

Life Insurance In Depth - Supplementary Reading

While the topics in this section are not specifically listed on the exam content outline, this information will help you enhance your knowledge and understanding of the subject matter, and to better prepare for the exam. The information is also presented in a less formal manner to help you understand and remember it.

A. Life Insurance Contracts

There are several details that you will have to pay attention to in your career as an insurance agent. However, the first major duty you have as a producer is completing applications with clients and delivering the policies that result.

Let's take an in-depth look at some of the basics about the world of insurance. You probably know most of this already, based on your interest in entering this profession. This information will just ensure that everyone starts from the same baseline of knowledge.

Insurance is a form of protection against losses people know or predict they are going to experience. To do this, insurance creates a situation in which several people are paying into a pool that only a fraction of people will draw from. For example, everyone knows that there is a possibility that they will get sick and have medical bills, so most people will pay premiums on health insurance. However, only a few of those people paying for health insurance will actually have a loss that they need insurance to pay for, so the loss actually gets spread out over several people. If only a fraction of people actually get sick, then why does it make sense for so many people to have insurance? Because no one knows for sure if they're going to get sick or not. If a person doesn't have insurance, but gets sick, he has no financial aid beyond his own resources.

Of course, with life insurance, everyone knows they're going to die, so the goal is different. In this case, life insurance helps create an immediate estate for the policyholder's survivors. When an insured purchases a life insurance policy, he will have an estate of at least the amount of the policy from the moment the first premium is paid. Estate creation can be important in several different scenarios. It can help young families who haven't had time to accumulate assets. It can also be used to cover the life of a primary wage earner whose death would severely affect the lives of his or her family. In general, life insurance will create a financial security blanket for a policyholder's survivors.

Obviously, insurance is important. So, how does an agent go about helping someone GET insurance?

The first step is to work on completing the application. This goes beyond making sure someone's name is spelled right. The agent is responsible for making sure

not only that the application is completely and correctly filled out, but also that the content of the application is true to the best of the applicant's knowledge. This means agents must not take what is presented in the application at face value, especially if they suspect the applicant is lying or has concealed something. Now, this doesn't mean that every mistake is an intentional lie. Some mistakes could come from an applicant's confusion over a question. However, it is still the agent's responsibility to help the applicant through the process, and explain everything. And if the agent feels that there could be something wrong with an application, it is the agent's responsibility to tell the insurance company.

The application isn't just used so the insurance company knows an applicant's name and address. The application is instrumental in the underwriting process. This is where the agent, and by extension, the insurance company, work to classify applicants by analyzing the information they gave on their applications. Because of the agent's role in this process, he is often referred to as a field underwriter.

So let's take a closer look at the application. This is where the whole insurance process begins. Applications differ from company to company, but they all have three basic sections: Part 1 – General information, Part 2 – Medical information, and the agent's report.

Part 1 – General information is pretty self-explanatory. It covers the applicant's name, age, address, gender, income, marital status, and occupation. This is usually the section where the applicant identifies what type of insurance coverage he is applying for. It will also include information about any insurance policies the applicant currently has.

Part 2 – Medical Information is also just like it sounds. It NOT ONLY covers the applicant's health, including the medical background, present health, and any medical visits the applicant has had in recent years, BUT ALSO covers the health of the applicant's relatives, including the cause of death of deceased relatives and the current health status of any living relatives. Depending on the amount of insurance, the applicant may be required to undergo a medical examination before getting coverage.

The final part of the application is the agent's report. This is where the agent shares his or her personal analysis of the applicant. The agent is one of the most important sources of information for the underwriter, so it's important for the agent to be upfront and complete in the information he puts in his report. This section will also address whether the policy being sought will replace another policy.

The application must be signed by both the agent and the proposed insured, who is usually the applicant.

What happens if the application is completed and signed, but the insurer realizes that the applicant made a mistake on the application? Can the insurer correct it and submit it anyway? No, he can't. If ANYTHING needs to be changed on an application, there are two different ways to address the issue, depending on company policy. In some cases, the agent can correct the information and have

the applicant initial the change. In other cases, an agent and applicant will have to complete a new application.

One of an agent's duties, as we learned earlier, is making sure applications are filled out completely. If an insurer receives an incomplete application, the company will return the application for completion. **HOWEVER**, if the insurer issues a policy based on an incomplete application, it will be assumed that the company has waived its right to have answer to that question.

Let's look at an example. While rushing through an application for life insurance, Brenda accidentally "glosses over" the medical history section of the application. This means that the insurance company doesn't know about her family's history of heart disease and Brenda's own high blood pressure. The company overlooks the missing medical history section, and issues Brenda a policy with a very good premium and excellent death benefits. A year later, Brenda dies after suffering a heart attack. Though the company might have denied Brenda's application had they known about her medical history, they must pay the death benefits because they DID issue the policy, even without that information.

With all the information required on an insurance application, it CAN be hard for applicants to keep everything straight. That's where the concepts of warranties and representations come in handy. In casual conversation, these may seem to be similar. But when speaking in terms of insurance, they are very different.

Both are statements made by applicants.

HOWEVER, warranties are ABSOLUTELY TRUE statements, and the validity of the insurance policy depends on them. In fact, if a warranty is breached, it can result in a policy being voided as well as the return of premium. Because of the stringent nature of a warranty, statements made by life and health insurance applicants are not usually considered warranties.

On the other hand, representations are statements that are merely BELIEVED TO BE TRUE to the best of the applicant's knowledge. There is NOT GUARANTEE as to the truthfulness of a representation. In insurance, representations are the answers an applicant gives to the questions on an application.

This doesn't mean that an applicant couldn't lie about a representation. If an insured INTENTIONALLY answers a question dishonestly, this would be considered a MISrepresentation and could void the contract. If it is also material to the risk and was an attempt to defraud the insurance company, this would be considered fraud.

Let's look at an example. While filling out the medical history portion of his insurance application, Bill writes that no one in his family has any history of heart disease. He turns in the application and is accepted as a standard risk. A month later, Bill finds out that he was adopted, and that his biological mother died of cardiac arrest. In theory, the insurance would remain in place: At the point Bill completed the application, he didn't know that his biological family's history included heart disease, and therefore, his answer, which is taken as a representation, would stand. Remember, representations just have to be true to the best of the applicant's knowledge.

Now that we have our application, how does the applicant actually start being covered? Many agents will make it routine to collect the first premium, the initial premium, at the same time they get the application and submit both to the insurer. This ensures that coverage for the applicant will begin as soon as possible and increases the chances that the applicant will accept the policy as soon as it is issued.

Regardless of when the premium is collected, the agent should issue a premium receipt.

The type of receipt will determine when coverage will start.

A conditional receipt is most common. It makes coverage effective either on the date of the application or the date of the medical exam. This doesn't apply, of course, if coverage is declined or issued with exclusions for specific coverage.

Let's look at an example. An agent collects the initial premium from an applicant and gives the applicant a conditional receipt. The underwriting process starts as usual, but during the process, the applicant dies. Rather than just stop the underwriting process, because the premium was paid and the applicant got a conditional receipt, underwriting will continue as if the applicant were still alive.

If the applicant's coverage is approved, the applicant's beneficiary will receive the death benefit provided by the policy. It will be no different than if the applicant had had the policy in force for years.

The conditional receipt is basically saying you are covered as long as everything checks out. That agreement can't be negated, even by the applicant's death.

What is the policy being applied for is new, but will be used in place of a current policy? Then it's called a replacement policy.

A transaction in a replacement policy will usually happen if an existing life insurance policy or annuities policy has been or will be

- Lapsed, forfeited, or otherwise terminated.
- Reissued with a reduction in cash value.
- Converted to reduced paid-up insurance, continued as extended term insurance or otherwise reduced.
- Amended in such a way that there is a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid.
- Pledged as collateral or subjected to borrowing. OR
- Used in a financed purchase.

In terms of replacement, a Replacing insurer is the company that issues the new policy, and an existing insurer is the company whose policy is being replaced.

Producers responsible for the application for a policy that will replace another policy must submit certain statement to the insurance company with each application. One statement, that must be signed by the applicant, must merely state whether the transaction involves the replacement of an existing life insurance or annuity contract. The other statement is signed by the producer, and

must state whether the producer knows replacement is or may be involved in the transaction.

The producer must also present to the applicant a Notice Regarding Replacement that is signed by both the applicant and the producer. A copy must be left with the applicant. He must also obtain a list of all existing policies to be replaced and the names of the companies being replaced and submit to the replacing insurance company, with the application, a copy of the replacement notice.

- Leave the applicant with the original or a copy of written or printed communications used for presentation to the applicant.
- Submit to the replacing insurance company, with the application, a copy of the replacement notice.

Duties of the replacing insurance company:

- Require from the producer a list of the applicant's life insurance or annuity contracts to be replaced and a copy of the replacement notice provided to the applicant.
- Send each existing insurance company a written communication advising of the proposed replacement within a specified period of time of the date that the application is received in the replacing insurance company's home or regional office. A policy summary or ledger statement containing policy data on the proposed life insurance or annuity must be included.

Let's take a close look at the underwriting process and then review how insurance policies can be delivered.

The insurance application isn't just used so the insurance company knows an applicant's name and address. The application is instrumental in the underwriting process. This is where the agent, and by extension, the insurance company, work to classify applicants by analyzing the information they gave on their applications. Because of the agent's role in this process, he is often referred to as a field underwriter.

This doesn't mean the agent is the end of the road in the insurance approval process. Once complete, the application is sent to the insurance company's office, where it undergoes a process called underwriting. Underwriting is, in general, a risk selection process.

Of course, the underwriters don't have a crystal ball they consult to see who will be the best applicants to accept. If they did, underwriters would almost always choose to cover healthy people who are expected to live a long time. That's because these people would have few bills that needed covering and would live long enough to pay enough premiums to more than cover the cost of doing business.

No, instead, the underwriters crunch numbers. This is the part of the process where the information an applicant has given is analyzed and the company's exposure to risk is calculated. The underwriter is responsible for selecting only risks that are considered insurable and that meet the insurer's underwriting standards. They are also the insurance company's last line of defense against adverse selection, or risks that are more likely to suffer a loss than other risks.

Underwriters have 2 choices: to deny insurance to an applicant, or to accept that risk. Once the risk is accepted, underwriters will use one of three ways to classify the risk represented by an applicant. These classifications are Standard, Substandard, or Preferred.

Standard risks are people who are entitled to insurance protection without extra rating or special restrictions. Standard risks are representative of the majority of people in their age and with similar lifestyles. They are the average risk.

Substandard, or High Exposure, Risk applicants are not acceptable at standard rates because of physical condition, personal or family history of disease, occupation, or dangerous habits. These policies are also referred to as "rated" because they could be issued with the premium rated-up, resulting in a higher premium.

Preferred Risks are people who meet certain requirements and qualify for lower premiums than the standard risk. These applicants have a superior physical condition, lifestyle, and habits.

An underwriter won't just use a person's age or income to make this decision. This process includes a look at the person's health (current and past), occupation, lifestyle and hobbies or habits.

Let's look at an example. Twins Bob and Bill want to apply for life insurance. They both are married, teach high school, live in the suburbs, and are social drinkers. They seem like a couple of average guys. However, they differ wildly when it comes to hobbies. Bob enjoys competing in chess tournaments, while Bill windsurfs. In the insurance company's eyes, Bill presents a bigger risk, because he is more likely to be injured or killed doing his hobby than Bob in doing his. If both brothers are accepted for coverage, Bill may end up paying a higher premium because he represents a bigger risk to the insurance company.

There are other criteria used in underwriting. The information doesn't come SOLELY from the applicants. Information also comes from Medical Information and Consumer Reports.

If an applicant is asking for higher amounts of coverage, or if the application process brings up questions about an applicant's health, an underwriter may ask for a medical exam.

An underwriter may also request a report from the Medical Information Bureau, or MIB. The Medical Information Bureau is owned by hundreds of insurance companies who are also its members. It's a nonprofit organization that stockpiles and distributes adverse medical information from insurance companies. In short, it is a one-stop resource for insurance companies seeking confidential medical impairment information on individuals. It provides a way for companies to compare information on applicants with information other companies may have. This is not meant to replace an agent's care in the application process, nor is it meant to "trap" an applicant who may have accidentally misrepresented something on the application. This is meant to be used SOLELY to help insurers know what they might need to investigate further. Because of this, an applicant

can't be refused coverage simply because of something discovered through the Medical Information Bureau.

An underwriter may use this information as a reason to order an inspection report on the applicant from an independent investigating firm or credit agency. Companies that use inspection reports are subject to the rules and regulations outlined in the Fair Credit Reporting Act. The Fair Credit Reporting Act is enforced by the federal trade commission, and establishes procedures that consumer-reporting agencies must follow to ensure that records are confidential, accurate, and relevant. They must also ensure that records are properly used. If a reporting agency or a person who uses the information provided by the agency doesn't comply with the regulations of the Fair Credit Reporting Act, they are subject to civil action. Consumers can collect for damages between \$100 and \$1,000 if the reports are used improperly.

Additional records that can be requested generally fall into two categories: Consumer Reports and Investigative Consumer Reports. These can be used only by someone with a legitimate business purpose.

Consumer Reports include information about a consumer's credit, character, reputation, or habits collected from employment records, credit reports, and other public sources.

Investigative Consumer Reports also provide information on the consumer's character, reputation, and habits. However, this type of information is obtained through an investigation and interviews with associates, friends and neighbors of the consumer. For these reports, the consumer is advised about the report within 3 days of the date the report was requested.

Under the Fair Credit Reporting Act, if an insurance policy is declined or modified because of information in a consumer or investigative report, the consumer must be advised and provided with the name and address of the reporting agency. The consumer has the right to know what was in the report. The consumer also has a right to know the identity of anyone who has received a copy of the report during the past year.

In addition to all the information being gathered, it is also important to realize that every life insurance policy issued hinges on the concept of insurable interest. This is the idea that the policyowner is seeking insurance to cover something or someone that, if lost, would take a toll on the policyowner. This toll can be financial or some other kind of loss. This means that policyowners may insure their own lives, the lives of family members, or the lives of business partners, key employees, or people who has a financial obligation to them.

Let's look at a hypothetical couple, Richard and Diane. Diane is a businesswoman responsible for 90 percent of the household income. Richard is an artist and stay-at-home dad who cares for the couple's children. When it comes time to get life insurance, it's easy to see why Richard could get insurance on Diane: Without her income, the family breaks down. It literally cannot exist without Diane. However, Diane can just as easily make a case for getting insurance on Richard. Though he does NOT bring in as much money as Diane, his contributions come in the form of

caring for the family. This, of course, does not touch on the issue of the love that exists between the two.

What if the person seeking insurance does NOT love the person for whom he's seeking insurance? This is common when it comes to business. Let's say Amber and Hayden are starting a design business together. Hayden is the designer, while Amber does the bookkeeping. They hold life insurance policies on each other because the business would fall apart if either one of them died.

Insurable interest must exist at the time the application for life insurance is made. This does not mean that it must continue to exist throughout the life of the person covered by the policy. Once a life insurance policy is issued, even if the situation that created insurable interest has disappeared, the insurer must pay the policy benefit upon the death of the insured person.

Let's revisit the situation with Amber and Hayden, the people who started the design business. Let's say that 3 years after they start the business, they dissolve it and go their separate ways. Their professional lives are no longer entangled. However, if either one dies, the insurance policy taken out when they formed a partnership will still be in effect and pay out.

So, now that the application has been written, and it's gone through the underwriting process, the company issues a policy. What's the next step? The agent must now deliver the policy to the insured. This doesn't mean literally placing it in the insured's hands, although personal delivery is best. Mailing a policy is also legal.

If the agent personally delivers the policy, it gives him one last chance to make sure that the insured understands the contract. A review should involve pointing out any areas, provisions or riders that may be different than anticipated. The agent should also explain the rating procedure to the client and any other choices available to the policyowner at this time, including the free look provision. The free-look provision goes into effect at this time.

1. Life Insurance Contracts - Frequently Asked Questions

Take another look at the topics discussed in this section. The information will be presented in a less formal structure, which may help you learn and retain the information. It may help to imagine this as a question-and-answer period between a student and a teacher.

Q: *Can you explain the differences between the various parties to an insurance policy?*

A: There are 4 roles to be filled on every insurance policy.

1. Applicant — the person who applies for the insurance
2. Insured — the person or persons whose lives are protected by the policy
3. Owner — the person who pays the premiums and holds the ownership rights under the policy.
4. Beneficiary — the person(s) who will receive the death benefit after the death of the insured.

It is possible that there might be four different persons who fulfill each of these roles. An example would be when a grandparent pays the premium on a policy insuring a grandchild, where the parents are the beneficiaries. However, in many cases, the applicant is also the insured and the owner.

Q: *In all of the study material, it seems the application is a big deal. Why is that?*

A: The application IS important. Remember that a contract is not enforceable unless all of the required elements have been met, consideration, legal purpose, offer/acceptance, and competent parties. The application and the initial premium make up the applicant's consideration. The application is the offer that the applicant gives to the insurance company to entice the company to accept the risk and issue the policy. The application actually ends up being attached to the policy if it is issued. That makes it extremely important that the information on the app is correct to the best of the applicant's knowledge. That makes the answers representations. As a part of the contract, any changes must be done legally, that is, by having the applicant initial them. Erasures are not acceptable. The application actually has 3 parts. Part 1 is the general information section. Part 2 is the medical history section. Most applications also include a section called the "Agent's Report", in which the producer provides his or her personal observations to the underwriter. The agent's report is not attached to the policy. Both the applicant and the producer must sign the app.

Q: *If a warranty is guaranteed to be true, as opposed to a representation, which is something that is just believed to be true, what is the difference between a misrepresentation and fraud? After all, both are based in information that isn't true.*

A: In order to somehow affect the policy an untrue statement must be "material". That is, significant to either the pricing or the acceptability of the insurance. A material misrepresentation may void the policy, if it is discovered during the "incontestable period" of the policy. Fraud may also void the policy. However in order to be fraudulent, a statement must be three things. First the misstatement must be material. Secondly, it must be given with the intention to harm the insurance company. In addition the harm that was intended must occur. That is, the insurance company must have allowed the harm to happen by issuing the policy. Without all three of these things fraud is not present. You will learn later that even when fraud can be proven, with life insurance policies it must be discovered within the incontestable period.

Q: *What is replacement? Is it illegal?*

A: Replacement occurs when anything is done to a life insurance policy that affects more than 25% of the policies benefits. Canceling, forfeiting, lapsing, or even borrowing against the cash value if it is 25% or more of the cash value is considered "replacing" the policy. Replacement is absolutely not illegal. Replacement may be the very best thing a producer can do for the insured. However, because there are many possible downsides to replacing a policy, it is highly regulated to assure full disclosure of those risks.

Q: *I am not clear on the Fair Credit Reporting Act and its purpose.*

A: The Fair Credit Reporting Act is unusual because it is one of just a few Federal laws that apply to insurance. As you may recall, insurance is primarily regulated by the states. It applies to anyone who uses credit information, for example, banks,

credit unions, and insurance companies. It does not forbid the use of credit reports; it simply regulates how they are used. There are two types of reports covered by the act-Consumer Reports and Investigative Consumer Reports. Consumer reports are written information about the credit history, character, reputation and habits which have been obtained from public records, employment records, and credit reports. Investigative consumer reports include all of these, plus information received from personal interviews with neighbors, friends and associates. If a company wishes to obtain an investigative consumer report the applicant must give his or her permission to have the report obtained. In addition, if asked, the company must inform the applicant of the source of the report, and the applicant then may request additional information from the reporting agency. Failure to comply with these provisions is a crime, and may result in a \$5,000 fine and/or imprisonment for the abusing users of the credit report. If the report is requested for a policy or loan of less than \$150,000, bankruptcy information cannot be kept for more than 10 years, and all other information has to be purged after 7 years.

Q: What is a “rated up” policy? Who would have to purchase such a policy?

A: Once the underwriter has looked over all of the appropriate information such as the three parts of the application, attending physician’s statement, and investigative consumer report, the risk is then classified for rating purposes. There are basically 3 classes into which the risk may be assigned. The classes are Preferred, Standard, and Substandard. Standard risks are those that have normal or average health, occupation, and lifestyle characteristics. They would pay regular or “manual” premiums. An applicant who had much better than average characteristics than would be considered a “preferred” risk and would pay a lower than normal premium. On the other hand, a risk that exhibits poorer than normal characteristics would be considered Substandard or High risk. That risk would pay higher than normal premiums. These premiums are also known as “rated up” premiums.

B. Types Of Life Insurance

1. Understanding the Principles of Insurance

Introduction

Life insurance policies are now available from more than 2,000 life insurance companies in the U.S., as well as from financial institutions that are now getting into the marketplace.

Life insurance is used to replace in whole or part the economic value of human life for either family purposes or business purposes. In exchange for premium payments, the life insurance company agrees to pay a death benefit upon the death of the insured to the beneficiary named in the application for the policy. Life insurance policies may provide other uses and benefits as well.

Life insurance is an agreement between the insured and an insurer. Under the terms of a life insurance policy, the insurer promises to pay a certain sum to a person named as a beneficiary upon the death of the insured, in exchange for premium payments. Proper life insurance coverage should provide peace of mind, knowing that one's family will be financially protected after death.

An individual needs life insurance if he or she wants to provide financial protection for dependents in the event of death. A business may want to use life insurance to fund its employee benefit plans, protect against the premature death of a key person or to provide for business continuation.

The following are typical examples of family and business purposes to consider when assessing the need for life insurance:

- Dependent children.
- Dependent spouse, parent or grandparent.
- Credit enhancement.
- Key person indemnification.
- Business continuation.
- Employee benefit plans.

The amount of life insurance a person needs will depend on particular circumstances and the reasons for purchasing the policy. One approach to determine how much life insurance one should purchase is to analyze the various needs of a family in the event of the death of a family member. Life insurance may satisfy a number of these needs by providing a fund that can be used to:

- Pay off an individual's last debts;
- Meet estate taxes and other expenses;
- Provide life income for the spouse;
- Pay off a mortgage;
- Pay for the children's education;
- Provide funds for retirement;
- Provide a monthly income until the children are grown and out of school.

Thus, the current and future financial needs particular to your family can be a significant consideration in determining the amount of life insurance that is right for you. Another factor that may be taken into consideration in determining how much life insurance you need is the amount of your annual salary.

Liability and Loss Exposures

Throughout history, unexpected economic losses have occurred. Through the operation of an insurance system, combined losses can be predicted. The predictability of losses is basic to an insurance system's operations. Because insurance allows a group's losses to be predicted accurately, it allows the cost of losses to be financed and redistributed in advance.

Insurance is a financial arrangement that redistributes the costs of unexpected losses. Insurance involves the transfer of potential losses to an insurance pool. The pool combines all of the potential losses and then transfers the cost of the predicted losses back to those exposed.

Liability losses arise from three sources.

1. A court if an organization responsible for negligently injuring someone must pay legal damages awards one of these to the injured party;

2. Another is the cost of a legal defense;
3. The third is loss prevention arising from potential legal liability is the third source.

One of the most serious financial risks covered by insurance is that of loss through legal liability for harm caused to others. Insurance for liability losses is more complex than property insurance, because people other than the insured and the insurer are involved. Liability is usually determined by proving negligence, a concept that is difficult for most people to understand.

Types of Liability Exposures

The types of liability exposures arise out of different functions performed and standards of care required of persons or organizations. Bodily injury liability includes liability for losses a person may incur because his body or mind has been harmed. Such losses include payments for medical bills, loss of income, rehabilitation costs, loss of service, pain and suffering damages, and punitive damages.

Personal injury liability losses result from libel, slander, and invasion of privacy, false arrest, and the like. Libel involves written, printed, or pictorial material that damages a person's reputation by defaming or ridiculing the person. Slander involves spoken words that are defamatory and/or injurious to a person's reputation.

Legal expenses are incurred when individuals or organizations are sued. They must be prepared to retain a lawyer for their defense, as the defense process can be very costly. In some types of loss exposures, such as product liability, the cost of defense may be as great or greater than damage awards.

Employer Liability

Workers compensation laws do not cover all classes of employees. Farm workers and workers of an employer who hires fewer than a specified number of people are often excluded from coverage. The duties owed by an employer to employees and, which if not covered properly, may give rise to liability are the following:

- The employer must provide a safe place to work.
- The employer must employ individuals reasonably competent to carry out their tasks.
- The employer must warn of danger.
- The employer must furnish appropriate and safe tools.
- The employer must set up and enforce proper rules of conduct of employees, as they relate to safe working procedures.

The employer may use the common-law defenses in suits by employees, providing these defenses have not been lost for one reason or another. If a worker brings an action against an employer for some breach of care, the employer may argue either that:

- The worker was partly to blame (contributory negligence defense) or that
- The worker should have known there were certain risks on the job and cannot complain because one of these risks materialized (assumption of risk).

Loss Exposures in the Workplace Assault

Usually assaults are not within the scope of the risk if they have been prompted by malice or personal motives. Assaults are considered to be within the scope of the risk and to arise out of one's employment when the nature of the employment increases the likelihood of such an occurrence, or if the assault has grown out of a controversy that is work related. Assaults in some cases, such as those by stranger, lunatics, and children may be viewed as neutral risks outside coverage.

Heart Cases

One of the most problematic areas in the law of workers compensation is that of heart cases. Commonly these cases are approached on the basis of whether or not a personal injury by accident has occurred. This approach requires that unusual strain or exertion precipitate the heart attack. It is better to approach this issue from a scope of risk perspective. If ones employment has contributed to the heart attack because of exertion or other work-related circumstances, the attack may be found to have arisen out of one's employment.

Imported Dangers

It is common for employees to be exposed to a risk of harm that they or their fellow employees have imported to the worksite. Examples of this would be matches, explosives, or firearms. Traditionally, risks imported by the injured employee were viewed as personal and outside of the scope of risk of employment. A danger imported by ones co-employee, while it may appear to be a neutral risk, could give rise to recovery on the basis of increased, actual, or positional risk theories.

Intentional Injuries

Several jurisdictions have refused to allow tort actions to be brought as exceptions to the workers compensation exclusivity provisions unless the plaintiff has established that the employer intended the injurious results of its actions as well as the intended actions themselves. Sometimes although the injured worker need not prove that the employer intended to cause the injury, there must have been a substantial certainty of the injurious result of the employers actions.

Occupational Exposures

According to one study, Italian researchers reported that patients occupationally exposed in their jobs to hydrocarbon solvents were at risk for developing symptoms of Parkinson's disease. Even though compensation might be denied to an employee who was killed when his hunting gun accidentally discharged while he was getting a work uniform from his car, the court could indicate that recovery would have been allowed if the gun had belonged to another employee. The most common occupational exposures were found among petroleum, plastic, and rubber workers.

Pre-Existing Injury or Disease

It is not uncommon for employees to bring pre-existing medical problems to the workplace. However, if one is able to demonstrate that one's employment

aggravated a pre-existing medical problem, recovery may be permitted. The obvious problem facing employees is that of factual cause and medical proof.

Sexual Harassment

Depending upon the facts giving rise to a plaintiffs claim for sexual harassment, a defendant employer may be able to characterize plaintiffs injuries as arising out of and in the course of employment and successfully argue that the exclusive remedy injury lies under workers compensation.

Street Risk

Today an employee who is subjected to a greater exposure to the risks of the street, despite the fact that such risks are common to the public, may be covered on the basis of the increased risk approach, the actual risk, or positional risk doctrines.

Unexplained Accidents

A strict application of the neutral risk or personal risk theories could result in a denial of coverage, even if a fall or death occurred in the course of employment. The positional risk doctrine could also permit recovery in idiopathic fall situations in which the fall was the result of a purely personal condition, if, for example, the fall occurred at work.

Legal Issues in Insurance

In 1944, the subject of insurance regulation came before the U.S. Supreme Court to help organize insurance companies and ensure proper and fair treatment of consumers. With the passing of the McCarran-Ferguson Act and various others, insurers are now required to follow strict guidelines, as outlined by any particular state.

The Principle of Indemnity

Indemnity is a collateral contract or assurance by which one person secures another against an anticipated loss that signifies compensation has been given to an insured in order to relieve him or her from a loss.

Insurance arrangements are structured to provide funds to offset a loss, either wholly or partly. The payments made by the insurer are generally limited to an amount not greater than what is required to restore the insured to a condition relatively equivalent to what existed before the loss. The principle of indemnity is the concept that says insurance contracts should confer no benefit greater in value than the loss suffered.

However, the principle of indemnity does not imply that the amount of an insurance payment must be equal to the loss. When insurance provides only partial reimbursement, the principle of indemnity is not compromised. In fact, in many situations, purchasers acquire insurance contracts that do not provide complete and total indemnification in the event of a loss.

The principle of indemnity has an influence on insurance law but is only one of the facts that affect legal disputes.

The Principle of Insurable Interest

A person has an "insurable interest" in something when loss or damage to it would cause that person to suffer a financial loss or certain other kinds of losses.

The doctrine of insurable interest requires that there must be some significant relationship between the insured and the person, object, or activity that is the subject of the insurance transaction. The specific justification for the doctrine of insurability is avoiding one or more of the potential evils which might result from allowing insurance contracts which afford opportunities for net gain as a result of the loss.

For purposes of life insurance, everyone is considered to have an insurable interest in their own lives as well as the lives of their spouses and dependents. For property and casualty insurance, the insurable interest must exist both at the time the insurance is purchased and at the time a loss occurs. For life insurance, the insurable interest only needs to exist at the time the policy is purchased.

Injury to a Third Party

Another type of liability to consider is that which arises as a consequence of an injury to a third party. In the event that a claim by a third party produces legal liability, there is no possibility that the insured will derive a net benefit, as long as the insurance proceeds are ultimately used to pay a liability claim or as long as they are used to indemnify the insured who has already paid the claim.

Understanding Consumer Protection

The intent of consumer protection legislation is generally to protect consumers against unfair or deceptive practices and to provide relief to consumers through efficient and economical procedures in order to secure this protection. Consumer protection is a form of government regulation which protects the interests of consumers. Consumer protection is linked to the idea of consumer rights, and to the formation of consumer organizations which help consumers make better choices in the marketplace.

If an insurance consumer maintains an action against an insurer, it must be based upon one of the following theories of recovery.

- Breach of contract;
- Fraud;
- Deceptive Trade Practices;
- Negligence;
- The Breach of the Duty of Good Faith and Fair Dealing;
- Unfair Insurance Practices;
- Untimely Claim Payment or Claim Denial;
- Identity Theft.

Elements of Creative Underwriting

When evaluating a medical history, the insurance company through its underwriting and medical departments, may determine that a rating is necessary to cover a certain risk. The insurance company looks at the clients physical condition as a potential risk, knowing that it must evaluate the medical condition in a very narrow window of time.

Detailed and current information helps the underwriting to better understand the mortality expectations and risk factors that apply to an assessment of a particular case. Impaired risk underwriters also use this approach. As underwriters use this approach, they are actually involved in a risk evaluation and risk acceptance process. This makes underwriting aggressive and competitive.

Reasons for and Uses of Life Insurance Policies

The main use of life insurance is to protect a dependent or a family from the premature death of the breadwinner. The purpose of life insurance is to take care of dependents. As such, it's an important part of a financial plan. About seven of ten adults have some form of life insurance.

One of the most common reasons for buying life insurance is to replace the loss of income that would occur in the event of the death of either of the income earners. When either of the income earners dies and the paychecks stop, a family may be left with extremely limited resources. Proceeds from a life insurance policy make cash available to support a family almost immediately in the event of death.

Life insurance is also commonly used to pay any debts that an individual may leave behind. Life insurance can be used to pay off mortgages, car loans, and credit card debts, leaving other remaining assets intact for a family. Life insurance proceeds can also be used to pay for final expenses and estate taxes or to create an estate for heirs.

Instant Estate to Benefit a Charity

Life insurance policies can create an instant estate to benefit a charity. Making a financial gift to a favorite charity is a goal shared by many people. A substantial gift may seem to be out of reach, but a policy owner will be able to do just that through the use of discounted dollars to make this happen. This is an overview of the many areas that a life insurance policy can be used for and can make the lives of many people a little more cushioned.

Benefit Upon Death of Insured

Again, with the principal reason for a young or middle age person to purchase life insurance being to pay a benefit upon the death of the insured person, the insured individual who has a spouse and children who depend on his or her income may need to consider other situations in his or her life in need of security.

If there are business associates who depend on a key person for the operation of the company, the firm may need to insure his or her life for the future of the business. The last thing a family or business associates needs to worry about is coping with the financial consequences of an untimely death.

Present and Future Needs

Life insurance can be used as an estate-planning tool or as a means of saving for retirement. It can be used to make a charitable gift, or it can be borrowed against for present needs. If the family is also left without sufficient money to meet basic living needs or prepare for future goals, they will have to cope with a financial crisis at the same time. Families with young children have a clear need for life insurance. If both spouses work, the loss of one income will cause the family immediate economic hardship and make it harder for them to realize future goals, such as paying for the children's education.

2. Important Features in a Life Insurance Plan

The features and provisions of a life insurance policy mold the efficiency of any insurance policy and defines its usability. The features of an insurance policy are the perimeters within which it operates and which gives it application to the insured and the insurer as well as to the beneficiary. The insurer sets these perimeters but they can be adjusted to give the best advantage.

Cash Value Feature

The cash value build-up in a life insurance policy supports various other features. These features could be the policy owner loan provision and the non-forfeiture options. The insurance industry as a whole strongly promotes cash value life insurance including traditional whole life, universal life, and variable life insurance.

Front-End Charge

A cash value policy may very well involve a substantial front-end charge or load which will appear as a reduction or in some instances as an elimination of cash value in the first years of the policy. However, as the cash value policy matures, the policy owner will have the advantage of having cash at his or her disposal to finance a new home or a college education.

Four Factors in Determining Cash Value

In the newer cash value policies the cash value is not predetermined but is primarily a function of the size of premium payments, over which the insured exercises considerable control, and also the future investments returns. The cash value of these newer products is determined by a formula approach in which the amount of cash value is a function of four factors.

These factors are the premium paid, the expenses charged, the cost of term insurance, and the investment earnings. So true, in the first couple years of a policy, the cash value is equal to zero because the insurance company deducts certain expenses including the agent's sales commission. But over the life of the policy, there is a steady increase in the amount of the cash until at age 100, the cash value is exactly equal to the policy's face amount.

If a policy owner is fortunate enough to live to age 100, and own a \$200,000 whole life policy, he or she will get a \$200,000 check as a birthday present from the insurance company. Whole life policies do not need to be held until death or

age 100 in order for benefits to be available. The cash value is guaranteed, which means if the policy owner cancels or surrenders the policy after paying premiums for a number of years, he or she will receive the cash value. If the policy owner does keep the policy in effect by paying premiums, the individual may access the cash value by borrowing it in the form of a policy loan.

If an individual purchases a \$100,000 policy at age 25, the fixed monthly premium he or she would pay over the next 75 years to reach a \$100,000 cash value by age 100 would be much lower than it would be if he or she purchased the policy at age 55 and have only about ten more income-producing years to accumulate the same amount of money.

Cash Value and Taxes

When the cash value portion is paid as part of the death benefit, it is not taxable at all. The cash value on an account merges with the death benefit when a claim is made. This effect is recognized by the tax code, which permits the cash value portion of the death benefit to be paid free of income tax when it is part of the death benefit. If the policy owner dies leaving a death benefit of \$50,000, the \$10,000 that is the cash value portion of the death benefit would be paid to the beneficiaries free and clear of the IRS. Money borrowed against cash value is usually not taxed either.

Dividends

Dividends are different from cash value. Dividends, which are paid on participating whole life policies, are a refund of the premium. The dividend declared by a company is based on its investment success and whether the company correctly forecasted the number of insureds who died. Dividends are not taxable because they are simply a partial return of the policy owners money.

State laws generally require that the benefits of an insurance policy must be reasonable in relation to the premiums charged. The way this is determined is by examining company loss ratios, or the amount of benefits that are eventually returned to policy holders as compared to the aggregate premiums earned. State regulators try to keep a close eye on the insurance premiums charged older policy owners. In regulating some senior health insurance products, many laws require minimum loss ratios of 65% to 75%.

Death Benefit Feature Benefits to Equal or Exceed Premiums Paid

In general, during its first ten years, life insurance covered by the rule had to provide benefits that equaled or exceed the premiums paid so far, plus interest. The rule did not apply to policies that had a minimum death benefit of \$25,000 or more.

A number of representatives from various insurance companies testified at public hearings and argued that the rule exceeded the Commissioners statutory grant of authority. The Commissioners response explained that the intent of the rule was to deal with small life insurance policies issued to older buyers where high mortality rates and heavy expense loading could result in unfair results.

Spendthrift Clause

The spendthrift clause is designed to protect the beneficiary from losing the life insurance proceeds to creditors, assigning the proceeds to others, or spending large sums recklessly. The spendthrift clause is not applicable to lump sum settlements but is operative with settlement options. It only protects the portion of proceeds not yet paid from the claims of creditors to the extent permitted by law.

Flexibility Feature

While to some people, the level premiums, level face amounts, and fixed benefits associated with whole life insurance imply stability and safety, to others these features reflect inflexibility and missed investment opportunities. Insurance contracts offering guaranteed interest rates of four to six percent compared unfavorably to the extremely high interest rates experienced in the 1970s.

Individuals who purchased whole life policies watched as their cash values were eroded by inflation. So in order to satisfy consumer demands for more flexibility in terms of premiums, face amounts, and investment objectives, the insurance industry developed flexible policies. The main types of flexible policies are adjustable life, universal life and variable life insurance.

Free Look Feature

Since life insurance is such an important and expensive item for an individual to purchase most states allow the life insurance purchasers a 10-day-free look period. This allows the life insurance purchaser to cancel the policy within 10 days of its purchases. Many companies allow the free look to continue for 15, 20, or even 30 days. Second Look or Free Look is not a federal law. It is a state law.

The Free Look feature provides that an individual can get all of his or her money returned by the insurance company should he or she decide that the purchase was a mistake. The policy will be considered void, as if it had never been issued.

Grace Period Feature

Another important feature that life insurance carriers provide is that of a grace period. The grace period involves the time that an insurance company gives to a policy owner to pay a late premium. Usually that period is 31 days. Sometimes a payment gets lost in the mail or is made a little late because of financial or other difficulties. The length of the grace period depends on company policy.

This feature of a life insurance policy is given to protect the insured against an inadvertent lapse in the policy, there is an extended period of time in which the policy remains in full force despite the fact that the premium has not been paid. This feature is to protect the beneficiaries if the policy owner happens to die during the late payment period since the death benefit remains payable. However, any premium due to cover the grace period extension would be deducted from the final settlement.

Without the Grace Period feature, if a payment were even one day late, the benefits could be denied and technically the policy owner might have to furnish evidence of insurability to continue coverage at a later date.

If the premium is not paid during the grace period, the policy terminates or lapses, in insurance terminology, and no further insurance protection exists. In some cases, the policy could, in fact, be continued under one of the non-forfeiture options.

Interest Feature

Low Interest Rate

The low interest rate traditionally charged for policy loans is one of the features that has made loans attractive, with a 4% to 6% fixed rate being common in the past. Most insurers now charge a fixed rate of around 8%. Variable interest rates are also available, tied to a financial indicator such as the rate on U.S. Treasury bills or Moody's long-term bond rate.

Variable Rate

When a variable rate applies, the policy specifies when the insurer will adjust the rate, such as on the first day of each calendar quarter. Interest accrues on a daily basis from the date of the loan on policy loans and from the premium due date on premium loans, and is compounded annually. Interest unpaid on a loan anniversary is added to and becomes part of the loan principal and bears interest on the same terms.

For universal and variable life policies, insurers might pay a lower interest rate on the borrowed portion of cash value that is serving as collateral for a loan. That is, the typically higher current interest rate is paid on cash values that are not collateral and a lower rate, often the guaranteed rate, is paid on the portion borrowed.

Payment Feature

Payment modes are the variety of methods from which an insured may choose to pay premiums. Sometimes single premium policies are available. However, more often an insured will choose to pay in one of these modes:

- Annually, or once every 12 months;
- Semi-annually, or twice every 12 months;
- Quarterly, or once every three months out of 12;
- Monthly, or once every month.

The gross premiums computed on the basis of the elements already discussed are annual premiums. If the policy owner wants to make smaller but more frequent payments, the insurance company incurs slightly higher processing expenses. As a result, a small additional charge is added when the mode is more frequent than annually.

Therefore determining the premium to be paid semi-annually is not simply a matter of dividing the annual premium by two because the insurer will calculate another small charge to be added for expenses. After the original payment mode

has been established, a policy owner might request permission to make premium payments either more or less frequently. In some cases, the insurance company might require this change to be requested and approved in writing; in others, the change can be handled over the telephone.

Policy Loans Feature

After a cash value policy has been in force for a specified period of time (usually three years), it must contain cash value which the policy owner is entitled to borrow. He or she may use this money as money in a savings account, but without having to repay it.

The policy owner is responsible for paying the interest which is typically 6% to 8%. The rate of interest is stated in the contract. It may seem strange for the policy owner to pay on his or her money that is being lent. The cash value accumulation the insurance company has guaranteed to the policy owner depends on the interest that the money has earned while being held by the insurer.

If the policy owner has withdrawn cash value, the insurance company can only meet its obligation to this policy owner by charging interest. On all loans, the

interest is deducted from the amount of the loan. Even if a policy owner has to pay interest, when a loan is taken out, any income tax is deferred to a later date, and if death occurs before the loan is paid back, no tax is due at all. If the loan is not repaid, the death benefit to the beneficiary is reduced in the amount of the loan plus the interest. With Whole Life, the only way to get money out is through a loan.

With Universal and Variable Life, a policy owner can either take out a loan or take a withdrawal. On a loan, the clock starts ticking right away. With a withdrawal, there is a \$25 administrative fee. And the money never has to be repaid. The insurer has the right to defer a loan request for up to six months unless the reason for the loan is to pay premiums due. The loan value that is available to the policy owner is the largest amount which, with accrued interest, does not exceed the cash value either on the next premium due date or at the end of one year from the date of the loan.

Loan Repayment

Because borrowing cash values represents in some respects a loan, repayment is expected. Practically speaking, though, the loan need never be repaid. The policy owner may continue paying interest on the loan indefinitely. The negative consequences for not repaying loans from cash values can include the following items.

- reduction of the death benefit of the amount of the loan;
- reduction of the surrender value if the policy owner terminates the policy to take all the cash value;
- effect of dividend payments in par policies;
- reduction of interest earned;
- potential depletion of values, causing lapse of universal or variable policies.

Automatic Premium Loan

Although not part of the policy's non-forfeiture values or options, the automatic premium loan (APL) option or feature is related to the policy's available cash value. If an insured fails to pay his premium on time, and the policy lapses beyond the 31-day grace period, the automatic loan provision kicks in and the premium is paid.

The only requirement is that enough cash remains in the cash value portion of the policy to cover the loan. It does not mean this provision is automatically included in every cash value life insurance contract. Typically, the insured must request the automatic premium loan provision in the insurance application. This is only good with Whole Life Insurance.

With Universal and Variable there is a similar provision. But it is not an APL. The policy owner just tells the company to use accumulated proceeds to pay the premium. This is possible only if there is sufficient cash value. The automatic part of this provision means that the insurer will automatically use the premium loan feature to keep the policy in force. This transaction is treated as a loan to the policy owner.

The insurer expects to be repaid and the policy owner pays interest on the amount used. If the loan is not repaid before the insured dies, the loaned amount will be deducted from the death benefit. There is no charge for this option as the premium is being paid by the policy's cash value. However, since the automatic premium loan depends on guaranteed cash values, it is not available with term insurance as term does not have cash value.

Premium Feature

There are three primary components to an insurance projection that affect the insurance premium:

- expense rate for costs of administering the policy;
- mortality risk rate based on death assumptions;
- the rate of dividends to be credited as earnings.

Because no two companies produce exactly the same life insurance policy and since there are over 2000 companies selling the policies there are various methods that each company incorporates into their method. Traditionally, life insurance premiums are quoted as annual premiums, however.

Net Premium vs. Gross Premium

At this point, the insurer has arrived at the net premium. But this is not the premium the insured pays because there is still another element that goes into premium computation. Since insurers are in business to make a profit, they must consider their operating expenses as all businesses do when pricing products.

Operating expenses include such things as payroll, sales commissions, overhead, taxes, and other costs of doing business which includes the loading element. So when operating expenses are factored into the net premium figure, the result is the gross premium. This is the amount, finally, that the purchaser pays for the policy.

Lowering Life Insurance Premiums

Life insurance premiums can be lowered if a policy owner shows evidence that he or she is making an effort to improve his or her health. At that point the policy owner can ask for the insurance company to re-evaluate him or her. This may be possible if the policy owner has been involved in a dangerous sport or a hazardous occupation and that circumstance changes to a less dangerous one, this can be a reason to lower the premium rate. The annual premium is not the policy's cost. A policy owner cannot know a policy cost until the death claim is paid or the policy is surrendered.

Endowments

There are two types of endowment contracts: **endowment insurance**, which was described in the previous text; and **pure endowments**, which are contracts that promise to pay a specific amount only if the contract-holder survives the endowment period. If the contract-holder dies before the end of the endowment period, his/her estate/beneficiary receives nothing. If the contract-holder does survive the endowment period, the benefits received consist in part of the contributions of those who do not survive to collect. Pure endowment contracts have been illegal under the laws of some states for many years.

Endowment life insurance policies promise to pay the face amount of the policy if the insured survives until the end of a specified period (e.g. 20 years; 30 years; or until the insured's age 65), and also agrees to pay the face amount if the insured dies within the same specified period, which is known as the endowment period. In effect, an endowment policy is an investment instrument. They require premiums far in excess of the amount required to fund the death benefit. Because of changes in the Tax Code, this now creates undesirable tax consequences with many contracts and will likely make endowment policies a thing of the past.

3. Total Needs at Time of Death

If married without children or single, an individual may think that he or she does not need life insurance for there are no kids dependent on a parents income. However, the individual needs to remember the financial needs of a partner or surviving family members against the costs associated with his or her death. Funeral expenses, probate and administrative fees, outstanding debts, special obligations to charities, and federal and state taxes are costs that everyone must consider as expenses that will occur no matter what the marital status might be.

Then as a policy owner ages, there are valid reasons to increase the life insurance protection, especially, if he or she has accumulated a large estate of more than \$600,000.

Quantity of Life Insurance One Can Afford

Just as several variables determine the amount of coverage that is needed, many factors determine the cost of coverage. The type of policy that is chosen, the amount of coverage, one's age, and health all play a part. The amount of coverage you can afford is tied to your current and expected future financial situation, as well.

Cost of a Life Insurance Policy

Although there may be a myriad of fees, expenses, interest assumptions, and other factors used to develop a given life insurance company's premiums for a policy, the rates for life insurance are ultimately based upon one factor: the statistical chances of the insured dying in a given year. Such statistics, based upon insurance company experience and government records, are used to calculate an annual death cost for each \$1,000 of life insurance benefit.

Since statistically few people will die at younger ages, the death cost for those years will be extremely low. As people age, the statistical chance of death increases, slowly at first, then more rapidly after the insured passes middle age, and therefore so does the annual death cost.

Comparison of Costs

Since term insurance only provides a benefit if the insured dies during the policy term, its premiums will be the closest to pure death cost. This is why term is the least expensive coverage to buy at younger ages. At older ages, however, the cost of a term policy rises rapidly along with the increasing death cost, and may soon become prohibitive for many senior citizens. A term insurance policy's premium will remain the same during the term, and then increase at each renewal.

A five-year renewable term policy's premium will remain level for the five-year term, and then increase at the renewal. Once renewed, the policy premium remains level until the next renewal, and so on until the renewal provision expires (typically at age 65), or when the insured either decides the premium has risen too high or the insurance is no longer wanted.

Permanent insurance rates are also fixed for the policy term. However, since the policy is permanent, this fixed premium must represent an average death cost over the entire expected life of the insured. The result is that permanent policy rates will often be significantly higher than term rates at the younger ages, but then significantly lower at older ages.

Risk Cover vs. Investment Return

Insurance options range from policies with low premium that offer almost no returns to those with high premium that effectively offer post-tax returns of around 8% to 9.5% per annum. These returns are at the lower end of fixed-income returns available, and are relatively unattractive. It is often recommended that an individual buy an insurance policy skewed towards investment returns only if one is in the high-tax bracket, prefer to invest in low-risk, fixed-income options and have exhausted all the other such investment options available.

Whole Life vs. Limited Period

When an individual ages, he or she may not have as many dependents, or wealth may reach a level where it can support dependents financial needs in the event of death. These possibilities bring up the question for Whole Life or for a limited term. It is often recommended that an individual insure for Whole Life only if he or

she never expects wealth to reach a level where it can support the financial needs of dependents.

Assessing Features of Variable Life Insurance

Variable Life policies carry many of the features of Universal Life with the added distinction that death benefits and premiums are more directly linked to the performance of investments, and policy-owners have a say in how their funds are invested. Below are some of its distinct features.

An individual can select a level death benefit or choose a death benefit that increases as the cash value grows. The guaranteed death benefit period is shorter at older ages and on policies issued on a substandard basis. Guarantees are based on the claims paying ability of the Insurance Company and do not extend to the variable sub-accounts, which may fluctuate with market or other economic conditions.

Cash Value Account Feature

Some policies, such as Whole Life, Universal Life, and Variable Life insurance, also have a cash value account. On top of a minimum guaranteed death benefit, these policies create a cash value account - - cash that builds up over time and can be used by the policy-owner for non-insurance purposes during his or her lifetime.

All policies with a cash value account cost substantially more than term policies that offer only a death benefit, because the premium payment must be large enough to fund the desired accounts as well as to cover the cost of pure insurance. Variable Universal Life is the type of insurance that gives one more control of cash value account policy features than any other insurance type. It pays a death benefit to the beneficiary that the policy-owner names and offers low risk tax deferred cash value options. It offers separate accounts to invest in such as money market, stock, and bond funds.

Regular Policy Loan Feature

The Regular Policy Loan allows one to borrow from a cash value at 2.5% net interest cost. There are up to 30 different investment choices within some Variable Life Insurance policies. They also have access to their cash value accumulations. An individual can withdraw accumulations or arrange tax-free loans against the policy. Loans and withdrawals reduce the cash value of the policy and the death benefit.

Enhanced Policy Loan Feature

The Enhanced Policy Loan Feature lets one borrow from his or her cash value (at zero net interest cost) when specific cash values are achieved or when the policy has been in force for 12 years or more.

Adjustable Premium Feature

An individual needs to decide how much premium to pay and when to pay it based on the performance of one's investment portfolios and his or her changing needs.

Tax Free Access

With life insurance, increases in cash values resulting from investment income are not taxable as long as the policy remains in force. If a policy is surrendered, the amount received, including any existing policy loan, is taxable as ordinary income to the extent of gain in the policy, if any.

Cash withdrawals from such policies are generally taxed only to the extent that a withdrawal exceeds investment in the policy, and policy loans are not generally treated as taxable distributions. However, in certain circumstances, withdrawals in the first fifteen policy years which result in a reduction in death benefits can trigger income taxation of gain.

Variable Savings Feature

However, the savings portion is not tied to a fixed-income investment. The cash buildup is dependent on the performance of the money invested in stocks or bonds, typically through mutual funds.

Variable Life Insurance and Client Needs

Variable is a form of Whole Life insurance, and because of investment risks it is also considered a securities contract and is regulated as securities under the Federal Securities Laws and must be sold with a prospectus.

Variable Whole Life Insurance

In addition to a guaranteed level fixed premium and a guaranteed death benefit, Variable Whole Life offers a variety of investment choices:

- Benefits,
- Tax advantages,
- Features,
- Tax-free transfers between funds.

One may choose the death benefit option and the premium level, subject to underwriting guidelines and company qualifications. A policy is guaranteed to stay in force provided one pays the required premiums when due; the death benefit will never be less than the face amount (reduced by any outstanding loans). Currently, one may change the asset allocation of the cash value up to twelve times per year.

Variable Second-To-Die Life Insurance

Variable Second To Die Life Insurance policy allows one to control the composition and diversification of investments within the policy. There are up to 30 different investment choices within some Second to Die Insurance policies, and tax-free transfers within investment sub accounts.

A Variable Second To Die Life Insurance policy has access to tax-deferred cash-value accumulations. One can withdraw accumulations or arrange tax-free loans against the policy. Loans and withdrawals reduce the cash value of the policy and the death benefit.

Variable Universal Life Insurance

Variable Universal Life Insurance offers the best of two worlds -- insurance protection and investment opportunity. Earnings from insurance are tax-deferred while accumulating--all types, at any level. For qualifying plans, cash may be withdrawn income tax free. Additionally, life insurance has a death benefit that is income tax free to whomever the owner names as beneficiary.

This type of policy, with investments chosen by the policy-owner--individual funds with specific objectives-- helps one increase the cash value through professionally managed accounts under the umbrella of life insurance. It also protects investment earnings, accumulated and withdrawn, from income taxation during lifetime. Finally, one is able to pass a death benefit tax-free to beneficiaries.

Variable Universal Life insurance has advantages and disadvantages for individual policies as well as business insurance. The flexibility and growth of cash values and death benefits are necessary or attractive features. It can be used to provide potentially higher tax-deferred cash value accumulations in non-qualified deferred compensation plans than traditional policies or even in Universal Life insurance.

Survivorship Life Insurance and Client Needs

Second-To-Die (survivorship life) policies pay only upon the death of which ever spouse (or other insured person) dies last. Survivorship Life policies are relatively new, and there are many variations. They can be either Term or Whole Life.

Frequently, a need is anticipated strictly for tax cash. With the unlimited marital deduction having been used after the death of the first spouse, it is often only at the second death that federal estate tax is actually payable. Likewise, business partners might recognize that ready cash needs to be available to fund their business continuation plan. In these cases, survivorship life insurance can be a cheaper way to go than purchasing two individual policies. A Second-To-Die policy can also be used as an income replacement fund, for a family able to financially withstand the loss of one breadwinner, but not both.

However, if it is not necessary to keep premiums to the bare minimum, buying even one traditional life policy might be a better overall deal than a Second-To-Die policy. The rationale goes like this: If you insure one spouse, and he or she dies second, you are in much the same situation as if you had bought a second to die policy, anyway. If he or she dies first, however, the policy proceeds go to the survivor. True enough, this payment comes before the anticipated need. But, so what? The survivor can just invest the money till it is needed. Survivorship life is definitely something to consider for those in certain situations. One has to lay out options and use real numbers, though, to know if it is the best choice.

Adjustable Survivorship Life

Adjustable Survivorship Life provides unprecedented flexibility at a cost comparable to other Second-To-Die products. This highly effective approach is unique in two ways. Adjustable Life policies provide maximum flexibility. Premiums and death benefits can change with the estate size and estate-planning

needs. The policy-owner has the option to elect greater coverage after the first death.

Like a line of credit with the bank, this line of coverage on the surviving spouses policy can be activated at the death of the first spouse. As a result, the extra coverage is available if an individual needs to acquire it, but does not cost anything until that person is sure it is needed.

Joint Survivor Life (Step)

This version of our Joint Survivor Life product portfolio is more conventional in design because it insures two lives under one policy and provides a tax-free death benefit at the second death.

Joint Survivor Life (Level)

This also is a conventionally designed second-to-die policy. It insures two lives and provides a tax-free death benefit at the second death. Also placed in an irrevocable trust, this design provides you with guaranteed level annual premium payments. If guaranteed premiums are not important to an individual but lower premiums are, a special product feature can provide a more affordable plan.

Assessing Cash Value Insurance

For most retirement plans, term life is great. But Cash Value insurance coverage can be sound addition if the following conditions are true:

- One needs lots of insurance, such as more than \$750,000.
- One is already contributing the maximum to IRAs for himself and his spouse, to a 401(k) plan if he qualifies, or any other tax-sheltered retirement savings plan available to him.
- One can afford it, which is to say that one probably is earning more than \$150,000 per year.

Part of what one pays in premiums each year goes to pay for the life insurance coverage, but the bulk of the money is devoted to the savings and investment features that are intended to build cash value for one's retirement.

This type of policy has a value that increases over time and that one can tap for retirement income. It is very similar to a tax-favored savings plan with life insurance attached. Part of one's premium pays for insurance, part goes to ones savings, and investment earnings are allowed to accumulate tax-free. Because commissions and fees take such a large bite out of one's cash value during the first few years, he needs to keep funding a policy for at least 10 years for his investment to pay off.

Morality and Law

Morality is not a matter of personal taste or social standards. Neither is it a matter of the law. Law and morality are, of course, connected. We want our laws to reflect our morality. But they are different domains with different agendas, and we should not confuse the two.

Law and morality do not always intersect. Lying is morally wrong, but unless you lie on the witness stand it is not illegal. Parking in a no-parking zone is illegal, but unless you're putting people's lives in danger, it isn't immoral. Complicated problems often generate both legal and moral issues but require different answers. Before you tackle a moral problem, you need to separate the moral aspect from the social, legal, and factual background. Let's see how the process of moral judgment works.

In general, is one in trouble with the law if he or she does not adhere to a high standard of ethics? An individual can probably read into ethics or a legal responsibility to adhere to ethics anything that is wanted. If the important part of ethics to you is to have them, then probably at will you will twist them ever so slightly to get your advantage.

On the subject of the prevailing ethos, we can detect another trend in our litigious society. In brief it is, if something is legal, it is fine; that is, the important question becomes, is it legal? The other question--Is it ethical?--often suffers the indignity of not even being asked. Legal considerations crowd out the ethical. If this is true, it is most unfortunate. Surely, it is obvious that legal is not synonymous with ethical.

Corporate Ethics

Most corporate observers believe that successful, well-managed companies set guidelines for appropriate values and standards of ethical behavior. Well-managed companies keep in touch with customers' needs and strive to meet those needs. A company that does not set high ethical standards or fails to censure employees who do not meet those standards is putting itself in jeopardy.

Volatile economic conditions confront the financial services industry with increasingly difficult ethical dilemmas. In the financial services industry, the integrity and professionalism of employees determine the company's image and its ultimate success in the marketplace. The facts are that ethics have become a strategic corporate consideration. The climate for ethical conduct has become much more volatile. A confluence of forces has put the entire financial services industry under intense scrutiny. National, as well as world-wide, financial services are under siege.

4. The Basics of Needs Analysis

Defining Needs Analysis

Needs Analysis is the systematic basis for decisions about the gap between a current situation and the desired situation and then to focus resources where they're most needed. The analysis must determine root causes. Needs Analysis on the personal side of the question includes a great many items such as evaluating an individual or a family; a property that is owned; examining who is the breadwinner and how much that amount is.

After the income amount has been determined, then an insurance agent must look at the life insurance needs and health insurance needs that will care for the family upon the occasion of the death of the breadwinner. An insurance agent

usually speaks directly with key members of the staff to determine each area or department's needs.

Life Insurance Selling Methods

There are two general ways in which life insurance is sold;

- Total Needs
 - Total needs selling involves identifying all the needs a prospect has for insurance and then covering all those needs or prioritizing them.
- Single Needs
 - Single needs refers to picking one sales idea (concept), selling the person on it, and coming back at some future date to sell another.

Common sense suggests that total needs selling is the best way. In practice that is not the case. It is time-consuming, considered intrusive, and frequently takes the prospects attention away from buying another policy to trying to deal with the myriad of issues that a total needs analysis tends to raise. Most needs analysis is generated through single need or concept selling. The producer selects one of many proven sales concepts that have generated strong interest from prospects or clients in similar positions.

Basic Approaches to Needs Analysis

Calculating the economic value to a family is an important part of buying life insurance. Every person's situation is different, and although ones financial situation may look the same as a colleague's next door, the needs are different. Calculating how much life insurance an individual needs should not be a guessing game. It is possible to assess needs -- and the needs of loved ones -- and make a calculated assessment with a variety of methods.

Multiple Income

One of the oldest and most well-known methods is Multiple Income. This method uses a multiple of an annual income, ranging from five to eight times the annual income. While simple, this earnings-multiple method misses a range of important factors such as ignoring household demographics, past savings, Social Security offsets, housing expenses, taxes, etc.

Cover Debts

Cover Debt method entails buying only enough life insurance to cover debts -- such as mortgage, student loans, or outstanding car notes. The disadvantages with this method are similar to those for the multiple of income approach. This method misses a whole range of factors, such as future debts or needs. This method is also too simplistic to provide any real value.

Considering the Life Cycle Model of Consumption

The Life Cycle Model of Consumption and Savings is a new approach based on the life cycle model developed in the 1950s and 1960s which built on early work by Yale economist Irving Fisher in the 1920s.

The model assumes that an insured's goals are to secure the living standards of the household and ensure comparable living standards to survivors. Spending targets are derived by calculating how much the household can afford to consume in the present and still be able to preserve the same living standard in the future.

The Capital Needs Analysis approach incorporates the concept that as other assets grow, the need for life insurance to replace income will diminish. This approach is very complex and depends on a number of assumptions, and the more assumptions that are relied upon, the greater the chance that the calculations will be off.

Determining an individual's consumption pattern is one of the ways to do Needs Analysis. Such planning gives one a better idea of what he or she should do with the money made. The current level of consumption is based on the necessities of life and the average propensity to consume. A minimum level of consumption would allow one to obtain only the necessities of life such as food, clothing, and shelter. Given a certain level of income, one can either spend it now or save a portion of it for future consumption. Determining both the current and the future consumption patterns is an important part of the personal money management process.

Inflow

With any inflow there may be penalties, charges, or reductions for early withdrawal. The major points of Social Security Benefits are listed here even though it is difficult to figure out the numbers.

- Available to surviving spouse if there are children under the age of 16 to 18 or 19, if still in high school;
- Available to surviving spouse at age 60 if the spouse was covered by social security;
- Blackout Period - The period when no social security benefits are available.
- Liquid assets hopefully will reduce the future amount of needed life insurance;
- Present amount of group and personal life insurance;
- Retirement Assets such as IRAs, 401(k) plans, Keoghs, pension and profit sharing plans;
- Savings and Investments including bank accounts, CDs, stocks, bonds, mutual funds, real estate/rental property, etc;
- Survivors Income;

People exhibiting high average propensities to consume may do so because their income is low and they must spend a large portion of it just for basic necessities or many "ultra consumers" choose to splurge on a few items and scrimp elsewhere. Individuals earning large amounts quite often have low average propensities to consume, because the cost of necessities represents only a small proportion of their income.

An individual should review needs annually or at a minimum of every three years since insurance needs when an individual has any major life changes. If an individual knows when certain life events will be occurring, he or she may have an idea of how long it will be necessary to have certain amounts of life insurance.

Life Insurance Needs

Life insurance is a unique and valuable financial planning tool when it comes to looking after the needs of loved ones. But determining how much insurance one really needs is the big question. Age and circumstances is a vital determining factor, however, as always there are many factors that affect any type of financial decision. The methods of assessing one's life insurance needs are marital status, number of dependents, one's income, and their college expenses. By weighing these and other factors, one can calculate life insurance needs.

Needs Analysis includes determining the kinds of risks one should protect his or her family against. It is the insurance agents responsibility to guide an individual through the insurance maze, showing how to decide the coverage needed, and how to get it at a competitive price. Car accidents occur, homes are broken into or damaged by fire, and people die before their time or find themselves no longer able to work due to a disability. These are all events that are unknowns but insurance is the vehicle to prevent them from becoming a financial disaster.

Young singles have little need for life insurance except to cover funeral expenses and any debts not insured elsewhere. Mortgages and car loans can be purchased with their own insurance protection. If an individual has dependents — a spouse, children, or others — then life insurance is often the only feasible way to provide financial security in one's absence.

Financial Planning Need

Financial success is the realization of one's financial objectives in a timely and preplanned manner. The amount of money required for financial success differs from person to person. Financial strategies work independently of the people who use them and are not simply a theory. Financial strategies are equivalent of scientific principles that govern the way money, finance, and financial institutions really work for or against individuals.

There is an ever-increasing trend today towards long range personal financial planning to ensure security in the coming years that should start with an individual's basic financial condition. Most importantly, families and individuals need to establish and maintain a program of cash flow management, provide liquid resources, maintain expense management and an adequate debt ratio.

A persons standard of living and patterns of consumption are related and can profoundly affect the accumulation of wealth particularly if ones primary financial goal is to achieve maximum wealth accumulation.

One of the major benefits of personal financial planning is that it helps one to acquire, use, and control financial resources more efficiently so it can include necessities, comforts, and the luxuries of his or her possessions. The quality of life for most of the population is closely tied to the presence or absence of certain material items such as a home, cars, and jewelry.

In a carefully developed financial plan, a portion of current income will be set aside for deferred or future consumption to build up a retirement fund to maintain a desirable standard of living in later years. The money put aside for such deferred consumption is placed in various savings or into an investment vehicle to generate a return over the time it is held. The portion of current income

committed to future consumption will be a function of the amount of money earned on the one hand, and the level of current spending on the other hand.

Catastrophic Coverage Needs

The financial pressures that may result from some types of life crisis can only add to an already emotionally draining situation when one spouse may have been responsible for the couple's financial affairs more than the other. Financial pressures may arise from inequalities that occur when a divorcing couple's financial affairs are separated because they have been so intertwined.

Remarriage brings additional financial considerations, including decisions involving children from prior marriages and managing the assets each spouse brings to the marriage. Often the most important benefit is the reduction of financial pressures that a personal financial plan or a prenuptial contract.

Death of a spouse is another change that greatly affects financial planning because the surviving spouse is faced with decisions on how to receive and invest life insurance proceeds and manage other assets. Couples should, on a regular basis, review all aspects of their finances.

Analyzing Financial Goals

Achieving goals is not always simple, either in young adulthood or later in life. Students dependent upon a parent to pay college tuition may have to fund their education themselves if the parent becomes ill or unemployed. Having a second child may force one parent on a career track to cut back to part-time work, or another to take a second job to make ends meet. An accident, a change in the economy, a move, a change of mind, and an inheritance can all affect the methods or achievability of a specific goal.

Typically, the goals of high school and college students are career, marriage, starting a family-cover the first few years of their adult lives. But when those goals are accomplished or changed, a new set of goals emerges which includes financing college, saving for retirement, comprehensive health coverage and, ultimately, retirement and estate planning.

Financial Long Term Goals

As people go through different stages in their lives, their income patterns change as well as the types of financial goals they pursue. Typically for college graduates, income rises after college and through their 40s and 50s; then it begins to taper off as they grow older.

Most recently the signs of movement to cash, investors selling stocks, can be seen in the mark-down of many non-technology stocks. Growth managers began to sell these names in an effort to raise cash. Investors should instead consider looking to the future, re-allocating, rebalancing and reassessing their growth versus income needs.

Stocks often lead the economy out of a slowdown and in this slowdown they have not been a leading indicator.

Long-term planning can lead to financial success and it is never a good time to make emotional investment decisions. A long-term financial plan can help

- Assess financial situations by helping track income and expenses;
- Assess risk tolerance and develop an asset allocation strategy;
- Establish an emergency fund, and determine net worth;
- Save for major expenses like funding a child's education, buying a house or car, or developing a cash reserve for special occasions like weddings and vacations;
- Plan an estate to ensure assets are distributed the way one desires, fund estate taxes, and minimize their effects where possible;
- Plan for retirement by estimating retirement income and expenses and the value of government programs;
- Plan to reduce taxes, project the effect of federal income taxes, and develop a tax-deferred strategy;
- Protect against financial crisis should one become disabled or die.

A financial plan can give a clear picture of where an individual is, a strategy about where he or she is going, and peace of mind about the future. Most individuals have three long-term goals:

- Retirement;
- Children's education;
- Buying a home.

But there can be other goals, like planning for an income stream later in life so that an individual can pursue a second career. A person with a 30-year horizon can afford to assume more risk than someone investing for a goal just seven or eight years because 30 years provides plenty of time for a portfolio to recover if stocks decline in the short-term. The precise asset mix will depend on such factors as time horizon and level of risk tolerance.

Next, an individual must figure out how to get there. Since stocks have historically outperformed bonds and cash investments over the long term, equities will likely play a key role in a portfolio.

Financial Short Term Goals

Short-term financial goals are set annually as they cover a twelve-month period and should be consistent with established long-term goals. These short-term goals become the key input for the cash budget --a tool used to plan for short-term income and expenditures. The individual's or family's immediate goals, expected income for the year, and long-term financial goals must all be taken into account to define short-term goals.

Consideration must also be given to the latest financial position, as reflected by the current balance sheet, and spending in the year immediately preceding, as reflected in the income and expenditures statement for that period. Short-term planning should include establishing an emergency fund with three to six months' worth of income. Expenses that would be included are rent or mortgage payment, utilities and the cushion that should be allowed for each month.

Considering Factors in Needs Analysis

A financial profile and the needs are different from that of one's neighbor. And the same is true for insurance needs. Irrespective of the differences, the number of

dependents and their financial needs are the most important factors to consider. Issues to consider include:

- Inheritance to leave them;
- Lifestyle wanted to provide for them;
- Significant foreseeable expenses;
- Wealth, income, and expense levels of dependents.

Obviously the above factors mean nothing to the insurance planning process unless they are quantified. Whenever any of the factors discussed above change, an individual should re-evaluate his or her life insurance needs.

Dependent Factor

Insurance Needs Analysis advice seems to be based, many times, on one's marital status. The most important factor, however, is if one has any dependents — those who are (or who will be) counting on the policy owner to support them, either partially or fully — and how many dependents there are. Below are some additional factors to consider:

- A family's college expenses;
- A working spouse, who would retire to raise children;
- Any debts that one wants paid off (such as a mortgage, car loan or credit card);
- Parents, who may become financially dependent on the policy owner;
- Special needs, such as a handicapped child;
- The style of lifestyle one wants to provide for a family;
- The non-working spouse, who would not have an income.

Life insurance should be considered necessary even if an individual is wealthy and thinks that he or she might not need coverage or ones taxable estate approaches \$700,000 and he or she is single, or \$1.4 million if married.

Married but Childless Factor

If an individual is married and does not have children, insurance needs will vary from almost nothing to needing heavy coverage. If a spouse can live on his or her income alone and there is no mortgage, or there is no concern about paying it off in the near future, ones only need may be to cover any final expenses incurred at death. This individual still should consider the possibility that parents may depend on a son or daughter in the future, or that there may be an opportunity to help pay for college costs for a family member.

Single or Divorced Factor

Single people are often told that they don't need insurance, or that the small policy that comes with their work benefits is enough. If one leads a simple life with no mortgage and no significant other, a life insurance policy may be an unnecessary expense. The financial pressures that may result from a divorce can only add to an already emotionally draining situation. Financial pressures may also arise from inequalities that occur when a divorcing couples financial affairs are separated.

Divorced people have special insurance needs. If one falls into that category, one had better dig out the divorce agreement. It may stipulate that one has to keep a certain amount of life insurance in force for an ex-spouse or to pay part of a child's

education. Even if the divorce agreement does not require it, if one has children, he or she should have life insurance in order to leave them an inheritance and to cover his or her part of the college costs.

5. The Basics of Group Life Insurance

Group insurance is almost always issued as a yearly renewable one-year term insurance with coverage expiring at the end of each year but renewable automatically without a medical examination and without further evidence of insurability. The premium rate per \$1,000 of protection increases from year to year. Death benefits are paid upon the insured's death from any cause.

Defining Group Life Insurance

Life insurance companies offer employers, professional societies, unions and other organizations the option of providing life insurance to their members or employees through group life insurance policies.

Although most group life policies provide term coverage, most states require a conversion privilege allowing employees to convert their policies to permanent insurance and pay premiums directly to the insurer when they leave their jobs or the organization. Some employers offer permanent insurance policies, under which employees pay for the entire policy and can retain coverage after leaving the company by paying premiums directly to the insurer.

Group life insurance provides insurance for a group under a master contract between the insurer and the employer. Group term life insurance policy contracts usually contain provisions for the protection of disabled employees -- waiver of premium and maturity value benefit.

Types Of Groups

The life insurance coverage provided by most group plans is one-year term. The plan comes up for renewal each year, and both the insurance company and the employer have the opportunity to consider whether to continue it. The employer is the policyholder and each covered individual is issued a certificate showing his or her certificate number. Some group plans include cash value insurance as an option.

Creditor-Debtor Groups

These groups refer to when a lending institution offers the borrower or debtor the opportunity to purchase insurance coverage. The purpose of this could be to protect the creditor by making funds available to pay off the loan if the debtor dies before doing so.

Employer-Employee Group

This group has an arrangement where the employer makes insurance available to his or her employees.

Multiple Employer-Employee Groups

This group can be referred to as multiple employer trusts or METs with an arrangement that allows small employer-employee groups to join together to receive the same group insurance considerations as larger employers. A group must have a minimum number generally of ten.

Organized Union Groups

This group could be provided for all members of the United Auto Workers or the Communication Workers of America or any other organized labor or workers union.

Types of Policies

Basic Group Term Life

Basic group term life is term insurance that is affordable and practical, designed to meet the needs of a diversifying work force. An accelerated benefit option provides terminally ill individuals with up to 50% of their life insurance benefits prior to their death.

Dependent Group Term Life

Dependent Group Term Life extends voluntary life insurance protection to the employees entire family - up to \$15,000 in coverage for the employees spouse and up to \$2,500 in coverage for each dependent child and offers conversion coverage without evidence of insurability and a waiver of premium for disability.

Dependent Life

Dependent Life is a renewable term life insurance policy that provides for the payment of a specified amount in the event of the death of an employees insured dependent. Employer-paid premiums for Dependent Life insurance are tax deductible by the employer and tax-free for the employee to the extent that the coverage is considered incidental.

Generally, this coverage is limited to no more than 50% of the employees coverage and is almost always further limited by insurers to \$55,000 or \$10,000. When the premiums are employer-paid, the amount of \$2,000 or less of coverage for a spouse and each dependent child is excluded from a covered employees gross income.

Group Creditor Life Insurance

Banks, finance companies, credit unions, retailers, and others may qualify for Group Life insurance on the lives of individuals who borrow money from the creditor. Although one purpose of Group Creditor Life insurance is to protect lenders against financial loss due to the death of a debtor, these companies are often in the business of selling the insurance.

Group Survivor Income Benefit Insurance

Group survivor income benefit insurance provides a continuing monthly income benefit to qualified family survivors at the death of a covered employee with a fixed percentage of the covered employees basic monthly earnings or a flat

specified amount applicable to all insureds. Payments made to a surviving spouse stop at the earlier of a specified age such as 62 or the survivors death. Payments made to surviving children ends when the youngest unmarried child is 19.

Group Universal Coverage

Group Universal Life is a Group Life insurance product that allows covered employees/members and their covered spouses the option of contributing to a cash value fund in addition to purchasing Group Term Life insurance. Group Universal Life combines the economy of scale and other advantages of group coverage with the flexibility and potential for gain of a Group Universal Life insurance contract because it is a combination of Group Term Life insurance with a cash accumulation feature.

The typical Group Universal Life contract is held by a large group of 1,000 or more employees. Employees pay the entire premium for the coverage, and the employers only outlay is for indirect costs such as installation and administration. Premiums are flexible, not fixed. Group Universal Life Insurance provides tax savings benefits that are all interest earnings on the cash accumulation contributions accrued on a tax-deferred basis.

Optional Life Insurance Coverage

Employees must have basic life insurance coverage to purchase optional coverage. Participants may elect up to two times the basic life insurance election amount, in multiples of \$10,000 only. Coverage amounts range from \$5,000 to \$200,000 on the employee only. The employee pays this coverage in full and the premium amount changes every five years of age increments.

To enroll outside open season or after 31 days from appointment to a regular position, the employee must complete and submit an evidence of insurability form. Benefits eligible employees may elect to purchase optional Group Life insurance coverage through additional payroll deductions. Employees must apply within 14 days of their date of hire or during an open enrollment period, which is held for two weeks in February every even numbered year.

Optional Life Insurance for Retirees

Optional Life Insurance Coverage for Retirees is a plan for employees who participated in the Optional Life Insurance Plan for the five-year period immediately preceding retirement - or if the employee participated for 15 years, the employee is eligible to continue the lowest amount of optional coverage in effect during the five years just before retirement. The retiree must pay the full cost of the coverage until age 65, at which time there is no cost. Beginning at age 65, the amount of the benefit will be reduced 2% each month for 50 months, at which time this coverage will end.

State Group Life Insurance

The employer pays the entire cost of this coverage. The group life insurance coverage provides an insured death benefit, which is currently 150% of the employee's annual rate of compensation. Upon termination of employment or

retirement, an employee may convert the life insurance to an individual policy. This conversion must be made within 31 days of termination or retirement, whichever may occurs first.

Supplemental Group Term Life

Supplemental group term life is for companies employing 50 or more people to make additional life insurance available to their work force at no cost to the employer. Supplemental Group Term Life offers the same features as Basic Group Term Life, subject to a few special limitations. To offer this coverage, companies must have an active employee participation level of at least 65%

Features and Benefits of Group Life Insurance

One of the primary features of Group Life insurance is that it is made available to everyone in the group at much more attractive rates than would be available with an individual policy because of the law of large numbers. Some members will leave the group before they die, thus terminating their insurance coverage since Group Life is usually term insurance. New, often younger, members will join the group, generating additional life insurance premiums.

Insurability

Usually only members of the very smallest groups are required to prove their individual insurability, while members of larger groups are often covered automatically when they become eligible. This is typical, but there are exceptions, so it is important to know exactly how a particular insurer writes Group Life coverage.

Schedule of Benefits

A Benefit Schedule is a predetermined statement of the formula under which benefits will be provided. These Benefit Schedules generally generate coverage amounts by using five different formulas.

Duration of Service

This will reward long-term employees and may also decrease an employee's incentive to leave the company. Few employees would stay with a company only because of the group coverage or of its formula or the insurance coverage provided to employees under this method.

Occupational Classification

Uniform amounts of coverage are provided within each classification. The advantage of this type of formula is that it is simple to administer and is somewhat related to the employees survivors needs, to the employees ability to pay in the case of a contributory plan, and to the employers assessment of the employees worth to the business.

Earnings

Proponents of an earnings basis schedule point out that this type of formula benefits survivors by providing an amount equal to full salary for a limited time after death and by tending to increase with inflation since it is tied to salary. The employees who may be more productive and consequently are paid more are rewarded accordingly, and if the plan requires contributions, cost is directly related to the employees ability to pay.

Flat Benefit

This formula provides a flat benefit amount for all participants, thus being the easiest formula to administer. Giving everyone the same benefit bears a close relationship to a needs and abilities to pay policy and is a good choice for a large multiple-employer group providing coverage under collective bargaining agreements.

Combination of Factors

Perhaps the most common formula will base the amount of insurance on a multiple of the employees income -- from one to three times earnings. Most insurers require a minimum of \$5,000 on each covered employee or even \$10,000 in the case of small groups. However, most insurance companies will issue up to \$500,000 or more on any particular life. Group insurers use medical examinations for ultra large amounts, sometimes establish special reserves, and reinsurance at least a portion of the coverage.

Master Contract

The master contract is held by a master policy-owner, such as the employer. The master contract details the coverage just as any other life insurance policy does, but instead of individual policies, insured employees receive certificates of insurance as proof of coverage. This certificate provides essential information such as:

- Who is covered?
- When the coverage takes effect?
- How long it lasts?
- The amount of insurance provided?
- The claims procedures?

Since the employer is considered to be the master policy-owner, he or she is responsible for paying premiums to the insurance company, although the employee may share in the payment of the policy premiums.

When the employer signs the master contract, he or she will be assured that the insurance company cannot refuse to renew the contract as long as the employer wishes to continue coverage and pays the premiums. The insurance company will have the right to cancel the contract if the number of employees falls below a specified number. There are four important clauses in the master contract.

- **Adjustment in Premiums Clause** ~ When an employee's age is overstated, the employer will receive a refund or if it is understated, there is no change in the employee's coverage, but the employer will be required to make up the difference in premiums.

- **Claims Limitation** ~ A death benefit claim must be made within one year of the last premium paid for a deceased employee.
- **Grace Period** ~ This period is often 31 days after the premium is due.
- **Incontestable Clause** ~ The policy is incontestable except for fraud.

Eligible Employees

Rules for eligibility can vary among groups, as long as the rules are neither discriminatory nor unfair to the insurance company. Typically, employers require employees to be continuously employed for a certain length of time before they become eligible. In some cases, only employees who are paid a specified minimum salary are eligible or only full time employees are eligible while part time and seasonal employees are not.

Contributory and Non-Contributory Plans

When the employer pays the entire premiums with no contribution from the employee, the plan is *non-contributory* and 100% of eligible employees must be included in the plan to prevent discrimination. Plans that require any premium payment from employees are called contributory. In this plan employees have the option to choose whether they are covered or not. Usually at least 75% of the eligible employees must participate to maintain profitability and to avoid adverse selection.

Conversion Privilege

Some Group Life insurance plans permit the covered person to convert the Group Term Life insurance coverage to an individual cash value life insurance policy if the employee leaves the group. When this conversion privilege is available, the individual must exercise it within 30 or 31 days.

The Beneficiaries

The covered employee has the freedom to name or change any beneficiary he wants, although some states prohibit the naming of the employer as a beneficiary. If the named beneficiary does not survive the insured, and there is no secondary beneficiary named, the death benefit will be paid to the estate of the covered employee or to a successive beneficiary specified in the master contract.

The facility of payment clause in the master contract allows the insurer to pay \$500 funeral or last illness expenses for the covered employee.

Qualifying for Group Life Insurance

The Employee Retirement Income Security Act (ERISA) requires that a Group Life insurance plan be established and maintained in writing providing a procedure of amending the plan should the occasion arise, and the inclusion of one or more named fiduciaries who administer the plan.

The plan documents must specify the basis on which payments are to be made to and from the plan. The claims review procedure of the plan has the following prerequisites for a Group Term Life policy:

- The plan's benefits must be offered to a group of employees as compensation for their services;
- The amount of insurance provided to each employee must be computed under a certain formula;
- The plan must provide a specific death benefit that meets the definition of the contract.

Life Insurance Policy Dividends

Dividends are profits the insurance company shares with its policyholders. Dividend payments are not guaranteed and they may change annually. Dividends are not included in the face amount of the policy. When a death benefit is paid, the dividends or additional paid up insurance purchased with dividends will be added to the face amount of the policy. Dividends can be used in several ways:

- They can be left with the company to accumulate interest;
- They can be left to offset the premium due on the policy;
- They can be left to buy additional insurance;
- You can ask the company to send them to you.

Life Insurance Policy Exclusions

A life insurance company has the right to deny benefits if:

- The insured commits suicide within the first two years of the policy.
- The insured dies as a result of war or act of war while serving in the naval or military service or while serving in any civilian noncombatant unit serving with such forces.
- The insured's death is related to aviation, except when riding as a fare-paying passenger of a commercial airline flying on regularly scheduled routes between definitely established airports.

6. The Basics of Life Insurance Policies

Life insurance policies are divided into two main types: those that provide only death protection without any side fund buildups or cash values (least expensive cost per \$1,000 of death coverage purchased) and those which offer or require cash value accounts in which a return-on-investment component becomes an often complex and expensive part of the policy (most expensive cost per \$1,000 of coverage).

The two major types of life insurance are term and whole life. Whole life is sometimes called permanent life insurance, and it encompasses several subcategories, including traditional whole life, universal life, variable life and variable universal life. In 2003, about 6.4 million individual life insurance policies bought were term and about 7.1 million were whole life.

Life insurance products for groups are different from life insurance sold to individuals. The following information focuses on life insurance sold to individuals.

Term Life Insurance

The simplest of all life insurance to understand and the cheapest of all life insurance to buy on a net cost basis is term life insurance. Term life insurance provides death benefit protection without any savings, investment or cash value

components for the term of the coverage period. Term life insurance is available for set periods of time, such as 5, 10, or 20 years, during which the premiums are guaranteed not to increase.

As long as you pay your premium, the company cannot cancel you. Some new universal life policies perform like term life insurance in that they can be configured at the time of purchase to provide both level death benefits and level premiums that are guaranteed for life as long as you pay the scheduled premium.

Term life insurance has become very popular with consumers in recent years because of the new and longer rate guarantee periods and because premiums for new policyholders have recently dropped to all-time lows. Term life insurance premiums have recently dropped to all-time lows.

Nonguaranteed term life provides coverage only for a short time (usually a year) and is pure death-benefit protection. The risk with term life is that your health might deteriorate and you could be unable to get another policy once the term is up. Premiums can also increase dramatically as you age, but term life insurance is usually a good choice for young people who can't afford the higher expense of permanent insurance, or for people covering specific needs that will disappear in time, such as a car loan or a mortgage.

Yearly **renewable** term insurance offers a longer term, usually for 5, 10, or 20 years. By buying a longer term policy, your costs can be stretched out to avoid the annual increases found in nonguaranteed term life.

Convertible term is like yearly renewable term but it also offers conversion to a permanent policy in the future -- when regular term premiums might become cost-prohibitive or if your health declines. Convertible term policies usually provide the maximum protection with the smallest amount of cash outlay required. This is a good choice especially for young people who are unable to afford the higher cost of permanent insurance right now but need maximum life insurance and also want to have the option of converting to permanent coverage in the future.

Permanent Life Insurance Whole Life or Ordinary Life

Similar to yearly renewable term and convertible term, whole life policies stretch the cost of insurance out over a longer period of time in order to level out the otherwise increasing cost of insurance. It is spread not over a few years but over an entire life. Ones excess premium dollars are invested in the company's general portfolio. With this type of policy the inflexibility of premium payments could become a burden if expenses increase or if there is some other adverse financial event.

Whole Life

Let's turn our attention to whole life policies. We will examine the main features of whole life insurance and basic types of policies available to consumers.

The first thing to remember is that whole life insurance provides permanent protection. What does that mean? That means that the insured is usually covered for life, as long as the policy premiums are paid. Premiums and death benefits are both guaranteed, and will remain level (or unchanged) as long as the policy is in force. There is, however, a certain age limit at which the policy matures, and if the insured is still living, it's the insured, and not the beneficiary who would receive the policy face amount. Currently, that age is set to 100; however, insurance companies are gradually adopting a new age limit. Whole life policies mature according to current mortality tables, which are being updated to reflect longer life spans and include maturity age of 120 years.

Another very important feature of whole life policies is that they build cash value. The cash value usually starts to accumulate in the third policy year, grows tax deferred, and is available to the insured to borrow. It can also be used as cash-out if the policyowner decides to surrender the policy before it matures.

Let's look at a couple of these features in greater detail.

When a policy matures, cash value will be equal to the face amount. The benefit is paid out and the policy is no longer in force.

You should remember that an insured can borrow money against the cash value. The insured has the right to take out a loan – another feature of a whole life policy. The loan doesn't have to be repaid per se; however, any outstanding loan balances will be deducted from the face amount.

You should also remember that cash value accumulates tax deferred. That means that the insured doesn't pay taxes on the cash accumulation until they access it through policy loan or the payout of death benefit to a beneficiary.

One of the distinguishing features of whole life is that the premium paid by policyowner does not change during the life of the policy, or during the premium-payment period if it's shorter. The insurer front-loads the policy by "overcharging" the insured in the earlier years of the policy as a way to compensate for increasing mortality, as both the policy and the insured age.

So to recap: Whole life policies provide permanent protection, which means they offer cash value, which means you can borrow that cash value in a form of a loan. When the policy matures, the cash value equals the face amount, and is paid out to the policyowner. Of course, there are many more features of whole life policies, but for the purposes of your prelicensing education, you need to remember the basic concepts.

Now, let's take a look at some of the types of whole life policies. The first three we'll discuss based on how the policyowner pays the premium. They are ordinary or straight life, limited-pay life, and single-premium policies.

Straight Life, also known as continuous premium whole life, charges a level annual premium for the lifetime of the insured and provides a level, guaranteed death benefit. As any whole life policy, straight life insurance builds cash value. All other factors being equal, straight life policies have the lowest annual premium among whole life policies.

A variation on straight life is limited-pay whole life. The only difference between straight life and limited-pay life is that a limited-pay policy specifies a set number of years during which the policyowner must pay premium. After the premium is paid up, the policy remains in force for the insured's lifetime. Two common examples are a 10-pay life, where the policy is paid up after 10 years of premium payments, and limited-pay to age 65 (or LP65), where the policy premium is calculated to be paid up by the insured's age 65. Again, the policy then stays in force for the remainder of the insured's life.

Limited-pay policies usually have higher premiums than straight life policies because the premium payment period is condensed. Also note, because the premiums are higher, limited-pay policies accumulate cash value more quickly and continue to build cash value after the premium payment period ends.

LP65 policies are becoming more common as people decide they want life insurance coverage during retirement, but don't want to have to worry about paying premiums with limited retirement income.

10-pay policies are popular as children's policies. The difference in premium between a straight life, and a 10-pay on a young child is generally very small, and customers are seeing the value of paying slightly more for a shorter period of time.

Another type of policy that relates to the way the premium is paid is called single-premium whole life. These policies use a one-time, lump-sum premium payment to provide a level death benefit to the maturity of the policy. Single premium policies generate immediate cash value due to the size of the lump sum premium payment. This type of policies is often purchased with the death benefit of a previous policy or with a severance package if a job change occurs.

The way these policies differ from other traditional whole life policies is that they are subject to a surrender charge if the policy is surrendered within a certain time period. Generally, the surrender period is 7 to 10 years on a diminishing basis. In other words, the charge will be higher if the policy is surrendered in year 3 than if it is surrendered in year 7.

We'll begin by looking at interest-sensitive whole life insurance. This type of policy is also referred to as "current assumption life". This name comes from the fact that the insurer changes its premium assumptions based on mortality, investment factors and expenses.

The following are the features of interest-sensitive life policies:

- Varied premium; and
- Cash value that can be greater than what's guaranteed in the policy (due to a higher interest rate).

Here is how the premium may change in the policy. For the first couple years the policy is in force, the premium will remain the same (based on the insurer's original assumptions). If later the actual cost decreases, the insured's premium also decreases. If the cost goes up, the insured can either pay a higher premium or reduce the death benefit.

The main difference between traditional whole life and interest-sensitive whole life is that interest-sensitive products pay current interest rates, so they can accumulate cash more quickly or shorten the premium payment period.

There are two kinds of interest-sensitive whole life—Modified and Graded Premium. Both of these types of policies are a compromise between convertible term life and straight life insurance.

Modified life offers a lower premium in the first 3 to 5 years of the policy, and then a higher level premium for the rest of the insured's life. These policies would be ideal as key-person or buy-sell business policies for start-up businesses. While the business may not be able to afford the premiums of a straight life policy when they first need it, they expect their income to increase and can plan on higher premiums in a few years.

Another appropriate use for modified whole life is for newlyweds who want the cash value growth provided by whole life, but can't afford the higher premiums when compared to term coverage. With modified whole life, they can have both lower premiums and cash value.

Graded premium whole life is similar because the premiums start out low and then level off in the future. The premium will start out at 50% or lower than a straight life policy, it will increase each year for 5 to 10 years, and then level off for the life of the insured.

With either type of policy you will pay the same amount of premium over the life of the policy as you would for a straight life policy.

Now that you are familiar with the basic features of both term and permanent coverages, move on to adjustable life policies that actually can be either term or whole life. The insured chooses the amount of coverage they need, and how much premium they can afford. The policy can be adjusted as the insured's needs change. Usually, the policyowner can:

- Increase or decrease premium,
- Change the premium-paying period,
- Increase or decrease the face amount of coverage, or
- Change the period of protection

Please note that increasing the death benefit, or changing to lower premium payments will normally require proof of insurability. Still, adjustable life policies offer a lot of flexibility to the policyowner, including converting from term to whole life and vice versa.

Adjustable policies have most of the features of whole life policies, such as loan provisions, nonforfeiture options, and others. The difference is that the cash value of adjustable life grows only when the premiums that are paid in are more than the cost of the policy.

Variable Life

As with whole life, you pay a level premium for life. However, neither the death benefit nor cash value are predetermined or guaranteed; they fluctuate

depending on the performance of investments in what are known as sub-accounts. A sub-account is a pool of investor funds professionally managed to pursue a stated investment objective. The policy owner selects the sub-accounts in which the cash value should be invested.

Universal variable life is a combination of universal and variable life. Premiums can be paid at any time, in any amount, as long as policy expenses and the cost of insurance coverage are met. The amount of insurance coverage can be changed, and the cash value goes up or down based on the performance of investments in the sub-accounts.

Universal Life

This kind of policy, while offering greater flexibility than whole or term life in terms of making changes while the policy is in force, can have many moving parts which should be understood before purchase occurs. After your initial payment, you have the option of reducing or increasing the amount of your death benefit. If an individual chooses to increase a benefit, he or she may have to provide medical proof that his or her health has not deteriorated. Also, after an initial payment, premiums can be paid any time and in any amount, as long as the policy owner does not miss a minimum payment. In some cases, there are limits to how much extra can be paid in advance premiums.

Specialized Policies and Combination Plans

In addition to the traditional forms of life and interest-sensitive policies, insurers have developed a variety of other policies or combination plans that are primarily the result of packaging two or more coverages. In this session, we'll examine specialized policies and combination plans, and then study other life insurance products such as endowments and viatical settlements.

The first policies to study are specialized policies designed to serve a variety of needs of the insured.

First is **juvenile life** insurance. And as the name implies, it is any life insurance written on the life of a minor. In this type of coverage, application for insurance, and policy ownership are maintained by an adult – a parent or a guardian. The adult will also pay the policy premiums. These policies usually come with a payor rider that provides that in the event of death or disability of the adult premium payor, the premiums on the policy will be waived until the insured child reaches a specified age.

Next, let's look at several types of **family plans**, which are considered combination policies. Remember, combination policies combine term, whole life or endowment insurance to meet specialized insurance requirements.

A family maintenance policy is life insurance based on a family income policy which combines whole life with level term insurance to provide a beneficiary with income over a specified period of time (such as 15 or 20 years). If the insured dies within the time period, the level term insurance is sufficient to pay the monthly income portion of the contract.

The policy also contains permanent insurance protection to be paid upon the death of the insured. Should the insured survive the specified time period, then the term portion expires without value, and the contract is left with only the permanent life protection.

Next type of family policies is a Family Protection policy, which also combines whole life with term insurance to cover family members in a single policy, but insuring every member of a family. The family policy typically provides whole life insurance on the breadwinner, and convertible term insurance on the other family members. The spouse has the opportunity to convert his or her term coverage to permanent coverage until age 65. Children are automatically covered after birth for a specified period of time, usually 30 or 31 days. To continue coverage for the newborn after the initial period, the parents must inform the insurer of the birth within that time period. Children may convert their term coverage to permanent coverage when they turn the age of 21, or the maximum age for coverage as a dependent that is stated in the policy, without evidence of insurability.

The last type of family policies is the Family Income Policy, which is a combination of decreasing term insurance and whole life insurance on the breadwinner of the family. The policy is designed to provide an income period which begins from the effective date of the policy and commonly runs for 20 years, but it also could be issued for 10 years or even to age 65. This income period is funded with decreasing term insurance. If the insured should die any time during the income period, the term coverage will provide the surviving family with a monthly income for the remainder of the income period. At the end of the income period, the face amount of the whole life coverage is paid to the beneficiary. If the insured dies after the income period, only the whole life portion will be paid to the beneficiary.

For example, if one purchases a 20-year family income policy and dies five years after the policy is issued, the decreasing term portion of the plan would provide his or her surviving family with a monthly income for 15 years. At the end of the 15-year period, the whole life death benefit would be paid to the family.

Family policies may not suit the needs of families today; they were designed a few decades ago to meet the needs of the baby-boomers generation. In your experience as a producer, you may still encounter these policies.

Moving on. The next 2 types of combination plans we'll talk about provide multiple protection. They are **Joint Life** and **Survivorship Life**.

Joint Life is a single policy that insures two or more lives. The key feature to remember about this type of policy is that it pays the death benefit upon the FIRST death. Even though the policy covers 2 or more lives, as soon as one of the insured dies, the coverage stops.

Joint life policies can be in the form of term insurance or permanent insurance. The advantage of this policy to the insured, is that the premium would be lower than if the insured each bought individual policies. Why is that? Well, the premium in joint life policies is calculated based on a joint average age of all the insured. Most commonly these policies insure a husband and wife.

Joint Life Policies are used when there is a need for two or more persons to be protected; however, the need for the insurance is no longer present after the first of the insureds dies.

For example, a married couple purchasing a house may use a Joint Life Policy for mortgage protection if both spouses work and earn close to the same amount of income. If one spouse dies, the insurance pays the mortgage for the surviving spouse.

Now what if the surviving spouse actually needs additional protection? What type of insurance should they choose then? Survivorship life. Also called "second-to-die" or "last survivor" policy, it is very similar to joint life, but as we just established, the policy will pay the benefit upon the LAST death. As in joint life, the policy premium is based on the average age of both insured. However, since the death benefit is not paid until the last death, the joint life expectancy, in a sense, is extended, resulting in an even lower premium than what is typically charged for joint life. This type of policy is often used to offset the liability of the estate tax upon the death of the second spouse.

By now you should be familiar with features of a whole life policy. **Endowment policies** are another type of whole life insurance, and have all the same characteristics of traditional whole life insurance. However, there is a slight variation in the maturity date. Endowments provide permanent protection with a level death benefit, and accumulate cash values.

Premiums can be paid up before the endowment date, for a limited period of time, or in a lump sum single payment.

The primary difference between a whole life policy and an endowment is that an endowment matures (or endows) at an earlier age, before age 100.

Endowments could be a double-edged sword for the policyowners. On the one hand, they offer some great advantages. First is a rapid growth of cash value. Next, is deferral on taxes on cash value growth, and finally, the possibility of avoiding paying income taxes all together if the insured dies and the proceeds are paid as a death benefit.

The same features, however, could just as easily become the disadvantages of endowment policies. Endowments are known for their high cost (remember, the sooner the policy matures, the higher the premium will be). If the insured lives to the endowment age, there will be immediate tax liability once the benefit is paid.

While endowment insurance is widely available in international markets, they are no longer sold in the United States due to the tax law change enacted by the Tax Reform Act of 1984. As an insurance producer, you may still find endowment policies in force though.

Now, let's take an in-depth look at **universal life** policies. The generic name for universal life is flexible premium adjustable life. This is very important: a universal policy has two components - an insurance component and a cash account. The insurance component of a universal life policy is always annual renewable term insurance. Universal life policies are offered as unbundled products, which means

that all the pricing elements are disclosed separately by the insurer. There is the insurance protection element, the savings element, and the expense element (also known as loading). In contrast, in traditional term or whole life insurance the policyowner is charged a single gross-premium amount.

Universal life policies provide some unique rights to the policyowners, such as

- Increasing or decreasing the death benefit;
- Increasing the premium amount paid in, and then decreasing it again in the future;
- Skipping premium payments.

In this case, the policy cash value will pay the monthly cost of insurance, so the key here is to make sure that there is enough cash value in the policy to pay for the cost of insurance without letting the policy to lapse.

Finally, universal life policies allow partial withdrawals or surrender of cash value.

When the policyowner withdraws part of the policy's cash value, those funds do not have to be repaid, and the policy does not incur any interest on the withdrawn amount. In fact, that's the main difference between a loan and a withdrawal. With the latter, there is no assumption that it will be repaid. Since it's treated as a permanent withdrawal, the death benefit, and the remaining cash value are immediately reduced.

The cash account provides tax-deferred accumulation at either the guaranteed contract rate or the current interest rate, whichever is higher.

Regarding the death benefit in universal life policies, there are 2 options: Option A – the level death benefit, and Option B – Increasing death benefit.

Option A provides a level death benefit and the cash value that increases. This is a lot like whole life insurance. In later policy years though, the death benefit may increase just enough to maintain the IRS mandated gap between the death benefit and the cash value. If that corridor is not maintained, the policy doesn't meet the definition of insurance and will lose its tax advantages.

Option B is the increasing death benefit option. In this scenario, the death benefit increases each year by the same amount as the cash value. The total death benefit is always the cash value plus the face amount. All other factors considered, Option B will have a higher premium than Option A.

There are a few additional types of **interest-sensitive life policies**, so here are the most common types:

- Equity indexed whole life,
- Enhanced ordinary life, and
- Equity indexed universal life

As the name states, equity index policies use an equity index as their investment feature. They offer flexible premiums, an adjustable death benefit, and allow the policyowner to decide where the cash value will be invested. Under the Equity Index Universal policy, the policy's cash value is dependent upon the performance of the equity index. Cash values and death benefit are not guaranteed.

The next category of insurance products to study in-depth is **variable life**. While elements and characteristics of variable life policies could be very complex, the underlying principles of that type of insurance are pretty straightforward. That's what is going to be outlined here, to help you remember the key features.

First, you need to remember that there are some elements that are the same in both traditional and variable insurance. Variable whole life policies offer permanent protection for the life of the insured. There is always a guaranteed minimum death benefit, and the policy premiums are fixed and level.

Now, unlike traditional life insurance policies that guarantee fixed benefits stated in the contract, variable policies include cash value that accumulates based on a specific portfolio of stocks with NO guarantees as to performance. Fixed policies invest in the company's general account, but variable products use separate accounts for their investments.

The death benefit in variable life policies may increase or decrease throughout the life of the policy, although remember: it will always be at least the minimum stated in the policy.

Since variable life insurance is dually regulated by the state Department of Insurance AND by the federal Securities and Exchange Commission, or SEC, producers selling variable products must be licensed for both insurance and securities, and are required to register with the Financial Industry Regulatory Authority, or FINRA.

So, as an insurance producer, to whom would you recommend variable products? Variable products are best suited for younger people who will not need access to the cash value for the long term, who are willing to invest more aggressively than in traditional whole life, and who can withstand the ups and downs of the market. Variable policies are a good alternative for someone who doesn't have the ability to purchase both life insurance and investments, since variable policies provide both.

So let's recap some of the characteristics of variable life insurance:

Their advantages to the owner? A hedge against inflation and control over investments. However, the disadvantage is that the policyowner bears the investment risk.

Our final topic for this section of the text is **viatical settlements**. Viatical Settlements are unique contracts that allow someone living with a life threatening condition or a terminal illness to sell their life insurance in order to have the money when it's most needed. The insured who is selling the policy is called viator. Viators usually receive a percentage of the policy's face value from the purchaser. Viatical companies typically offer 60 to 90% of the death benefit to the viator. The new owner then continues to pay the policy premiums and will eventually collect the entire death benefit (once the viator dies).

Viaticals are regulated by the Department of Insurance that has established specific rules on how they can be transacted, and what licensing is required. In order to sell viatical settlements, a person or an entity must be licensed as a

viatical settlement provider. The license may be issued only if the provider has produced a detailed plan of operation, is deemed to be competent and trustworthy, and has a good business reputation and appropriate training, education, and other qualifications. The viatical settlement provider's license expires every year.

Burial Insurance

Burial insurance usually refers to a whole life insurance policy with a death benefit of from \$5,000 to \$25,000. As its nickname implies, people buy this type of policy to provide money for funeral and burial costs for themselves and/or family members. It is possible to buy a policy after answering a few health-related questions on the application and with no medical exam.

Premiums are payable weekly or monthly. The premium is usually collected at the policy owners home or workplace, and the premium is usually a small round number, such as \$2 or \$3 per week; the death benefit is whatever that premium will buy given the insured's current age.

Burial policies may be designed to cover one person or everyone in a family. Under some state laws, funeral homes may be licensed to sell burial insurance, but it is mainly sold through brokers and agents of insurance companies licensed to sell life insurance.

An approach that is similar to burial life insurance (and sometimes called burial or pre-need insurance) is pre-payment of your funeral arrangements. Under this program, an individual may select the funeral home, type of service, casket (or cremation), flowers, headstone, burial plot, the cost of digging and filling the grave, and other items, and lock in the prices for them by paying in advance.

Cash Value Life Insurance

If an individual wants more than death benefits from a life insurance policy and wants to expand its purpose into that of a long-term savings account or stock market investment in addition to its life insurance component, one might consider cash value life insurance such as whole life, universal life or variable life. It is possible that an individual will have to pay much higher premiums per \$1,000 of coverage precisely because a cash value account is being funded in addition to paying for expected mortality (death) costs.

In many cash value policies, the annual premium does not increase from year to year but remains level throughout the premium-paying period. Some universal life policies allow you to adjust your death benefit amounts or to skip premium payments altogether for some periods of time.

Because of its complexity and dizzying array of possible outcomes as respects the death benefit and premium payment schedules, regulators insist that cash value insurance be sold using pre-approved illustration formats. As a forewarning, be aware that the illustrations for cash value insurance can run to 15 or more pages. Cash value life insurance illustrations are divided into two major sections: the guaranteed section and the projected or illustrated, non-guaranteed section.

Vanishing Premium

Many people think that the feature of a vanishing premium is attractive. They like the fact that at some future point, the internal build-up of values will offset the annual premium resulting in no more out-of-pocket payments. A vanishing premium is possible when there are dividends. A major component in the dividend is the return of investment income in excess of what is guaranteed by the contract. In other words, if there's no excess interest, the premium will never vanish.

Borrowing Against the Cash Value

A procedure used by some insurers to accelerate the point at which the premium vanishes is to pay the premium by borrowing against the cash values. However, the internal borrowing may not be apparent in a projection. A way to spot internal borrowing is to compare guaranteed cash value with actual cash value. Because the internal borrowing will have reduced the actual cash values, they will be lower than the guaranteed amount. If an individual sees that happening they can request an expanded projection that considers all borrowings.

The Current Dividend Scale

There are companies that make aggressive projections for potential policy owners using the current dividend scale and the assumption that both policy owners live forever. Unfortunately, that is only true in the world of projections.

A potential policy owner will want to see real life assumptions from projects that show how the contract operates when the first death occurs in years one, five and ten. In addition to knowing whether the insurer is capable of delivering a check at the second death, it is important to recognize additional characteristics of the second-to-die policy. Listed below are some of the points to consider.

- In the event of a divorce, what happens to a policy that insures both a husband and a wife.
- In the event of a repeal of the Unlimited Marital Deduction or a substantial decrease in estate tax rates, what happens to a policy that insures both husband and wife?
- Does the insurance company pay the same dividend interest rate to all policy owners regardless of when the policy was purchased? Or does the company toss old policy owners in the race for sales volume?

Modified Premiums

Because premiums on cash value life insurance can be fairly high, some insurers allow modified premiums, which are lower originally -- usually for the first three of five years -- and are then raised and remain level for the duration of the policy. This arrangement can be helpful for a lower-income person who wants the benefits of cash value life insurance, but is currently unable to pay the higher cost.

The downside is that, because the premiums are lower, cash values build more slowly. In addition, these policies typically end up costing more than similar policies without the premium modification.

Graded Premiums

Graded premiums are similar to modified premiums. Graded Premiums start out lower and gradually rise on a continuous basis rather than jumping to a higher amount after several years. At a specified point, the premiums become level and that level amount is paid for the duration of the policy.

The disadvantage of the Graded Premium arrangement is that it can take 10 or 20 years before the premiums generate any significant cash value. And, like the modified premium arrangement, Graded Premium policies cost more in the long run than similar policies without the graded feature.

Ownership Rights

The owner of a life insurance policy is entitled to certain valuable rights. These include the right to assign or transfer the policy, and the right to select and change the payment schedule, beneficiary and settlement option. The owner also has the right to receive cash values and dividends and the right to borrow from the cash values.

The owner and the policyholder may be two different parties. This is something to consider when assigning ownership of the policy to someone other than the policyholder. Assigning a life insurance policy to another person is the right of the owner of the policy. There are two types of assignment -- collateral assignment and absolute assignment. There are advantages to assigning ownership to a third party. One of the advantages is a tax advantage.

Life insurance death benefits are generally received by the beneficiary free of federal income tax but the proceeds are included in the gross estate for federal estate tax purposes. If an individual does not own the policy on his or her life, then the proceeds would not be included in the estate, thereby reducing the federal estate tax liability.

The policy owner may also have considered exchanging a life insurance policy in return for an immediate, reduced cash amount. Viatical companies surfaced in the 1980s, offering discounted, cash amounts of, say \$75,000 in return for a policy with a \$100,000 death benefit. While it might be tempting to assign the policy in such a manner, especially in the event of a catastrophic illness, such assignments can be to the policy owners extreme disadvantage especially with regard to taxation.

The insurance company can many times offer better terms through accelerated benefit products. Accelerated benefits allow the prepayment of death benefits if, for example, the policy owner has been diagnosed with a terminal illness.

7. The Basics of Life Insurance Needs Analysis

Life insurance is essential to financial planning. It can take care of immediate obligations that would arise if an individual were to die. And it can help keep the long-term commitments this individual has made to the members of a family -- promises to always be there, to protect them, to support their goals and dreams. A well-written Needs Analysis is detailed and takes into account existing insurance, existing financial resources and assets, government benefits, income needs, tax liabilities and other liabilities.

The Life Insurance Focus

There are different ways of looking at life insurance markets. One way is to look at it through the eyes of a prospect and focus on what are likely to be key concerns given the age and stage of life that he or she is currently at. Disintermediation has become the buzzword of the financial services industry as it refers to the process of removing or reducing the involvement of intermediaries in delivering financial products or services to the consumer saving costs. Those involved in the sale of life insurance products can take comfort from the fact that life insurance is not bought; it must be sold. In most life insurance sales, the sales person has a crucial role to play in getting the consumer to buy the product.

Some say that life insurance death benefit is purchased with discounted dollars. Their point is that the annual premium will usually be only one percent to five percent of the policy face value, but that full amount is available from day one. So, life insurance is the only investment able to guarantee that a definite sum of cash will be available immediately. The ultimate discount will depend on the cumulative premiums paid by the time the death benefit is received.

The discounted dollars concept enables substantial wealth transfer at reduced (or zero) gift tax cost. A program of yearly gifts, intended to be used by the children (or others) for premiums, can take advantage of the annual \$10,000 gift-tax exclusion. That way, no tax is paid by anyone on those gifts, and the donor's full federal gift and estate tax shelter remains available for use at death. Better yet, the certainty of the death benefit will produce a sizable, predictable, instant estate that can be quickly created and regularly increased by additional premium payments.

Estate Creation

The individuals who want to do the estate creation are made up primarily of younger prospects. They have not yet been able to build an estate through personal savings, but they want to make sure that an estate is available for those they leave behind, if they die prematurely. Preference is usually given five or ten year term to provide the largest amount of insurance for the lowest premium outlay.

Estate Preservation

The Estate Preservation market are generally middle aged prospects who have succeeded to the point where they have managed to accumulate enough to create an estate and now want to make sure that it stays intact when they die. Their incomes are usually above average and their main concerns are estate settlement costs in general, and capital gains taxes and taxes on registered funds in particular. The product of choice is term to 100 or quick pay Universal Life for the least possible cash outlay.

Estate Maximization

Leaving a larger estate is generally of interest to prospects approaching or already in retirement. They have income or capital now, and probably in the future, in excess of lifestyle needs. They wish to protect their assets from taxes while

living and at death and, in the process, welcome the opportunity to create a larger estate. The most suitable product is Maximum Funded Universal Life to shelter nonregistered and registered income or capital, and to tax-shelter savings and investments that are probably going to end up in the estate.

Creating Additional Retirement Income

There is a relatively new, but nevertheless very large market for creating additional retirement income. The following has contributed to its growth:

- Increased life expectancy,
- Reduced dependence on the Government to provide for retirement,
- Reduced dependence on life-long, full-time employment to create adequate retirement income.

The tax-sheltering properties of certain life insurance products make them attractive in this market, especially for those who are maximizing RRSP contributions and are looking for tax-effective investments. The products can be used to generate the additional retirement income through personal planning or through planning involving a small or large corporation.

Determining Life Insurance Needs

The amount of life insurance depends on needs, personal circumstances, and a personal objective. The most common goal for life insurance is to provide income replacement for a surviving spouse and dependents. Life insurance professionals and financial planners use a number of tools to help people decide how much insurance is necessary to meet income replacement goals. Two popular methods are the times-earnings approach and the more comprehensive capital Needs Analysis.

One of the best ways to determine coverage is to do a Needs Analysis on a family's needs if the breadwinner dies. The analysis should consider Social Security, inflation, and income from other assets. Enough insurance is needed to accomplish desires for loved ones in the event of death.

It's important to buy life insurance if one's death or a spouse's death would create financial hardship for a family. Many households rely on two incomes. If an income is an essential part of the budget, an individual probably needs protection so a family could continue paying daily living expenses. Also, consider the value of a stay-at-home spouse. Life insurance can be used to fund essential services like child-care, and household tasks.

"Time-Earnings" Method

A traditional rule of thumb is that total death benefits from all sources (including both individually owned and group life insurance through your employer, if any) should equal between six and ten times the gross income of the person to be insured. Future earnings on such amounts (plus the Social Security benefits most families will qualify for) may adequately replace income lost because of a breadwinner's death.

Rules of thumb do not address the complexities of every situation, although they have the advantage of being quick and easy to understand. In general, younger families should consider buying insurance amounts closer to the ten-times level, since they typically have less savings, fewer investments, and modest amounts in their retirement plans. Families whose providers are closer to retirement age may find the lower end of the range (i.e., the six-times level) is enough.

"Capital Needs" Method

Analyzing capital needs is a more thorough way to decide how much insurance protection is needed. It considers not only the annual income, but also debts, savings and other assets, final expenses, future education expenses for children, and numerous other factors. While it takes a little longer, our capital needs worksheet will provide a coverage recommendation more closely tailored to specific circumstances and the needs of those who are dependent on the breadwinner.

The Capital Needs Analysis method is used by most insurance agents/planners and at most financial-planning web sites. Chartered Life Underwriters (CLUs) know the method as the Human Life Value Concept or the Human Capitalization Method. These methods give you the income you will earn from your present age until retirement, assuming a rate of interest that represents salary increases through that period. These concepts are sometimes treated the same, and sometimes as differing methods.

According to this concept, an individual's net worth is the present value of that person's future income stream that will be allocated to others. Present Value tells an individual what his or her money will be worth in a given number of years while earning a specific rate of interest. A variation of this method is used in wrongful death litigation to compute the present value of the decedent's anticipated future income, minus personal expenses, to compensate the survivors for lost net earnings.

Like the earnings-multiple method, the Capital Needs Analysis projects the income the insured will earn between now and retirement and discounts these flows. But this procedure goes further: It calculates the net contribution of the insured to the family's living standard by subtracting the insured's present value of future tax payments and living expenses from his or her present earnings. The net contribution is then compared with the pending needs of potential survivors, including mortgage payments, household expenses, and special expenditures. To use this method:

- Estimate the individual's average annual earned income from the person's present age to the age of retirement.
- Deduct the amount that is not allocated to others. Money spent for income taxes, life and health insurance premiums, and all other self-maintenance expenses should be deducted in this step.

Typically this is a percentage of salary. A good starting point is the Consumer Expenditures Survey by the Bureau of Labor Statistics. Using a reasonable rate of interest, determine the present value of the amounts allocated to others for the working period used in step one. Most financial calculators can perform this equation.

Concerns of the Capital Needs Analysis

If the household sets a spending target too high for survivors, the method will generate a larger amount of life insurance than is appropriate. If the spending target is set too low, the recommended amount will leave the household underinsured.

- It does not take into account what a beneficiary's needs will be;
- The percentage of gross income required is an average, not exact;
- It assumes that educational expenses are taken care of separately and the mortgage is paid for;
- It does not integrate with Social Security or other sources of income;
- This method only factors in the replacement of income and does not take into account any lump sum needs at death.

Decisions about buying insurance, spending and saving money are interrelated and need to be jointly determined. The amount of life insurance purchased affects the amount of premiums paid, which impacts the household's living standard, which in turn influences how much life insurance the household needs. A complex mathematical formula is needed to account for all these factors, which this method does not employ. Unless future tax payments are calculated accurately on a year-by-year basis, they can easily be overstated or understated, which will throw off the calculation of the amount of life insurance needed.

For married couples, tax payments are generally made via a joint return. This makes distinguishing each spouse's individual taxes difficult to determine. Again, without an accurate calculation of future tax responsibility, the life insurance Needs Analysis will not be reliable.

"Human Life Value" Concept Model

The Human Life Value Concept deals with human capital. Human capital is a person's income potential. We all have a Human Life Value, and insuring human life value is the primary purpose of life insurance. The human life value concept goes beyond numbers and into considering the entire impact caused by the loss of a human being. Here are some questions to give a start:

- If one has been killed in a car accident last week, and someone else had been responsible for the death, how much money would a family sue the responsible party for?
- If an individual has been killed in a car accident last week, how much money would a family need to receive?
- If someone died of cancer last week, how much money should the family receive?
- How much are tomorrow's worth? What is one's Potential Earning Power (PEP)?
- How much insurance is there on one's life?

Analyzing Family Needs

It is not enough to just provide for a family's cash needs. They are accustomed to receiving a regular pay check that stops when the breadwinner does. There are many ways to calculate the amount of cash needed to provide the proper income. Short of doing a complete calculation, which is beyond this simple worksheet, here is a method to do.

How much of one's income does his or her family need if all the above cash needs are met? What are the income needs? Do you have a budget? Below enter the minimum or desired monthly income need. In order to determine the amount of assets needed to produce the desired income, divide the need by an assumed rate of return. The rate of return used should be on the conservative side. Figure that over time, inflation, taxes and the economy will impact the actual spending power of those dollars. A rule of thumb in today's economy is to use 6%-10%.

Understanding Key Concepts in Needs Analysis

Understanding how much insurance is needed is the single most important factor to evaluate before selecting a life insurance policy. This can be accomplished by considering the current expense profile of dependents and the current wealth level of the family along with what the dependents risk tolerance level is. It's important to consider several factors and several types of insurance:

- think about major medical insurance to protect one in case of a catastrophic illness or injury;
- an individual may also want to look at disability coverage to protect an income if one cannot work.

If there are loved ones that depend on this individuals income, the individual should consider life insurance to protect them. Individuals will need to make both short term and long-term financial decisions as they become more knowledgeable about changing government policies. The financial services industry will have a role to play being regulated to protect the consumer.

Crediting Interest

Some companies index the policy's current interest rate to interest rates on third party money instruments, such as treasury bills or certain bond indexes. In other cases, insurance companies credit interest to individual policies using one of two distinct methods -- portfolio rates or new-money rates. If the company uses the portfolio method, all non-borrowed values within all contracts receive the same rate, regardless of when the premium is received.

Since single premium policy-owners make just one payment, the trend of market rates will determine whether the portfolio method or the new money method is more favorable. If market rates are historically high, the new money method will give the most favorable performance.

Policy Bailout

A bailout feature allows policy-owners to change their minds after the policy is issued and still obtain a refund of their entire original investment if the specified conditions are met. But the bailout provision applies only to the insurance company surrender charges, not to any income tax or income tax penalties that may be payable on amounts received upon surrender.

Surrender Charges

Most single premium policies charge a back-end fee if the policy is surrendered within the first five to ten years. The charge usually starts at seven percent to

10% of the initial premium and declines each year the policy is in force. Other policies charge a declining percentage of the cash value. Since cash values grow each year, surrender charges will generally be higher on those policies that charge a declining percentage of the cash value than on those that charge a declining dollar fee each year or a declining percentage of premium.

Policy Loans

Many single premium policies allow the policy-owner to borrow against the interest accumulated in the policy at what the companies call a zero-percent net cost. The borrowing interest rate for principal amounts is generally one percent to two percent higher than the rate credited to policy cash values. Policy loan feature should be checked carefully because the net borrowing rate may be effectively higher than the stated rate in many cases. Frequently, in current-assumption policies the company sets aside an amount of the remaining cash value as collateral for the loan.

8. Types of Life Policies - Frequently Asked Questions

Take another look at the topics discussed in this chapter. The information will be presented in a less formal structure, which may help you learn and retain the information. It may help to imagine this as a question-and-answer period between a learner and an instructor.

Q: *What are the basic types of life insurance policies?*

A: All types of life insurance policies fall into two basic categories: term and whole life.

Q: *What are the differences between them?*

A: Term insurance simply provides coverage for the term of years specified in the policy, and it costs less than whole life. So, when people need protection for a short period of time or more coverage for less cost, term insurance may be the best choice. It can also help to bridge the gap between having no protection at all and having a more costly but permanent whole life policy.

Whole life insurance, on the other hand, is designed to last for the rest of the insured's life. It can also provide an array of features such as cash value, adjustable premiums, and investments. By mixing and matching these various features, many different insurance needs can be met by whole life policies.

So, those are the two big categories. Now let's look at term insurance little closer. Again, if you want the greatest amount of coverage for the lowest amount of money, this is the policy that you want to buy. There are, however, a few drawbacks. In a whole life policy, you can take loans out on the cash value. But you can't do that with term insurance. These policies don't have cash values. The only thing that they offer is a death benefit. The other disadvantage is that these policies only last for a certain amount of time. If you buy a whole life policy, you're basically covered for the rest of your life. But with term insurance, you're only covered until the policy's expiration date. You can renew the policy, but only up to a certain age.

Q: *How does term insurance break down?*

A: The main types of term insurance are level, increasing, and decreasing term. In all of these cases, the only thing that changes over time is the death benefit. The

premium amount won't vary at all. So, with level premium term, the death benefit will remain constant from the very beginning of the policy to the very end. With increasing term, the death benefit increases as time goes on. With decreasing term, the death benefit decreases as time goes on. Decreasing term policies have the lowest premiums. The most expensive is level premium term, since you get the highest amount of death benefit possible throughout the entire life of the policy.

There's one other type of term policy: annual renewable term. The only difference between this policy and level premium term is that the premiums increase as you get older. The death benefit remains the same throughout.

Q: *How is whole life different from term life?*

A: Buying a whole life contract is a lot like buying a car. You have a huge expense that you want to pay off in the least amount of time. The longer the timeframe, the lower the monthly amount will be. If we go for 36 months instead of 60, we'll shorten the timeframe and get the car paid off quicker.

Q: *Does that mean there are some whole life policies that pay off years before others.*

A: Yes. In fact, a policyowner could theoretically just pay off the full amount at one time. That would make the whole life policy a single premium policy. However, the typical whole life insurance policy is designed to be paid for over a long period of time. This period of time is defined by the applicant's current age and the number of years until he or she reaches a specified age. This specified age is typically 100. So, if the applicant is 40 years old, the timeframe will be 60 years. Premium payments stretched out over 60 years will be fairly low. Now, let's say that I'm 65 and don't want to pay premiums after I retire. I could explain that fact to my agent, who could then structure my policy to be paid off by that age. Somewhere in my policy description, it would say "life paid up at 65". I would then make payments for only 25 years. I started at age 40 and I'm done at age 65. The timeframe is much shorter, but just like the car example, the monthly payments will also be higher.

Q: *Can you explain a life insurance policy's cash value? Does this apply to all life insurance policies?*

A: A policy's cash value applies solely to whole life insurance policies.

Q: *Where does the cash value come from?*

A: Premium payments actually consist of two parts. One part is the actual cost of the insurance. The part that is "left over," so to speak, goes toward the cash value. Let's say that the monthly premium is determined to be \$100. The actual cost of the insurance is \$60. This means that the remaining \$40 per month begins to build up in a cash value account. This is one of the advantages of a whole life insurance policy. Remember how we determined that adjusting the payment timeframe affects the payment amount? Well, this also works in our favor, because if the timeframe is shorter and we pay higher premiums, the cash value builds up faster.

C. Annuities

Before you read this section on annuities, here is a quick overview of the information that will be covered:

- The definition of annuities, and look at the reasons people use them;
- You'll learn the parties to an annuity, and the two phases of an annuity;
- You will study about how annuities are categorized based on how the premiums are paid or when the benefits begin; and
- Finally you will examine surrender charges and tax consequences for annuities.

Annuities are often an intimidating subject for insurance applicants or newly licensed producers, but they don't have to be. We can break them down into a few simple principles.

Annuities are not technically insurance policies. An annuity is a payment contract that guarantees income for a specific period of time.

In the simplest terms, annuities work like this: The owner makes premium payments; the premiums are invested and earn interest, and at a specified time, regular payments are made to the person designated in the contract.

Why would somebody want to buy an annuity? The most common reasons people buy annuities is to fund retirement. You pay into the account during your working years when you can afford it - and then receive income benefits in retirement, while you are still living, and want to maintain the lifestyle you are accustomed to. Annuities provide income you CANNOT outlive.

Another common use of annuities is to build education funds for children.

Now let's take a closer look about how annuities are structured. In addition to the insurance producer, there are 3 parties to an annuity contract:

The owner is the person who purchases the annuity. The owner, however, doesn't have to be the person receiving the benefits, but the owner does have all the rights to name the beneficiary or surrender the annuity.

The next player is the annuitant, or the person who receives payments from the annuity. The annuity contract is also based on the life expectancy of the annuitant.

The owner and the annuitant are often the same person, but again, they don't have to be. While the annuity owner can be an individual, a corporation or a trust, an annuitant must always be a natural person. In other words, there must be a measurable life on which to write an annuity.

The beneficiary to an annuity is the person who will receive benefits if the annuitant dies prior to the benefit payout time. In this situation, the beneficiary will receive the greater of the cash value, or the premiums that have been paid in. If no beneficiary is named, the proceeds are paid to the annuitant's estate – just like in life insurance.

So let's use John as our customer. John has \$50,000 and wants to purchase an annuity to provide himself with income during his retirement years. John will be the owner of this annuity because he is paying for it. Because John wants the annuity to provide income for himself after retirement, he will also be the

annuitant. Let's say, John has named his wife as the beneficiary. If John happens to die after the annuity has been in force for 5 years. By that time, John has paid \$20,000 into the annuity in the form of premium payments, but the policy cash value now equals \$25,000, John's wife will receive the \$25,000 benefit, since the annuity's cash value is greater than the premiums paid.

Ok, moving on: all annuities have 2 distinct phases – the accumulation period and the annuity period.

The accumulation period is also called the pay-in period. It is the time after an annuity has been purchased, but before distributions begin. The owner is paying INTO the annuity while it is accumulating money.

The annuity period, also called annuitization period, or liquidation period, or pay-out period, is the time over which the annuitant receives income payments. This is reward phase. The annuity period may set for the annuitant's lifetime or for a specified period of time.

To help you better remember different terms used in describing annuity products, we need to categorize annuities as follows:

- By how they are funded;
- When the income payments begin;
- The way income payments are made; and
- The investment configuration.

First let's look at the ways a customer can fund an annuity. An annuity can be purchased as a single premium or flexible premium contract. These are pretty self-explanatory. A single premium is a one-time, lump-sum premium. A flexible premium annuity means it is purchased with periodic premiums.

The next thing to decide is when will the annuity start making income payments? The choices are to have an immediate annuity, which begins making payments practically at the time you purchase an annuity (usually within 30 days), or a deferred annuity, where payments begin sometime after 1 year of the purchase date. An immediate annuity can only be funded by a single payment – which makes perfect sense. In order to start paying out immediately, the annuity must contain available funds, so that's where the single premium fits in.

You may have heard the term "Single-premium immediate annuity (SPIA) - so considering what we just discussed, what does that mean? It means that the annuity was purchased with a single premium and has funds available to immediate payout.

Deferred annuities, on the other hand, can be funded by either single or flexible premium payments.

Annuities can also be categorized based upon life contingency. For example, the term pure life (also known as life only, or straight life) means that a specific amount of income will be available to the annuitant for the remainder of his or her life. Once the annuitant dies, however, the payments stop, hence the name – life ONLY.

Life with Guaranteed minimum also pays a specific amount for the remainder of the annuitant's life. However, if the annuitant dies before the balance of the annuity is paid out, the payments will continue to the beneficiary. This is sometimes called "refund life" and it guarantees that the balance of the annuity is paid to someone.

The second choice for payment structure is Annuities Certain. Annuities certain are used with immediate annuities and have two options—fixed-period installment where the pay-out time is limited to a certain period, and fixed-amount installment where payments are made until a certain amount is paid out. Pretty self-explanatory.

The fixed period installment option allows the annuitant to choose how long payments will be made—often 10 or 20 years. The insurer then uses the value of the account and future earnings projections to calculate how much each payment will be. If the annuitant dies before the end of the period certain, payments will continue to a beneficiary until the end of the period certain.

A fixed amount installment annuity allows the annuitant to choose how much each payment will be, and the insurer determines how long payments will be made based on the value of the account, and projected future earnings. If the annuitant dies before the balance is exhausted, the payments will continue to the beneficiary.

So now let's say your client has a single-premium deferred annuity using the Life with guaranteed minimum benefit payment option. There is one more decision to make—how is the premium will be invested? Here we have 3 choices:

- Fixed annuity;
- Equity indexed annuity; or
- Variable annuity;

Fixed annuities provide guaranteed minimum interest rates and level income payments. The insurance company guarantees the amount of each payment, and the payment period is decided when the annuitant chooses a settlement option – or how the payments will be made. Premium payments for fixed annuities go into a general account, which is part of the insurance company's investment portfolio, and is usually made up of pretty conservative investments.

Variable annuities offer a varying rate of return on investment. The premiums paid in are held in a separate account by the insurer, and are usually invested in common stock. This means the interest will vary based on the performance of those stocks. Variable annuities have 3 main characteristics:

- The first is interest rate: the insurance company doesn't guarantee a minimum interest rate, but it does guarantee a specified benefit payable to the beneficiary if the annuitant dies before the pay-out period begins.
- The second characteristic is the underlying investment: Premium payments are deposited into the insurance company's separate account that can be invested in different funds than the general account, and hopefully, earn a higher return.
- The third characteristic of a variable annuity is the license requirements: a variable annuity is a security product, so the producer must have both life insurance and securities licenses.

The last type of annuity we need to talk about is an Equity Indexed Annuity. Equity indexed annuities are not securities, but they do invest on a fairly aggressive basis. Equity indexed annuities have a guaranteed minimum interest rate, and a current interest rate. The guaranteed rate is written into the contract, but the current rate is usually tied to a common index/ like the Standard & Poor's 500 (or S&P500).

Now that we've covered the different ways to build an annuity contract, what happens if the annuitant needs to access the money and surrenders the contract?

Deferred annuities have guaranteed surrender values, but there is also a surrender charge. The surrender charge is usually a diminishing percentage of the value of the annuity. Let's use an example a contract with a 7 year, 10% surrender charge. If an annuitant surrenders the annuity during the 2nd year of the contract, he or she will pay a 9% penalty. Surrender in year 4, and the penalty will be 7%. If the annuitant keeps the annuity until year 8 or longer, there is NO surrender charge.

So WHY is there a surrender charge in the first place? The insurance company makes the money to pay the administrative costs and overhead in the first 7 years of an annuity. If the owner surrenders the annuity earlier, the insurance company could lose money.

There are also tax ramifications to annuities. The first thing you need to remember is that annuities are funded with after-tax dollars, and that the cash value accumulates tax deferred. When the annuitant begins receiving income payments, the Internal Revenue Code has established the exclusion ratio to determine how much of each payment is principal and how much is earned interest. In simple terms, the principal is NOT subject to additional taxes; however, the interest will be taxed as income.

If the annuitant dies before the annuity is paid out, here may be tax consequences for the beneficiaries, as well. A premium payment test will determine the value of refund or survivor benefits that will be included in the annuitant's estate:

- If the deceased annuitant paid ALL of the premium, the entire balance is included in the gross estate.
- If the annuitant paid part of the premium, the ratio of the balance included in the estate is equal to the amount paid. Let's make that easier to understand. If the annuitant paid 50% of the premium, then 50% of the balance of the annuity is included in the gross estate.
- If the annuitant paid none of the premium, then there is no tax effect to the beneficiary.

If the annuitant dies before the pay-out period begins, the interest becomes taxable unless the beneficiary is a spouse. The spouse has the option to continue the annuity tax deferred.

You have to remember that every dollar has to be taxed somehow. You pay taxes on the principal at the beginning because you fund the annuity with after-tax dollars. You pay taxes on the interest at the back end, when you take the money out.

This is a lot of information in a short time, so I encourage you to review this section as much as needed. For the purposes of your exam, keep it simple, and once you go back to those basic concepts of who are the parties to the annuity, how the annuities are funded and when the payments begin, you'll be able to apply that knowledge to any situation.

1. Annuities - Frequently Asked Questions

Q: *What are annuities?*

A: You know how buying life insurance is like buying a car? Well, the same idea applies to annuities. Most folks who buy an annuity make level payments over a long period of time. Once again, the longer the time, the lower the payments will be. Of course, the option to make a large one-time payment is still open if you can actually afford it. Something a bit different here is that an annuity payment schedule can be set up where the amount and frequency of payments can be flexible. Also, just like in life insurance policies, annuities can be fixed or variable. The general and separate accounts operate in the exact same way as in life insurance.

Q: *How does money get into an annuity?*

A: As the purchaser of an annuity is putting money in during the accumulation period, those dollars are buying what are called accumulation units. When the annuity reaches its payout period, the units are converted into annuity units.

Q: *How does the money come out of the annuity?*

A: There are a lot of ways to do this.

First, the annuitant might elect an option called life only. If this is the case, the income can't be outlived. The company will pay checks on schedule as long as the annuitant is alive. But if the annuitant dies before he or she receives all of the money paid into the annuity, the company will keep whatever is left over. No beneficiaries are involved here. And, incidentally, this option will pay out the highest monthly amount.

A refund life annuity option still guarantees an income for the life of the annuitant. However, when the annuitant dies, the beneficiary receives the refunded portion. This will be equal to the remainder of the purchase price, if there is anything left. Since the company is liable for at least the original purchase price of the annuity, the monthly payments will be somewhat lower than they would be for a life only option.

And then we have the life with period certain option. This can be used to provide protection for the beneficiary. If the insured dies early, the beneficiary will receive the payments for the duration of a specified period. For example, let's say that you have a life with 10-year period certain contract. You die at the end of the sixth year. Your beneficiary would receive payments for the remaining four years.

A joint life option would begin payments for two or more annuitants and would continue until the death of the first one. At that time, all payment would cease. Joint and survivor would set up payments for two or more that could not be outlived. After the first death, the survivor will still receive payments, although they will probably be of a lower amount. And these will continue for the life of the survivor.

Two more to go. With the lump sum option, the annuity would pay out what has been paid in, plus all accumulated interest. The catch is that taxes would be due

on the interest. And if the annuitant is younger than 59 1/2, more taxes would be due.

Finally, an annuity certain option would pay out for a fixed period of time or a fixed dollar amount. When the time is up or the dollars are paid out, all payments stop. And that does it for annuities. One of the most important aspects to consider in this selection process is that the more risk or liability for payments the company takes on, the lower the monthly payout will be.

D. Policy Provisions

At this point, you should have a working knowledge of the concepts that apply to insurance in general as well as to life insurance. Now, we're going to look at general provisions, options and riders that apply solely to life insurance policies.

Let's start by looking at the differences between provisions, riders and options.

Provisions are fairly universal among policies. They serve to explain the rights and characteristics of the contract.

Riders are amendments that "ride on" the provisions that already exist in the policy, so they modify the provisions.

Options are the different ways the insured can invest or distribute an amount of money, such as dividends, income, or the death benefit.

OK, let's start with the provisions:

There are some basic provisions that will be included in any life insurance policy, such as Entire Contract, Insuring Clause, Free Look, Consideration, Owner's Rights, Assignment, Beneficiary designation, premium payment, Grace Period, Reinstatement, Incontestability, Misstatement of age and gender.

The entire contract provision basically states what must be included for the insurance contract to be considered complete. It's not just the policy itself, but also a copy of the signed application, and any endorsements. Changes to the contract must be made with written permission of all parties before they can become part of the contract, and can only be made by an executive officer of the company, not an agent at that point.

Every policy must also include an insuring clause. It is a general statement, usually found on the first page of the policy, identifying the insured, the insurance company, and the types of loss that will be covered.

A policy's free look period is the amount of time an insured has, to review a policy with no strings attached. Also called the "right to examine," this provision gives an insured a certain number of days to go over the policy and make sure that it covers everything they want it to cover. During this time, the insured can return the policy for a full refund of premiums, if the insured is dissatisfied with the policy for any reason. Free look period begins when the policy is delivered, NOT on the issue date. Even though the most common free look period is 10 days, some types of policies may offer a longer free-look period.

The consideration provision is found on the first page of the policy and makes clear that both parties to the contract must give something of value for the contract to be effective. Consideration on the part of the insured is the premium paid; while consideration on the part of the insurer is the coverage and benefits.

The ownership provision states that the policyowner has all ownership rights, including the responsibility to pay premiums. The owner must have insurable interest in the insured at the time of application for insurance.

Under the assignment provision, a policyowner can transfer the policy to another person without the insurer's consent. The policyowner has to notify the insurer of the assignment, but the insurer's permission is not required. There are two types of assignment – absolute and collateral.

Absolute assignment is permanent and involves the total transfer of all rights of ownership to another person or entity. The new policyowner doesn't have to have insurable interest in the insured.

Collateral assignment, on the other hand, is a temporary and partial assignment of rights of ownership. This is commonly used when a life insurance policy is used as collateral to obtain a loan. Ownership is transferred to the loan company until the debt is paid. At that point, ownership reverts back to the original policyowner.

The beneficiary designation provision doesn't just say to whom money will go, after the death of the insured. It also gives the insured certain rights regarding changes to beneficiaries and how the policy proceeds will be paid.

You know that the beneficiary is the person or entity that receives the policy proceeds upon the death of the insured. The beneficiary can be a person; a class of people, such as "my children" the insured's estate; or an entity such as a foundation, charity, trustee, or corporation. The beneficiary does not have to have insurable interest in the insured, nor does the policyowner have to name a beneficiary for the policy to be valid. Now let's look at the order in which the policy beneficiaries will be paid. These classifications apply if the beneficiary is an individual.

The primary beneficiary has the first claim to the death benefit. Secondary beneficiaries are next in line to the proceeds if the primary beneficiary dies before the insured.

Secondary beneficiaries can also be called contingent beneficiaries. The term "contingent beneficiary" actually applies to any beneficiary or group of beneficiaries after the primary beneficiary.

The policyowner can name more than one primary or secondary beneficiary, and may designate how the proceeds are to be divided.

Categorizing beneficiaries by class is a bit vague. An example of this would be "my children." Because this type of grouping can be open to interpretation, it can cause trouble. Using the example of "my children," what if the policyowner has been married more than once and has children from both marriages? If you think that "my children" includes only the children from the current marriage, that

interpretation could exclude his children from previous marriages or his wife's children from previous marriages.

Does he mean children solely with whom he has a biological connection? If you believe that, it could then apply to children he has had no hand in raising, but who were the result of a previous relationship. That would also shut out any adopted or foster children.

Or does he mean children he raised? This interpretation allows for the inclusion of adopted or foster children, and biological children in the household, but could seem to exclude children from previous marriages.

These may seem like exaggerated circumstances, but it is easier to avoid any potential confusion by naming each beneficiary specifically and designating a percentage of the death benefit to go to each.

Another way to distribute life insurance policy proceeds is to use one of two designations: per capita or per stirpes.

Per capita literally means "by the head." Under this designation, the death benefit is divided equally among the named survivors.

Per stirpes translates as "by the bloodline." Under this classification, if a beneficiary dies before the insured, the share of proceeds that would normally go to that beneficiary, would now be distributed to that beneficiary's heirs, even though they are not explicitly named in the policy.

Now what happens to the policy proceeds if the policyowner did not name a beneficiary or if none of the beneficiaries is alive? The policy pays the death benefit to the insured's estate. This might result in the death benefit being included in the taxable estate.

A trust is another beneficiary option. The specific purpose of a trust is to give legal title of property to a trustee to be used for the benefit of the trust beneficiary. The trustee can't benefit from the trust but is a paid administrator of funds according to the instructions of the trust. When structured correctly, trusts keep life insurance proceeds out of the insured's taxable estate.

Revocable and irrevocable designations are the last consideration for beneficiaries. The policyowner can change a revocable designation at any time. An irrevocable designation must have the written consent of the beneficiary before it may be changed. A policyowner with an irrevocable beneficiary can neither borrow from the policy cash value, nor assign the policy to another person without written consent of the beneficiary.

Let's review a few more life policy provisions. Most life insurance policies contain a Common Disaster Clause. That clause stipulates that if the insured and beneficiary die at approximately the same time, from a common cause with no clear evidence of who died first, it may cause problems determining how the death benefits should be distributed. Under the Uniform Simultaneous Death Law, it is always assumed that the primary beneficiary died first in a common disaster.

Next is the Payment of Premiums provision. This provision states when premiums are due, how often they are to be paid (monthly, quarterly, semi-annually, or annually), and to whom.

If you've ever been late making a payment on your car insurance, you've taken advantage of your policy's grace period. This is the period after a premium payment has been missed, but during which the policy is still in effect. Once the grace period has passed, however, the policy will lapse if the premium is not paid.

That's when the reinstatement provision applies. If the premium has not been paid by the end of the grace period, the policy coverage will terminate. The reinstatement provision details the conditions that will allow the insured to bring back coverage. For example, the policyowner is required to pay all past due premiums, plus interest, and may be required to pay outstanding loans and interest before the policy will be reinstated. The maximum time limit for reinstatement is usually 3 years after the lapse.

Let's look at the grace period and the reinstatement provision in action. Let's say Robert pays a monthly premium on his life insurance policy. Because he makes monthly premium payments, the policy has a 10-day grace period. An installment was due November 1. Robert was hospitalized, however, and lost the notices from his insurance company. Robert doesn't realize he's missed his payment until November 15. At this point, his insurance policy has completely lapsed. If Robert dies now, his policy will not pay out. But let's say that in March, Robert has decided that he wants to be covered by life insurance again. Due to the reinstatement provision, all he has to do is pay any missed premiums he would have paid between November and March, plus interest, and he will again be covered by his life insurance policy.

Next is the incontestability clause, which prevents an insurer from denying a claim due to statements in an application after the policy has been in force 2 years, even on the basis of material misstatement of fact, or concealment of a material fact.

The misstatement of age or gender provision allows the insurer to adjust the policy at any time. If the applicant misstated his or her age or gender on the application and there is a claim, the insurer is allowed to adjust the benefits to an amount that the premium would have purchased had the correct age or gender been listed.

We've just finished studying the provisions that will be present in Life policies. Let's move to common exclusions in life policies. The following are usually excluded from coverage in life policies: Aviation, Hazardous occupations or hobbies, Exclusions for War or military service, and Suicide.

The Aviation exclusion is less common in standard policies than it used to be. Most life insurance companies will cover a fare-paying passenger on a regularly scheduled airline, but many will exclude coverage, or require additional premium for pilots.

One factor that life insurance policy underwriters must consider is the lifestyle of the applicant. If the insured has a hazardous occupation or dangerous hobbies, such as sky-diving or rock-climbing, the policy may exclude deaths that occur as a

result of those activities. The underwriter usually has the option of providing coverage at a higher premium if they feel the risk is not significant enough to exclude.

There are two clauses that can be used to limit the death benefit received if the insured dies as a result of war or while serving in the military. The status clause excludes death while the insured is on active military duty. The results clause excludes the death benefit if the insured is killed as a result of war. Most insurance policies today do not contain a war or military service clause.

Finally, the suicide exclusion states that if the insured commits suicide within 2 years after the effective date of the policy, the insurer's liability is limited only to refund of premium paid into the policy. After 2 years, however, the death benefit will be paid to the beneficiary the same as any other cause of death. This clause is designed to protect insurance companies from individuals who buy life insurance with the intention of committing suicide and leaving money to their survivors.

1. Policy Provisions, Options, and Other Features - Frequently Asked Questions

Take another look at the topics discussed in this chapter. The information will be presented in a less formal structure, which may help you learn and retain the information. It may help to imagine this as a question-and-answer period between a student and a teacher.

Q: What exactly is the point of having provisions in an insurance contract?

A: Every policy has provisions in it. Some are required by law, and others can be included at the option of the insurer. Provisions explain the terms of the contract itself. They spell out who has certain rights and what the general characteristics of the policy are. These provisions are fairly universal from one policy to the next. For instance, they tell you what will happen if premiums don't get paid on time and how you can change the beneficiary. Provisions won't tell policyholders how much the contract is worth or when it expires. Provisions focus on how the policy itself functions.

Q: What are some standard policy provisions?

A: An important one is called the "beneficiary designation provision." It explains who gets the death benefit when an insured person dies. First of all, the policyowner gets to make all the decisions here. Basically, the owner is going to set up a "food chain" to determine who gets the benefits first. Primary beneficiaries get paid first, then secondary, and finally tertiary. But remember that not all of the beneficiaries collect benefits. If all goes as planned, the primary beneficiary would get all of the benefits. But what if the primary beneficiary dies before the benefits are paid? That's why there's a secondary and tertiary beneficiary. It's just a way to make sure that someone of the policyowner's choosing gets the benefits. That said, the owner could just name the estate as the beneficiary if that met his or her needs better. And a lot of that has to do with taxes.

Let's look at another one. It's called the "grace period." This provision states that if you don't pay your premium on time, your policy will still be in effect for a certain number of days past that date. You'll see 30 days as a common number. Under this provision, if a premium is due on a certain day, and the policyholder

forgets to send the payment, the contract will still pay out if, say, the policyholder is killed in a wreck before the grace period expires. In situations such as this, the unpaid premium would be deducted from the death benefits paid out to the beneficiaries.

Q: What are riders and what is the purpose of them? How are they different from provisions?

A: Riders are added as a way to further customize a policy to the needs of the policyholder and the company. They can add, modify, or even delete policy provisions. Now, remember that a policy is a legal contract. So, a rider that is going to change the contract must be attached to the basic policy. By adding one or more riders, a client can customize the policy to meet a particular set of needs. It's sort of like customizing a car. It comes with standard features, but you can add more features that meet your needs or wants a little better. That's different from a provision, which just explains the nature of the contract. That said, riders can affect which provisions are included.

Q: What are some popular riders?

A: The first one is Accidental Death and Dismemberment. If the policyowner meets the definitions of "accidental death" or "dismemberment," the death benefit can be multiplied by two or three times the basic amount. If the insured's circumstances do not meet the definition, then only the basic death benefit will be paid. However, remember that because it's a rider, and would be used to customize a basic policy, a policyholder would have to pay extra for it, just like with options on cars. Just remember, there's no guarantee that the policy will pay out, if the circumstances surrounding the death or dismemberment don't meet the specific definitions in the rider. The definition is absolutely critical to making a determination as to what dollar amount will be paid out. And the fun doesn't stop there. If the policy has a dismemberment portion on the rider, another definition is required. It's critical to know whether the limb must be completely severed from the body or whether it's enough to have lost the use of the limb.

Another important rider is called a "living benefit rider" or an "accelerated benefit rider." With this one, the death benefit can be paid out even if death has not yet occurred. It can provide for this because it adds a feature that allows all or part of the death benefit to be paid out before death occurs, provided that certain conditions are met. People use this rider when they've been diagnosed with a terminal illness and only have a short amount of time to live. Usually, the contract will let allow the policyholder to use this rider if they are expected to die within 2 years. By receiving the death benefit early, they can use the money to pay medical bills and other expenses. This can really help an insured's family to avoid financial hardships. If you read one of these riders, you'll see that the amount payable is usually expressed as a percentage of the full death benefit. The remaining percentage will be given to the beneficiary after the insured's death.

Q: What's about options?

A: Policy options offer even more flexibility to the policyowner. While riders are used to customize the policy to meet specific needs of the client, policy options customize in a different way. They are selected by the client to determine how certain circumstances should be handled during the life of the policy. Some of the options are selected at the time of application, while others are selected when certain events occur.

Q: What are some examples of these?

A: The first two options apply to whole life policies. Since whole life policies have cash value, the policyowner has a variety of ways of accessing the cash. One way is to simply surrender the policy and ask for the cash. This will certainly get the money in the hands of the policyowner, but it will also sever the contractual relationship between the policyowner and the insurance company. Why? Because once all of the cash is paid, the policy is surrendered, and the contract therefore ends. This action should not be taken lightly because it could result in a gain of cash but loss of coverage for the client.

Now for the second option. If the policyowner wants to continue coverage but still wants to use the cash value to his or her advantage, the reduced paid-up or extended term options might be better. The reduced paid-up option allows the policyowner to exchange the cash value for something else of value. In this case, the cash is used as a single premium to purchase a new policy with a somewhat smaller death benefit.

The key with reduced paid-up is that the new policy is of lesser value. Now, the extended term option also allows the policyowner to exchange the cash value for something else of value. This time, though, the cash value is used as a single premium to purchase a new policy with the same death benefit as the old policy. However, the new contract will be a term policy that lasts for whatever term the cash would pay for.

In some types of policies, the policyowner receives dividends. With a third type of options, the owner gets to decide how to receive these payments. The options here run the gamut from a cash payout to exchanging the value of the dividend for another insurance product. Basically, if the policyowner doesn't want cash, the dividend can be used to reduce future premium payments, increase coverage, or even pay the policy up earlier. The owner could also decide to let the insurance company keep the dividend and invest it on his or her behalf. The return on that investment can be used then in several different ways. Once again, these decisions all have different consequences at tax time.

Finally, there are settlement options. The payout will be given lump sum in cash unless some other option is selected. The cash option will also sever any future relationship between the beneficiary and the insurance company making the payment. Again, once you take all of the value out of the policy, the policy ends. So, a lump sum cash payout might not always be in the best interests of the beneficiary. But, as you might imagine, we have more options for those circumstances. These options will either be chosen by the policyowner at the time of application or by the beneficiary when death of the insured occurs. They can be stated in dollar amounts or timeframes. When a dollar amount is selected, the insurance company will determine how long the payments will last. When a timeframe is selected, the insurance company will determine what amount will be paid at specified intervals. Or there's another option. The death benefit can be left with the insurance company. The company will then pay out interest as it accrues at specified intervals. This is considered to be a temporary option, since the recipient can elect any of the other options at a future date.

Q: How will a policyholder know what riders and options are right to add to the policy?

A: With a properly completed application, an agent can help the policyowner with this decision. The trick to this process is identifying the needs to be met. Once the needs are known, a policy can be customized accordingly. The problem is that the

client will rarely know just how flexible policies can really be. You as the agent will have to ask the right questions, and your client will have to try as hard as possible to give you accurate answers. When these two actions come together, a life insurance policy can accomplish all that it was meant to do!

E. Policy Riders

In this section, we will talk about policy riders.

There are four riders that can be added to a disability policy: waiver of premium, waiver of cost of insurance, disability income benefit, and payor benefit.

We'll start with Waiver of Premium. This rider is designed to waive the premium for the policy if the insured becomes totally disabled. The waiver remains in force until the insured is able to return to work. There is generally a 6-month waiting period from the time of disability until the first premium is waived. If the insured remains disabled after the waiting period, the insurer will refund all premiums paid from the start of the disability.

How about an example? Let's say that Svetlana works in a hospital as a nurse. She is involved in a car accident and becomes quadriplegic. She is totally disabled and will be for the rest of her life. For the first six months of the disability, she will still have to pay her Life insurance premiums like she normally would. But after the 6th months, the premium will be completely waived, and she will be reimbursed for the 6 months of premium that she already paid. The coverage will remain in force for the rest of her life.

Now, let's say that her injuries were less dramatic, and she was able to return to work after 8 months. She would still receive a premium refund for the initial 6 months, and she won't have to repay the premium that was waived for the seventh and eighth month.

This rider usually expires when the insured reaches age 65. So, if Svetlana had been 67 years old at the time of the accident, her premiums would not have been waived.

The second rider is Waiver of Cost of Insurance. This rider is found in Universal Life policies and says that in the event of the insured's disability, the cost of insurance is waived. The downside is that the policy will not accumulate cash value during this time.

Next is the Disability Income Benefit rider. In the event of disability, this rider will waive the policy premiums and pay a monthly income to the insured. The amount is normally based on a percentage of the face amount of the policy. So, this is like the waiver of premium rider with extra income thrown in.

The last disability rider is Payor Benefit Life or Disability. This rider applies to juvenile policies. If the adult who pays the premiums becomes disabled or dies, the insurance company will waive premiums until the child reaches a specified age, usually 21.

Now we'll switch gears and talk about accelerated death benefits or living riders. Insureds can only use this rider if they are near death or they need extraordinary care for a serious medical condition. The insured will receive part of the policy's face amount, which will hopefully help to pay the medical bills. The face amount of the policy will be reduced by the amount paid out. This will, in turn, affect the policy's cash value and premiums.

Now we'll talk about some optional riders that cover additional insureds.

The Spouse Term Rider allows the spouse to be added to the policy for a limited time and for a specific amount. The rider is generally level term insurance and expires when the spouse turns 65.

The Children's Term Rider allows children to be added to coverage for a limited time and for a specific amount. This rider is also term coverage and ends when the minor reaches a certain age, usually 18 or 21. Children are permitted to convert their coverage to permanent insurance without evidence of insurability.

Family Term Riders incorporate the spouse and children's term rider into one.

And now for the last group of riders. They affect the death benefit.

The Accidental Death Rider pays a multiple of the face amount if death is the result of an accident as defined in the policy. The benefit is normally twice the face amount, and death must occur within 90 days of an accident. This rider usually expires at age 65. The Accidental Death benefit applies only to the face amount of the policy, not the cash value or other benefits.

Let me illustrate this with an example. Bill and Ted each have life insurance policies with a face amount of \$100,000, and they both opted to have an accidental death rider. They are driving down an icy highway and are involved in a serious wreck. Bill dies shortly after arriving at the hospital. Ted dies 4 months later due to a condition caused by the accident. Even though both men died as a result of the accident, only Bill's beneficiary would benefit from the rider because he died within 90 days. Ted's death occurred too late for the rider to apply to his situation.

Now we'll move on to Guaranteed Insurability riders. These riders give the insured a chance to purchase additional coverage at specified future dates without needing to provide evidence of insurability. These dates are usually every 3 years or at the time of specific events, like marriage, birth, or when children reach a certain age. This rider usually expires at the insured's age 40.

The guaranteed insurability rider is not modified or defeated by other riders on the policy. For example: Alan's life insurance policy has both a guaranteed insurability rider and a waiver of premium rider. Three years after the policy is issued, Alan is totally and permanently disabled. Alan's premiums will be waived, and Alan may still purchase additional insurance at the specific times indicated in the policy. Even though his medical status has definitely changed since the beginning of the policy, the guaranteed insurability rider protects him from needing to provide proof of insurability as a condition of receiving the additional insurance. Again, though, this only applies to specific times. If he wants to

purchase additional insurance at any other time, he will have to provide proof of insurability.

There are 3 other riders available for life insurance and disability policies: Cost of Living riders, Return of Premium riders, and Term Riders.

Cost of Living riders address inflation. They will increase or decrease the face value by a cost of living factor, which is calculated each year.

Return of Premium riders are created with increasing term insurance. Adding this rider to a whole life policy means that if the insured dies before a specific age, the beneficiary will receive the death benefit AND all of the premiums that have been paid into the policy so far. This rider usually expires at a specified age.

Term Riders allow for additional amounts of temporary coverage on the insured /without issuing a separate policy.

F. Settlement Options

While the topics below are not specifically listed on the exam content outline, this information will help you enhance your knowledge and understanding of the subject matter, and to better prepare for the exam. The information is also presented in a less formal manner to help you understand and remember it.

In this section, we will examine policy options in more depth. We begin our discussion with nonforfeiture options.

Let's take a look back in time. Before nonforfeiture options were available, any time the policyowner failed to pay the required policy premiums, the policy would lapse and lose or forfeit any equity it had accumulated. While that definitely worked for the insurance companies, it was not very fair or forgiving for the consumers. First insurance companies themselves started offering plans and options that would allow policyowners reinstate policies, or at least keep the cash value, and then in the late 1940s, the Standard Nonforfeiture Law was passed to define the minimum standards for nonforfeiture values. Since then, the nonforfeiture benefits have been required by law.

First you need to understand where those values come from. Since permanent life insurance builds cash value; that essentially becomes the surrender or nonforfeiture benefit. It is a guarantee built into the policy. What triggers that benefit is the nonpayment of premium or policy surrender.

There are 3 nonforfeiture options available: cash surrender option, reduced paid-up option, and extended term insurance option. Let's review each in detail.

The simplest way to receive the policy surrender value is in cash. When this option is selected, the coverage stops, and the insurer has no further obligation to the insured. The policyowner can exercise this option at a time when coverage is no longer needed or affordable. There could be tax consequences, however; if the cash value is higher than the premiums paid into the policy, the excess amount will be taxed.

For example, Mary has a whole life policy which with the face amount of \$150,000, and a cash value amount of \$10,000. Mary had paid a total of \$7,000 in premium when she decided she no longer wished to keep the policy. She surrendered the policy for the cash value of \$10,000. Since only \$7,000 was contributed by Mary, she will need to pay taxes on the remaining \$3,000.

Next option is called Reduced paid-up insurance. While it might seem like a strange combination of terms, it is exactly what it sounds like: the cash value of the original policy is used to purchase a new fully paid -up policy, only with a reduced face amount. The Cash value is used as a net single premium to purchase the policy. Keep in mind that the new policy must be of the same kind as the original. For example, if the original policy was a participating whole life policy, the reduced paid-up policy must be a participating reduced paid-up. The new reduced policy builds its own cash value and will remain in force until death or maturity.

Let's look at an example: Jason owns a whole life policy with a \$300,000 face amount and a cash value of \$25,000. He is afraid that he won't be able to make premium payments in the future due to a change in his employment. He would like to continue some sort of coverage, however. Jason chooses to select a reduced paid-up non-forfeiture option. The insurance company takes Jason's \$25,000 as a lump sum payment for another whole life policy which will have a reduced face amount of \$75,000. Jason will never have to make another premium payment and his \$75,000 whole life policy will remain enforce until his death or age 100.

Finally, there is the Extended term option. Under this option, the insurer uses the policy cash value to purchase term insurance in the amount equal to the original policy's face value. The new term coverage lasts for as long as the amount of cash value will purchase.

One final note about the reduced paid-up option, but a very important one – take note: if the policyowner has not selected a nonforfeiture option, the insurer will automatically implement the extended term option in the event of termination of the original policy.

So here is a recap of key concepts regarding the nonforfeiture options:

Number 1. Nonforfeiture options are triggered by a policy lapse or surrender.

Number 2. There are 3 nonforfeiture options: cash, reducer paid-up insurance, and extended term insurance.

Number 3. Extended term insurance is automatic if no other option is chosen.

In order to understand dividends and dividend options, you need to understand the types of policies that can offer those payments. Dividends can only be offered by participating (or par) policies, in which the policyowner receives shares of the divisible surplus of the company. While stock companies can issue either participating or nonparticipating policies, mutual companies can issue only participating policies. Mutual companies are insurance organizations owned by the policyholders. Profits are returned to the policyholders in the form of non-taxable dividends.

Dividends are generally paid once a year through one of the following 5 options:

The first option is to take dividends in cash. When dividends become payable, they are paid on the policy anniversary date in the form of a check to the policyowner.

Another option is to apply dividends against premium payments. Under this option, the dividend is used to reduce the insured's premium for the next year. This option lowers the owner's out-of-pocket expenses.

Next is the accumulation at interest option, which is set up so that the insurance company keeps the dividend. From there the dividend accumulates interest, and the policyowner is allowed to withdraw dividends at any time. The insured's policy will determine the amount of interest accumulated, which would compound annually. While the policy dividend is not taxable, any interest it accumulates will be taxable income in the year it is credited to the policy.

The paid-up additions option is the next choice. This one is actually a default option if the policyowner has not selected any other options. Under the paid-up additions option, a dividend is used to purchase a single premium addition to the face amount of the permanent policy. No new policies will be issued.

However, each of the small single premium payments increases the death benefit of the original policy. This increase will be based on the amount the dividend will buy. This dividend option also allows the policy to accumulate cash value. The insured's attained age at the time the dividend is declared determines the amount of additional coverage that can be purchased.

Finally, there is the one-year term option. With this option, the dividend is used to purchase additional insurance. This insurance will be in the form of one-year term insurance that increases the overall policy death benefit. The policyowner may then choose whether to use the dividend as a single premium on as much insurance as possible, or to purchase one-year term insurance up to the amount of the policy's cash value. Should the insured die during this one-year term, the beneficiary will receive the death benefit of the original policy AND of the one-year term insurance.

Next, we'll take an in-depth look at settlement options available in life insurance policies. As you already know, life policies deliver their proceeds in the form of death benefit to the beneficiary upon the insured's death. That death benefit can be paid out in a variety of ways. The policyowner can choose from 5 available options, and once a settlement option is selected by the policyowner, it cannot be changed by the beneficiary:

The easiest way to pay out the policy proceeds is in cash, in a single lump-sum amount. In fact, this option would be automatically used by the insurer if the policyowner did not designate a preferred settlement method. Lump-sum payments are usually not taxable to the beneficiary.

All the other settlement options outlined next would consist of a payment of the principal and an accumulated interest. The principal amount will be received tax free, but the interest will be taxed. So let's review these other options.

The first optional settlement option we will discuss is the fixed-period option, also called period certain. Under this option, equal installments are paid to the recipient for a specified period of years. The principal and the interest are liquidated together over that period of time. If the recipient dies before the end of the period, the payments will still continue.

The amount of proceeds available in the policies and the length of time during which the proceeds will be paid out would determine the size of each installment. The longer the period, the smaller each installment will be. Any additional interest will merely increase the size of the installment, but not the period of time. Fixed-period option guarantees that the entire principal will be paid out.

Next settlement option is the fixed-amount option. It is similar to the fixed-period, only this time we are talking in terms of dollar amounts instead of time limits. This option will pay a fixed, specified amount in regular installments until the principal and interest proceeds are exhausted. If the beneficiary dies before the proceeds are paid out, then installments continue to a contingent beneficiary or to the insured's estate.

The fixed amount option differs from the fixed period option in that, under the fixed period option, the length of the income period determines the amount of each installment. Under the fixed amount option, [contrast] the size of each installment determines how long benefits will be received. But just like a fixed-period option, a fixed amount option guarantees that all of the proceeds from the policy will be paid out.

Life income option is next, and it is designed to provide an income that the recipient cannot outlive. Unlike the fixed period and fixed amount options, the installment payments are guaranteed for as long as the recipient lives. So in this case, what determines the amount of each installment? The recipient's life expectancy, and of course, the amount of principal and interest available in the policy. However, if a beneficiary lives an especially long time, payments from the policy may exceed the total principal. The reverse is also true, if a beneficiary dies shortly after installments begin, the payments stop.

For example: Jim is the beneficiary of his wife's \$100,000 life insurance policy. Because Jim's wife did not choose a settlement option on the policy before she died, Jim is free to choose the option he wants. He decides to choose the life income settlement option to make sure he cannot outlive that income. Since Jim is in his 70s, and his life expectancy is not very high, the policy will pay him a higher monthly installment than it would if he were in his 50s. It is possible that Jim could receive a total amount more than \$100,000 if he lives a very long time. It is also possible that Jim could receive much less than \$100,000 if he dies sooner.

There are some variations of life income option that I would like to discuss next. The policyowner can choose a life income with period certain option. With this option, the recipient is given advantages from both the lifetime income and guaranteed installment period options. Payments are guaranteed for the lifetime of the recipient, and there is also a specified period that is guaranteed. This way, if

the beneficiary dies early into receiving payments, the payments will continue for the policy-specified period of time.

Another variation is life income joint and survivor. This option is designed to pay two or more recipients a guaranteed income for as long as they live. Generally, once the first recipient dies, any other recipients will receive reduced payments.

The most common reduced payment option is the joint and 1/2 survivor, or joint and 2/3rds survivor. In these options, the surviving beneficiary receives a fraction of the amount received when all the beneficiaries were alive. The policyowner may also include a period certain option. As we discussed before, this option insures that if the beneficiaries die soon after payments begin, payment will continue for the remainder of a specified period of time.

For example: David is concerned about his elderly parents in the event of his death, so he chooses a Joint and Survivor settlement option and names his parents as the beneficiaries. If David dies, his elderly parents will both receive a monthly installment from the insurance policy until the day each parent dies. It is possible for the total amount of payments to exceed the original death benefit if the parents live a long time. It is also possible for the total amount of payments to be much less than the original death benefit if the parents live only a limited amount of time.

The final settlement option is the interest only option. With this option, the insurance company keeps the policy proceeds, paying the interest to the beneficiary at regular intervals. This can be monthly, quarterly, semiannually or annually. Generally, the insurer will guarantee a certain rate of interest and frequently pay more than that guaranteed rate. This settlement option is considered temporary, as the proceeds will eventually be paid out in a lump sum or through another settlement option.

In the case that the beneficiary is allowed to select the settlement option, the interest only option is commonly used as a default while the decision is being made. This option can also be used if the policyowner wishes for someone to receive the principal who is not the primary beneficiary.

For example: After Beverly's death, Richard chooses the interest only settlement option. The insurance company will retain the \$200,000 death benefit and sends Richard the interest that the benefit acquires. Richard utilizes the flexibility this option provides to take time and choose another settlement option. After some time has passed, Richard decides to take a lump sum payment and the insurance company sends Richard a payment for the \$200,000.

This has been a short overview of dividends, dividend options, and settlement options available to policyowners. You need to remember that dividends are return of unused premiums offered by participating policies. These are 5 dividend options: cash, reduced premium, accumulation at interest, paid-up additions and one-year term.

Settlement options determine how the death benefit will be paid out to the beneficiary. Again, the policyowner may select one of the 5 options: lump-sum, fixed-period, fixed-amount, life income, and interest-only option.

G. Other Life Topics

1. Personal Uses of Life Insurance

Survivor Protection

The death of the primary wage earner will usually stop the flow of income to a family. Equally financially devastating can be the death of a nonworking spouse who cares for minor children. Life insurance can provide the funds necessary for the survivors of the insured to be able to maintain their lifestyle in the event of his/her death. Planning for survivor protection requires careful examination of current assets and liabilities as well as determining what survivors' needs may be.

Estate Creation

A person may create an estate through earnings, savings, and investments over a period of time, but all of these methods require disciplined action. If time is not available, they all will fail. The purchase of life insurance, in the event of death, **creates an immediate estate**. Estate creation is especially important for young families that are getting started and have not yet had time to accumulate assets. When an insured purchases a life insurance policy, he/she will have an estate of at least that amount the moment the first premium is paid. There is no other legal method whereby an immediate estate can be created at such a small cost.

Cash Accumulation

Life insurance may be used to accumulate specific amounts of monies for specific needs and guarantees that the amount of money will be available when needed. An example of a life product that provides cash accumulation would be a whole life policy that offers an insured living benefits in the form of cash values.

Liquidity

Liquidity in life insurance refers to availability of cash to the insured. Some life insurance policies offer cash values that can be borrowed at any time and used for immediate needs.

Estate Conservation

Life insurance proceeds may be used to pay state inheritance taxes and federal estate taxes so that it is not necessary to sell off assets from the estate to pay these costs.

Viatical Settlements

Viatical Settlements allow someone living with a life threatening condition to sell their existing life insurance policy and use the proceeds when they are most needed, before their death. While viatical settlements are not policy options, they are **separate contracts** in which the insured sells the death benefit to a **third party** at a discounted rate.

There are several important concepts you need to understand about viaticals:

- The insureds are referred to as **viators**;

- Viatical producers represent the providers;
- Viatical brokers represent the "insureds".

Viators usually receive **a percentage** of the policy's face value from the person who purchases the policy. The new owner continues to maintain premium payments and will eventually collect the entire death benefit.

2. Determining Amount of Personal Life Insurance

Human Life Value Approach

This method requires the calculation of the probable future earnings of the insured using wages, inflation, the number of years to retirement, and the time value of money. To calculate an individual's life value, the agent must do the following:

- Determine the insured's after-tax income from the present date until retirement.
- Deduct the insured's annual expenses for food, clothing, medical and other expenses.
- Calculate the number of years to retirement.
- Estimate the effect inflation would have on income over the required number of years.

This method will give the insured an estimate of what would be lost to the family in the event of the premature death of the insured.

Needs Approach

The needs approach in purchasing life insurance is based on the predicted needs of a family after the premature death of the insured. This method provides the proper amount of coverage immediately. When using the "needs approach," always assume that the insured's death will occur immediately.

Types of Information Gathered

The type of information that needs to be gathered falls under 4 categories:

1. Debt.
2. Income.
3. Mortgage.
4. Expenses.

Determining Lump-sum Needs Costs Associated with Death (Post Mortem)

These costs would take into account the final medical expenses of the insured, funeral expenses, and day to day expenses of maintaining the family including rent or mortgage payments, car payments, utilities, groceries, etc.

Other Lump-sum Needs and Objectives

Other needs and objectives would include estate taxes, day care, insurance premiums, etc.

Debt Cancellation (versus Transfer to Heirs)-Insurance may be used to create a fund to pay off debts of the insured such as home mortgage, auto loans. (Most

lenders require a collateral assignment of life insurance as a condition for a loan.)

Emergency Reserve Funds-Insurance proceeds may be used to assist in paying for sudden expenses following the death of the insured, such as travel expenses and lodging for family members coming from a distance.

Education Funds-Insurance proceeds may be used to pay for children's education expenses so they can remain in school, or sometimes a surviving spouse that has worked in the home caring for children will need to receive education or training in order to re-enter the job market.

Retirement Fund-Cash values of a matured life insurance policy may be a source of retirement income.

Bequests-An insured may wish to leave funds to their church, school, or other organization at the time of their death.

Planning for Income Needs Replacing Salary or Lost Services of the Deceased

Unless funded by insurance, the surviving spouse who was the caregiver of the children may have to train to enter the job market. If they do work outside the home, expense for day care needs to be considered.

Social Security Income "Blackout" Period

Social Security **blackout period** is the time during which the surviving spouse and/or children do not receive any social security survivor benefits. Blackout period begins when the youngest child reaches the age of 16, and ends when the surviving spouse qualifies for retirement benefits, as early as age 60. Social Security full retirement age depends upon the year in which the individual was born.

Unmarried children under the age of 18 (up to 19 if they are attending elementary or secondary school full time) can also receive benefits. *Technically, the social security check will be made out to the surviving spouse until the youngest child is 16, and to the child him/herself between the ages 16 and 18.*

Liquidation vs. Retention of Capital

Selling assets (liquidation) is a method of raising capital. Retention is the retaining of assets. If the principal asset is the home, selling the home would require that the survivors then pay rent. Under the retention of capital approach, enough insurance is purchased so that when added to other liquid assets, there is enough to pay income benefits without invading the principal

3. Examples of Insurance

Insurance is the **transfer** of financial responsibility associated with a potential of a loss (**risk**) to an insurance company, which in turn spreads the costs of unexpected losses to many individuals. It is a contract in which one party agrees to indemnify the other against loss, damage or liability arising from an unknown event. In most

situations only a small number of those insured will actually suffer a loss. Insurance redistributes the financial consequences of individual losses to all persons insured. If there were no insurance mechanism, the cost of a loss would have to be borne solely by the unfortunate individual who suffered the loss. With insurance, the cost of the loss up to the amount of the policy face amount will be covered by the insurance provider. However, the cost of the loss may exceed the limit of insurance.

In the law, a **person** is a legal entity which acts on behalf of itself, accepting legal and civil responsibility for the actions it performs and making contracts in its own name. **Persons** include individual human beings, associations, organizations, corporations, partnerships, and trusts.

Insurance is the legal agreement, or contract, whereby the two parties involved agree to the limits of the indemnification, the circumstances under which it will occur and what things of value (**consideration**) will be exchanged by the parties to the contract.

4. Social Security Income "Blackout" Period

Social Security **blackout period** is the time during which the surviving spouse and/or children do not receive any social security survivor benefits. Blackout period begins when the youngest child reaches the age of 16, and ends when the surviving spouse qualifies for retirement benefits, as early as age 60. Social Security full retirement age depends upon the year in which the individual was born.

Unmarried children under the age of 18 (up to 19 if they are attending elementary or secondary school full time) can also receive benefits. *Technically, the social security check will be made out to the surviving spouse until the youngest child is 16, and to the child him/herself between the ages 16 and 18.*

5. Definition and Types of Risk

Risk is the uncertainty or chance of a loss occurring. The two types of risks are pure and speculative, only one of which is insurable. **Pure risk** refers to situations that can only result in a loss or no change. There is no opportunity for financial gain. Pure risk is the only type insurance companies are willing to accept.

Speculative risk involves the opportunity for either loss or gain. An example of speculative risk is gambling. These types of risks are not insurable.

Example:

Jim likes to go to the local racetrack and bet on the horses. His favorite horse is a two year old thoroughbred named "Old Betsy." Anytime Jim bets on "Old Betsy" he has the opportunity to win or lose. Consequently he could experience a loss or gain of his money. His bet on each race, therefore, is speculative.

6. Methods of Handling Risk

Avoidance

One of the methods of dealing with risk is **avoidance**, which means eliminating exposure to a loss.

Example:

One of Robert's fears involves being killed in a plane crash. If he wants to avoid the risk of being killed in an airplane crash, Robert should choose never to fly in an airplane. In this way, risk avoidance is effective, even though it seems as if it would seldom be practical.

Retention

Risk retention is the planned assumption of risk by an insured through the use of deductibles, co-payments, or self-insurance. It is also known as self insurance when the insured accepts the responsibility for the loss before the insurance company pays. The purpose of retention is

1. To reduce expenses and improve cash flow;
2. To increase control of claim reserving and claims settlements; and
3. To fund for losses that cannot be insured.

Example:

Harry realizes that he is at a higher risk of cancer since it runs in his family. Harry got numerous quotes for cancer policies and determined that he could not financially afford the most comprehensive policy. Harry decided to accept the highest deductible plan (\$5,000); however, he does not have enough money to cover the deductible in his bank account. Harry only has \$2,500 in his emergency fund to cover his \$5,000 deductible. Therefore, Harry is retaining \$2,500 of additional risk by choosing this deductible and plan.

Sharing

Sharing is a method of dealing with risk for a group of individual persons or businesses with the same or similar exposure to loss to share the losses that occur within that group. A reciprocal insurance exchange is a formal risk sharing arrangement.

Example:

Five fur hunters send their merchandise via aircraft to the mainland for sale of the goods. If a hunter placed all of his furs into one aircraft, and the aircraft went down, then all of his furs would be lost. However, if each of the five hunters put 1/5th of his furs into each of 5 aircrafts, only 1/5th would be lost if one aircraft was lost. In the second scenario, the risk of loss was shared between the five hunters. The same concept of sharing applies in insurance today. A policyowner gives a small consideration - a premium - in exchange for the insurance company's promise to pay for a large claim.

Reduction

Since we usually cannot avoid risk entirely, we often attempt to lessen the possibility or severity of a loss. **Reduction** would include actions such as installing

smoke detectors in our homes, having an annual physical to detect health problems early, or perhaps making a change in our lifestyles.

Transfer

The most effective way to handle risk is to **transfer** it so that the loss is borne by another party. Insurance is the most common method of transferring risk from an individual or group to an insurance company. Though the purchasing of insurance will not eliminate the risk of death or illness, it relieves the insured of the financial losses these risks bring.

There are several ways to transfer risk, such as hold harmless agreements and other contractual agreements, but the safest and most common method is to purchase insurance coverage.

7. Perils and Hazards

Perils are the **causes** of loss insured against in an insurance policy.

- *Life insurance* insures against the financial loss caused by the premature death of the insured;
- *Health insurance* insures against the medical expenses and/or loss of income caused by the insured's sickness or accidental injury;
- *Property insurance* insures against the loss of physical property or the loss of its income producing abilities;
- *Casualty insurance* insures against the loss and/or damage of property and resulting liabilities.

Example:

In an attempt to minimize her "getting ready" time, Veronica decides to apply makeup while driving in the high-occupancy vehicle lane on her way to work. She rear ends a car in front of her causing damage to both vehicles. The application of makeup while driving is an example of a **morale hazard** (or her attitude about safety) and the "collision" with the other vehicle is the **peril** causing damage or loss.

Hazards are conditions or situations that increase the probability of an insured loss occurring. Hazards are classified as physical hazards, moral hazards, or morale hazards. Conditions such as lifestyle and existing health, or activities such as scuba diving are hazards and may increase the chance of a loss occurring.

Example:

A hazard is something that increases the likelihood of a loss. An oily rag (which is the hazard) on top of a furnace increases the chance of a fire (which is the peril). In life insurance, smoking (hazard) increases the risk of early death (peril).

Physical hazards are individual characteristics that increase the chances of the cause of loss. Physical hazards exist because of a physical condition, past medical history, or a condition at birth, such as blindness.

Moral hazards are tendencies towards increased risk. Moral hazards involve evaluating the character and reputation of the proposed insured. Moral hazards

refer to those applicants that may lie on an application for insurance, or in the past, have submitted fraudulent claims against an insurer.

Morale hazards are similar to moral hazards, except that they arise from a state of mind that causes indifference to loss, such as carelessness. Actions taken without forethought may cause physical injuries. (I'm not going to spend my money for a flu shot. If I get sick, my insurance will pay for my care.)

8. Law of Large Numbers

The **law of large numbers** is a principle stating that the larger the number of similar exposure units considered, the more closely the losses reported will equal the underlying probability of loss. This law forms the basis for statistical prediction of loss upon which rates for insurance are calculated.

Example:

When an insurance company issues a policy on a 35-year old male, the company really has no way of knowing or accurately predicting when he would die. However, the Law of Large Numbers looks at a large group of similar risks and makes some conclusions based on statistics of past losses. This allows the insurance company to have a general idea as to the predicted time of death for this type of insured and set the premiums accordingly.

9. Loss Exposure

Exposure is a unit(s) of measure used to determine rates charged for insurance coverage. In life insurance, all of the following factors are considered in determining rates:

- The age of the insured;
- Medical history;
- Occupation; and
- Sex.

A large number of units having the same or similar exposure to loss are referred to as **homogeneous**. The basis of insurance is sharing risk between a large homogeneous group with similar exposure to loss.

Example:

Insurance companies market and sell policies to applicants for insurance. Producers, as first-line or field underwriters, attempt to sell their company's policies to qualified applicants. However, due to each individual's specific past medical history, occupation, habits, age, sex and other factors, the insurer's exposure to loss varies. The true nature of that exposure is not known until the underwriting process is completed.

10. Risk Situations That Present the Possibility of Loss

In the process of establishing an insurance program, insureds must first identify their exposure to losses, along with the probability of how likely it is that a loss will occur and how "big" the loss might be. Certain risks, because of the severity of the possible loss, will demand attention above others.

For example, an individual who uses power tools to work on avocational woodworking projects is exposed to the possibility of hand injuries. If the individual is a brain surgeon, this would be considered a critical risk of financial loss, since the injury could prevent the person from doing his or her job. If the individual is, however, a radio announcer, the loss of hand function may be deemed a less "important" risk.

Exposures to possible losses should be ranked into appropriate groups and classified in the order of their importance:

- **Critical risks** include all exposures in which the possible losses are of the magnitude that would result in financial ruin to the insured, his or her family, and/or to his or her business;
- **Important risks** include those exposures in which the losses would lead to major changes in the person's desired lifestyle or profession; and
- **Unimportant risks** include those exposures in which the possible losses could be met out of current assets or current income without imposing undue financial strain or lifestyle changes.

In making a decision for establishing an insurance program, it may be wise to apply the following commonsense principles:

- Consider the odds;
- Don't risk more than you can afford to lose; and
- Don't risk a lot for a little.

11. Ideally Insurable Risks

Though insurance may be one of the most effective ways to handle risks, not all risks are insurable. As noted earlier, insurers will insure only **pure risks**, or those that involve only the chance of loss with no chance of gain. However, not all pure risks are insurable. Certain characteristics or elements must be present before a pure risk can be insured.

The loss must be due to chance. In order to be insurable, a risk must involve the chance of loss that is outside the insured's control.

The loss must be definite and measurable. An insurable risk must involve a loss that is definite as to cause, time, place and amount. An insurer must be able to determine how much the benefit will be and when it becomes payable.

The loss must be statistically predictable. This enables insurers to estimate the average frequency and severity of future losses and set appropriate premium rates. (In life and health insurance, the use of mortality tables and morbidity tables allows the insurer to project losses based on statistics.)

The loss cannot be catastrophic. Insurers typically will not insure risks that will expose them to catastrophic losses. There must be limits that insurers can be reasonably certain their losses will not exceed. Typically, insurance policies

exclude coverage for loss caused by war or nuclear events because there is no statistical data that allows for the development of rates that would be necessary to cover these events, if and should they occur.

The loss exposure to be insured must be large. There must be a sufficiently large pool to be insured and those in the pool must be grouped into classes with similar risks so the insurer is able to predict losses based upon the **law of large numbers**.

The insurance must not be mandatory. An insurer must not be required to issue a policy to each applicant applying for coverage. The insurer must have the ability to require that certain underwriting guidelines be met.

12. Insurable Events

If a possible future event could result in loss or liability to a person, it may be considered insurable. These insurable events may never occur, but insurance policies can provide protection when those times come.

The more **predictable** a loss becomes, the **less insurable** it becomes. The more **unpredictable** a loss becomes, the **more insurable** it becomes. *For example*, you can't be insured for gambling, waging or lottery outcomes.

There are not usually any set limits as to the level of loss that may be insured against; regulations tend to only specify the type of event that is insurable. The level of loss to be indemnified is agreed upon by the parties to the insurance contract.

13. Stranger-Originated Life Insurance

Stranger-originated life insurance (STOLI) policies are similar to viatical and life settlements in that they deal with the transfer of life insurance benefits available under a policy. However, STOLI policies are financed and purchased solely with the intent of selling them for life settlements.

In STOLI policies, people with no relationship to the insured initiate and fund the policy. They later either sell the policy for a portion of the face value (life settlement) or wait to receive the death benefit after the insured dies.

In either case, STOLI policies violate the principle of insurance interest, which is in place to ensure that a person purchasing a life insurance policy is actually interested in the longevity rather than the death of the insured.

Because of this, insurers take an aggressive legal stance against policies they suspect are involved in STOLI transactions.

STOLI Policies in Depth

As we learned, stranger-originated life insurance is a type of insurance arrangement in which people with no relationship to the insured initiate and fund the policy.

So, why would a stranger do something like that? Well, in some cases, partners in business ventures will take out stranger-originated life insurance on their business partners will take out a STOLI policy covering their business partners to secure their financial future if a certain business partner dies. However, these are not STOLI policies in the strictest sense. After all, the business partners may not know each other as well as the parties in typical life insurance policies, such as a husband and a wife, a parent and a child, or a brother and a sister, but they at least have some formal relationship based on a previous connection and each has an interest in keeping the other alive. It is for financial reasons as opposed to emotional reasons, but that interest is there nonetheless.

In other cases, however, a person will take out a stranger-originated life insurance policy while planning to resell it to an investor. The whole process is done with the goal of making a large sum of money when the insured person dies. This flies in the face of the concept of insurable interest because the interest is clearly not in the person's life, health or well-being, but instead solely in the insured person's death. STOLI policies, then, basically amount to little more than wagering on human lives. In addition to this distasteful truth, there is also a potential, in STOLI policies, for a consumer to become a victim of unexpected taxes and the inability to obtain appropriate life insurance coverage in the future.

This is illegal in some states. In fact, according to the American Council of Life Insurers, as of 2008, more than half of state legislatures were considering legislation that would help curtail the ever-broadening practice of stranger-originated life insurance.

What is a STOLI Scheme

In most cases, the person insured by the stranger-originated life insurance policy is an elderly person. In these cases, according to the American Council of Life Insurers, senior citizens are persuaded to buy life insurance by investors, such as hedge funds. The senior purchases the policy in his or her own name, but agrees to allow the investor to be put in a position to profit from the insured's death, so long as it occurs after the expiration of the standard two-year contestability period.

In these situations, seniors receive a payment upfront for buying the life insurance in their own name and agreeing to allow the investor to profit from the death.

So, how do the investors make money in this scheme? They profit when the senior citizen dies and they collect the death benefits.

STOLI Cases

In 2009, the New York Law Journal reported on a case in which a life insurance company refused to pay the death benefit on a policy it considered a stranger-originated life insurance policy.

In the ruling on the motion dismissing the claim on the life insurance policy in the case of *Phoenix Life Ins. Co. v. Irwin Levinson Ins. Trust II*, Justice Carol Edmead wrote that in STOLI arrangements, "A policy is purchased, not with a view of the

insured paying premiums for the benefit of the insured's family, but with a view toward reselling the policy to an 'outside investor' in a secondary market for life insurance. The outside investor pays the insured in order to make a 'wager' on the duration of the insured's life.

"The entire secondary market for life insurance policies (sometimes called the 'life settlement' market) is a multibillion dollar financial industry that provides life insurance policyholders who do not wish to continue maintaining their policies alternatives besides either allowing their policy to lapse or selling it back to the insurer for its cash surrender value, but also involves parties who seek to invest in an 'insured's imminent demise.' ...

"In 2006 alone, more than \$12 billion in life insurance policies (measured by face value) were sold to purchasers in the secondary market such as Goldman Sachs & Co., Credit Suisse, and UBS AG. Phoenix itself created its own separate division, Phoenix Life Solutions, to participate in the life settlement market."

In New York law, insurable interest is defined as "a substantial interest engendered by love and affection." In terms of business, it is considered "a lawful and substantial economic interest in the continued life, health or bodily safety of the person insured, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the insured."

So, how did the company that established the trust in the case of *Phoenix Life Ins. Co. v. Irwin Levinson Ins. Trust II* manage to skirt the law? Justice Edmead wrote, "To conceal the real policyholder's lack of insurable interest from the insurer, as well as to induce the insured's application, investors establish an irrevocable trust solely to hold the target insurance policy. The trust is established around the time that the insured submits his application, and is named as the owner and beneficiary of the policy, with the beneficiary being entitled to the death benefits payable under the policy. The beneficiary of the trust is typically disclosed to the insurer and designated as the insured or a family member. Once the policy is issued, the insured transfers the beneficial interest in the policy to an outside investor in exchange for a significant lump sum payment."

In 2008, two California women were convicted of murder and sentenced to life in prison for murder in a stranger-originated life insurance scam. The prosecutors in the case said that the two women conspired to sign up homeless men for life insurance policies, then later killed them to benefit from the life insurance policies. Murder is, of course, the major crime in this case by far. However, if more insurance companies were aware of stranger-originated life insurance policies and the signs of stranger-originated life insurance policies, these would have been avoided.

More Information on Stranger-Originated Life Insurance

In September 2009, Susan E. Voss, the commissioner of the Iowa Insurance Commission and the vice president of the National Association of Insurance Commissioners, testified before the House Financial Services Subcommittee on Capital Markets, Insurance and Government-Sponsored Enterprises on the impact of securitization on life insurance settlements.

In her testimony, as printed on the National Association of Insurance Commissioners website, she said, "Life insurance settlements are necessary transactions for some consumers, but they require appropriate regulation with a focus on disclosure and consumer protection. As such, nearly all the states have moved to pass regulations or laws specifically establishing strong oversight of life settlement transactions, but it's important to note that all states have the authority to protect consumer from fraud and misrepresentation in this area. All state insurance regulators enforce licensing and form requirements, and have examination and enforcement authority, and require mandatory disclosures to the consumer about his/her rights.

"This oversight is critical, particularly as 'stranger owned life insurance', or STOLI, has emerged in recent years. Under STOLI, investors solicit a healthy and high net-worth individual, who is typically at least 70 years of age, to obtain a life insurance policy with a certain minimum death benefit. The individual buys the insurance with the specific intent of selling it to those investors, and after a minimum period of incontestability ends, ownership of the policy is transferred in exchange for a taxable lump sum. The investors then receive the death benefit when the insured individual dies.

"This concept violates state 'insurable interest' laws that require a direct interest and relationship between the policyholder and beneficiary, but it is difficult to determine a policyholder's true intent when purchasing a policy - making it challenging to distinguish between STOLI and a legitimate life insurance settlement. As such, the states are implementing requirements to target the timing of these transactions to make them unappealing to would-be STOLI investors, while preserving a policyholder's right to sell his/her policy."

14. Adverse Selection

Adverse selection is the insuring of risks that are of a poorer class (more prone to losses) than the average risk. Poorer risks or less desirable insureds tend to seek or continue insurance to a greater extent than better risks. One of the functions of the underwriting department is to protect the insurer from adverse selection.

Underwriters protect the insurer against adverse selection by some of the following methods:

- Restriction of coverage;
- Acceptance only at a higher rate;
- Refusal to accept the risk.

Example:

Adverse Selection can be described in terms of poorer or substandard risk individuals "lining up" first to purchase insurance. These individuals want to limit their personal exposure to the financial consequences of an unexpected loss, so they transfer this potential loss to the insurance companies. This causes the increase in the Adverse Selection for the insurer. It takes the collective efforts of all participants in the underwriting process to reduce adverse selection as much as possible.

15. NAIC

The **National Association of Insurance Commissioners** (NAIC) is an organization composed of insurance commissioners from all 50 states, the District of Columbia and the 4 US territories.

The NAIC resolves insurance regulatory problems. They are active in the formation and recommendation of model legislation and regulations designed to bring uniformity from state to state and simplify the marketing of insurance.

North Carolina Laws About the NAIC

According to North Carolina state statutes, each domestic, foreign, and alien insurer that is authorized to transact insurance in North Carolina must file with the NAIC a copy of its financial statements required by state law, applicable rules, and legal directives and bulletins issued by the Department. The statements must, in the Commissioner's discretion, be filed annually, semiannually, quarterly, or monthly and must be filed in a form or format prescribed or permitted by the Commissioner. The Commissioner may require the statements to be filed in a format that can be read by electronic data processing equipment. Any amendments and addenda to the financial statement that are subsequently filed with the Commissioner must also be filed with the NAIC.

Financial test ratios, data, or information generated by the NAIC Insurance Regulatory Information System, any successor program, or any similar program will be disseminated by the Commissioner consistent with procedures established by the NAIC.

Immunity

In the absence of actual malice, or gross negligence, members of the NAIC, their duly authorized committees, subcommittees, and task forces, their delegates, NAIC employees, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from filings will be seen as acting as agents of the Commissioner under the authority of this Article and will not be subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required under this Article.

Revocation or Suspension of License

The Commissioner may suspend or revoke the license of any insurer failing to file its financial statement when due or within any extension of time that the Commissioner, for good cause, may have granted.

16. NCOIL

The National Conference of Insurance Legislators (NCOIL) was created to help legislators make informed decisions on insurance issues affecting their constituents. NCOIL also opposes federal encroachment of state authority to oversee the insurance industry. Many members of NCOIL either chair or are members of committees responsible for insurance legislation.

NCOIL works to achieve the following:

- Educate state legislators on current and perennial insurance issues;
- Help state legislators from different states work effectively with each other;
- Improve the quality of insurance regulation;
- Assert the prerogative of legislators in making state policy concerning insurance; and
- Speak on Congressional initiatives that attempt to encroach upon state primacy in overseeing insurance.

17. Reduction in Coverage

Policies that offer a misstatement of age provision must provide that if the insured's age was misstated on the application, any amount payable under the policy will be determined according to how much coverage the premium paid would have purchased at the correct age.

18. Terms Used in Insurance Situations

Application--A written request to an insurance company for insurance. It must honestly represent the facts regarding the person to be insured. Otherwise the policy will be voided.

Policy **riders** are added to the basic life insurance policy in order to add, modify or delete policy provisions.

Policy-- A contract between an insured and an insurance company which agrees to pay the insured for loss caused by specific events.

Cancellation is the act of revoking or terminating one's insurance policy.

A policy that is terminated because of nonpayment of premiums is known as a **lapsed** policy.

Renewal is the continuance of an insurance policy beyond its original term.

Nonrenewal is the discontinuance of an insurance policy beyond its original term. The renewal or nonrenewal may occur on a date specified in the contract (usually on the policy anniversary or premium due date).

A **grace period** is the period of time after the deadline or due date of a premium in which a late premium payment may be made without penalty, or without the policy lapsing.

The price of insurance for each exposure unit is called the **rate**. The **premium** is the payment required by the insured to keep the policy in force. The **premium** is determined by multiplying the **rate** by the number of units of insurance purchased.

$$\text{Premium} = \text{Rate} \times \text{Units of Insurance}$$

An **earned premium** is the portion of a premium that belongs to the insurance company for providing coverage for a specified period of time. The **unearned premium** is the portion of the premium the insurance company has collected but has yet to "earn" because it has not yet provided coverage for the insured. *For*

example, if an insured pays an annual life insurance premium and dies before that year is up, the insurance company would have to return the portion of the premium that was "unused" or "unearned."

19. Violent Crime Act

The Violent Crime Control and Law Enforcement Act of 1994, also known as the Biden Crime Law, was enacted into law in response to the 1993 workplace killing of 7 people in San Francisco at the hands of a disgruntled worker using two semi-automatic assault weapons. In addition to banning 19 types of assault weapons, other provisions of the law included a variety of new and federal offenses, in areas such as immigration law, insurance fraud, hate crimes, sex offenses, and gang-related crime.

The Biden Crime Law provided guidelines for potential or future employment in the insurance industry. Individuals who have *ever* been convicted of any criminal felony charges involving dishonesty or a breach of trust (including, but not limited to, bribery, embezzlement, fraud and theft) are prohibited in engaging in the business of insurance in interstate commerce without the written consent of an insurance department official who is authorized to do so. The law is loosely worded to include all employees of an insurer, including customer service representatives, agents, brokers and third party administrators, with the obvious exception of employees such as janitors and groundskeepers.

The Biden Crime Law prohibits the willful employment of an individual with such a felony conviction in the business of insurance; and the employer of such an individual is subject to criminal penalties. There is no grandfather provision for those individuals with convictions that occurred prior to the effective date of the statute who are currently employed or licensed in the business of insurance. Any person or firm engaged in the business of insurance in interstate commerce must notify the appropriate state insurance department of all individuals who are subject to said laws and, if employment of such individuals is desired, will have to apply for an exemption from the employment prohibition before such individuals can engage or continue in the business of insurance in interstate commerce.

20. Buy-Sell Agreements

In an **Entity Plan** the business (partnership) owns, pays for, and is the beneficiary of the policies on the lives of each partner. Upon the death of one of the partners, the partnership purchases the deceased partners' interest in the business from his or her estate. If there were four partners, under an entity plan, the partnership would own four life insurance policies, one for each of the partners.

Closely held corporations also have the need for buy-sell agreements, but not for the same reason as a sole proprietorship or a partnership. Unlike a sole proprietorship or partnership in which the business is sold following the death of one of the owners, a corporation has an *unlimited* life. The owners in a corporation are the stockholders who have invested in the business. Upon the death of a stockholder, the business continues. However, in closely held corporations in which the stock is owned by a few individuals, such as family members, problems may arise if a prior arrangement has not been made to purchase the deceased

stockholder's interest (stock) in the business. In the case of a closely held corporation, the family of a deceased shareholder may be forced to sell the stock, which could ultimately devalue the price of the stock. In addition, if the corporation is unable to purchase the stock, the stock may have to be sold to someone who does not have the same interest in the continuation of the business.

Buy-sell agreements for closely held corporations are similar to those used in partnerships, only with different names. A stock purchase plan is similar to a partnership cross-purchase plan in which each stockholder purchases insurance on the lives of each of the other stockholders. The corporation is not a party to the agreement. This type of arrangement is only feasible if there are a small number of stockholders.

21. Split-dollar Plans

Life insurance can also be used to provide employee benefits. **Split-Dollar Plans** are not actually a type of life insurance, but rather a way of purchasing permanent life insurance as a fringe benefit to key employees. The employer may be very selective in determining which employees participate and, therefore, the plans are considered nonqualified and do not require government approval; however, the employer does not receive a tax deduction for contributions to the plan. The basic Split Dollar plan insures the life of the employee and splits the premium payments between the employee and their employer. Generally, the employer's contributions to the plan equals the annual increase in the policy's cash value, while the employee's payments represent the pure death protection (term rates) and decline annually. When death occurs, the employer receives that part of the death benefit equal to the cash value of the policy or the amount of premiums paid, whichever is greater. The balance of the death benefit is paid to the employee's beneficiary. (The ownership rights and death proceeds of the policy are divided between the parties paying the premiums.)

22. Stock Redemption Plan

If there are more than a few stockholders involved in a close corporation, a stock redemption plan is recommended. A stock redemption plan is an agreement under which a close corporation purchases a deceased stockholder's interest.

A stock redemption plan is similar to a partnership entity plan. The corporation is the owner, premium-payor, and beneficiary of life insurance on the lives of each of the stockholders.

The amount of insurance carried by the corporation on the lives of the stockholders is equal to each stockholder's proportionate share of the purchase price. When a stockholder dies, the proceeds of the policy insuring that person are paid to the corporation. The corporation then uses the proceeds to buy the deceased's business interest represented by the stock in the deceased's estate.

Premiums for the insurance paid by the corporation are not tax deductible, however, the proceeds are generally received income tax free.

23. Third-party Ownership

Most insurance policies are written where the insured and owner of the policy are the same person. However, there are situations in which the contract may be owned by someone other than the insured. These types of contracts are known as third-party ownership. Most policies involving **third-party ownership** are written in business situations or for minors in which the parent owns the policy. *Third-party owner* is a legal term used to identify an individual or entity that is not an insured under the contract, but that has a legally enforceable right under it.

24. Vesting Requirements

With a defined benefit plan, an employer has two basic scheduling options to choose from in order to determine when an employee becomes fully vested. The employer may require employees to have 5 years of service to become 100% vested in employer funded benefits. Or, the employer may choose a graduated vesting schedule, requiring an employee to work for 7 years to become 100% vested. This system provides

- 20% vesting after 3 years;
- 40% vesting after 4 years;
- 60% vesting after 5 years;
- 80% vesting after 6 years; and
- 100% vesting after year 7.

An employer may choose neither, and provide a different schedule, so long as it is more generous than these vesting schedules.

With defined contribution plans, such as 401(k) plans, again there are two vesting schedule options. The employer may choose a schedule in which employees are 100% vested in employer contribution after 3 years of service. This is called cliff vesting. The employer may also choose graduated vesting, where an employee must be

- At least 20% vested after 2 years;
- 40% after 3 years;
- 60% after 4 years;
- 80% after 5 years; and
- 100% after six years.

25. Tax-qualified Retirement Plans

The information in this section will provide you with a greater understanding of important topics; however, it will not appear on the state exam. The following are concepts relating to Qualified Plans that are new to you, or expanded upon from what was discussed previously in your text.

Types of Qualified Plans

All qualified plans fall into one of two categories. Those that shelter otherwise taxable income without promises of specific future benefits are called **defined**

contribution plans. Others that promise a specific retirement benefit are termed **defined benefit plans.**

There are many types of plans that are considered defined contribution plans. These include profit-sharing plans, money-purchase pension plans, thrift plans, and stock bonus plans. In addition, a target benefit or assumed benefit pension plan, though having many characteristics of the defined benefit approach, is also considered a defined contribution plan.

Defined Contributions Plans

Advantages

The advantages of a defined contribution approach and conditions that favor these plans include the following:

- Employer liability is generally less severe. Unlike some defined benefit plans, the contributions tend to be relatively constant as a percentage of payroll. Profit-Sharing plans offer the greatest flexibility. Under all these approaches, however, an employer can terminate the plan as long as current contributions are met. A flexible, profit-sharing formula is attractive if the business is volatile.
- Compound interest adds to the participants' account and increases the ultimate benefit. Interest assumptions serve only for demonstration or comparison. During periods of high inflation or attractive investment markets, the defined contribution plan can shelter yields and gains from current income tax for the future benefit of highly compensated employees.
- Since compound interest works most effectively over relatively long periods of time, the defined contribution approach favors the younger employees. This is true because allocations are generally the same for similarly compensated individuals with respect to age.

Individual accounts provide recognition of value received. Employees tend to appreciate these plans more than unsecured promises of future retirement income. Furthermore, the defined contribution approach is attractive to younger, aggressive employees who correctly view employer contributions as additional compensation.

Assets can be invested more aggressively in defined contribution plans. (This advantage is due to the fixed nature of the liability under defined benefit plans.) The individual employee may be given some choice in the investment of his or her account without disqualifying the plan. Under certain plans, the assets may be invested in the stock of the employer.

More life insurance may be available under defined contribution plans. A portion of the assets or contributions can be directed to pay premiums on a wide range of policy types. The premium, which determines the face amount of protection, buys more insurance at younger ages--potentially when it is most needed.

Participants can retire when they attain retirement age under the plan. Alternatively, they can continue to share in employer contributions by postponing retirement.

Disadvantages

The amounts that can be contributed and deducted are restricted. Consequently, this may fail to completely satisfy the employer's need for maximum current income tax deduction.

Because contributions and earnings take time to provide a meaningful accumulation, older participants who are counting on the plan to provide a large part of their retirement income may have to postpone retirement or suffer a reduction in their standard of living.

Compound interest can also turn negative. The final accumulation, even for an employee hired at a young age, may be inadequate unless investment earnings outpace inflation. This is the case because contributions are typically based upon a participant's annual compensation, which is lower in the early years. The risk of investment performance is borne by the participant, who also has little or no control over the timing and direction of plan funds.

Plan trust accounting calls attention to asset mix and performance. Unless a solid employee communication program regarding the retirement plan is maintained, participants may regard the plan assets as their own and put unusual demands on the employer. If funds build to a sizable amount, the employee actually may be motivated to resign so these can be withdrawn, defeating the objective originally established for the plan.

Past service is not easily recognized and rewarded under the defined contribution approach, although a profit-sharing allocation method that provides some weighting for service can be implemented.

Participants can never accurately plan for retirement, since the ultimate benefit will be based upon whatever account balance exists at the time of retirement, regardless of the individual's final salary level.

It may not be possible to purchase enough life insurance using only a portion of the contribution premium, particularly for older or rated persons. Also, the net benefit may not be determinable until the end of the year. Typically, the benefit consists of both face amount of insurance, if any (could be an annuity), plus the participant's account balance on the date of death or after a break in service.

Defined Benefit Plans

Advantages

The cost of funding retirement benefits is currently deductible without strict contribution limitations, provided that the funding is reasonable. This often permits deductions against current income exceeding those available under other approaches.

The participant's pension benefit is not affected by investment results, and because it is usually based on final average compensation for specified years immediately preceding retirement (i.e., the final five years), this approach provides some protection against inflation. This benefit is insured by the Pension Benefit Guaranty Corporation.

Because assets are usually commingled (aggregate method of funding) and benefits may be deferred to retirement, participants are motivated to stay with the employer.

Adequate benefits can be provided even for participants covered by the plan for only a short time. Furthermore, it is possible to reward key older employees or those with many years of service--an advantage that can be used to attract and keep experienced personnel.

A defined benefit pension plan can provide an insured a pre-retirement death benefit (plan using life insurance). The coverage is a function of the benefit provisions contained in the plan document. The participant's age or rating classification need not be a factor in the amount of insurance. Regardless of other funding, premiums can be continued, as long as the death benefits are warranted. Annuities are an exception to this rule.

Benefits can be fairly accurately determined for purposes of retirement planning. Benefits may be integrated with Social Security to provide a retirement program that, together with a personal savings program, is adequate to continue pre-retirement living standards.

Excess interest and gains earned by the plan investments will be added to the value of the plan for the participant to offset some inflation.

Disadvantages

Defined benefit plans are very expensive in cases where participants are at or near retirement. Conversely, contributions required for young employees are relatively low for the same proposed benefit, due to the time value of money and tax-deferral on accumulations. This factor may be perceived as inequitable if both employee groups are roughly equal in terms of job classification, such as machine tool operators.

Employers are liable for benefits because they are considered to be part of the employment contract. If a plan is terminated or inadequately funded, the PBGC can attach assets of the business (up to 30% of net worth).

Administration is more difficult and costly than under defined contribution approaches. Most defined benefit plans require actuarial valuation and certification.

Plan funding is typically inflexible. At precisely the time the employer can least afford required annual plan contributions, as would be the case in business downturns, the plan may require larger deposits because investments may have declined in value. If investments do exceedingly well during economic recovery, the employer may be required to reduce contributions. Viewed negatively, reduced contributions can result in reduced income deductions precisely in years that they are needed most.

Complicated benefit provisions, common to integrated plans, may be difficult to communicate to covered employees.

Defined benefit plan assets must be invested in a prudent manner, diversified and, because benefits are normally paid in cash, liquidity must be maintained. This may prevent the employer from taking risks with pension funds, even if an aggressive investment strategy is in the best interests of the business and, consequently, the employees. Only a small portion of the funds may purchase the business's stock or notes (usually 10% in most plans) and then only if such action is deemed prudent.

It should be noted that the above guidelines are broad generalizations. Within these categories are found specific plans and specific plan provisions to meet the ever changing pension market. Always check with the desires of the company as to which will serve it the best.

Employer Contributions to Retirement Planning Programs

An employer's contributions to a profit-sharing plan may be directly tied to the corporation's profit and very often is. Profits may be defined differently, depending on the situation of the employer. For example, a profit-sharing plan covering a self-employed person will define profits differently than a regular corporate profit-sharing plan. Profits may be increased or decreased by non-cash items such as depreciation. Where these items eliminate or reduce profits, contributions may be made from retained earnings--but only in accordance with plan provisions or a board resolution. It should be noted that neither profits nor positive retained earnings are required to obtain a plan contribution reduction.

Alternatively, a profit-sharing plan may call for a fixed contribution amount or percentage of eligible payroll contingent upon profits. A third option is offering no formal provision for contributions. The board of directors may declare a profit-sharing contribution under a "discretionary" plan formula. This is unique to this type of plan. Although this approach is flexible, it must be handled carefully. The corporation should commit itself to the tax year in order to deduct the contribution for that year. The employer then has until its tax filing deadline to make the actual contribution.

The following examples illustrate different contribution formulas:

Example 1: A.B.C. Inc. will contribute 10% of profits for each fiscal year to the profit-sharing plan, provided that the profits remaining after such contribution provide at least a 15% return on stockholder's equity-but not more than can be deducted for the fiscal year. (This is an example of contributions made on a "modified percentage of profits" basis.)

Example 2: Lady Inc. will contribute to the plan a sum equal to 10% of each participant's compensation for each plan year, provided that the company's profits for the fiscal year ending immediately prior to the beginning of such plan year were at least sufficient to make the contribution. (This is an example of contributions made on a "percentage of compensation, contingent on profits" basis.)

Example 3: Billy Inc. annually schedules a board of directors meeting on December 1st to declare the amount from current or accumulated profits that will be contributed to the company's profit-sharing plan. If the meeting does not take

place and sufficient profits exist, the employer will contribute an amount equal to 10% of total covered payroll to the plan. (This is an example of contributions made on an "annual declaration with a default provision" basis.)

The IRS limits the amount that can be deducted as a contribution to a qualified profit-sharing plan. It also limits the amount that can be contributed to the benefit of each participant under the plan and all other qualified plans sponsored by the employer or other employers under the control of the same owners.

Allocation of Plan Funds

As outlined in the previous examples, most profit-sharing plans define only the total annual amount to be contributed by the employer. This is in keeping with the fact that profit-sharing plans do not have to have a definite contribution formula. However, qualification does require that these types of plans include a definite allocation formula to define the method by which plan funds are apportioned or credited to individual participants' accounts.

Similarly, the plan needs to provide for allocation of earnings, interest and gains or losses on investments held by the trust. (This may not be necessary if 100% of the funds are transferred into individual annuities.) Another source of funds results from "forfeitures." These are amounts surrendered by employees upon termination prior to 100% vesting. **Vesting** refers to the percentage of ownership that a participant has in a plan assets attributable to employer contributions. Although some plans use forfeitures as part of the next year's employer contribution, more often they are reallocated among the remaining plan participants. (Parity between employees of all types of employers, both incorporated and unincorporated, was largely accomplished by the Tax Equity and Fiscal Responsibility Act.)

The actual allocation formula can be based on a variety of methods, depending on the source of funds being allocated and the objectives of the employer.

Let's examine some of these methods:

- **Relative compensation:** The compensation earned by the participant (as defined by the plan) is divided by the total of compensation earned by all participants covered by the plan. This produces a decimal fraction.
- **Relative account balance:** The beginning or end of year account balance of the participant is divided by the total of all similar account balances held for other participants to produce a decimal fraction.
- **Point allocation:** Each participant is given numerical points for compensation (generally one point for each \$100). Additional points may be given for years of credited service. A typical point structure is one point for each \$100 of compensation earned during the plan year, plus one point for each year of credited service on the plan's anniversary. The participant's points are divided by the total points for all participants to produce a decimal fraction.

Employer contributions are allocated using either the first or third method. Earnings and gains or losses are most fairly allocated on the basis of assets, as described in the second method. This prevents a large gain from being allocated disproportionately to a new participant with a relatively high salary. Insurance policies are held outside this allocation process with cash values building as a separate asset within the participants' accounts. Also, where investments are

different and can be identified to individual accounts, the earnings are credited directly to the asset account. Forfeitures are usually treated as employer contributions but do not always have to be. Forfeitures under a profit sharing plan can be either be reallocated to remaining plan participants' accounts or applied to reduce further employer contributions or plan administration costs.

Distribution of Plan Funds

Distributions from a profit-sharing plan are permitted upon the attainment of a stated age or in the event of a layoff, illness, disability, retirement, death or separation from service. As such, profit-sharing plans tend to be less restrictive as to distribution than most other forms of retirement plans.

Philosophically, the profit-sharing plan is designed to reward employees for current performance, while sheltering the plan from current taxation. Vesting is generally more rapid than any other type of pension plan. In addition to distributions for disability, death, and early retirement, some plans contain limited "hardship provisions" that allow employees to petition the trustee for a current distribution. Upon termination of employment, the vested account balance may be distributed in a lump sum. After vesting, a participant can retire at any time and count on getting the funds in his or her account (with penalty before 59 1/2 years of age). Most plans allow alternate forms of distribution, including various installment arrangements, life insurance policies, annuities, or even property held in a trust investment.

Another form of distribution is a loan. For many years, loans from qualified plans, including profit-sharing plans, to any participant were controversial. From a strictly legal aspect, plan loans were considered to violate the thrust of ERISA-prohibited transaction provisions. In extreme cases, plans had loaned large sums to the executives and back to the corporation, with plan participants suffering the ultimate loss when defaults occurred. From a more philosophical point of view, a plan that allows borrowing undermines the nature of the retirement aspect of the program. There were also problems with "constructive receipt", under which sums are to be included in taxable income at the time the money could freely be enjoyed or withdrawn.

These problems concerning plan loans have partially been overcome. TEFRA authorizes loans to participants (with limitations imposed by the Tax Reform Act of 1986), provided that the provisions and plan in operation do not discriminate in favor of highly compensated or key employees. Before deciding to implement loan provisions, however, the employer should consider the administration cost involved. Loans received or renewed after 1986 must be repaid within 5 years to avoid the taxable distribution rules, unless the loan proceeds are applied to the purchase of a principal residence by the plan participant. Home improvements, second homes, and homes for family members are subject to the 5-year rule of repayment.

The 401(k) Plan

Cash or deferred arrangements--or 401(K) plans, as they are commonly called--are actually a variation on the basic deferred profit-sharing plan. Instead of

requiring all eligible employees to defer their allocation, this plan allows the participants two options:

1. Take employer contributions in cash; or
2. Defer a portion of current salary into a tax sheltered account.

Of course, if everyone elects cash, the plan essentially reverts to a nonqualified cash bonus plan. As such, there are no special tax advantages that accrue to the employee.

The Money Purchase Plan

The terms "money-purchase pension plan" and "defined contribution pension plan" are often used interchangeably. Technically, the money-purchase pension plan is a type of defined contribution plan, calling for specified contributions to be made by the employer based on each participant's compensation and, in rare cases, services. This makes the allocation formulas unnecessary. The contributions required for each participant determine the required outlay. Unless the plan contribution formula is amended, the employer has little flexibility in making contributions, which are independent profits.

Typically, contribution formulas come in two formats: The first is a fixed amount per participant per year. The second is a contribution calculated as a percentage of the individual's compensation. The following examples illustrate these formats:

- Little Inc. will contribute \$0.50 per hour to the money-purchase pension plan for each employee who is a member of the collective bargaining unit subject to an arm's length negotiated settlement. (This is an example of a contribution formula based on a fixed dollar amount basis.)
- XYC, Inc. will contribute an amount equal to 5% of each participant's compensation in excess of \$15,000 annually to the money-purchase pension plan for all salaried employees. (This is an example of a contribution formula based on a flat percentage of compensation basis.)
- NNN, Inc. will contribute to its money-purchase pension plan the greatest of 12% of a participant's compensation or \$500 in each plan year. (This is an example of a contribution formula based on a combination of the above two formulas.)

The nature of the contribution formula reflects the objectives of the employer. Example 1 would be a viable approach to reduce pressures for union organizations. It may also be used to counter absenteeism, particularly if only regularly scheduled hours of service are credited with contributions, thus eliminating the effect of overtime on the employer's required contribution. Seasonal or cyclical businesses might also use this approach to tie benefit costs more closely to production. Example 2 favors the higher-paid individuals and motivates employees to move ahead in the organization, since contributions are directly tied to compensation. Combinations and variations of this formula may be used to solve several objectives. Example 3 primarily rewards the highly compensated by providing them with a contribution of 12% of compensation; however, the \$500 provision places a floor under the contribution level for lower-paid and part time personnel.

The funding of the money-purchase pension plan is constant, per the terms of the plan. This puts employees covered by these plans in a stronger position than those covered by a profit-sharing plan. It also assures a constant stream of

investment and premium dollars. Insurance and annuity funding is less susceptible to lapse. In addition, continuous funding provides an excellent means to the average purchase price of fluctuating investments, such as common stocks, allowing stability in returns on investments. Because this plan is created for retirement income, investments should generally be more conservative than profit-sharing plans.

Provisions for distribution of funds are similar to those covered earlier. However, with money-purchase plans, there is a greater tendency to pay retirement benefits in the form of monthly life income, as opposed to profit-sharing approaches, which favor lump-sum distributions. Thus, alternate forms of payment may be more prevalent. Employees can be provided lump-sum distributions of vested account balances in the event of termination of employment.

Employers under both profit-sharing plans and money-purchase plans may either reallocate forfeitures to accounts of remaining participants or reduce required future employer contributions. Reallocations must be made in a manner that does not discriminate in favor of highly compensated employees.

The Stock Purchase Plan

Any defined contribution plan that invests primarily in the common stock of the sponsoring employer corporation is called a **stock purchase plan**. This is a particularly popular approach under the thrift plan and the profit sharing plan, which may then be called an **employee stock bonus plan**. A more technically complex and distinct type of plan is the ESOP or Employee Stock Ownership Plan.

Although all of these stock purchase plans have attractive features, they have not really caught on, particularly in the small, closely held corporations. This is most likely because closely held stock has a limited market, and the present owners may not wish to relinquish control over the business. ERISA generally requires that investments be carried on the company books at market value. As a result, valuation becomes problematic in the small corporate stock purchase plan, just as in business valuation for a buy-sell or stock redemption plan. Valuation problems are aggravated by involvement with non-owner/employees. As in the case with a business continuation insurance program, the plan might insure the lives of key individuals (with a portion of the plan assets) to assure a purchase price for the shares, in the event of their deaths. Such plans must also generally agree to buy back shares distributed to terminating or retiring workers, since markets typically do not exist for their sale.

These problems may be offset by the following advantages:

- Stock interest can be removed from the estate of the participant.
- The sheltering of shares may be a means to prevent unfriendly merger or takeover attempts by outsiders.
- Plans meeting certain criteria may be given tax incentives to form capital for business expansion.
- Employee performance motivation is the highest under one of these types of plans because the fortunes of the business directly influence the value of employee accounts.
- Stock purchase plans and provisions, ESOP's, have special rules that must be applied. And while full coverage of these plans extends beyond the scope of this

section, the pension planner may wish to consider further study of the area.

Thrift Plans and Defined Benefit Pension Plans

Thrift Plans

The qualified thrift plan is another variation of the defined contribution plan. It has become a popular option with many employers because it can meet a number of objectives and provide for the payment of benefits under several situations. Thrift plans offer many of the advantages of profit-sharing plans--but at a lower administration cost.

Basically, a thrift plan is a savings plan established by an employer as a vehicle to accept employee contributions. Although the contributions are not tax deductible, they accumulate and grow on a tax-deferred basis. Employee contribution rates vary from plan to plan, but it is customary to allow an employee to elect to contribute to any one of several levels. *For example*, a plan can allow an employee to contribute 1%, 2%, or 3% of compensation--or any percentage amount between 1% and 6% of compensation, or employee contributions may be set at a flat dollar amount.

Most thrift plans include a provision that allows employer contributions, as an incentive to employees as a reward for performance. Typically, the amount of the employer contribution is tied directly to the employee contributions. For example, a thrift plan may call for a \$0.50 contribution by the employer for every \$1.00 that the employee contributes, up to a stated maximum. In cases like these, employer contributions are a result of a direct formula, similar to money-purchase pension plans. Employer contributions may also be made on a periodic basis, as is the case with profit-sharing plans. Thus, an employer may decline to make contributions to the plan during unprofitable years.

Both employer and employee contributions are generally made to a trust fund and/or an insurance company, which in turn, invests the funds for the benefit of the plan participants.

Generally speaking, thrift plans are excellent for young companies that are interested in a retirement plan but want to limit its costs. For example, if a company can afford to contribute an amount equal to a small percentage of its current payroll to a retirement plan, it could install a thrift plan. This means the company could provide a retirement plan today for its employees, rather than waiting for some unspecified future date when it can "afford" a plan. Thus, the employees can begin a plan of investing for retirement under favorable tax deferral treatment now.

Employee contributions that directly influence the contribution or allocation of employer money are referred to **mandatory employee contributions**, regardless of whether they are a condition of employment. Voluntary employee contributions are made by the employee without influencing other funding for the plan. All employee money is accounted for separately because it is always 100% vested. Vesting schedules for employer contributions vary, depending on the plan. A typical thrift plan vesting approach is class-year vesting. Assets purchased with employer contributions vest after a certain period following the end of the plan or class year. Under current law, plans with last-year vesting will not meet legal

constraints for tax qualification unless a plan participant's accrued benefit vests under a 3 to 7-year vesting schedule or a 2 to 5-year vesting schedule.

Thrift plans may allow participants to choose from several investments for their accounts. For example, the participant may have the contribution directed to purchase employer stock and be credited with one share by the employer for every two purchased. Another employee may choose annuity funding, although the employer agrees only to contribute one dollar for every three contributed by the participant. Participants may be allowed to change the level of their contributions periodically or switch funds among investments.

Investment appreciation and earnings are reinvested by the thrift plan trustee. Funds are not segregated on behalf of individual participants (although separate accounts are maintained for accounting and recordkeeping purposes.) When the time comes to distribute a participant's savings, the amount finally distributed is a pro-rata share of employer contributions and the earnings and appreciation of the fund, in addition to the employee's own contributions.

Each thrift plan sets forth the time and manner in which the funds credited to an employee's account will be distributed. One plan may provide the automatic distribution of contributions held for more than two years after a period, such as three to five years, unless the participant elect so otherwise. A second plan may have fairly lax withdrawal and distribution elections. This encourages participation because funds are not tied up until retirement. However, in those plans that stress the retirement aspects of the plan, plan accumulations may be held until retirement, death, disability, or termination of employment.

Most thrift plans defer distribution unless otherwise directed by the participant. This approach maximizes compounding of interest and gains on a tax sheltered basis and avoids pre-age 59 1/2 distribution penalties.

After deferral is elected, payment of proceeds is made only in the subsequent event of termination, death, disability or retirement, except in plans with hardship provisions, which would be treated in a manner similar to profit-sharing plans. Some plans allow participants to withdraw their own funds on a more liberal basis; however, early withdrawal usually means loss of employer matching contributions and may trigger a 10% penalty tax in addition to current income tax.

Again, because thrift plans are so flexible, they can be designed to meet a wide variety of objectives. Their primary advantages include the following:

- Employees are encouraged to supplement any other retirement and savings programs by their own contributions.
- The aggregation of funds reduces the cost of investing. Larger funds may be invested by a professional, who otherwise might not be available.
- Individual participants may be given some measure of control over their investments, in line with their personal objectives.
- Qualified status allows contributions to grow on a tax-advantaged basis.

Disadvantages to a thrift plan include the following:

- Accounting records may involve large numbers of separate entries to track employee contributions, vested and deferred employer contributions, nonvested employer contributions, and earnings on these accounts;

- If enough employees can't afford to contribute, the plan may terminate due to lack of coverage;
- Cash flow (in and out of investment) can adversely affect those holding the balance of that account and add to administrative expenses as a percent of the asset's value.

Defined Benefit Pension Plans

As mentioned earlier, the defined benefit approach is the only one that provides definitely determinable benefits. This is accomplished by the provisions set out in the plan document and includes the conditions under which benefit payments are made, as well as the amounts. Although the primary purpose of any defined benefit plan is to provide retirement income, ancillary benefits may be paid for death, disability or early retirement.

In order to define the plan's benefit, the following basic types of formulas are commonly used:

- The retirement benefit may be expressed as flat or fixed-dollar amount paid monthly (for example, \$150 per month for life, which is a flat dollar amount).
- A benefit may be provided based on a percentage of compensation (for example, a monthly life income equal to 20% of the participant's highest years' earnings divided by 60, which is a flat percentage, final average).

Example 1: Normal retirement benefit will be equal to 2% of the participant's final average compensation (using the highest three consecutive years prior to normal retirement), multiplied by all years of service, but not to exceed 40 years (Flat percentage, final average).

Example 2: Normal retirement benefit will be \$10 per month multiplied by total years of service (Flat dollar unit benefit.)

Example 3: Normal retirement benefit will be equal to 1% of the participant's compensation as earned each year while participating in the pension plan (Flat percentage unit benefit based upon career average compensation).

As you can see, each of the previous examples stresses the ultimate benefit that will be paid at some future date. Contrast this approach with the defined contribution plan that emphasizes the amount that contributed to the plan.

Defined benefit pension plans can also be integrated with Social Security. The previous examples can be modified in a variety of ways to accomplish specific objectives. With inflation, the benefit payable under the fixed-dollar approach must be periodically reviewed for adequacy. Indexing benefits to the general cost of living is not yet widespread but a future possibility. The pension planner may suggest a "floor" (minimum benefit level) or "cap" (maximum benefit level) to contain required contributions. Service or participation-related reductions or restrictions also can control costs. Lastly, these approaches can be combined within the plan to accomplish special objectives.

Ancillary Benefits

A defined benefit pension plan can be designed to provide benefits ancillary to retirement. One of the most common is pre-retirement death benefits. These

benefits may be insured or uninsured. Uninsured death benefits are paid directly from the general plan assets and are therefore relatively small--at least initially. Insured death benefits can be provided through any one of the following ways, with the first being the most typical:

- **Multiple of Expected Benefit:** The participant's current salary is assumed to be constant to retirement, with service or participation likewise calculated. The benefit resulting from the plan provisions is applied to a multiple to determine current death benefits. For example, 1 100 multiple applied to a \$1,000 monthly benefit calls for a \$100,000 death benefit.
- **Accrued Benefit:** The calculation under this approach begins much the same as above. Rather than using all service or participation, however, only that already credited (accrued) is used to calculate the benefit. Or the benefit figure above may be multiplied by a fraction reflecting current service or participation over the total expected at normal retirement date, in line with plan provisions. For example, if the participant has half the service expected by normal retirement benefit, the accrued benefit might be \$500 in the first example. This is then paid to the surviving spouse for life. This type of benefit, if not insured, requires some form of special funding to avoid plan insolvency.
- **Present Value of the Accrued Benefit:** The figure derived above is converted to a lump sum that roughly equals the purchase price of that benefit if it were paid at 65 (normal retirement age.) It is the actuarially reduced, reflecting the difference in time between deferred and current payment. The benefits, then, a lump-sum figure.
- **Present Value of the Vested Accrued Benefit:** This is the same figure that was derived immediately above if the participant is fully vested; otherwise, the result is multiplied by a percentage based on the vesting schedule.
- **A Death Benefit Equal to the Face Amount, Cash Value, or Premiums Paid (if Greater):** This approach could be used with plans funded with retirement annuities or endowments. Plan provisions, therefore, may transfer or limit liability for death protection to that provided by purchased policies.
- **A Fixed Amount:** Either in the form of a lump-sum or monthly payment. This approach must meet the requirements of an "incidental benefit."

A defined benefit plan can also provide for disability benefits, which could be paid out in ways similar to the above methods. Any promised benefits must be carefully funded.

Finally, post-retirement death benefits, although not common (except where the participant elected a joint and survivor annuity at retirement), are another ancillary benefit option. Some plans may provide a post-retirement benefit of up to one year's salary to the surviving spouse.

The "Target" or Assumed Benefit Pension Plan

The target or assumed benefit plan is something of a hybrid, combining features of both defined benefit and defined contribution plans. Unfortunately, this approach has not been utilized to its maximum advantage because it requires the understanding of two concepts within one plan.

The target plan first defines a retirement pension benefit. Provisions are similar to those covered under the defined benefit pension plan. This benefit is then converted to a contribution rate amount using either specified methods or conversion factors provided as part of the plan. Unlike defined benefit plans, this must always result in an individual cost or deposit for each participant. Then, after the contribution is determined, the plan operates like a money-purchase plan. The

actual interest or earnings eventually will cause the actual retirement benefit to be more (higher interest rates earned than assumed) or less (lower interest rates earned than assumed) than the targeted or assumed benefit.

Some pension specialists believe that the target plan offers the best features of the defined benefit and define contribution approaches.

- The target or assumed benefit, like the defined benefit approach, favors the older participant, typically the owner. This is because larger deposits must be made to fund targeted benefits in a shorter period of time.
- High interest rates and investment performance don't reduce future employer contributions and deductions but rather add to the tax-deferred accumulation.
- The employer liability is limited to making current contributions, not to providing future benefits.
- Actuarial valuation and certification is avoided.
- Investments made under the plan can be more aggressive than under a defined benefit plan (but should be more conservative than under thrift or profit-sharing plans).
- Insurance premiums may be paid from contributions. This may purchase more insurance than under the defined benefit plan.

Plan Design: Part 1

Prior to the enactment of ERISA in 1974, a retirement or profit-sharing plan was often viewed as an extra fringe benefit provided gratuitously by the employer for the financial security of his or her employees. This thinking left employers free to be as generous or restrictive in plan design as they deemed appropriate.

History, however, changed this viewpoint. During World War II, wartime conditions caused many employers to give pension or other fringe benefit increases rather than additional wages. This shifted the emphasis, and employees justifiably began to perceive pensions as a form of deferred wages that should not be taken away for little or no reason. In addition, organized labor pushed the concept of employees' rights under pension plans, and labor negotiations increasingly included retirement benefits for workers.

This reversal in philosophy led to identification of abuses by employers in the handling of benefits. Under the old philosophy, an employer could default on pension promises without fear of repercussions because employees' interests were secured by nothing more than promises made by the employers. However, under the new philosophy, the media began to focus public attention on circumstances in which employees, after years of service, were stripped by the employer of rights they had accumulated. The situation reached a crescendo in the late sixties when Studebaker closed its plants in South Bend, Indiana and informed workers that their pension plan was without funds.

For these reasons, ERISA was signed into law in celebration of Labor Day, 1974. With subsequent regulations and amendments, this piece of legislation forms the basis of the legal constraints that guide the design of a qualified plan. ERISA, along with the Revenue Act of 1978 (RA '78), the Economic Recovery Act of 1981 (ERTA), the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Tax Reform Act of 1984 (TRA '84), the Retirement Equity Act of 1984 (REA), the Tax Reform Act of 1986 (TRA '86), and the Technical and Miscellaneous Revenue Act

of 1988 (TAMRA '88) expanded the restrictions on tax-qualified retirement plans, including individual retirement accounts and simplifies employee pension plans.

Plan Qualifications: In General

In general, tax-qualified plans strive for compliance for two reasons:

1. Tax incentives
2. Tax and criminal penalties

Tax incentives. Only plans that meet the requisite legal constraints will receive favorable treatment, including the following:

- Employer contributions to a qualified plan are tax-deductible by the employer.
- There are no current income taxes to the participant for employer contributions, within prescribed limits.
- Investments held under a qualified plan accumulate on a tax-deferred basis.
- Distributions from a qualified plan may receive special income tax treatment.
- Employer contributions to a qualified plan effectively remove corporate assets from exposure to other taxes (such as the tax on excess accumulated earnings) or exposure to claims of creditors.

Tax and Criminal Penalties: The employer, or others connected with a qualified plan, may be penalized for violation of certain provisions of the law. Under law, the employer is treated as a fiduciary, one who acts on the behalf of those whose beneficial interests are at stake.

It is evident that the tax advantages provided by qualified plans are significant for both the employer and employee. Attaining qualified status requires complying with the rules and regulations set forth in the Internal Revenue Code and by the IRS. There are 15 major provisions of federal law that a pension plan must meet in order to be qualified.

1. The primary purpose of the plan must be to offer employees a future retirement benefit or deferred share in the company's profits. Contributions must be for the exclusive benefit of the employees and cannot revert to the employer.
2. The provisions of the plan must be set forth in a written document, such as a plan description, a trust agreement, a group permanent insurance contract, or a group annuity contract. The details of the plan must be communicated to the employees.
3. The plan participation requirements must not discriminate in favor of a group of statutorily-defined highly compensated employees. The plan may establish eligibility requirements to eliminate short-term employees. However, these eligibility requirements must apply to the group as a whole and not on a selective basis.
4. The contributions to, or benefits of, the plan cannot discriminate in favor of highly compensated employees. In addition, when determining benefits, the Code restricts the amount of employee compensation that can be considered.
5. Employees must receive proper credits for hours of service and participation.
6. The plan may require special provisions if the employer integrates benefits with contributions from Social Security.
7. The Code, as amended by various laws, prescribes "vesting requirements," or under what circumstances a participant must be given the right to his or her account balance.
8. The employer must restrict the amount of total benefits, as well as employer deductions for the plan.
9. The form retirement benefits take and under what conditions they are paid legally mandated.

10. Minimum funding standards must be followed.
11. The employer must identify key employees. Top heavy plan provisions, including rapid vesting, become operative when certain conditions are met. In general, these provisions operate to support and protect the benefits of non-key employees.
12. Certain plan types must contain specific limitations. For example, a 401(k) plan must meet actual deferral percentages tests.
13. In general, a plan must conform to the most restrictive of the applicable legal constraints. Thus, for example, if a 401(k) plan satisfies the general coverage requirements for defined contribution plans, it still won't qualify unless it also satisfies regulations for 401(k) plans.
14. The written document must identify the plan fiduciary and spell out the responsibilities required to protect the interests of participants. If the plan includes a trust, the trustee must be identified and his or her responsibilities outlined. The employer, including affiliates or members of a controlled group, must also be identified in the plan. In addition, a plan limitation year is specified for purposes of measuring certain benefit accruals.
15. Investments held under the plan must meet certain Department of Labor guidelines. In addition, defined benefit pension plans are insured by the Pension Benefit Guaranty Corporation (PBGC). This insured status protects against plan termination and loss of benefits to covered participants.

Coverage Requirements

Every employer considering a qualified plan will have specific objectives regarding which employees should be covered. It is important to keep in mind that only "employees" may be included in a corporate retirement plan. Shareholders who are not employees may not be covered. Members of the board of directors may be employees; otherwise, they are not generally eligible for coverage. Attorneys, accountants, or other professionals on retainer are generally not employees.

Lastly, those performing work on their own schedules and under their own methods as independent contractors are also ineligible. In general, the determination of whether or not an individual is an employee can be made on the basis of who is obligated to make payments (on his or her behalf) to Social Security. If the responsibility falls on the employer, the individual is deemed an employee and is eligible for plan coverage. The life insurance agent is an exception. For most practical purposes (and legal identification) the agent is an independent contractor. Full-time agents are employees for the insurance company for Social Security purposes (and pension plan coverage). Broker and independent agents, however, are usually independent of the carrier.

Practically speaking, the question often in an employer's mind is not who can be restricted. The objective of most employers is to reward the faithful, devoted, aggressive employees who, by their activities, contribute to the profits of the business.

Typically, these individuals are already higher than average in compensation and position. In addition, those employees who are also stockholders in the corporation are generally favored to the extent legally allowed.

Congress has gone to great lengths to prevent abuse of the qualified plan for the limited enjoyment of the elite group at the top. Nondiscrimination rules are set up to prevent discrimination in coverage and benefit. Failure to comply with these rules may result in loss of plan qualification. Even with these restrictions, however,

a qualified retirement plan can be quite attractive to business owners and other members of the 'elite group."

The application of the nondiscrimination rules varies, depending on whether the plan is a defined benefit or defined contribution plan.

If a plan is a defined benefit plan, the IRS generally will test the benefits for nondiscrimination. More precisely, if the rate of benefit accruals is more favorable for highly compensated employees than for the non-highly compensated employees, the plan may be disqualified as discriminatory. Amounts contributed annually to the plan may be any amount needed to actuarially fund the benefits within certain limits.

If the plan is a defined contribution plan, the IRS will test the contributions to the plan to determine whether or not they are nondiscriminatory.

Although the importance of discrimination should not be deemphasized, we will see that an employer does have some latitude in determining who can be included in the plan, when they will retire, the amount of pension and death benefits, and who will contribute how much to the plan. Before we discuss these specific aspects of a plan, however, let's consider some IRS rules that allow latitude in plan design.

A plan that may appear discriminatory in one aspect may qualify if the overall picture satisfies applicable coverage and eligibility requirements. For example, simply because a plan covers a few higher paid employees, it may nevertheless qualify under the nondiscriminatory coverage tests.

The payment of larger benefits to higher paid employees and the allocation of a substantial share of employer contributions for their benefit is permissible if these results are by-products of a plan design that is otherwise acceptable (such as Social Security integration) and the overall plan does not involve prohibited discrimination.

A plan that is top-heavy, or one whose benefits may tend to favor key-employees, is not automatically disqualified; however, some extra consideration in design must be focused on another objective--providing more meaningful benefits for the rank and file employees. The extra benefits required must not destroy the plan. In fact, many employers may have simply overlooked the advantages, in terms of productivity and goodwill, that accrue to the business because employees are given better benefits.

With these general rules in mind, let's consider provisions related to employee eligibility.

Who Must be Included in the Plan

An employee generally has a broad range of employees in terms of age, level of experience, length of employment, income, and responsibility in the organization. Within that range, there are typically one or more employees who are considered to be the most valuable to the organization. Consequently, the employer may want to discriminate in favor of these individuals in the qualified plan. Although

there is a general prohibition against discrimination, the federal government does recognize that all employees are not permanent and that an employer who attempts to provide benefits for all may be unable to afford a plan or at least may be unable to provide adequate benefits for the permanent group. Thus, consistent with the principle that an employer-sponsored plan is for all employees, the federal government permits certain restrictions on employee entry into a plan.

The choice of these provisions may affect other plan provisions. For example, a plan that requires 6 months' service to participate needs only one plan enrollment date. If 12 months' service is required, dual enrollment dates are required, generally on the plan's anniversary date and a date 6 months later. If a fractional year of service is required for eligibility, then the 1,000 hour service requirement can't also be used. As eluded to, any plan that uses more than 12 months' service as a requirement (up to 24) must provide for immediate vesting. The plan must define "age" and "service." Some use the attained age as of the employee's last birthday. Others, notably insured plan prototypes, may use age at the nearest birthday. This, too, affects coverage under these legal constraints.

Example:

Plan: XYZ Pension Plan provides that a full-time employee will become a participant in the plan on the anniversary next following completion of 6 months of employment and after attaining a minimum age of 21.

Facts: Jane Doe is hired by XYZ at age 18 and works continuously on a full-time basis.

Question: When is she "in the plan?"

Analysis: Jane satisfies the three eligibility requirements (age, full-time status, and credited service) upon reaching age 21. She is then eligible to participate in the plan. However, she may not enroll or become a participant until the next plan enrollment date. On the enrollment date, she may have to elect to become a participant (if, for example, employee contributions are required) or may be enrolled automatically. She is then a covered participant.

Eligibility provisions are one of several plan qualification requirements that can cause the IRS to disqualify the plan as being discriminatory. Recognizing that certain restrictions on entry are reasonable and necessary for efficient plan operation and are not discriminatory, per se, the law allows the exclusions that we have discussed. These are commonly referred to as **statutory exclusions**. The IRS also tests actual coverage (net result of eligibility restrictions and participation) to determine whether an acceptable number of employees is actually covered. We will now cover these eligibility provisions and nondiscrimination tests.

Plan Design: Part 2 Nondiscrimination Tests

The statutory exclusion rules act as a filter. The entire employee census is the starting point. In stages, the provisions of the plan are applied to remaining employees (those not excluded in previous steps). Finally, the results are analyzed for compliance.

Once employees have been filtered out, the employer's plan is subject to nondiscrimination testing. To meet nondiscrimination standards (as set forth in Code Section 410(b)), the plan must satisfy one of the following tests:

1. **The Percentage Test:** 70% of all non-highly compensated employees must be covered by the plan.
2. **The Ratio Test:** The percentage of non-highly compensated employees covered by the plan must be at least 70% of the percentage of highly compensated employees covered under the plan.
3. **The Average Benefit Percentage Test:** The average benefit provided to non-highly compensated employees must be at least 70% of the average benefit provided to the highly compensated employees in relation to each group's relative compensation. This test also requires that all the facts and circumstances of the employer must be considered when the IRS determines whether or not a fair cross section of employees is covered.

In addition, if the plan is to remain qualified, it must benefit no fewer than the lesser of 50 employees or 40% or more of all employees of the employer.

As you can see, the purpose of these rules is to assure an equitable benefit for all employees and to prevent discrimination in favor of the highly compensated group. For purposes of satisfying these rules, an employee is highly compensated if he or she:

- Is a 5% owner of the employer-plan sponsor;
- Earns more than \$78,353 (as indexed) in annual compensation from the employer;
- Earns more than \$52,235 (as indexed) in annual compensation from the employer and is a member of the "top paid group" of employees (generally, the highest paid 20%); or
- Is an officer who receives \$45,000 or more of compensation.

Some examples may help to clarify these non-discrimination tests.

Example 1: The accounting firm of Fred, Edward and Smith has 48 employees. Since eight of these employees work part-time and have not met the minimum-service requirements for participation in the plan, the percentage test would apply only to the remaining 40 employees. Of these employees, 24 fall within the statutory definition of "highly-compensated", and 16 do not.

12 of the 16 employees who are not highly compensated belong to the Bryn Mawr, Pennsylvania office (the group covered by the plan) and 4 belong to the Cherry Hill, New Jersey office (which does not have a plan). Under the percentage test, the plan must benefit at least 70% of the 16 employees who are not highly compensated. (Note that employees from both offices are counted.) Thus, 12 employees (0.70×16 , rounded) must benefit. Since the firm's Bryn Mawr plan benefits 12 of the non-highly compensated employees, the plan passes the percentage test.

Example 2: ABC Company has 220 employees on its payroll. Since 20 of these employees have not yet met the minimum age and service requirements of the plan, the ratio test would apply to only 200 employees. 60 of the remaining employees are highly compensated, and 30 of the 60 highly compensated employees actually participate in the plan. (The other 30 are part of a separate group that does not have a plan). The remaining 140 employees are non-highly

compensated, and 80 of the 140 non-highly compensated employees participate in the plan. (The other 60 are part of the separate group that does not have a plan.)

Since 50% (30 out of 60) of the highly compensated employees participate in the plan, the ratio test requires that at least 35% of the non-highly compensated employees must benefit under the plan ($0.70 \times 0.50 = 0.35$). In other words, at least 49 ($0.35 \times 140 = 49$) non-highly compensated employees must benefit under the plan. Since ABC Company has 80 non-highly compensated employees benefiting under the plan, the plan satisfies the ratio test.

Example 3: The XYZ plan has an average benefit percentage for highly compensated employees of 14%, and the average benefit percentage for non-highly compensated employees is 10%. The average benefit percentage test requires that the average benefit provided to the non-highly compensated group must be 70% of the average benefit provided to the highly compensated group. The XYZ plan will meet part of this test because 10% is more than 70% of 14%. Regarding the remainder of this test, the IRS requires that a fair cross section of employees must be covered. Basically, it measures all employees of the nonexcluded group to determine if this group contains an unusually large percentage of those members who are considered highly compensated employees.

Controlled Business and Affiliated Service Groups

In the past, some employers split their business entities to exclude a group of employees from the company retirement plan. Some businesses formed sister companies and transferred lower-paid employees to the new company. Then the company would set up a generous qualified plan for those in the one corporate structure. In some cases, workers of the two corporations functioned interchangeably, performing the same assignments for the same superiors in the same location as before.

These practices were curtailed by ERISA and, under current law, business units are tested for cross or interlocking ownership or control. To simplify the actual methodology, the following three steps are taken:

1. All common owners of the business entities are identified, with the percentage of shares listed (Technically, the procedure distinguishes classes of ownership.), either directly or attributed to family connections.
2. If the top five (by ownership position) of Business A also owns 80% of Business B, the two organizations are controlled.
3. If identical ownership (by the same individual or individuals) in both organizations is greater than 50%, the two organizations are controlled.

Where control is found to exist, employees are treated as employed by a single employer for the purpose of applying the previously discussed nondiscrimination tests for plan qualification.

Example:

Ownership Percentages

Name	Jones, Inc. (Corporation)(Partnership)	Jones Products
Mr. Jones	40%	40%
Mrs. Jones	12%	---
Mr. B	30%	---
Mr. C	18%	10%
Mr. D	---	50%
Total % Ownership	100%	100%

The owners of the corporation collectively hold less than 80% of the partnership. Actually, only 50% is collectively owned in common by Mr. Jones (40%) and Mr. C (10%). Therefore, their ownership in the partnership is not considered to be a controlled organization. As such, the relationship shown fails to meet the requirements of a controlled business group. Consequently, the qualified plan in each organization must be measured on its own with the nondiscrimination tests that we have covered.

Section 410(b)

The primary source of nondiscrimination rules can be found in Section 410(b) of the IRS Code. The purpose of this section is to prevent discrimination that could develop in situations involving different groups of employees, and it also delineates how these groups are to be covered by a retirement plan. Employers will sometimes seek to have their retirement plan cover only certain employees while excluding other employees. The statutory tests discussed previously establish a dividing line between an employer's goal of covering only those employees that he or she may want to cover and the government's goal of making sure that as many non-highly compensated employees as possible are covered by a qualified plan.

An employer's goal of covering only certain classes of employees is made difficult because of these nondiscrimination tests. While it may be possible to pass one of the three tests (percentage, ratio, or average benefit) and still cover selected classes, it is through a strong application of some subsidiary rules under Section 410(b) derived from the average benefit percentage test that the employer's objective becomes extremely elusive.

Separate Lines of Business Rule

One application of Section 410(b) deals with separate lines of business. An employer can only have a separate line of business in his or her business operation if it is in a separate geographic area (for example, 35 to 50 miles is a standard separation distance). In addition, the separate line of business must be operated for bona fide business reasons and must have at least 50 employees. If highly compensated employees constitute more than a specified percentage of the employees in a separate line of business, the IRS will conduct an audit to determine if the separate line of business covers a fair cross section of the employees as discussed under the average benefit percentage test.

The 50/40 Rule

As discussed earlier, part of the average benefit percentage test is the application of the 50/40 rule. In other words, an employer's plan will not be qualified unless it covers on each day of the plan year the lesser of 50 employees or 40% of the

employer's employees. How this rule is applied: an employer with more than 125 employees can no longer maintain a plan covering fewer than 50 participants. If the employer has fewer than 125 employees, the 40% rule will apply. Thus, the old method of applying multiple plans to small groups of employees cannot meet the requirements, and the plans will lose their qualified status.

Aggregation Rule

As we have seen, controlled business operations and affiliated groups at one time were created to avoid the nondiscrimination rules of ERISA and the IRS. Current regulations close off the loopholes by treating each of the separate plans as one single plan to determine whether the plan meets the nondiscrimination tests. Since all of the separate plans are treated as one common plan, efforts to avoid the rules are futile.

Leased Employees Rule

Employer efforts to avoid the nondiscrimination rules by using employees "rented" from independent leasing organizations, and not having them on the payroll so that they can be excluded from benefit coverage, will usually fail by the application of the leased employee rule. The Code states that if a leased employee has performed services on a substantially full-time basis for at least a year, and the services are the sort usually performed by an employee of that company, then the leased employee must be counted in the nondiscrimination test. If the leasing organization itself maintains a money-purchase pension plan with immediate participation and full and immediate vesting as part of its plan, this rule does not apply. This latter application of the rule is known as the **safe harbor rule**.

The safe harbor leased employee rule, however, will not override common-law employee rules. Thus, an employee who is under the direction and control of the lessee corporation or business may be treated as an employee without regard to any leasing arrangement, depending on facts and circumstances.

Contribution and Benefit Limitations

After the decision is made as to who will be covered by the plan, the next step is to determine the benefits to be provided or the contributions that will be made. As noted, the primary reason that an employer chooses a formal tax-qualified plan is the deductibility of contributions to the plan. However, in order to be deductible, the plan contributions and benefits must be reasonable in relation to the operation of the business and must meet specified benefit and contribution limits (depending on the type of plan involved). Recall from previous materials that there are two basic types of qualified plan designs: the defined benefit plan and the defined contribution plan, with its various approaches. Let's consider the rules that govern these plans' benefits and contributions. Unless noted, the following rules apply to employer contributions or to benefits paid for entirely by the employer.

Plan Design: Part 3 Defined Benefit Plans

A defined benefit pension plan is one that provides a specified or formulated benefit at "normal retirement age" (which is covered later). Amounts reasonable and necessary to provide such benefits are deductible by the employer. Under these types of plans, limitations are placed on the benefits that can accrue to the participant--but not the cost of the contributions to the plans. These benefit limitations take three forms, and all apply:

1. **Replacement of earnings:** In general, a plan may not provide a final benefit that exceeds 100% of the participant's final three years average compensation.
2. **Dollar Amount:** To partially limit the tendency of retirement plans to favor highly compensated individuals, the law imposes a ceiling on the annual dollar amount a defined benefit pension plan can provide. This dollar limit was originally set at \$90,000 and has been raised to \$94,023 due to indexing. This amount will be adjusted each year to reflect inflation.
3. **Dollar considered:** When calculating a participant's benefit, only the first \$200,000 of compensation that a participant earns can be taken into account.

In addition to the above, the "normal retirement age" under a defined benefit plan must correlate with the applicable retirement age for Social Security. If a plan participant retires earlier than the Social Security age in effect for that year, the dollar amount of benefits under the plan may have to be actuarially reduced.

This rule is complicated by future increases in the Social Security retirement age for maximum benefits. The retirement age will rise from 65 to 67 by 2017. For purposes of benefit reduction for early retirement, plan participants who attain age 62 by 1999 have an actuarial adjustment based on age 65. For persons attaining age 62 after 1999 and before 2017, the equivalent age is 66. For persons attaining age 62 after 2016, the reduction is based on 67. To simplify the incremental increases under Social Security for age 65 to 67, employers can use the above rules to compute actuarial adjustments for early retirement.

For persons retiring after the maximum Social Security retirement age, benefits may be increased actuarially in a manner analogous to the required reduction. The maximum \$94,023 benefit limit is conditioned on a retiree having completed 10 years of plan participation (rather than 10 years of service with the employer). This rule discourages the adoption of a defined benefit plan for highly compensated employees who are close to retirement.

Defined Contribution Plans

Under defined contribution plans, limitations are placed on the contributions made to the plan. Employers sponsoring these types of plans are limited to the lesser of:

- 25% of compensation of plan participants; or
- \$30,000 for annual contribution deductions to the plan.

The \$30,000 limit for defined contribution plans will not be increased until a future year, in which the defined benefit limit will be increased from \$94,023 to \$120,000 (approximately a 1:4 ratio). Unlike defined benefit plan rules, defined contribution plan dollar limits are not tied to Social Security dollar limits. But like defined benefit plans, only the first \$200,000 of compensation can be counted for purposes of determining a participant's contribution.

Employee Contributions

In some plans, employee contributions may be mandated as a condition for participation; in other plans, employer contributions may be geared to the employees' contributions. And in some plans, the employee may be permitted voluntary contributions. For example, John earns \$300,000 and is a member of the ABC 10% money-purchase pension plan. John can only receive a contribution of \$20,000 (10% of \$200,000) and will not receive a contribution of \$30,000 (10% of \$300,000).

Multiple Employer Plans

Some employers have adopted more than one tax-qualified retirement plan. For example, an employer may have a profit-sharing plan that limits employer contributions to 15% of the participant's compensation and a money-purchase plan that provides for employer contributions of 10% of participant compensation. (15% plus 10% = 25% of participant compensation, which is the maximum percentage allowed under Code 415).

Two restrictions apply to multiple plans. First, an overall limit is imposed on benefits received by a participant in all tax-qualified or tax-favored retirement plans. The limit is \$112,500 (as indexed) in annual benefits and is applied on an individual basis, rather than an employer-sponsored plan basis. The limit may be increased if the individual receives a lump-sum distribution (full vested credit to the individual's plan account received within one year). Any amount received over the multiple plan limit is subject to a 15% penalty tax. Second, if both defined benefit and define contribution plans are used by a single employer, restrictions apply to the overall deductibility of contributions. The maximum annual dollar amount that may be put in the plans is not a combination of the limits for defined contribution plans and define benefit plans but rather an amount that is slightly greater than the maximum for either type. This amount equals 125% of the dollar limits considered individually or 140% of the dollar limits considered individually.

Mandatory Contributions

For some retirement plans, the requirement that employees contribute toward their own retirement benefits may be the difference between a meaningful plan and an inadequate one. In other plans, the employees' contributions may be used to purchase a needed life insurance benefit with the plan. The employee contribution requirement can heighten the employees' interest in the plan and the benefits it provides. Whatever the reasons for its use, the requirement of employee contributions as a condition for receiving benefits is a part of many qualified retirement plans.

The tax law states that the mandatory employee contributions cannot be burdensome to lower-paid employees. Employee contributions of up to 6% of compensation are common under contributory plans. Contributions up to 8% are found in certain public school pension plans. (However, since government units are generally exempt from ERISA, government employee deferred compensation programs involve special considerations that go beyond the scope of this program, except as covered under 403(b) or tax-deferred annuity plans.)

The term "mandatory employee contribution" should be explained. Although employers encourage employees to participate in contributory plans, participation is not a condition of employment. "Mandatory" refers to expectation of benefits from the plan. The mandatory contribution is not taxable. This means that all contributions made by the employee are made with after-tax dollars. Any employee contribution that is a condition for receiving benefits provided by the employer is classified as "mandatory." As covered earlier in this course, failure to obtain enough enrollments at lower job levels can have an adverse effect on coverage percentages for nondiscrimination purposes, potentially leading to plan disqualification.

In general, to avoid this problem, the employer-provided benefits should be proportionately large enough that employees consider participation a valuable opportunity.

Matching Contributions

In some plans, employer contributions are geared toward matching contributions by the employees. A common type of matching plan is a thrift plan.

As we discussed earlier, the employer under a thrift plan will match the employee \$0.50 for every dollar contributed, a dollar for every dollar contributed, etc. The matching contribution is technically a type of mandatory employee contribution, since the employee must make a contribution in order to receive a matching employer contribution.

Matching employer contributions and after-tax employee mandatory contributions under a qualified plan are subject to the nondiscrimination rules mentioned earlier. If matching employer contributions and after-tax employee contributions fail to satisfy one of two nondiscrimination tests, the plan will fail to meet the nondiscrimination requirements of Code 401. The plan will not be disqualified for that plan year, however, if the excess contributions (and related income) are distributed or forfeited before the end of the next plan year. Because after-tax thrift plans are subject to many of the same rules as 401(k) plans, many employers have an incentive to convert thrift plans into 401(k) plans.

Voluntary Contributions

Some plans allow voluntary employee contributions in order to supplement benefits. The limit on these contributions is 10% of the employee's compensation. Note that voluntary contributions are not tax deductible by the employee and are made with after-tax dollars. However, the advantage of these contributions (in addition to increasing the ultimate benefit) is that their earnings are not subject to taxation until retirement. The matching employer contribution nondiscrimination test applies to voluntary employee contributions.

Five Years-100% Schedule

Under the **five years--100% schedule**, a plan will meet the minimum vesting requirements if the employees are provided with nonforfeitable rights to 100% of their accumulated benefits after a period of five years. Under this provision, an employer has the latitude of adopting a number of different vesting schedules.

For example, a vesting schedule that would meet the above requirements could provide for 0% vesting for service between one and two years, 50% after three years for service and 100% in the employer's benefit at the end of the fourth year of employment.

Another, more traditional, variation of the above would provide 0% vesting from one to four years and 100% vesting after the fifth year. This type of schedule, known as a **cliff vesting schedule**, may be best applied to retirement plans in which there is a high degree of turnover in the early years of employment.

Three to Seven Year Graded Schedule

The **three to seven year vesting schedule** is a graded standard under which employees must be at least 20% vested in their accrued benefits derived from employer contributions after three years of covered service and vest by at least 20% increments for each additional year of service. The schedule is as follows:

Years of Service	Nonforfeitable	Vested Percentage
0-20%		
320%		
440%		
560%		
680%		
7 or more	100%	

Additional Rules

Five additional rules should be kept in mind when designing and implementing a qualified vesting schedule:

1. In addition to the vesting schedules, defined benefit pension plans must satisfy rather strict accrued benefit tests. Their purpose is to prevent the circumvention of the minimum vesting schedules by minimizing the rate of benefit accruals until an employee is within a few years of retirement. This concept is known as **backloading**.
2. Vesting provisions of a plan must not restrict the rights of employees to receive their ultimate benefits at retirement. Upon normal retirement, employees must automatically become 100% vested in all benefits called for by this plan.
3. A plan must provide for 100% vesting for all participants upon its termination or upon the complete discontinuance of contributions for the benefit of the participants. This provision, however, does not apply to certain officers or highly compensated employees during the early years of the plan if this kind of vesting would result in discrimination on their behalf.
4. Special vesting schedules apply to top-heavy plans.
5. For vesting purposes, it is possible to exclude years of service (vesting years of service) before the employee reaches age 18 or years prior to the effective date of the plan. Typically, vesting years of service begin on the employee's original date of employment with the employer and end on each service anniversary.

Plan Design: Part 4

The ultimate purpose of any qualified plan is to provide future retirement or savings benefits. Federal law specifically mandates that it is so. Let's take a closer look at benefit payment provisions for qualified plans.

Normal Retirement Provisions

The latest date that an employer can provide for "normal retirement" under a qualified plan is the later of:

- The participant's age 65; or
- The tenth anniversary of commencement of participation in the plan.

Other formulas can be used that may appear to violate these rules. Where this is the case, the above restrictions interplay as a legal constraint, even if not specifically incorporated into the plan retirement provisions. Let's look at an example of how normal retirement provision works.

Example:

Plan: Normal retirement shall commence, with unreduced benefits, on the participant's 30th anniversary of employment.

Facts: Mrs. Goodie is hired on July 1. On her last birthday, she was 45 years old.

Conclusion: Mrs. Goodie's normal retirement date will occur at age 65, not at age 75, which is 30 years from her hire date. Again, plan provisions cannot delay normal retirement beyond the rules that we have outlined.

Early Retirement Provisions

Not all employees will want to work until age 65. Therefore, it may be good planning to permit an early retirement, with some restrictions. For example, a plan could specify early retirement at age 55 and the completion of a minimum period of service, such as ten or fifteen years. Where the consent of the employer is required, the early retirement benefit cannot exceed the benefit that the employee would be entitled to if he or she terminated employment with a "vested" interest. Under a new plan, the consent of the employer may be essential to maintain the plan on a sound basis. An unscheduled retirement could drain funds from the plan, jeopardizing the normal retirement benefits of the other employees.

Often, unrealistic early retirement ages are included in a plan design. The employer should consider that many entrepreneurial persons actually find that retirement is less rewarding upon its arrival than anticipated. This often leads to postponing early retirement to a date that would have been closer to the normal retirement age. Unrealistic provisions lead to funding problems. Also, lower-paid employees may receive larger proportional benefits than the highly compensated executive because the maximum dollar benefit limitations actuarially reduce benefits received before Social Security maximum retirement ages.

Of course, an employee covered by a defined contribution plan can "retire" whenever he or she is fully vested by simply quitting, provided that the plan calls

for current distribution of terminating employees' vested account balances.

Postponed Retirement

Some employees who reach normal retirement dates may wish to continue working, and management may wish to have them continue. Whether a company should allow such individuals to stay on is subject to debate. Some personnel people favor a retirement policy; others prefer a policy of deferment. Mandatory retirement, at any age, is now prohibited by federal law. So, a provision for deferred retirement must be made in a qualified plan.

Disability Retirement

In most small corporate plans, employees who become disabled are generally considered to be entitled to all of the contributions on their behalf and are, in effect, treated as early retirees under the plan. If benefits larger than the actuarial equivalent of their normal pension are to be provided, care must be taken that the benefits properly integrate with Social Security under integrated plans.

The subject of disability benefits is not often given adequate attention. A well-designed provision may reduce or eliminate the need for a separate employer disability benefit plan. If one dollar in the pension plan can do the job of more dollars, it can be viewed as working overtime.

Technically, disability provisions are an employee welfare benefit rather than a retirement benefit. Benefits paid in relation to a qualifying disability claim are eligible for favorable tax treatment.

Without further funding, a disability could quickly deplete the participant's account or strain the resources of the unallocated trust. Clarifying laws allow the employer to continue making contributions to increase or maintain a disabled employee's benefits. This may not be feasible, however, where a key employee becomes disabled, causing the business to collapse. An adequate key-executive business health program (outside the pension plan), which includes disability income insurance, may solve this problem.

Death Benefits

To attain qualified status and the tax benefits available to qualified plans, a retirement plan must adhere to its primary purpose: to provide retirement benefits. Any other purpose, such as providing life insurance on the lives of the plan participants, is subject to limitations.

For example, the value of the pure insurance protection purchased on the life of the participant is considered to be additional, taxable income to the participant. The cost of this insurance is called the **P.S. 58** cost and is furnished annually by the insurer or can be obtained from the P.S.58 tables supplied by the insurer.

Another limitation imposed by the IRS is that a retirement plan may include life insurance protection only if the life insurance is incidental to the plan's primary purpose. To secure compliance with this rule, the IRS will test a retirement plan under its incidental death benefit rule.

Incidental Death Benefits

Death benefits are incidental to any type of pension or profit-sharing plan--whether insured or not--if the cost of the death benefit for any participant does not exceed 25% of the total cost of all benefits for that participant.

It has been determined that a qualified retirement plan that invests all of its funds in life insurance and annuity contracts--a "fully insured" plan--and provides a death benefit equal to 100 times the participant's retirement benefit or the cash value of the policy (whichever is greater) automatically satisfies the 25% rule. A typical retirement income insurance policy maintains this 100 times ratio or cash value death benefit. By contrast, a retirement annuity contract provides a death benefit equal to a return of premiums or the cash value of the policy, whichever is greater. Thus, both types of policies will satisfy the incidental death benefit test when purchased by any type of qualified retirement plans, whether it is a defined benefit pension plan, a defined contribution pension plan, or a profit-sharing plan.

For plans funded in part through the purchase of ordinary insurance contracts, the 25% test is met if less than 50% of the employer contributions credited to the participant's account are used to purchase ordinary life insurance. (For term insurance and universal life insurance, this contribution percentage is 25%).

A defined benefit pension plan that purchases insurance other than retirement income insurance or annuity contracts — such as ordinary life insurance — will also qualify if it meets the 100-to-1 rule. Hence, the plan cannot be funded entirely with ordinary life policies, even though the cash values will provide an annuity at retirement. The amount of the annuity would be insufficient to satisfy the 100-to-1 ratio. Under such a plan, the additional funds needed at retirement must be accumulated in a "side fund" or through contracts that do not provide additional death benefits.

A profit-sharing trust that has accumulated funds for a period of two years is not subject to the incidental death benefits test to the extent that such benefits are purchased with the accumulated funds. However, a profit-sharing trust that purchases ordinary life insurance, for example, on the lives of the participants--with money that was not accumulated at least two years--must meet two conditions if the death proceeds of the policies are payable to the employee's beneficiary:

1. The aggregate premiums paid for the insurance on each participant's life must be less than one-half the aggregate contributions and the forfeitures allocated to his or her account at any particular time. For example, if, over a 10-year period, a participant's total account comes to \$5,000, premiums paid during that time must be less than \$2,500.
2. The plan must require the trustee, at or before an employees' retirement, to either:
 - Distribute the policy;
 - Convert its entire value into cash; or
 - Elect a periodic income option so that trust-owned insurance will not continue beyond the employee's retirement.

If the plan meets the above conditions, the life insurance is deemed incidental to the main purpose of the plan: deferred distribution of profit-sharing funds.

Mandatory Death Benefits

Under current law, qualified pension plans are required to provide death benefits in two instances:

1. For vested participants who retire under the qualified plan, the accrued benefit must be provided by a qualified joint and survivor annuity (QJSA).
2. In the case of a vested participant who dies before the annuity starting date and who has a surviving spouse, a qualified pre-retirement survivor annuity (QPSA) must be provided to the surviving spouse.

A qualified joint and survivor annuity pays a benefit for the life of the participant with a survivor annuity for the life of the spouse that is not less than 50% of the amount of the annuity payable for the joint lives of the participant and spouse.

The qualified pre-retirement survivor annuity provides a survivor benefit for the life of the spouse--a benefit not less than the amount that would be payable under the QJSA described above.

The QPSA is defined differently for defined benefit plans and defined contribution plans. In both cases, however, the QPSA must be provided only for married participants who had been married for one year before the participant's death. (Your clients may want to waive the one-year requirement for administrative convenience.) For a defined benefit plan, the amount of the survivor annuity is basically equal to the amount that would have been paid under the qualified joint and survivor annuity (the plan's normal form of benefit for married individuals). This amount is determined by assuming that the participant had survived until the plan's earliest retirement age--then retired with an immediate joint and survivor annuity on the day before death. For a defined contribution plan, the qualified pre-retirement survivor annuity is an annuity for the life of the surviving spouse that is actuarially equivalent to at least 50% of the vested account balance of the participant as of the date of death.

The QPSA does not need to be an employer-sponsored benefit; the employer can require employee contributions to fund this benefit or, conversely, reduce the normal benefit actuarially. If this is the case, the employee generally has the option of electing out at any time after age 35. A written confirmation of the spouse's consent to the election out is required. If the employer decides to fund the QPSA, an election out is not necessary, and the employer will save the administrative complication of accounting for employee contributions, judging the validity of spousal consent forms, and risking the potential litigation associated with a spousal mistake.

Plan Design: Part 5 Top Heavy Rules

In many ways, the top heavy rules are similar to the previously-discussed nondiscrimination rules. However, their purpose is to measure potential discrimination in accumulated benefits rather than discrimination caused by eligibility. The top heavy rules were introduced to restrict the use of qualified plans as tax shelters for business owners. This is frequently the case in small, closely-held businesses where owner-employees are prone to the temptation of structuring the organization's qualified plan primarily to benefit themselves. The

rules of top heavy plans are tax qualification requirements so that a trust forming part of a top heavy plan meets the qualification requirements of the law if additional requirements are met. We will cover those requirements next.

Most small plans (those with 10 or fewer employees) are, by their nature, top heavy plans. Financial services professionals typically design the plan document according to top heavy specifications. Larger plans do not generally meet the requirements of top-heaviness and need not meet the additional restrictions. However, all plans, whether large or small, must include provisions that automatically take effect, should the plan become top-heavy in actual operation.

When is a Plan Top-Heavy

A defined benefit plan is top-heavy if the present value of accumulated benefits for key employees under the plan exceeds 60% of the value for all participants under the plan. In the case of defined contribution plan, the 60% test is applied to account balances of key employees and all participants, respectively. In other words, if a plan provides more than 60% of accrued benefits or contributions to key employees, the plan is top-heavy.

When an employer maintains two or more plans, the plans will be aggregated for determining whether the group of plans is top-heavy. The top-heavy group rules will apply to all plans of related employers under existing controlled group and affiliated service group rules.

Who is a Key Employee

A **key employee** is any plan participant who, during the current year or four preceding years, is:

- An officer of the employer who earns more than \$45,000;
- One of the ten largest owners of the employer, provided that he or she earns in excess of the individual contribution dollar limit;
- A 5% owner of the employer; or
- A 1% owner of the employer with annual compensation in excess of \$150,000.

The officer category is limited to a maximum of 50 employees. If the employer has fewer than 50 officers, the number is the greater of three employees or 10% of the total of all employees. The attribution rules (to determine constructive ownership of stock) apply for making the key employee identification. In determining stock ownership, an employee is treated as owning stock, even it is owned by other members of his or her family or certain partnerships, estates, trusts, or corporations in which the employee has an interest.

Example:

Facts: The Health Care Group has four employees.

Employee	Key Employee Status	Money-Purchase Plan
Dr. Bill	Yes	\$150,000

Dr. Bill Yes \$150,000

Dr. John Yes \$150,000
Nurse Lynne No \$60,000
Nurse Mary No \$40,000

Analysis: The Health Care money-purchase plan is top-heavy. The key employees' account balances amount to 75% of the aggregate account balances. (Key employee account balances equal \$300,000; all accounts equal \$400,000.)

Conclusion: The Health Care Group money-purchase plan is subject to top-heavy rules.

Accelerated Vesting

For any plan year for which a plan is top-heavy, an employee participant's right to accrued benefits must be nonforfeitable under one of the following two vesting schedules:

1. **Three-Year Cliff Vesting:** This alternative schedule is satisfied if an employee with at least three years of service has a nonforfeitable right to 100% of the accrued benefits derived from employer contributions.
2. **Six-Year Graded Vesting:** A plan satisfies the second alternative schedule if an employee has the nonforfeitable right to a percentage of the accrued benefit from an employer contribution.

Minimum Contributions or Benefits

A top-heavy plan must also provide for minimum nonintegrated benefits and minimum nonintegrated contributions for non-key employees.

In the case of a defined benefit pension plan, for each year (maximum of ten) in which a defined benefit plan is top-heavy, each non-key employee must accrue a benefit of at least 2% of compensation from this employment, times years of service. The compensation is for plan years of pay (highest-paid five years of all years, excluding compensation for plan years beginning before January 1, 1984 and only such years' service when the plan was top-heavy). The minimum nonintegrated benefit need not exceed a total of 20% of the base compensation. **Nonintegrated** means that Social Security benefits, contributions, and the covered wage base are not taken into account in arriving at the minimum.

In the case of a defined contribution plan, the minimum employer contribution must be no less than 3% of each non-key employee's compensation (provided that the key employees receive at least 3%). As with defined benefit plans, the minimum amount cannot be eliminated or reduced through Social Security integration. What's more, if a non-key employee participates in both a defined benefit plan and a defined contribution plan maintained by the employer, the employer is not required to provide the employee with both the minimum benefit and the minimum contribution.

Restrictions on Multiple Plans

If the employer maintains both a defined benefit plan and a defined contribution plan for key employees, the aggregate amount that can be contributed for both plans is lower than would be possible if the plans were top-heavy. If multiple plans

cover non-key employees, however, the employer generally does not need to duplicate the minimum benefits by providing the minimum benefit for both plans.

The laws simultaneously reward the employer and employee for establishing and participating in a qualified plan and penalize those abusing the rules of conduct relating to such plans. You must be aware of these broad legal constraints.

The following is an outline of major limitations imposed by ERISA and current laws and regulations on qualified plans:

1. A written, legal document is necessary to establish a plan.
2. Various acts impose requirements related to the establishment of the plan, provisions contained in the plan, and the funding and operation of an established plan.
3. Although the plan is established by the employer, it must be for the exclusive benefit of the employees as a group. (Coverage cannot be on a pick-and-choose basis.)
4. "Employer" may extend beyond the business entity considering certain plans.
5. Statutory limits exist for either benefits or contributions.
6. "Compensation" is defined in each plan document. The law, in some instances, restricts the definition of "compensation" and "service" to prevent discrimination.
7. The law provides extensive provisions for integrating plan benefits or contributions with those proved by Social Security.
8. An employee must be given rights to receive benefits accrued under the plan, even if he or she separates from service with the employer. This known as "vesting."
9. All qualified retirement and profit-sharing plans must be prefunded.
10. The primary purpose of qualified plans must be to provide future benefits to covered employees.
11. A plan must be permanent--not a temporary tax-avoidance scheme.
12. Those connected with any qualified plan in a fiduciary capacity are legally obligated to act in the plan's best interest.

The list seems long and full of restrictions. Indeed, the laws covering this area are many. One reason is the importance to those affected. However, these rules still leave a lot of room for design choices.

Plan Funding: Part 1

Minimum Funding Standards: In General

One of the first considerations in determining the cost of a plan is its method of funding benefits. The funding method of a qualified retirement plan is the way in which the ultimate expenses of the plan are to be met; in other words, it is what the employer should or must do to provide or purchase retirement benefits for the employees.

Prior to ERISA, a plan could be funded in a variety of ways. Three general classifications were the pay-as-you-go method, the terminal-funding method, and the advance-funding method. ERISA eliminated the pay-as-you-go method; however, the rationale behind these methods will help to explain the necessity for advance funding.

Pay-As-You-Go Method

The informal **pay-as-you-go method** has facetiously been referred to as the "owe-as-you-go" method. Under this method, no funds were set aside prior to

retirement to provide benefits for the payment of special benefits. Benefits paid to employees were derived from the company's gross income and were deducted as a normal business expenses at the time of payment.

Historically, this method of funding future defined benefits proved highly unsatisfactory. What seemed to be a nominal cost at inception of the plan gradually increased as more employees entered retirement. Consequently, the burden of providing the increasing retirement benefits became too large for most businesses to absorb, and most pay-as-you-go plans either collapsed or had to be converted to some other method of funding.

Terminal-Funding Method

The **terminal-funding method** is basically what its name implies. Upon an employee's retirement, an employer would purchase an immediate annuity in the amount called for by the plan's benefit formula. This method of funding resembled the pay-as-you-go method in that the employer did not accumulate funds prior to an employee's retirement and expenses were met from the employer's normal operating income. However, under the terminal-funding method, the employer provided a principal sum at retirement that, in turn, guaranteed future benefit payments. Thus, the pre-retirement lack of security that existed under the pay-as-you-go plan was also characteristic of this program, but the post-retirement lack of security was eliminated.

Advance-Funding Method

Today, the **advance-funding method** is required by law for private pensions. Advance-funding has the following four characteristics:

1. It is the process of setting aside periodic sums to provide the payments of future retirement benefits.
2. It is an organized program of budgeting expenses for retirement benefits.
3. It provides a tax advantage applicable to funds held under the plan because the employer has the capacity to make deductible contributions in years of high income. In other words, the employer can charge accumulated pension expenses to current operating expenses.
4. Since benefits are secure, it provides a beneficial psychological effect for employees.

Minimum Funding Standards

Because advance-funding is dependent upon the benefits ultimately paid from the plan, a basic aspect of all funding methods is to determine what benefits will be paid — or what contributions are directly required under the terms of the plan provisions.

In the famous Studebaker case, the plant closed and the employee pension plan was terminated. Those employees who had looked forward to receiving benefits were shocked to find that assets held in trust were insufficient to make good on all of the commitments provided for by the plan. Under existing laws at the time, these employees had no recourse against the employer, whose liability had been restricted to making contributions as the corporation chose to the trust. The

creditors of the corporation therefore had a claim on the corporation's assets, while people who had been employed there for 30, 40, or 50 years had none.

Under the regulations put into effect since the Studebaker case, a large number of safeguards have been established to help guarantee the rights and future benefits of pension plan participants. One of the primary safeguards has been the establishment of minimum funding standards by which qualified plans are monitored to assure that the funds needed to pay future benefits are being contributed and invested in a safe and prudent manner.

To assist the Treasury Department and the IRS, a separate governmental agency, the Pension Benefit Guaranty Corporation was established. As previously discussed, this agency also monitors qualified plan financial activity and, should a plan be terminated, provides a guaranteed benefit to all qualified participants of the terminated plan. These guaranteed benefits are financed by an insurance program to which all qualified plan employer-sponsors must pay premiums. Secondly, the Pension Benefit Guaranty Corporation can also impose liens of up to 30% of the assessed valuation of the employer's company, should the need for funds to pay the pension plan participants arise.

Another established safeguard is that most defined benefit plans in operation must be certified as being "reasonably funded" by an enrolled actuary. An **enrolled actuary** is a person who, in addition to meeting the professional standards of his or her professional society, must also meet the standards of the federal government. Once met, the enrolled actuary is given authority to establish, review, and audit the mathematical and financial standards under which the defined benefit plan is functioning. Every three years a plan must be certified using Form 5500 Schedule B and attested to by the enrolled actuary.

The law itself provides additional safeguards by allowing participants to bring claims against the corporation to collect promised benefits or contributions. Additionally, the law also provides that standards of investment and fiduciary conduct be followed exactly as written. In general, the plan must invest assets in a "prudent manner." Specifically, with exceptions, the assets must be diversified, marketable, and liquid.

From the above, it is evident that employees can expect to receive the benefits promised. However, most employees do not clearly understand what their plan provides, under what circumstance benefits are payable, or such matters as "present values," "accrued benefits," or an actuarial equivalent. Of the complaints received by federal agencies, a large number involve a misunderstanding of the plan provisions on the part of the participant.

Plans Not Subject to Minimum Funding

Minimum funding rules apply to most operations by private sector businesses engaged in interstate commerce. This has been interpreted liberally to include merchants, farmers, manufacturers, and most vendors of products or services, regardless of immediate transactions across state lines. Plans that apply to the IRS for qualified status must adhere to the minimum funding rules.

For example, a not-for-profit organization establishes a retirement program. Because it is not included in this group, it does not need to comply with minimum funding standards, even if its plan takes the form of a defined benefit plan. However, if the organization wishes to formalize its plan (for a variety of reasons, including advance funding under a separate qualified trust) and seeks a determination from the IRS, it then must comply.

Government plans are generally exempt from funding requirements, and because they are exempt, they will use the pay-as-you-go funding method. Church plans are also exempt, unless they elect to comply. Plans funded entirely with annuity or life insurance products are exempt, if premiums are paid as they become due and no policy loans are permitted.

The law also recognizes the difference between pension plans and certain profit-sharing plans, thrift plans, or employee stock ownership plans. In these plans, and plans providing for individual employee-directed accounts, general exemptions are made for funding standards, particularly the requirement that assets must be diversified.

Full-Funding Limitation

As stated earlier, the minimum funding standards were developed to protect employees. As important as this is, the government is also concerned with excess funding. Through excess funding, funds could be put into the pension plan, which should actually be paid to stockholders as a dividend or considered income to the unincorporated business. The reasonable costs of funding a defined benefit pension plan are tax deductible by the employer, provided that the plan is qualified. What is "reasonable"? As this section explains, cost methods are numerous. Perhaps even more importantly, assumptions used to estimate future liabilities can make the "fund normal cost" or current recommended deposit vary widely. Some plans establish separate liabilities "accounts" that are amortized (paid off over a fixed period of time).

It is not important for you to understand all of the high-level mathematics and funding details. That's the responsibility of the actuary. What is important, however, is that you get the feeling for where a "glitch" can arise. Remember the following rule:

Full-funding Limitations: An employer cannot deduct as a current business expense more than the full-funding limitation, which (with refinements) equals the outlay determined under standard cost methods and assumptions prescribed by the IRS, taking into account existing plan assets. An employer may contribute amounts above the limitation. The excess is not currently deductible but can be carried forward to future tax years.

Example:

Facts: Slim Oil Company has a pension plan. The corporation is closely held. Its founder, Slimmer Slim, is now age 59. The company has a major tax problem and wants to boost its deductible pension plan contributions. The company calls in Larry Davis and asks for his suggestions.

Larry points out that the plan assets have been yielding a compound growth rate, with dividends and interest of 11% per year. In fact, the assets now exceed the accrued benefit liabilities several-fold. The actuary has been using a 6% assumed rate. The plan benefit is based on past and future service. Slimmer has 35 years of credited service.

Larry recommends that the company amend the plan to provide a normal form of annuity that is guaranteed for 10 years, instead of the current life-only form. Reducing the normal retirement age from 65 to 59 is also proposed. He recommends adding nonparticipating ordinary life insurance to provide a pre-retirement death benefit and the guaranteed settlement option rate. He also called for the actuary to revise the assumptions to a 2% interest rate. He explains that the increase in liability due to these changes should be segregated and amortized over three years, based on Slim's retirement age. The result is a tenfold increase in this year's deposit.

When the plan actuary heard these suggestions, he reported to Slim that the agent overstated the amount that could be deducted and obviously knew nothing about full-funding limitations. The life insurance policies were not taken.

Analysis: Amortizations cannot be spread out or taken in a period as short as three years; usually, an amortization is spread out over thirty years. In addition, an interest rate assumption is not an arbitrary factor to be used for manipulative purposes. Finally, the full-funding limitation must not ignore the accumulated plan assets.

Plan Funding: Part 2 Defined Contribution Plans

Thus far, our discussion of minimum funding standards has concentrated on the actuarial and financial cost methods used to calculate the annual cost of a plan. The question arises as to whether these methods should apply to a defined contribution plan, since these contributions are usually fixed for each year, and also since the plan formula usually specifies a certain percentage of compensation of the participants. Since these costs can be determined rather easily, it would seem that there is little need for the elaborate standards and formulas of the defined benefit approach.

While these statements may be true and easily documented, the past history of plans that suddenly turned bankrupt has made the need for government control all the more evident. Consequently, defined contribution plans do have to meet certain minimum funding standards:

1. For all plans in existence on January 1, 1988 and after, the liabilities of a pension plan must be calculated on the basis of actuarial assumptions and cost methods that are reasonable and offer the actuary's best estimate as to project experience under the plan. Each individual assumption made by the actuary must be reasonable (conservative).
2. Single-employer plans must be amortized (costs spread out over a period of time) over a 5-year period. This is in stark contrast to previous amortization periods of 18, 30, and 40 years granted in the past.
3. In 1989, additional minimum funding requirements were imposed on plans covering more than 100 participants and that were not at least 100% funded for current liabilities. Any additional contributions needed to bring the plan up to

minimum funding standards will also take into account benefit improvements that are being planned, a payment for unpredictable events, and for an 18-year amortization of the 1988 unfunded liability.

4. Self-directed defined contribution plans and all other defined contribution plans must be diversified as to the placement of assets as an investment.
5. All employer contributions must be in cash-- no IOUs. This is aimed at previous abuses, where employers did contribute IOUs that turned out to be noncollectable. For all practical purposes, this technique created current deductions with no real intent to provide benefits.

Minimum Funding Standards: Defined Benefit Plans

In many instances, the corporation with a large current cash position might want to fund its defined benefit plan as soon as possible. This is one approach to advance funding, and it is possible under the following conditions:

- The actuary uses reasonable assumptions;
- Past service liabilities are amortized over at least 10 years; and
- Guaranteed contracts are purchased for certain liabilities.

In addition, it is possible to use conservative assumptions regarding future events to build up current funding subject to the full-funding limitations on deductibility. This also may be desirable to reduce corporate assets for estate tax purposes or remove them from possible attachment by creditors.

On the other hand, a firm short of cash will want to fund as few current liabilities as possible and use advance funding to fund future benefits as "slowly" as possible. This was popular during periods of double-digit inflation because employers felt it would be unwise to use current dollars when future dollars would be worth less.

The approaches to advanced funding are varied. There are, however, three major individual methods:

1. The unit cost method (single premium);
2. The level-annual-deposit method (level annual premium); and
3. The entry-age normal method.

Knowledge of these funding methods will serve as a foundation for virtually all acceptable variations of advance funding. As discussed, these funding methods also provide the background for determining the amounts of deductible contributions permitted by the IRS Code and the concepts to calculate the full-funding limitation.

Cost methods should not intimidate you. In establishing an actuarial cost method, the purpose is to provide a systematic means of providing funds from the employer to the plan so that sufficient funds will be available to pay benefits as they come due. This is really not much different than a person who budgets for the college expenses of children who are now toddlers. Because of familiarity with household budgeting, most pension specialists feel relatively comfortable with the individual cost methods. This course also covers aggregate (or groups) methods because even smaller plans often choose such methods for administrative convenience.

Unit Cost Method

The **unit cost method** or **single premium method** involves setting aside sufficient funds to pay for benefits currently earned by an employee. Its historic use has involved a compensation-times-percentage-of-salary benefit formula, such as 1% of current compensation for each year of service. Under this combination of benefit formula and funding method, the employee annually accrues a benefit equal to 1% of salary and the employer deposits funds that, when accumulated to retirement, will be sufficient to purchase that year's benefits.

Unless a newly-established plan provides for past service benefits, the unit cost method of funding normally creates a fully funded plan. Because the deposits for each year are sufficient to provide for the accrued benefits, there is theoretically enough money in the fund to offset the accrued benefits under the plan.

Originally, single-premium annuities were used in conjunction with this type of plan. Each year, as benefits accrued, an additional annuity unit was purchased. This approach, however, has yielded to other combinations of funding methods and funding vehicles. When a single-premium annuity is combined with a unit benefit plan, the effect is one of increasing costs. Each year, as the employee ages, the cost of the single-premium annuity increases. Many actuaries wanting to avoid this increasing-cost aspect utilize other combinations of formula and funding methods.

Level-Annual-Deposit Method

Contrasted to the unit cost method is the **level-annual-deposit method**. The deposits needed to provide the benefits of a plan funded under this method are spread equally over the employee's working career, from his or her attained age to retirement. The cost of the benefits to be provided is projected to retirement, and level annual deposits are made to offset the ultimate cost of the benefits.

Conceptually this is easy to understand if it is thought of in terms of an annual premium retirement annuity or endowment. Level premiums accumulate the amount needed to buy the benefit using either guaranteed settlement options or other purchase factors. This type of level-cost method is rarely used, except in fully-insured plans. This is because it is administratively cumbersome, since each incremental change in benefits must be tracked separately.

The fact that the level-annual-deposit method is based on attained age does not preclude its use with a unit benefit formula providing for past service benefits. In such cases, the cost of past and future service benefits is projected to retirement as a single cost factor, and a level annual deposit is employed to provide the required money.

Entry-Age-Normal Method

The third major type of individual funding is referred to as the **entry-age-normal method**. This method is similar to the level-annual-deposit method, with one major exception: deposits are calculated on a basis that assumes an employee has been participating in the plan from some date prior to his or her attained age. Normally, under the entry-age-normal method of funding, level premium deposits are calculated from the employee's date of first employment to his or her retirement date and not merely between the attained age and retirement.

Example:

To illustrate this method of funding, let's assume an employee, age 25, with five years of past service, enters a plan with an anticipated monthly retirement benefit equal to \$300. Also assume that the cost of a \$10 monthly annuity at age 65 is \$1,400. Thus, the fund should accumulate \$42,000 by age 65 to pay the employee a monthly benefit of \$300. Under the entry-age-normal method of funding, the actuary would calculate the annual deposits needed to accumulate the \$42,000 over a 45-year period—from age 20, her employment age, to age 65, rather than the 40-year period between her actual attained age of 25 and 65.

The primary reason for using the entry-age-normal method of funding is to provide flexibility in the required schedule of deposits. The practice of calculating the deposits over a longer period of time has two major effects. Initially, it reduces the amount of the level annual deposit because of the extended time period. Secondly, an immediate deficit exists under the plan equal to the sum of payments and interest that were missed prior to the employee's actual participation in the plan.

Under a newly-created plan, this liability is technically referred to as an **initial past service liability**, while under an existing plan is termed an **accrued liability**.

Continuing the previous illustration, it is assumed that contributions equal to the normal cost calculations will be made each year toward the accumulation of future benefits. The flexibility in making deposits under this funding method is derived from the way in which the past service liability is funded. Deposits to offset the past service liability may be varied from year to year. Thus, in years of high income, an employee may contribute larger amounts to reduce the liability, while in years of low income, the deposits can be reduced.

An original point raised in favor of this approach was that it provided a truer ongoing view of the plan's cost. The new employees hired by the firm would, except for a small eligibility period, be covered immediately, thus requiring no special past service liability. The entry-age-normal method, then, attempted to treat existing participants the same way. That portion of the deposit not attributed to payment for past service liabilities, therefore, labeled the fund normal cost. After the past service liability is paid off, the ongoing cost of the plan is represented by that figure. However, as often happens, that seldom turns out to be reality. Any realized variation from the actuarial assumptions causes a change in the supplemental amortized. Small plans on this method over the last two decades have frequently had a larger "past service liability" than when they began, largely caused by plan amendments and changes made in actuarial assumptions.

Aggregate vs. Individual Cost Methods

In all of the cost methods, the actuary established a benefit level and then a deposit estimate for each individual first. As we saw, this may include a minimum and a maximum deposit, reflecting different rates of amortization of the past service deficit. These individual deposits were simply added together to determine the total deposit. Collectively, these are referred to as **individual cost methods**.

Disadvantages -- Individual Cost Methods

As eluded to earlier, there are some fundamental and practical problems with such approaches. Although this is subject to actuarial argument, there are considerations against these individual cost methods:

- Plan costs may have to be artificially "allocated" to individuals. For example, if a group annuity is used, there seems to be an extra effort to try to assign part of the initial cost of the contract to individual participants. Investment of assets, plan administration costs, and other items are "general overhead" and typically paid for by the employer anyway.
- A natural result of these methods is the expectation of an "account balance" as is the case in a defined contribution plan. Typically, the employer-client wants to know, "what's going on in this plan for me?" Although this is a good sales tool, this eventually leads to problems. In actuality, even when these methods are used, it can't be determined what the value of benefits are until they are actually paid.

Example:

Plan Provisions: Simple, Inc's Pension Plan provides a pre-retirement death benefit equal to 100 times the monthly retirement benefit. To be eligible, the participant must have three years of service (although only six months is required for entry into the basic plan), and the participant must be insurable at standard rates. No initial or increased death benefit is provided at or beyond age 60.

Facts: Mrs. Bigclone met all of the requirements when her organization established the plan. She was age 40 at the time. She is now 64 and intends to postpone retirement. The benefit is \$2,000 monthly. The death benefit which is frozen is \$150,000 and is insured by 12 individual life insurance policies purchased by the trust at various ages. The total cash value is \$50,000. Based on actuarially determined deposits, her "side fund" or the investment portion of her retirement account is worth \$185,000. (\$185,000, plus the projected insurance cash value of \$55,000 will be just enough to buy the retirement benefit.) She dies unexpectedly.

Analysis: The insurance company pays (either directly or preferably through the trust) the \$150,000 death benefit to Mrs. Bigclone's beneficiary. However, had she been able to retire immediately before her death, the lump-sum equivalent to her \$2,000 monthly-pension would have been \$235,000. Also, what happened to her "account balance" of \$185,000? The answer: it remains in the trust and is an "actuarial gain" because now the trust doesn't have to pay her a retirement pension.

Conclusion: If it is absolutely essential that a client monitor his or her interest in a plan, either a fully insured defined benefit plan should be used or the employer should establish a defined contribution plan, perhaps using a target benefit approach.

Not all employees will collect benefits. Some may die, as in this example, become totally disabled, or quit before retirement. These considerations will be discussed next. Briefly, it is a logical and sound actuarial policy to anticipate these and other contingencies in establishing a deposit figure. Individual cost methods, however, have a conceptual problem in doing this. Any given individual either will or will not

collect the pension benefit. Therefore, it is not logical to discount, for example, the employer's deposit for a particular person, just because actuarial tables show that at this age, "only 30% of him or her" will remain to retirement. As stated earlier, individual cost methods may add unnecessarily to administration costs.

Aggregate Level-Cost Methods

The primary characteristic of the aggregate level-cost method is that the normal cost accruals are calculated for the plan as a whole without identifying any part of such costs accruals with the projected benefits of specific individuals. The cost accruals are usually expressed as a percentage of compensation or as a specified dollar amount.

Under an aggregate method, the normal cost accrual can be calculated by dividing the present value of the participant's estimated future compensation. This normal cost accrual is then multiplied by the total annual earnings to determine the initial cost of the plan. Once the initial cost is determined, later calculations of cost accruals must take into account the accumulated plan assets that have built up to be used as an offset to the cost accruals calculated at that time.

The normal cost accrual can also be calculated with what is termed a **supplemental liability**. This can be done by excluding the past service benefits in the projection of the aggregate future benefits. Doing it this way creates an unfunded supplemental liability (past service) and a smaller-than-normal cost accrual, paid for by current contributions to the plan. In this case, the employer has the option of funding the supplemental liability at a slower pace than the normal cost rate.

Naturally, the normal cost accrual can be calculated without a supplemental liability by taking into account past service. Doing it this way funds both past and future service at the same pace.

Here the actuary follows a different procedure. Although variations exist, the following steps are commonly used:

1. All benefits are analyzed as to the amount, cost, and time of (contingent) payment.
2. These are then discounted to present value and added together.
3. Discounts or adjustments are made for the probability of payment.
4. Certain liabilities may be separated, such as a past service liability or current death benefits.
5. Amortization factors are applied to certain supplemental liabilities.
6. A "spread" factor is applied to the normal liabilities to derive the fund normal cost.

The past service liability is often "frozen" from adjustment for future years' actuarial gains and losses. Methods to achieve this objective are the "FIL" cost method (frozen initial liability), the "Unit Credit" method and the "Aggregate." Those plans that don't separate this liability are known as "aggregate aggregate," "true aggregate," or in one special variation, "modified aggregate."

The "spread factor," which is item 6 in the list of procedures, has a great deal of effect on the incidence of cost and, therefore, the required deposit. There are

three basic variants, which have counterparts in the individual cost methods that we covered earlier:

1. **Level dollar or future years' service:** The plan's liability is spread over a period of future years--not individual by a "salary weighted" average of all participants' future service. If all goes as assumed, the plan cost remains the level. This differs from the individual level-annual method only in second and subsequent years. Benefit increases, actuarial gains or losses, etc., are poured into the collective liabilities and spread over then-existing future service.
2. **Level-percent-of-payroll:** The plan's liability is paid off as an average of expected future payroll. If the actuary assumes that future salaries increase by 5%, everything else will be equal, and the plan's fund normal cost will rise by the same percentage.
3. **Entry-age variant:** This is used to spread payment of liabilities over the greatest period. Typically, although not absolutely necessary, it is used to spread the balance of liabilities after the actuary has selected the frozen initial liability cost method.

The above are listed roughly in the order of expected deposit, from highest to lowest. Another way of expressing this is that level is a "faster" method of funding than level-percent-of-payroll.

Plan Funding: Part 3

Advance funding involves making certain assumptions that affect the size of the annual deposits to a plan. Let's review these assumptions and the influence they have on year-to-year deposits. Normally, the following factors should be considered:

- Mortality;
- Turnover;
- Interest; and
- Salary changes.

Mortality

Because the primary purpose of a qualified pension plan must be to provide retirement benefits, the actuary is interested in determining the number of deaths that will occur among participants prior to retirement. Death obviously eliminates the need for paying retirement benefits. In a plan that does not provide for pre-retirement death benefits, mortality acts as a gain to contributions already made. Likewise, as demonstrated in the previous example, under a plan providing insured pre-retirement death benefits, mortality acts as a gain if the insurance coverage is separate from the accumulating retirement fund. Such gains, when anticipated in advance funding calculations, result in a reduced current deposit.

The mortality table used in computing fund deposits is of considerable importance. Traditionally, mortality studies are divided into two major groups: those based on insured lives and those based on annuitants. It has been found that people who buy insurance have a higher mortality rate than purchasers of annuities. For this reason, pension deposits based on life insurance mortality tables reflect a higher mortality discount (thus a lower annual deposit) than similar calculations based on annuity mortality tables. It is also recognized that mortality among working employees more closely approximates annuity mortality

rates. Consequently, annuity mortality tables are better suited for determining advance-funding deposits for employee retirement plans.

Turnover

Another form of gain to a retirement plan is employee turnover. The rate at which employees terminate employment can have considerable effect upon the accumulated fund. A terminating employee who is not fully vested can create an unexpected gain to the fund. This is true because money accumulated to meet the employee's anticipated benefits becomes available to meet other obligations.

There are several types of turnover tables available for computing deposits. These tables reflect employee turnover, dependent upon the basic composition of the group involved.

The implementation of a qualified retirement plan may have some favorable effect on turnover. Hopefully, if properly explained, this additional benefit will encourage some employees to stay that might otherwise leave. However, where salary levels are substantially lower than in competing firms or even other industries, the turnover rate will undoubtedly remain high. Certain jobs, such as convalescent care, have higher rates of turnover than others, partially attributable to low wages--but also because of the psychological adjustment needed to work in such conditions.

The vesting schedule of a plan should be carefully considered when dealing with turnover rates. A plan providing early and extensive vesting will have relatively little turnover gains. The greater the amount an employee is entitled to keep upon termination, the smaller the plan's gain.

Interest

The third major factor used in determining advance-funding deposits is the anticipated interest and other earnings of the fund. These earnings are obviously gains and serve to reduce the required annual deposits.

Investment earnings can significantly affect the ultimate cost of the plan. For example, level deposits to a fund earning 5% over a 20-year period would be 19% smaller than a level deposits to fund earning 3% over the same period.

The importance of the interest assumption is obvious. Consequently, competition with other financial houses in pursuit of the retirement plan may create the desire to project overly ambitious plan earnings projections. However, the purpose for creating the fund requires a degree of conservatism. Most pension actuaries will project earnings cautiously because the true cost of the plan will be determined by the actual interest earned, not by projections.

Salary Scales and Other Projections

Most defined benefit pensions are salary-based. That means that as salaries increase, so will benefits. Plans generally use some form of a salary or compensation averaging period to smooth out fluctuations at or near retirement. The shorter this period and the closer it is to retirement, the greater the effect of

inflation-induced adjustments on benefits. Benefit increases at older ages are disproportionately expensive.

It is generally believed that inflation is a permanent feature of a competitive democracy and paper currency. Because the actuaries' main thrust is to fund toward benefits most likely to become payable, in as smooth of a manner as possible, it is quite common to anticipate escalating benefits. This is done by applying a "salary scale" to current compensation levels to estimate those levels of compensation that will be earned. The benefit provisions are then applied to the result to estimate "projected benefits". It should be noted, however, that the employee--and possibly even the employer--should never see this projected benefit. It could be misleading because current benefit accruals are not affected.

In simplest form, a linear escalator percentage is used. In the mid-70s, a 3% to 3½% rate of assumed salary increase became somewhat common. In the early 80s, this was increased to 5 to 6%, reflecting continuing wage increases.

Currently, rates are typically somewhat in the middle of these figures. Because actuaries look many, many years into the past and into the future, immediate changes to current salary increase rates is not practical (or, as we will see, desirable). More complex salary scales, known as "S curves," are sometimes used to attempt to model the corporation's actual experience. These assume fairly moderate increases for both very young and older employees. Those in middle management progress quite quickly in their middle-age years of employment.

Miscellaneous Assumptions

An actuary attempts to measure variables that have some influence on the ultimate benefits and costs of operating the plan. We have discussed the most obvious examples of variables that concern actuaries. Those that follow are considerations--but not necessarily in all plans.

1. **Retirement age:** One would assume the retirement age is the age stated in the plan. This is not always the case; however, the plan must allow employees to postpone actual retirement. Conversely, some plans provide for early retirement. If the actual retirement age differs significantly from the normal retirement age, the actuary may anticipate this shift. In many cases however, this doesn't materially affect funding unless early or deferred retirement provisions are unrealistic, such as an early retirement age of 55.
2. **Hours employed:** As we've discussed, the employer contributions (and in some cases, benefits accrued) are based on a "cents per hour" formula. The actuary must make some estimate of the hours an employee works for this employer because it enters into funding calculations. Typically, this may range from 1,500 hours for cyclical industries to 2,000 hours for stable industries with an established labor force.
3. **Insurance rates:** If the plan self-insures death benefits, this may be a very complex, derived assumption. More often, the plan insures death benefits using an attractive group or individual life insurance product.
4. **Annuity purchase rates:** As mentioned, mortality enters into the rate used to "buy" the retirement income. Small plans may sometimes use guaranteed policy settlement option rates. Others "feather in" current annuity purchase rates as the participants near retirement. Regardless of choice, this factor is an "assumption."

Avoiding Pitfalls and Future Shock

There are two basic pitfalls that should be avoided in funding defined benefit pension plans. The first is the tendency to "toy" with actuarial methods and assumptions toward meeting a perceived objective. For example, some pension sales are made by competing on assumptions. The employer may be presented with a proposal that shows him or her receiving twice the benefits at half the cost. Here are some basic tactics you can use when faced with this situation:

- Educate the client. Explain the rules outlined.
- Recalculate the proposal using the same assumptions, but point out the requirement that an actuary will need to certify the funding as "reasonable."
- Compare products used to fund both proposed plans. Risk is a hidden potential cost that may not be apparent upon the plan's inception.
- Review with the decision-maker your credentials and the reputation of your company.
- Conduct a point-by-point comparison.
- Point out possible differences in administration services and fees. Lower costs may be due to less quality and/or a lower degree of professionalism.

A second major pitfall is the failure to adequately consider liabilities and liquidity needs. Although a cost method and a set of assumptions may be "actuarially sound" according to standards normally applied, the plan may suffer insolvency because of contingent, overlooked, or emerging liabilities. Here are some broad guidelines to avoid this:

- Be wary of a plan that has very low deposits for fairly generous benefits. For example, it should be obvious that a plan that promises to pay a benefit of \$50,000 to the executive in a mere five years must provide for a deposit of at least \$8,000 to \$9,000 per year or face potential insolvency.
- Ancillary benefits should be scrutinized to see that the plan is either properly insured or has sufficient assets to cover them. Be especially careful of death benefits that pay some portion of the "accrued benefit."
- Existing plans with large actuarial losses should be carefully reviewed. Also, the most recent Form 5500 Schedule B should also be reviewed to see if the plan has satisfied the minimum funding standard account.
- A new plan, or amendment to an existing plan, that gives benefits to those already eligible to retire should be carefully reviewed by an actuary.

Fund Valuation

Inherent in advance funding is the actuarial valuation. At least once every three years, and in many cases every year, a plan's accumulated funds are tested against projected benefit payments. In so doing, the actuary is evaluating the future costs of the plan.

Although the actuary, using the mortality and interest tables, can project future events with some degree of accuracy, it is rare indeed for original assumptions to coincide exactly with the actual experience of the fund. The valuation determines just how much the discrepancy exists. If this discrepancy is significant, necessary adjustments are made in the schedule of future deposits. Thus, we see that the year-to-year deposits to meet the ultimate cost of the plan are really estimates of future events.

Full-Funding Limitation (Conclusion)

As we discussed before, tax laws limit how much an employer can deduct for contributions to a qualified pension or profit sharing pension plan. In the case of

the defined benefit plan, these should be monitored by a qualified specialist.

An employer's contributions to a qualified pension plan are deductible to the extent provided under Code 404. The maximum amount deductible in a given year is an amount equal to the full-funding limitation for the year. An employer's full-funding limitation is the excess (if any) of the following:

- The accrued liability (including normal costs) under the plan determined under the entry-age-normal funding method, if such accrued liability cannot be directly calculated under the funding method used; or
- The lesser of the fair market value of the plan's assets or their value as actuarially determined.

Two alternate provisions are available to determine the maximum deductible employer contribution if either one exceeds the full-funding limitation. The first permits a deduction for a contribution that will provide the unfunded cost of past and current service credits for all employee-participants, distributed as a level amount or as a level percentage over the remaining future service (as determined under the regulations) of each participant. Under this rule, if the remaining unfunded cost for any three participants is more than 50% of the total unfunded cost, the unfunded cost attributable to these employees must be distributed over a period of at least five years.

The second provision permits an employer to deduct the normal cost of the plan plus, if past service or other supplementary pension or annuity credits is provided, an amount necessary to purchase or completely fund such credits over a period of ten years in equal annual payments.

An actuary performing a plan evaluation must disclose trends or events that have the potential for a materially adverse impact upon the plan. Any factor now taken into consideration must be disclosed, as well, if a material change in plan contributions could be required. In any plan year in which the fair market value of plan assets exceeds the cost of the assets, it is likely that the use of fair market value in the actuary's calculations will reduce the amount required to meet the minimum funding standard and thus reduce the required employer contribution. This is of special significance at a time when the fortunes of the employer are at a low point (for example, in a recessionary economy). A careful monitoring of asset valuation techniques may reveal an understatement of plan assets when compared to their current fair market value. The adoption by the plan actuary or plan administrator of a new asset valuation technique based on fair market value can actually reduce costs.

During the congressional committee discussions that precede the passage of ERISA, committee members recognized that in some cases, the difference between the total liabilities and total assets of a plan might be less than the minimum funding requirement for the plan year. This could occur, for example, where plan assets had substantially increased in value over the prior year. Congress believed that an employer should not have to contribute more than the amount of the excess liability because, after contribution of this amount, the plan would be fully-funded. The amount to be contributed each year (and charged to the funding standard account) is therefore limited to the difference between total plan liabilities and the current fair market value of plan assets.

Whether the full-funding limitations apply generally is to be determined at the end of the plan year after all plan liabilities for that year have been accrued. For purposes of full-funding limitation, the value of plan assets is generally to be determined as of the usual valuation date for the plan. Because contributions can typically be made to a plan after the end of the plan year, there should be no timing problems with respect to these year-end calculations.

It should be noted that some actuaries perform the actual valuation of defined benefit pension plans at the beginning of the plan year, while others do it at the end of the plan year. Regardless of timing, the full annual funding review consists of a retrospective accounting to recognize gains or losses, turnover, etc. A prospective valuation then budgets for future benefit liabilities. The full-funding limitation is calculated at the end of the year. Thus, the timeliness of information input may differ.

Closely associated with the method of funding a plan is the plan's investments. Investments can dictate a plan's method of funding. The level-annual-deposit funding method is inherent with retirement income insurance and level premium retirement annuities. Let's turn to the subject of investing the plan's funds.

Funding with Trusts, Insurance and Annuities: Part 1

Of prime concern to an employer establishing a qualified plan is the choice of the organization or entity that will administer the plan and the selection of a funding vehicle. Basically, a **funding vehicle** is the method by which assets are accumulated and benefits are paid under a qualified plan. To this end, a wide variety of funding vehicles are available. Organizations that administer qualified plans encompass the entire financial services industry: insurance companies, securities firms, banks, brokerage houses, and corporate trustees. All are actively involved in the qualified plan business. The insurance industry, for example, offers an attractive and competitive array of funding vehicles that are available on an individual or group basis. Investment houses, banks, and brokers offer equally attractive products which are also frequently used for plan funding. The purpose of this section is to offer you an overview of the funding vehicles.

For purposes of this discussion, we will use the following definitions:

- A **noninsured plan** is any plan, trustee or otherwise, that contains no group term or individual policy-insured death provisions.
- A **fully insured plan** is one in which benefits are insured by an insurance company as defined by regulations to be exempt from actuarial certification.
- A **combination funded plan** uses a mixture of policy types (annuities and life insurance) available through an insurance company. These plans may also be fully insured--and either trustee or otherwise.
- **Split-funded plans** are trustee plans mixing life insurance products with outside investments. Although some "split-fund" a plan using annuities as the insurance product, more often this term applies to a plan with an insured death benefit plus a "side" or "auxiliary fund."
- A **trusteed plan** is one that exists under a trust agreement. This gives the trust legal existence apart from the employer.

With these definitions in mind, we can discuss the various funding options available under trustee plans, group insured plans, and individual plans.

Trusted Plans

One of the most popular ways to fund a plan is to use a trusted plan. Basically, a **trusted plan** is an arrangement under which contributions to a qualified plan, whether they are employer-provided, employee-provided, or both, are deposited with an organization (the trustee) that is responsible for the investment and administration of these funds and the earnings on the funds. Usually, the trustee is also responsible for the payment of benefits to the participants. The association between an employer and a trustee and the duties of the trustee are formalized under a trust agreement.

A trusted plan that satisfies the requirements set forth in ERISA can use a wide latitude of investment vehicles.

Mutual Funds

The term "mutual fund" is the commonly-used designation for an open-end investment company. These companies pool funds deposited by many investors and invest in a managed portfolio of securities. A mutual fund share represents proportionate ownership of the investment company's portfolio of securities.

The choices available in mutual funds are many and varied and have expanded in recent years as competition in this field has increased. Types of mutual funds include balanced funds, index funds, growth funds, specialty funds, and industry segment funds.

A **balanced fund** is one that selects from both fixed-income securities, such as Treasury notes, and equities (usually common stocks).

An **index fund** attempts only to duplicate an index such as the Standard and Poor's 500 stock index. In other words, its investment objective is to do no better or no worse than the stock index does. This type of fund purchases the same stocks, in the same proportions as the components in the selected index. One advantage of this fund is that advisor's fees can be reduced or eliminated because purchases are mechanical.

A third type of mutual fund is a **growth fund**. Growth funds specialize in common stocks of companies whose earnings are trending upward, since return (and not dividends) is the objective. Growth funds sometimes seek moderate levels of dividends, which are normally reinvested to supplement expected capital appreciation. Other times, however, speculative funds or aggressive growth funds aim directly for capital appreciation. For example, some may buy common stock in companies being taken over in a buyout. The majority of these funds' holdings pay little or no current yield. But investors hope that capital appreciation will be significant.

Switching Funds

Switching funds allows investors to move money between various funds within a "fund family" in order to take advantage of different cycles and timing of the special markets. The simplest form of fund switching offers a switch between the aggressive position in stocks, bonds, or other combination and a more

conservative money-market fund. The latter invests in very short-term debt obligations and has little or no price movement, but it offers an interest rate that is competitive with other liquid investments. In theory, this allows the investor to move out of the aggressive fund at market peaks and into safe positions. Then, as the price drops back to bargain levels, the money market is liquidated in favor of the aggressive fund. Promoters of this concept point to the long periods during which stocks moved up and down but finished after inflation, losing value. Perfect timing, buying at low points and selling at the next high, would have converted such losses into attractive gains. However, it should be noted that while this is great in theory and in hindsight, few economists and technical specialists have shown the ability to correctly call such moves over a long period. In addition, there are fees for these calls, with no guarantees.

Desirability of Mutual Funds

At one time, retirement plans funded exclusively with mutual fund shares drew considerable criticism, particularly from the insurance industry, because such plans lacked annualized or lifetime benefit payments. Retirement benefits were available either as a lump-sum payment or as installment payments until the employee's accounts were exhausted. Many funds have overcome this drawback through a contractual arrangement, such as a terminal funding agreement, with life insurance companies providing an annuity option for the retiring employees.

The increasing number of plans that allow individuals some choice in directing their own accounts has affected the way in which mutual funds are used. For instance, a 401(k) plan may offer two, three, or more investment options, including mutual fund units. A young participant who is unmarried may seek aggressive growth, perhaps balanced with a portion of the account directed to high yield bonds. A married individual with children planning to attend college may select a safety-oriented mutual fund, such as a government-backed money Markey fund. Regardless of position, from time to time participants may want the flexibility to select against one or another fund that has shown poor performance. As a funding vehicle, this is a significant advantage that mutual funds can offer.

Mutual funds do not eliminate expenses relating to investments. They generally have administration charges ranging from under 1% of net asset value to over 2%. However, the mutual fund spreads commission charges over a greater pool of securities than most self-directed funds.

Bank Common Trust Funds

Recent years have brought about tremendous changes in the way banks operate. The distinctions between industrial banks and commercial banks are diminishing. Financial institutions are trying to compete for funds from businesses, government units, and other institutions, as well as individual savers and investors. For some, diversification has been a strategy, within regulatory constraints. Because pension funds represent such a tremendous pool of assets, it is quite natural for banks to eye this market.

To this end, banks have displayed an aggressive interest in developing administrative and investment facilities for the sales of retirement plans. Sample trust agreements have been prepared that provide for a variety of plans.

A bank trustee retirement plan offers a wide variety of investments, rooted in three basic investment philosophies:

1. A portfolio of fixed-dollar investments, such as bonds;
2. A portfolio of common stocks or equity growth; or
3. A balanced portfolio consisting of both fixed and equity investments.

These trust funds may be used to fund retirement benefits exclusively or, as we'll talk about later, in conjunction with life insurance products.

Such banks also seek to serve as trustees using funding media offered by outside financial organizations. A primary example of this type of plan involves a bank trustee plan that provides for investment of retirement funds partly in life insurance and partly in a common stock fund. Such plans are referred to as **split-funded plans**. Bank fund management performances have been mixed. While bigger banks employ security analysts, in general, they've concentrated on fixed-income investments. Local banks may obtain their investment advice from larger institutions or outside consultants.

Self-Directed Trust Funds

In self-directed trust funds, the employer wishes to make all of the investment decisions for the retirement plan. In order to self-direct the investments of the retirement funds, a trustee plan is generally required.

The following are advantages of pension or profit-sharing trusts:

- A pension is designed to be a long-term program. Creating a separate legal entity can give continuity to the plan, extending beyond the lifetime of individual trustees and fiduciaries. In today's environment of employer mergers, liquidations, and takeovers, a separate trust has appeal.
- The pension trust is, as a legal entity, a separate taxpayer. Although most qualified trusts pay no tax, there are exceptions. Most notably, a pension trust pays tax on unrelated income.
- Particularly where the plan allows individual participant-directed accounts, greater flexibility exists in asset mix. For example, Mr. Slow may direct a trustee to invest his profit-sharing account into a fixed-rate annuity, whereas Mrs. Fast may want her account to be invested in shares of the corporation's common stock.
- A pension trust may have several trustees to share in the responsibility of overseeing investments.

For these reasons, the trusted plan is now very popular. Clearly, these plans only perform as well as the underlying skills of the trustees or investment advisers. Trusted plans may invest all or part of the pension assets into products offered by insurance companies.

Drawbacks to having a trust involve expenses and liability. The trustee has responsibilities outlined by the trust agreement. The job is not to be taken lightly, but unfortunately, it is often delegated to someone in the employer's business. Horror stories abound about plans where the president of one or more small businesses assumed the role of the trustee. Detailed records may be lost or overlooked. The investment of funds may take on the look of a hit-or-miss strategy. In still worse cases, the trustee violates prohibited transaction provisions.

General Rules Applicable to Self-Directed Funds

Prior to ERISA, there were few restrictions on the investment activities of pension trusts. As a result, some performed extraordinarily well. Unfortunately, others did so poorly that the pensions of retired workers were threatened. In some instances, participants had no control over investments and were unaware of the emerging impact that such investment choices might have on their future welfare. ERISA imposed fairly rigid requirements on the investment of plan assets where participants' future welfare (retirement) was at stake. Profit-sharing, thrift plans, ESOPs, and plans with individually-directed accounts are mostly exempt from these provisions. Also, plans funded with insurance products (which are backed by reserves of the company) are generally deemed to satisfy these requirements. These requirements are partially and briefly listed below:

- **Diversification:** In general, no more than 10% of the assets can be invested in one type of investment. For example, a defined benefit pension trust violates this rule by investing 25% of its assets in Moneybags, Inc. common stock, even though that may be an excellent investment.
- **Liquidity:** A plan must not lock up assets where little or no current market exists.
- **Prudent management:** A fiduciary is one who is charged with looking after someone else's welfare. Thus, a trustee must apply standards of prudence that may exceed the standards used even for personal investments.
- **Self-dealing:** ERISA recognized the difficulty in performing transactions where two parties do not have separate self-interests at stake. A trustee may, in essence, "wear many hats." The law prohibits transactions involving "parties-in-interest."

Example:

On January 1, Mr. Wills, the president of Ace Transport, decided that his company needed three more mechanics. Because their participation in the pension would come at a time when the company was short of cash, he agreed, as the trustee, that the trust would surrender \$50,000 of the annuity and loan it back to the business. After this transaction was completed, Larry, a driver, heard of the "deal" and grumbled to another worker that it just didn't seem fair that "his money should be used to help fund more Wills family yachts." He was dismissed for his "attitude" and immediately filed a complaint with the Department of Labor.

Conclusion: The employee in this example may not have recovered his job (or wanted it). However, his complaint could lead to investigation of the plan and result in possible penalties under ERISA. The bottom line is that Mr. Wills, the trustee, was guilty of self-dealing.

Funding with Trusts, Insurance and Annuities: Part 2

Over the years, many variations and changes have taken place in pension products. Evidence of this is seen in the types of products that life insurance companies now offer to fund employee retirement benefits. These products are far more flexible than those of the past, enabling the planner to tailor the plan and the insurance product to meet the specific needs of the employer-client.

One broad distinction should be made between group pension products that invest in the reserves of the insuring company (but may offer "new money rates") and those that invest the reserves in separate accounts with identified assets.

Historically, insurers have directed much of their assets into fixed-dollar investments. State laws designed to protect the obligations and contractual guarantees of life insurance companies require this kind of conservative investment philosophy. However, assets held in separate accounts are not mixed with the insurer's general assets and are thus exempt from their state laws restricting investments. Separate account funds can be invested in stocks, bonds, mortgages, etc. Separate account funding has allowed insurance companies to compete with trust fund plans and securities firms in making equity investments available to fund qualified plans.

A further distinction may be made between allocated and unallocated contracts. Allocated contracts segregate employer contributions and provide benefits to its specific employees. Unallocated contracts collect employer contribution on an undivided basis to provide benefits to employees. Allocated funding contracts would include, for example, individual insurance and annuity contracts. Unallocated contracts would include group deposit administration plans and group immediate participation guarantee plans.

Additionally, certain types of contracts require the agent to be licensed in securities. Variable annuity contracts are an example. The following are key features to watch for in comparing the different types of contracts (regardless of the label put on the policy by the insurer):

- The method of crediting interest;
- Provisions whereby actual expenses are recovered by the insurance company;
- Interest rate "floor" guarantees;
- Withdrawal penalties. A "market adjustment" may be applied to compensate for changes in the overall level of interest rates between the time that the deposits are made and those that are currently available;
- Provisions for purchase of benefits; and
- Availability of special or directed accounts.

With these points in mind, let's look at the various types of group plans that insurers offer.

Group Deferred Annuity Contracts

Group deferred annuity contracts are the "granddaddies" of the pension plan industry in the United States. Initially marketed after World War I, these contracts were specifically designed to meet the funding needs of the pension plans then in existence. Because of the inflexibility of these contracts, they are rarely used as a funding vehicle today. The next generation of pension contracts, group deposit administration contracts, evolved to correct this inflexibility.

Group deferred annuity contracts, as a matter of course, provide for the funding of benefits through the purchase of units of single-premium deferred annuities for each participant. As discussed earlier, the cost for this type of funding increases as the age of the participant increases, giving the plan actuary very little flexibility in planning for the ultimate costs of the program.

Because of the costs involved in setting up programs based on group deferred annuities, companies issuing such contracts usually require a minimum of 75% participation if the plan is contributory and 100% participation if the plan is paid

totally by the employer. Companies also impose additional fees and minimum premiums to justify the administrative expenses involved.

Group Deposit Administration Contracts

In a **group deposit administration plan**, actuarially-determined contributions are accumulated in an undivided or unallocated deposit fund that is maintained by an insurance company under the terms of a master contract and invested with the other assets of the insurance company. The deposit fund is credited with guaranteed interest rates. When a participant becomes eligible for a benefit under the plan, the fund is debited with the amounts withdrawn to pay death, disability, or termination benefits or, if the participant is retiring, to purchase an immediate annuity at contractually-guaranteed purchase rates. Therefore, employer contributions are not allocated to specific employees until a specific future date.

A particular contract may guarantee X% of interest for the first five years of the plan and lesser rates after that because future investment conditions are obviously less predictable. The guaranteed interest rate merely sets the minimum rate.

Most insurance companies use the investment year method or "new money" method for purposes of crediting the actual investment yield on the assets of the plan. All assets in the plan (both active and retired funds) are credited during the first year with the yield secured by the insurance company on new investments during that year, rather than the average investment earnings of its entire investment portfolio. The second year's credit is based on the rate secured on new investments for that year, and so on.

The insurance company also guarantees benefit purchase rates (i.e., annuity premium charges). These rates are generally lower guaranteed rates after that. After the annuity is purchased, the insurance company guarantees to pay the retiree the annuity income for balance of his or her life, regardless of what may happen to the employer's pension plan. The purchase rates set a maximum on benefit costs to the plan. If benefit costs are less than the maximum, the lower cost is the benefit cost of the plan. For that reason, group purchase rates are not comparable to individual annuity rates. Normally, a deposit administration plan guarantees insurance company expenses.

As you can see, the employer--not the insurance company--has primary control over the amount and frequency of contributions made to the plan. As long as the minimum funding requirements are met, deposit administration contracts can be quite flexible in this regard.

Group Immediate Participation Guaranteed Contract

A variation of deposit administration is the **group immediate participation guaranteed IIPG contract**. In this type of contract, insurance company expenses are directly charged to the employer's deposited fund, the full new money rate is directly credited to the fund, and benefit payments are also charged against the fund as they are paid. (The payments usually are guaranteed for life). So, an employer has an immediate picture of its plan's actual experience. However, under

these plans, there are no minimum interest guarantees nor maximum benefit cost limitations as in the case with deposit administration plans. In fact, immediate participation guaranteed contracts are similar to trust fund arrangements, since guarantees are limited and there is an immediate reflection of actual experience under these plans. For the most part, there is a group pension contract that is competitive with any given administered fund. The choice of contracts depends largely upon the guarantees that the employer desires.

Guaranteed Investment Contract

Under the **guaranteed investment contract** arrangement, the insurer guarantees an interest rate for a number of years after the lump-sum payment is made. There are two basic types of GIC's: the bullet and the extended guaranteed contract.

Under the **bullet contract**, a single deposit is made by a plan sponsor, and the funds are held for a specified period of time at a specified interest rate. Upon maturity, usually three to ten years later, the funds are paid.

Under the **extended guarantee contract**, the plan sponsor makes a series of deposits over a period of years. Each payment is credited with the agreed-upon interest rate. To fiduciaries and investment managers concerned with prudent management of the funds placed under their control, the guaranteed investment contracts have been very attractive. Moreover, plan actuaries also prefer them because they are able to use a higher assumed interest rate in determining required contributions and plan reserves.

Pooled Separate Accounts

As mentioned earlier, insurance companies offer investment diversification beyond the fixed-income investment year method that is normally basic with a deposit administration contract. These are pooled separate accounts. Separate pools of investments have been established by these insurance companies, apart from their general accounts. A typical company that offers these accounts for pension use may make available, for example, three pools:

1. Mortgages;
2. Bonds; and
3. Common stocks.

Most often these companies offer pooled separate accounts (generally the equity pool) for group pension cases that generate in excess of \$25,000 of annual recurring contributions, although this is not a hard-and-fast rule.

The assets of a particular pension plan share the investment gains and losses of the investment pool that it has chosen to join. The investment expenses of the separate account are charged against the unit value of the account. There is considerable flexibility with separate accounts. If annual recurring contributions are large enough, some insurance companies even permit the employer to direct the investment of deposits made to a separate account.

Funding with Trusts, Insurance and Annuities: Part 3

As we covered these products, you may have visualized sales applications and objectives that these contracts solve. By way of emphasis and summary, here are some advantages to insured group plans:

- Insurance company reserves, and the annuities backed by them, are diversified;
- Safety of principal (if contract provisions so state) is guaranteed. Even during the Great Depression, insurance companies paid their obligations;
- Depending on the client's objectives, interest rate minimums and benefit purchases rates can be guaranteed;
- Premiums can be conveniently billed to fit almost any requirement;
- Local, personalized service is provided by a life insurance agent; and
- The plans provide reduced administration expenses. Many accounting and asset valuation problems are reduced or eliminated by transferring assets to an insurance company. If allocated annuities are used, this saves time in administering plans that have individual participant's accounts. Insurance company plan prototypes, combined with their administrative service packages, save small-sized and moderate-sized employers' funds that can be used for contributions and benefits, rather than the administration of the plan.

Individual Funded Plans

The individual funded plan is a popular funding arrangement with smaller employers, a fact due perhaps to its simplicity. Under these arrangements, separate contracts are issued on plan participants. Through periodic contribution payments made on behalf of each covered employee, a given level of benefits is funded. At retirement, those benefits are paid in a lump-sum or as annuitized payments. The contribution or premium rate is based on a participant's sex and age at issue. Increases in benefits are available through the purchase of additional contracts.

Essentially, there are two basic types of contracts used to fund an individually insured plan: the retirement annuity and the flexible premium annuity. Although the retirement annuity is seldom used today, a discussion of it will give you a better perspective on these plans in general.

Retirement Annuity

A retirement annuity contract, when purchased under a qualified retirement plan, usually calls for the payment of fixed premiums at least annually, from the year it is issued until retirement age. The basic function of the contract is twofold: first, it allows for the buildup of values through premium payments and interest earnings throughout the annuitant's working years; second, it generates an orderly liquidation of those values during the retirement years. Because there is a period of time between the initial payment of premiums and payments of benefits, such contracts are generally referred to as "deferred annuities."

Typically, the deferred annuity contract is issued in units of \$10 monthly income, payable for life, with a ten-year guaranteed payout. However, a different payout may be selected, including a lump-sum distribution at retirement or termination of employment. If the annuitant dies prior to retirement, the contract typically makes provision for payments to beneficiaries of its cash value or net premiums paid to date, whichever is greater. Here again, death benefits may be taken in a lump-sum or installments.

Interest rates are fixed by the terms of the contract, typically at rates between 3% and 5.5%. Participating contracts pay a dividend that allows some adjustment for prevailing market rates (or, more correctly, for actual earnings on that block of company reserves). Because the contracts provided a fixed, guaranteed monthly retirement income based on settlement options in the policy, special enabling provisions in ERISA exempted them from many of the funding standards applied to other plans. The plans, for example, were exempted from defined benefit actuarial valuations. These were often used with very simple, limited-option prototypes.

Let's look at an example of how a retirement annuity can be used as a funding vehicle.

Plan: CS-CS pension plan provides a flat 20% retirement benefit based on the highest five years' compensation, excluding those five immediately preceding normal retirement.

Data: Big Insurance Company offers a policy called The Big Policy to fund such retirement benefits. Bill's last five years of salary averages to \$5,000 monthly. The employer purchases 100 units of coverage, which will mature for \$1,500 monthly at retirement.

Analysis: In this instance, Bill's final five years of average compensation will not be used in the calculation of his retirement benefit. If Bill's final five-year average was his best, he would lose this in his calculation of his monthly retirement benefit.

Some industry observers have castigated these contracts as being grossly unfair to the employer and have pointed to nominal investment rates of two or three times those under some of these contracts. Also, as illustrated, the front-end reduction or loads were irksome to many consumers. Not only did they reduce the immediate cash value, but this resulted in smaller balances than would have occurred otherwise. This load recurred when future policy additions were made. In addition, the policies performed poorly when the employer had high levels of employee turnover.

Flexible Premium Annuity

Most insurance companies now offer individual flexible premium annuities for use in retirement plans. Premiums for these contracts may be raised or lowered from year to year without affecting the value of the annuity units already purchased in prior years. So, these contracts are advantageous for use in profit-sharing plans where either the employer's contributions or the employees' salaries vary annually. These flexible premium annuities typically offer a stop-and-go provision. This means that the contributions, or premiums, can be suspended and resumed, or decreased and stopped, as circumstances require. The stop-and-go provision can be especially useful in a profit-sharing plan where there are no contributions for years.

Flexible premium annuity policies are generally not purchased in units. Rather, the contract simply states how premiums will be handled, how and under what circumstances expense factors are applied, how interest is credited, and how

benefits are to be paid. Thus, these contracts are much like one of the forms of group annuities, except that only one individual is covered. Premiums can be paid in any amount and at any time (within broad policy provisions). IRAs have a lot to do with expansion of this contract because, as we will cover later, only flexible premium contracts are permitted if the IRA invests in an annuity.

Interest is usually credited monthly, although the interest may be compounded annually. This may consist of guaranteed interest and "excess interest." Unlike group annuities, most individual policies do not recognize "new money" or, if they do, it is in a very limited way. Insurance company total reserve rates reflect many years of investing and may include, as an asset, policy loans that are returning only 5% to 8%.

Expenses are recovered by a "load" and by interest earned on investments above that credited to the contract. The risk of investment (either capital gain or loss) is borne by the insurance company. Like banks, insurance companies have become very proficient at operating on small interest rate spreads. Returning to expenses, the load may be "front-end" or "back-end." Still other contracts offer "no-load" or disappearing termination charges. The following examples will clarify these concepts.

Example 1: Policy #1 provides that for each \$1 of regular premium, \$0.92 will be credited to immediate cash value. This is an example of an 8% front-end load or expense charge, applied on a level basis.

Example 2: Policy #2 provides that the first year premiums will be reduced by 15% (plus \$5 per transaction) and that renewal premiums will be reduced by 3% (plus \$5 per transaction). Any premium increase above the highest previous level will be treated as new first-year premium. This is an example of graduated front-end loading.

Example 3: Policy #3 provides that every \$1 of premium is immediately credited to cash value and therefore begins to earn interest. However, a participant may only withdraw cash value according to a policy schedule. This schedule is called **back-end loading**. For the most part, this assures the insurance company that it can expect to hold the money for a stated number of years, improving its ability to profit on the interest spread.

There is no hard and fast rule to apply in choosing whether an individual or group funding vehicle is most appropriate. As mentioned earlier, an allocated group variable annuity has many characteristics in common with the individual policy pension plan. In general, the individual policy approach will have the following characteristics:

- Individual applications and policies are required for initial coverage.
- Although a guaranteed or simplified issue may be available, some form of underwriting is typically required (where there is an element of insurance).
- Although list or "group" billings may be used, policies are identified and the name of each participant is included.
- Individual policies may have "load" (expense or penalty charges) applied to amounts allocated to the policies. These "load" can be predetermined for the individual so that they have no effect on the individual policy issued to another person who would have his or her personal "load" applied to their policy.

- Increases and decreases in coverage are handled separately by the participant and may require additional applications, underwriting, policies, and related expenses.
- Dividends paid on participating policies will usually not be the same for two participants, since they are dependent upon age, sex, or policy features.

Historically, individual funding vehicles have had lower fees and interest rates, plus higher commission and other expenses as a percentage of premiums paid. This is due to the differences noted above and reflects the very low levels of premium that are accepted. Recently, however, the individual policy pension market has become more competitive. Older policy types such as retirement annuities (fixed premium) and retirement income policies (fixed-premium endowment at normal retirement) have all but died out, having been replaced by flexible, higher return, lower-expense contracts.

Some companies used cutoff points for separate appropriated funding for pensions. For example, 25 lives and a \$25,000 premium was often used as a benchmark. Anything at or above this level of the plan was reviewed for group funding. Some practitioners feel that it is not necessarily incongruous to have several hundred participants covered by individual policies if this approach satisfies the objectives of the plan participants.

Funding with Trusts, Insurance and Annuities: Part 4

Split-funded and combination-funded pension plans, especially if trustee, can purchase a wide range of policy forms. The trend is now for insurance companies to use an "open rate book" approach to policy underwriting. That is, as long as the policy is applied for by a plan trustee, any policy will be issued as applied for. If the insurance company later administers the plan, additional restrictions are applied.

Some carriers, on the other hand, offer pension clients a special series of split-funded life insurance products, which have been specially developed for this market. Usually, they reflect one or more of these factors:

- **Mortality.** Those covered by pensions are relatively better off and may live longer.
- **Interest on reserves.** Due to special income tax provisions, insurance companies pay less tax on earnings attributed to qualified reserves.
- **Guaranteed or simplified issue.** If offered, this may be considered, especially if limits are very liberal and no extra charge is made. Policy issue may be less expensive.
- **Administration expenses.** In earlier days most companies did "free administration" to attract premiums. As administration and personnel costs have gone up, the trend has veered away from this practice. However, the ultimate cost of handling a pension policy may be different than a personal line, even if full annual administration is covered by a separate fee schedule.
- **Commissions, bonuses, overrides.** To support regional technical sales support personnel, some companies have experimented with split commissions. Due to competitive pressures, most have dropped this practice. However, the basic field expense factors used in developing a pension series may be reflected in the premium or cash values of the policies.
- **Policy lapse rates.** In general, life insurance issued to a pension trust is good business, in that it stays in force until retirement. However, this is less true when turnover is severe and with certain forms of policies. The incidence of lapses may be more level (overall years), rather than concentrated in the first 13 to 26 months.

The net result of all of these factors, depending on the weight given to each, may be a pension policy series with higher, lower, or comparable premium rates as compared with those offered elsewhere in the rate book. However, such policies may offer special riders or underwriting procedures, making direct comparison difficult.

Whole Life Insurance

Whole life insurance has traditionally been the "backbone" of split-funded plans. This is because the coverage provides a level premium rate and permanent protection. Where this will not or cannot be continued beyond retirement, the policy is surrendered for its cash value to supplement other trust assets to provide the retirement benefit. Coverage must be incidental to this retirement objective.

Defined benefit pension plans can use any type of coverage, as long as the total death benefit paid to the beneficiary is equal to, or less than, 100 times the retirement benefit. (There are ways to exceed this limit, but they aren't commonly used.) For safety, the trust is usually the beneficiary.

Defined contribution plans may legally use up to 49.99% (less than 50%) of the contribution to purchase this type of coverage (Life Paid-Up at 65 or Life Paid-Up at age 95, etc.).

Term Life Insurance

The IRS considers term insurance to be roughly one-half of the whole life contract, under an assumption that the whole life contract is half savings element and half pure insurance protection. This translates into the following rules:

- Defined benefit plans can still purchase insurance so that the trust can provide a death benefit equal to 100 times the retirement benefit (or less). Group term life can also be purchased to insure against current death liabilities.
- Defined contribution plans can use up to 25% of the participant's cumulative allocations (employer contributions) to purchase term insurance. Group term is not used because the incidental rules monitor individual premiums.

The disadvantages of term approaches have made them less than popular. For example, policies lapse easily because they lack cash values. In addition, no cash value is generated to help purchase the retirement benefits. Finally, policies may disappear or become prohibitively expensive if they are maintained beyond normal retirement age.

Adjustable Life

Although variations and labels exist, there are actually two forms of adjustable life coverage:

- **Type A** is a computer-generated policy that meets the face amount, cash value, and premium requirements requested. This is like a super rate book with hundreds of policy types. The computer, for example, may begin with Life Paid-Up at age 95, and if the premium calculations show this to be too expensive, move to Life Paid-Up at 96, 97, 98, and so on. The resultant policy appears, in format, to be "traditional," i.e., it has a cash value, etc.

- **Type B** will "mix" together basic protection and savings via the computer to build a policy. This theoretically gives the computer basic actuarial cost factors, assumptions, profit margins and an interest vehicle to use in assembling almost infinite variations on the whole life concept. One carrier describes this as "uncoupling" cash values from death protection.

Adjustable life is typically not being used extensively to provide death protection under qualified retirement plans. This may be an oversight. Although features may differ, the following may be potential advantages of adjustable life in a qualified plan:

- Multiple policies may be eliminated. If one policy (per individual participant) can be adjusted upward or downward, it may save hundreds of dollars in policy fees.
- Policy lapses may be reduced because the policy can be restructured to continue meeting the insured's needs.
- Storage costs of data may be reduced, since the data is already in the hands of the insured.
- Cash value may build at more favorable rates, and smoothly, under a single policy.
- Non-level amounts may be programmed. For example, increasing face amount with level or increasing premium over the period needed may be programmed.
- The adjustable life structures still allow commissions to be paid more or less at levels customary for whole life insurance.

Adjustable life policies often allow the client to identify the separate pieces of construction of the program. This offers advantages and disadvantages. It allows products to be developed more quickly than otherwise. By using policy forms that have already been approved by state insurance departments, development time is primarily constricted by the creation of mathematical models and computer software that drive the packaging and the development of underwriting and issue guidelines.

Universal Life Insurance

Universal life insurance works along the lines of the "Type B" adjustable life policy. Instead of blending together pieces of the policy and riders, it directly charges mortality expenses to premium flows or against accumulated cash values. One cannot tear the policy into component portions of term insurance, etc. Other than this construction difference, the outward operation of "Type B" adjustable life and most forms of universal life are similar-- it's just that the computer utilizes different legal forms to get the variables needed to program the protection, premium rates, and cash values demanded. Universal life is limited under the incidental death benefit rates to a maximum of 24.99% of the account balance being used for premium payments.

Variable Life Insurance

Variable life insurance is to ordinary life insurance what variable annuities are to retirement annuities. "Variable" refers to the way investment yields, gains, or losses are credited to the policy, typically with an equities base. So, rather than receiving a guaranteed 5% interest plus excess interest, these contracts are "direct recognition" policies. If the stock market does particularly well, one might experience a 20% to 23% return in that year. In its purest form, a severe drop in the investment portfolio could cause cash values to decline. The amount of investment risk passed through to the policyowner depends on contract

provisions (e.g., floor interest rate guarantees or principal amount safety nets) and the nature of the investment portfolio.

In other words, variable life insurance is a level fixed premium investment based product. It is in essence a combination of decreasing term insurance and an investment fund. Under this policy, the amount of the premium is fixed, but the face amount of the policy varies over time with the performance of a fund invested in equities or some other instrument, but the amount of insurance bears the same ratio to the reserve as in a fixed dollar policy.

At the same time, the face amount of the policy never declines below the original amount of insurance. This means the face amount may move upward, but not below the original amount of insurance. Like traditional forms of life insurance, these policies have fixed premiums and a guaranteed minimum death benefit. The cash value of the policy, however, is not guaranteed and fluctuates with the performance of the portfolio in which the premiums have been invested by the insurer.

Variable products are governed in part by the Securities and Exchange Commission; therefore, agents selling variable life policies must also secure a securities license.

Example:

Bill's variable life policy had a \$100,000 face amount. In one year Bill's cash value exceeded \$100,000 and was worth \$200,000 at one time. During this time his policy face amount was increased to \$250,000. In the following year Bill's cash value took a significant decline and was only worth \$5,000. Since his cash value decreased his face amount was lowered back down to the original \$100,000. It cannot be lowered any more than his guaranteed minimum of \$100,000.

Separate Accounts

The variable contract holder bears an investment risk. Because the insurance company is not sustaining the investment risk of the contract, the underlying assets of the contract cannot be kept in the insurance company's general account. These assets must be held in a **separate account**. Any domestic insurer issuing variable contracts must establish one or more separate accounts. Each separate account must maintain assets with a value at least equal to the reserves and other contract liabilities.

Summary: Life Insurance in Split-Funded Qualified Retirement Plan

The need for life insurance is presumed to have been determined. Now the pension specialists are confronted with how best to provide it. Should it be "inside" as part of the plan or "outside" the plan as in the side fund? The outside alternatives include personal insurance, split-dollar, employer-sponsored group life, Section 79, and the retired lives reserve. Inside the qualified retirement plan, the employer can take advantage of specialized underwriting and deductibles contributions. Each approach meets certain objectives and fits certain financial conditions. A combination of more than one approach may be necessary to round out the individual or business program. The correct program is situational and for

optimum cost efficiency should reflect existing benefits, individual and business tax brackets, accumulated and projected estate liquidity and needs, business ownership, and related conditions.

Universal life and traditional cash value life insurance do not receive identical treatment as funding vehicles for tax-qualified plans. Under some plans, for example, twice as much of an employer contribution can be allocated to traditional policy premiums as universal life premiums. This differing treatment relates back to revenue rulings issued by the IRS well before the development of universal life insurance as a viable product and well before the tax code provided a uniform definition of what constitutes an acceptable "policy of life insurance" for federal income tax (and qualified plan) purposes. The unequal treatment of universal life (limited to less than 25% of the account balance under the incidental benefits rules) by the IRS continues, notwithstanding clarification under federal income tax law of which policies do, and which do not, meet the tests for life insurance.

By definition, universal life policy ratios typically differ from those of traditional cash value contracts. Moreover, death benefits under a universal life policy are permitted to change over the life of the policy.

Defined contribution plans not utilizing the 100-times-incidental-death-benefit rule must place universal life in the 25% category under the IRS policy statement. Under defined benefit plans, the 100-times-incidental-death-benefit rule applies. The practical result of this policy is that universal life is treated as traditional ordinary life insurance under a defined benefit plan and as term insurance under defined contribution plans.

Social Security Integration and Pension Enhancement

Social Security Integration

Almost every individual, regardless of whether he or she is a common-law employee or self-employed individual, is covered by the U.S. Social Security system. In most cases, the employer and the employee share the tax payments that support the system. However, Social Security benefits extend to nonworking spouses and children. Although a direct connection between benefits available and taxes paid into the system does not exist, through their contributions to Social Security, employers are helping to provide employees with a retirement program. This discussion will offer you a basic overview of Social Security. In addition, you will learn how to design a plan to take Social Security benefits into account so that high-paid employees receive a better retirement plan than would otherwise be available.

The Integration Concept

The purpose of an **integrated plan**, or one that links an employer's plan to Social Security, is to allow an employer to take credit for his or her contributions toward an employee's Social Security benefits. When combining a private retirement plan with Social Security, the private plan integrates correctly if the employer provides benefits that are no greater than an extension of the employer-sponsored benefit rate found under Social Security. If the combined benefits of the employer's

private plan and Social Security are nondiscriminatory in favor of the employer's higher-paid employees, the plan integrates properly.

The Social Security System

To fully understand the integration concept, it is important to have a basic knowledge of the Social Security system. You should be aware of the following:

- Social Security coverage is mandatory for the majority of employers and employees in the United States. One of the largest groups of employees is comprised of federal government workers. Railroad workers and religious groups and professionals who opt out for religious purposes are large groups that are typically not covered.
- The Social Security system provides a wide range of benefits, including retirement income, health benefits (Medicare), disability and survivor benefits, and a small element of death protection.
- There is no direct connection between levels of contributions into the Social Security system and benefits that the covered individual will actually receive. This is like a private pension plan trying to define both the contribution and the benefit. In the case of Social Security, past contributions have proven to be too low to fund future promised benefits. Therefore, Social Security tax rates and the maximum taxable wage base on which taxes are collected have risen dramatically to cover deficit projections. The primary reason for this deficit is rising benefits based on cost-of-living adjustments (COLAs) for retired workers who paid taxes years ago based on lower wages. As a result, current workers are subsidizing retirees.
- Social Security benefits have historically been fully adjusted for inflation on a regular basis after retirement.
- Hospital insurance and welfare benefits for family members have been built into Social Security. Part A of Medicare (the hospital portion) is available at no monthly charge to persons covered under Part A. Part B of Medicare pays 80% of physicians' and surgeons' fees resulting from office visits.
- The actual dollar amount of Social Security benefits that an employee is eligible to receive depends on a host of variables, such as quarters of coverage, actual retirement age, total compensation earned in a selected number of years, marital status, etc. A private plan that integrates its benefits with specific employee Social Security benefits can expect its plan benefits to vary, even if two employees earn exactly the same salary on the job.
- The rules for Social Security keep changing. To integrate, the plan document must anticipate and address how the process is applied in benefit calculations. The plan actuary must anticipate benefit levels 30, 40 or more years in the future, subject to constant changes made by Congress.
- Social Security benefits and contributions are weighted toward lower-paid employees.

Examples

Let's consider some of the examples that demonstrate these principles:

Example 1: An employee who earned \$20,000 had total contributions to Social Security of \$3,004 (7.51% or \$1,502 paid by her and 7.51% paid by her employer). This total represents approximately 15% of her pay. However, an employee earning \$150,000 had a total of \$7,210 paid into her program--or only 4.8% of total salary (7.51% of only the first \$65,000 compensation by the employee and 7.51% by the employer).

Example 2: Although benefit comparisons must be made on personal circumstances, a married employee retiring at age 65 with \$15,000 in annual earnings could expect to receive a Social Security benefit of about \$771 per month, while an employee earning \$150,000 could expect to receive a benefit of about \$1,551 per month. Thus, even though the second employee earned 10 times that of the other, the expected benefit may only be twice as large.

Example 3: An employee who earns the maximum covered wage base for Social Security each year for ten years may receive more benefits than one who earns significantly more but did so only in the last few years before retirement.

Example 4: An employee who retired began receiving both a pension from Social Security and one from his qualified retirement plan, \$250 and \$100 per month respectively. Due to subsequent cost-of-living adjustments, the total is now \$515 (\$415 and \$100 per month respectively). Based on his final average pay, this low wage earner may actually be receiving in excess of 100% of his compensation. On the other hand, an individual who received \$400 from Social Security and \$1,000 monthly from a private plan, respectively, might now be receiving \$1,665 (\$665 and \$1,000). Thus, the low wage earner's total retirement checks have increased by nearly 50%, while the employee who earned more in wages and benefits has had an increase of only about 20%. This is due to the nature of Social Security cost-of-living adjustments.

Legal Discrimination

Because Social Security weighs benefits toward lower-paid individuals, the employer can adjust this factor by weighting its plan benefits in favor of higher-paid employees. This is one of the tools available to the pension planner for circumventing the 401 nondiscrimination requirements of a qualified plan. In general, these rules forbid disparity in contributions or benefits between highly-compensated employees and all other employees, unless the disparity results from Social Security integration.

Offset Integration

The **offset integration method** can be used with defined benefit plans and is not available for defined contribution plans. Under the offset method, the employer calculates what a contribution to the plan would be if Social Security taxes were not considered. The actual tax or "contribution" to Social Security for the benefit of the employee is then subtracted. Social Security tax contributions, therefore, directly reduce or "offset" the liability on the part of the employer to make plan contributions. In other words, a certain part of the Social Security benefit is subtracted from the retirement benefit promised under the nonintegrated benefit formula.

Maximum Offset

Under defined benefit offset plans, a participant's accrued plan benefit may not be reduced through integration with Social Security by more than the lesser of the following:

- 50% of the benefit that the participant otherwise would have been entitled to under a nonintegrated plan; or
- 3/4% of final average compensation based upon amounts up to the applicable annual maximum taxable Social Security wage base, times the participant's years of service (up to 35) taken into consideration under the plan formula and plan description.

Example:

John has a final-average compensation of \$60,000 and has worked for his employer for 20 years. His maximum offset is \$9,000, calculated as follows: 0.0075 (maximum offset allowance), x \$60,000 (final average compensation) x 20 (years of service).

If John's nonintegrated benefit formula provided for 50% of final average salary (\$30,000), then his integrated annual plan benefit would be \$21,000 (\$30,000 - \$9,000), assuming that his employer used the maximum offset integration possible.

Advantages and Disadvantages

There are a number of advantages to using an integrated plan:

- An integrated plan clearly recognizes the income replacement concept. This is illustrated by adding back together the employer pension benefits with expected Social Security retirement benefits.
- This approach maximizes the effect of integration, in favor of higher-paid employees.
- It recognizes directly the differences in personal circumstances and thus appeals to employers who view a retirement plan as an extension of social consciousness.
- Because the offset is applied once (at retirement), the plan partially self-adjusts for inflation.
- Plan costs may move less erratically with changes in wages due to inflation. This is because wage increases and the expected offset both move in the same direction and dampen or cancel each other.
- The employer can give the appearance of providing generous benefits but, in reality, have fairly low costs. For example, a 60% benefit (less the maximum offset allowance) may sound much larger than a flat 45% at retirement, yet actually may cost less.

The disadvantages of offset plans include the following:

- Results may appear to be inequitable.
- Administrative delays are sometimes experienced while the participant's benefit is determined.
- Plan benefit commencement (normal retirement date) should, ideally, coincide with Social Security retirement. This causes practical problems with a plan that has a normal retirement age of 62.

Integration-Level Approach-Defined Benefit Plan

Defined benefit plans that use the integration-level approach are called **excess plans** or **stepped-up plans**. Here's how the integration-level approach works:

1. A specific level of compensation, called **integration level**, is defined in the plan. The integration level of an excess plan is the level of compensation below which

an employee receives a reduced benefit. Under the basic excess rules, the integration level is based on an employee's "covered compensation."

2. Rather than actually determining each participant's covered compensation, the government authorizes the use of a prepared table, which is then incorporated into the plan. These tables assume that the current monthly salary is representative of all past years. However, the wages defined in the plan (for example, the highest five consecutive years of compensation as final average) will be applied to the table. Actually, these tables are available in short form (Table I) and long form (Table II). Most prototypes use only the short form for ease in administration. Updated tables are produced to reflect cost-of-living adjustments but are only available to existing plans through amendment.
3. The benefit formula provides the participant with a higher rate of benefits for compensation above the integration level (called the **excess benefit percentage**) than for compensation below the integration level (called the **base benefit percentage**). In other words, dollars earned in excess of the integration level carry a higher benefit rate than dollars earned below the integration level.
4. The difference between the excess benefit percentage and the base benefit percentage is restricted by the IRS to protect against discrimination.
5. The maximum difference between the base benefit percentage and the excess benefit percentage is limited. Benefits based on participant compensation over the permissible integration level may not exceed the lesser of the following:
 - Twice the benefits under the integration level; or
 - Benefits under the integration level, plus 3/4%, multiplied by the participant's years of service with the employer, not to exceed 35 years.

An *example* will prove helpful here: The XYZ plan provides a benefit of 0.5% of compensation below the integration level (the base benefit percentage) for each year of service. The XYZ plan cannot provide more than 1.25% of compensation above the integration level (excess benefit percentage) for each year of service.

Integration Level Approach-Defined Contribution Plans

Defined contribution plans may be integrated with Social Security, only to extent that the employer's contribution rate above the integration level does not exceed the lesser of the following:

- Twice the contribution rate below the integration level; or
- The contribution rate below the integration level, plus 6.06% (Social Security tax rate attributable to old-age insurance).

Example:

CCD, Inc. maintains a tax-qualified profit-sharing plan, under which benefits are integrated with Social Security. The company's annual contribution to the plan is based on 8% of aggregate participant compensation in excess of the applicable annual minimum Social Security taxable wage base. Under the plan contribution and integration formula, CCD is required to contribute at least 4% of participant compensation up to the maximum taxable wage base.

Summary

Social Security integration rules are an important planning tool for pension professionals. Integration helps you do a more professional job of retirement planning. A corporate plan may contribute to the owner's account many times the \$4,000 available in an IRA but keep employee allocations within an affordable range. Integration is a logical extension of "needs selling" because Social Security

will partially supplement efforts to provide a satisfactory income replacement level retirement.

When working with integration, the following considerations should be kept in mind:

- An integrated benefit formula is advantageous if a client desires to provide larger contributions for key employees and, at the same time, minimize costs attributable to lower-paid employees. For this reason, most small-sized employers integrate their plans.
- The adoption agreement for an integrated plan will include various integrated formula choices, as well as covered-compensation tables (when applicable).
- Defined contribution plans are integrated less frequently, partly because these plans are not usually intended to neither maximize owner-employee tax shelters nor minimize expenses for other employees. Conversely, the defined contribution plan that is intended to maximize owner-employee tax shelters and minimize rank-and-file expenses (such as the target-benefit plan of the piggyback profit sharing/money-purchase combination) is a likely candidate for integration.

Pension Enhancement Taxation of Qualified Plans

As we've stated throughout this course, one of the primary reasons to establish and participate in a qualified retirement plan is the advantageous tax treatment that these plans are given. The federal government recognized the value of private retirement plans and, in support of a secure retirement for all citizens, "encourages" these plans by providing participating employees and sponsoring employers certain tax breaks. These tax breaks serve as incentives for employers to establish and contribute to retirement plans and for employees to participate in them. This treatment is even extended to individual retirement programs, such as IRAs.

On the practical side, a qualified plan is virtually the only recognized method where tax-favored treatment is provided for the contribution, accumulation, and distribution of funds. There is no question that this tax-favored status holds tremendous appeal to a successful business person and thus can be used as a powerful selling tool by you. If it can be shown that the plan provides additional total dollars for the business owner's personal enjoyment, the sale is even easier. The purpose of this course is to re-examine concepts previously discussed in light of the tax treatment rendered.

Improves Wealth Position

The IRS has ruled that, within specified limits, a retirement plan is a necessary business expense to attract and retain qualified employees. As such, the cost of setting up and administering the plan is a deductible business expense. In addition, contributions made by the employer on behalf of plan participants, within limits, are deductible.

Qualification Requirements for Tax-Favored Status

In order for any pension or profit-sharing plan to be qualified and eligible for favorable tax treatment, it must meet the following general requirements:

- The plan must be written.
- The plan must be in effect.
- The plan must be communicated to the employees.
- The plan must be established by the employer.
- Contributions to the plan must be made by both the employer and the employee.
- The plan must be permanent.
- Any life insurance benefits must be incidental.
- Minimum participation standards of age 21 and of one year of service for eligible employees must be met.
- Minimum funding standards must be met.
- The plan must not discriminate in coverage.
- The plan must not discriminate in contributions or benefits on the basis of income or gender.
- The plan must comply with IRS limitations on contributions and benefits.
- There must be no assignment of benefits.
- Annuity payments must include joint and survivor benefits.
- The plan must meet Social Security rules on integration and on reduction of benefits because of Social Security.
- The plan must meet the rules for multi-employer plans.
- Comprehensive vesting standards must be met.
- The plan must meet the rules of mergers and consolidations.
- The plan must be for the exclusive benefit of the employees.
- The plan must fulfill plan termination requirements.
- The plan must meet special requirements for special plans.
- A top-heavy plan with a high percentage of benefits going to officers or employees must contain contingency provisions that will limit the benefits to be paid.

Tax Treatment of Plan Contributions

The tax treatment of monies contributed to a qualified plan is favorable. Both employers and employees benefit in this regard.

Employer Contributions

Contributions made by an employer to a qualified plan for the benefit of the plan participants are, within limits, deductible by the employer. These limits are imposed to insure that plans meet minimum funding standards and to prevent possible abuse by owner-employees. Many rules govern employer contributions to a qualified plan:

- To be deductible, contributions must be made to an established plan. This means that money set aside on the premise that a retirement plan may be established at some future date, or put into an informal plan, will not be deductible by the corporation.
- Except for certain types of plans (such as SEPs), the plan must have been in existence before the end of the tax year in which the deduction is claimed.
- In general, contributions must be made in cash. ESOPs, however, may be funded directly with employer securities.
- An employer may make a deductible contribution for an existing plan up to the time the tax return is due, including extensions. Rules for specific plan types, however, may differ.
- An employer may deduct only contributions actually required by a money-purchase pension plan. Excess contributions under this and most plan types can be carried over for future deduction.
- Only "reasonable" amounts for funding of a defined benefit plan can be deducted, as certified by an enrolled actuary.
- Plan contributions made by the employer, plus other compensation paid to employees, must represent "reasonable" compensation for services rendered.

- Plan contributions may not be deducted unless the plan is established as a permanent employee benefit. For example, an employer who only declares profit-sharing contributions for one out of several years may risk disallowance of the deduction.
 - Employer contributions to profit-sharing plans are no longer required to be based on current or past (retained) earnings. The astute pension specialists, however, will look beyond the net profit figure to ascertain the ability to make deductible contributions.
 - Life insurance premiums, if paid under the terms of the plan, are 100% deductible, within limits. It may, therefore, be possible to increase the total deduction available under a defined benefit plan by adding life insurance.
 - All reasonable expenses related to plan operations are deductible within statutory limits if paid by the employer. If paid by the trusts, these may or may not result in additional deductions for the employer, depending on the type of plan.
 - The organization must have a business or other qualifying purpose. For example, a bridge club cannot incorporate merely to establish a tax-deductible retirement plan. Associations may have plans; however, each member must have a legitimate business. Qualifying not-for-profit organizations can establish plans.
- Discretionary profit-sharing plan contributions can be made, irrespective of whether the employer is a tax-exempt organization.
- Deductions cannot exceed those permitted under aggregate deduction limitations in Code 404, which limits deductions to 15% of payroll under a profit-sharing plan and 25% of compensation under all other defined contribution plans.
 - Contributions are not taxable to the employee until they are received or made available. These dollars, and the income they earn, are sheltered while in the plan.

Taken as a whole, these requirements should not pose a problem in the majority of situations. However, you should always be cautious when the employer seeks to thwart the purpose of a retirement plan, which is to provide retirement income to a broad base of covered employees. Although it may be popular in some circles to design elaborate schemes involving interlocking corporations, multiple plans with complicated provisions and actuarial models designed to achieve a given end, these tactics may result in the loss of all deductions for the corporation if circumstances justify. In most instances, the additional tax savings under these schemes is not worth the risk.

Employee Contributions

There are three ways in which an employee can make contributions to a qualified plan:

1. Through mandatory employee contributions;
2. Through regular, non-deductible, employee voluntary contributions; and
3. Through salary reductions or deferred amounts under a 401(k) arrangement.

Let's briefly review each method.

Mandatory Employee Contributions

As we discussed earlier, "mandatory" does not mean that the employee must contribute to the plan as a condition of employment. Rather, it means that employees who do contribute receive benefits provided by employer contributions or larger allocations than noncontributing employees. In defined contributions plans, this usually involves a "matching" provision. Employee contributions are not deductible; however, these amounts--and their earnings--are always vested.

Regular Employee Voluntary Contributions

Regular or nondeductible voluntary contributions are treated in a manner similar to mandatory contributions, except that there is no employer matching provision, and the amount of employee contribution does not affect employer-provided benefits. The main attraction is that the account accumulates free of current income tax. Simply put, if an individual wanted to save, this approach is no worse than other methods and is convenient, since it's typically done on a payroll deduction basis. Lastly, it offers reduced acquisition costs because investments are purchased in blocks.

Salary Reductions or Deferrals

Arrangements whereby employees can reduce or defer a portion of their earnings into a qualified plan are generally known as 401(k) plans. These plans are covered later; what we want to review here is the tax treatment of these reductions or deferrals.

Briefly, under these plans an employee is given an option: he or she can choose to take his or her full earnings in cash or elect to defer a portion of those earnings into the plan. Earnings taken in cash are considered ordinary income and are currently taxed. Earnings that are deferred are not considered part of the employee's gross income and thus are not taxed until withdrawn from the plan. It should be noted that deferred amounts are not exempt from Social Security.

Many 401(k) plans include a "matching" provision for employer contributions. For example, for every \$1 that an employee contributes, the employer will contribute \$0.50. Matching employer contributions are not currently taxable to the participating employee.

Deferral into a 401(k) plan is not deductible, per se; this is simply not counted as earned income. The maximum amount that an employee can elect to defer in any one year changes with each year. Any amounts in excess of the approved amount each year indexed by limitation must be reported as taxable income. If the plan participant is a highly compensated employee, his or her elective deferral is limited to the greater of the following:

- 125% of the average elective deferral percentage for non-highly compensated employees; or
- Twice the average elective deferral percentage for all other eligible employees (but not more than two percentage points greater than the average deferral percentage of the other employees).

Taxation of Distributions and Benefits

Before we get into a discussion of the taxation of plan distributions and benefits, it may be helpful to consider a few fundamental rules of taxation in general:

- Tax Rule #1: In general, income that hasn't previously been taxed will be.
- Tax Rule #2: An economic benefit that has a reasonably determinable value may be taxed as though it is paid to an individual or employee as compensation.
- Tax Rule #3: Many states tax income in the same manner as the federal government.

- Tax Rule #4: The same dollar of income should not be taxed twice. Under certain circumstances, this may happen if applicable rules aren't followed.

In keeping with Rule # 4, benefits paid from a qualified plan are usually fully taxable as ordinary income. This is because no taxes were previously paid on the dollars that were contributed by the employer. Employee deferrals into a 401(k) plan will be treated the same way. However, this general rule has some exceptions. Whether a benefit from a qualified plan is taxed, and to what extent it is taxed, depends on what type of distribution it is and what form the distributions take. Distributions can be allowable, premature, excessive, or delayed. Within these categories, distributions can be taken as a lump-sum or as periodic payments. Let's take a look at each.

Pension Enhancements Disability

Almost all plans provide that plan benefits are payable in the event that the participant becomes disabled. If the benefit is paid from (or can be attributed to) employer contributions and is paid as a substitute for wages to an employee who retired because of total and permanent disability, the employee may exclude from taxes up to \$100 per week. For income in excess of \$15,000, this exclusion must be reduced. Beyond this exclusion, which applies until the tax year in which the disabled retiree reaches age 65, the payments are taxed as ordinary income.

If the benefit is paid from employee contributions, then all proceeds as a result of such contributions are received income tax-free.

Death

Death benefits paid from a qualified plan must be considered with both federal income taxes and estate taxes in mind. If payments are made in monthly or periodic installments, the recipient-beneficiary pays income tax on them just as the retiree would. In other words, the cost basis is recovered tax-free; the balance is taxable as ordinary income.

If the beneficiary receives a lump-sum distribution from the plan, he or she is allowed to take an income deduction for any estate tax paid as a result of the distribution.

A \$5,000 exclusion is allowed for death proceeds attributed to employer contributions and paid to a named beneficiary.

The rules pertaining to after-death distributions have been subjected to many changes, with the IRS attempting to achieve equitable treatment for beneficiaries of plan participants, while limiting abuses that thwarted attempts to tax such amounts. For example, a current requirement specifies that where amounts were being paid to a plan participant, any subsequent benefit after death must be distributed at no lesser rate.

Hardship

Hardship provisions can be added to a qualified plan, under which a participant can apply for an interim distribution of funds prior to retirement age. Exactly what

constitutes “hardship” has, until fairly recently, been the subject of much debate. The IRS applies two requirements:

1. The participant must have an immediate and substantial need; and
2. No other immediate resources can be available to meet that need.

Additionally, hardship distributions are limited to the extent they cannot exceed the amount necessary to meet the immediate financial need.

Whether or not a plan participant is qualified to receive a hardship distribution will be determined on an individual basis. This determination of financial need and the amount of money necessary to meet the need must be made in accordance with uniform and nondiscriminatory standards set forth in the plan document. In general, the following situations appear to meet the standards for hardship:

- Medical expenses incurred by the participant (or his or her spouse or dependents);
- The purchase of a principal residence for the participant; or
- College tuition for the participant (or his or her spouse or dependents).

Premature Distributions

A **premature distribution** is any distribution from a qualified plan received prior to age 59 1/2. The tax ramifications for premature distributions can be significant. In addition to the distribution being subject to ordinary income tax, there is a 10% penalty tax imposed on the amount distributed. For example, a 54-year-old man receives a \$10,000 distribution from his company's defined contribution plan. In addition to ordinary income taxes, he will be assessed a \$1,000 penalty tax. The effect of this penalty tax is to place qualified plan distributions on parity with IRA distributions.

There are some forms of premature distributions that are exempt from the 10% penalty tax:

- Distributions made on account of the plan participant's death;
- Distributions made on account of the plan's participant's disability;
- Distributions from state and local government unfunded deferred compensation plans and plans maintained by tax-exempt employers;
- Distributions received by a participant who has attained at least age 55, separated from service with the employer and who has satisfied applicable plan provisions governing early retirement;
- Distributions made for tax-deductible medical expenses;
- Certain distributions of excess deferrals under a 401(k) profit-sharing plan (where the employer or plan administrator returns excess contributions); and
- Distributions to an “alternate payee” (usually a former spouse or dependent child) under a divorce decree.

Excess Distributions

Current law imposes a limit on the total amount of retirement benefits and/or qualified plan distributions that an individual can receive in any one year. Amounts in excess of this limit may be assessed a 15% penalty tax. The burden for paying this tax falls on the participant, as opposed to the employer.

Annual distributions from all sources, including defined contribution plans, profit-sharing plans, defined benefit plans, IRAs, 403(b) plans, and 401(k) plans are limited each year to the greater of \$112,500 (indexed) or \$150,000.

Amounts received in excess of the applicable limits are subject to the 15% penalty tax, which is nondeductible.

Lump-sum distributions based on forward averaging provisions are also subject to the 15% penalty, to the extent that they exceed five times the applicable annual exemptions.

There are some distributions that are accepted from the rule:

- Distributions that are attributable to the participant's nondeductible or after-tax contributions;
- Distributions that are rolled over into an IRA or other qualified plan; and
- Distributions payable at death.

The 15% excess distribution penalty tax is reduced by any premature distribution penalty tax paid by the participant.

Delayed Contributions

As has been noted many times, the primary purpose of a qualified retirement plan is to provide income during retirement. To this end and to prevent the use of retirement plans as a means to indefinitely shelter income from taxes, Congress has mandated that all plan participants must begin receiving plan distributions by age 70 1/2. More precisely, the required initial distribution date is April 1 of the year following the year in which the participant reaches age 70 1/2. Subsequent distributions must be made by December 31 each year thereafter. Furthermore, there is a required minimum amount that must be distributed each year, depending on the type of plan in question.

Participants who do not comply will be subject to a stiff penalty. A 50% excise tax is imposed on the amount by which the actual distribution is effected.

The method by which the minimum distribution is calculated for each type of plan will be further discussed.

Taxation of Pension Plans

Introduction

The qualified retirement plan, in addition to providing for income-tax-deductible contributions, also provides a shelter under which investment earnings can accumulate free of current federal income tax. This means that common stock dividends can be completely reinvested without reduction for tax. Similarly, interest is received free from current income tax and can be compounded at the normal rates of return on tax-qualified plan products, reflecting this tax-sheltered reserve.

There is one major exception to the above rule. A pension trust must pay taxes on investment income under two circumstances:

1. If the investment was purchased with debt; or
2. If the investment is unrelated to the purpose of the plan.

Borrowing against insurance cash values has been held to be debt for purposes of these rules. If cash acquired from the policy loan is used to purchase a Treasury bill (or other investment), the interest received from the investment is taxable, after a \$1,000 exemption, at the rate applicable to the trust as a separate tax entity. If a loan is used to pay insurance premiums (of policies held by the plan), this too may cause such assets to be treated as “debt-financed-property.” However, if the loan purchased pure protection, the return on the investment is nothing. Where loan proceeds are used to partially purchase investment property, the attribution of income to debt-financed property can be onerous. For practical reasons, most trust documents do not authorize the purchase of property with debt or loans against plan assets, including life insurance.

Investment unrelated to the plan is not frequently encountered; however, the rule may be invoked where the plan uses assets for causes that are worthwhile but that are not related to the purposes outlined for the plan. For example, if the trustee used plan assets to run a concession stand for employees, this could be unrelated income. (Note that if the investment generated a low rate of return, it could also be considered imprudent and a violation of other provisions.)

Expenses of Plan Operation

In many plans, the plan operation expenses are paid directly and are deductible as they are incurred. Some expenses may be paid out of trust assets, either with or without later reimbursement from the employer. If reimbursed, it may be necessary for the employer to establish that there was legitimate obligation to incur the expense, in order to deduct the payment. Otherwise, provided that the expense is reasonable, the reimbursement is treated for tax purposes as though it was paid directly.

It is common for certain types of plans to incur some items of expense. For instance, the services of an investment adviser might be paid out of a profit-sharing plan’s assets. This has the effect of reducing the participant’s accounts. Another way of viewing this is that employer contributions are reduced by the amount of such nonreimbursed expenses. These are not deductible because the original contributions have already been deducted.

Increasingly, plan documents carefully outline each category of expense and designate which are to be paid directly by the employer, which are reimbursed to the plan, and which are paid out of trust assets.

Funding Regulations

In most cases, retirement plans are evaluated annually by an enrolled actuary who determines the amount of contribution to be made for that plan year by the employer or plan sponsor. There are specific rules in the Tax Code that must be followed by the enrolled actuary and employer. There are two unique points that bear special attention in this session. These are the under-funded and over-funded qualified retirement plans.

Under-Funded Qualified Plans

An under-funded plan results when the liabilities of the plan (money owed for future benefits of the participants) exceed the value of the plan's assets. This type of situation can result when an employer or plan sponsor finds that a contribution cannot be made because of a temporary financial hardship in the company.

Under the Code regulations, under-funded plans must be reviewed through specific formulas which are applied to measure the unfunded liabilities. These unfunded liabilities must be separated into old, current, and new liabilities. Appropriate funding will be determined by use of these formulas to assure the plan's solvency and to provide for a more rapid funding of the plan.

An employer or plan sponsor can apply to the IRS for a funding waiver if the firm is suffering a financial hardship. Application for the waiver must include a statement that the financial hardship is a temporary one and that all plan participants have been notified of the request for the waiver. Once the waiver is granted, interest will be charged on the unpaid contributions. A security deposit may be required in cases where the deficiency exceeds one million dollars. An employer may apply for three waivers over a 15-year period. Under-funded plans are not restricted on amounts contributed to bring the plan into balance with current liabilities.

Over-Funded Qualified Plans

An over-funded plan, as defined by the Tax Code, is a plan toward which contributions have been made to fund liabilities which do not, as yet, exist. This means that the plan is serving as a tax-free savings account for the employer.

To guard against such activity, the Tax Code again provides for specific formulas to be applied to qualified plans to determine whether or not the plan is over-funded. Under the Code, annual contributions to a qualified plan cannot exceed 150% of current liabilities, with current liabilities defined as all liabilities owed to participants and their beneficiaries.

Contribution Rules

All employers and plan sponsors of defined benefit plans are required to make their annual contribution to the plan in four quarterly installments. If the quarterly installment is not made on the due date, interest will be charged on the outstanding balances. The Code also specifies that a lien can be imposed on an employer's assets for missed contributions.

State and Other Taxing Bodies

Although this discussion has emphasized federal income taxes, a more complete analysis might consider state and local taxes. Although these generally involve fewer dollars than the former, the rates and amounts are increasing. Local governments raise revenues primarily from property or sales taxes. As discussed, another tax increasing at a rapid pace is the Social Security pay-roll tax. Consider that each employee dollar of tax is matched by the employer up to a maximum wage base. Other taxes include the excise tax, license tax, and special assessments.

To analyze all of these taxes goes beyond this course. They are covered here only to suggest that they have a different impact than the federal tax. Where appropriate, the pension specialist might cover this subject with the employer's accountant. The following examples may serve as the basis for further study.

Examples

Example 1: In general, no Social Security tax is paid on contributions made to a qualified plan, even though they are a form of deferred compensation. Subject to change, no Social Security tax is paid on retirement benefits, either. This is one of the only legal methods to avoid this tax (to the extent that the contribution would have been paid as wages below the maximum wage). IRA contributions, on the other hand, are income tax deductible within limits prescribed by the Code. Plans funded all or part by employee salary reduction originally avoided payment of Social Security taxes. However, the Social Security Amendments Act raised this. Profit-sharing contributions that can be deferred at the participants' election are subject to taxation. Likewise, amounts that are elected through a reduction in compensation are subject to FICA taxes.

Example 2: For federal income tax purposes, Employer A may deduct \$15,000 to a qualified plan. However, State Z may limit deductions to \$7,500. This points out that not all states automatically adopt federal provisions. Even though they may later amend their laws to conform, there may be some time lag.

Summary

Because the tax laws provide a number of advantages to the employer and employee, the full ramifications of the taxation affecting the qualified retirement plan are extensive and should be properly delegated to the employer's tax attorney or accountant. However, in summary, these nine general principles apply to tax-qualified retirement plans:

1. Employer contributions and related costs of plan operation are deductible within statutory limits for purposes of federal (and most states) income tax.
2. No state is paid by the individual on employer contributions going into the plan. However, the pure cost of insurance is considered taxable to the participant if provided by employer contributions.
3. Investment earnings accumulate free of current income tax under most circumstances.
4. Proceeds paid in a lump-sum can generally be rolled over into an IRA, allowing the participant or beneficiary to escape taxable receipt until as late as age 70 1/2.
5. Social Security taxes may be reduced or avoided.
6. Proceeds paid from the plan at normal retirement may receive favorable income tax treatment in a lump-sum (five year averaging) or be spread out over the life expectancy of the participant and surviving spouse.
7. Pure insurance death proceeds paid to a named beneficiary may escape both federal income tax and estate tax.
8. No tax is paid on a properly structured loan to a plan participant. Loan interest income is not taxed to exempt trusts.
9. Up to \$1,000 of unrelated business income can be earned with no tax liability. Beyond this amount, the trust is a separate taxpayer entity with its own graduated tax rates.

In addition to the above, there may be state tax advantages to establishing a retirement plan. These generally parallel the comparable federal provisions--but

not always.

The Tripartite Alliance: Part 1

Pension experts over the years have expressed the need for all of us to organize a plan for our retirement. They cite the fact that inflation can have a devastating effect, not only on the nation's economy, but on the hopes, dreams, and ambitions of all who desire to spend their later years in security.

The proper execution of an individual's retirement planning focuses on the fact that there are three sources of funds for a retirement benefit:

1. Social Security;
2. The company retirement plan where a person works (or benefits from a retirement plan where a person used to work); and
3. Personal savings.

Each of these three sources form one unit of a tripartite alliance, which, when blended together at retirement, should provide the necessary benefits for a total of monthly retirement income needed. Much of the rest of this chapter is devoted to discussions of each aspect of the tripartite alliance. However, before we address these sources of retirement income, let's investigate what is recommended monthly income at retirement.

Recommended Retirement Income Benefits

Much has been written about the amount of income needed during the retirement period. Some retirement planning experts state that 60% to 75% of pre-retirement income is sufficient. Others maintain that 100% of pre-retirement income should be the norm, since it is this amount that the retiree and his or her spouse is used to earning to maintain their standard living.

As a partial answer to this question, it can be pointed out that the retirement years need not to be as costly as the pre-retirement period. By this time, children have grown into young adults and have "fled the nest." Usually, the mortgage has been paid off, or the house has been sold with the retired couple having moved to more convenient (and cheaper) quarters. Lastly, the expenses involved in a daily job have also been eliminated. Hence, some degree of cost reduction is involved once the individual and his or her spouse retire.

One study conducted by the Center for Risk Management at Georgia State University indicates that, as the level of pre-retirement income rises, the percentage of income needed for retirement decreases to a point but then begins to increase again.

This percentage increase in retirement income needed as a level of pre-retirement income increases is due to higher expectations of individuals in the upper income brackets who do not plan to lower their standard of living when they retire.

One marked contrast to this higher expectations feature is the fact that Social Security benefits decrease (in terms of a percentage of income) as the level of pre-retirement income increases. As was discussed earlier, Social Security

benefits are actuarially organized so that those in the higher income brackets receive lesser return in benefits per dollar of Social Security tax paid. This places additional emphasis on the employer-sponsored retirement plan and on the personal retirement program of the individual. Let's look at this subject of Social Security benefits, the first area of our tripartite alliance.

Social Security Benefits

The annual amount of Social Security benefits as a percentage of total annual retirement benefits can easily be calculated. The replacement percentage of Social Security benefits decreases as the retirement income dollar need increases. As was also discussed earlier, an integrated plan enables an employer to take credit for his or her contributions to an employee's Social Security benefits. When combining a private retirement plan with Social Security, the private plan integrates properly if the employer provides benefits that are no greater than an extension of the employee-sponsored rate found under Social Security. And if the plan is nondiscriminatory in favor of the employer's higher-paid employees, the plan integrates properly.

To illustrate a plan that provides an extension of Social Security benefits, assume that Social Security benefits credited to an employer's contributions are 37 1/2% of each employee's compensation covered by Social Security. The employer then may install a private pension plan providing retirement benefits equal to 37 1/2% of each employee's compensation in excess of his or her Social Security-covered compensation. Thus, if an employee earns \$15,000 a year and Social Security benefits are based on the first \$7,800 of compensation, the employee would receive 37 1/2% of salary in excess of \$7,800 in retirement. Under this type of plan, only employees earning above the "covered compensation" level receive benefits from the plan. Under this illustration, the excess benefits are limited to 37 1/2% of salary above the employee's compensation covered by Social Security. A plan may, however, provide benefits greater than 37 1/2% if proportionate benefits are given to all employees regardless of earnings. A plan providing benefits equal to 10% of an employee's compensation covered by Social Security, plus 47 1/2% of his or her excess compensation, would also integrate properly because the combined benefits of Social Security and the private pension plan provide a proportionately equal benefit for all employees.

The net effect of these mathematics is that the higher-paid individual, earning the maximum taxable wage base and paying the maximum amount in taxes, receives a smaller percentage of Social Security benefits than the lower-paid participant.

Assuming that Social Security taxes remain level over a 40-year period, these two individuals would have combined (personal and employer FICA) taxes paid, with benefits paid.

These comparison percentages mean that the individual with consistent compensation of \$20,000 per year over a 40-year period receives \$1.37 in benefits for every dollar of FICA taxes paid. However, the individual at a consistent compensation of \$50,000 per year over the same period will receive \$0.70 in benefits for every dollar of FICA taxes paid.

This shift of Social Security benefit income, while welcome as an integration tool in the design of an employer-sponsored retirement plan, pulls Social Security dollars away from highly compensated upon retirement, thus placing additional emphasis on the employer-sponsored retirement plan, the personal retirement plan, and the personal retirement income program of the individual employee.

Employee-Sponsored Plans

Earlier we discussed the example of Larry and Jane, both 55 years old, who plan to retire in ten years with an inflation-adjusted monthly benefit of \$3,400 per month (\$2,100 per month in today's dollars).

If Larry is currently earning \$60,000 per year and is the sole income earner of his family, how should the employer's plan be set up to provide its share of Larry's retirement income goal?

Larry's estimated Social Security benefit at age 65 is \$1,005 per month, plus an additional \$502 per month spouse benefit for a total monthly benefit of \$1,507.

If Larry were to represent a typical employee in that age bracket, and there were 75 employees within 10 years of retirement, it can be easily seen that a gross annual investment of well over three-quarters of a million dollars would have to be made each year just to fund the benefits of these 75 employees.

However, as we discussed briefly in the chapter on plan design, there are built-in factors that tend to decrease the amount of contribution needed each year. These factors are mortality, turnover, interest, and salary changes. Let's review them.

The Tripartite Alliance: Part 2

Thus far, we've discussed two parts of our retirement planning alliance: Social Security and the employer-sponsored retirement plan. Depending upon income before retirement, these two elements should make from 60% to 70% of needed retirement income.

The Need for Planning

Janet Townes wants to buy a new sweater that became popular at her junior high school. A few years later, she takes a job at a supermarket to earn enough money to buy and maintain a second-hand car. Later, married, she buys a home; then she pays for the children's education and, finally coming full circle, saves money on the food budget for sweaters and cars for her children. Now, at age 55, she and her husband sit down to plan for their retirement.

Don't think that our example is one of foolhardy procrastination. What has just been illustrated is that word: reality. Again, the setting of goals during one's lifetime must match the reality of today and the potential reality of tomorrow.

To illustrate, would Janet really want to sit down with a financial planner at age ten to plan for her retirement? Would she really care that one dollar set aside per year for the next fifty years or so would amount to \$2,700 at 10% interest? In reality, current attitudes toward retirement planning run along these lines.

Retirement planning is greeted with a great deal of cynicism and a "why bother" attitude, and this has to change. This is your challenge as a pension specialist: to show that retirement planning is important because fewer than 5% of our population make it to retirement with any degree of financial security. On the contrary, many are heavily in debt and have less than a year's income in savings. It all begins with individual objectives.

Measuring Individual Objectives

Goals reflect our dreams. Dreams won't come true unless they are converted into the substance of dollars and cents. The retirement goal is one of the hardest to measure and convert to an objective. While this chapter is limited to key points, this step is so important that it must be given serious attention.

Because it is one concrete piece of information that is available, the typical objective begins with today's budget. How much is it costing the family to maintain its present lifestyle? This is then adjusted for factors cited earlier. Savings are ignored in this computation. The result is the personal cost of living for this family, based on retirement conditions and goals.

For the moment, assume that this is the first day of retirement. Ignoring interest or inflation, the amount needed would simply be the adjusted monthly amount multiplied by the number of months during retirement. Ignoring the previous guidelines, this might be 20 or 25 years' needs, for illustration purposes.

Inflation vs. Interest Fields

Even a quick calculation may cause a person to recoil. For example, if a person is 65 and needs to maintain a lifestyle that costs \$3,000 every month, a 20-year period calls for \$720,000 (240 times \$3,000).

You may reach for a calculator and point out that at 8% interest, that same sum could yield \$4,800 each month. So why do we need so much money? The answer is that you will need more than you think.

Example:

The Townes figure they can get by on \$3,000 per month. John has become more conservative in his investments and gets 9% on taxable Treasury securities. Because his house is paid for and he and Janet raise some of their own food, he figures that their cost of living will increase 6% next year. For ease in calculations, assume they are in the 28% tax bracket.

What started out to be a required retirement benefit each month turned out to be something less than two-thirds of the amount needed. That's why a true, or net, yield should be calculated when developing retirement planning assumptions.

By further example, the value of 65% annual turns \$3,000 per month for 20 years into \$561,814 and reduces our original needed amount of \$720,000 by \$158,186: a far cry from our projected yield of 9%. Our next section deals with some methods that an individual can implement to build up his or her retirement fund.

Choosing an Investment Strategy

There are certain fundamental steps that can be taken to improve one's chances of a financially secure retirement. The actual product selection should be differentiated from the accommodating legal vehicle. For instance, an annuity or stock is a specific asset that may be used to fund an IRA, a corporate pension, or a private savings program.

While the general suggestions in this course can be used for standard guidance, specific strategies should be reviewed by independent counsel. No specific products are advised. The most powerful tools, appropriate to the timeframe, should be used to the maximum. Risk should be controlled by properly diversifying both strategies and specific investments. As a general rule, in the following paragraphs, the strategies are covered in order of power but also may be less liquid, involved in higher risks, etc. For maximum effectiveness, strategies should be separated by length of time until the goal date. In general, the longer the person can wait without using the money, the greater the risk that can be taken.

Employer Pensions

The part of any employer-sponsored plan that costs the individual nothing is, of course, a welcome fringe benefit. Any matching feature may also be quite high on this selection list.

Example:

Assume that John could contribute up to 6% of compensation to a 50% matched thrift plan. His \$4,500 contribution would then actually be \$6,750. The fund is conservatively invested and yields an average of 8%. At 8%, this \$6,750 could grow to \$246,037 in 17 years.

Real Estate

More fortunes probably have been made investing in real estate than any other single type of asset. This is particularly true for inflationary periods such as the 1970s and the 1980s when rents could be raised, occupancy rates were high, and interest rates--after allowing for tax deductions and inflation--were reasonable. For a period of time, raw farmland increased in value at 18% each year.

Developed property provided so many favorable tax advantages prior to 1987 that overbuild in many cities led to excess supplies of office buildings. These advantages included tax credits on certain property, which were later reduced or eliminated by Congress and the IRS. Currently in place is a system called "ACRS" or the Accelerated Cost Recovery System, which provides depreciation deductions.

Individuals purchasing real estate directly should be aware of the risks. The crash in farmland prices during the 1980s was an example of the "greater fool theory," which, roughly translated, means that you have to find a "greater fool" than you to buy your unwise investment. Real estate is a subject for study in and of itself and is not for every investor.

Annuities

Personally-owned commercial annuities, outside the IRA, TDA, or other tax-advantaged vehicle, currently accumulate values on a tax-deferred basis and therefore can be quite attractive. No deduction is allowed at the time the premium is made. Taxes on income are assessed at ordinary rates on distributions under Tax Code's cost basis recovery rules. A tax penalty restricts distributions before age 59 1/2, with certain exceptions for death and disability. Yields may be lower than comparable taxable vehicles to the extent the insurance company is forced to recognize reserve income on its own tax return. Beyond these sketchy details, other courses should be reviewed in depth for technical details.

Annuities are an ideal vehicle for the period of distribution during retirement. No other investment can legally guarantee an income that precisely lasts for a lifetime. Plus, the cost basis can be recovered out of each monthly check.

Collectibles and Tangible Assets

A few collectibles, notably numismatics (collector grade) coins, have been used for centuries in European countries as a means to preserve wealth. The economic instabilities throughout the world have caused renewed interest in collectibles, gold, silver, strategic and precious metals, commodities, and other tangible assets. Some forms later can be consumed (e.g., fine wine), but most are held for bartering. The most desirable "hard" assets manage to change in value tandem with inflation, thus preserving real purchasing power. However, as an example of the price of gold points out, this relationship is far from guaranteed.

U.S. Savings Bonds

U.S. savings bonds offer deferred interest and total safety. Series EE bonds, if held to maturity, offer floating rates tied into the market.

Common Stocks

During many long periods of time, common stocks have been outstanding investments and an excellent vehicle to save for retirement. Mutual funds have experienced mixed results. Some have managed to outpace the broader market indicators, while others have performed worse than a purely random stock selection. Very aggressive funds tend to trade up to 20% or more for several years--but down 30%, 40%, or even 50% when market enthusiasm cools.

The Tripartite Alliance: Part 3

Few people buy these financial products individually, except perhaps certificates of deposit. In periods of extreme stability, they have offered investors predictable, safe turns. However, interest rate volatility, combined with inflationary expectations, has shaken confidence in long-term commitments. Because these securities compare more inversely to yields, retirement dollars should be invested only under the following conditions:

- The outlook for inflation seems to be steady or lower.
- Interest rates are at or near their recent peak.
- Short-term interest rates are also near their peak.

- Money won't be needed until maturity.
- Other assets are sufficient to hedge against a resurgence of inflation.

Because retirement extends many years into the future, most of the dedicated funding should be intermediate to long-term.

Short-Term Assets

The rate of return on very liquid, short-term, cash-equivalent assets (savings accounts, CD's of 12 months or less maturities, money-market accounts, etc.) is lower than longer maturities, except during inverse yield curves. An inverse yield curve is caused by extreme tightening of the money supply and is generally short-lived.

People will normally demand a higher return on money that they don't expect to get back for a longer period because they give up security in the process.

These types of vehicles are used for extra safety during times of instability. They also offer positive yields during climbing interest rates and rising inflation (but not necessarily outpacing inflation.) During such periods, stock and long maturity bonds can decline. Many mutual funds offer such vehicles for investors to switch into when trouble is anticipated. However, because "trouble" has grown to be more or less constant, many investors have come to treat liquid assets as a permanent strategy. Who can remember when interest rates were 1.5% to 3%?

As can be seen, each of these investment strategies should be reviewed conservatively and should fit in with the prospective retiree's plans for his or her future. For the married individual, the choice also includes a strategy for increasing the retirement benefit expected from the employer-sponsored plan and continuing that increased benefit for his or her spouse. This is known as **benefit enhancement**.

Pension Benefit Enhancements

Pension benefit enhancement has been popularly described as "more bang for the buck." The principle behind the strategy is to choose a higher-paying single-life option or annuity over a joint-life option or annuity as a pension benefit payout. The single-life option will pay higher benefits, since it has been actuarially calculated to pay that higher benefit during the lifetime of the payee. Once the payee dies, the benefits stop. Under the joint-life option, if the principal payee dies, the benefit continues to be paid to the second-named payee. The benefit is less because there are now two individuals receiving a benefit. Under benefit enhancement, the individual purchases a life insurance policy of sufficient face amount to have the monthly benefit paid to his or her survivor, should that individual die.

The following is an *example* of the pension benefit enhancement:

John plans to retire at age 65. He wants to obtain the highest possible monthly benefit for both his wife and himself, but at the same time, he wants to be able to provide for her if he should die.

If he chooses the single-life payment option, the monthly benefit will be \$3,538. Annually, this would be \$42,456. However, this benefit would not be paid to his survivor, since it is a single-life option.

If he chooses a joint and survivor option, the initial benefit would be \$3,000 per month, or \$36,000 per year. Should he die, this would be reduced to 75% of \$36,000 or \$27,000 per year (\$2,250 per month).

If John chooses the single-life option, he can “enhance” his pension benefit by \$538 per month. With this additional \$538, he can use part of it to purchase life insurance or a sufficient face amount so that the \$2,250 per month can be paid to his wife, just as if he had selected the joint-and-survivor option.

In the crudest form, the mechanics of pension benefit enhancement involves taking that 75% of the initial payout of \$36,000 ($0.75 \times \$36,000 = \$27,000$) and capitalizing that amount by a selected rate of return.

An 8.35% equals \$325,000, which represents the face amount of life insurance that John should purchase to establish the fund needed to continue the benefit if John should die. However, this crude method does a grave disservice to John and his wife, since this method does not take into account the federal taxes on the interest that the fund would earn, nor the inflationary pressures that the fund would have to endure over his widow’s lifetime. A more professional approach would be to take these factors into account to determine the true insurance need. In addition, we should also discuss the cost of the insurance itself and its impact upon the clients’ or prospects’ stated objectives.

Calculating the necessary amount of life insurance to properly fund the continued benefit can be a difficult process. This process involves calculating the first years’ needs, the arbitrarily chosen last years’ needs, and then calculate the interim years’ needs, working backwards to the first year. We’ll cover this method next.

Developing an Enhancement Example

For obvious reasons, each pension benefit enhancement case will differ: the client’s or prospect’s goals will vary; the federal tax rate will differ; and the anticipated growth or interest rate will not be the same as in another case.

There are similarities, however, in developing the enhancement example to be presented to the prospect or client. One similarity is the fact that there is a difference in the federal income tax treatment of regular pension benefits and life insurance proceeds. As discussed, regular pension benefits are fully taxable. Hence, in John’s case, the single-life option will be taxed at ordinary income rates.

On the other hand, life insurance proceeds are paid tax free, either as a single sum, or paid out over a series of payments. Only the interest paid when the proceeds are invested is taxed.

The Net Yield Calculation

Earlier we discussed the concept of the true yield and how it is represented by a far different number than the gross yield. This true yield can also be termed the

"net yield" if calculations are performed to account for loss of earnings due to taxes.

For example, if you have a dollar in the bank at 8% interest, and if you make arrangements with the bank to pay the IRS 28% of your earnings each year, your net yield from the one dollar earnings will be as follows:

\$1.00 + \$0.0576=\$1.0576 principal plus net earnings for the year

Simply reviewing the above calculation, you can see that the net yield of 8%, less 28% federal tax, is 0.0576 or 5.67%. To skip past the above five steps, all you have to do is multiply the initial principal by 1.0576 to calculate the year-end net balance.

Inflation Factor

For example, a dollar a day would have to equal \$1.05 one year from now at 5% inflation factor. Our benefit enhancement example will have to take into account this inflation factor by accounting for anticipated increases in the cost of living. This can be handled by allowing for an annual growth factor and using the after-tax investment gain that your initial account earns for the year.

This is crucial because a fund that does not take inflation into account in its design could easily be overwhelmed and eventually be exhausted by the need for additional sums because of high inflation rates.

Let's assume that our account must self-liquidate at the end of three years with a \$5,000 payout. The fund must be established to take into account a 5% inflation rate and an 8% gross yield (5.76% net yield).

If the mathematical gymnastics of the previous section seemed difficult, reread the material because it is important to understand the basics of pension enhancement. There are computer software packages available that can assist you in developing pension enhancement proposals with illustrations. In our discussion, the important thing to understand is the concept of net yield, or the gross yield less taxes, along with the fact that any pension enhancement table must take into account anticipated rates of inflation. The best method of showing pension enhancement would be to show several projected rates of inflation.

An Application of Pension Enhancement

We can show through illustration how our enhancement formulas work. To do so, let's go back to our previous example of John and his wife. As you'll recall, John's single-life benefit would equal \$42,456 per year, pre-tax, or \$3,538 per month, pre-tax. If John should die while he and his wife were under the joint-and-survivor option, his widow would receive a reduced benefit of \$27,000 per year or \$2,250 per month, pre-tax ($75\% \text{ of } \$36,000 = \$27,000$).

Our goal is to enhance John's monthly pension benefit by using the single-life option, thereby gaining for John and his wife an additional \$538 of pre-tax income per month. The pension benefit would also be enhanced by the purchase of life insurance which, if John should die, would pay the face amount tax-free to his

widow, thus replacing the monthly pension benefit John's widow would have received if they had selected the joint-and-survivor option. That's the strategy. Now the challenge is to develop a schedule that details how much life insurance will be needed to provide an inflation-adjusted income, at a selected net yield, over a pre-determined period of time.

A software program can be created to give you year-by-year analysis of what has to be on hand, at the stated rate of interest, to provide the needed funds.

Note that the beginning balance \$534,901 represents the face amount of life insurance that would have been paid and deposited (\$535,000 rounded) at a gross yield of 8% to generate the numbers shown in the illustration.

Costing the Program

There is still one more challenge: How much is this going to cost?

If John waits until age 65 to begin this program, the cost of life insurance could be far more than John's monthly benefit enhancement of \$538. Remember, this \$538 represents pre-tax dollars, and, if taxed at 28%, would amount to \$538 multiplied by 0.28 = \$151(rounded)

\$538 benefit enhancement (per month) minus \$151 federal tax at 28% equals \$387 net benefit enhancement (per month).

The best way to approach this challenge is to begin a program at age 55--ten years prior to John's retirement.

Benefit Enhancement Review

Benefit enhancement can go a long way toward helping solve the problem of having to face the retirement years without enough money. But it has to be carefully calculated, and each case has to be properly designed to fit the goals and the objectives of the individual client.

The previous examples were prepared as if the individual's three-stage retirement program were in perfect order: that the company pension plan reflected enough years of service to adequately provide for secure benefits and that the Social Security program would be intact and capable of providing the projected monthly benefit.

More importantly, the third part of our tripartite alliance, or personal retirement planning, has to involve a great deal of care. Benefit enhancement, as you can see, helps a great deal, but only when embarked upon early enough to properly fund the needed personal program to supplement benefit enhancement.

Summary

As we've seen in this chapter, personal retirement planning can be a complex process that must be initiated as soon as possible. This is demanded of all of us because of the forces of inflation, simple arithmetic, and the necessity of planning for a secure future. Thanks to the three-part alliance of personal planning, Social

Security, and employer-sponsored pension plans, the future can be made more secure. To attain this goal of a financially-secure future, it will take effort, strategic planning, and a zealous attention to detail throughout the individual's working lifetime.

Specialized Products: Part 1

The Individual Retirement Approach

Thus far, we have concentrated on retirement plans that primarily involve the employer as the initiator of the plan and the provider of the funds needed for the employee's monthly benefit at retirement. However, this type of program represents only a segment of the market. We have discussed the needs of the self-employed entrepreneur, the company with less than 25 employees, or those individuals who do not have a retirement plan at their place of employment and who may never have the opportunity to have a retirement plan. Moreover, there are individuals who may be covered by a retirement plan who feel that the future has no ironclad guarantees and want to assume responsibility for a supplemental plan of their own.

Even in circumstances where employees are covered by a substantial retirement plan with a sound history of permanence, individuals do terminate employment. Their benefits are often forfeited when they take positions elsewhere in order to advance their careers. Trying to earmark funds for retirement is difficult for the following reasons:

- The money must come from after-tax dollars.
- After the savings accumulate to a fund of some size, they are still taxed.
- Interest and dividends become a restricting factor.
- The temptation to use the savings to cope with inflation and current financial needs is too great to resist or avoid.

It is for these reasons and more that an individual may have a hard time saving for retirement. However, many wage earners and self-employed persons can provide for their own retirement (or supplement an employer's plan) with an individual plan that offers these five outstanding features:

1. Income tax-deductible contributions within the limits of law;
2. Accumulation of interest and dividends free from current income tax;
3. 100% vested benefits;
4. Fund transfers from one financial institution to another; and
5. Withdrawals restricted from distribution before the age of 59 1/2 to encourage "forced savings."

In short, an individual plan offers most of the advantages of an employer-sponsored plan. Let's begin with a discussion about IRAs.

Individual Retirement Accounts

Since individual retirement accounts, or IRAs as they are called, were first established by Congress in the 1970's, the total account balance has grown to hundreds of billions of dollars. To be sure, amendments to our tax laws were somewhat limited to access the market, but it has changed as the nation's financial industry met the initial challenge of public confusion with a strong education program that explained just what was permissible under the law. Now what is needed are equally strong creative marketing strategies designed to

convince the skeptical that individual retirement accounts are, and always will be, a sound and prudent path to secure retirement. We will discuss the following:

- The purpose and definition of these plans;
- Tax advantages;
- The establishment of these plans and participation rules;
- Contribution limits;
- Tax regulations on contributions and distributions;
- Rollovers; and
- The reporting and disclosure requirements.

IRAs Defined

In simplest terms, an IRA is a method by which a qualified individual can divert a portion of his or her earned income for retirement and gain some distinct advantages. IRAs are long-term programs and should be established and maintained only on that basis. As you will see, the provisions of the law that govern IRAs discourage the use of them for short-term purposes. An individual establishing an IRA should plan to make contributions to it consistently over a long period of time, from the time the plan is opened to the time the individual retires.

There are many vehicles that are acceptable for the investing of IRA assets. The law purposely imposes few restrictions in this regard, leaving the decision in the hands of the individual IRA participant (or plan trustee), who can make the selection based on individual need and objectives. The common types of IRAs accounts include the following:

- Individual fixed dollar retirement annuities;
- Individual variable retirement annuities;
- A bank time deposit account;
- A savings and loan fixed term savings certificate;
- A savings and loan savings deposit;
- An insured credit union account;
- Mutual fund shares;
- Common trusts funds or common investment funds; and
- Self-directed brokerage accounts;

Financial products not permitted to serve as IRA accounts are life insurance contracts and collectibles such as stamps, artwork, antiques, and precious gems.

Tax Advantages

There are two prime tax advantages to be gained from an IRA:

1. Most IRA contributions are tax deductible. This means that they can be made and deducted from gross income, with no taxes due or payable. Thus, these savings are tax-deferred until distributed. (Some contributions will not qualify as deductible, the reasons for which we will discuss later.)
2. All IRA earnings (whether they are attributable to deductible contributions or not) accumulate tax-free. Unlike a savings account, CD, or money market account, annual earnings do not have to be reported, as long as the IRA is maintained as a retirement savings plan.

Example:

Clara is age 40 and single. She has been working for ABD Company for five years. ABD terminated its pension plan last week, and Clara has to now develop a retirement plan of her own. Based on her gross income of \$29,550 a year, Clara finds that a \$2,000 annual contribution to an IRA provides this tax reduction benefit. The tax savings of \$560 really represents a “subsidy” from Uncle Sam. In effect, the federal government allows an IRA participant the privilege of not having to pay immediate tax on the \$2,000 (which assumes a 28% income tax bracket). This reduces the out-of-pocket \$2,000 contribution by \$560 because the taxpayer would have to pay \$560 in taxes if she didn’t have the IRA.

In addition to the subsidy, Uncle Sam is also allowing the IRA participant the use of a powerful investment tool as she heads down the road to retirement. The \$560 that normally would be paid as taxes can now be used as part of the \$2,000 contribution. This \$560, tax-deferred to begin with, can also accumulate tax-free until received.

Active Participant Rule

In general terms, the active participant rule states that if an individual is an active participant in an employer-sponsored retirement plan and has earned income in excess of certain levels, that person cannot take an income tax deduction for his or her contribution to an IRA. An individual is considered to be an active participant in a retirement plan if he or she “participates in” one of the following:

- A qualified defined benefit plan;
- A qualified defined contribution plan;
- A qualified profit-sharing plan;
- A government-sponsored retirement plan;
- A 403(b) annuity or 403(b) custodial account plan; or
- A simplified employee pension plan.

However, note that there is a second part of the active participant rule: "and has earned income in excess of certain levels." Only active participants who have adjusted gross income above certain levels will see their deductions affected. These individuals are subject to phase-out rules, meaning that as their AGI rises, the deductible amount to the IRA lowers. At the upper end of these income limits, no deduction is available. Active participants whose incomes are less than the range for their categories can make a contribution each year of \$5,000 or 100% of income, whichever is less, and take a corresponding deduction for that amount. They are eligible to make this contribution and to take the deduction even if they are covered by an employer-sponsored retirement plan.

For those covered by an employer-sponsored retirement plan whose income falls within the ranges, the deduction for an IRA contribution is phased out according to the schedule, at the upper limit of which no deduction is allowed. The official rule on the phase-out is rather complicated, but a translation is that, starting at the lower end of the range, for every \$50 increase in AGI, the allowable deduction decreases by \$10.

Taxpayers could construct their own tables showing the decreases in the contribution/deduction limit per \$50 increase in AGI. The important point to remember is that if an individual is an active participant in a retirement plan and

his or her AGI for the year exceeds the upper limits of the filing schedule, that person cannot take a deduction for IRA contributions that year.

One very important point should be emphasized: active participants whose deductions are phased-out or eliminated can still make contributions up to the \$4,000 limit and have the earnings on those contributions grow tax-deferred until they are distributed.

Individuals not covered by an employer-sponsored retirement plan may deduct the full amount to the IRA (limited only by the \$5,000 or 100% of income requirement), regardless of their earned income or AGI levels.

Spousal IRAs

The nonworking spouse of an eligible worker may establish a special spousal IRA, provided that the other spouse has earned income. The eligibility rules for the nonworking spouse are that he or she must have less than \$5,000 per year for earned income or only unearned income. Such a couple could contribute up to \$10,000 per year to 2 separate IRAs based on the income of the working spouse.

Example:

Ralph and Betty open a spousal IRA with their local bank, and it consists of two accounts—one for Ralph, the other for Betty. Their maximum allowable contribution to the spousal IRA is \$10,000, which can be split up in different ways. They must be married on December 31st of the contribution year, and the couple must file a joint return. Lastly, no more than \$5,000 can be contributed to either spouse's separate IRA.

As stated earlier, the above rules apply, whether or not the contribution qualifies for a tax deduction.

Rollover IRAs

Individuals can transfer assets from an IRA or a terminated qualified employer plan to another IRA, provided that certain conditions are met. The new IRA account is called a rollover IRA, and its purpose is to provide flexibility of transfer and investment for retirement savings. Rollover IRAs can be more than one IRA, and any amount of qualifying distribution to the taxpayer can be transferred to a Rollover IRA without being taxed if the transfer is trustee to trustee and within 60 days.

Individuals establishing rollover IRAs can be active participants in an employer's retirement plan. It is best to limit the rollover of a single-sum distributions, which are eligible for a one-time, five-year-forward average election if they are received after age 59 1/2.

Specialized Products: Part 2

All contributions to an individual retirement account are regulated as to the amount that can be contributed and the time limit during which that contributions

can be made. These twin rules hold whether the IRA contribution is deductible or nondeductible.

Time Limit on Contributions

There is a standard deadline for all contributions to an IRA, no matter if the participant is an individual investor, a self-employed person, or a person covered under a simplified employee pension plan. That deadline is April 15th of the subsequent year following the tax year for which any tax deduction applies.

Example:

Bill's 2007 contribution to his IRA is due by April 15, 2008. This deadline applies whether Bill's contribution is deductible or not. If Bill's tax return for the year has already been filed, he still has until April 15 to make the contribution, and if he qualifies for a deduction, can file an amended tax return to claim the IRA deduction.

Form 8606 must be filed by April 15th of each year with the IRS. The purpose of this form is to designate whether the participant's IRA contribution for that year was deductible or nondeductible, thus establishing for both the participant and the IRS which nondeductible contributions will be returned tax-free upon the participant's retirement.

Distribution from an IRA

Distributions from an individual retirement account can take place on an allowable, premature, or excess accumulation basis. Whatever the basis, each type of distribution has its own IRS-approved format and tax penalties if the standards are not met.

Let's take a look at each of these types of distributions.

Allowable Distributions

In general, an **allowable distribution** usually takes place between the ages of 50 1/2 and 70 1/2. During this period, the individual may elect to take a distribution from the account at any time and for any amount. The participant may also elect to make either deductible or nondeductible contributions to his or her individual retirement account during this time period.

There are three methods of allowable distributions:

1. The withdrawal of the entire balance in a single sum;
2. The election of installment options based on the individual's life expectancy or the joint-life expectancy of the participant and his or her spouse; and
3. The purchase of an immediate IRA, single-life annuity, or joint-life annuity from a life insurance company.

The income tax treatment of these distributions depends upon the after-tax or deferred-tax status of the contributions made to the individual retirement account over the years. If the contributions were all tax deferred, the participant's cost basis is zero. (The cost basis represents the amount of after-tax or already-

taxed dollars that the individual participant has invested in the program.) Consequently, if the cost basis is zero, meaning that the fund consists of contributions previously deducted, all dollar amounts of the distributions would be treated as ordinary income to the participant and taxed at regular ordinary income tax rates.

If the individual had been making contributions to his or her plan over the years with after-tax dollars, those dollars should be factored out of any distribution, with the remainder taxed at ordinary income tax rates.

If the allowable distribution is made in a single sum, the calculation to determine the tax is relatively easy (assuming that an accurate record of IRS Form 8606 has been maintained). In this case, the total amount of after-tax dollars invested in the plan is subtracted from the amount of gross amount distributed.

Example:

Dolores elected to receive her IRA distribution in a single sum, which amounted to \$178,000. Over the years, she had contributed \$78,000 on a nondeductible or after-tax basis to the IRA. Here is the taxable amount of her single sum distribution:

- \$178,000 total distribution
- \$78,000 after-tax dollar investment
- \$100,000 taxable distribution

You should note that single sum IRA distributions are not allowed the preferential treatment accorded to other retirement plan distributions, such as ten-year averaging.

Premature Distributions

A **premature distribution** of an IRA is any distribution of funds that occurs before the participant reaches age 59 1/2. Unless otherwise accepted, a premature distribution is subject to a 10% penalty tax.

Exception distributions made due to the following circumstances are not subject to the penalty:

- The participant's death;
- The participant's disability;
- The participant's divorce;
- A rollover distribution;
- The purchase of an immediate annuity; or
- The correction of an excess contribution.

Death Benefit Distributions

An IRA participant may designate a beneficiary to receive the IRA benefits in the event of his or her death. As stated above, a distribution of a death benefit from an IRA will not be considered a premature distribution, although the beneficiary will have to report the IRA proceeds as taxable income that year.

To soften the tax effects, a beneficiary can withdraw the IRA balance in the deceased's account over a five-year period after the death of the participant. There is no required method or timing schedule that must be followed; however, the entire balance must be distributed by the end of five years. A beneficiary who is a surviving spouse can select one of the following withdrawal methods:

- Withdraw the funds over a 5-year period;
- Take advantage of the IRA rollover provisions; or
- Withdraw the account over his or her life expectancy.

Disability Distributions

A **disability distribution** is permitted prior to age 59 1/2. To establish proof of disability (For these purposes, "disability" means the inability to engage in any substantial gainful activity.), a participant must submit to the IRS a medical report certified by a licensed physician, along with a completed IRS Form 2440. Once accepted, the participant may elect any of the withdrawal options discussed under normal distribution methods.

Note that while the disabled IRA owner avoids the premature penalty tax, no other tax relief is available. The full amount of any distribution is taxable as ordinary income.

Divorce Settlement Distributions

If a distribution from a participant's IRA has been ordered as a result of a **divorce settlement**, the former spouse receiving the distribution can elect to take funds under two options:

1. He or she can take the entire distribution and report it as ordinary income for that tax year; or
2. He or she can roll the IRA over to another IRA.

Rollover Distributions

Rollover distributions can be allowed. However, the handling of a premature distribution through the use of rollover carries with it a very special set of rules and methods.

Distribution to Purchase an Immediate Annuity

The 10% tax penalty imposed on premature distributions is also waived when a **life annuity contract** is purchased before the age of 59 1/2, even when payments begin prior to this age. The annuity must provide equal payments over the lifetime of the IRA owner and his or her beneficiary.

Correction of an Excess Contribution

An excess contribution to an IRA or SEP can occur under many circumstances. The most common would be to have an excess over the \$5,000 deposit into an IRA account. An excess contribution is not entitled to a deduction from gross income and is, by itself, subject to a 6% penalty tax. It could also, if not handled properly as a return to the participant, be subject to a 10% penalty tax as a

premature distribution if, for example, it is allowed to remain in the IRA or SEP-IRA, and is then distributed to the participant.

The tax code allows for a correction of an **excess contribution** to an IRA or SEP-IRA if the excess contribution is returned before the tax filing date and no deduction is taken for excess contribution. If the excess contribution has earned investment income, the income must be distributed with the return of the excess contributions and must be included in the individual's gross income for that tax year.

Excess Accumulation

As stated earlier, IRAs were approved by Congress as a source of retirement income for participants. Part of the legislation authorizing IRAs included the regulation that distributions were to be taken (or withdrawn) between the ages of 59 1/2 and 70 1/2. If, after age 70 1/2, withdrawals have not been taken from the IRA account, the account is subject to **excess accumulation and distribution excise taxes**.

IRS regulations state that distributions from an IRA account must begin no later than April 1 of the year following the calendar year in which the covered individual attained the age of 70 1/2. The first distribution from a plan can be delayed until April 1, but subsequent distributions must be made by December 31 of each year after the age of 70 1/2.

To further understand these regulations, we must first discuss the **minimum distribution**. This is the amount that IRS tables indicate is the life expectancy for individual payouts and joint-life payouts. The account balance at age 70 1/2 is used as the base amount from which, through the use of these life expectancy multiples and divisors, the minimum distribution is calculated.

This minimum distribution amount is equal to the amount that is supposed to be paid continuously over the life-expectancy of the individual--or the individual and his or her joint-life beneficiary of the IRA funds. When benefits are not distributed in accordance with these rules, the result is an excess accumulation. An **excess accumulation** is the difference between the amount that is supposed to be distributed and the amount that was distributed. An excess accumulation carries a penalty tax of 50%.

Example:

John reaches age 70 1/2 on May 1, 2007, and has not, as yet, withdrawn any funds from his IRA. He is single. Based on the IRS life expectancy tables and his account balance, John's minimum distribution for the year in which he attains 70 1/2 is \$7,500. This amount must be distributed by April 1, 2008. A second distribution of \$7,500 must also be made to John by December 31, 2008.

If we assume that John only takes \$1,500 for each of these distributions, his excess accumulation penalty would be calculated as follows:

$$\$7,500 - \$1,500 = \$6,000 \times 50\% = \$3,000 \text{ (first distribution)}$$

$\$7,500 - \$1,500 = \$6,000 \times 50\% = \$3,000$ (second distribution)

A total of \$6,000 of excess accumulation excise taxes would be imposed on John.

Excess Distributions

Closely related to the excess accumulation rule is the rule concerning **excess distributions**.

The IRS Code states that the aggregate of all retirement amounts payable (from a qualified employer-sponsored retirement plan, from an IRA, from a SEP, and from a 403(b) plan) to a single individual cannot exceed the greater of \$150,000 or \$112,500 (indexed) in any one year. In the case of lump-sum distributions, the limitation is applied separately to the lump-sum and is increased to five times the annual amount.

The amount by which total distributions in any one year exceed this greater of the \$150,000/\$112,500 (indexed) limit is an excess distribution. Excess distributions are subject to a 15% penalty tax.

Specialized Products: Part 3 Rollover Requirements

One of the most important areas of individual retirement account management is rollovers. Before an IRA participant can request a rollover, he or she must first be aware of the rules governing rollovers. An IRA rollover is subject to the following conditions:

- Rollovers must be of "like kind." This means that the proceeds of one IRA can be rolled over into another IRA. As in our example, a person could be seeking a shift of investments, as in the case of rolling over a certificate of deposit IRA to a mutual fund IRA (or the reverse). Rollovers of qualified plan accounts must be handled under a different manner.
- After a transfer is made, no additional rollovers can be made within the following 12-month period. A trustee-to-trustee transfer or a rollover from a qualified plan to an IRA does not count as a rollover for purposes of the one-year time restriction and may be made at any time.
- The rollover IRA receiving the transfer of funds must be established and maintained by the same individual as the owner of the IRA making the distribution.
- The amount rolled over must contain no funds other than those received by the distributing IRA.
- The transfer must be completed within 60 days after a distribution is received from the distributing IRA.
- A statement of intent by the owner to the trustee, custodian, or life insurance company to transfer the assets must be made.
- If property other than cash is to be distributed from the IRA, the same property must be rolled over to the new IRA. For example, you cannot take a stock distribution from one IRA, sell the stock, and then rollover the proceeds from the stock sale to the new IRA.
- As stated earlier, a rollover must occur within 60 days of distribution. This means that a person could request a distribution from his or her current IRA, invest the proceeds in another investment for 59 days, and then roll over to another IRA on the 60th day. Any earnings gained during the 59 days must be kept separate from the distribution and reported as ordinary income.
- A participant can roll over the entire amount of the distribution or retain part of the distribution and rollover the remainder. The amount retained, however, must

be reported as ordinary income for that tax year and could also be subject to a 10% penalty if it is deemed to be a premature distribution (i.e., the participant is less than 59 1/2).

- A person is allowed to make a rollover contribution after age 70 1/2.

Example:

John Smith, age 43, has held a mutual fund IRA for the last eight years and has now lost his patience with the low rate of return he is earning on his investment. He wants to make a change to a certificate of deposit IRA, which carries a guaranteed rate of interest.

He can accomplish this objective by making a written request to his IRA sponsor (i.e., the bank or financial institution acting as his custodian of the funds), to distribute the funds credited to his account. This request must indicate the amount of the distribution and the reason why the request for distribution is being made. The IRA sponsor will then complete a distribution form that details the transaction, attach John's request forms, and forward all of this material to the IRS. The sponsor will then distribute the funds.

Once John receives his distribution, he has 60 days in which to roll these funds trustee to trustee into his CD account. If these funds do not roll in the 60 days, John will be subject to 10% distribution penalty, as well as ordinary income tax on the full amount of the distribution. However, if John complies with the rollover rules, no taxes will be imposed.

This example, while somewhat oversimplified, represents one of the most requested types of rollover transfers. The other, a request for rollover funds from a qualified pension plan to an IRA, can also be accomplished--but through another channel.

Transfer Rules: Qualified Plan to IRA Rollover

Most often a distribution from a qualified pension plan occurs when a plan participant retires and begins to look at his or her options as to what can be done with the account balance. Another common distribution occurs when the participant terminates his or her employment prior to retirement. In addition, the plan itself may have been terminated by the employer. Whatever the reason, if a distribution is not handled correctly, serious tax consequences could occur with funds that should be earmarked for future economic security.

If a participant elects to take the distribution in cash, he or she must declare that the distribution is ordinary income for that year. If the person is less than 59 1/2, the distribution could be defined by the IRS as a premature distribution, and the participant could be assessed an additional 10% penalty tax.

The IRS does allow two avenues of tax relief:

1. If the plan participant was age 50 or over as of January 1, 1986, taxes on the distribution could be calculated on the basis of five-year averaging or ten-year averaging.
2. A person receiving a single-sum distribution from a qualified plan could elect a tax-free rollover to an IRA. This tax-free rollover will occur if the rules applicable

to IRA to IRA rollovers are followed (i.e., the 60-day, same property rules), in addition to meeting the direct transfer rule.

Direct Transfer vs. Conduit IRAs

Earlier we discussed the fact that an IRA participant can transfer the funds of one IRA account to another IRA account. There are times, however, that he or she cannot transfer the assets or funds from a qualified retirement plan to another qualified plan directly. A conduit IRA must be used.

In this instance, a conduit IRA can be viewed as a temporary account into which the qualified plan distributions can be deposited and then rolled over into another qualified plan.

This can be accomplished on a tax-free basis under the following conditions:

- The amount received from the qualified plan is a lump-sum distribution or a termination distribution.
- The funds are transferred to a conduit IRA within 60 days after the individual receives the distribution, and all previously non-taxed deductible funds on deposit in the qualified plan (i.e., personal deposits contributed to the qualified plan) are withdrawn within one tax year.

A tax-free rollover is also available for distributions of 50% or more of the balance of the participant's qualified pension, profit sharing, or 403(b) plan. However, once transferred, the balance remaining in the participant's account loses its tax-favored treatment, should it be withdrawn at a later date.

Application of the Conduit IRA

The most common application of the conduit IRA occurs when an individual terminates his or her employment and receives a distribution from the retirement plan. This distribution could be moved into a conduit IRA, then moved to another qualified plan once the individual completes any applicable eligibility "waiting period." As seen before, the purpose of the conduit IRA is to receive the favored tax treatment underwritten by the Tax Code.

If that participant joins a new company and is covered by a new retirement plan that accepts rollover contributions from an IRA, these funds could be moved to another conduit IRA and then transferred into the qualified plan. However, if the participant has made any contributions to the IRA during the intervening period, he or she cannot roll over the IRA to a qualified plan.

IRA Disclosure Rules

As in the case of an employer-sponsored plan that must meet the disclosure rules, an individual contributing to an IRA is subject to IRS disclosure requirements, especially in the years in which a rollover occurs or in which the participant is subject to a penalty tax.

Individual Reporting Requirements

There are three tax reporting forms that IRA participants use to provide required information to the IRS:

1. **IRS Form 1040.** This is used to report annual deductible contributions to an IRA and any distributions, as well as taxable amounts of distributions or rollovers.
2. **IRS Form 8606.** When a participant makes a nondeductible contribution to an IRA, it must be reported on this form. In addition, he or she must also furnish information on the total amount of nondeductible contributions from previous years and the total balance in all IRAs at the close of the year.
3. **IRS Form 5329.** This form is used to calculate the amount of penalty taxes due to excess contributions, premature distributions, and excess accumulations.

Educational Review

This session will focus on qualified retirement plans, their features and benefits, and tax considerations. You will hear me use the terms employer and sponsor interchangeably, so just be aware that both terms refer to the same thing.

Retirement plans provide a way for your clients to save money during their working years so that they will have funds available once they retire. There are two main types: qualified and nonqualified. Qualified plans come with tax benefits, while nonqualified plans do not. Qualified plans are almost always sponsored by an employer and provided as a benefit to the employee.

There are federal requirements for a plan to be qualified. First, the plan must provide a benefit exclusively for employees and their beneficiaries. It must be formally written and clearly communicated to employees, and it cannot discriminate in favor of the officers, stockholders, or highly-paid employees. A plan must be permanent, approved by the IRS, and must have vesting requirements. Vesting is the employee's nonforfeitable rights to money that an employer puts into the plan. It is expressed as a percentage of the total amount in the plan and is typically determined by the number of years that the employee has been in the company.

For example: Let's say that you work for a company with a qualified retirement plan. You put 3% of every paycheck into the plan, and your employer contributes an equal amount. The plan states that you will be 50% vested after 3 years of employment and 100% vested after 5 years. So, if you quit your job after 3 years, you will be entitled to keep 100% of the money that you contributed to the plan, but you can only keep 50% of the money your boss put into the plan. If you quit during your fifth year, however, you would be entitled to keep 100% of your contributions and 100% of the employer's contributions.

Furthermore, let's say that you contribute 3% per year for 3 years. During year 4, you are barraged with unexpected expenses. You can tell your employer that you would like to discontinue your contributions until you get back on your feet. There will be no penalty for this. The money that you have already contributed will continue to earn interest, and you can start contributing again at any time.

Now let's talk more specifically about taxes. When an employer sponsor chooses to provide a qualified retirement plan, the employer contributions are tax-deductible. So, when you contributed 3% of your paycheck and your boss matched that amount, your boss could deduct that contribution from his or her taxes. And the 3% that you contributed was basically disregarded from your income. In other words, if you make \$30,000 a year and contribute \$5,000 to your retirement plan, only \$25,000 will be subject to taxation.

Now, the money in this account is going to get invested, and it will earn interest. This interest will grow tax-deferred, so you won't have to worry about paying taxes on the money while it is growing. But the golden rule of taxation is that earned money must be taxed at some point. If you don't pay taxes on it while it is growing, then you'll have to pay taxes on it when you withdraw that money from the plan.

There is an advantage to this arrangement, though. You may be in a much lower tax bracket after you retire and your income has been reduced. So, in the end, the overall hit that you will take from taxation will be lower.

But what if you don't want to wait until retirement to use that money? You can do this, but if you are younger than age 59 and a half, you will have to pay a 10% early withdrawal penalty. And, as with other investment products, there are exceptions to that rule. There is no penalty if you take the money as a loan, if you transfer that money to a different retirement plan, or if the money is taken as a result of death, divorce, or disability.

Just as you will be penalized for withdrawing the money too early, you will also be penalized if you wait too long. You must remove some of that cash value by the age of 70 and 1/2 in order to avoid penalties.

Essentially, employers will choose a qualified plan because of the tax advantages, while employees will choose to participate because they won't pay income taxes until they begin receiving distribution payments after they retire.

So what types of plans are available?

We'll talk about the most common employer-sponsored plans. Each one has contribution limits that you will need to know when you're talking with your clients, but for the licensing test you'll want to be comfortable with the differences.

Individual Retirement Accounts, also called IRAs, are available to anyone with earned income who is under the age of 70 and a half. A person with an IRA can contribute 100% of earned income, up to a specified amount. That limit is set by the IRS and changes almost every year. Now, a married couple can contribute double that amount, even if only one person earns income. However, each must maintain a separate account that does not exceed the maximum individual limit. For a taxpayer who is over 50 years old, it is permissible to make extra contributions—specifically about \$1,000---beyond the typical limit. This is called a catch-up contribution.

Those who do exceed the maximum contribution limit for a traditional IRA will be penalized 6%.

You learned earlier that in order to set up an IRA, an individual must be earning income. In this case, earned income includes salary, wages, and commissions. It does not include income from investments, unemployment benefits, or income from trust funds.

Any contribution that an individual makes to a traditional IRA is tax-deductible for the year of the contribution. An eligible person not participating in a qualified retirement plan can take a full deduction from taxable income, up to the maximum limit. A participant in another qualified retirement plan is subject to income limitation tests to determine how much of that participant's IRA contribution is tax-deductible, if any. Those not covered by an employer-sponsored plan are permitted to deduct the full amount of their IRA contributions, regardless of income level.

The last point to examine about IRAs is that if you withdraw money early, you will have to pay taxes on that withdrawal and a 10% penalty, with a few specific exceptions.

A variation of a traditional IRA is a Roth IRA. Roth IRAs differ from traditional IRAs, in that contributions do not have to stop at age 70 and a half, and distributions do not have to begin at that time. A Roth IRA will grow tax-free, as long as the account is open for 5 years.

Roth IRA contributions are not tax-deductible. You can contribute 100% of earned income up to a specific maximum, just as you can with a traditional IRA. You will also pay the same 6% tax penalty for excess contributions.

Roth IRA distributions are not included in taxable income. A qualified distribution, however, cannot be made before the fifth year after the account is created. Examples of qualified distributions include those made after age 59 and a half, those made to the estate or beneficiary upon the owner's death, those made to a disabled owner, or those made to a first time homebuyer. A qualified distribution has no 10% penalty for early withdrawals and is subject to the same tax consequences as traditional IRAs.

Now we'll talk about Simplified Employee Pensions, or SEPs. SEPs are designed for small employers. The employee sets up an IRA, and the employer makes contributions to it. With an SEP, the employee can contribute a much larger amount each year than to a traditional IRA. The employee is always 100% vested in an SEP plan.

SIMPLE Plans are another option for small business. SIMPLE stands for Savings Incentive Match Plan for Employees. To qualify for a SIMPLE plan, an employer must have fewer than 100 employees who earn more than \$5,000 a year. So, if the company has 250 employees and they all earn \$15,000 a year, the company doesn't qualify for a SIMPLE plan.

To qualify for a SIMPLE plan, the employer cannot also have another qualified retirement plan. But why would a company already have a qualified plan in place? It is rare, but it is possible and legal for a company to offer more than one retirement plan option.

Keogh or HR10 plans are for self-employed people or a working partner with 10% ownership who might not be eligible for other qualified plans. Keogh plans can also be an employee benefit for unincorporated small businesses, as long as the employer makes the same contribution to the employee's account as they do to

their own. Unincorporated businesses include sole proprietorships, partnerships, and limited liability companies.

Keogh plans have higher administrative costs than Simplified Employee Pension plans, but they also have higher contribution limits. Distributions from a Keogh plan must begin by the participant's age 70 and a half.

Keogh plans can be set up as Defined Benefit Plan or a Defined Contribution Plan.

Defined benefit plans tell you how much you will receive after you retire. Some Defined benefit plans take the number of years you worked for the company times a contractual amount per month.

Defined contribution plans set how much the employer and employee will contribute to the fund. The employee can determine how the money is invested. The amount that the employee will actually receive at retirement is not set, because it depends on how much interest the invested money earns. Defined contribution plans are the most common because they are cheaper to administer and easier to set up and understand.

Let's move on to two more types of plans: profit sharing plans and 401(k) plans. Profit sharing is when part of the company's profits are shared among the employees through contributions to the plan.

401(k) plans give the employee an opportunity to defer part of their pre-tax income into a retirement plan. So, the employee puts money in, and then the employer will either match that contribution dollar-for-dollar or will contribute a percentage. So, if you contribute 3% of every paycheck, your employer may also contribute that same amount into the plan.

Another important type of plan is the 403(b) Tax Sheltered Annuity, or TSA. TSAs are retirement plans that are only available to specific groups of employees, including nonprofit charitable, education, religious, and 501c(3) organizations, as well as all public education employees.

Remember, each of these plans has contribution limits set by the IRS. The limits vary from plan to plan and from year to year.

So, with all of those plans on the table, how does your client know which plan to choose? Talking with a tax advisor, in addition to an insurance producer, is a good first step. Even though insurance producers are not experts on investments and taxation, there are still some basic questions that you can ask that will help rule out plans that would definitely not work. The tax advisor can take it from there.

Is your client's business a nonprofit or religious organization? Is he a teacher? Does he work for a 501c(3) or charitable group? If so, he may qualify for a 403(b) TSA.

Is your client self-employed? Does she own at least 10% of a business? Is she an employee of an unincorporated business? A Keogh plan may be the answer. If she doesn't need or want the higher contribution limits and doesn't want to pay higher administrative costs, she may choose an SEP instead.

If your client owns a small business with fewer than 100 employees making at least \$5,000 a year, he may choose to set up a SIMPLE plan. However, if the employer already has a qualified plan in place, he is not eligible for a SIMPLE plan.

Now that we have covered what it means for a plan to be qualified, and what plans fall under that category, we're ready to discuss nonqualified plans.

Nonqualified plans are primarily deferred compensation and salary continuation plans. They are nonqualified because they don't need to meet guidelines for participation, discrimination, and vesting that are required of qualified plans. A nonqualified plan doesn't require approval from the government. These plans are used as a means for an employer to discriminate in favor of a valuable employee. Nonqualified plans do accept after-tax contributions.

An employer does not receive the same tax advantages from a nonqualified plan that it would from one that is qualified. An employer is not allowed to deduct contributions to a nonqualified plan until benefits are distributed to an employee. This usually occurs at retirement.

And that describes nonqualified plans in a nutshell. This session was designed to help you learn general information about qualified retirement plans that you will need to pass the licensing test. There are a lot of details to remember, so please continue to study this material on your own, as well.

26. Terms and Definitions

In this section, you will have the opportunity to go over some basic terms and concepts that you need to know as an insurance producer. We'll begin with key terms and definitions, then define a contract and its essential elements, and finally talk about the insurance application process. The information is presented in less formally to aid in understanding and to better help you remember the information.

Before we begin talking about insurance, let's define what the term insurance actually means and its main purpose. The role of insurance is to provide financial protection against losses. In this way, people who seek out insurance protect themselves from financial ruin if anything bad happens.

In the insurance words, a loss is defined as the decrease or disappearance of value of the person or property by a peril insured against.

What is a peril? A peril is the cause of the loss that the person sought insurance for.

Then there are hazards – those are conditions or situation that increase the probability of a loss occurring.

Let's look at an example that specifically pertains to life insurance: smoking, which would be considered the hazard in this scenario, increases the risk of early death, which is the peril.

Finally, there is risk. Risk is an uncertainty or a chance of loss. Keep in mind that not all risks are insurable. Let's say you go to a casino with the hopes of winning some money. You have to spend some of your own money first, right? There is a risk that you will experience loss. This type of loss, however, is considered speculative – there is a chance of loss, but there is also a chance of gain. Speculative losses are NOT insurable.

Insurers will insure only pure risks, or those that involve only the chance of loss, with no chance of gain. This includes death, injury, damage or blame. It breaks down quite easily into the four major lines of insurance: life, health, property and casualty. There are more stipulations: certain characteristics must be present before even a pure risk can be insured.

The loss must be due to chance. Any risk covered by an insurance contract must be due to a loss that was beyond the insured's control. Basically, they couldn't have seen it coming. Think of it this way: If people knew their house was going to catch fire, or that they were going to break their legs, they'd always get insurance coverage right before the incident that causes them to lose something. If everyone did this, the entire insurance business would eventually break down because companies would end up paying benefits all the time. Of course, when it comes to life insurance, the rules are slightly different. After all, everyone knows that they are going to die at some point. However, they don't know the circumstances or the precise time. That is one reason that life insurance still works.

The loss must be definite and measurable. That means an insurable risk must be strictly accountable. The cause, time, place and amount of the loss must be definite.

The loss must be statistically predictable. This involves some of the number-crunching done around the application and underwriting part of the process. By looking at each individual applicant and considering all the information on the application and in the other reports, insurers can predict the mathematical likelihood of a certain loss happening to this applicant when compared to the losses suffered by a huge pool of similar people. Let's look at an example. We're going to exaggerate everything for the purposes of explaining this concept. Let's say that, according to an insurance company's statistics, 100 percent of 7-year-old boys with brown hair and blue eyes will trip over their shoes and skin their knees on the first day of spring. So, according to this insurance company, when faced with an applicant who is a 7-year-old boy with brown hair and blue eyes, they can predict that on the first day of spring, he will trip over his shoes and skin his knee. There's nothing mystical about it: They have come to this conclusion based on the statistics. Of course, in the real insurance world, things are slightly more complicated than in this example. But the result is basically the same: Insurers in life and health insurance use mortality tables and morbidity tables to project losses based on statistics and can estimate the average frequency and severity of future losses and set appropriate premium rates.

The loss cannot be catastrophic. This is just a form of self-preservation by insurers. After all, if insurers regularly insured risks that exposed them to catastrophic losses, they'd eventually go out of business. So, unless there are

established limits that insurers can be reasonably certain their losses will not exceed, they won't allow a policy to be written. That's one reason insurance policies will typically exclude coverage for losses caused by war or nuclear events: There isn't statistical data available to support the development of rates that would be necessary to cover these events.

The loss exposure must be large. In part, this goes back to idea of being able to statistically predict the loss. If the insurance company doesn't have a way to group the people who represent the loss exposure with similar risks, they have to way to predict the loss based upon the law of large numbers.

Finally, the insurance must not be mandatory. An insurer cannot be required to issue a policy to each applicant applying for coverage. The insurer must have the ability to require that certain underwriting guidelines be met.

There are also ways to control risk, which I will outline next.

One of the methods of dealing with risk is avoidance, which means eliminating exposure to a loss. For example, if a person wanted to avoid the risk of being killed in an airplane crash, he/she might choose never to fly in an airplane. Risk avoidance is effective, but seldom practical.

Next is risk retention - a planned assumption of risk by an insured through the use of deductibles, co-payments, or self-insurance. To use a metaphor here, the insured decides to "confront" the risk when it occurs.

You can also share a risk. Sharing is a method of dealing with risk for a group of individuals or businesses with the same or similar exposure to loss to share the losses that occur within that group.

Risk Reduction is another method of coping with risk. Since we usually cannot avoid risk entirely, we often attempt to lessen the possibility or severity of a loss. Reduction would include actions such as installing smoke detectors in our homes, having an annual physical to detect health problems early, or perhaps making a change in our lifestyles.

Finally, there is risk transfer. It is the most effective way to handle risk which allows the loss to be borne by another party. And this brings us back to insurance. Insurance is the most common method of transferring risk from an individual or group to an insurance company. Though the purchasing of insurance will not eliminate the risk of death or illness, it relieves the insured of the financial losses these risks bring.

We've established earlier that insurance uses insurance policies or contracts to collect premium funds from individuals into a pool of funds used for insurance claims. So Insurance Policy is a contract between a policyowner (who can also be the insured) and an insurance company which agrees to pay the insured or the beneficiary for loss caused by specific events.

A policyowner is the person who holds the rights and privileges in the policy. While the policyowner and the insured do not have to be the same person, they often are.

Since an insurance policy is a legal agreement between two parties, it is required to adhere to certain minimum standards. There are 4 essential elements to any insurance contract

Number 1: Offer and acceptance. There must be a definite offer by one party, which must be accepted in its exact terms by the other party. For example, in life or health insurance, the offer is usually made by the applicant when the application is submitted with the premium. When the insurer issues and delivers the policy, it has accepted the offer.

Number 2: Consideration. In simple terms, consideration is a promise given by both parties. The insured promises to provide accurate information on the application and pay the required premium. The insurer promises to provide coverage and pay for losses to the extent of its contractual obligations.

Number 3: Competent parties. In order for a contract to be legal, both parties must meet certain requirements. The insurer or its producer must be authorized (or licensed) to write insurance, and the insured must be of legal age, and mentally competent.

Number 4: Legal purpose. Again, in order to be enforceable, the purpose of the contract must be legal and not against public policy.

Another unique characteristic of an insurance contract is the existence of insurable interest, which must exist between the applicant and the insured.

Let's go back to the concept of consideration. If you remember, the consideration on the part of the policyowner is the payment of premium (let's say it's \$100 a month, and \$1,200 a year). Consideration on the part of the insurer is the payment of claims (let's say an insured had a surgery, so the insurance company paid \$20,000 for it). A \$1,200 premium in exchange for a \$20,000 benefit is an unequal exchange. That's because insurance contracts are aleatory in nature. The premium paid by the insured is small in relation to the amount that will be paid by the insurer in the event of loss.

They are also considered contracts of adhesion, where if the insurance accepts the terms of the contract, he or she basically "adheres" to them.

Even though the insured signs the contracts and give the insurer his consideration, what will happen if the insured stops paying the premium? The policy will lapse and the insured has no further obligations to the company. The insurer, however, makes a legally binding promise to pay for losses to the insured. That's why insurance contracts are unilateral - which means only one of the parties to the contract is legally bound to do anything.

Finally, insurance contracts are also considered conditional. As the name implies, certain conditions must be met by the policyowner and the company in order for the contract to be executed.

Now that we've covered insurance contracts, let's take a look at the underwriting process, particularly, the insurance application.

The application is a very important document for insurance underwriters since it is the first source of insurability information.

The application has 3 basic parts:

Part I is General Information. It would include the following information on the proposed insured: name, address, birth date, gender, marital status, occupation. This section of the application will also include the information about the type of policy applied for, the amount of insurance, information about the beneficiary, and information about other insurance coverage.

Part 2 of the application – Medical Information - includes information on the prospective insured's medical background, present health, any medical visits in recent years, medical status of living relatives, and causes of death of deceased relatives.

The last section of the application is called Agent's Report. This section is usually filled out by the agent and includes the agent's personal observations about the proposed insured.

Upon completion, the application must be signed by the agent, the applicant and the proposed insured, if different from the applicant.

What if the application has been completed and signed by all the required parties, but when the insured left, the agent noticed a mistake on the application? Can the agent simply correct it in an effort not to delay the underwriting process? That's a big no-no. The best way to correct an error on the application is ... to fill out a new one, and collect all the signatures again. The agent could draw a line through an erroneous statement, write the correct answer and then have the applicant initial the change. Again, under no circumstances can an agent make a correction without a signature from the applicant.

Another scenario: an application was completed to the best of the applicant's knowledge. Both the agent and the applicant signed it, and the agent submitted it to the insurance company. The company promptly issued an insurance policy. Since the policy was issued with questions left unanswered, the contract will be interpreted as if the insurer waived its right to have an answer to the question. They would be later prohibited from any right of denying coverage based on any information that the unanswered question might have developed. To avoid that, any unanswered questions need to be answered before the policy is issued.

Before we conclude this session, I wanted to make sure that you are familiar with the concept of a material misrepresentation, and that you understand the distinction between a representation and a warranty.

Just remember a simple rule: any statements made by the applicant on the application for the insurance are considered representations, or statements made to the best of the applicant's knowledge. Untrue statements are called misrepresentations. If a misrepresentation could change the underwriting decision of the insurance company, it is considered a material misrepresentation. Material misrepresentations that are intentional are considered fraud and would be grounds for voiding a contract.

A warranty, on the other hand, is a statement that is guaranteed to be true. Statements of an agent or the insurer are considered warranties.

27. General Insurance - Frequently Asked Questions

Take another look at the topics discussed in this chapter. The information will be presented in a less formal structure, which may help you learn and retain the information. It may help to imagine this as a question-and-answer period between a student and a teacher.

Q: *I'm reading the insurance material, but some words don't seem to be used the same way I use them.*

A: Understanding the language of insurance is critical to your success on the exam. You will see some words that you use all of the time in ordinary conversation that have a special “insurance” meaning for the test. You will see some new words that are new to you that you need to learn as “key words” for the exam, so that when you see them in a question you will easily recognize one from the other.

For example the words risk, peril, and hazard are all words that you use often, possibly interchangeably, in normal conversation. For the exam, each has a particular meaning, they are not interchangeable, and it is easy to miss several questions by not having a clear understanding of the differences between them. Risk is simply the mathematical chance that a loss may occur. Peril is defined as the cause of the loss, for example fire. A hazard is something that increases the chance that a loss may occur. The risk of having a fire to your home may be 1 in 100,000. In this example fire is the peril, and hazards would be-old wiring; smoking in bed; improper storage of flammables.

Q: *Are all risks insurable?*

A: No, in fact, there are two types of risks-pure and speculative. All pure risks have only one possible outcome-financial loss. These are generally insurable.

Speculative risks have a possibility of gain or loss. Speculative risks may generally not be insured. Examples of pure risks would be the risk of fire, illness, death, or injury. If one of these occurs to you, a financial loss would occur, and you would not “profit” from them. Speculative risks would include gambling, the lottery, and investing in the stock market. Participating in these might produce either a loss or a gain. When there is possibility of either loss or gain, the risk is not insurable.

Q: *I don't get that law of large numbers thing.*

A: In addition to insuring only pure risks, as we have discussed, there are other requirements for a risk to be insurable, like the law of large numbers must apply. The principle is that the larger the number of similar risks that you have, the more accurate probability statistics become. The mortality tables tell us that 3 out of 1,000 forty year old males will die before reaching age 41. If we had a test group of 1,000 and 4 died, our statistics would be “off” by 1/3. If we had a group of 100,000 we would expect 300 to die, based on the mortality table. In a group of that size, even if 310 died, the margin of error would be much lower. So, if the law of large numbers applies to a given risk, the insurance company may limit the amount of cushion put in the rate for unexpected losses, and pass that savings on to the insured in the form of lower rates. It is also important to understand that the law of large numbers does not help in identifying the size or date of a loss to a

particular risk. It only applies to the losses of the entire group of homogeneous (similar) risks.

Q: *I'm also confused about the different types of hazards. Can you explain the differences?*

A: Physical, Moral, and Morale hazards are each unique. As you recall a hazard is something that increases the chance that a loss may occur. Physical hazards are those that have to do with characteristics of the risk to be insured. In the case of Life or Health insurance, the age and sex of the insured, family and personal medical history, i.e., things that cannot be changed. In the case of Homeowners insurance, the age, construction, and location of the house would be examples of physical hazards. Moral hazards are those circumstances which might lead to an intentional or "caused" loss. Insuring a house for \$100,000 that you only paid \$10,000 for would create a moral hazard. In contrast, morale hazards have to do with carelessness or lack of taking proper care of yourself or your property. Lack of exercise, smoking, being overweight would be examples of morale hazards.

Q: *What is the difference between Stock and Mutual companies?*

A: Both types of companies pay dividends to their "owners". However, there is a critical difference between the dividends from a Stock (non-participating) and a Mutual (participating) company. In the case of Stock companies, who are owned by stockholders, the dividends represent the stockholders share of the profits. As such, they are considered investment income, and are taxable. However, Mutual companies are owned by their policyholders, are technically not for profit organizations, and when they pay dividends are simply returning the part of the premium paid by the policyholder that was not needed to pay the bills of the Mutual Company. This dividend, then, is the return of an overcharge, is not a return of profit, and is not taxable.

Q: *If a company is non-admitted, they cannot do business in a particular state. If that's true, how does "Surplus Lines" insurance work?*

A: There are two reasons why a particular insurance company may be non-admitted or non-authorized. If the company has not filed all of the paperwork and met the financial requirements of the state for admission, they are not allowed to do any business in that state. However, a company who wishes to write only specialty lines of coverage (Life and Health insurance on professional athletes) may ask to be an "approved, non-admitted" carrier, thereby being allowed to write only a special group of coverages known as Surplus Lines.

Q: *Before I started studying insurance, I thought I was buying insurance. But through studying, it seems as if my agent isn't really MY agent, but is an agent of the company.*

A: Because the agent is the agent of the insurance company, legally he or she speaks for the company. The agent's word commits either the company or the agent to doing whatever the agent has said. The agent's authority falls into one of three categories, expressed, implied, or apparent. Expressed authority is given to the agent by the company, usually in the Agent's contract. It may be specifically given orally by an authorized employee of the company. Implied authority is also given to the agent by the company, but here it is in the way the company allows the agent do business on a day to day basis, but isn't actually directly given to the agent. In both of these cases, the claim will be paid, by the company because they

were directly or indirectly responsible for the agent's actions. The third type of authority is called apparent. It is similar to implied, except that in this case, the agent has gone out on a limb of his or her own, without any sort of permission of the company. Here, the customer will still recover, but from the agent, not the company.

Q: *How can I remember the difference between “aleatory” and “adhesion”?*

A: Both of these are characteristics of insurance contracts. Most other contracts do not have these traits. As you know, when you buy an insurance policy, the customer must accept the wording in the policy as given by the company. Because you have no ability to alter or change the wording, if there is any confusion about what is intended by the words, the disagreement is settled in the favor of the insured. This is known as adhesion. The client is “stuck” with the words, and the company is “stuck” to what the judge or jury thinks they mean, not what the company intends for the words to mean. Aleatory, on the other hand, is the term describing the fact that seldom in an insurance contract is the “consideration” exchanged between the insured and the insurance company equal. Either the client pays his premium year after year and has no claims for the company to pay, or the insured pays very little premium and then has a major claim.

Q: *What does "unilateral" mean?*

A: Unilateral describes the fact that only the insurance company has any duties to perform after the contract is consummated. It is therefore “one sided”. Aleatory and adhesion describe the “unequal” nature of insurance contracts.

Q: *I always thought that applicants, by signing the applications, were swearing that the info on the app was true. The book says something about a “representation”. What is that?*

A: Warranties are guaranteed to be true. Representations are believed to be true. Application information is not “guaranteed” to be true; it is only “believed” to be true. In fact, in order to void the policy, the information must be untrue, AND material, that is, something that would have affected either the price or acceptability of the risk. Fraudulent misstatements may also void the policy. The material misrepresentations become fraud, if made intentionally, and harm results from their use.