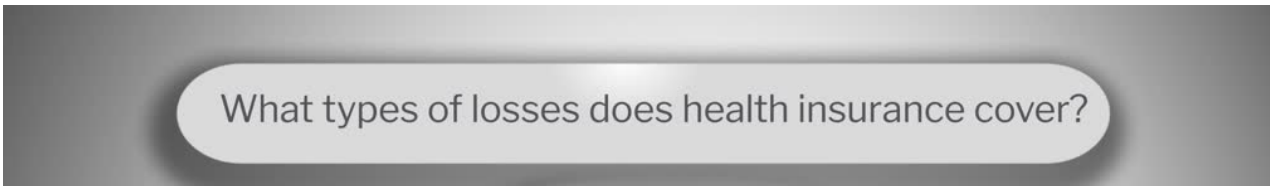
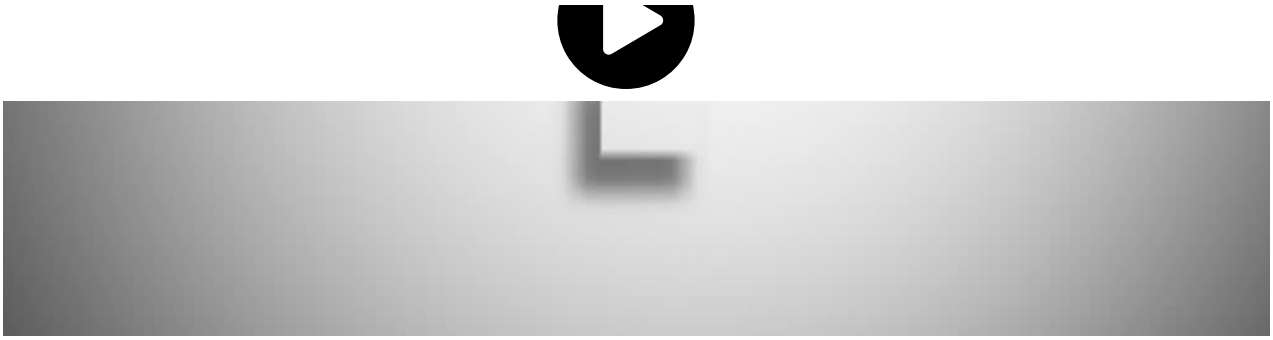
Study Chapter

Accident and Health Insurance Basics





This section will present different classes of health insurance policies, as well as concepts that generally apply to health insurance. You will begin by learning about the principal types of losses and benefits, common exclusions from coverage, and producer's responsibilities and liabilities for errors. This section will take an in-depth look at health insurance underwriting. This type of underwriting is particularly prone to unfair discrimination because of the presence of certain health conditions and the use of genetic information. Finally, you will learn about the concept of policy replacement and factors to consider in determining the best course of action.

TERMS TO KNOW

Comprehensive coverage — health insurance that provides coverage for most types of medical expenses
Copayment — an arrangement in which an insured must pay a specified amount for services "up front" and the provider pays the remainder of the cost
Deductible — the portion of the loss that is to be paid by the insured before any claim may be paid by the insurer
Dependent — someone relying on the insured for support
Enrollee — a person enrolled in a health insurance plan, an insured (doesn't include dependents of

the insured)
Insolvent — unable to meet financial obligations
Pre-existing conditions — conditions for which the insured has received diagnosis, advice, care, or treatment during a specific time period prior to the application for health coverage
Riders — added to the basic insurance policy to add, modify or delete policy provisions
Solicitation — an attempt to persuade a person to buy an insurance policy; it can be done orally or in writing
Waiting period — a period of time that must pass after a loss occurs before the insurer starts paying policy benefits

A. Definition of Perils

There are two major causes of loss (perils) under a health insurance policy. Policies may cover both accident and sickness or accident only.

1. Accidental Injury

Accidental bodily injury is an unforeseen and unintended injury that resulted from an accident rather than a sickness.

2. Sickness

Sickness is normally defined as an illness that first manifests itself while the policy is in force. The majority of health insurance claims result from sickness rather than accidental injury. An emergency medical condition is one which is so severe in pain or symptoms that if not treated quickly and properly could cause serious bodily harm, or possibly death.

Know This! The two major perils covered in health insurance policies are accidental bodily injury and sickness.

B. Types of Losses and Benefits

1. Loss of Income From Disability

Loss of income caused by accident and/or sickness that results in the insured's inability to work and earn income is covered under disability income policies or coverages. Disability income insurance is a valued contract or stated amount that pays weekly or monthly benefits due to an injury or sickness. Benefits may be determined by the insured's past earnings and may be limited to a percentage of that income.

2. Medical Expense

A medical expense contract covers many of the expenses one incurs from an accident or sickness, such as a physician or hospital expense. Expenses may be paid directly to the insured, and the insured would be responsible for paying the medical expenses. This type of benefit payment is called **reimbursement**. If expenses are paid on a scheduled basis, the insurance company will refer to a list determining the cost of the treatment, and it will only pay up to a certain amount. If a person were covered as a dependent under their spouse's group insurance, payment of medical expenses would be coordinated.

Know This! Medical expense benefits are considered reimbursement benefits.

3. Dental Expense

Dental expense insurance is a form of medical expense health insurance that covers the treatment, care and prevention of dental disease and injury to the insured's teeth. An important feature of a dental insurance plan which is typically

not found in a medical expense insurance plan is the inclusion of diagnostic and preventive care (teeth cleaning, fluoride treatment, etc.). Some dental plans require periodic examinations as a condition for continued coverage.

4. Long-term Care Expense

Long-term care policies provide benefits for medically necessary services that an insured receives in a nursing home or their own home (home health care), but not care received in an acute care unit of a hospital.

C. Limited Policies

1. Types of Limited Policies

Accident-only

Accident-only policies are limited policies that provide coverage for death, dismemberment, disability or hospital and medical care resulting from an accident. Because it is a limited medical expense policy, it will *only pay for losses resulting from accidents* and not sickness.

Accidental Death and Dismemberment (AD&D)

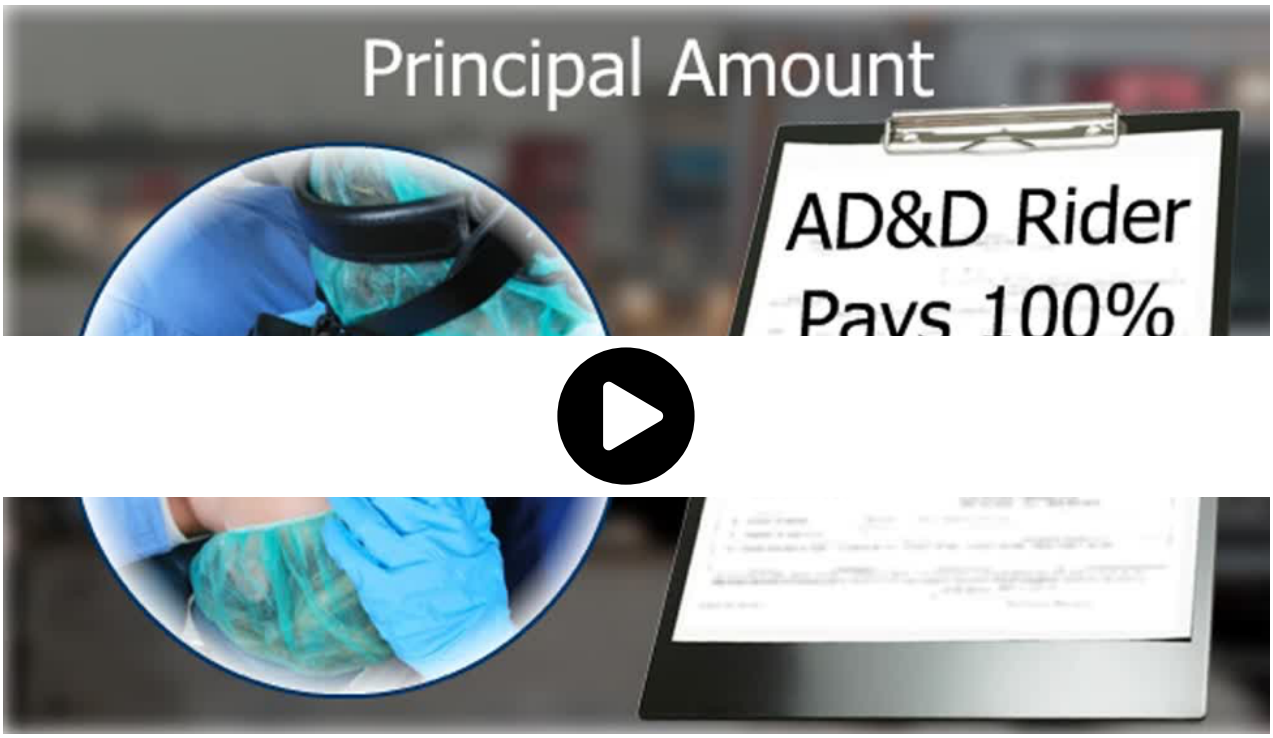
Accidental Death and Dismemberment (AD&D) coverage can be written as a rider or as a separate policy. It is, however, most frequently part of group life and group health plans. It provides for the payment of a lump-sum benefit in the event that the insured dies from an accident, as defined in the policy, or in the event of loss of certain body parts caused by an accident.

Accidental Death and Dismemberment coverage only pays for accidental losses and is thus considered a pure form of accident insurance. The **principal sum** is paid for accidental death. This amount is usually equal the amount of coverage under the insurance contract, or the face amount. In case of loss of sight or accidental dismemberment, a percentage of that principal sum will be paid by the policy, often referred to as the **capital sum**. The amount of the benefit will vary according to the severity of the injury.

The policy will usually pay the full principal for the loss of sight in both eyes, or two or more limbs; however, it may only pay **50%** for the loss of one hand or one foot. In addition, some policies will pay double or triple indemnity, meaning the policy will pay **twice** or **three times** the face amount in the event of accidental death.

Most policies will pay the accidental death benefit as long as the death is caused by the accident and occurs within **90 days**.

Know This! In AD&D policies, the principal sum means the full face amount (100%), and the capital sum is a percentage of the face amount.



Travel Accident

A **travel accident** policy provides coverage for death or injury resulting from accidents occurring while a fare-paying passenger is on a common carrier. The benefits are *only paid if the loss occurs* during the time of travel.

Specified (Dread) Disease

A **dread disease**, or limited risk, policy provides a variety of benefits for a specific disease such as cancer policy or heart disease policy. Benefits are usually paid as a *scheduled, fixed-dollar amount* of indemnity for specified events or medical procedures, such as hospital confinement or chemotherapy.

In Pennsylvania, these policies provide coverage for specifically named diseases with deductibles of less than $250 and an aggregate benefit limit of not less than $5,000. The benefit period for these policies is no less than 2 years. The following expenses are specifically covered:

- Hospital confinement in amounts of at least $100 per day, for at least 500 days;
- Surgical expenses not to exceed an overall lifetime maximum of $3,500; and
- Radium, cobalt, chemotherapy or X-ray therapy expenses – incurred outside the hospital – of at least $1,000. This benefit must be restored after an insured is treatment-free for at least 12 months.

Hospital Indemnity (Income)

A **hospital indemnity** policy provides a specific amount on a daily, weekly or monthly basis while the insured is confined to a hospital. Payment under this type of policy is unrelated to the medical expense incurred, but *based only on the number of days confined in a hospital.* This can also be called a hospital fixed-rate policy.

Critical Illness

A **critical illness** policy covers multiple illnesses, such as heart attack, stroke, renal failure, and pays a lump-sum benefit to the insured upon the diagnosis (and survival) of any of the illnesses covered by the policy. The policy usually specified a minimum number of days the insured must survive after the illness was first diagnosed.

Blanket Insurance

A **blanket** policy covers members of a particular group when they are participating in a particular activity. Such groups include students, campers, passengers on a common carrier, or sports teams. Often the covered insureds names are not known because they come and go. Unlike group health insurance,

the individuals are automatically covered, and they do not receive a certificate of insurance. Blanket policies are commonly written and pay on an accident-only basis.

Prescription Drugs

Prescription drug coverage is usually an optional benefit under a group medical policy. Generally, the insured pays a copayment amount (like $10) and the insurance company pays the balance. There are generally limitations on quantities that one can purchase at one time (such as 30-day supply).

Vision and Health Care

Some employers provide this form of group health insurance to their employees to cover eye examinations and eyeglasses, or hearing aids on a limited basis. Know that per the Affordable Care Act, pediatric vision benefits are mandatory.

It is common in most vision expense insurance plans to restrict benefits to one exam and one pair of glasses in any 12-month period.

Dental

Usually dental insurance distinguishes among several classes of dental expenses, and provides somewhat different treatment for each.

Routine and preventive maintenance is covered up to an annual maximum without a deductible or copayment. This coverage benefit usually includes routine examinations and teeth cleaning once a year, and perhaps full-mouth X-ray once every 3 years. (The absence of a deductible and copayment is intended to encourage preventive maintenance.)

Routine and major restorative care includes treatments for cavities, oral surgery, bridges and dentures. These procedures are covered up to a specific maximum, subject to an annual deductible per insured family member and a coinsurance.

Orthodontic care, if included, will have a separate maximum and a separate deductible, which may differ from the deductible for restorative care.

D. Common Exclusions from Coverage

The following losses are typically **not covered** in individual or group medical expense policies:

- **War or act of war** injuries or sicknesses; active military duty may be also excluded from coverage;
- **Intentionally self-inflicted injuries**;
- **Elective cosmetic surgery**; however, if treatment is required to correct a condition due to an accident or a birth defect, or is medically necessary, then coverage may be available;
- **Experimental/investigation procedures**;
- **Conditions covered by workers compensation** if they are covered under workers compensation laws or other legislation;
- **Government plans:** health insurance policies exclude expenses either paid or eligible for payment under Medicare or other federal, state, or local medical expense program;
- **Participation in criminal activity:** if a person is injured while committing an illegal act, health insurance will not cover the expense of the injury;
- **Injuries resulting from drug or alcohol intoxication** (unless administered by a physician).

E. Producer Responsibilities

1. Marketing Requirements

Advertising Standards for Accident and Health Insurance

The purpose of rules and regulations regarding **advertisements** is to ensure truthful and adequate disclosure of relevant information to the consumer, and to prevent unfair competition among insurers.

Advertising rules apply to any accident and sickness 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. The term *advertisements* includes any printed or published material, descriptive literature and sales aids, prepared sales talks and presentations, and material included with a policy.

Every insurance company must establish and at all times 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 these advertisements, regardless of who wrote, created, presented, or distributed the advertisements.

When an advertisement refers to a dollar amount or a period of time, it must disclose any exceptions, reductions or limitations affecting the basic provisions of the contract – without which the advertisement would have the capacity to mislead.

An advertisement may not represent broad insurance coverage when under the terms of the contract, without disclosing the applicable exception, reduction or limitation.

If a policy contains waiting periods between the effective date of the policy and the effective date of coverage, the advertisement must disclose the existence of such periods.

An advertisement may not use the words such as *only*, *just*, *merely*, *minimum* or similar to describe the applicability of exceptions and reductions.

An advertisement may not contain descriptions of a contract limitation, exception or reduction worded in a positive manner, such as describing a waiting period as a "benefit builder" or making statements such as "even pre-existing conditions are covered after 2 years."

Sales Presentations

Sales presentations must be **accurate and complete**. Sales materials include any and all promotional materials, policy applications, replacement forms, outline of coverage and any other forms or information used in connection with solicitation or sale of accident and health insurance.

Outline Coverage

An **outline of coverage** must be delivered at the time of application or upon delivery of the policy. With direct response sales, however, the insurer does not have an opportunity to provide the outline of coverage at the time of application, so it is not required. The purpose of the outline of coverage provision is to provide full and fair disclosure to the applicant.

The outline of coverage must include all of the following:

- A description of the benefits and coverage provided by the policy;
- A statement of the exclusions, reductions, and limitations contained in the policy;
- A statement of the terms under which the policy or certificate may be continued in force or discontinued – including any reservation in the policy of a right to change premium;
- Continuation or conversion provisions of group coverage must be specifically described;
- A statement that the outline of coverage is only a summary, not a contract of insurance, and that the policy contains governing contractual provisions;
- A description of the terms under which the policy may be returned and premium refunded; and
- A brief description of the relationship of cost of care and benefits.

Life and Health Insurance Guaranty Association

State **Life and Health Guaranty Associations** are nonprofit legal entities created to protect policyowners, insured, and beneficiaries against insolvent insurers within certain limitations. All licensed insurers are members of the Guaranty Association and must remain members as a condition of their authority to do business in this state. When a company goes bankrupt, all other members of the Association contribute to help financially the policyowners of the insolvent company.

The Association's liability is generally limited to those of the impaired insurance company. The liability of the Association may not exceed the lesser of the contractual obligations for which the insurance company is liable, or the following amount with respect to any one life, regardless of the number of policies or contracts:

- $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
- $100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values.
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

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 first step in the total process of insuring health risks. The basic purpose of health insurance underwriting is to **minimize the problem of adverse selection**. Adverse selection involves the fact that those most likely to have claims are those who are most likely to seek insurance. An insurance company that has sound underwriting guidelines will avoid adverse selection more often than not.

In health insurance, **field underwriting** is far more important than in life insurance. The basic purpose of health insurance underwriting is to minimize the problem of adverse selection. Adverse selection involves the fact that those most likely to have claims are those who are most likely to seek insurance. An insurance company that has sound underwriting guidelines will avoid adverse

selection more often than not. Note that the **specific underwriting requirements will vary by insurer.**

Moral hazard is a significant factor in health insurance underwriting because of the possibility of malingering, and it is the agent, not the home office underwriter, who actually has personal contact with the applicant. It is the responsibility of the agent to ask the applicant questions clearly and precisely and to record the answers accurately.

A producer's function as the field underwriter is to gather credible information from an applicant that would assist the underwriter in screening marginal or unacceptable risks before taking an application for an insurance policy.

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

Application Procedures

An application for insurance begins with a form provided by the company and completed by the agent as questions are asked of the applicant, and the applicant's responses are recorded. This form – often called the "app" – is then submitted to the insurance company for its approval or rejection. The application is the applicant's written request to the insurance company to issue a policy or contract based upon the information contained in the application. If the policy is issued, a copy of this application is stapled in the back of the policy and it becomes part of the **entire contract.**

A **notice to the applicant** must be issued to all applicants for health insurance coverage. This notice informs the applicant that a credit report will be ordered concerning their past history and any other health insurance for which the applicant has previously applied. The agent must leave this notice with the applicant.

Completeness and Accuracy

The agent must take special care with the accuracy of the application in the interest of both the company and the insured. Because the application is often the main source of underwriting information, 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.

Know This! It is the agent's responsibility to make sure that an application for insurance is complete and accurate to the best knowledge of the applicant.

Signatures

Every health insurance application requires the signature of the proposed insured, the policyowner (if different than the insured), and the agent who solicits the insurance.

Changes in the Application

Because the application is so important, most companies require that it be filled out in ink. The agent might make a mistake when filling out the app or the applicant might answer a question incorrectly and want to change it. There are two ways to correct an application. The first and best is to simply start over with a fresh application. If that is not practical, draw a line through the incorrect answer and insert the correct one. **The applicant must initial the correct answer.**

Know This! Any changes on the application must be initialed by the applicant or

insured.

Premiums with the Application

Under the terms of the insurability conditional receipt, the insurance coverage becomes effective as of the date of the receipt, provided the application is approved. This receipt is generally provided to the applicant when the initial premium is paid at the time of application.

Disclosure of Information about Individuals

An insurance company or an agent cannot disclose any personal or privileged information about an individual unless any of the following occurs:

- A written authorization by the individual dated and signed within the past 12 months has been provided;
- The information is being provided to all of the following:
  - An insurance regulatory authority or law enforcement agency, pursuant to the law;
  - An affiliate for an audit, but no further disclosure is to be made;
  - A group policyholder for the purpose of reporting claims experience;
  - To an insurance company or self-insured plan for coordination of benefits; and
  - A lien holder, mortgagee, assignee or other persons having a legal or beneficial interest in a policy of insurance.

Common Situations for Errors and Omissions

At any time during the sales process there can be a misunderstanding or misrepresentation that could lead to legal action being taken by the insured. Agents should document everything: interviews, phone conversations, requests for information, etc. The **sales interview and the policy delivery** are the most common occasions for errors and omissions (E&O) situations to occur that may result in providing inadequate coverage or failure to maintain and service coverage.

3. Policy Delivery

Although policy delivery may be accomplished without physically delivering it in the policyowner's possession, an agent should personally deliver policies whenever possible. Once the delivery of a policy is made, the free-look period begins.

Delivery Receipt

Policy proof of delivery is required by obtaining the owner's/insured's signature on a delivery receipt which is mailed to the home office.

Policy Review

When delivering the policy, the agent should review the insured's original goals and needs. The policy should also be thoroughly reviewed with the insured.

Statement of Good Health

In many cases, the initial premium is not paid until the policy is delivered. Most insurance companies require that when collecting the premium, the agent must also obtain a statement signed by the insured testifying to continued good health.

Effective Date of Coverage

Under the terms of the insurability conditional receipt, the insurance coverage becomes effective as of the date of the receipt, provided the application is approved. This receipt is generally provided to the applicant when the initial premium is paid at the time of application.

Premium Collection

All premiums, return premiums, or other funds received by an agent must be kept in a fiduciary capacity. An agent must, in the regular course of business, account for and pay these funds when due to the insurer, insured, or the insured's assignee.

All funds received by an agent must be kept in a fiduciary account which is separate from all other business and personal funds. Funds deposited into the separate fiduciary account must not be commingled or combined with other funds except for the purpose of advancing premiums.

F. Company Underwriting

The underwriter's function is to select risks, which are acceptable to the insurance company. The selection criteria used in this process, by law, must be only those items that are based on sound actuarial principles or expected experience. The underwriter cannot decline a risk based on blindness or deafness, genetic characteristics, marital status, or sexual orientation.

When underwriting health insurance policies, the prime considerations are age, gender, occupation, physical condition, avocations, moral and morale hazards, and financial status of the applicant.

1. Sources of Underwriting Information

Application

An accurate and thorough application is imperative to the insurance company.

Producer Report

Only the agent/producer is involved in completing the agent's (producer's) report. It asks questions about the length of time that the applicant has been known to the agent, an estimate of the applicant's income and net worth and whether the agent knows of any reason that the contract should not be issued. The agent's statement **does not** become part of the *entire contract*.

Attending Physician Statement

If the underwriter deems it necessary, an attending physician's statement (APS) will be sent to the applicant's doctor to be completed. This source of information is best for accurate information on the applicant's medical history. The physician can explain exactly what the applicant was treated for, the treatment required, the length of treatment and recovery, and the prognosis.

Investigative Consumer (Inspection) Report

An investigative consumer report includes information on an applicant's character, general reputation, personal habits, and mode of living that is obtained through investigation. For example, this report could include interviews with associates, friends, and neighbors of the applicant. Such reports may not be performed unless the applicant is clearly and accurately informed of the report in writing. The consumer report notification is usually part of the application. At the time that the application is completed, the agent will separate the notification and give it to the applicant.

Medical Information Bureau (MIB)

The Medical Information Bureau (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. Reports on previous insurance information can be obtained from the Medical Information Bureau. Members of MIB can request a report on an applicant and receive coded information from any other applications for insurance submitted to other MIB members. MIB information cannot be used in and of itself to decline a risk, but it can give the underwriter important additional information.

Medical Examinations and Lab Tests (Including HIV Consent)

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.

If an insurer requires an applicant to take an HIV test, the insurer must first obtain the applicant's written consent for the test. The consent form must explain the purpose of the test, and inform the applicant about the confidentiality of the results, and procedures for notifying the applicant about the results. Underwriting for HIV or AIDS is permitted as long as it is not unfairly discriminatory. An adverse underwriting decision is not permitted if based solely upon the presence of symptoms, but only if HIV is confirmed in relation to the symptoms. Insurance companies must maintain strict confidentiality regarding HIV-related test results or diagnoses.

Before a written consent for HIV-related tests is obtained, the insurer must provide the following in writing:

- A disclosure of the effects of the test results on the approval of the health insurance application or the risk classification;
- Information about AIDS, HIV and the HIV-related test, and alternative testing and counseling;
- A description of the insurer's confidentiality standards; and
- A statement advising the applicant to seek counseling before undergoing the test due to the serious nature of the HIV-related illnesses.

If the **test result is negative**, the insurer is required to disclose the results to the subject only upon a request for notification.

If the **test result is positive**, the insurer may not disclose the result to the subject, but to a physician, department or an approved local community-based organization designated on the written consent to the HIV-related test. The positive test result will then be disclosed to the subject by that designated party.

2. Classification of Risks

Once the underwriters have collected and reviewed all the necessary information on the applicant, they will make a decision to either accept or decline the applicant for insurance. The applicants that have been accepted will fall into one of the 3 categories: preferred, standard or substandard.

Preferred

Preferred risks reflect a reduced risk of loss and are covered at a reduced rate. Nonsmokers would be an example of preferred risks.

Standard

Standard risks reflect average exposures and may be insured at standard rates and premiums.

Substandard

Substandard risks are those that reflect an increased risk of loss. These applicants may be able to obtain health insurance coverage but at an increased premium. An applicant could be rated substandard for a poor health history or a dangerous vocation or avocation.

G. Considerations in Replacing Accident and Health Insurance

1. Benefits, Limitations and Exclusions

When an agent attempts to replace the insured's current health insurance policy with a new one, the agent needs to be careful not to mislead the insured or provide coverage that is to the insured's detriment. It is the agent's responsibility to carefully compare the benefits, limitations and exclusions found in the current and the proposed replacement policy. **The agent also must make sure that the current policy is not cancelled before the new policy is issued.**

Know This! There cannot be any coverage gap between the existing coverage and replacement coverage.

2. Pre-existing Conditions

Pre-existing conditions are a very important consideration when replacing a

policy. A pre-existing condition is a medical condition for which the insured sought medical advice or treatment within a specified period of time prior to the policy issue. Health conditions covered under the current policy may not be covered under the new policy because of pre-existing condition limitations, or new waiting periods may be required in a new policy. While the Affordable Care Act eliminated pre-existing conditions for individual and group accident and health insurance policies, they may still apply to Medicare, long-term care, and disability income coverages.

3. Waiting Periods

During policy replacement, an insurer may apply a probationary or waiting period, usually 10 to 30 days after the policy issue date. No benefits will be available for sickness during the waiting period; however, accidents are usually covered from the date of policy issue.

4. Underwriting Requirements

Underwriting is important when replacement is involved. It is an underwriter's duty to evaluate risk and decide whether or not a person is eligible for coverage. The insured may be under the assumption that a replacing policy is in his/her best interests, but after being evaluated by an underwriter, where premium and risk are exchanged, an insured may not be paying the same premium or receiving the same benefits.

Example:

When Robert applies for health insurance at age 25, as a nonsmoker without health problems, he should have a different premium than if he applied for a replacing policy at age 45, after suffering a heart-attack, and having smoked for 15 years. Let's assume that at the age of 25 Robert paid an excessively high policy premium because he was issued an overpriced policy. *What happens at age 45?* Robert is evaluated, with age and health taken into account (along with other factors), and the premiums are higher due to these factors. Even though Robert was told he was paying excessive premiums on his original policy, if a new policy is written, he will be judged on the factors that affect his policy at that time, not at the time the original policy was written.

5. Producer's Liability for Errors and Omissions

If an agent or broker engages in misrepresentation during the replacement of health insurance contracts, he/she may be exposed to errors and omissions liability as well as having their insurance license suspended or revoked.

6. Pennsylvania Replacement Requirements

Health insurance application forms in this state must contain questions that would elicit information to determine whether the new insurance policy will be replacing any other accident and health insurance already in force.

If the sale involves replacement, at the time of the application, the insurer or its agent must provide the applicant with a **notice regarding replacement of accident and sickness insurance**. A copy of the notice signed by the applicant must be retained by the insurer. This requirement does not apply to single premium nonrenewable policies and accident only policies. The notice must inform the applicant that the existing health policy will lapse, explain the free-look, pre-existing condition and waiting period provisions, and advise the

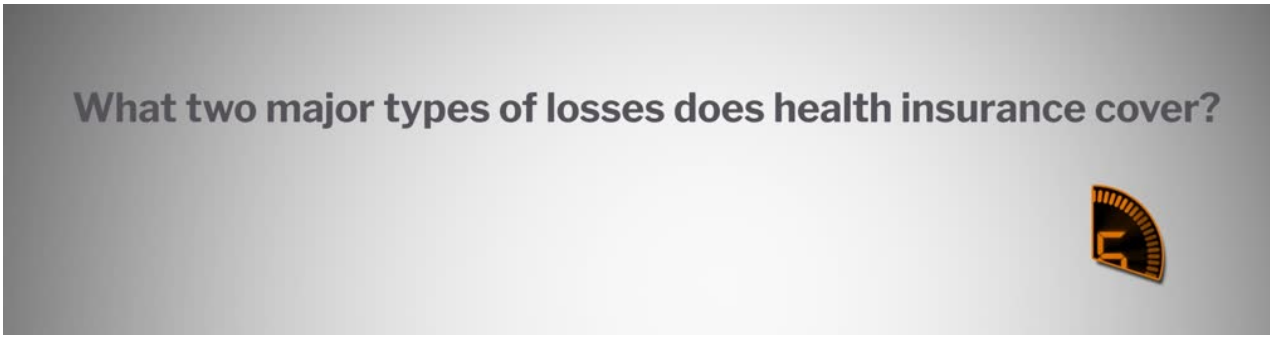
applicant to seek professional guidance in order to make an educated decision.

H. Chapter Recap

This chapter explained the basics of health insurance and underwriting procedures for health insurance policies. Let's recap them:

TYPES OF LOSSES AND EXCLUSIONS	
Principal Types of Losses and Benefits	• *Disability loss of income* - caused by insured's inability to work • *Medical* - medical or hospital expenses incurred from an accident or sickness • *Dental* - usually stand-alone plans; cover diagnostic and preventive care • *Long-term care* - covers expenses for care in a nursing home or in the insured's own home
Classes of Health Insurance Policies	• Individual vs. group • Private vs. government • Limited vs. comprehensive
Types of Limited Policies	• *Accident* - coverage for disability, medical care, death or dismemberment resulting from an accident • *Dread disease policy* - variety of benefits for a specific disease such as cancer policy or heart disease policy • *Critical illness* - pays a lump sum to the insured upon diagnosis and survival of a critical illness • *Hospital indemnity* - provides a specific amount on a daily, weekly or monthly basis while the insured is confined to a hospital • *Dental plans* - covers the treatment, care and prevention of dental disease and injury to the insured's teeth • *Vision/hearing plans* - type of group health insurance that covers eye examinations and eyeglasses, or hearing aids on a limited basis • *Credit disability* - covers payments on loans if the insured becomes disabled • *Prescription drugs* - the insured pays a copay and the insurer pays the rest of the prescription balance
Common Exclusions	• Injuries resulting from war or active military service • Intentionally self-inflicted injuries • Elective cosmetic surgery • Experimental procedures • Conditions covered by workers compensation insurance • Expenses paid for by government plans • Injuries caused by participation in criminal activity
UNDERWRITING	
Steps in the Underwriting Process	• Field underwriting – by agent • Company underwriting • Premium determination

	• Policy delivery: *Effective date of coverage* - if the premium is not paid with the application, the agent must obtain the premium and a statement of continued good health at the time of policy delivery
Sources of Insurability Information	• Application - must be completed and signed • *Producers/agent's report* - agent's observations about the applicant that can assist in underwriting • *Attending Physician Report* - best for accurate information on the applicant's medical history • *Investigative consumer report* - includes information on an applicant's character, general reputation, personal habits, and mode of living that is obtained through investigation • *MIB report* - helps companies share adverse medical information on insureds
REPLACEMENT	
Agent's Responsibility	• Compare benefits, limitations and exclusions found in the current and the proposed replacement policy • Provide Notice Regarding Replacement • Ensure that the current policy is not cancelled before the new policy is issued



Chapter Complete

Previous Next