated value had fallen to $300,000.

Analysis:

The death benefit of Kishan's variable annuity was $500,000 (the total premiums paid), because this value was greater than the accumulated value of $300,000.

Guaranteed Living Benefit Riders

Many variable deferred annuities and some fixed indexed annuities offer ***guaranteed living benefit riders (GLBs)***, which are annuity riders that offer contract owners protection from downturns in the market by guaranteeing certain income, withdrawal, or accumulation amounts. These amounts are calculated with reference to a "benefit base," which is determined separately from the annuity's accumulated value. The initial benefit base is typically the greater of (1) the total premium payments less total withdrawals on the date the rider is purchased or (2) the accumulated value on that date.

Four types of GLBs that insurers offer are the

- ***Guaranteed lifetime withdrawal benefit (GLWB)***, which is a GLB that allows the contract owner to take withdrawals for life without annuitizing the contract, even if the accumulated value is completely depleted. The withdrawal amount is usually specified as a percentage of the benefit base or the accumulated value, whichever is greater. For variable deferred annuities and fixed indexed annuities, the GLWB is the most popular of all the GLBs.

- ***Guaranteed minimum income benefit (GMIB)***, which is a GLB that offers a lifetime minimum annuity payment amount when the benefit base is annuitized, regardless of the investment performance of the accumulated value. Typically, the contract owner must keep the annuity in force for a certain number of years—known as the *waiting period*—before annuitizing. Variable deferred annuities, but not fixed indexed annuities, may offer the GMIB.

- ***Guaranteed minimum withdrawal benefit (GMWB)***, which is a GLB 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. Variable deferred annuities, but not fixed indexed annuities, may offer the GMWB.

- ***Guaranteed minimum accumulation benefit (GMAB)***, which is a GLB 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. Few insurers offer the GMAB.

Financial Aspects of Annuities

As part of the contractual agreement between the parties to an annuity, the contract owner pays a single premium or multiple premiums to the insurer. The insurer pools the premiums it receives from a large group of contract owners and invests the pooled funds. The insurer uses the pooled funds—and investment earnings on those funds—to provide the benefits promised under the annuity contract. In this section, we discuss how insurers determine the amounts of annuity payments. We also explain how insurers cover certain costs through annuity fees and charges.

Determining Annuity Payment Amounts

How an insurer determines annuity payment amounts differs depending on whether the annuity is a fixed annuity or a variable annuity. The calculation also differs for fixed immediate and fixed deferred annuities. In this section, we discuss

how insurers determine annuity payments for fixed single-premium immediate annuities (fixed SPIAs), fixed deferred annuities (FDAs), and variable annuities.

Determining Annuity Payments for Fixed SPIAs

When an individual purchases a fixed SPIA, the insurer informs him of the amount of his annuity payments. Insurers determine the annuity payment amount by calculating payout factors. A ***payout factor*** represents the amount of each annuity payment per thousand dollars of premium (for an immediate annuity) or accumulated value (for a deferred annuity).

For an immediate annuity, the basic formula for determining the actual amount of each annuity payment is

Immediate annuity payment = (Single premium ÷ 1,000) × Payout factor

Example:

Trey Lee, age 65, is interested in purchasing a fixed single-premium immediate annuity (SPIA). The monthly payout factors per $1,000 of premium for a male age 65 are

Life Only	Life with 10-Year Period Certain	Life with Lump-Sum Refund
$5.91	$5.68	$5.40

Analysis:

If Trey pays $100,000 for a life only fixed SPIA, he will receive $591 per month for life (100,000 ÷ 1,000 = 100; $5.91 × 100 = $591).

Payout factors differ among products and among insurers. Payout factors take into account the insurer's costs, the rate of return the insurer is estimating it will earn on the premiums over the life of the annuity, the annuitant's average life expectancy (mortality) based on age and gender, the annuity option selected, and the frequency of the annuity payments. All other factors being equal, for a fixed SPIA,

- The higher the estimated rate of return, the larger the amount of each annuity payment.
- The older a person is, the larger the amount of each annuity payment because his average life expectancy is shorter than a younger person's. Note, though, that the payout factors for fixed period annuities and fixed amount annuities do not take into account mortality.
- A man's annuity payment amount will be larger than a payment to a woman of the same age because a man's average life expectancy is less than a woman's.
- The longer the annuity option guarantees payments, the smaller each annuity payment amount will be.
- The less frequently annuity payments are made during the year, the larger each annuity payment amount will be.

Determining Annuity Payments for FDAs

Fixed deferred annuity contracts contain a payout schedule, which guarantees the annuitant will get at least a minimum level of annuity payments per $1,000 of accumulated value. Figure 11.1 illustrates such a payout schedule. In this chart, notice how, for each age, the payments for the life only annuity are the highest. All other factors being equal, as period certain guarantees are added to life annuities, the annuity payments will decrease.

For an FDA, the basic formula for determining the actual amount of each annuity payment is

FDA payment = (Accumulated value ÷ 1,000) × Payout Factor

Example:

Emma Maier, age 65, owns an FDA that has an accumulated value of $300,000. Emma wants to annuitize her contract and begin receiving annuity payments for life only.

Analysis:

According to Figure 11.1, the appropriate payout factor is $4.27. With an accumulated value of $300,000, Emma will receive $1,281 per month for life (300,000 ÷ 1,000 = 300; $4.27 × 300 = $1,281).

Figure 11.1. Guaranteed Annuity Payments for a Fixed Deferred Annuity

Female Annuitant's Age	Minimum Monthly Annuity Payment for Each $1,000 of Accumulated Value			
		Payments for Life with Period Certain		
	Payments for Life Only	10 Years	15 Years	20 Years
40	$2.13	$2.12	$2.11	$2.09
45	2.36	2.34	2.32	2.28
50	2.65	2.62	2.58	2.52
55	3.05	2.99	2.91	2.82
60	3.56	3.45	3.32	3.14
65	4.27	4.07	3.82	3.48
70	5.33	4.89	4.38	3.76
75+	6.95	5.89	4.87	3.92

Determining Annuity Payments for Variable Annuities

Variable deferred annuity contract owners who annuitize their contracts must (1) select an annuity option and (2) choose between fixed or variable annuity payments or a combination thereof. Fixed is the more popular of the payment options.

If the contract owner elects fixed payments, the insurer "cashes in" the subaccounts by transferring their accumulated value from the separate account to the general account. The insurer then uses the funds from the accumulation units and from any fixed accounts to make annuity payments under the selected annuity option.

Example:

Willow Tannenbaum owns a variable deferred annuity from the Reliable Insurance Company. Willow decides to annuitize her contract, and she selects a life only annuity option with fixed payments. Reliable will transfer the contract's accumulated value to the general account.

Analysis:

Willow will receive payments for life based on the following formula:

(Accumulated value ÷ 1,000) × Payout factor

An insurer uses this same formula to determine the amount of the fixed annuity payments for a variable immediate annuity, except that the lump-sum premium payment is substituted for the funds from the accumulation units and fixed accounts.

If the contract owner annuitizes his variable deferred contract and elects variable annuity payments, the amount of each annuity payment will vary. In this situation, the accumulation units are used to purchase annuity units. An ***annuity unit*** is a share in an insurer's subaccount that is used in the calculation of variable annuity payments; it is obtained by converting a variable deferred annuity's accumulation units upon annuitization or by making a premium payment for a variable immediate annuity. Although the number of annuity units is set when the contract is annuitized, the value of each annuity unit fluctuates daily. The insurer calculates the value of an annuity unit based on the investment experience of the subaccount. The insurer then calculates the amount of the annuity payment by multiplying the total number of annuity units by the current value of an annuity unit.

Example:

Todd Lovett is the contract owner of a variable deferred annuity from the Reliable Insurance Company. Todd recently decided to annuitize his contract. At this time, Reliable used the accumulation units in Todd's annuity to purchase annuity units. Todd then had

300 annuity units in Subaccount A
150 annuity units in Subaccount B
200 annuity units in Subaccount C

On the date when Reliable made its first monthly annuity payment to Todd, the value of an annuity unit in

Subaccount A was $5.00
Subaccount B was $4.00
Subaccount C was $2.50

Example (*continued*):

Therefore, Todd's first monthly annuity payment was $2,600, found as (300 × $5.00) + (150 × $4.00) + (200 × $2.50).

On the date when Reliable made its second monthly annuity payment, the value of an annuity unit in

Subaccount A was $4.00
Subaccount B was $3.50
Subaccount C was $2.00

In this case, Todd's second monthly annuity payment was $2,125, found as (300 × $4.00) + (150 × $3.50) + (200 × $2.00). This amount was less than the previous month's annuity payment.

Each month Reliable will perform a similar calculation to determine the amount of Todd's annuity payment.

Fees and Charges for Annuities

Insurers must cover the expenses they incur for designing, distributing, and administering annuities. With immediate annuities, insurers build the expenses into the payout factors. With deferred annuities, insurers charge contract owners certain fees and charges during the accumulation period to cover these expenses. These charges can be one-time charges or periodic charges, which are assessed at predetermined intervals, such as every day or every year. Whether a particular fee applies to an annuity depends on the insurer and the product.

The following types of fees and charges apply to both fixed and variable deferred annuities during the accumulation period:

- **Contract fee and contract maintenance fee.** These fees are periodic charges that insurers assess to cover the general expenses of administering the contract, such as the preparation of account statements. For fixed deferred annuities, this charge is generally known as the ***contract fee***; for variable deferred annuities, it is usually called the ***contract maintenance fee***. Insurers deduct this fee from the annuity's accumulated value. It is typically a flat monetary amount, although it may be the lesser of a flat amount or a specified percentage of the accumulated value. Many insurers waive this fee when an annuity's accumulated value exceeds an amount—such as $50,000 or $100,000—specified in the contract.

- **Front-end load.** When a contract owner pays an initial premium and additional premiums, an insurer may impose a charge known as a ***front-end load*** to cover its acquisition, issue, and sales costs. A front-end load is calculated as a percentage of the premiums paid. Insurers subtract the front-end load from the premiums before applying the premiums to the annuity's accumulated value.

- **Surrender charge or contingent deferred sales charge (CDSC).** Recall that insurers assess this fee when a deferred annuity contract owner makes excess withdrawals as defined in the contract or fully surrenders the contract before the surrender period is over. This charge compensates the insurer for acquisition, issue, and sales costs. Typically, when an annuity has a front-end load, it has no surrender charge. Because most customers don't like front-end loads, more contracts impose surrender charges than front-end loads.

- **Service fee.** Insurers use a ***service fee*** to charge for specific services or transactions requested by the contract owner. For example, an insurer might impose a service fee of $20 per additional withdrawal if a contract owner makes more than the permitted number of free withdrawals from the annuity's accumulated value in any calendar year.

The following types of fees and charges apply only to variable deferred annuities:

- ***Mortality and expense risks (M&E) charge***. This charge covers various risks and expenses assumed by the insurer, such as the risk of providing the death benefit and certain other guarantees. The M&E charge is generally expressed as a percentage of the accumulated value. The addition of a GMDB or GLB may increase the amount of the M&E charge, although some contracts charge for these optional benefits separately.

- ***Fund operating expense charge.*** Each investment fund underlying a subaccount assesses an annual charge to cover the advisory and administrative expenses of the fund. Thus, each subaccount will have its own fund operating expense charge, which can be found in the prospectus for the subaccount's underlying investment fund. The amount of each subaccount's charge will vary.

Taxation of Annuities

In the United States, annuities are classified for tax purposes as either qualified or nonqualified:

- A ***qualified annuity*** is an annuity that is purchased to fund or distribute funds from a tax-advantaged retirement plan or IRA.

- A ***nonqualified annuity*** is an annuity that is purchased outside of a tax-advantaged retirement plan or IRA. All of the examples of annuities in the previous chapter and this chapter have been nonqualified annuities.

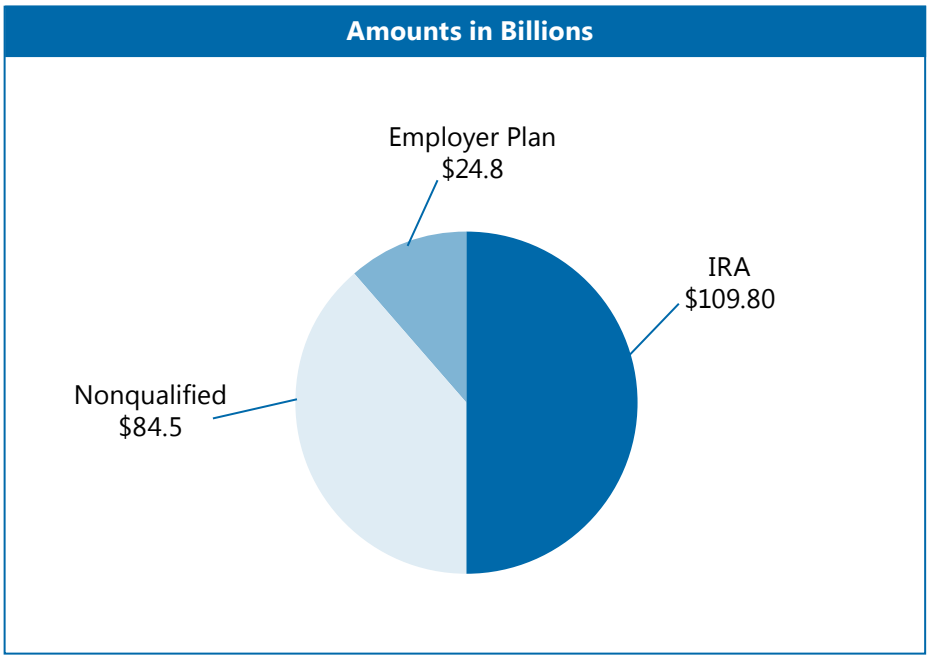
Figure 11.2 illustrates qualified and nonqualified deferred annuity sales in the United States in 2014.

Under current U.S. federal tax laws, qualified annuities are taxed in accordance with the tax laws that apply to the plan or IRA that the annuities fund or distribute funds from. In contrast, all nonqualified annuities are treated the same for purposes of U.S. federal income taxes: premiums are not tax deductible, but investment earnings are tax deferred until payments are received from the annuity. Thus, each annuity payment received under a nonqualified annuity is considered to consist of the following two parts:

1. One portion of each annuity payment is considered a return of premiums, which is not taxable because the purchaser has already paid income taxes on that amount.

Figure 11.2 Qualified and Nonqualified Deferred Annuity Sales in the United States, 2014

In the pie chart below, the segments "IRA" and "Employer Plan" represent qualified annuities.



Source: Adapted from Todd Giesing, *U.S. Individual Annuity Yearbook—2014* (Windsor, CT: LL Global, Inc., © 2015), 37. Used with permission; all rights reserved.

2. The remainder of each annuity payment is considered taxable income because the purchaser has never paid income taxes on the contract's earnings.

In contrast, tax laws in many countries, such as Canada, do not provide this favorable treatment for annuities. In these countries, investment earnings from an annuity generally are taxable as income during the accumulation period of the annuity unless the annuity is used to fund a retirement plan that qualifies for special tax treatment.

Individual Retirement Arrangements

The governments of many countries have enacted laws that provide tax advantages to certain individuals who deposit funds into specific types of retirement savings vehicles. These laws are designed to encourage taxpayers to save money for their retirement. In this section, we describe individual retirement arrangements in the United States. Many individuals also participate in employer-sponsored retirement plans, which we describe in a later chapter.

An ***individual retirement arrangement*** is a tax-favored retirement savings vehicle that allows a person with taxable compensation to deposit a stated amount of that compensation into the vehicle.

An individual retirement arrangement can take one of two forms:

- An ***individual retirement account*** is a trust or custodial account created in the United States for the exclusive benefit of a taxpayer or a taxpayer's beneficiaries. The trustee or custodian must be a bank, federally insured credit union, savings and loan association, or other entity (such as a broker-dealer or investment company) approved by the Internal Revenue Service (IRS) to provide individual retirement accounts. The IRS is the U.S. agency that is responsible for collecting federal taxes and enforcing laws and regulations concerning such taxes.

- An ***individual retirement annuity*** is an individual retirement arrangement that takes the form of an annuity issued by an insurance company. Individual retirement annuities can be any of the annuity types we have discussed, but the most popular are deferred annuities—fixed, variable, and fixed indexed annuities.

The financial services industry uses the acronym *IRA* to refer to individual retirement arrangements as a whole, as well as to individual retirement accounts and individual retirement annuities. To avoid confusion, we use the acronym *IRA* to refer to both types of individual retirement arrangements. When individual differences exist, we distinguish between an individual retirement account and an individual retirement annuity.

The sponsoring financial institution handles the administrative aspects of an IRA. For example, the insurance company that issues an individual retirement annuity ensures that the annuity meets the legislative requirements to qualify as an individual retirement arrangement. The insurer invests the funds deposited into the individual retirement annuity and manages the account.

Whether an individual chooses to open an IRA as an account or an annuity, the financial institution that issues and holds the IRA assesses various kinds of fees, such as initial setup fees, maintenance fees, and fees associated with any investments funding the IRA.

Individual retirement arrangements also can be categorized as either traditional IRAs or Roth IRAs, depending on their tax treatment:

- A ***traditional individual retirement arrangement (traditional IRA)***, also known as a *regular IRA*, is a type of individual retirement arrangement into which a person with taxable compensation can make annual contributions, which may be tax deductible. Investment earnings are tax deferred until funds are withdrawn.

- A ***Roth individual retirement arrangement (Roth IRA)*** is 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.

Federal tax laws impose certain restrictions on both traditional IRAs and Roth IRAs. For example, the law imposes limits on the amount of contributions an individual can make to an IRA in any year. In addition, because IRAs are intended to be retirement vehicles, the law typically imposes tax penalties if an individual who is younger than age 59½ makes a withdrawal from an IRA.

Figure 11.3 compares the features of traditional IRAs and Roth IRAs.

Figure 11.3 Traditional IRAs versus Roth IRAs

	Traditional IRA	Roth IRA
Annual contribution limits?	Yes	Yes
Withdrawals taxable?	Yes, unless the owner made nondeductible contributions	No, provided certain requirements are met
Contributions deductible from taxable income?	Yes, up to certain limits, unless the owner made nondeductible contributions	No
Penalties for early withdrawals (before age 59½)?	Yes, with certain exceptions	Yes, with certain exceptions

Key Terms

annuity options
lump-sum distribution
fixed period annuity
period certain
fixed amount annuity
life only annuity
joint and survivor annuity
life income with period certain annuity
life income with refund annuity
guaranteed minimum death benefit rider (GMDB)
guaranteed living benefit riders (GLBs)
guaranteed lifetime withdrawal benefit (GLWB)
guaranteed minimum income benefit (GMIB)
guaranteed minimum withdrawal benefit (GMWB)
guaranteed minimum accumulation benefit (GMAB)
payout factor
annuity unit
contract fee
contract maintenance fee
front-end load
service fee
mortality and expense risks (M&E) charge
fund operating expense charge
qualified annuity
nonqualified annuity
individual retirement arrangement (IRA)
individual retirement account
individual retirement annuity
traditional individual retirement arrangement (IRA)
Roth individual retirement arrangement (IRA)

Endnote

1. Investment Company Institute. *2015 Investment Company Fact Book: A Review of Trends and Activities in the U.S. Investment Company Industry*, 55th ed., (Washington, D.C.: ICI, 2015), 151, https://www.ici.org/pdf/2015_factbook.pdf (24 September 2015).

Chapter 12

Health Insurance Products

Objectives

After studying this chapter, you should be able to

12A Identify some common types of basic medical expense coverage and describe the benefits that each provides

12B Identify the purpose of expense participation features in major medical expense policies and give examples of commonly used expense participation methods

12C Identify and describe common types of medical expense coverage other than basic and major medical expense coverage

12D Describe the techniques that managed care plans use to manage access to health care services and the costs of health care services

12E Describe the major characteristics of a consumer-driven health plan (CDHP), and differentiate between a health savings account (HSA), a health reimbursement arrangement (HRA), and a health care flexible spending account (HCFSA)

12F Explain the effects of the Patient Protection and Affordable Care Act (ACA) on insurers that offer medical expense insurance coverage

12G Identify the criteria used to classify disability income coverage as either short-term coverage or long-term coverage

12H Identify the various definitions of *total disability* that are commonly used in disability income insurance policies and distinguish among these definitions

12I Explain the purpose of including an elimination period in a disability income insurance policy and identify the length of the typical elimination period

12J Identify and describe some supplemental benefits that may be included in a disability income insurance policy

12K Identify the causes of disability that a disability income insurance policy may exclude from coverage

12L Identify two types of specialized disability coverage that are designed to meet the needs of closely held businesses for disability coverage of owners, partners, and key people

12M Describe the important features of long-term care insurance (LTCI) policies, such as benefit triggers, benefits, and elimination periods

Outline

Medical Expense Coverage
- Traditional Medical Expense Insurance
- Government-Sponsored Medical Expense Coverage
- Managed Care Plans
- Consumer-Driven Health Plans
- The Patient Protection and Affordable Care Act

Disability Income Coverage
- Types of Disability Income Insurance
- Definitions of Total Disability
- Elimination Period
- Benefit Amounts
- Supplemental Disability Benefits
- Exclusions
- Specialized Types of Disability Coverage

Long-Term Care Coverage
- Important Features of LTCI Policies
- Benefits of LTCI Policies

Most people cannot afford to pay the full costs of their medical treatment should they become seriously ill or require long-term care. Nor can most people afford a loss of income when they are unable to work because of an extended illness or injury. Life and health insurance companies market a variety of individual and group health insurance products designed to protect against the financial losses that insureds are likely to experience as the result of an illness or injury. In this chapter, we describe three important types of health insurance products: medical expense coverage, disability income coverage, and long-term care coverage.

Medical Expense Coverage

You may recall from Chapter 1 that *medical expense coverage* is a type of health insurance that provides benefits to pay for the treatment of an insured's illnesses and injuries and some preventive care. In the United States and a number of other countries, most people are covered by some form of medical expense coverage. Medical expense coverage in the United States is provided to individuals and groups primarily by a private system of commercial life and health insurance companies and other private health insurance providers. Government-sponsored medical expense insurance programs are designed to cover only specified people, such as the elderly or the poor. In contrast, in a number of other countries, including Canada and the United Kingdom, virtually every resident has medical expense insurance coverage provided by government-sponsored programs. In these countries, life and health insurance companies market products designed to supplement the coverages that governmental programs provide.

Four important forms of medical expense insurance in the United States are (1) traditional medical expense insurance policies, which offer indemnity benefits; (2) government-sponsored medical expense coverage; (3) managed care plans; and (4) consumer-driven health plans.

Traditional Medical Expense Insurance

Traditional medical expense insurance products provide ***indemnity benefits***, or *reimbursement benefits*, which are contractual benefits that are based on the actual amount of the insured's financial loss. When an insured receives medical treatment for an illness or injury from a licensed provider of recognized medical services, the insured or the medical care provider files a claim with the insurance company for the policy benefits. If the insurer determines that the charges are covered under the policy, the insurer reimburses the insured or the provider for the expenses according to the terms of the insurance policy. The insured is responsible for paying any amount that remains after the insurer pays its share of the claim.

Traditional medical expense insurance provides three types of coverage: (1) basic medical expense coverage, (2) major medical expense coverage, and (3) other medical expense coverage. These coverage options can be offered under separate policies or combined under a single policy, and the coverage can be offered on a group or individual basis.

Basic Medical Expense Coverage

Basic medical expense coverage provides separate benefits for each of the following types of medical care costs:

- ***Hospital expenses***, which 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
- ***Surgical expenses***, which include charges for inpatient and outpatient surgical procedures
- ***Physicians' expenses***, which include charges associated with physicians' visits both in and out of the hospital

Basic medical expense coverage typically provides ***first-dollar coverage***—that is, the insurer begins to reimburse the insured for eligible medical expenses without first requiring an out-of-pocket contribution from the insured. However, benefits provided under basic medical expense policies typically are limited, and many types of medical expenses are not covered.

Major Medical Expense Coverage

Today, rather than offering basic medical expense coverage, most health insurers offer ***major medical expense coverage***, which provides substantial benefits for (1) basic hospital, surgical, and physicians' expenses; (2) additional medical services related to illnesses and injuries; and (3) preventive care. People insured under major medical expense policies typically receive comprehensive health care in exchange for a fixed, periodic—usually monthly—premium.

Covered Expenses

The benefits that major medical expense coverage provides include payment for many different types of medical treatments, supplies, and services. Major medical expense policies usually cover a wider range of medical expenses than do basic medical expense policies. The covered services and treatments typically include all or some of the following medical expenses:

- Hospital charges for room and board in a semiprivate room
- Miscellaneous inpatient hospital charges, such as laboratory fees, X-rays, medications, and the use of an operating room
- Surgical supplies and services
- Anesthesia and oxygen
- Physical, occupational, and speech therapy
- Surgeons' and physicians' services
- Registered nurses' services
- Specified outpatient expenses, such as laboratory fees, X-rays, and prescription drugs
- Preventive services, such as childhood immunizations and periodic screening and diagnostic tests

Major medical policies allow the insured to seek medically necessary treatment from any licensed provider of recognized medical services.

Benefit Amounts

Major medical expense policies, like all health insurance policies, pay benefits only for *allowable expenses*—that is, those expenses that the insured incurs that are covered under the policy. Most policies specify a maximum benefit amount that the insurer will reimburse for any allowable expense. In most cases, the maximum benefit amount payable for a particular service is based on the usual, customary, and reasonable fee for that service. The ***usual, customary, and reasonable (UCR) fee*** is the amount that medical care providers within a particular geographic region commonly charge for a particular medical service. For example, an insurer might set its maximum benefit amount for an appendectomy in a given state at 90 percent of the UCR fee for the procedure in that state. If an insured files a claim for an amount that is equal to or less than the maximum benefit for the treatment received, then the insurer will allow the entire amount of the claim. If the amount of the claim is greater than the maximum benefit, then the insurer will allow expenses up to the maximum, and the insured is responsible for paying expenses that exceed the maximum benefit amount.

Expense Participation Requirements

Under most major medical expense policies, allowable expenses are subject to expense participation, or cost-sharing, requirements that are designed to encourage insureds to control the amount of their medical expenses. The two most common forms of expense participation requirements are deductibles and coinsurance, and most major medical expense policies include both a deductible and a coinsurance feature.

A ***deductible*** is usually a flat dollar amount, such as $200 or $500, that the insured must pay for eligible medical expenses before the insurer begins making any benefit payments under a medical expense insurance policy. Most major medical expense policies contain a ***calendar-year deductible***, which is a deductible that applies to the total of all allowable expenses an insured incurs during a given calendar year. In other words, an insured is required to pay the deductible specified in the policy each calendar year in which she submits claims.

Example:

Kara Garner is covered by a major medical expense policy that specifies a $500 calendar-year deductible. Last year, she incurred a total of $400 in allowable expenses. This year, she incurred a total of $800 in allowable expenses.

Analysis:

Because Kara's allowable expenses for last year were less than the $500 calendar-year deductible specified in her policy, she was required to pay the entire $400 in expenses she incurred. For this year, she was required to pay $500 of the $800 in allowable expenses she incurred to satisfy the policy deductible, but she was eligible to receive at least a portion of the remaining $300 from the insurer.

Coinsurance is 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. Most major medical expense policies set the coinsurance amount at 10, 20, or 30 percent of the allowable expenses that remain after the insured has paid the deductible.

Example:

Duncan Wu is covered by a major medical expense policy that specifies a $400 calendar-year deductible and a 20% coinsurance requirement. Last year, Duncan incurred $1,000 in allowable expenses in March and $500 in allowable expenses in September.

Analysis:

When Duncan incurred the $1,000 in allowable expenses in March, he first had to pay the $400 calendar-year deductible. He was responsible for paying coinsurance of 20% of the remaining $600, or 0.20 × $600 = $120. So his total expenses in March were $520, found as $400 + $120, and the insurer paid the remaining $480, found as $1,000 – $520.

In September, Duncan had already satisfied the calendar-year deductible, so he paid only coinsurance of 20% on the $500 in allowable expenses: 0.20 × $500 = $100. The insurer paid the remaining $400, found as $500 – $100.

Most major medical expense policies limit the amount of money the insured must pay under the coinsurance provision by including a maximum out-of-pocket provision. The ***maximum out-of-pocket provision***, also known as the *stop-loss provision*, specifies 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.

Example:

Marisol Lopez is covered by a major medical expense policy that specifies a $500 calendar-year deductible, a 20% coinsurance requirement, and a $5,000 annual out-of-pocket maximum. Last year, Marisol incurred allowable expenses of $2,500 in January and $30,000 in May.

Analysis:

Of the $2,500 in allowable expenses that Marisol incurred in January of last year, she was required to pay $500 to meet the policy's calendar-year deductible and an additional $400, or 0.20 × $2,000, in coinsurance. The insurer paid the remaining $1,600. Because she satisfied the deductible in January, Marisol was required to pay only the 20% coinsurance on the allowable expenses she incurred in May. The amount of this coinsurance was $6,000, found as 0.20 × $30,000. However, the maximum annual out-of-pocket provision in her policy requires Marisol to pay only $5,000 of her expenses per calendar year. Because she had already paid $900 in deductible and coinsurance amounts in January, Marisol paid only $4,100 of her May expenses, found as $5,000 - $900. The insurer paid the remaining $25,900.

Exclusions

Although major medical expense policies cover most medical expenses, they commonly exclude from coverage any medical expenses that result from the following health care services:

- Cosmetic surgery other than corrective surgery required as a result of an accidental injury or for other medical reasons
- Treatment of an illness or injury that occurs while the insured is in military service or that results from an act of war
- Treatment of intentionally self-inflicted injuries
- Treatment that is provided free of charge in a government facility or that is paid for by other organizations
- Routine dental treatments, routine eye examinations, and corrective lenses

An insured who incurs expenses for excluded services or services not covered under the policy is required to pay the full amount of those expenses. In addition, excluded or nonallowable expenses are not counted toward the insured's deductible.

Other Medical Expense Coverages

Insurance companies offer a range of other medical expense coverages to provide benefits for expenses that exceed the benefit levels covered by major medical expense policies or for expenses that are not covered under those policies. Examples of these other medical expense coverages include

- ***Dental expense coverage***, which provides benefits for routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the tooth and jaw. Dental expense coverage typically is provided under a stand-alone dental expense policy.

- ***Prescription drug coverage***, which provides benefits for the purchase of drugs and medicines that are prescribed by a physician and are not available over the counter. Prescription drug coverage usually requires the insured to pay part of the cost of the prescription out of pocket at the time of purchase. Benefit levels and expense participation requirements for prescription drug coverage usually vary according to the type of drug. For example, some policies require insureds to pay one out-of-pocket amount for generic drugs and a higher amount for brand-name drugs. Prescription drug costs are a covered expense under many major medical expense policies, but prescription drug coverage can also be provided under a stand-alone policy.

- ***Vision care coverage***, which provides the insured with benefits for expenses incurred in obtaining eye examinations and corrective lenses. Vision care coverage generally provides benefits to cover one routine eye examination per year for each insured. Policies also specify the maximum benefit amount the insurer will pay for eyeglass lenses and frames or contact lenses.

Government-Sponsored Medical Expense Coverage

In many countries, governments or public agencies provide citizens with comprehensive medical expense coverage, including hospital care and physician services. The scope of such government-sponsored coverage varies greatly from country to country.

In Canada, for example, the provincial governments each have established medical expense insurance plans that meet the conditions set out in the federal *Canada Health Act* to qualify to receive federal funding for their plans. Each province and territory provides a medical expense insurance plan that provides health care benefits to qualified residents. Although the Canadian health care system is comprehensive, some health benefits vary from province to province. In addition, insurance companies can offer medical expense coverage to supplement the benefits provided by the provincial plan. For example, commercial insurers typically offer coverage for the added cost of a semiprivate or private hospital room. Many employers offer supplemental health care coverage to their employees under group health insurance plans issued by life and health insurance companies. Individual health insurance policies also are available.

The U.S.government provides medical expense insurance benefits through several government programs, including Medicare and Medicaid. ***Medicare*** is a federal government program that provides medical expense benefits to people age 65 and older and those with certain disabilities. Because Medicare covers only a portion of enrollees' expenses, Medicare recipients frequently purchase supplemental Medicare coverage. These supplements are private medical expense insurance policies that reimburse insureds for out-of-pocket expenses, such as deductibles and coinsurance payments, and may also provide benefits for medical expenses excluded from Medicare coverage. Federal laws contain extensive rules to prevent overlap or duplication of the benefits provided by Medicare and private Medicare supplement policies.

Medicaid is a joint U.S. federal and state program that provides basic medical expense and nursing home coverage to low-income individuals and to certain elderly and disabled individuals.

Managed Care Plans

In the past, most medical expense insurance coverage was concerned only with financing an individual's medical bills. Today, most insureds in the United States are covered by some type of managed care plan. A ***managed care plan*** is 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.

Managing Access to Health Care Services

Managed care plans manage access to health care services through the use of provider networks. A ***network*** is 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. Ancillary, or supplemental, service providers include laboratories, radiologists, home health care providers, and physical, speech, and occupational therapists. Provider contracts specify how the managed care plan will pay the providers.

Managed care plans typically require plan members to choose providers from within the network or offer financial incentives to members who choose network providers. Some managed care plans also require plan members to select a ***primary care provider (PCP)***, also referred to as a *primary care physician*, who is a network member selected by a plan member who coordinates the plan member's medical care and treatment. In a PCP-based system, a plan member selects a PCP from among the network of providers and receives basic care directly from the PCP, without obtaining authorization from the plan. To receive specialized care, however, the plan member often must obtain authorization or a reference from the PCP. The PCP thus serves as a plan member's point of entry into the managed care system and as a gatekeeper to additional services. Plans typically encourage members to obtain care through PCPs by offering lower out-of-pocket costs for PCP-based care.

Managing the Cost of Health Care Services

Managed care plans seek to manage health care costs by requiring plan members and medical care providers to share the cost of health care services. In most managed care plans, plan members receive comprehensive health care in exchange for a fixed, periodic—usually monthly—premium. This premium covers the cost of most health care services, no matter how often the member uses those services. In addition, at the time a plan member receives certain medical services from a network provider, the plan member generally pays a specified, fixed amount, known as a ***copayment***, to the provider.

Example:

Melvin Smith is a member of a managed care plan that requires a $30 copayment for physician office visits and a $20 copayment for prescription drugs. On February 1, Melvin visited his PCP for treatment of a sprained ankle. During the office visit, X-rays were taken of Melvin's ankle. The PCP also wrote Melvin a prescription for pain medication.

Analysis:

Before leaving the PCP's office, Melvin paid a $30 copayment to cover the office visit. The remaining charges for the office visit, including the X-rays, were covered by the managed care plan. When Melvin took his prescription to the pharmacy, he paid a $20 prescription drug copayment. The pharmacy billed the managed care plan for the remaining cost of the prescription drug.

Figure 12.1 describes some common types of managed care plans.

Consumer-Driven Health Plans

In the United States, an alternative approach to providing medical expense insurance coverage is the consumer-driven health plan. A ***consumer-driven health plan (CDHP)*** is 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. The two key components of a CDHP are (1) financial incentives for individuals to manage health care costs and utilization and (2) information—usually in the form of Internet-based medical information tools—to enable individuals to make informed decisions about basic health care.

The financial incentives for managing health care costs are built into each plan's funding mechanism. In most CDHPs, a specified amount is available each year to pay a participating employee's medical expenses. If an employee's medical expenses exceed the amount in the employee's account, the employee must pay these excess costs out of pocket. As a result, employees have a considerable incentive to manage their use of medical services and to ensure that they have a complete and accurate picture of the quality and cost of those services.

Some CDHPs are accompanied by a ***high-deductible health plan (HDHP)***, which is 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. In these plans, after the employee uses up the funds in her account, she then pays for medical expenses until the HDHP deductible is satisfied. After the deductible is paid, the HDHP pays benefits according to its terms. In plans not accompanied by an HDHP, the employee's out-of-pocket costs are likely to be greater.

Figure 12.1 Types of Managed Care Plans

Type of Managed Care Plan	Definition	Characteristics
HMO	A ***health maintenance organization (HMO)*** is 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.	An HMO generally • Requires subscribers to gain access to services through a primary care provider • Requires subscribers to use in-network providers • Does not provide benefits for services rendered by non-network providers (exceptions are made for emergency care) • Requires subscribers to pay a copayment at the time of service, but does not require subscribers to pay deductibles or coinsurance, or to file claims for benefits
PPO	A ***preferred provider organization (PPO)*** is 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.	A PPO generally • Resembles a traditional indemnity plan in that it reimburses in-network providers on a fee-for-service basis, although network providers agree to discount those fees for plan participants
POS plan	A ***point-of-service (POS) plan*** is 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.	A POS plan generally • Provides a lower level of coverage for services received from non-network providers • Requires a plan member to select a primary care provider

Example:

Katrina Whitley is a member of a CDHP sponsored by her employer, the Quark Corporation. This CDHP is accompanied by an HDHP with a deductible of $1,300. Last year, Quark contributed $2,500 to an account for Katrina to use for medical expenses. During the year, Katrina incurred $4,800 in medical expenses.

Analysis:

Katrina used the $2,500 in her account to help pay for the $4,800 in medical expenses. After the account was depleted, she then paid $1,300 out of pocket to satisfy the HDHP's deductible. After the deductible was satisfied, the HDHP paid the remaining $1,000 in medical expenses.

In a CDHP, information provided through Internet sites allows customers to (1) track and manage health care bills, (2) manage and improve their health through health education and preventive services, and (3) gather information about provider quality and services.

In the United States, CDHPs come in several different forms, the most popular of which are health savings accounts (HSAs), health reimbursement arrangements (HRAs), and health care flexible spending accounts (HCFSAs). All of these CDHPs can be used to pay for *qualified medical expenses*, which generally include any amounts paid for medical care. Employers who sponsor CDHPs generally provide information to employees on the particular types of medical expenses that qualify under an HSA, an HRA, and an HCFSA.

Health Savings Accounts

A ***health savings account (HSA)*** is a tax-advantaged account in which an individual can accumulate money to pay for qualified medical expenses. HSAs can be established by individuals under age 65 and employers. Both the employee and the employer can contribute to an HSA. (Note that an eligible individual can establish an HSA on her own, without involving her employer.) HSAs can be used to cover the qualified medical expenses of the individual, a spouse, and any dependents. To be eligible to contribute to an HSA, an individual must be covered by an HDHP.

HSAs have significant tax advantages:

- Contributions to an HSA are not taxed, provided they do not exceed the maximum annual limits. For 2016, the maximum annual contribution limit to an HSA is $3,350 for single coverage and $6,750 for family coverage. Individuals age 55 or older can make an additional catch-up contribution of $1,000. The maximum annual contribution limits apply to contributions made by the employer and those made by the employee. For example, if in 2016 an employer contributed $2,500 to the HSA of a 40-year-old employee with single coverage, the employee could contribute no more than $850, found as $3,350 – $2,500.

- Any earnings, such as interest earnings on the funds in an HSA, grow on a tax-deferred basis.

- HSA distributions used to pay for qualified medical expenses are tax free. Although distributions can be taken to pay for nonmedical expenses, these distributions are subject to income tax and may also be subject to an additional 20 percent penalty tax. Exceptions to the penalty tax are for distributions that occur after the accountholder dies, becomes disabled, or becomes eligible for Medicare.

Other important characteristics of HSAs are that funds can be carried over from one year to the next, and HSAs are *portable*, meaning that an employee who terminates her employment can take her HSA with her.

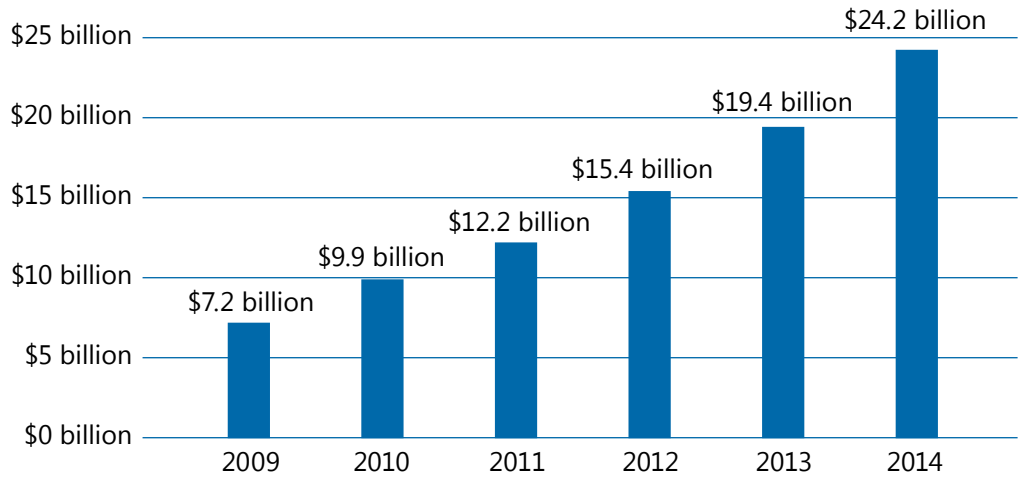
Figure 12.2 illustrates the growth in HSAs in the United States from 2009 until the end of 2014.

Health Reimbursement Arrangements

A ***health reimbursement arrangement (HRA)*** is an employer-sponsored health plan that is used to pay for qualified medical expenses and that allows contributions only by the employer. An HRA receives tax-favored treatment, provided it satisfies specific requirements. Unlike an HSA, an employee does not have to be covered by an HDHP to be eligible to enroll in an HRA; however, the employee must be enrolled in a qualified group-sponsored health insurance plan. In practice, most individuals covered by an HRA are also covered by an HDHP.

The employer's contributions to the HRA are not taxed, and distributions used to pay for the qualified medical expenses of the employee are tax free. Unlike with an HSA, the employer typically decides whether coverage is also provided for the employee's spouse and dependents. In addition, distributions for nonmedical expenses are prohibited. If such a distribution is taken, the account will lose its tax-favored status.

Figure 12.2 National HSA Assets (in Billions)



Source: LIMRA analysis of the *2014 Year-End HSA Market Statistics & Trends Executive Summary*, Devenir Research, February 2015. *The Retirement Income Reference Book* (Windsor, CT: LL Global, Inc., © 2015), 186.

The employer may provide that any unused amounts in an HRA are carried over from one year to the next. HRAs are not portable, however.

Health Care Flexible Spending Accounts

A ***health care flexible spending account (HCFSA)*** is an employer-sponsored health plan that allows employees to set aside a predetermined amount of their pretax wages to pay for qualified medical expenses. For 2016, the maximum annual pretax salary reduction contribution to an HCFSA is $2,550.

To receive favorable tax treatment, an HCFSA must satisfy strict requirements. For example, an HCFSA generally must stipulate that the employee will forfeit any unused amounts at the end of the year. However, the employer can allow a limited rollover amount of up to $500 per employee per year. In addition, distributions used to pay for qualified medical expenses must be *substantiated*—that is, the employee must prove that she has incurred the expenses before she receives reimbursement for them.

For an employee to be eligible to enroll in an HCFSA, the employer must have offered the employee coverage through a qualified group-sponsored health insurance plan. (Note that the employee does not have to accept this coverage, but the employer must have offered it to the employee.)

Figure 12.3 compares the features of HSAs, HRAs, and HCFSAs.

The Patient Protection and Affordable Care Act

In recent years, insurance companies that offer medical expense insurance coverage in the individual and group market have been affected by the enactment in 2010 of the ***Patient Protection and Affordable Care Act***, also known as the *Affordable Care Act* or the *ACA*. The intent of the ACA was to make health care more affordable for and accessible to Americans.

One important result of the ACA was the creation of health insurance exchanges. A ***health insurance exchange***, also known as an *exchange* or an *insurance marketplace*, is an online marketplace in which individuals and small businesses can purchase medical expense insurance coverage. This coverage is offered in the form of standardized plans—known as *qualified health plans*, or *QHPs*—offered by insurers licensed in a given state. A health insurance exchange may be state-based; it may be a partnership with the federal government; or it may be operated entirely by the federal government.

Another important outcome of the ACA is that most of the new medical expense insurance plans offered in the United States must satisfy certain requirements:

- **Guaranteed issue**. Health insurance issuers, including insurance companies, are required to accept all applicants for medical expense insurance coverage, regardless of age, gender, or health status.

- **Guaranteed renewal**. Health insurance issuers, including insurance companies, must continue medical expense coverage at the option of the insured, as long as premiums are paid.

Figure 12.3 Comparison of Consumer-Driven Health Plans

	HSA	HRA	HCFSA
Is an HDHP required?	Yes	No, but individual must be covered under a qualified group-sponsored health plan	No, but employer must offer to cover the individual under a qualified group-sponsored health plan
Must an employer be involved?	No	Yes	Yes
Who can contribute?	Both employee and employer	Only employer	Both employee and employer
Are there contribution limits?	Yes, subject to maximum annual dollar amounts (adjusted annually for inflation)	No	Yes, subject to maximum annual dollar amounts (adjusted annually for inflation)
What is the tax treatment of distributions to pay for qualified medical expenses?	Tax free	Tax free	Tax free
What is the tax treatment of distributions to pay for nonmedical expenses?	Subject to income tax and may be subject to additional 20% penalty tax	HRA will lose tax-favored status if a distribution is taken under these circumstances	HCFSA will lose tax-favored status if a distribution is taken under these circumstances
Can unused funds be carried over?	Yes	Yes, if employer specifically allows carryover	The employer can allow a limited rollover of $500 per employee per year
Is it portable?	Yes	No	No

- **Essential health benefits**. Medical expense insurance plans offered in the individual and small group market must provide a minimum level of basic health coverage, known as *essential health benefits*. Essential health benefits include 10 categories of care, such as emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, and preventive care.

- **Coverage of preventive care**. Medical expense insurance plans, including HDHPs, must provide benefits for preventive care without imposing cost-sharing mechanisms such as deductibles.
- **Limitations on cost sharing**. Medical expense insurance plans must impose annual limits on the maximum out-of-pocket costs that individuals and families pay under a medical expense plan each year. These limitations apply to cost-sharing mechanisms such as deductibles, copayments, and coinsurance.
- **No limitations on coverage for essential health benefits**. Medical expense insurance plans must not impose annual or lifetime limits on coverage for essential health benefits.

Disability Income Coverage

You may recall from Chapter 1 that *disability income coverage* provides income replacement benefits to an insured who is unable to work because of illness or injury. When a person is unable to work due to a disability, the financial effect on the individual's family is potentially much greater than if the individual had died. When a wage earner dies, the family is left without a source of income. When a wage earner is disabled, the family loses a source of income *and* also faces additional expenses resulting from the disability. To help relieve the financial stress created by disability, insurance companies offer income replacement benefits in the form of disability income coverage. In addition, in many countries, such as the United States and Canada, government programs provide certain benefits to individuals who become disabled.

Types of Disability Income Insurance

Insurance companies issue both individual and group disability income insurance policies. The coverage provided by such policies is classified as either short-term or long-term coverage, depending on the length of the benefit period. The ***benefit period*** is the time period during which the insurer agrees to pay income benefits to the insured. The criteria used to classify the benefit period are different for individual and group coverages.

Individual disability income coverage is seldom offered with a maximum benefit period of less than one year:

- ***Short-term individual disability income coverage*** provides a maximum benefit period of one to five years.
- ***Long-term individual disability income coverage*** provides a maximum benefit period of five years or more. For this type of coverage, the maximum benefit period for illnesses commonly extends until the insured reaches age 65. However, for accidents, benefits are often provided for the insured's lifetime.

Group disability income coverage generally specifies shorter benefit periods than those included in individual policies:

- ***Short-term group disability income coverage*** provides a maximum benefit period of one year or less; such coverage typically specifies a maximum benefit period of 13, 26, or 39 weeks.

- ***Long-term group disability income coverage*** provides a maximum benefit period of more than one year. Many policies extend the maximum benefit period to the insured's normal retirement age or to age 70.

Definitions of Total Disability

Each disability income policy specifies the definition of ***total disability*** that the insurer uses to determine whether a covered person is entitled to receive disability income benefits. Although this definition varies from policy to policy, we describe the definitions that insurance companies most commonly include in disability income policies.

Any Occupation

At one time, disability income policies defined total disability as a disability that prevented the insured from performing the duties of *any occupation*. Because a strict interpretation of this definition would prevent most people from ever qualifying for disability income benefits, most insurers now define *total disability* more liberally.

Current Usual Definition

Most disability income policies issued today use a two-part definition of *total disability*. Under this definition, an insured is considered totally disabled if, at the start of disability, the disability prevents her from performing the essential duties of her *regular occupation*. At the end of a specified period after the disability begins—usually two to five years—the insured is considered totally disabled if the disability prevents her from working at *any occupation for which she is reasonably fitted by education, training, or experience*.

Example:

Enzo Scanno, a surgeon, is insured under a disability income policy that contains the "current usual" definition of total disability; the policy's definition of total disability changes after the insured has been disabled for two years. Enzo was involved in an accident and lost his left arm. Although he is unable to perform surgery, he has been hired to teach at a medical college.

Analysis:

Because Enzo's injury prevents him from working as a surgeon, he meets the policy's initial definition of total disability and therefore will be eligible to receive disability income benefits for up to two years. At the end of that time, Enzo will no longer be considered disabled because his disability does not prevent him from teaching, an occupation for which he is reasonably fitted by his education and training.

Own Previous Occupation

Some insurers have further liberalized the definition of *total disability* included in certain disability income policies. This definition, which is included more often in individual policies than in group policies, specifies that *total disability* is the

inability to perform the essential duties of the insured's *own previous occupation*. In fact, policies using this "own previous occupation" definition specify that benefits will be paid even while the insured is gainfully employed in another occupation, as long as she is prevented by disability from engaging in the essential duties of the occupation specified in the policy. Policies containing this definition of total disability often are sold to people who are employed in certain professional occupations.

Example:

Suppose that Enzo Scanno from the last example is insured under a disability income policy that contains this "own previous occupation" definition of total disability. Because of his accident, Enzo is unable to perform surgery and has begun teaching at a medical school.

Analysis:

Enzo is unable to perform surgery and therefore will never be able to work in his own previous occupation. Therefore, even though Enzo is working as a teacher, the insurance company will pay Enzo the full disability income benefit until the end of the policy's benefit period.

Presumptive Disabilities

Some disability income policies classify certain conditions as presumptive disabilities. A ***presumptive disability*** is a stated condition that, if present, automatically causes the insured to be considered totally disabled and thus eligible to receive disability income benefits. An insured with a presumptive disability receives the full income benefit amount provided under the policy, even if he resumes full-time employment in a former occupation. Presumptive disabilities include total and permanent blindness, loss of the use of any two limbs, and loss of speech or hearing.

Elimination Period

Although some forms of disability income coverage are designed to provide benefits beginning on the first day of an insured's disability, most policies specify an elimination period. An ***elimination period***, often referred to as a *waiting period* or a *benefit waiting period*, is the specific amount of time that the insured must be disabled before becoming eligible to receive policy benefits.

Like the deductible amount found in medical expense policies, the purpose of the elimination period is to reduce the cost of coverage. By specifying an elimination period, the insurer can substantially reduce the expenses involved in processing and paying claims for disabilities that last for only a very short time. This expense savings is reflected in the cost of the coverage; the longer the elimination period, the lower the cost for otherwise equivalent disability income coverage.

The length of the elimination period included in both short-term and long-term individual disability income policies is typically 30 days to 6 months. The elimination period in a group policy is typically related to the length of the maximum benefit period:

- *Group short-term disability income policies* typically specify no elimination period for disabilities caused by accidents and an elimination period of one week for disabilities caused by sickness.

- *Group long-term disability income policies* typically specify an elimination period of 30 days to 6 months, although such plans also typically coordinate their short-term and long-term coverages so that short-term coverage ends at the same time that long-term benefits become payable.

Benefit Amounts

As a general rule, the benefit amount provided by disability income coverage is not intended to fully replace an individual's pre-disability earnings. Instead, disability income benefits are limited to an amount that is lower than the individual's regular earnings when not disabled. Without such restrictions, a disabled insured could receive as much income as he received while working and would have no financial incentive to return to work.

Disability income benefit amounts, however, should not be so low that a disabled insured suffers a drastic reduction in income and lifestyle; the purpose of disability insurance, after all, is to provide protection against the economic consequences of income loss. Therefore, the benefit amount should be related to the amount of the individual's income before disability and should be available for a premium that the insured can afford.

Disability income providers use two methods to establish the amount of disability income benefits that will be paid to a disabled person: (1) an income benefit formula or (2) a flat benefit amount. The method used generally depends on whether the coverage is provided by a group or an individual policy and on whether the coverage is short term or long term.

Income Benefit Formula

Group disability income policies typically include an income benefit formula that the insurer uses to determine the amount of the periodic benefit that is payable to a disabled insured. An income benefit formula usually expresses the disability income benefit amount as a stated percentage of the insured's pre-disability earnings and considers all sources of disability income that the disabled insured receives.

The amount of the stated percentage in the formula varies from policy to policy:

- In group long-term disability income policies, the percentage typically ranges from 60 to 75 percent. For example, the formula may specify that the insured will receive a disability income benefit amount equal to 75 percent of her pre-disability earnings.

- In group short-term disability income policies, the percentage is often higher than in group long-term policies, often ranging from 90 to 100 percent of pre-disability earnings.

Income benefit formulas in both long-term and short-term group disability income policies also typically state that the insurer will reduce the benefit amount by the amount of any disability income benefit the insured receives from other sources.

Flat Benefit Amount

Individual disability income policies usually specify a flat benefit amount that the insurer will periodically pay to an insured who becomes totally disabled. The specified benefit amount is based on the amount of the insured's income when she purchased the policy. Unlike the benefit paid under group disability income policies, the specified benefit amount typically is paid to a disabled insured regardless of any other income benefits she receives during the disability. The income benefit amount that an individual disability income policy provides is lower than the amount of income the insured earned before becoming disabled. Insurers also limit the maximum amount of the disability income benefit that an applicant can purchase.

Supplemental Disability Benefits

What if an insured wants coverage for a partial disability, or wants coverage that will increase along with increases in her salary or the cost of living? For these situations, the insurer can offer supplemental disability benefits. These benefits may be automatically included with the basic coverage or may be available on an optional basis for an additional premium amount.

Partial Disability Benefits

Some disability income policies provide benefits for periods when the insured person has a ***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. The amount of the disability income benefit paid when an insured has a partial disability is described in the policy. The benefit amount is either a specified flat amount or an amount established according to a formula specified in the policy. Under the formula method, the amount of the income benefit will vary according to the percentage of income that the insured has lost due to the partial disability.

Future Purchase Option Benefit

Some disability income policies that specify a flat benefit amount contain a ***future purchase option benefit***, which grants the insured the right to increase the benefit amount in accordance with increases in the insured's earnings. This benefit provision generally specifies that benefit increases can be made only if the insured can prove a commensurate increase in income. In addition, the amount of such increases generally is limited to a specified maximum. The insured, however, is usually permitted to increase the benefit amount without providing evidence of insurability.

Cost-of-Living-Adjustment Benefit

A ***cost-of-living-adjustment (COLA) benefit*** provides for periodic increases in the disability income benefit amount that the insurer will pay to a disabled insured. These increases usually correspond to increases in the cost of living. When a policy or rider provides a COLA benefit, it usually defines an increase in the cost of living in terms of a standard index, such as the Consumer Price Index (CPI), that measures changes in the prices of goods and services.

Exclusions

Disability income policies often specify that income benefits will not be paid to a disabled insured if the insured's disability results from certain causes, including

- Injuries or sicknesses that result from an act of war
- Intentionally self-inflicted injuries
- Injuries received as a result of active participation in a riot or the commission of a crime
- Occupation-related disabilities or illnesses for which the insured is entitled to receive disability income benefits under a government program

Specialized Types of Disability Coverage

In addition to disability income coverage, insurers market specialized types of disability coverage designed to provide benefits for specific expenses—other than loss of income—that may result from an insured's disability.

- Just as businesses that rely on the work of a key person may need to purchase key person life insurance, businesses also may need ***key person disability coverage***, which provides benefit payments to the business if an insured key person becomes disabled. When a key person is unable to work because of disability, the business loses the person's services and therefore loses money. Such losses can be offset by key person disability benefits.
- In Chapter 5, we described buy-sell agreements and how they can be funded by life insurance policy death benefits. A buy-sell agreement also may include provisions concerning the purchase of a partner's or owner's interest in the business should the partner or owner become disabled. ***Disability buyout coverage*** provides benefits designed to fund the buyout of a partner's or owner's interest in a business should he become disabled.

Long-Term Care Coverage

With increasing life expectancies in many parts of the world, growing numbers of people are likely to need long-term care at some point in their lives. The costs of long-term care can quickly deplete an individual's or couple's savings, so to protect themselves against this risk, people may purchase long-term care insurance. In Chapter 1 we defined *long-term care insurance (LTCI)* as a type of health insurance that pays benefits for medical or other health-related services needed by an insured who, because of a serious impairment, needs care in his own home or a qualified facility.

Insurance companies issue both individual and group LTCI policies. In addition, many insurers offer long-term care coverage as a rider to life insurance policies (discussed in Chapter 7), disability income policies, or annuities. In recent years, sales of these "combo" products have greatly outpaced those for individual LTCI policies.

An individual generally needs long-term care as the result of a cognitive or physical impairment. A ***cognitive impairment*** is a reduction in a person's ability

to think, reason, or remember. The most common causes of cognitive impairment are Alzheimer's disease and dementia. A ***physical impairment*** is a treatable, but generally incurable, chronic condition such as arthritis, emphysema, heart disease, diabetes, and hypertension. The physical impairments that may require long-term care services are typically expressed in terms of how difficult it is for an individual to perform activities of daily living. The ***activities of daily living (ADLs)*** are 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. Some people can manage ADLs but have difficulty with less essential types of activities that are called ***instrumental activities of daily living (IADLs)***. IADLs are 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. Most LTCI policies provide benefits for individuals who need help with IADLs as well as ADLs.

Important Features of LTCI Policies

Important features of an LTCI policy include benefit triggers and elimination periods.

Benefit Triggers

A ***benefit trigger*** in an LTCI policy specifies the conditions that establish an insured's eligibility to receive long-term care benefits. For LTCI policies, the following two occurrences serve as benefit triggers:

- The inability of the insured to perform at least two ADLs without assistance for a period of time expected to last at least 90 days
- The need for supervision to protect a person from threats to health and safety due to a severe cognitive impairment

A licensed health care practitioner, such as a physician, registered nurse, or licensed social worker, must certify that the insured meets at least one of these two criteria. Although the inability to perform IADLs is not a benefit trigger, most LTCI policies provide help with IADLs when an insured becomes eligible for benefits.

Elimination Period

The ***elimination period*** refers to the number of days that a person insured under an LTCI policy must receive care before benefit payments under the policy can begin. For individual LTCI policies, the insured generally chooses the elimination period. Common elimination periods are 30 days, 60 days, and 90 days. Some individual LTCI policies also offer a 0-day elimination period. In this case, benefits will begin on the first day that the insured receives care. In general, the longer the elimination period is for a policy, the lower the policy's premium. Group LTCI policies typically have a set elimination period of 90 days.

Benefits of LTCI Policies

When applying for an LTCI policy, the applicant chooses a certain dollar amount of benefits to be received. In most policies, these benefits are expressed in the form of a daily dollar amount, although some policies use a monthly dollar amount. Sellers of LTCI policies generally recommend that an applicant select a daily or monthly benefit amount that is based on the average cost of a skilled nursing facility in the area where the applicant plans to receive any needed care.

Example:

Sharon Baumer, age 55, an applicant for an LTCI policy, is trying to determine the proper daily benefit amount for her policy. Sharon does not plan to relocate when she retires.

Analysis:

After conducting some research, Sharon chose $250 a day because that amount represented the average daily cost of nursing home care in her area.

After choosing a daily or monthly benefit amount, the applicant must select a *benefit period*, such as three, four, or five years. In general, longer benefit periods increase the cost of a policy. In fact, lifetime benefit periods are rarely offered anymore because of their prohibitive cost.

LTCI policies typically have maximum lifetime benefits, which take one of two forms: (1) a maximum time period over which benefits will be paid or (2) a maximum dollar amount of benefits that will be paid. A policy that uses a maximum time period stipulates that benefits will be paid for the benefit period chosen by the applicant. A policy that uses a maximum dollar amount of benefits—sometimes called the "pool of money" method—multiplies the benefit period by the daily or monthly dollar amount for the policy. The resulting amount becomes the maximum lifetime benefit under the policy.

Example:

Sharon from the previous example chose a four-year benefit period for her policy, which provides a $250 daily amount.

Analysis:

If Sharon's policy uses the maximum time period to determine maximum lifetime benefits, the policy will pay benefits for four years. If it uses the maximum dollar amount of benefits, the maximum lifetime benefit will be $365,000, calculated as $250 × (4 years × 365 days).

In the past, comprehensive LTCI policies frequently provided 100 percent of the daily or monthly benefit amount for facility care and 50 percent for home health care. Today, however, most insurers allow the applicant to choose whether she wishes to receive the same benefit amount for both types of care.

LTCI policies generally offer two different options for paying benefits: the reimbursement method or the indemnity benefit (per diem) method.

Most LTCI policies sold today use the reimbursement method. With the ***reimbursement method***, the insurer reimburses eligible expenses that are incurred by the insured, up to the policy's daily or monthly benefit amount.

Example:

Riley Nugent owns an LTCI policy that pays a monthly benefit amount of up to $3,000. The benefit payment option for his policy is the reimbursement method. Riley incurs charges in a skilled nursing facility of $2,800 a month.

Analysis:

Because Riley's policy uses the reimbursement method, Riley will pay the skilled nursing facility $2,800 a month, and the insurer will then reimburse Riley for $2,800 a month. The remaining $200 a month will remain in the policy to be used at a later time if needed.

The ***indemnity benefit method***, also known as the *per diem method*, pays a stated benefit amount to the insured, regardless of the amount of expenses incurred.

Example:

Assume that Riley from our previous example had an LTCI policy that uses the indemnity benefit method of paying benefits.

Analysis:

The insurer will pay benefits of $3,000 a month, even though Riley's actual expenses are only $2,800 a month.

The premium for an LTCI policy varies based on the benefit payment option that the policyowner chooses. For example, all other factors being equal, an insured who owns an LTCI policy that uses the indemnity benefit method will generally pay a higher premium than he would with the reimbursement method.

Key Terms

indemnity benefits
basic medical expense coverage
hospital expenses
surgical expenses
physicians' expenses
first-dollar coverage
major medical expense coverage
usual, customary, and reasonable (UCR) fee
deductible
calendar-year deductible
coinsurance
maximum out-of-pocket provision
dental expense coverage
prescription drug coverage
vision care coverage
Medicare
Medicaid
managed care plan
network
primary care provider (PCP)
copayment
health maintenance organization (HMO)
preferred provider organization (PPO)
point-of-service (POS) plan
consumer-driven health plan (CDHP)
high-deductible health plan (HDHP)
health savings account (HSA)
health reimbursement arrangement (HRA)
health care flexible spending account (HCFSA)
Patient Protection and Affordable Care Act (ACA)
health insurance exchange
benefit period
short-term individual disability income coverage
long-term individual disability income coverage
short-term group disability income coverage
long-term group disability income coverage
total disability
presumptive disability
elimination period
partial disability
future purchase option benefit
cost-of-living-adjustment (COLA) benefit
key person disability coverage
disability buyout coverage
cognitive impairment
physical impairment
activities of daily living (ADLs)
instrumental activities of daily living (IADLs)
benefit trigger
elimination period
reimbursement method
indemnity benefit method

Chapter 13

Principles of Group Insurance

Objectives

After studying this chapter, you should be able to

13A Identify the parties to a group insurance contract and distinguish between contributory and noncontributory group insurance plans

13B Describe the operation of the probationary period and the actively-at-work requirement

13C Compare group underwriting with individual underwriting and identify the risk characteristics that group underwriters consider

13D Identify the common types of insurable groups

13E Describe the purpose and operation of benefit schedules in group life insurance policies

13F Explain the method insurers use to calculate group insurance premiums

13G Define self-administered group plans and insurer-administered group plans

Outline

Group Insurance Contracts
- Certificates of Insurance
- Eligibility Provisions

Group Insurance Underwriting
- Reason for the Group's Existence
- Size of the Group
- Flow of New Members into the Group
- Stability of the Group
- Participation Levels
- Determination of Benefit Levels
- Nature of the Business

Group Insurance Premiums
- Premium Amounts
- Premium Refunds

Group Plan Administration

In previous chapters, we discussed mostly individual life and health insurance products. In this chapter, we turn our attention to group insurance. ***Group insurance*** is a method of providing life or health insurance coverage for a group of people under one insurance contract. In many parts of the world, group insurance represents a substantial portion of the overall life insurance market. Figure 13.1 illustrates the growth of group life insurance coverage in the United States from 1950 to 2014.

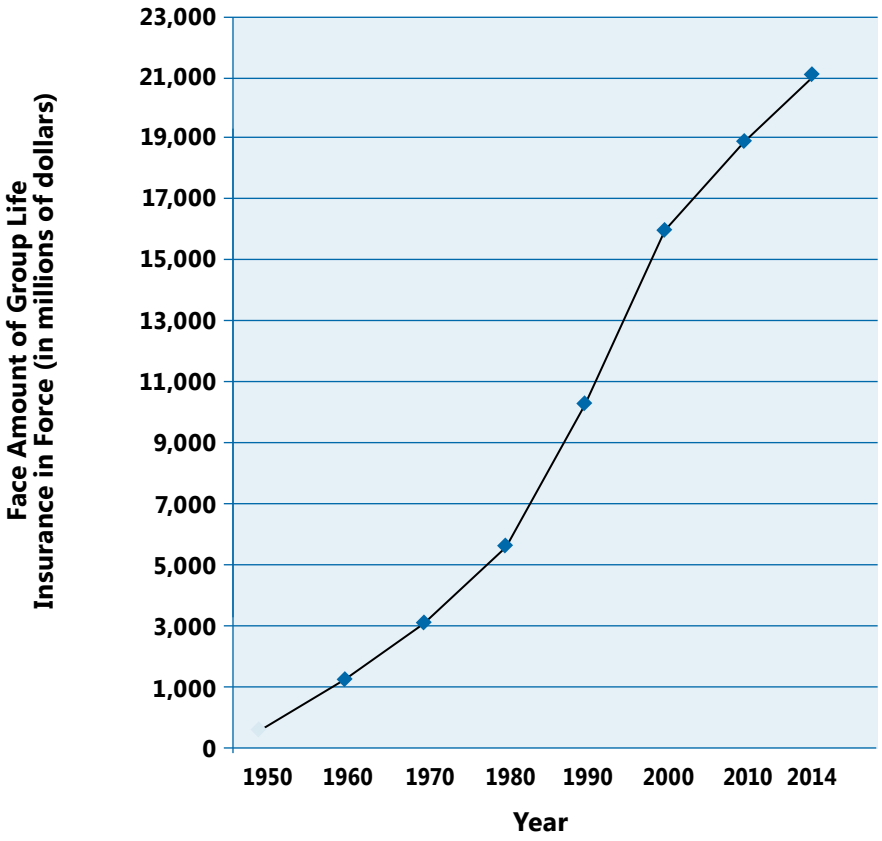
Group Insurance Contracts

Although individual insurance and group insurance are similar in many ways, these insurance products have some striking differences. For example, an individual insurance policy typically insures one person or one family. In contrast, a group insurance plan insures a number of people, such as a group of employees, under a single insurance contract. This single insurance contract, which is called a ***master group insurance contract***, describes the relationship between an insurer and a group policyholder and specifies the benefits provided by the contract to the insured group members.

The parties to a master group insurance contract are the insurance company and the *group policyholder*, which is the entity or organization that decides what types of group insurance coverage to purchase for the group members, negotiates the terms of the group insurance contract with the insurer, and purchases the group insurance coverage. The term *policyholder* is used rather than the term *policyowner* because the group policyholder does not have the same ownership rights in the group insurance policy that a policyowner has in an individual insurance policy. Instead, some of these rights are granted to the insured group members. For example, each group member insured under a group life insurance policy generally has the right to name the beneficiary who will receive the benefit payable upon the group member's death.[1] In contrast, an individual life insurance policy gives that right to the policyowner.

In most jurisdictions, the individuals covered by a group insurance policy are referred to as the ***group insureds***, or simply as the *insureds*, and we use those terms in this text.

Figure 13.1. Group Life Insurance in Force in the United States



Source: Adapted from ACLI, *Life Insurers Fact Book 2015*, Copyright © 2015 American Council of Life Insurers, Washington, DC, (November 2015, 19,) 72 https://www.acli.com/Tools/Industry%20Facts/Life%20Insurers%20Fact%20Book/Documents/FB15_All.pdf (15 February 2016). Used with permission.

Businesses purchase group life and health insurance for their employees as an employee benefit. Although insurers issue group insurance policies covering other types of groups, which we will discuss, most group insurance policies insure a group of employees. For that reason, this text concentrates on employer-employee group insurance policies. We sometimes refer to the group policyholder as the *employer* and to the group insureds as the *employees*.

The group policyholder usually is responsible for handling some of the administrative aspects of the group insurance plan. For example, the group policyholder typically handles the enrollment of new group members into the plan. The group policyholder also is responsible for making all premium payments to the insurer, although the insured group members may be required to contribute some or all of the premium amount. If the insured group members are not required to pay any part of the group insurance premium, the group plan is a ***noncontributory plan***. If insured group members must pay part or all of the premium for their coverage, the group insurance plan is a ***contributory plan***. A contributory plan usually requires covered employees to pay their portion of the premium through payroll deductions.

Certificates of Insurance

The group insureds are not parties to a master group insurance contract, do not participate in the formation of the contract, and do not receive individual copies of the contract. However, as we discussed, insured group members have certain rights under the contract. Insurance laws typically require the insurer to provide the group policyholder with written descriptions of the group insurance plan; the group policyholder then delivers a written description to each group insured. This document, known as the ***certificate of insurance***, describes (1) the coverage that the master group insurance contract provides and (2) the group insured's rights under the contract. As a result, an insured group member often is referred to as a ***certificate holder***. Many policyholders describe the group insurance coverage in a special benefit booklet. In such cases, the benefit booklet contains the information that would be included in a certificate, and the benefit booklet serves as the group insurance certificate.

Example:

Sudoku Manufacturing Company purchased from Origami Life Insurance Company a group life insurance policy covering its employees.

Analysis:

Sudoku and Origami are the parties to the *master group insurance contract*. Sudoku is the *group policyholder*. Sudoku's employees who are covered under the policy are the *group insureds*. Each group insured receives a *certificate of insurance* describing the coverage provided under the group insurance contract and his rights under the contract.

Eligibility Provisions

An important term found in every group insurance policy is a description of the individuals who are covered by the policy. A group policy often defines the individuals who are eligible for coverage as those employees in a specified class or classes. These classes typically are defined by requirements that are related to conditions of employment, such as salary, occupation, specific division within the company, or length of employment.

Example:

Many group insurance policies state that all full-time employees are eligible for coverage; therefore, at these companies, part-time workers are excluded from the class of eligible employees.

Group insurance policies also impose requirements that new group members must meet to be eligible for coverage. The most common of these eligibility provisions are the actively-at-work provision and the probationary period.

An ***actively-at-work provision*** 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. If the employee is not actively at work on the day the coverage is to take effect, then the employee is not covered by the group

insurance policy until he returns to work. For example, according to this provision, if an employee who would otherwise become eligible for coverage on March 1 is absent due to illness on that date, coverage would not begin until the day the employee returns to work.

A ***probationary period*** is the length of time—typically, from one to six months—that a new group member must wait before becoming eligible to enroll in the group insurance plan. A probationary period requirement can reduce a plan's administrative costs by avoiding the cost of enrolling new employees who work for the company for only a short period. Under a noncontributory group insurance plan, a new employee who has met all other eligibility requirements is automatically covered at the end of the probationary period. In contrast, if the plan is contributory, then an eligibility period typically follows the probationary period.

An ***eligibility period***, also called an *enrollment period*, is a specified 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. As part of the enrollment process, the employee must sign a written authorization allowing the employer to make payroll deductions from her salary to cover the amount of her premium contributions. Coverage under a contributory group insurance plan will not become effective until the employee completes such an authorization.

Example:

John Talbot and Enrique Ramirez both began work on September 1. John and Enrique are both eligible for coverage under group life insurance policies that their employers provide. Both policies have a 30-day probationary period. John's employer has a noncontributory plan, whereas Enrique's employer has a contributory plan.

Analysis:

Both John and Enrique became eligible for life insurance coverage on October 1, the first day following the end of their probationary periods. John's coverage under his employer's noncontributory plan was automatically effective on that date. Because Enrique's plan was contributory, his group coverage will become effective when he enrolls and signs the payroll deduction authorization form during the eligibility period.

Sometimes when an employee first becomes eligible for group insurance coverage under a contributory plan, she declines the coverage. In such cases, she must usually submit satisfactory evidence of insurability before she is allowed to join the plan at a later date. However, some contributory group insurance plans for larger groups feature an ***open enrollment period***, which is 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.

Example:

Paige Higgins works for a company that offers a contributory group life insurance plan to its eligible employees. When Paige first became eligible to enroll in the plan, she declined the coverage. A year later, however, she decided she wanted to join the plan. Her company offers an open enrollment period in December of each year.

Analysis:

As long as Paige enrolls during December, she will be allowed to join the group life insurance plan without providing evidence of insurability.

Some group insurance policies provide coverage both for eligible group members and the dependents of covered group members. Group insureds who are covered as dependents typically do not have the same rights as do members of the insured group, such as the employees who are covered by an employer-employee group policy. For example, a covered dependent typically does not have the right to name the beneficiary of his group life insurance coverage. Instead, the beneficiary of any dependent group life coverage usually is either (1) the insured group member himself or (2) a beneficiary selected by the insured group member. Further, if dependent coverage is optional, then the insured group members—not their dependents—have the right to elect or reject that coverage.

Example:

David Hewitt works for Tallulah Enterprises, which purchased a group life insurance policy to insure its employees and their dependents. The group policy provides $100,000 of life insurance coverage on David and $25,000 of life insurance coverage on both David's wife and his son.

Analysis:

According to the requirements of most insurance companies, David has the right to name the beneficiary who is entitled to receive any group life insurance benefits following his own death. In addition, depending on the terms of the group policy, either David is the beneficiary of the coverage on his wife and his son, or David has the right to name someone else as the beneficiary of this coverage.

Group Insurance Underwriting

Individual and group insurance policies both require underwriting to determine whether the proposed insured or group presents an acceptable degree of risk for the insurer. However, individual life and health insurance underwriting requires that the proposed individual meet the insurer's underwriting requirements. In contrast, group insurance underwriting generally focuses on the characteristics of the group and, with the exception of very small groups, usually does not require each proposed group insured to provide individual evidence of insurability. Each insurance company establishes underwriting guidelines that define the types of groups it will insure.

In general, group underwriting has the following objectives:

- To determine whether the proposed group is an acceptable risk
- To prevent antiselection
- To keep the administrative costs as low as possible
- To determine the appropriate premium rates to charge for the group insurance

Group underwriters consider a number of specific characteristics of a group when evaluating whether that group is an acceptable risk. These risk characteristics include the reason for the group's existence, the size of the group, the flow of new members into the group, the stability of the group, the required percentage of eligible group members who must participate in the plan, the way in which benefit levels will be determined, and the activities of the group. The group underwriter may also consider additional characteristics of the group.

Reason for the Group's Existence

Group underwriting guidelines usually require that the group must have been formed for a reason other than obtaining insurance. Antiselection would be likely in a group formed solely for the purpose of obtaining group insurance. People who believe they are uninsurable individually would be more likely to join such a group than would individuals who believe they can qualify for individual insurance. In general, groups that are eligible for coverage can be placed into one of the following categories:

1. A **single-employer group** consists of the employees of a single employer and is also known as an *employer-employee group*. Most group insurance policies insure the employees of a single employer.
2. A **labor union group** consists of workers who are members of a *labor union*, which is an association that promotes the welfare, interests, and rights of its members.
3. A **multiple-employer group** consists of the employees of (1) two or more employers in the same industry, (2) two or more labor unions, or (3) one or more employers *and* one or more labor unions.
4. An **association group** consists of individuals who share a common bond. For example, group members may work in a specific industry or may share a common characteristic, such as individuals who are alumni of a specific college. An association group is eligible for group insurance only if it was formed for a purpose other than obtaining group insurance. Figure 13.2 describes some of the types of association groups that are eligible for group insurance coverage.
5. A **debtor-creditor group** consists of persons who have borrowed funds from a lending institution, such as a bank.
6. A **credit union group** consists of the members of one or more *credit unions*, which are cooperative associations that pool the savings of their members and use those funds to make loans to members.
7. A **discretionary group** consists of the members of any other type of group that qualifies for group insurance coverage according to applicable insurance laws.

Underwriting guidelines vary for each of the preceding types of groups. For example, group underwriting guidelines typically require the employer in an employer-employee group insurance plan to pay at least a portion of the group insurance premium. This requirement, which is imposed by law in many jurisdictions, gives the employer a financial interest in the operation of the plan. In contrast, other group policyholders usually are not required to pay a portion of the group insurance premium.

Some underwriting guidelines are more stringent for some types of groups than others. For example, antiselection by individual group members is much more likely to occur in association groups in which group membership is voluntary than in an employer-employee group. As a result, insurance companies often impose more stringent underwriting requirements on association groups than on employer-employee groups. An insurer might be willing to issue an employer-employee group insurance policy to a group with as few as 10 members, but it might refuse to issue an association group insurance policy covering fewer than 50 association members.

Size of the Group

The size of the group has a strong impact on the underwriter's ability to estimate the group's probable loss rate. In general, the larger the group, the more likely that the group will experience a loss rate that approximates the estimated loss rate.

Figure 13.2. Types of Association Groups

Trade association. An association of firms that operate in a specific industry.

Professional association. An association of individuals who share a common occupation, such as an association of medical doctors, attorneys, or engineers.

Public employee association. An association of individuals employed by a governmental entity.

Common interest association. An association of individuals who share a common bond, background, or interest. Examples include associations of retired persons, participants in a specific sport, or alumni of a specific college. Sometimes referred to as an *affinity group*.

The underwriting process varies depending on the size of the group. For very small groups, such as groups with fewer than 15 members, group underwriting guidelines may require each individual member of the group to submit evidence of insurability.[2] When calculating the anticipated loss rate of a slightly larger group, such as a group with between 15 and 50 members, the underwriter often pools several groups that are of the same approximate size and are in the same business sector. In this case, the underwriter is expecting the experience of those small groups taken as a whole to approximate the experience of a single large group.

Most insurers establish minimum size requirements for groups they are willing to insure. Minimum group sizes typically range from 3 to 50, depending on the insurer.

Flow of New Members into the Group

Another important group underwriting requirement is that a sufficient number of new members enter the group periodically. Ideally, underwriters seek a steady flow of young, new members to replace those members who leave the group. A steady flow of new members into the group means that both the group's size and its age distribution will remain relatively stable. If a group did not add young, new members for a number of years, then the increasing age of the group's original members would adversely affect the group's age distribution, and the group's loss rate and premium rate would increase as a result. If young, new members are continually joining the group, the age distribution of the group should remain more stable, as should the expected loss rate.

Stability of the Group

Despite the generally favorable results of changes in group membership, the insurance company also must be able to expect that the group will remain a group for a reasonable length of time and that its composition will remain relatively stable. Otherwise, the costs of administering the plan, such as the costs of enrolling new members in the plan, could become prohibitively high.

Example:

A group of seasonal or temporary workers generally would not be considered an insurable group.

Participation Levels

Group insurance underwriting requirements impose limits on the minimum percentage of eligible group members that a group insurance plan must cover. Note that these requirements relate to participation by *eligible group members*. Minimum participation requirements minimize antiselection. Employees who believe themselves to be in good health are less likely than other employees to choose to participate in group insurance plans. Without minimum participation requirements, an insurance company could not rely on the group underwriting process because an unusually large percentage of group members might be individuals who were uninsurable on an individual basis.

Minimum participation requirements vary depending on whether the group insurance plan is a noncontributory plan or a contributory plan:

- Typically, a noncontributory plan requires 100 percent participation of all eligible employees; to do otherwise could be discriminatory.
- Because participation in a contributory plan is voluntary, some employees may decide not to enroll in the plan. Most insurers require that at least 75 percent of all eligible employees participate in a contributory group insurance plan.[3] A higher percentage of employees may participate in the plan, but a participation level of lower than 75 percent would cause the group to lose its eligibility for coverage.

Determination of Benefit Levels

The group policyholder typically works with the insurer to establish a fair and nondiscriminatory method to determine the benefit levels—that is, the types and amounts of coverage offered to the group insureds. Group life insurance policies typically include a schedule, known as a ***benefit schedule***, that defines the amount of life insurance the policy provides for each insured. Including benefit amounts in the master group contract prevents group insureds from selecting their own coverage amounts and, thus, helps prevent antiselection. Otherwise, those group members who are in poor health and unable to secure individual insurance would probably select larger benefit amounts than healthy members would select.

Some group life insurance plans offer the same benefit amount to all group members. A more common method is to vary the benefit amount according to specific objective criteria, such as salary, job classification, or length of employment. For example, a benefit schedule might provide life insurance coverage to all eligible employees in an amount equal to one year's salary. In another benefit schedule, the amount of life insurance coverage might vary depending on whether the employee is a senior executive, a manager, or a nonmanagement employee. Figure 13.3 provides some illustrations of the types of benefit schedules that might be included in group life insurance policies.

Some group life insurance policies allow covered group members to purchase additional coverage—under certain conditions—from a schedule of optional coverages. For example, a covered employee might receive group life insurance coverage in an amount equal to one year's salary and also have the option to purchase additional coverage in the same amount. To avoid antiselection in such situations, the group insurer may (1) limit the optional coverages that the group plan can offer and/or (2) require the insured group member to provide satisfactory evidence of insurability if the optional coverage selected exceeds a certain amount.

If a group life insurance policy provides coverage for dependents, then the policy includes a separate benefit schedule that defines the amount of coverage provided for each covered dependent. Such a benefit schedule may specify a flat amount of coverage for all covered dependents, or the benefit schedule may specify one amount for the group member's spouse and a lower amount of coverage for each covered dependent child. Insurance company requirements and the laws of some jurisdictions require that the amount of coverage provided on the dependents of an insured group member be less than the amount provided for the group member.

Figure 13.3. Examples of Group Life Insurance Policy Benefit Schedules

Benefit Schedule Based on Standard Amount

Salary	Amount of Life Insurance
Any	$50,000 per group insured

Benefit Schedule Based on Annual Salary

Salary	Amount of Life Insurance
Less than $50,000	1 × salary
$50,000 to $100,000	2 × salary
Over $100,000	3 × salary

Benefit Schedule Based on Length of Employment

Length of Employment	Amount of Life Insurance
Less than 5 years	1 × annual salary
5 years to 10 years	2 × annual salary
Over 10 years	3 × annual salary

Benefit Schedule Based on Job Classification

Job Classification	Amount of Life Insurance
Nonmanagement personnel	$30,000
Supervisors	$50,000
Managers	$100,000
Officers	$250,000

Nature of the Business

The type of work that group members perform affects the degree of risk the group presents to an insurer. For example, a group of coal miners has a higher probability of being injured or killed on the job than a group of office workers. To develop appropriate group insurance underwriting guidelines, insurers consider claim experience data concerning the likelihood of people in certain jobs to incur covered losses.

If an insurer determines that, due to the nature of the group members' work, a group can be expected to have a higher-than-average loss rate among its members, the insurer charges the group more than the standard premium. Some insurers increase their standard premium rate by a certain percentage to account for the greater risk that a group in a particular occupation presents. Other insurers charge a flat extra premium for certain types of coverage for groups that work in hazardous occupations, such as logging. If a group's occupation is extremely dangerous, some insurance companies decline the group for coverage.

Example:

Many insurers would decline to issue group disability income coverage to a team of professional hockey players.

Group Insurance Premiums

Insurance companies typically establish group insurance premium rates on a case-by-case basis. The insurer evaluates each group and establishes a premium rate that is adequate to pay the group's claims. The premium rate should also be equitable to the group policyholder—that is, it should fairly reflect the group's risk. To establish premium rates that meet these criteria, the insurer must determine what costs it will incur in (1) providing the benefits promised by the group insurance policy and (2) administering the group insurance plan.

Unlike individual insurance level-premium rates, the premium rate for a group insurance policy usually is recalculated every year that the policy remains in force. The insurer generally guarantees the group's premium rate for only one year. However, some group life insurance policies guarantee rates for a longer period of time, such as two or three years. An insurer that is allowed to change a group's premium rate may do so at the beginning of a policy year or on any premium due date. The insurer may not, however, change the premium rate more than once in any 12-month period.

Insurance companies generally use one of three methods to calculate the premium rate to charge for group coverage:

- ***Manual rating*** is 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. Insurance companies typically use manual rating to set the initial premium rates for groups that have not been previously insured and to set both initial and renewal premium rates for small groups. In both cases, the groups have no reliable claims experience that the insurer can use to set the premium rate. The claims experience of a small group generally is unreliable because the group is not large enough for the insurer to determine whether the group's prior experience is a result of chance or actually reflects the group's average experience.

- ***Experience rating*** is a method of setting group insurance premium rates in which the insurer considers the particular group's prior claims and expense experience. Insurance companies typically use experience rating to set renewal premium rates for large groups. In many cases, insurers also use experience rating to set the initial premium rate for a large group that is currently insured by another insurance company. In such a case, the insurer can obtain information about the group's prior experience.

- ***Blended rating*** is a method of setting group insurance premium rates in which the insurer uses a combination of manual rating and experience rating. Insurers typically use blended rating for groups that are too small for an insurer to rely fully on experience rating, yet large enough for the insurer to consider their claims and expense experience to be significant. The larger the group is, the more the insurer relies on the group's own experience and the less the insurer relies on manual rating.

Setting a group's premium rate is often a complicated process. In addition to determining whether or to what extent a group's own experience can be used, an insurer must consider a number of other factors. For example, the insurer must consider the specific benefits provided by a particular group plan. Also, the amount of administrative expenses an insurer incurs in connection with group insurance coverage varies widely from one group to another and depends on how much of the plan's administration the group policyholder will handle. We discuss group insurance administration later in this chapter.

Premium Amounts

Group insurance premiums typically are payable monthly. The insurer establishes the premium rate for a group insurance policy at the beginning of each policy year. That premium rate usually is calculated on the basis of a stated benefit unit.

Example:

The premium rate for group life insurance usually is stated as a rate per $1,000 of death benefit provided by the policy.

Although the *premium rate* for a group insurance policy generally is guaranteed for one year, the *premium amount* payable each month varies, depending on the amount of insurance in force that month. A group life insurance policy, for example, requires a monthly premium amount that is equal to the premium rate per $1,000 of coverage multiplied by the number of benefit units ($1,000 of coverage) in force that month. If additional employees become eligible for coverage during the policy year, the number of benefit units in force increases, and the premium amount the employer pays to the insurer each month increases. The premium rate per $1,000 of coverage, though, does not change during the year.

Example:

The Polyhedron Company provides $50,000 of noncontributory group life insurance coverage for each of its full-time employees. The current monthly premium rate for this coverage is $0.40 per $1,000 of coverage. In January, Polyhedron had 10 full-time employees. In March, Polyhedron hired 2 new full-time employees, who became eligible for group life insurance coverage in April.

Analysis:

In January, February, and March, Polyhedron provided $50,000 of group life insurance coverage to 10 employees, resulting in a monthly premium of $200 for each of those three months, calculated as

Coverage per employee	×	Number of employees	=	Total group coverage
$50,000	×	10	=	$500,000

Example (*continued*):

Monthly premium rate (per $1,000 of coverage)	×	Number of coverage units ($500,000 ÷ $1,000)	=	Monthly premium amount
$0.40	×	500	=	$200

In April, Polyhedron provided $50,000 of group life insurance coverage to 12 employees, resulting in a monthly premium of $240 for April, calculated as

Coverage per employee	×	Number of employees	=	Total group coverage
$50,000	×	12	=	$600,000

Monthly premium rate (per $1,000 of coverage)	×	Number of coverage units ($600,000 ÷ $1,000)	=	Monthly premium amount
$0.40	×	600	=	$240

Premium Refunds

Depending on the size of the group and the insurance arrangement, at the end of each policy year, a portion of the group insurance premiums paid during the year may be refunded to the group policyholder. Group insurance premium refunds are similar to the policy dividends paid on individual participating life insurance policies. These refunds are usually called *dividends* by those companies that also issue individual participating policies. Companies that do not issue participating policies generally call premium refunds for group insurance *experience refunds*.

The insurer determines the amount of a premium refund by evaluating the group's claims experience and expense experience during the policy year. If the group incurred fewer claims or if the insurer incurred lower administrative expenses than anticipated when the prior year's premium rate was established, then the insurer may refund a portion of the premium paid for the coverage.

All premium refunds are payable to the group policyholder, even if the plan is contributory. If the amount of the refund to the policyholder of a contributory plan is greater than the portion of the group premium that was paid out of the policyholder's funds, then the excess amount must be used for the benefit of the individual participants in the plan.

Example:

The Marzipan Company has a contributory group life insurance plan for its employees. Last year, the premiums that Marzipan paid were higher than the claims and expenses incurred by the plan. Therefore, Marzipan received a premium refund for last year's coverage under the plan.

Analysis:

Marzipan must use this excess refund to benefit the employees who participate in the group life insurance plan. For example, Marzipan could use the excess refund to pay a portion of the employees' contributions for this year, or it could use the excess refund to pay for additional benefits for its covered employees.

Group Plan Administration

In general, the expenses an insurer incurs in administering a group insurance policy are lower than those it would incur in administering a number of individual insurance policies. For example,

- The underwriting costs are generally lower for group insurance because the insurer usually underwrites the group as a whole rather than each individual member.
- Policy issue costs are lower because the insurer issues a master policy rather than many individual policies.
- Commissions are much lower for one group policy than for a number of individual policies.

Group policyholders can reduce an insurer's administrative expenses further—and reduce their premium rates as a result—by performing much of the necessary administrative work themselves. The administration of a group insurance policy is primarily a matter of recordkeeping. For example, some of the necessary records for a group life insurance plan include the name and address of each group insured, the amount of coverage for each group insured, and the name of each beneficiary. Many group policyholders maintain these records and provide all the needed reports to the insurer. A ***self-administered group plan*** is a group insurance plan in which the group policyholder is responsible for handling the administrative and recordkeeping aspects of the plan. Alternatively, an ***insurer-administered group plan*** is a group insurance plan in which the insurer is responsible for handling the administrative and recordkeeping aspects of the plan.

Key Terms

group insurance
master group insurance contract
group insured
noncontributory plan
contributory plan
certificate of insurance
certificate holder
actively-at-work provision
probationary period
eligibility period
open enrollment period
benefit schedule
manual rating
experience rating
blended rating
self-administered group plan
insurer-administered group plan

Endnotes

1. The same rules and restrictions that apply to individual life insurance beneficiary designations also apply to group life insurance beneficiary designations. In addition, a group insured may not name the group policyholder as beneficiary unless the group insurance plan is a group creditor life plan, which we discuss later.
2. Group life insurance underwriting requirements may vary according to the amount of coverage on an individual. For example, some insurers may require evidence of insurability from group insureds with coverage in excess of a certain amount. In addition, in the United States, various state and federal laws limit the ability of insurers to require evidence of insurability for health insurance under certain circumstances.
3. In determining minimum participation percentages, insurers typically do not consider employees who decline coverage because they have other coverage available to them, such as through another employer or a spouse's employer.

Chapter 14

Group Life Insurance and Group Retirement Plans

Objectives

After studying this chapter, you should be able to

14A Identify and describe typical provisions contained in a group life insurance policy and compare these provisions with similar provisions contained in individual life insurance policies

14B Describe the features of group term life insurance plans, group accidental death and dismemberment plans, group cash value insurance plans, and group creditor life insurance plans

14C Explain the tax benefits generally provided to qualified retirement plans in the United States

14D Identify the components of a qualified retirement plan and describe the types of provisions that a plan document contains

14E Identify and describe four common types of qualified retirement plans and four types of tax-advantaged retirement plans in the United States

14F Describe examples of government-sponsored retirement plans in the United States and Canada

Outline

Group Life Insurance
- Group Life Insurance Policy Provisions
- Group Life Insurance Plans

Group Retirement Plans
- Components of a Retirement Plan
- Types of Qualified Retirement Plans
- Other Types of Retirement Plans
- Government-Sponsored Retirement Plans

Now that you are familiar with the basic principles of group insurance, we turn to a more specific discussion of group life insurance and group retirement plans.

Group Life Insurance

We begin our discussion of group life insurance by describing some of the provisions that group life insurance policies typically include. Then we describe various types of group life insurance policies.

Group Life Insurance Policy Provisions

Group life insurance policies usually include a number of standard provisions, many of which are similar to provisions found in individual life insurance policies. In Chapter 13, we described typical provisions relating to eligibility for group insurance coverage. In this chapter, we describe some other provisions typically found in group life insurance policies.

Grace Period Provision

Group life insurance policies typically contain a 30- or 31-day grace period provision. As in the case of an individual life insurance policy, the insurance coverage provided by a group life insurance policy remains in force during the grace period. If the group policyholder does not pay the premium by the end of this period, the group policy terminates. Unlike the grace period provision in an individual life insurance policy, the grace period provision in a group life insurance policy specifies that if the policy terminates for nonpayment of premiums, then the group policyholder is legally obligated to pay the premium for the coverage provided during the grace period.

Example:

The Moonbeam Corporation provides a group life insurance plan for its eligible employees. The plan specifies a 31-day grace period. Moonbeam failed to pay the premium that was due on January 1. On February 1, Moonbeam had still made no premium payments.

Analysis:

Although Moonbeam's group life insurance plan terminated for nonpayment of premium on February 1, Moonbeam is obligated to pay the insurer the premium for the coverage in January.

Incontestability Provision

Group life insurance policies include an incontestability provision, which limits the period during which the insurance company may use statements in the group insurance application to contest the validity of the master group insurance contract. Generally, the incontestability provision in a group life insurance policy limits the period during which the insurer may contest the contract to two years from the date of issue. Material misrepresentation occurs much less frequently in group life insurance applications than in individual life insurance applications. As a result, insurance companies rarely contest the validity of group life insurance contracts.

Individuals insured under a group life insurance policy usually are not required to provide evidence of insurability to be eligible for group coverage. Sometimes, however, group insureds are required to provide such evidence. If a group insured makes material misrepresentations about his insurability in a written application, then the insurance company can contest the individual group member's coverage on the grounds of material misrepresentation without contesting the validity of the master group contract itself. The incontestability provision of a group life insurance policy typically states that the insurer cannot contest the insurance coverage of any group insured after the coverage has been in effect during the lifetime of the insured for a period of one or two years from the date on which the group insured's coverage became effective.

Example:

Jocelyn Picard was required to fill out a medical questionnaire to be eligible for group life insurance coverage. In completing the questionnaire, Jocelyn made material misrepresentations about her health. Jocelyn died six months after her coverage became effective. While investigating the claim, the insurance company discovered Jocelyn's material misrepresentations. The group policy contained a two-year contestable period.

Analysis:

Jocelyn died while her group insurance coverage was contestable. Therefore, the insurer had the right to contest the validity of Jocelyn's coverage on the basis of the material misrepresentations in her medical questionnaire. Jocelyn's material misrepresentations did not affect the validity of the master group contract.

Beneficiary Designation

Under the terms of a group life insurance policy—*unless* it is a group creditor life policy—each insured group member has the right to name a beneficiary who will receive the insurance benefit that is payable when that group insured dies. (We describe group creditor life policies later in the chapter.) The insured group member also has the right to change the beneficiary designation.

The beneficiary designation rules and restrictions that apply to individual life insurance beneficiary designations also apply to group life insurance beneficiary designations. The only other restriction on the insured group member's right to

name the beneficiary is that he may *not* name the group policyholder as beneficiary *unless* the plan is a group creditor life plan.

We discussed beneficiary designations for dependent coverage in the previous chapter.

Portability Provision

Many group life insurance policies contain a ***portability provision***, which allows a group insured whose coverage terminates for certain reasons to continue her coverage under the group plan. Group insurance coverage that can be continued if an insured employee leaves the group is known as ***portable coverage***. Continued coverage usually is term insurance coverage.

To continue coverage under the portability provision, a group insured generally must complete an application and pay the initial premium within a stated time—usually 31 days or less—after her group coverage terminates. Depending on the amount of coverage requested and the age of the applicant, the insurer may also require the group insured to answer some medical questions or submit evidence of her insurability. The maximum amount of continued coverage available under the portability provision may be less than the amount of coverage the group insured had under the group plan. The premium rate is based on the insured's attained age when the continued coverage begins.

Some group life insurance policies include a ***conversion privilege***, which 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. The group insured usually can purchase any type of individual life insurance policy that the insurer is then issuing, but the amount of coverage the group insured can purchase is limited. The premium rate for converted coverage typically is higher than for an equivalent amount of continued coverage. Some group life insurance policies contain both a portability provision and a conversion privilege, but the eligibility requirements and amounts of coverage available may vary depending on the type of coverage.

Misstatement of Age

The misstatement of age or sex provision included in individual life insurance policies specifies that the insurer will adjust the amount of the death benefit payable to reflect a misstatement of the insured's age or sex. In contrast, the amount of the benefit payable following a group insured's death is specified in the group life insurance policy's benefit schedule. As a result, the misstatement of age provision in most group life insurance policies specifies that, if the amount of the premium required for the coverage is incorrect as the result of a misstatement of a group member's age, then the insurer will retroactively adjust the amount of the premium required for the coverage to reflect the group insured's correct age. Note that the misstatement of age provision comes up most often with *voluntary* group life insurance plans, in which employees are given the option of purchasing life insurance coverage and, if they choose to receive the coverage, they pay 100 percent of the premiums.

Example:

The Einkorn Corporation provides a voluntary group life insurance plan for its eligible employees. One of Einkorn's employees, Patricia McElroy, applied for $100,000 of life insurance coverage under the plan. Patricia was 35 years old, but her age was mistakenly reported to the insurer as 45 years old. The insurer discovered the mistake one year later when it received a claim for the policy proceeds.

Analysis:

In this situation, the insurer will retroactively adjust the amount of the premium for Patricia's coverage. Because Patricia's age was younger than reported to the insurer, the insurer will refund the difference to Patricia's beneficiary.

The amount of the death benefit payable remains unaffected. Because group life insurance premium rates typically do not vary according to the sex of the insured, such policies typically do not include a misstatement of sex provision.

Settlement Options

When a person insured under a group life insurance policy dies, the beneficiary of the group insured's coverage usually receives the death benefit in a lump sum. Sometimes settlement options also are available. If so, the group life insurance policy gives the group insured or the beneficiary the right to choose a settlement option. All of the usual settlement options described in Chapter 9 are generally made available. However, for a group insured or beneficiary to select the life income option, the death benefit payable usually must be at least a stated minimum amount.

Group Life Insurance Plans

The majority of all group life insurance policies are yearly renewable term (YRT) insurance plans. Group accidental death and dismemberment policies are also commonly issued, either as separate plans or in addition to other group life insurance coverage. Some insurers issue cash value life insurance plans, but they are less common than group term life insurance plans.

Group Term Life Insurance

The YRT insurance coverage under group life insurance policies is similar to YRT coverage under individual policies. The insurer does not require the group insureds to submit evidence of insurability each year when the coverage is renewed. Group term life insurance policies do not build cash values, and the insurer typically has the right to change the premium rate each year.

When employers pay the premiums to provide their employees with group term life insurance, the employees receive a financial benefit. The income tax treatment of such group term life insurance coverage varies from jurisdiction to jurisdiction. In some countries, such as the United States and Canada, some or all of the premiums paid by the employer for group term life insurance coverage for employees are considered taxable income to the employee. In other countries, such as the United Kingdom, such premiums are not considered taxable income to the employee.

Accidental Death and Dismemberment Insurance

Accidental death and dismemberment (AD&D) benefits may be included as part of a group life insurance policy, or an insurer may issue them under a separate group insurance policy. The low cost of AD&D benefits makes them an attractive addition to group insurance plans. When the accidental death benefit is added to a group term life insurance plan, the accidental death benefit amount is usually equal to the amount of the death benefit provided under the basic group term insurance plan. For example, a group insured with $50,000 of basic group life insurance coverage would typically have a $50,000 AD&D benefit as well. If the group insured dies as the result of an accident, the beneficiary would be entitled to receive $100,000.

Many AD&D plans provide an additional travel accident benefit that covers only accidental deaths occurring while the employee is traveling for the employer. If the accident occurs while the employee is on vacation, his beneficiary will receive benefits under the AD&D coverage only; if the accident occurs while the employee is on a business trip, his beneficiary will receive benefits under the AD&D coverage plus an additional benefit because he was traveling for the employer.

Example:

Karl Bernhard is covered under the group life insurance plan his employer provides. The group insurance policy provides $100,000 of group term life insurance, $100,000 of group accidental death and dismemberment insurance, and $50,000 of business travel accident insurance.

Analysis:

If Karl dies in an accident while he is traveling on business for his employer, his beneficiary would be entitled to receive $250,000 in benefits, calculated as $100,000 + $100,000 + $50,000. If Karl dies in an accident while he is on a vacation trip, then his beneficiary would be entitled to receive $200,000 in benefits, calculated as $100,000 + $100,000.

Group Cash Value Life Insurance

Employers use group cash value life insurance plans to help employees purchase life insurance coverage that will continue after their retirement, when their group term insurance coverage typically ends. Covered employees usually are required to pay a significant portion of the premium for group cash value life insurance plans. Therefore, participation levels in group cash value life insurance plans generally are much lower than those that insurers require under other contributory group insurance plans.

The specific characteristics of group cash value life insurance coverage vary from plan to plan. Three commonly offered group cash value life insurance plans are level premium whole life plans, group universal life plans, and group variable universal life plans.

Level Premium Whole Life Plans

Some insurance companies make level premium whole life insurance available on a group basis. Level premium coverage usually is written on a limited-payment whole life plan, such as whole life paid-up at age 65. If the employee leaves the group prior to her planned retirement age, her group whole life insurance coverage typically terminates. Whether the employee has a right to the cash value that has built up depends on whether the group insurance plan is contributory or noncontributory:

- If the plan is a contributory plan, the accumulated cash value belongs to the employee, based on the portion of the premium that the employee paid. For example, if the employee paid 25 percent of the premium, then 25 percent of the accumulated cash value would typically belong to the employee.
- If the plan is a noncontributory plan, the accumulated cash value generally belongs to the employer.

Group Universal Life and Group Variable Universal Life Plans

Some insurers offer group universal life (UL) plans or group variable universal life (VUL) plans. In many ways, group UL and VUL plans function more like individual insurance policies than like typical group insurance policies. The employer typically does not pay any portion of the premium. Instead, each employee chooses the amount of the premium she wishes to pay; the amount of the policy's cash value depends on the amount of the premiums paid. As with individual VUL insurance, the participants in a group VUL plan are given a choice of different subaccount options for investing their cash values.

Group UL and group VUL plans offer certain advantages to employees. For example, such coverage generally

- Can be obtained with minimal underwriting
- Is portable
- Is cheaper than would be a comparable individual UL or VUL plan

Group Creditor Life Insurance

Group creditor life insurance is insurance issued to a creditor, such as a bank, to insure the lives of the creditor's current and future debtors. Unlike other group life insurance policies, group creditor life policies designate the group policyholder—the creditor—as the beneficiary who receives the benefit payable when a group insured dies. At any given time, the amount of insurance on each group insured is equal to the amount of the outstanding debt that person owes to the policyholder-creditor. The premium for group creditor life insurance coverage usually is paid by the debtor, although it may be paid entirely by the creditor or by both the creditor and the debtor.

Group Retirement Plans

As we discussed in Chapters 10 and 11, people often purchase individual annuities to provide themselves with an income after they retire. Individual annuities are not the only source of retirement income, however. Often, people receive retirement income from various government programs and from private retirement plans sponsored by employers and unions. Life insurance companies are involved in the funding and administration of many private retirement plans.

In the United States, the term *qualified retirement plan* refers to a retirement plan that receives favorable income tax treatment by meeting the requirements imposed by federal tax laws and the Employee Retirement Income Security Act (ERISA). The ***Employee Retirement Income Security Act (ERISA)*** is 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.

A qualified retirement plan provides tax incentives for plan sponsors to establish such a plan and for plan participants to participate in the plan. A ***plan sponsor*** is a business, government entity, educational institution, nonprofit organization, or other group that establishes a retirement plan for the benefit of its members. A ***plan participant*** is 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.

Qualified retirement plans provide the following tax benefits:

- Within stated limits, the contributions an employer makes to a qualified plan are considered a business expense and are deductible from the employer's current taxable income.
- The contributions an employer makes to a qualified plan on behalf of a plan participant are not considered current taxable income to the participant. Instead, these contributions are made on a *tax-deferred* basis. In other words, a plan participant's payment of income taxes on the employer's contributions is deferred until she withdraws funds from the plan.
- Employee contributions to a qualified plan are typically made on a tax-deferred basis.
- The investment earnings on plan contributions—whether these contributions are made by the employer or the employee—are allowed to accrue on a tax-deferred basis.

Components of a Retirement Plan

A qualified retirement plan generally consists of three components: (1) the plan, which describes how benefits are funded and paid to participants; (2) a method for administering the plan; and (3) the funding vehicle into which the plan assets are invested. Insurance companies engage in activities related to all three of these components—designing and implementing retirement plans, administering retirement plans, and providing retirement plan funding vehicles.

The Plan

The plan sponsor determines the type of plan to establish and the terms of that plan, which are described in a plan document. A ***plan document*** is a detailed legal agreement that establishes the existence of a retirement plan and specifies the rights and obligations of various parties to the plan. Among other matters, the plan document describes the individuals whom the plan covers, the benefits that the plan provides, and the method for funding the plan. Plan participants typically receive a summary plan description that informs them of their rights under the plan.

Coverage, Eligibility, Participation, and Vesting Requirements

The plan document describes which group members the plan covers. Plan documents are typically written to cover all employees, subject to a specific list of exclusions. For example, a plan may cover all employees, except leased employees.

The plan document specifies the requirements group members must meet to be eligible to participate in the plan. The most common eligibility requirement is a service requirement, which states a minimum length of employment a group member must have to be eligible to participate in the plan. Some plans also impose an age requirement, which states the minimum age the group member must be to be eligible to participate.

Example:

The Peaberry Company offers a qualified retirement plan to its employees who are 21 years of age or older and who have at least one year of employment.

Eligibility requirements are limited by law in some jurisdictions. In the United States, for example, a retirement plan is not allowed to set a maximum age for participants.

The plan document also specifies when employee participation in the plan becomes effective. Under an employer-sponsored retirement plan, an employee's participation in the plan typically becomes effective on the first day of the month, quarter, or semiannual period following the person's completion of the plan's eligibility requirements. Participation in an employer-sponsored retirement plan can be automatic or voluntary:

- If participation is *automatic*, all eligible group members are automatically enrolled as plan participants. Typically, noncontributory plans are automatic plans.

- If participation is *voluntary*, eligible group members have a choice between participating or not participating in the plan. Typically, contributory plans are voluntary plans. In recent years, *automatic enrollment* in contributory plans has become increasingly common. With automatic enrollment, eligible employees are enrolled in the plan at a specified salary deferral rate. However, the employee can choose to defer a different percentage or opt out of deferrals altogether.

The plan document also specifies the plan's ***vesting requirements***, which define when a plan participant is entitled to receive partial or full benefits under the plan even if he terminates employment prior to retirement. Vesting requirements differ for contributions made by plan participants and for those made by the employer:

- A plan participant's right to receive benefits funded by his own contributions vests immediately because those contributions belong to the participant.
- Qualified plans must also include minimum vesting standards, which state when a plan participant has the right to receive benefits funded by employer contributions. For example, a participant might become 20 percent vested in benefits funded by employer contributions each year, until 100 percent vesting is reached after the fifth year.

Benefit Formulas

A retirement plan's ***benefit formula*** describes the calculation of the plan sponsor's financial obligations to plan participants. Two types of benefit formulas are common:

- A ***defined benefit formula*** specifies the amount of the retirement benefit a plan sponsor agrees to provide to each plan participant. A retirement plan structured according to a defined benefit formula is referred to as a ***defined benefit plan***.
- A ***defined contribution formula*** specifies the contributions that the plan sponsor agrees to make to the plan. The benefit that a participant will receive is not determined in advance of the participant's retirement but depends on the investment performance of the funds in the plan. A retirement plan structured according to a defined contribution formula is referred to as a ***defined contribution plan***.

In recent years, defined contribution plans have become increasingly popular among plan sponsors establishing retirement plans. The reason for this rise in popularity is that when an employer establishes a defined contribution plan, it knows in advance what it will cost to fund the plan each year. In contrast, an employer that establishes a defined benefit plan must rely on actuarial estimates of what it will cost each year to fund the plan. The employer also has no guarantee that its costs will remain at or below the estimated amount.

Figure 14.1 illustrates the differences between defined benefit plans and defined contribution plans.

Plan Administration

The plan sponsor usually names a ***plan administrator***, who is the party responsible for handling the administrative aspects of a retirement plan. The plan administrator oversees the plan's operation and ensures that the plan is administered in accordance with the plan document. The administrator may be the sponsoring employer or it may be a board or committee that the employer establishes. The plan administrator also may need to obtain the services of other professionals, such as accountants, actuaries, and attorneys.

Figure 14.1. Comparison of Defined Benefit Plans and Defined Contribution Plans

Plan	Amount of Sponsor's Contributions	Amount of Participant's Retirement Benefits
For a Typical Defined Benefit Plan	• Uncertain, not specified • Can only be estimated	• Specified • Reasonably certain
For a Typical Defined Contribution Plan	• Specified • Reasonably certain	• Uncertain, not specified • Can only be estimated

Life insurers often provide administrative services for retirement plans. In some cases, a life insurer provides only administrative services to a plan. In others, the insurer provides administrative services and a funding vehicle for the plan.

Funding Vehicles

The sponsor of a retirement plan must choose a funding vehicle for the plan. A ***funding vehicle***, also known as an *investment vehicle* or a *funding instrument*, is an arrangement for investing a retirement plan's assets as the assets are accumulated. Life insurers offer a variety of products that are designed to serve as retirement plan funding vehicles, including group annuities.

Types of Qualified Retirement Plans

In the United States, four general types of qualified employer-sponsored retirement plans are (1) pension plans, (2) 401(k) plans, (3) profit sharing plans, and (4) employee stock ownership plans (ESOPs). Most pension plans are defined benefit plans, but 401(k) plans, profit sharing plans, and ESOPs are all defined contribution plans.

Pension Plans

The most common type of defined benefit plan is the ***defined benefit pension plan***, which is a type of qualified retirement plan that provides plan participants with a lifetime monthly income benefit—known as a ***pension***—at retirement.

The employer usually makes all plan contributions, and those contributions are mandatory. To adequately fund the plan, the employer must know how much money it needs to contribute each year to pay the promised benefits. Actuaries typically make the required calculations using actuarial methods and assumptions about the expected investment returns and the make-up of the employee group that will be entitled to benefits.

401(k) Plans

In the United States, the 401(k) plan has become the most popular type of retirement plan. A ***401(k) plan*** is 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. Therefore, when an employee contributes to a 401(k) plan, the amount of his contribution is typically not included in his current taxable income.

Example:

The Stardust Corporation provides a 401(k) plan for its employees. Jonathan Rydal, a Stardust employee, earned $70,000 last year and contributed $7,000 of that amount to his 401(k) account.

Analysis:

Jonathan's taxable income for last year was $63,000, found as $70,000 – $7,000. When Jonathan retires and begins to take distributions from his 401(k) account, he will then pay taxes on the money he contributed to the plan over the years.

To participate in a 401(k) plan, an employee must enter into a salary reduction arrangement that permits the employer to deduct the amount of the employee's plan contributions from her salary. In addition, the amount that can be contributed to a participant's account each year is limited by law.

In recent years, some 401(k) plans have added a *Roth contribution feature*, which operates in a similar manner to a Roth IRA. A participant is allowed to make after-tax contributions to her 401(k) account in place of all or part of the pretax contributions she is eligible to make to her 401(k) account.

Profit Sharing Plans

A ***profit sharing plan*** is a type of qualified retirement plan that allows the plan sponsor to make discretionary contributions funded primarily from its profits. Because a company's profits vary from year to year, the amount of the contribution the employer makes to the plan will also vary from year to year. If conditions warrant, the employer may not make any contribution in some years. Although a profit sharing plan accumulates retirement assets on behalf of plan participants, the plan does not agree to provide a pension for each participant. Rather, the amount available to each participant at retirement is determined by the investment performance of the funds. Although most profit sharing plans are noncontributory plans, some plans in the United States allow employee contributions.

Note that very few stand-alone profit sharing plans exist in the United States these days. The vast majority of 401(k) plans allow for profit sharing contributions, thus eliminating the need to establish a separate profit sharing plan.

Employee Stock Ownership Plans

An ***employee stock ownership plan (ESOP)*** is a type of qualified retirement plan in which employer contributions are invested primarily in the employer's stock. For employees, the main advantage of an ESOP is that, should the stock increase in value, they can sell it for a profit. The gains on such sales are also generally subject to favorable tax treatment.

Other Types of Retirement Plans

In the United States, employers don't necessarily have to establish a qualified retirement plan for their employees. Other types of tax-advantaged retirement plans are available, such as simplified employee pensions (SEPs), savings incentive match plans for employees (SIMPLE) IRAs, 403(b) plans, and 457(b) plans:

- ***Simplified employee pensions (SEPs)*** are written arrangements that allow plan sponsors to make deductible contributions to a traditional IRA—referred to as a *SEP IRA*—set up for each plan participant. Only the plan sponsor is allowed to contribute to a SEP.

- ***Savings incentive match plans for employees (SIMPLE) IRAs*** are tax-advantaged retirement plans for small businesses with 100 or fewer employees. SIMPLE IRAs offer retirement benefits through employee salary reductions and employer contributions. Like SEPs, SIMPLE IRAs use IRAs to fund the benefits for plan participants.

- ***403(b) plans*** are tax-advantaged retirement plans available only to tax-exempt organizations established for religious, charitable, and educational purposes and public schools. 403(b) plans operate in some ways like 401(k) plans.

- ***457(b) plans*** are deferred compensation plans established by a state or local government or a tax-exempt organization. Like 403(b) plans, 457(b) plans operate in some ways like 401(k) plans.

Government-Sponsored Retirement Plans

The governments of many countries have established plans that provide periodic retirement income benefits to qualified residents. For most people in the United States, government retirement income benefits are provided through Social Security. ***Social Security*** is a U.S. federal insurance program that provides specified benefits, including monthly retirement income benefits, to eligible individuals. The program also provides benefits to qualified disabled individuals, as well as to the surviving spouses and dependent children of qualified deceased workers. Nearly all people employed in the United States, including those employed by the armed forces, are covered under Social Security. Benefits are funded by mandatory contributions from covered workers and their employers.

Social Security provides a monthly income benefit to people who have contributed to the program during their income-earning years. These retirement benefits are available to covered individuals who are age 62 and older, although people who claim their retirement benefits prior to a specified retirement age—known as their *full retirement age*—receive a lower benefit amount than they would if they claim benefits at or after the specified retirement age. The federal government administers the Social Security program and makes frequent changes in the program's funding and benefits.

Many other countries have government-sponsored retirement plans; however, the exact provisions vary widely from country to country. Figure 14.2 describes government-sponsored retirement plans in Canada.

Figure 14.2. Government-Sponsored Retirement Plans in Canada

In Canada, three separate government plans provide pensions to retirees: (1) the Old Age Security Act, which is in effect throughout Canada; (2) the Canada Pension Plan, which operates in all Canadian provinces except Quebec; and (3) the Quebec Pension Plan.

Old Age Security Act

The federal *Old Age Security (OAS) Act* is a universal public pension plan that provides a pension to virtually all Canadian residents who are age 65 or older, regardless of a person's preretirement wages, current employment, or marital status. Each person who has reached age 65 and has met certain residency requirements receives the same pension amount. However, individuals whose incomes exceed certain amounts must repay part or all of the pension amount received. The overpayment amount is typically deducted from future pension payments. The money to fund these pensions is taken from federal government general tax revenues.

Canada Pension Plan and Quebec Pension Plan

The *Canada Pension Plan (CPP)* is a federal program that provides a pension for wage earners who have contributed to the plan during their working years. The CPP covers workers in all provinces except Quebec, which has elected to establish its own plan. The *Quebec Pension Plan (QPP)* functions in the same manner as the CPP, except that the QPP applies only to wage earners in Quebec.

Participation in the Canada Pension Plan and the Quebec Pension Plan is mandatory for employees covered by the plans, and virtually all employees and self-employed persons in Canada or Quebec, as applicable, are covered. Benefits are funded through compulsory contributions from employees, their employers, and self-employed persons. The amount of the monthly benefit paid following retirement is related to the amount contributed to the plan on behalf of the person. The amount is also limited to a legislatively established maximum amount. Benefit amounts are adjusted annually to reflect any cost-of-living increases.

Key Terms

portability provision
portable coverage
conversion privilege
group creditor life insurance
Employee Retirement Income Security Act (ERISA)
plan sponsor
plan participant
plan document
vesting requirements
benefit formula
defined benefit formula
defined benefit plan
defined contribution formula
defined contribution plan
plan administrator
funding vehicle
defined benefit pension plan
pension
401(k) plan
profit sharing plan
employee stock ownership plan (ESOP)
simplified employee pension (SEP)
savings incentive match plan for employees (SIMPLE) IRA
403(b) plan
457(b) plan
Social Security

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.**

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