

Other Life Topics

This chapter helps broaden your life insurance knowledge. It teaches you about a variety of topics, from group life insurance and plans specific for businesses, to retirement plans and social security benefits. Finally, this chapter details taxation rules that apply to life insurance premiums and proceeds.

TERMS TO KNOW

Earned income — salary, wages, or commissions; but not income from investments, unemployment

FIFO (First In, First Out) — principle under which it is assumed that the funds paid into the policy first will be paid out first

Gross income — a person's income before taxes or other deductions

LIFO (Last In, First Out) — principle applied to asset management in life insurance products, under which it is assumed that the funds paid into the policy last will be paid out first

Nonprofit organization — an organization that uses its surplus to fulfill its purpose instead of distributing the surplus to its owners or members

Policy proceeds — in life insurance, the death benefit

Pre-tax contribution — contribution made before federal and/or state taxes are deducted from earnings

Rollover — withdrawal of the money from one qualified plan and placing it into another plan

Surrender — early termination of a policy by the policyowner

Vesting — the right of a participant in a retirement plan to retain part or all of the benefits

A. Legal Concepts

1. Insurable Interest

To purchase insurance, the policyowner must face the possibility of losing money or something of value in the event of loss. This is called **insurable interest**. In life insurance, insurable interest must exist between the policyowner and the insured **at the time of application**; however, once a life insurance policy has been issued, the insurer must pay the policy benefit, whether or not an insurable interest exists.

A valid insurable interest may exist between the policyowner and the insured when the policy is insuring any of the following:

1. Policyowner's own life;
2. The life of a family member (a spouse or a close blood relative); or
3. The life of a business partner, key employee, or someone who has a financial obligation to the policyowner (for example, a debtor has a financial obligation to a creditor, so the creditor has a valid insurance interest in the life of the debtor).

Insurable interest is not required of beneficiaries. Since the beneficiary's well-being is dependent upon the insured, and the beneficiary's life is not the one

being insured, the beneficiary does not have to show an insurable interest for a policy to be purchased.

Know This! Insurable interest must exist at the *time of application*.

Know This! The policyowner must have insurable interest in the life of the insured.

2. Indemnity

Indemnity (sometimes referred to as **reimbursement**) is a provision in an insurance policy that states that in the event of loss, an insured or a beneficiary is permitted to collect only to the extent of the financial loss, and is not allowed to gain financially because of the existence of an insurance contract. The purpose of insurance is to restore, but not let an insured or a beneficiary profit from the loss.

Life and Health Example:

Brenda has a health insurance policy for \$20,000. After she was hospitalized, her medical expenses added up to \$15,000. The insurance policy will reimburse Brenda only for \$15,000 (the amount of the loss), and not for \$20,000 (the total amount of insurance).

Property and Casualty Example:

Brenda has a homeowners insurance policy for \$200,000. After her home was destroyed, her expense to rebuild the home added up to \$150,000. The insurance policy will reimburse Brenda only for \$150,000 (the amount of the loss), and not for \$200,000 (the total amount of insurance).

Know This! Indemnity means insureds cannot recover more than their loss.

3. Misrepresentation and Concealment

A **warranty** is an absolutely true statement upon which the validity of the insurance policy depends. Breach of warranties can be considered grounds for voiding the policy or a return of premium. Because of such a strict definition, statements made by applicants for life and health insurance policies, for example, are usually not considered warranties, except in cases of fraud.

Representations are statements believed to be true to the best of one's knowledge, but they are not guaranteed to be true. For insurance purposes, representations are the answers the insured gives to the questions on the insurance application.

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

Know This! Representations are statements *believed to be true*. Insured's statements on the application are *representations*.

Concealment is the legal term for the intentional withholding of information of a material fact that is crucial in making a decision. In insurance, concealment is the withholding of information by the applicant that will result in an imprecise underwriting decision. Concealment may void a policy.

4. Impersonation

Impersonation (also known as false pretense) refers to the act of assuming the name and/or identity of another person for the purpose of committing a fraud. In Life insurance, impersonation may occur when an uninsurable individual applying for coverage is asking another person to take the physical examination in his or her place. In regards to agent/producer regulations, impersonation may refer to the act of impersonating a candidate during the prelicensing examination.

Any form of impersonation in insurance is illegal.

5. Nature of Insurance Contracts

Unilateral

In a **unilateral contract**, only one of the parties to the contract is legally bound to do anything. The insured makes no legally binding promises. However, an insurer is legally bound to pay losses covered by a policy in force.

Adhesion

A **contract of adhesion** is prepared by one of the parties (insurer) and accepted or rejected by the other party (insured). Insurance policies are not drawn up through negotiations, and an insured has little to say about its provisions. In other words, insurance contracts are offered on a take-it-or-leave-it basis by an insurer. Any ambiguities in the contract will be settled in favor of the insured.

Aleatory

Insurance contracts are **aleatory**, which means there is an exchange of unequal amounts or values. 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.

Life and Health Example:

John purchases a life insurance policy for \$100,000. His monthly premium is \$100. If John only had the policy for 2 months, which means he only paid \$200 in premiums, and he unexpectedly died, his beneficiary will receive \$100,000. A \$200 contribution on the part of the insured in exchange for \$100,000 benefit from the insurer illustrates an aleatory contract.

Property and Casualty Example:

John purchases a homeowners insurance policy for \$100,000. His monthly premium is \$100. If John only had the policy for 2 months, which means he only

paid \$200 in premiums, and the home was unexpectedly destroyed by a covered peril, John will receive \$100,000. A \$200 contribution on the part of the insured in exchange for \$100,000 benefit from the insurer illustrates an aleatory contract.

Conditional

As the name implies, a **conditional contract** requires that certain conditions must be met by the policyowner and the company in order for the contract to be executed, and before each party fulfills its obligations. *For example*, the insured must pay the premium and provide proof of loss in order for the insurer to cover a claim.

B. Life Insurance Contract

1. Elements of a Legal Contract

In order for insurance contracts to be legally binding, they must have 4 essential elements:

1. Agreement – offer and acceptance;
2. Consideration;
3. Competent parties; and
4. Legal purpose.

Offer and Acceptance

There must be a definite offer by one party, and the other party must accept this offer in its exact terms. In insurance, the applicant usually makes the **offer** when submitting the application. **Acceptance** takes place when an insurer's underwriter approves the application and issues a policy.

Consideration

The binding force in any contract is the **consideration**. Consideration is something of value that each party gives to the other. The consideration on the part of the insured is the payment of premium and the representations made in the application. The consideration on the part of the insurer is the promise to pay in the event of loss.

Know This! *Insurer's consideration* is the promise to pay for losses; *insured's consideration* is the payment of premium and statements on the application.

Competent Parties

The **parties to a contract** must be capable of entering into a contract in the eyes of the law. Generally, this requires that both parties be of legal age, mentally competent to understand the contract, and not under the influence of drugs or alcohol.

Legal Purpose

The purpose of the contract must be **legal** and not against public policy. To ensure legal purpose of a Life Insurance policy, for example, it must have both: insurable

interest and consent. A contract without a legal purpose is considered void, and cannot be enforced by any party.

The process of issuing a life insurance policy begins with solicitation. In simplest terms, *solicitation of insurance* means an attempt to persuade a person to buy an insurance policy, and it can be done orally or in writing. This includes providing information about available products, describing the policy benefits, making recommendations about a specific type of policy, and trying to secure a contract between the applicant and the insurance company.

Any sales presentations used by insurers or their agents in communication with the public must be accurate and complete.



2. Field Underwriting and Completing the Application

Underwriting is the risk selection and classification process. It involves a careful analysis of many different factors to determine the acceptability of applicants for insurance. In other words, underwriting is the process in which an insurance company determines whether or not a particular applicant is insurable, and if so, what premium to charge.

The primary criteria an underwriter will use in assessing the desirability of a particular candidate for life insurance are the applicant's health (current and past), occupation, lifestyle, and hobbies or habits. The underwriter will use many different sources of information in determining the insurability of the individual risk.

The agent is the company's front line, and is referred to as a **field underwriter** because the agent is usually the one who has solicited the potential insured. As a field underwriter, the agent has many important responsibilities during the underwriting process and beyond, including the following:

- Proper solicitation of applicants;
- Helping prevent adverse selection;
- Completing the application;
- Obtaining the required signatures;
- Collecting the initial premium and issuing the receipt, if applicable; and
- Delivering the policy.

Know This! A life insurance producer is the company's *field underwriter*.

The Application is the starting point and basic source of information used by the company in the risk selection process. Although applications are not uniform and may vary from one insurer to another, they all have the same basic components: Part 1 - General Information and Part 2 - Medical Information.

Part 1 - General Information of the application includes the general questions about the applicant, such as name, age, address, birth date, gender, income,

marital status, and occupation. It will also inquire about the existing policies and if the proposed insurance will replace them. Part 1 identifies the type of policy applied for and the amount of coverage, and usually contains information concerning the beneficiary.

Part 2 - Medical Information of the application 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. If the amount of insurance is relatively small, the agent and the proposed insured will complete all of the medical information. That would be considered a *nonmedical* application. For larger amounts, the insurer will usually require some sort of medical examination by a professional.

It is the agent's responsibility to make certain that the application is filled out completely, correctly, and to the best of the applicant's knowledge. The agent must probe beyond the stated questions in the application if he or she has any reason to believe the applicant is misrepresenting or concealing information, or does not understand the specific questions asked. Any information that is misleading, inaccurate or illegible may delay the issuance of the policy. If the agent feels that there could be some misrepresentation, he/she must inform the insurance company. Some insurers require that the applicant complete the application under the agent's watchful eye, while other insurers require that the agent complete the application in order to help avoid mistakes and unanswered questions.

As a field underwriter, the agent (or producer) can be considered the most important source of information available to the company underwriters. The **agent's (producer's) report** provides the agent's personal observations concerning the proposed insured. The insurer may inquire whether the agent knows of any adverse information about the applicant, or ask the agent to express an opinion about the applicant's character, financial standing, and environment. The agent's report does not become a part of the entire contract, although it is a part of the application process.

Required Signatures

Both the agent and the proposed insured (usually the applicant) must sign the application. If the proposed insured and the policyowner are not the same person, such as a business purchasing insurance on an employee, then the policyowner must also sign the application. An exception to the proposed insured signing the application would be in the case of an adult, such as a parent or guardian, applying for insurance on a minor child.

Changes in the Application

When an answer to a question on the application needs to be corrected, agents have the option, depending on which insurer they represent, of correcting the information and having the applicant initial the change, or completing a new application. An agent should never erase or white out any information on an application for insurance.

Consequences of Incomplete Applications

Before a policy is issued, all of the questions on the application must be answered. If the insurer receives an incomplete application, the insurer must return it to the applicant for completion. If a policy is issued with questions left unanswered, the contract will be interpreted as if the insurer waived its right to have an answer to the question. The insurer will not have the right to deny coverage based on any information that the unanswered question might have contained.

3. Premiums with the Application

Most agents attempt to collect the initial premium and submit it along with the application to the insurer. In addition, collecting the initial premium at the time of the application increases the chance that the applicant will accept the policy once it is issued. Whenever the agent collects premiums, the agent must issue a **premium receipt**. The type of receipt issued will determine when coverage will be effective.

Insurability Conditional

The most common type of receipt is a **conditional receipt**, which is used only when the applicant submits a prepaid application. The conditional receipt says that coverage will be *effective either on the date of the application or the date of the medical exam*, whichever occurs last, as long as the applicant is found to be insurable as a standard risk, and policy is issued exactly as applied for. This rule will not apply if a policy is declined, rated, or issued with riders excluding specific coverages.

Example:

If an agent collects the initial premium from an applicant and gives the applicant a conditional receipt, and the applicant dies the next day, the underwriting process will proceed as though the applicant were still alive. If the insurer ends up approving the coverage, then the applicant's beneficiary will receive the death benefit of the policy. If, on the other hand, the insurer determines that the applicant was not an acceptable risk and declines the coverage, the premium will be refunded to the beneficiary, and the insurer is not required to pay the death benefit.

Know This! Conditional receipt means the applicant may be covered as early as the date of the application.

Approval Conditional

The **approval conditional receipt** coverage begins only when the prepaid application is approved by the insurer (but before the policy is delivered). Therefore, there is no coverage during the initial underwriting process. This type of receipt is rarely used.

Unconditional

The **unconditional (binding) receipt** is used most often with property and casualty insurance. With the binding receipt, coverage begins immediately for a specific length of time, until the policy is issued. Binding receipts usually stipulate that

coverage is effective from the date of the application for only a specified period of time, such as 30 or 60 days, or until the company either issues or declines coverage, whichever occurs first.

4. Company Underwriting

In order to properly select and classify insurance risks, the insurer needs to obtain the applicants' background information and medical history. There are several sources of underwriting information that are available to the underwriters.

Sources of Information Application

The person applying for insurance must submit an application to the insurer for approval for a policy to be issued. The application is one of the main sources of underwriting information for the company.

Know This! An insurance application is the *key source* underwriters use for information about the applicant.

Agent's Report

The agent's report allows the agent to communicate with the underwriter and provide information about the applicant known by the agent that may assist in the underwriting process.

Investigative Consumer Report (Inspection)

To supplement the information on the application, the underwriter may order an inspection report on the applicant from an independent investigating firm or credit agency, which covers financial and moral information. They are general reports of the applicant's finances, character, work, hobbies, and habits. Companies that use inspection reports are subject to the rules and regulations outlined in the Fair Credit Reporting Act.

Medical Information and Consumer Reports

For policies with higher amounts of coverage or if the application raised additional questions concerning the prospective insured's health, the underwriter may require a medical examination of the insured. There are two options, depending on the reason for the medical examination:

1. The insurer may only request a **paramedical report** which is completed by a paramedic or a registered nurse; and
2. The underwriter may require an **Attending Physician's Statement (APS)** from a medical practitioner who treated the applicant for a prior medical problem.

Medical Information Bureau (MIB)

In addition to an attending physician's report, the underwriter will usually request a **Medical Information Bureau (MIB)** report.

The MIB is a membership corporation owned by member insurance companies. It is a **nonprofit trade organization** which receives adverse medical information from

insurance companies and maintains confidential medical impairment information on individuals. It is a systematic method for companies to compare the information they have collected on a potential insured with information other insurers may have discovered. The MIB can be used only as an aid in helping insurers know what areas of impairment they might need to investigate further. An applicant cannot be refused simply because of some adverse information discovered through the MIB.

Medical Examinations and Lab Tests Including HIV

Medical examinations, when required by the insurance company, are conducted by physicians or paramedics at the insurance company's expense. Usually such exams are not required with regard to health insurance, thus stressing the importance of the agent in recording medical information on the application. The medical exam requirement is more common with life insurance underwriting. If an insurer requests a medical examination, the insurer is responsible for the costs of the exam.

It is common among insurers to require an HIV test when an applicant is applying for a large amount of coverage, or for any increased and additional benefits. To ensure proper obtaining and handling of results, and to protect the insured's privacy, states have enacted the following laws and regulations for insurers requiring an applicant to submit to an HIV test:

- The insurer must **disclose the use of testing to the applicant**, and **obtain written consent** from the applicant on the approved form;
- The insurer must **establish written policies and procedures** for the internal dissemination of test results among its producers and employees to ensure confidentiality.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that protects health information. HIPAA regulations provide protection for the privacy of certain *individually identifiable health information (such as demographic data that relates to physical or mental health condition, or payment information that can identify the individual)*, referred to as **protected health information**. Under the **Privacy Rule**, patients have the right to view their own medical records, as well as the right to know who has accessed those records over the previous 6 years. The Privacy Rule, however, allows **disclosures without individual authorization to public health authorities** authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

Use and Disclosure of Insurance Information

When insurers plan to seek and use information from investigators, they must first provide the applicant/insured with a written Disclosure Authorization Notice. It will state the insurer's practice regarding collection and use of personal information. The disclosure authorization form must be written in plain language, and must be approved by the head of the Department of Insurance.

Risk Classification

In classifying a risk, the Home Office underwriting department will look at the applicant's past medical history, present physical condition, occupation, habits and morals. If the applicant is acceptable, the underwriter must then determine the risk or **rating classification** to be used in deciding whether or not the applicant should pay a higher or lower premium. A prospective insured may be rated as one of the three classifications: **standard, substandard, or preferred**.

Standard risks are persons who, according to a company's underwriting standards, are entitled to insurance protection without extra rating or special restrictions. Standard risks are representative of the majority of people at their age and with similar lifestyles. They are the average risk.

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

Substandard (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.

Applicants who are rejected are considered **declined** risks. Risks that the underwriters assess as not insurable are declined. *For example*, a risk may be declined for one of the following reasons:

- There is no insurable interest;
- The applicant is medically unacceptable;
- The potential for loss is so great it does not meet the definition of insurance; or
- Insurance is prohibited by public policy or is illegal.

5. Policy Delivery

Once the underwriting process has been completed and the company issues the policy, the agent will deliver it to the insured. Although personal delivery of the insurance policy is the best method of finalizing the insurance transaction, mailing the policy directly to the policyowner is acceptable. When the insurer relinquishes control of the policy by mailing it to the policyowner, policy is considered legally delivered. However, it is advisable to obtain a signed **delivery receipt**.

Explaining the Policy and its Provisions, Riders, Exclusions, and Ratings to the Client

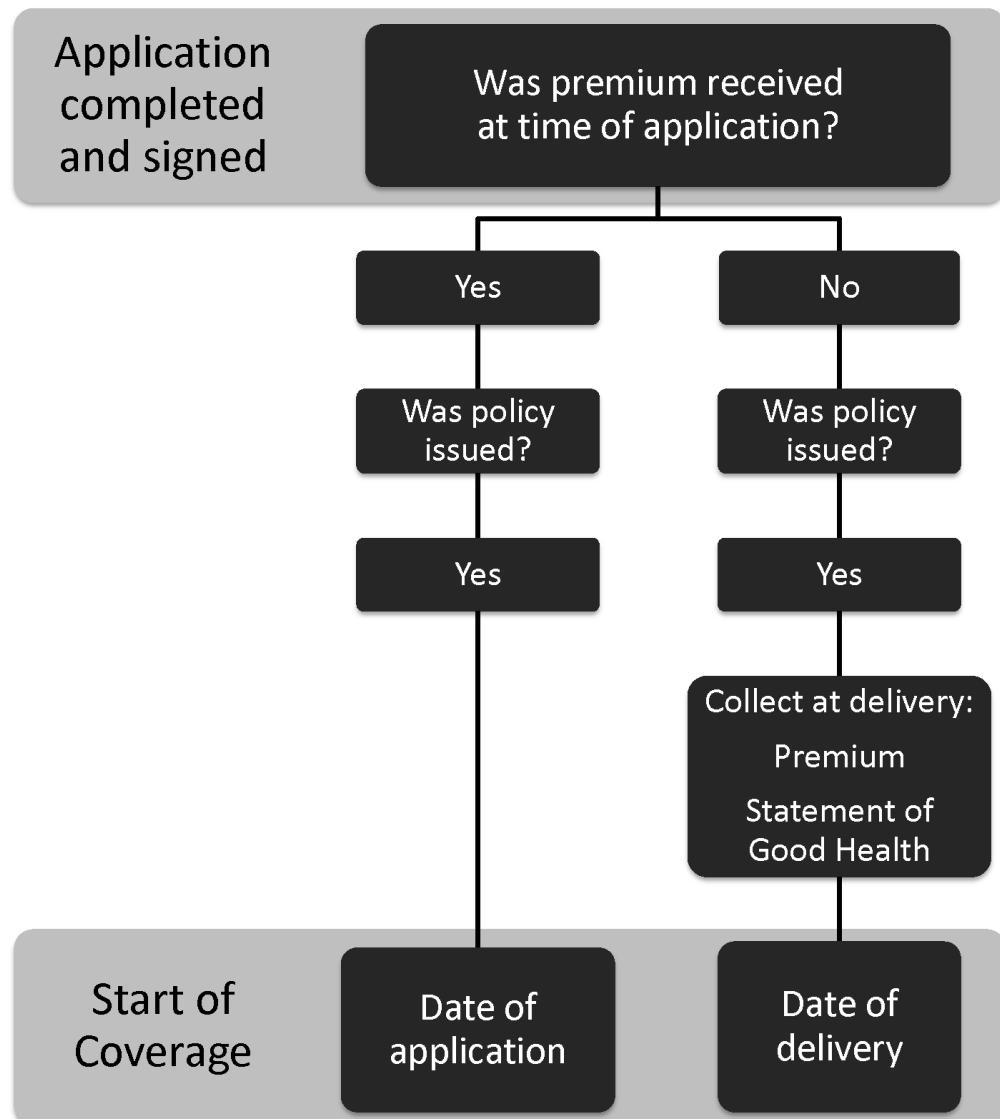
Personal delivery of the policy allows the agent an opportunity to make sure that the insured understands all aspects of the contract. Review of the contract with the insured involves pointing out provisions or riders that may be different than anticipated, and explaining what effect they have on the contract. In addition, the agent should explain the rating procedure to the client, especially if the policy is **rated differently** than applied for, or has been modified or amended in any other way. The agent should also explain any other choices and provisions available to the policyowner that may become active at this time.

When Coverage Begins

If the initial premium is not paid with the application, the agent will be required to collect the premium at the time of policy delivery. In this case, the policy does not go into effect until the premium has been collected. The agent may also be required to get a **statement of good health** from the insured. This statement must be signed by the insured, and verifies that the insured has not suffered injury or illness since the application date.

If the full premium was submitted with the application and the policy was issued as requested, the policy coverage would generally coincide with the date of application if no medical exam were required. If a medical exam is required, the date of the coverage will coincide with the date of the exam.

Know This! NO premium, NO coverage.



C. Cost Comparison Methods

To help consumers make educated decisions on purchasing life insurance, the industry developed specific methods and indexes that measure and compare the actual policy costs. These comparisons are usually included in policy illustrations.

The **Traditional Net Cost method** compares the cash values available to buyers if they surrender the policy in 10 or 20 years. This index does not take into consideration the time value of money (or investment return on the insurance premium had it been invested elsewhere). Although this is the easiest cost-comparison method and can be helpful in determining income tax liability under the policy, it can also be the most misleading when used to estimate policy costs. Use of this method for comparing policy costs is illegal in most U.S. jurisdictions.

The **Interest-Adjusted Net Cost** method considers the *time value of money* (or investment return on the insurance premium had it been invested elsewhere) by applying an interest adjustment to yearly premiums and dividends. This means that each year premiums and dividends are figured, interest is taken into consideration. Two versions of the interest-adjusted method are the **surrender cost index** and the **net payment cost index**.

D. Group Life Insurance

In contrast to individual life insurance, which is written on a single life, and in which the rate and coverage is based upon the underwriting of that individual, **group life insurance** is issued to the sponsoring organization, and covers the lives of **more than one individual** member of that group. Group insurance is usually written for employee-employer groups, but other types of groups are also eligible for coverage. It is usually written as **annually renewable term** insurance. Two features that distinguish group insurance from individual insurance are

- Evidence of insurability is usually not required (unless an applicant is enrolling for coverage outside the normal enrollment period); and
- Participants (insureds) under the plan do not receive a policy because they do not own or control the policy.

Instead, each insured participant under the group plan is issued a **certificate of insurance** evidencing that they have coverage. The actual policy, or **master policy/contract**, is issued to the sponsor of the group, which is often an employer. The group sponsor is the policyholder and is the one that exercises control over the policy.

Know This! Group insurance is written as annually renewable term insurance.

Know This! In group insurance, the master contract is for the employer, and certificates of insurance are for individual insureds.

Group underwriting differs from that of individual insurance, and is based on the group characteristics and makeup. Some of the characteristics of concern to a group underwriter include the following:

- **Purpose or nature of the group** — The group must be created for a purpose other than to obtain group insurance.
- **Size of the group** — The larger the number of people in the group, the more accurate the projections of future loss experience will be. This is based on the Law of Large Numbers of similar risks.
- **Turnover of the group** — From the underwriting perspective, a group should have a steady turnover: younger, lower-risk employees enter the group, and older, higher-risk employees leave.

- **Financial strength of the group** — Because group insurance is costly to administer, the underwriter should consider whether or not the group has the financial resources to pay the policy premiums, and whether or not it will be able to renew the coverage.

Another unique aspect of group underwriting is that the cost of the coverage is based on the average age of the group and the ratio of men to women. In addition, in order to reduce adverse selection, the insurer will require a minimum number of participants in the group, depending on whether the employer or employees pay the premium.

1. Conversion Privilege

Another characteristic of group insurance is the conversion privilege. If an employee terminates membership in the insured group, the employee has the right to convert to an individual policy ***without proving insurability*** at a standard rate, based on the individual's attained age. The group life policy can convert to any form of insurance issued by the insurer (usually whole life), ***except*** for term insurance. The face amount or death benefit will be equal to the group term face amount, but the premium will be higher. The employee usually has a period of **31 days after terminating** from the group in order to exercise the conversion option. During this time, the employee is still covered under the original group policy.

Other rules that apply to conversion involve the death or disability of the insured, and termination of the master policy. If the insured dies during the conversion period, a death benefit equal to the maximum amount of individual insurance which would have been issued must be paid by the group policy, whether or not the application for an individual policy was completed. If the master contract is terminated, every individual who has been on the plan for at least 5 years will be allowed to convert to individual permanent insurance of the same coverage.

Know This! When converting from group life to individual life insurance, evidence of insurability is not required.

2. Contributory vs. Noncontributory

The employer or other group sponsor may pay all of the premiums or share premiums with the employees. When an employer pays all of the premiums, the plan is referred to as a **noncontributory plan**. Under a noncontributory plan, an insurer will require that 100% of the eligible employees be included in the plan. When the premiums for group insurance are shared between the employer and employees, the plan is referred to as a **contributory plan**. Under a contributory plan, an insurer will require that 75% of eligible employees be included in the plan.

3. Types of Group Contracts

Group life insurance plans may be sponsored by employers, debtor groups, labor unions, credit unions, associations, and other organizations formed for a reason other than purchasing insurance. Insurance companies may establish a required minimum number of persons to be insured under a group plan.

E. Business Insurance

Businesses use life insurance for the same reason individuals use life insurance: it creates an immediate payment upon the death of the insured.

The most common use of life insurance by businesses is as an employee benefit, which serves as a protection for employees and their beneficiaries. There are also other forms of life insurance that can serve business owners and their survivors, and even protect the business itself. These include funding business continuation agreements, compensating executives, and protecting the business against financial loss resulting from the death or disability of key employees.

1. Key Person Insurance

A business can suffer a financial loss because of the premature death of a key employee – someone who has specialized knowledge, skills or business contacts. A business can lessen the risk of such loss by the use of **key person insurance**. Key person insurance may be issued as term or permanent life, with whole life and universal life policies being used most often.

With this coverage, the **key employee is the insured**, and the business is all of the following:

- Applicant;
- Policyowner;
- Premium payer; and
- Beneficiary.

In the event of death of a key employee, the business would use the money for the additional costs of running the business and replacing the employee. The business cannot take a tax deduction for the expense of the premium. However, if the key employee dies, the benefits paid to the business are usually received tax free. No special agreements or contracts are needed except that the employee(s) would need to give permission for this coverage.

Key person insurance may be term or permanent. An employer may have more than one key person policy.

2. Buy-Sell Agreements

A **buy-sell** agreement is a legal contract that determines what will be done with a business in the event that an owner dies or becomes disabled. This is also referred to as a *business continuation agreement*.

There are several types of buy-sell agreements that can be used for partnerships and corporations:

- **Cross Purchase** – used in partnerships when each partner buys a policy on the other;
- **Entity Purchase** – used when the partnership buys the policies on the partners;
- **Stock Purchase** – used by privately owned corporations when each stockholder buys a policy on each of the others; and

- **Stock Redemption** – used when the corporation buys one policy on each shareholder.

Example:

Here is an example of a cross-purchase buy-sell agreement: Partnership AB has two partners, Partner A and Partner B. The value of the business is \$1,000,000. The partners each have an equal interest (\$500,000 each). Partner A buys a life policy on Partner B for \$500,000, and Partner B buys a life policy on Partner A for \$500,000. If Partner A dies, Partner B gets 100% ownership of the business and A's heirs receive \$500,000.

F. Other Types Of Contracts

1. Credit Life

Credit insurance is a special type of coverage written to insure the life of the debtor and pay off the balance of a loan in the event of the death of the debtor. Credit life is usually written as **decreasing term insurance**, and it may be written as an individual policy or as a group plan. When written as a group policy, the creditor is the owner of the master policy, and each debtor receives a certificate of insurance.

The creditor is the owner and the beneficiary of the policy although the premiums are generally paid by the borrower (or the debtor). **Credit life insurance cannot pay out more than the balance of the debt**, so that there is no financial incentive for the death of the insured. The creditors may require the debtor to have life insurance; they cannot, however, require that the debtor buys insurance from a specific insurer.

Know This! Credit life insurance cannot pay out more than the balance of the debt.

Example:

Paige applied for a \$10,000 personal loan with American Bank. To secure the payment of the loan, the bank purchased a credit life insurance policy on Paige. Paige is the borrower, and therefore is responsible for paying the policy premiums. American Bank is the policyowner and the beneficiary.

Two years later Paige died in a car accident; her loan balance with the bank is \$7,350. Therefore, the maximum that American Bank can claim from the credit life insurance will be the balance of the debt, not \$10,000 (the amount of the original loan).

2. Mortgage Life

Decreasing term policies are commonly used to pay off a loan balance on the death of the insured, so they are most suitable as mortgage protection coverage.

Mortgage Protection Term Life (or Mortgage Redemption) policy is a type of decreasing term insurance in which the face amount directly correlates with the amount of outstanding loan and length of time remaining on a mortgage. If the insured dies during the mortgage period, the insurance company will pay the

outstanding balance to the beneficiary or to the mortgage company. Note that debt protection is provided on personal mortgages only.

G. Tax Treatment Of Insurance Premiums, Proceeds, Dividends

Generally speaking, the following taxation rules apply to life insurance policies:

- **Premiums** are not tax deductible; and
- **Death benefit:**
 - Tax free if taken as a lump-sum distribution to a named beneficiary; and
 - Principal is tax free; interest is taxable if paid in installments (other than lump sum).

1. Individual Life

Amounts Available to Policyowners

As you have already learned, permanent life insurance provides living benefits. There are several ways in which policyowners may receive those living benefits from the policy.

Dividends

Since dividends are a return of unused premiums, they are not considered income for tax purposes. When dividends are left with the insurer to accumulate interest, the interest earned on the dividend account is subject to taxation as ordinary income each year interest is earned, whether or not the interest is paid out to the policyowner.

Cash Value Accumulations

Any cash value accumulations in the policy can be borrowed against by the policyowner, or may be paid to the policyowner upon surrender of the policy. Cash values grow tax deferred. Upon surrender or endowment, any cash value in excess of cost basis (premium payments) is taxable as ordinary income. Upon death, the face amount is paid, and there is no more cash value. Death benefits generally are paid to the beneficiary income tax free.

Policy Loans

The policyowner may borrow against the policy's cash value. Money borrowed against the cash value is not income taxable; however, the insurance company charges interest on outstanding policy loans. Policy loans, with interest, can be repaid in any of the following ways:

- By the owner while the policy is in force;
- At policy surrender or maturity, subtracted from the cash value; or
- At the insured's death, subtracted from the death benefit.

Know This! Policy loans from the cash value are NOT income taxable.

Surrenders

When a policyowner **surrenders** a policy for cash value, some of the cash value received may be taxable as income if the cash surrender value exceeds the amount of the premiums paid for the policy. When the owner withdraws cash value from a universal life policy (partial surrender), both the cash value and the death benefit are reduced by the surrender.

Example:

Consider the following scenario:

- Face amount: \$300,000
- Premiums paid: \$70,000
- Total cash value: \$100,000

If the insured surrendered \$30,000 of cash value, the full \$30,000 would be income tax free. If the insured took out \$100,000, the last \$30,000 would be taxable because the \$100,000 exceeds the premiums that were paid in by \$30,000.

Accelerated Benefits

When accelerated benefits are paid under a life insurance policy to a terminally ill insured, the benefits are received **tax free**. When accelerated benefits are paid to a chronically ill insured (*for example*, someone who has cancer, Alzheimer's disease or other severe illness), these benefits are tax free up to a certain limit. Any amount received in excess of this dollar limit must be included in the insured's gross income.

Amounts Received by Beneficiary General Rule and Exceptions

Life insurance proceeds paid to a named beneficiary are generally **free of federal income taxation** if taken as a lump sum. An exception to this rule would apply if the benefit payment results from a *transfer for value*, meaning the life insurance policy is sold to another party prior to the insured's death.

Know This! Lump-sum cash payment of life policy proceeds are tax free for the beneficiary.

Settlement Options

With **settlement options**, when the beneficiary receives payments consisting of both principal and interest, the interest portion of the payments received is taxable as income. *For example*, if \$100,000 of life insurance proceeds were used in a settlement option paying \$13,000 per year for 10 years, \$10,000 per year would be income tax free and \$3,000 per year would be income taxable.

Know This! In settlement options, the principal is tax free, but the interest is taxable.

PERMANENT LIFE FEATURES

Premiums
Not tax deductible

Cash value exceeding premiums paid
Taxable at surrender

TAX TREATMENT

Policy loans Not income taxable
Policy dividends Not taxable
Dividend interest Taxable in the year earned
Lump-sum death benefit Not income taxable

Know This! Taxes must be paid either upon contribution or upon distribution, NOT both (if taxed on one end, will not be taxed on the other).

2. Group Life and Employer-sponsored Plans

The **premiums** that an employer pays for life insurance on an employee, whereby the policy is for the employee's benefit, **are tax deductible to the employer** as a business expense. If the group life policy coverage is \$50,000 or less, the employee does not have to report the premium paid by the employer as income (not taxable to the employee).

Any time a business is the named beneficiary of a life insurance policy, or has a beneficial interest in the policy, any premiums that the business pays for such insurance are not tax deductible. Therefore, when a business pays the premiums for any of the following arrangements, the premiums are not deductible:

- Key-employee (key-person) insurance;
- Stock redemption or entity purchase agreement; and
- Split-dollar insurance.

The **cash value** of a business owned life insurance policy or an employer provided policy accumulates on a tax-deferred basis and is taxed in the same manner as an individually owned policy.

Policy loans are not taxable to a business. Unlike an individual taxpayer, a corporation may deduct interest on a life insurance policy loan for loans up to \$50,000.

Policy death benefits paid under a business owned or an employer provided life insurance policy are received income tax free by the beneficiary (in the same manner as in individually owned policies).

3. Modified Endowment Contracts (MECs)

Following the elimination of many traditional tax shelters by the Tax Reform Act of 1984, single premium life insurance remained as one of the few financial products offering significant tax advantages. Consequently, many of these types of policies were purchased solely for purposes of setting aside large sums of money for the tax-deferred growth as well as tax-free cash flow available via policy loans and partial surrenders.

To curtail this activity, and to determine if an insurance policy is overfunded, the Internal Revenue Service (IRS) established what is known as the **7-pay Test**. Any life insurance policy that fails a 7-pay test is classified as a **Modified Endowment Contract (MEC)**, and loses the standard tax benefits of a life insurance contract. In a MEC, the cumulative premiums paid during the first 7 years of the policy exceed the total amount of net level premiums that would be required to pay the policy up using guaranteed mortality costs and interest.

Example:

Let's review the taxation of whole life insurance components:

- Premiums are usually paid with after-tax dollars and are not tax deductible;
 - Cash value grows tax deferred, but the earnings are taxed at withdrawal;
 - Policy loans are not subject to income tax.

With that in mind, the insured could use life insurance as a way to avoid paying taxes. They could overfund the policy by paying extra premiums, and only accessing the cash value by taking out loans. To close that loophole, the IRA created the Seven-pay test. Let me illustrate that concept:

Let's assume your client wants to purchase a \$100,000 pay to 100 whole life policy that requires \$100 monthly premium. Now let's apply the 7-pay test.

Let's say that it is calculated that a \$100,000 7-pay whole life policy requires \$500/mo premiums for 7 years and then it's paid for a total of \$42,000. So if your client pays excess premiums and exceeds \$42,000 in the first 7 years, the policy becomes a Modified Endowment Contract and loses its tax advantages.

All life insurance policies are subject to the 7-pay test, and any time there is a material change to a policy (such as an increase in the death benefit), a new 7-pay test is required. Whether from a life insurance policy or a MEC, the death benefit received by the beneficiary is tax free.

The following are taxation rules that apply to MEC's cash value:

- Tax-deferred accumulations;
 - Any distributions are taxable, including withdrawals and policy loans;
 - Distributions are taxed on LIFO basis (Last In, First Out), known as "interest-first" rule;
 - Distributions before age 59 ½ are subject to a 10% penalty.

TAX CONSIDERATIONS FOR LIFE INSURANCE AND ANNUITIES

Premiums

Not deductible (personal expense)

Death Benefit Not income taxable (except for interest)

Cash Value Increases Not taxable (as long as policy in force)

Cash Value Gains Taxed at surrender

Dividends Not taxable (return of unused premium; however, interest is taxable)

AccumulationsInterest taxable

Policy LoansNot income taxable

Surrenders Surrender value - past premium = amount taxable

Partial SurrendersFirst In, First Out (FIFO)*

Settlement Options - death benefit spread evenly over income period (averaged).

Interest payments in excess of death benefit portion are taxable.

Estate Tax - If the insured owns the policy, it will be included for estate tax purposes. If the policy is given away (possibly to a trust) and the insured dies within 3 years of the gift, the death benefit will be included in the estate.

**FIFO method applies to Life insurance only. The policyowner will receive their investment in the contract first before receiving any gains in the policy (or being taxed on those gains). Annuities follow a LIFO (last in, first out) format.*

H. Tax-Qualified Retirement Plans

An employer-sponsored **qualified retirement plan** is approved by the IRS, which then gives both the employer and employee benefits such as deductible contributions and tax-deferred growth.

Qualified plans have the following characteristics:

- Designed for the exclusive benefit of the employees and their beneficiaries;
- Are formally written and communicated to the employees;
- Use a benefit or contribution formula that does not discriminate in favor of the *prohibited group* – officers, stockholders, or highly paid employees;
- Are not geared exclusively to the prohibited group;
- Are permanent;
- Are approved by the IRS; and
- Have a vesting requirement.

Know This! Qualified plans have tax advantages.

In contrast, nonqualified plans are not subject to the requirements regarding participation, discrimination, and vesting found in qualified plans. Nonqualified plans require no government approval and are used as a means for an employer to discriminate in favor of a valuable employee with regard to employee benefits. Nonqualified plans accept after-tax contributions.

Examples of nonqualified plans are individual annuities and deferred compensation plans for highly paid executives, split-dollar insurance arrangements, and Section 162 executive bonus plans.

The table below highlights the differences between qualified and nonqualified retirement plans.

QUALIFIED NONQUALIFIED

Contributions currently TAX DEDUCTIBLE	Contributions NOT currently TAX DEDUCTIBLE
Plan APPROVED by the IRS	Plan DOES NOT NEED IRS APPROVAL
Plan CANNOT DISCRIMINATE	Plan CAN DISCRIMINATE
Earnings grow TAX DEFERRED	Earnings grow TAX DEFERRED
ALL WITHDRAWALS are TAXED	EXCESS over cost basis is TAXED

1. Individual Qualified Plans - IRA and Roth IRA

The 2 most common qualified individual retirement plans are Traditional IRAs and Roth IRAs. Anybody with **earned income** can contribute to either plan.

A Traditional **Individual Retirement Account (IRA)** allows individuals with **earned income** to make tax deductible contributions **regardless of age**. Plan participants are allowed to contribute up to a specified dollar limit each year, or 100% of their

salary if less than the maximum allowable amount. Individuals who are **age 50 or older** are entitled to make additional *catch-up* contributions. A *married couple* could contribute a specified amount that is double the individual amount, even if only one person had earned income. Each spouse is required to maintain a separate account not exceeding the individual limit.

In traditional IRAs, the owner may **withdraw** the funds at any time. However, withdrawals prior to age $59\frac{1}{2}$ are considered early withdrawals and are subject to a 10% additional tax. Starting at age $59\frac{1}{2}$, the owner may withdraw assets without having to pay the 10% additional tax. However, the owner *must* start receiving distributions from the IRA at the **age of 73***. Starting at age 73, the owner must receive at least a minimum annual amount, known as the **required minimum distribution (RMD)**.

**Effective January 1, 2023, the SECURE Act raised the required minimum distribution age from 72 to 73, and reduced the penalty for failing to take an RMD from 50% to 25%.*

The **Roth IRA** is a form of an individual retirement account funded with after-tax contributions. An individual can contribute 100% of earned income up to an IRS-specified maximum, as with traditional IRAs (the dollar amounts change every year). Roth IRA contributions can continue regardless of the account owner's age, and in contrast with a traditional IRA, distributions do not have to begin at a specified age. Roth IRAs grow tax free as long as the account is open for at least 5 years.

Know This! Traditional IRAs and Roth IRAs are for individuals with earned income.

Know This! Contributions to a traditional IRA are with pre-tax dollars (tax deductible); contributions to a Roth IRA are with after-tax dollars (NOT tax deductible).

Taxation of IRAs and Roth IRAs

The following taxation rules apply to **contributions** made to traditional IRA plans:

- Tax-deductible contributions for the year of the contribution (based on the person's income);
- Contributions must be made in "**cash**" in order to be tax deductible (the term *cash* includes any form of money, such as cash, check, or money order);
- Excess contributions are taxed at 6% per year as long as the excess amounts remain in the IRA; and
- Tax-deferred earnings (the money that accumulates in the account) are not taxed until withdrawn.

A **distribution** from an IRA is subject to income taxation in the year the withdrawal is made. In case of an early distribution (prior to age $59\frac{1}{2}$), a 10% penalty will also apply.

There are certain conditions, under which the 10% penalty for early withdrawals would not apply (penalty tax exceptions):

- Participant is age 59½;
- Participant is totally disabled;
- The money is used to make the down payment on a home (not to exceed \$10,000, and usually for first-time homebuyers);
- Withdrawals are for post-secondary education expenses; and
- Withdrawals are for catastrophic medical expenses, or upon death.

The following taxation rules apply to Roth IRAs:

- Contributions are not tax deductible; and
- Excess contributions are subject to a 6% tax penalty.

Know This! Traditional IRA distributions are taxable; Roth IRA distributions are NOT taxable.

TRADITIONAL IRA / ROTH IRA

Contribute 100% of income up to an IRS-specified limit

Excess contribution penalty is 6%

Grows tax deferred	Grows tax free (if account open for at least 5 years)
Contributions are tax deductible	Contributions are not tax deductible
(Made with "pre-tax dollars")	(Made with "after-tax dollars")
10% penalty for early nonqualified distributions prior to age 59½ (some exceptions apply)	Qualified distribution cannot occur until account is open for 5 years and owner is 59½
Distributions are taxable	Distributions are not taxable
Payouts must begin by age of 73	No required minimum age for payouts

2. Plans for Employers

In addition to individual plans, different types of qualified plans are available and have been designed for use by small and large employers.

Keogh or HR-10

HR-10 or Keogh plans make it possible for **self-employed persons** to be covered under an IRS qualified retirement plan. These plans allow the self-employed individuals to fund their retirement programs with pre-tax dollars as if under a corporate retirement or pension plan. To be covered under a Keogh retirement plan, the person must be self-employed or a partner working part time or full time who owns at least 10% of the business.

Contribution limits are the lesser of an established dollar limit or 100% of their total earned income. The contribution is tax deductible, and it accumulates tax deferred until withdrawal.

Upon a participant's death, payouts can be available immediately. If a participant becomes disabled, he or she may collect benefits immediately or the funds can be left to accumulate. When a participant enters retirement, distribution of funds must occur no earlier than age 59½ and no later than age 73 (*prior to January 2023, age 72*). If withdrawn before 59½, there is a 10% penalty. At any time payments may be discontinued with no penalty, and funds can be left to accumulate.

Under eligibility requirements, any individual who is at least 21 years of age, has worked for a self-employed person for one year or more, and worked at least 1,000 hours per year (full time) must be included in the Keogh Plan. The employer must contribute the same percentage of funds into the employee's retirement account as he/she contributes into his/her own account.

Simplified Employee Pension Plans (SEP)

A Simplified Employee Pension (SEP) is a type of qualified plan suited for the small employer or for the self-employed. In a SEP, an employee establishes and maintains an individual retirement account to which the employer contributes. Employer contributions are not included in the employee's gross income. The primary difference between a SEP and an IRA is the much larger amount that can be contributed each year to a SEP (an IRS established annual dollar limit or 25% of the employee's compensation, whichever is less).

SIMPLE Plans

A SIMPLE (*Savings Incentive Match Plan for Employees*) plan is available to small businesses that employ **no more than 100 employees** who receive at least \$5,000 in compensation from the employer during the previous year. To establish a SIMPLE plan, the employer must not have a qualified plan already in place. Employees who elect to participate may defer up to a specified amount each year, and the employer then makes a matching contribution, dollar for dollar, up to an amount equal to 3% of the employee's annual compensation. **Taxation is deferred** on both contributions and earnings until funds are withdrawn.

401(k) Plans

Profit-sharing plans are qualified plans where a portion of the company's profit is contributed to the plan and shared with employees. If the plan does not provide a definite formula for figuring the profits to be shared, employer contributions must be **systematic and substantial**.

A 401(k) qualified retirement plan allows employees to take a reduction in their current salaries by deferring amounts into a retirement plan. The company can also match the employee's contribution, whether it is dollar for dollar or on a percentage basis. Under a 401(k) plan, participants may choose to either receive taxable cash compensation or have the money contributed into the 401(k), referred to as *cash or deferred arrangement plans* (CODA). Contributions into the plan are excluded from the individual employee's gross income up to a dollar ceiling amount. The ceiling amount is adjusted annually for inflation. The plan allows participants age 50 or over to make additional catch-up contributions (up to a limit) at the end of the calendar year.

Plans permit early withdrawal for specified hardship reasons such as death or disability. Loans are also permitted in certain instances up to 50% of the participant's vested accrued benefit or a specified dollar limit (*set by the IRS annually*).

403(b) Tax-sheltered Annuities (TSAs)

A 403(b) plan or a tax-sheltered annuity (TSA) is a qualified plan available to employees of certain **nonprofit organizations** under **Section 501(c)(3)** of the Internal Revenue Code, and to employees of public school systems.

Contributions can be made by the employer or by the employee through salary reduction and are excluded from the employee's current income. As with any other qualified plan, 403(b) limits employee contributions to a maximum amount that changes annually, adjusted for inflation. The same catch-up provisions also apply.

Know This! 403(b) plans are for nonprofits and public-school systems.

WHO CONTRIBUTES ELIGIBILITY

HR-10 (Keogh)	Self-employed	Employer matches employee's contributions
SEP	Small employer or self-employed	Employer only
SIMPLE	Small employers (no more than 100 employees)	Employer matches employee's contribution
401(k)	Any employer	Employer matches employee's contribution
403(b) - TSA	Nonprofit organizations	Employer and employee

Know This! Contributions to qualified plans are limited to a maximum amount (established by the IRS).

I. Social Security Benefits And Taxes

Social Security, also referred to as **Old Age Survivors Disability Insurance** – OASDI, is a federal program enacted in 1935, which is designed to provide protection for eligible workers and their dependents against financial loss due to old age, disability, or death. With a few exceptions, almost all individuals are covered by Social Security. In some respects, Social Security plays a role of federal life and health insurance, which is important to consider when determining an individual's needs for life insurance.

Social Security uses the Quarter of Coverage (QC) system to determine whether an individual is qualified for Social Security benefits. The type and amount of benefits are determined by the amount of **credits** or **QCs** a worker has earned. Anyone working in jobs covered by Social Security or operating their own business may earn up to a maximum of 4 credits for each year of work.

The term **fully insured** refers to someone who has earned **40 quarters** of coverage (the equivalent of 10 years of work), and is therefore entitled to receive Social Security retirement, premium-free Medicare Part A, and survivor benefits. If an individual is entitled to premium-free Medicare Part A, they are automatically eligible for Medicare Part B, but must pay a monthly premium.

An individual can attain a **currently insured** status (or partially insured), and by that qualify for certain benefits if he or she has earned **6 credits** (or quarters of

coverage) during the 13-quarter period *ending with the quarter in which the insured:*

- Dies;
- Becomes entitled to disability insurance benefits; or
- Becomes entitled to old-age insurance benefits.

For younger workers, the number of quarters required to qualify for the benefits differs by age according to a table established by Social Security.

Social Security provides three types of benefits: Retirement, Disability and Survivors.

CONDITIONS FOR PAYMENTPAID TO TYPE OF PAYMENT

RETIREMENT BENEFIT:

Fully insured status and age 66* (or reduced benefits at age 62)	Retired individual and eligible dependents	Monthly benefit equal to the primary insurance amount (PIA)
------------------------------------------------------------------	--------------------------------------------	-------------------------------------------------------------

DISABILITY BENEFIT:

Fully insured status and total and permanent disability prior to the retirement age	Disabled worker and spouse and eligible dependents	Monthly disability benefit after a 5-month waiting period
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SURVIVOR BENEFIT:

Worker's death	Surviving spouse and dependent children	Lump-sum burial benefit if fully or currently insured
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Monthly income payments if fully insured

**The current full retirement age is 66, and is gradually increasing to age 67.*

Social Security is funded by the taxes imposed on a worker's earned income. This is a payroll tax paid for by all employees and employers, including self-employed individuals. This tax is imposed on a certain percentage of the employee's income, referred to as the taxable wage base. The employer deducts the taxes from the employee's paycheck and contributes an equal amount. Part of the tax is applied to OASDI under **FICA** (the Federal Insurance Contributions Act), and part of the tax funds Medicare. Self-employed employees pay an amount that is equivalent to both the employee and employer's contribution.

Survivor benefits are death benefits paid to the worker's surviving spouse and dependent children under specified circumstances. A lump-sum burial benefit is available for a spouse living with the worker at the time of death, or a spouse or child who is eligible for Social Security in the month of the worker's death.

Monthly income payments may also be paid to the following in the event of a fully insured (covered) worker's death:

- Surviving spouse, limited benefits available at age 60, full benefits payable upon reaching full retirement age (varies depending on year of birth).
- Surviving or divorced spouse, if caring for minor children under age 16 or disabled children, sometimes called a parent's benefit. Once the minor reaches age 16, the parent is not eligible for Social Security retirement benefits again until retirement or age 60 ("Blackout Period").
- Dependent parents, age 62 or older.

- Unmarried children under age 18, or up to age 19, if full-time elementary or secondary (high school) students.

Example:

Joe age 36 and Jolene age 30 are married and have two children. Mary Jo is age 10, and Little Joe is age 6. Joe is employed full time and is currently and fully insured according to Social Security. Joe dies unexpectedly and leaves Jolene to care for the children. Jolene will receive benefits from Social Security until Little Joe reaches age 16 at which time Jolene will be age 40. At this time, Social Security stops paying benefits to Jolene until Jolene reaches age 60. The time period between Jolene's age 40 and age 60 is the Social Security "Blackout Period."

J. Educational Highlights

Take another look at the topics discussed in this chapter. Try to answer the following questions on your own and then verify the correct answers:

1. *Name the three instances in which insurable interest exists.*
A policyowner is insuring his or her own life, the life of a family member, or the life of a business partner, key employee, or someone who has a financial obligation to the applicant.
2. *What does representation mean and how does it differ from a warranty?*
Representations are statements believed to be true to the best of one's knowledge. A warranty is an absolutely true statement upon which the validity of the insurance policy depends.
3. *If the insured intentionally answers any questions on the application for insurance untruthfully, and the information is material to the insurance, what type of statements are these? Can they void a contract?*
If the insured intentionally answers any of the questions untruthfully, the statements are considered misrepresentations and could void the contract.
4. *What does indemnify mean?*
To "restore" an insured to the same financial status as before the loss.
5. *What is underwriting?*
Underwriting is the risk selection and classification process.
6. *Describe the differences between Part 1 & Part 2 of the application.*
Part 1 of the application includes the general questions about the applicant, including name, age, address, birth date, gender, income, marital status, and occupation. Part 2 includes medical information about prospective insured.
7. *What is the purpose of the agent's report?*
The agent's (producer's) report is used by the agent to discuss his or her personal observations concerning the proposed insured.
8. *Who is required to sign the insurance application?*
Both the agent and the proposed insured (usually the applicant) must sign the application.
9. *At what point does coverage begin when an agent issues a conditional receipt?*
The conditional receipt says that coverage will be effective either on the date of the application or the date of the medical exam, whichever occurs last.
10. *When is a policy considered delivered?*
When the insurer relinquishes control of the policy by mailing it to the policyowner, legally the policy is considered delivered.
11. *What is the purpose of Key Person insurance?*
Key person insurance allows a business to insure a key person or officer in an organization whose death would cause financial hardship for the organization.
12. *Who owns a group life contract? Who are the parties to the contract? What does the insured receive?*

The actual policy (master policy/contract) is issued to the sponsor of the group, which is often an employer. The employees are the insured who are issued certificates of insurance.

13. What type of insurance is group life insurance?

Group insurance is typically written as annually renewable term insurance.

14. What are some of the group characteristics that an underwriter would look at?

Purpose, size, turnover and financial strength of the group.

15. What is the key feature of converting group term to whole life insurance? What is consistent and what changes, face amount or premium?

The employee has the right to convert to an individual whole life policy without proving insurability at a standard rate, based on the individual's attained age. The face amount or death benefit will be equal to the group term face amount but the premium will be higher.

16. What is the difference between contributory and noncontributory group life insurance plans?

In a noncontributory plan an employer pays 100% of the premium (employees are not contributing). In a contributory plan, the premiums are shared between the employer and employees.

17. Explain how the cash value of a life insurance policy can be taxed.

Annual increases in cash value are not taxed since it accumulates on a tax-deferred basis. However, upon withdrawal the amount of cash value that exceeds the sum of the premiums paid will be taxed to the policyowner as ordinary income.

18. If a policy is a Modified Endowment Contract, how are the withdrawals taxed?

The first dollars that are received by the policyowner are considered to be the excess amount of cash value over premiums (gain) and are immediately taxed. This is referred to as "interest-first rule" or LIFO ("last in first out").

19. What requirements must be met in order for a retirement plan to be qualified?

The plan must be for the exclusive benefit of the employees and their beneficiaries and be formally written and communicated to the employees. The plan's benefit or contribution formula cannot discriminate in favor of the "prohibited group," or be geared exclusively to the prohibited group. The plan must be permanent, be approved by the IRS and have a vesting requirement.

20. What are the consequences of withdrawing money from a traditional IRA prior to 59½?

10% penalty

21. How are income payments from a 403(b) plan taxed?

Funds contributed are excluded from the employee's current taxable income, but are taxable upon withdrawal.

22. Who is eligible to be covered under a Keogh Plan?

To be covered under a Keogh retirement plan, the person must be self-employed or a partner working part or full-time who owns at least 10% of the business.

Under eligibility requirements, any individual who is at least 21 years of age, has worked for a self-employed person for one year or more and worked at least 1000 hours per year (full-time) must be included in the plan.

23. Regarding Social Security, what does the term "fully insured" mean?

It refers to someone who has earned 40 quarters of coverage, and is therefore entitled to receive Social Security retirement, Medicare, and survivor benefits.

24. What are some differences between being fully insured and partially insured?

A person who is fully insured has met the Quarter of Coverage standards and is eligible to receive Social Security retirement, Medicare and survivor benefits. A partially insured person qualifies for certain benefits and has earned 6 credits during the 13-quarter period ending with the quarter in which the insured dies or becomes entitled to disability insurance or old-age insurance benefits.

25. How is Social Security funded?

Social Security is funded by the taxes imposed on a worker's earned income.

26. If a person takes benefits at age 62, what is the impact on his or her retirement benefits?

They are reduced to about 80% of what would have been paid at age 65.

27. Why is it difficult to qualify for Social Security Disability benefits?

Because they require the covered worker to be unable to engage in any

substantial, gainful employment.