Life Insurance Basics

Now that you have examined some basic terms that apply to the insurance industry as a whole, you'll focus on the concepts pertinent to life insurance. This chapter will explain why individuals and businesses would want to buy life insurance. You will also take a look at the process of underwriting and policy issue, and the role of the producer in this process.

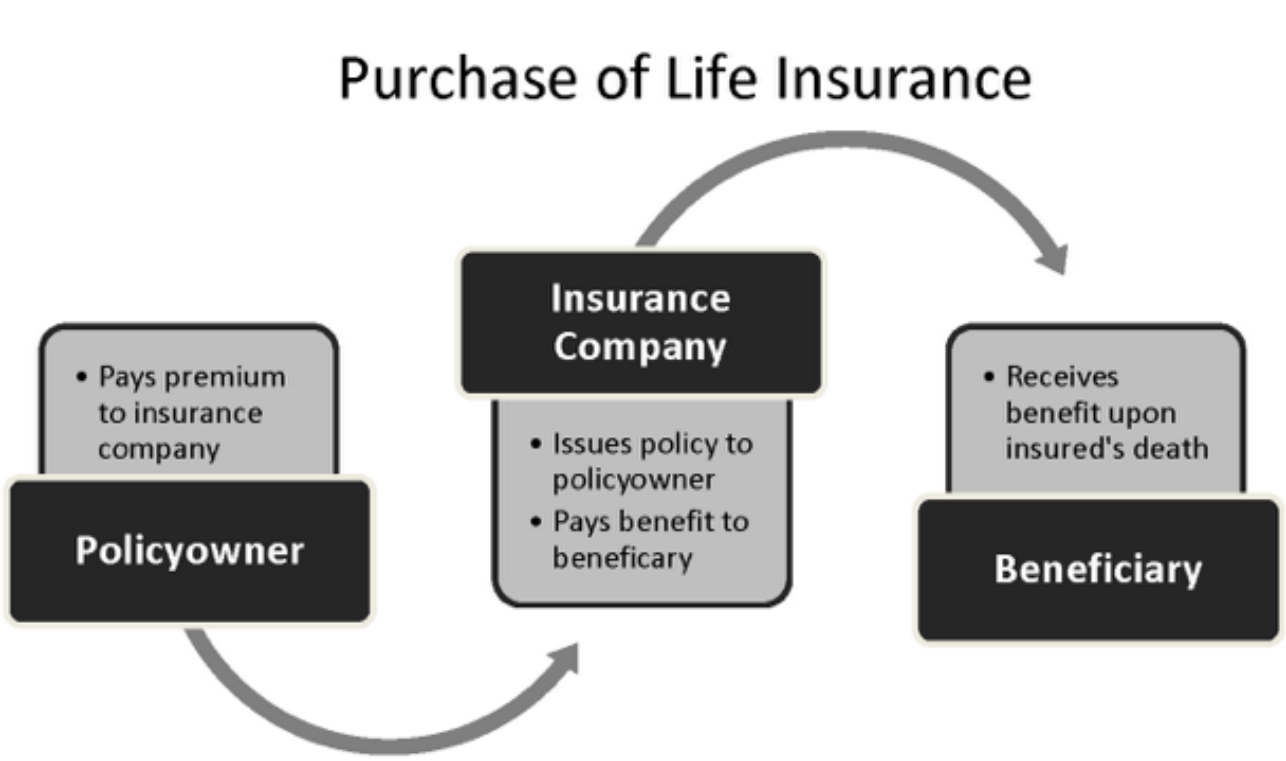
TERMS TO KNOW

Adverse selection — tendency of individuals with higher probability of loss to purchase insurance more often than those who present a lower risk
Death benefit — the amount paid upon the death of the insured in a life insurance policy
Cash value — equity amount accumulated in permanent life insurance
Estate — a person's net worth
Illustrations — presentation or depiction of nonguaranteed elements of a life insurance policy
Life insurance — coverage on human lives
Liquidation — selling assets in order to raise capital
Lump-sum — payment of the entire benefit in one sum
Minor — a person under legal age
Solvency — ability to meet financial obligations (e.g., an insurance company maintains enough assets to pay claims)

A. Purchase Of Life Insurance And Insurable Interest

Life insurance protects against financial loss associated with an insured's death, and pays a death benefit to beneficiaries upon the death of the insured. The policyowner of the insurance contract pays a premium to the insurer. The insurer issues a policy covering the insured. In the event of the insured's death, the insurer pays the death benefit to the beneficiary.

Life insurance may be purchased by individuals or businesses.



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.

B. Personal Uses Of Life Insurance

1. Survivor Protection

The death of the primary wage-earner will usually stop the flow of income to a family. The death of a nonearning spouse who cares for minor children can also cause great financial hardship for the survivors. Life insurance can

provide the funds necessary for the survivors of the insured to be able to maintain their lifestyle in the event of the insured's death. This is known as **survivor protection.** Planning for survivor protection requires careful examination of current assets and liabilities as well as determining what survivors' needs may be.

2. Estate Creation and Conservation

A person may create an estate through earnings, savings, and investments, but all of these methods require disciplined action and a significant period of time. The purchase of life insurance **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, they will have an estate of at least that amount the moment the first premium is paid. There is no other legal method by which an immediate estate can be created at such a small cost.

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

3. Liquidity

As a result of the cash accumulation feature, some life insurance policies provide **liquidity** to the policyowner. That means the policy's cash values can be borrowed against at any time and used for immediate needs.

4. Asset Protection

Asset protection is the use of life insurance to guard one's wealth against creditor claims without engaging in practices that are ultimately illegal, such as concealment or fraudulent transfer.

An insurance contract is between the policyowner and the insurer. When the insured dies, the contractual arrangement is between the insurer and the beneficiary, and the proceeds of the life insurance belong to the beneficiary. The insured's creditors have no right to the proceeds or the cash value. The following conditions apply:

- If the insured has filed a petition of bankruptcy within 2 years, the proceeds and cash value are only exempt under certain circumstances;
- The amount of premiums paid with intent to defraud creditors is not exempt; and
- A creditor possessing a valid assignment from the policyowner may recover the amount secured by the assignment with interest from either the cash surrender value or the proceeds of the life insurance policy.

C. Viatical And Life 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 settlement **provider** means a person, other than a viator, that enters into a viatical settlement contract;
- Viatical **producers** represent the providers; and
- 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.

1. Definitions

Chronically Ill

Chronically ill means a condition in which a person is unable to perform at least **2 activities** of daily living or that requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

Terminally Ill

Terminally ill means a condition (illness or sickness) that can reasonably be expected to result in death within **24 months**.

Viator

Viator means the owner of a life insurance policy who enters into or seeks to enter into a viatical settlement contract.

Viatical Settlement Broker

Viatical Settlement Broker means a licensed person that, for a fee, negotiates viatical settlement contracts between the viator and viatical settlement providers. The viatical settlement broker represents the viator.

Viatical Settlement Provider

Viatical settlement provider means a person (other than a viator) who enters into or effectuates a viatical settlement contract. This term does not include a bank, financing entity, or the issuer of a life insurance policy providing accelerated benefits.

Viatical Settlement Purchaser

Viatical Settlement Purchaser means anyone who gives a sum of money as consideration for a life insurance policy or interest in the death benefits of a life insurance policy. It also means a person who owns, acquires, or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy which is or will be the

subject of a viatical settlement contract.

This term does not include the following:

- A viatical settlement licensee;
- An accredited investor, qualified institutional buyer, or qualified purchaser who purchases a viaticated policy from a viatical settlement provider;
- A financing entity;
- A special purpose entity; or
- A related provider trust.

Fraudulent Viatical Settlement Act

Fraudulent viatical settlement act means an act or omission committed knowingly or with intent to defraud for the purpose of depriving another of property or for monetary gain by a person who commits or permits employees or agents to do any of the following:

- Present or prepare false information in support of or concerning a fact material to one of the following, with the knowledge that such will be presented to others:
    - An application for a viatical settlement contract or insurance policy;
    - The underwriting of a viatical settlement contract or insurance policy;
    - A claim for payment under a viatical settlement contract or insurance policy;
    - Premiums paid on an insurance policy;
    - Payments and changes in ownership or beneficiary of a viatical settlement contract or insurance policy;
    - Reinstatement or conversion of an insurance policy;
    - Solicitation, effectuation, offer, or sale of a viatical settlement contract or insurance policy;
    - Issuance of written evidence of a viatical settlement contract or insurance policy; and
    - A financing transaction;
- Destroy, remove, conceal or change assets or records of anyone engaged in the business of viatical settlements, with the purpose of furthering or hiding fraud;
- Misrepresent or conceal the financial condition of a licensee or insurer;
- Transact viatical settlements without a license, certificate of authority, or other necessary legal authority;
- File false information with or conceal information about a material fact from an insurance regulatory official;
- Knowingly present or prepare a fraudulently obtained insurance policy;
- Embezzlement, theft, misappropriation or conversion of moneys, funds, premiums, or other property of anyone engaged in the business of viatical settlements of insurance; or
- Attempt to commit, assist, aid or abet in, or conspire to commit any of the acts mentioned above.

2. General Rules

Viatical settlement providers must obtain the following information before entering into a contract:

- A witness document which contains the following:
    - The insured (viator) consents to the contract;
    - The viator has a full and complete understanding of the contract and the benefits of the policy;

    - The viator entered into the contract freely and voluntarily;
    - The insured is terminally or chronically ill and was diagnosed after the life insurance policy was issued; and
    - The viator is of sound mind and under no constraint or undue influence;
- A document giving the insured's consent to the release of medical records to the viatical settlement provider, broker, and insurance company; and
- A document giving the insured's consent to the tolling of the running of the policy's contestable period until after the insurer completes its good faith investigation, if the life policy is being viaticated within 2 years of the policy issue.

Within 20 days of completing the contract, the viatical settlement provider must give **written notice** to the insurer that issued the insurance policy that the policy has or will become a viaticated policy.

Contacts with the Insured

A viatical settlement broker or provider may contact an insured to request information regarding the insured's health status. The contacts cannot be made more often than every **3 months** if the insured has a life expectancy of *more than 1 year,* and **no more than once per month** if the insured has a life expectancy of *1 year or less.*

3. Disclosure to Consumers

Viatical settlement providers and brokers must supply applicants with a disclosure signed by the provider or broker and the viator. The disclosure must include the following information:

- Possible alternatives to viatical settlement contracts;
- Proceeds taxation information;
- Proceeds subject to claims of creditors;
- Effect on eligibility for Medicaid or other government benefits;
- That the viator has **15 calendar days** to rescind a viatical settlement. If the insured dies in the rescission period, the settlement contract will be deemed rescinded;
- That entering into a viatical settlement contract may cause other rights or benefits to be forfeited; and
- Funds will be sent to the viator within **3 business days** after the viatical settlement provider acknowledges that the ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

If the viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, that provider must inform the insured within **20 days** of the change.

4. Licensing

Anyone engaging in the business of viatical settlements as a provider or broker must be properly licensed. A license may be obtained by applying to the Department. An application for a viatical settlement license must include the following:

- An audited financial statement – not more than **1 year and 120 days** old; and

- An unaudited financial statement (as of the end of the most recent quarter).

Licenses may be renewed annually, on the anniversary month, by filing the proper renewal forms and paying the renewal fee. The following licensing fees are due at the time of initial and renewal application:

- For licensure as a viatical settlement provider, **$300**; and
- For licensure as a viatical settlement broker, **$100**.

Both providers and brokers must present to the Department new or revised information about changes in officers, **10%** or more stockholders, partners, directors, members or designated employees within **30 days** of that change.

All viatical applications will be approved or disapproved by the Department within **90 days** of their receipt. The applicant may waive this time period.

5. Life Settlements

The term **life settlement** refers to any financial transaction in which the owner of a life insurance policy sells a policy that is no longer needed to a third party for some form of compensation, usually cash. While *viatical settlements* are still used for persons who are terminally ill, most states regulate policies that are sold to a third party for compensation under the term *Life Settlements.*

In life settlements, the seller (the policyowner) could have a life expectancy of more than one year. Policyowners may choose to sell their policies because they feel they no longer need their coverage, or the premium costs have grown too high to justify continuation of the policy.

D. Determining Amount Of Personal Life Insurance

Individuals seeking to buy life insurance may need assistance trying to establish how much coverage is appropriate, based on their ability to pay the premium, serve their needs, and protect their survivors. Insurance companies have developed 2 basic approaches to help producers and buyers to determine the needed amount of protection: human life value approach and needs approach.

1. Human Life Value Approach

The **human life value approach (HLVA)** gives the insured an estimate of what would be lost to the family in the event of the premature death of the insured. It calculates an individual's life value by looking at the insured's wages, inflation, the number of years until retirement, and the time value of money.

Example:

Let's assume that a 40-year-old insured earns $50,000 a year and is expected to earn the same amount until he retires at age 65. Out of his

annual income, $40,000 is spent on family needs, and the remaining $10,000 goes to the insured's personal expenses. This means that the human life value of this insured to his family is $1,000,000 ($40,000 a year spent on family needs x 25 years to retirement). Based on this assumption, and taking interest and inflation into consideration, the insurance company will determine the right amount of insurance to produce the same annual amount of income for the family if the insured were to die.

2. Needs Approach

The needs approach is based on the predicted **needs of a family** after the premature death of the insured. Some of the factors considered by the needs approach are income, the amount of debt (including mortgage), investments, and other ongoing expenses.

Determining Lump-sum Needs

Insurance proceeds paid in a lump-sum may be needed for any of the following expenses:

- **Costs Associated with Death (postmortem)** — taking into account the final medical expenses of the insured, funeral expenses, and day-to-day expenses family maintenance;
- **Debt Cancellation (as an alternative to Estate Liquidation)** — paying off debts of the insured such as home mortgage, or auto loans. (Most lenders require a collateral assignment of life insurance as a condition for a loan.);
- **Emergency Reserve Funds** — paying for unexpected expenses following the death of the insured, such as travel expenses and lodging for family members:
- **Education Funds** — paying for children's education expenses so they can remain in school, or for a surviving spouse who may need additional education or training in order to re-enter the job market;
- **Retirement Fund** — as a source of retirement income;
- **Bequests** — leaving funds to the insured's church, school, or a charity.

E. Business Uses Of Life 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

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.

Change of Insured Provision

The change of insured provisions is found in some life insurance policies that are owned by businesses and to insure the life of a key employee. In the event the key employee quits or is terminated, the owner (business) may transfer the coverage to the replacement employee, subject to evidence of insurability.

2. Buy-Sell Funding

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.

3. Executive Compensation

Executive bonus is an arrangement where the employer offers to give the employee a wage increase in the amount of the premium on a new life insurance policy on the employee. The employee owns the policy and, therefore, has full rights to the policy. Since the employer treated the premium payment as a bonus, that amount is **tax deductible to the employer** and **income taxable to the employee**. It is assumed that if the employee were not willing to accept these conditions, the employer would not provide the benefit. Executive bonus plans are not subject to plan limits established by the IRS for qualified plans, so it is considered a nonqualified benefit plan.

F. Classes Of Life Insurance Policies

There are many types of life insurance products available for consumers. Although all life insurance products offer death protection, each type also includes its own unique features and benefits and is designed to serve different insureds' needs.

You will study different types of policies in greater detail later in this course. For the purposes of this chapter, however, you need to understand some basic definitions and characteristics of different classes of life insurance policies.

1. Permanent vs. Term

Regarding the length of coverage, all life insurance policies fall into 2 categories: temporary and permanent protection.

Term life insurance is *temporary* life insurance provided for a specific period of time. It is also known as pure life insurance.

Permanent life insurance is a general term used to refer to various forms of whole life insurance policies that remain in effect to age 100, as long as the premium is paid. Permanent insurance provides lifetime protection, and includes a savings element (or cash value).

2. Participating vs. Nonparticipating

A **participating (mutual)** life insurance policy refers to any policy that distributes its dividends to policyowners by cash payments, reduced premiums, units of paid up insurance, a savings program, or by the purchase of term insurance. A **nonparticipating** policy does not pay dividends to the policyowners.

Know This! Only participating policies distribute dividends to policyowners.

3. Fixed vs. Variable Life Insurance and Annuities

Fixed life insurance or annuities are contracts that offer guaranteed minimum or fixed benefits that are stated in the contract. **Variable** life insurance or annuities are contracts in which the cash values accumulate based upon a specific portfolio of stocks without guarantees of performance. Variable annuities keep pace with inflation, and are determined by the value of securities backing it.

4. Group vs. Individual

Individual life insurance is written on a single life. The rate and coverage are based upon the underwriting of that individual.

Group life insurance is written as a master policy covering the lives of more than one individual covered under the single policy. Individuals covered do not receive a policy but instead receive certificates of insurance. The rate and coverage are based upon group underwriting, with all individuals covered for the same amount and rate.

G. Producer Responsibilities

1. Solicitation and Sales Presentations

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.

In an effort to protect consumers and promote informed purchasing decisions, the State of Pennsylvania has established certain regulations and requirements that effect the solicitation of life insurance.

Advertisements

First and foremost, **advertising must be accurate and not misrepresent the facts**. Advertising rules apply to any insurance advertisement intended for presentation, distribution, dissemination or other advertising use when

used or made either directly or indirectly by or on behalf of the insurance company.

Every insurance company must establish and maintain a system of control over the content, form, and method of dissemination of all advertising of its policies. The **insurer** whose policies are advertised is **responsible for all its advertisements**, regardless of who wrote, created, presented, or distributed them.

The term *advertisement* may include printed material, audio visual material or descriptive literature. These advertisements could be used in any of the following ways: direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, circulars, leaflets, booklets, depictions, illustrations, form letters, prepared sales talks, and presentations.

The following rules apply to insurance advertising in this state:

- Insurers must submit **three copies** of all advertisement to the department of insurance for approval;
- Once a mail-order solicitation has been filed, it may be used for **2 years** without additional filing;
- Advertising material will remain filed for **4 years**, or until the next regular examination of the company, whichever is longer; and
- If a testimonial refers to benefits received under a contract, the specific claim data should be retained by the insurer for 4 years or until the filing of the next regular examination of that insurer, whichever is longer.

Illustrations

The term ***illustration*** means a presentation or depiction that includes nonguaranteed elements of a policy of individual or group life insurance over a period of years. A life insurance illustration must do the following:

- Distinguish between guaranteed and projected amounts;
- Clearly state that an illustration is not a part of the contract; and
- Identify those values that are not guaranteed as such.

An agent may only use the illustrations of the insurer that have been approved, and may not change them in any way.

Any insurer marketing a policy with an illustration must comply with the regulations established by the Commissioner that govern the form and content of illustrations. Each insurer must notify the Commissioner's office as to whether or not a life insurance policy or annuity product will be marketed with illustrations.

The illustrations are not to be part of or attached to the contract.

Those values that are not guaranteed must be identified as such. An agent may use only the illustrations of an insurer that have been approved and may not change them in any way.

All illustrations must be clearly labeled, and must be dated and signed by the agent and insurer. Agents cannot provide an applicant with an incomplete

illustration. A copy of all illustrations used must be provided for the applicant. The insurer must keep a copy of all illustrations used in the underwriting file.

In Pennsylvania, certification of the aforementioned notification must be provided, **annually**, within **30 days** of the anniversary of the original certification. Similarly, a certification must be provided at least 30 days prior to using an illustration with a new life insurance policy form. Insurers should retain copies of basic illustrations, and their certification, for 3 years after those policies are no longer in force.

Illustration actuaries certify the scale used in illustrations. Actuaries may not have resigned or been removed from similar positions within the past 5 years.

Life Insurance Disclosure Statement

Every applicant for a life insurance policy must be given a written disclosure statement that provides basic information about the cost and coverage of the insurance being solicited. This disclosure statement must be given to the applicant no later than the time the application for insurance is signed. Disclosure statements will help the applicants to make more informed and educated decisions about their choice of insurance.

The insurer must maintain the agent's certification that a disclosure statement was delivered for either **3 years**, or until the next regular examination, whichever is later.

Buyer's Guide

A **buyer's guide** provides basic, **generic** information about life insurance policies that contains, and is limited to, language approved by the Department of Insurance. This document explains how a buyer should go about choosing the amount and type of insurance to buy, and how a buyer can save money by comparing the costs of similar policies. Insurers must provide a buyer's guide to all prospective policy applicants prior to accepting their initial premium. If the policy contains an unconditional refund provision of at least 10 days (free-look period), a buyer's guide can be delivered with the policy.

Policy Summary

A **policy summary** is a written statement describing the **features and elements** of the policy being issued. It must include the name and address of the agent, the full name and home office or administrative office address of the insurer, and the generic name of the basic policy and each rider. A policy summary will also include premium, cash value, dividend, surrender value and death benefit figures for specific policy years. The policy summary must be provided when the policy is delivered.

Know This! A buyer's guide provides *generic* information on various types of policies. A policy summary provides *specific* information on the policy being issued.

Outline of Coverage

No policy may be delivered or issued for delivery in this Commonwealth unless an appropriate outline of coverage either accompanies the policy or contract, or is delivered at the time application is made.

Life Insurance Policy 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.

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**.

Life Insurance Surrender Comparison Index Disclosure

In Pennsylvania, all applicants for life insurance policies that are not specifically excluded must be given a Surrender Comparison Index Disclosure. The purpose of a surrender comparison is to provide a life insurance purchaser with a means of making a cost comparison of the same types of life insurance policies having the same premium payment period and pattern.

The interest adjusted method at **5%** will be used to provide **10** and **20 year** surrender comparison indexes – per **$1,000** of the face amount of basic insurance. This index is based on the premise that the policy will be surrendered at the end of either **10** or **20 years**.

The insurer will maintain the agent's certification of surrender comparison index disclosure delivery in its files for at least **3 years**.

This regulation does not apply to the following types of insurance products:

- Annuities;
- Group life;
- Credit life;
- Life insurance in amounts less than $5,000;
- Life insurance on substandard risks;
- Life insurance related to qualified retirement plans;
- Life insurance issued as the result of a contractual policy change;

- Life insurance where the cost is borne by an employer;
- Variable life insurance;
- Family policies;
- Term policies; and
- Riders.

Replacement

Replacement is a practice of terminating an existing policy or letting it lapse, and obtaining a new one. To make sure that replacement is appropriate and in the best interests of the policyowner, insurance producers and companies must take special underwriting measures to help policyowners make informed decisions.

Replacement means any transaction in which new life insurance or a new annuity is purchased and, as a result, the existing life insurance or annuity has been or will be any of the following:

- Lapsed, forfeited, surrendered, or otherwise terminated;
- Reissued with any reduction in cash value;
- Converted to reduced paid-up insurance, continued as extended term insurance or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
- Amended so as to affect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid; or
- Used in a financed purchase.

Replacing insurer is the company that issues the new policy.
Existing insurer is the company whose policy is being replaced.

Duties of the replacing producer:

- 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;
- Obtain a list of all existing life insurance and/or annuity policies to be replaced including policy numbers and the names of all companies being replaced;
- Leave the applicant with the original or a copy of written or printed communications used for presentation to the applicant; and
- Submit to the replacing insurance company a copy of the replacement notice with the application.

Each producer who initiates the application must submit the following to the insurance company with or as part of each application:

- A statement signed by the applicant as to whether replacement of existing life insurance or annuity is involved in the transaction; and
- A signed statement as to whether the producer knows replacement is or may be involved in the transaction.

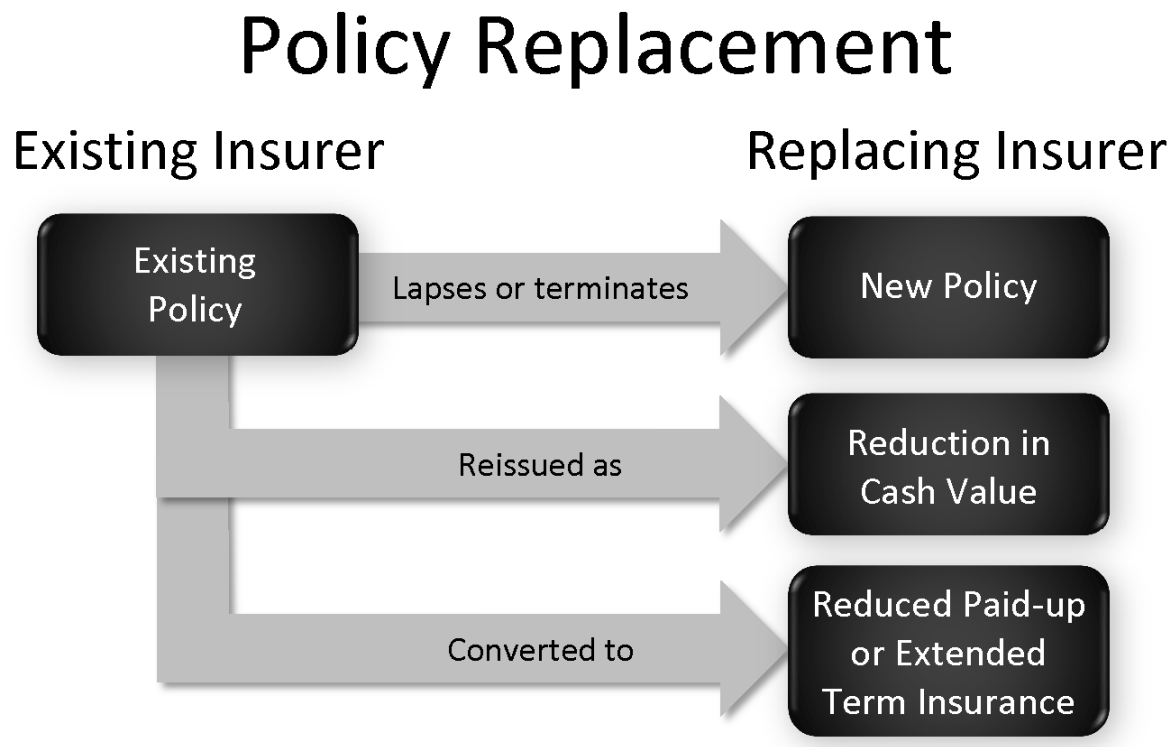
Duties of the replacing insurance company:

- 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; and

- 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.

Duties of the existing insurer:

- Retain all replacement notifications for at least 5 years or until the next regular examination by the insurance department – whichever is later;
- Send a letter notifying the policyowner of his or her right to receive information regarding the existing policy values. The information then must be provided within 5 business days of receipt of the request from the policyowner;
- Upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice advising the policyowner that the release of policy values may affect the guaranteed and nonguaranteed elements, face amount or surrender value.



In the state of Pennsylvania, the replacing insurer must notify the existing insurer of a replacement **within 5 business days** following the receipt of the application or on the day the policy is issued, whichever is sooner.

Any insurer, agent or broker that undertakes a conversion must provide the policyholder with a disclosure statement or ledger statement within 20 days.

Replacing insurers must inform applicants that they have a right to an unconditional refund of all premiums paid within 20 days of the policy delivery.

Evidence that these requirements have been met should be maintained for at least **3 years.**

Suitability

An insurance producer may not recommend the purchase, sale, or exchange of an insurance policy or annuity contract without the reasonable belief that the transaction is in the best interest of the insured.

Life and Health Insurance Guaranty Association

Guaranty Associations are formed to protect policyowners, insureds, beneficiaries, and anyone entitled to payment under an insurance policy from the incompetence and insolvency of insurers. The association will pay covered claims up to certain limits set by state law. The Association is funded by its members through assessment. All authorized insurers, which are required to be the members of the Association, contribute to a fund to provide for the payment of claims for insolvent insurers.

It is an **unfair trade practice** to make any statement that an insurer's policies are guaranteed by the existence of the Insurance Guaranty Association.

Know This! Insurers *cannot advertise protection* by the Insurance Guaranty Association.

2. Field Underwriting

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*.

Application Procedures

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.

Agent's Report

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.

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.

Signatures Required

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 on the Application and Amendments

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.

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.

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.

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.

H. 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.

1. Sources of Underwriting Information and Regulations

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.

Producer Report

The producer's (agent's) report allows the producer to communicate with the underwriter and provide information on the applicant that may assist in the underwriting process. It becomes part of the application.

Attending Physician Statement

When smaller amounts of insurance are requested and there is no prior medical history of concern, the home office underwriter may make an underwriting decision solely on the basis of the application. If, however, the underwriter sees answers to certain questions that could indicate greater risk, and the underwriter wants to obtain specific medical details, the underwriter will request a statement from the applicant's physician. This is called an **Attending Physician Statement (APS).** The insurance company must pay for this information, but it is often less expensive than ordering an examination.

The next step would be a paramedical exam (which often includes blood work and a urine sample). A paramedical exam is conducted by a registered nurse or a paramedic. Under certain circumstances the underwriter may require a full medical examination by a licensed physician for additional information. All these are at the insurer's expense.

A full medical exam occurs routinely for applicants requesting higher amounts of coverage, or if the application raised additional questions concerning the health of the prospective insured, or for applicants beyond a certain age. Each company establishes standard requirements, based on age and amount of coverage, and reserves the right to request additional

information and testing, at their own expense.

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 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** the purpose of which it is to collect, maintain, and make available to insurance companies important underwriting information on applicants for life and health insurance. 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.

Know This! Insurers cannot refuse coverage solely on the basis of adverse information on an MIB report.

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 insureds' privacy, states have enacted the following laws and regulations for insurers requiring an applicant to submit to an HIV test:

- Prior to testing, 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;
- The test must be administered in a manner that meets the protocol of the U.S. Department of Health and Human Services;
- The insurer must disclose the test results as authorized by the applicant in

writing;
- If the applicant has not identified a physician to receive test results, the positive test results and the identity of the applicant must be sent to the state Department of Health; and
- The reporting of test results must include the name and address of the reporting company.

Requiring an HIV test is not considered unfair discrimination as long as the following conditions are met:

- The testing is required for all individuals in the same class;
- Proposed insured is not denied coverage on the basis of such testing alone (if no other conditions specified in the Insurance Code apply); and
- The tests and testing procedures have been approved by the United States Food and Drug Administration (FDA) and otherwise comply with applicable state and federal laws.

Insurers are permitted to ask a proposed insured whether he or she has tested positive on an AIDS-related test.

HIV-related tests may only be performed with a written consent of the subject, and may be determined positive only with confirmatory testing. When revealing the test results, the insurers must provide counseling regarding the following:

- The significance of the test results;
- Methods for preventing the transmission of HIV;
- The benefits of counseling; and
- The availability of health care and support services.

Furthermore, insurers are only required to disclose negative test results to subjects that request such a disclosure. Insurers cannot disclose positive test results. Instead, the results will be disclosed to an individual designated by the subject.

The following insurer practices are acceptable:

- Considering AIDS to be the same as other medical conditions (such as cancer or heart disease);
- Keeping information obtained through the underwriting process confidential;
- Insuring applicants with AIDS at standard premiums or higher;
- Rejecting applicants with AIDS, based on underwriting; and
- Maintaining life insurance policies that do not include provisions excluding claims related to specific conditions (such as AIDS).

2. Selection Criteria & Unfair Discrimination

Information the companies obtain relating to risk factors helps the underwriters determine the extent of the risks involved. In order to avoid adverse selection, the company may discriminate in favor of good risks and against poor risks. However, insurance companies cannot unfairly discriminate between individuals of the same class and equal life expectancy in the rates, benefits, or any terms and conditions of the contract.

The following are examples of underwriting practices in life and health

insurance that would constitute **unfair discrimination** between **individuals of the same class**:

- Discriminating in policy rates and benefits based solely on
  - Age or gender;
  - Physical or mental impairment;
  - Blindness or partial blindness; or
  - Genetic characteristics or genetic testing.
- Investigating as part of the underwriting process a proposed insured's sexual orientation.

In Pennsylvania, violations of unfair discrimination law may result in any of the following penalties:

- Suspended or revoked licenses;
- Refusal to renew licenses for up to 1 year; and/or
- Fines of up to $500 for each violation.

3. Classification of Risks

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.**

Know This! The higher the risk, the higher the premium.

Preferred

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.

Standard

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.

Substandard

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.

Declined

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.

I. Premium Determination

Once the company determines that an applicant is insurable, they need to establish an appropriate policy premium. The premium will be used to cover the costs and expenses to keep the policy in force. **Premiums are paid in advance**.

1. Factors in Premium Determination

There are three primary factors that are used in premium determination: risk (mortality - rate of death within a specific group), interest and expense.

Mortality

Mortality is the ratio of the number of deaths in a specific population over a certain amount of time versus the number of living people in that population. **Mortality tables**, used by insurers, indicate the number of individuals within a specified group of individuals (e.g., males, females, smokers, nonsmokers) starting at a certain age, who are expected to be alive at a succeeding age. In other words, these tables help the insurers predict the expectation of life and the probability of death for a given group.

In 2001, the NAIC has adopted the 2001 Commissioners Standard Ordinary (CSO) Mortality Table, which extends the ultimate age to 120 (as opposed to age 100 previously). *For instance*, the 2001 CSO Table terminal reserves gradually grade to $1,000 per $1,000 at age 120, as opposed to the previously used 1980 CSO Table, in which terminal reserves grade to $1,000 per $1,000 at age 99. The state of Pennsylvania has adopted the 2001 CSO Table as mandatory for life insurance policies issued after 2008. This means that policies must use the new tables in development of reserves and nonforfeiture values.

Interest

Because premiums are paid before claims are incurred, insurance companies invest a large portion of the premiums in an effort to earn interest on these funds (invested in bonds, stocks, or mortgages). The interest earnings help insurers reduce the premium rates for policyowners.

Expense

The expense factor, also known as the *loading charge,* also affects premium rates. Insurers have various operating expenses, so each premium must carry

a proportionate share of these operating costs. The insurer's largest expense is the commissions paid to its agents. Other ongoing expenses include payroll, rent, and taxes.

2. Premium Concepts

Net Single Premium

The **net single premium** includes the mortality and interest components necessary to keep the policy in force until maturity.

Mortality - Interest = Net Premium

Gross Annual Premium

Gross annual premium is the one-year cost for mortality, plus the cost of operating the company (or expense loading). Loading includes commissions, taxes, advertising, and while not an expense, includes the amount added to a pure or basic rate to provide for a profit margin to the insurer.

Net Premium + Expense (loading) = Gross Premium

Example:

Assume that

$500 Mortality cost $400 Net premium

- $100 Interest + $200 Operating cost

$400 Net Premiumtherefore,**$600 Gross Premium**

3. Premium Payment Mode

In regard to insurance premiums, *mode* refers to the **frequency** the policyowner pays the premium. An insurance policy's rates are based on the assumption that the premium will be paid annually at the beginning of the policy year and that the company will have the premium to invest for a full year before paying any claims. If the policyowner chooses to pay the premium more frequently than annually, there will be an additional charge because the company will have additional expenses in billing the premium. However, the premium may be paid annually, semi-annually, quarterly, or monthly.

Higher Frequency = Higher Premium

Monthly > Quarterly > Semi-Annual > Annual

J. Policy Issue And 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**.

1. Delivery Receipt

When an agent hand delivers an individual policy or annuity to the policyowner, the agent must obtain a signed **delivery receipt**. The receipt will be in duplicate and state the date the contract was received. The free-look period will take effect on the date the receipt was signed.

If a policy is delivered by any other method, the insurer must establish a way to verify the policy delivery. A certificate of mailing is considered adequate proof of delivery.

2. Policy Review

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.

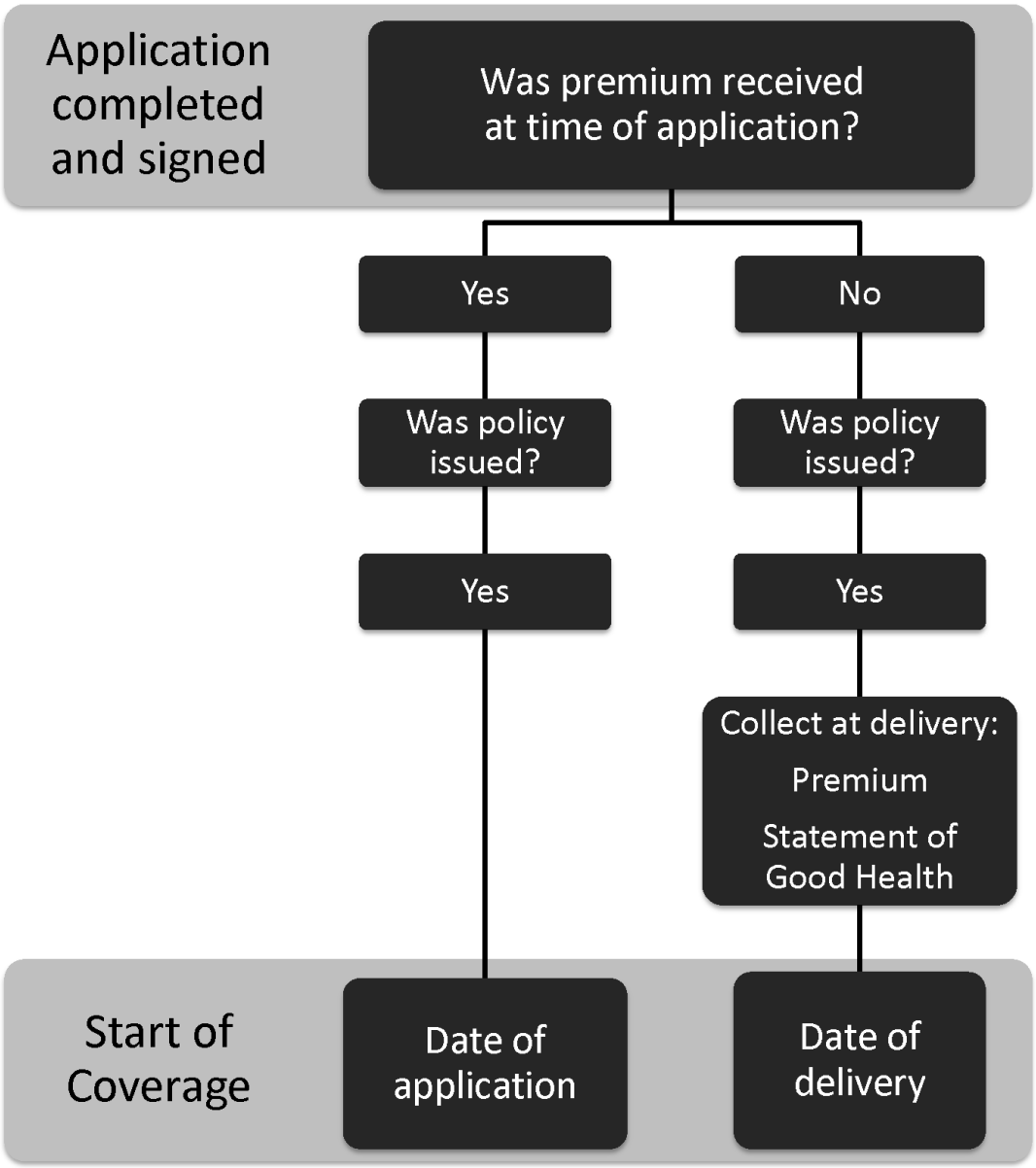
3. Effective Date of Coverage

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.

Sometimes it is possible to lower the premium rate by **backdating** *(or antedating)* an application for insurance. If the applicant chooses to do this, the policy may be backdated for no more than **6 months** before the date of the application or the medical examination, whichever is later. All premiums must be paid from the effective date of the policy. The only allowable reason that an application may be backdated is to **effect a lower premium.**



K. Chapter Recap

This chapter explained some of the basic principles and processes of life insurance. Let's recap them:

PURCHASE OF LIFE INSURANCE	
Personal Use	• *Survivor protection* - planning for survivor needs • *Cash accumulation* - permanent policies have living benefits • *Estate creation* - life insurance creates an immediate estate • *Estate conservation* - using life insurance proceeds to

	cover estate taxes
Amount of Insurance	• *Human life value approach* - potential earnings of the insured (considering salary, years to retirement, inflation) • *Needs approach* - predicted needs of the surviving family (considering debt, income, Social Security blackout, expenses)
Business Uses of Life Insurance	• *Key person* - third-party ownership - business is the owner; employee is the insured • *Buy-sell funding* - not really insurance, but a business continuation agreement • *Executive bonuses* - employer gives the employee a wage increase in the amount of insurance premium; employee is the policyowner

PROCESS OF ISSUING A LIFE INSURANCE POLICY

Solicitation and Sales Presentations	• *Advertisements* - must be truthful and not misleading • *Illustrations* - presentation of nonguaranteed elements • *Buyer's guide* - *g*eneric information about life policies; must be provided at the time of application • *Policy summary* - description of features and benefits of the policy being issued; must be provided when the policy is delivered
Underwriting	Field underwriting (by agent) • *Application* - completed and signed • *Agent's report* - agent's observations about the applicant that can assist in underwriting • Premiums with application and conditional receipts Company underwriting: • Multiple sources of information (e.g. application, consumer reports, Medical Information Bureau) • *Selection criteria* - cannot discriminate unfairly • *Risk classification* - 3 types of risks: standard, substandard, and preferred
Premium Determination	• 3 key factors for life insurance: mortality, interest and expense • Premium payment mode - the higher the frequency, the higher the premium
Policy Issue and Delivery	• Effective date of coverage - policy is delivered and the premium is paid • If the premium not paid with the application, the agent must obtain the premium and a statement of continued good health at the time of policy delivery