



**Chapter
1**

Introduction to Risk and Insurance

Objectives:

After studying this chapter, you should be able to

- Distinguish between speculative risk and pure risk
- Describe various ways to manage financial risk
- Identify the five characteristics of insurable risks
- Define antiselection and give examples of two factors that can increase or decrease the likelihood that an individual will suffer a loss
- Identify four risk classes for proposed insureds
- Define insurable interest and determine in a given situation whether the insurable interest requirement is met

Outline

The Concept of Risk

Risk Management

- Avoiding Risk
- Controlling Risk
- Transferring Risk
- Accepting Risk

Insurance

Managing Risks through Insurance

- Characteristics of Insurable Risks
- Insurance Underwriting
- Insurable Interest Requirement

No one knows for certain what will occur in the future. It may rain tomorrow, or it may not. You may become ill tomorrow, or you may not. Your home may be destroyed by fire tomorrow, or it may not. Many possible future events, such as the weather in other parts of the world, probably will not affect you. However, some possible future events, such as a severe illness or the destruction of your home, may result in substantial—even ruinous—financial loss. **Risk** is the chance or possibility of an unexpected result, either a gain or a loss. To understand insurance and how it works, you first need to understand the concept of risk.

The Concept of Risk

Risk exists whenever there is uncertainty about the future. Individuals and businesses experience two kinds of risk—speculative risk and pure risk. **Speculative risk** involves three possible outcomes: loss, gain, or no change. For example, if you invest money in the stock market, you are speculating that the value of your investment will increase, in which case you will make a profit. However, the value of your investment could decrease instead, in which case you could suffer a loss. If the value of your investment remains the same, you neither earn a profit nor incur a loss. Speculative risks cannot be insured.

Pure risk involves no possibility of gain; either a loss occurs or no loss occurs. An example of pure risk is the risk of becoming disabled as a result of illness or injury. If you do become disabled, you likely will experience a financial loss resulting from lost income. You probably also will incur other costs, such as costs for medical care. If, on the other hand, you never become disabled, then you will incur no financial losses related to disability, but you do not have any possibility for financial gain either. Pure risk—the risk of loss without the possibility of gain—is the only type of risk that can be insured.

Risk Management

Because the effects of an unexpected financial loss can be severe, individuals and businesses usually want to minimize their level of risk whenever possible. **Risk management** is the process by which individuals and businesses identify and assess the risks they face and take measures to eliminate or reduce their exposure to those risks. Four general techniques can be used to manage financial risk: avoiding the risk, controlling the risk, transferring the risk, or accepting the risk.

Avoiding Risk

The first, and perhaps most obvious, method of managing risk is simply to avoid risk altogether. We can avoid the risk of personal injury that may result from an airplane crash by not traveling by air, and we can avoid the risk of financial loss in the stock market by not investing in it. Sometimes, however, avoiding risk is not effective, practical, or desirable. For example, we cannot effectively avoid the risk of having our personal possessions destroyed or damaged.

Controlling Risk

We can try to control risk by taking steps to prevent or reduce potential losses. For instance, people can reduce the likelihood of contracting a number of diseases by exercising regularly, maintaining a healthy diet, and not smoking. People who become ill often can reduce the severity of the illness by taking proper medication or following a prescribed course of medical treatment. Similarly, a business can install smoke detectors and sprinkler systems in its office building to reduce the likelihood of fire damage and lessen the severity of any damage that might occur.

Transferring Risk

Transferring risk is a third method of risk management. When you transfer risk to another party, you shift the financial responsibility for that risk to the other party. For example, suppose you loan money to your neighbor, Jerry Anderson. You face the risk that Jerry may not repay the loan when due, so you require Jerry's father, George, to guarantee the loan. Thus, George will have to repay you if Jerry does not. By getting George to guarantee repayment, you have transferred the risk of Jerry's nonpayment to George. As we shall see, the most common way for individuals, families, and businesses to transfer risk is to purchase insurance coverage.

Accepting Risk

The final method of managing risk is to accept, or retain, risk. Simply stated, to accept a risk is to assume all financial responsibility for that risk. Sometimes, as in the case of an insignificant risk such as losing a pencil, the financial loss is not great enough to warrant much concern. We assume the cost of replacing the pencil ourselves. Some people consciously choose to accept more significant risks. For example, a couple may decide not to purchase disability income insurance because they believe they can reduce their standard of living if one of them becomes disabled.

Alternatively, accepting a risk can be an unconscious decision. Any risk you face that is not managed by other methods—either avoided, controlled, or transferred—is always accepted, whether you are aware of it or not. For example, for a number of years, many people and businesses were completely unaware of the methods that hackers could use to gain access to data on their computers. Because they were unaware of this risk and, therefore, took no steps to avoid, control, or transfer it, they often suffered significant financial losses as a result. To prevent the inadvertent acceptance of potentially disastrous risks, successful risk management first requires *identifying* all potential risks, then determining what techniques to use to manage them.

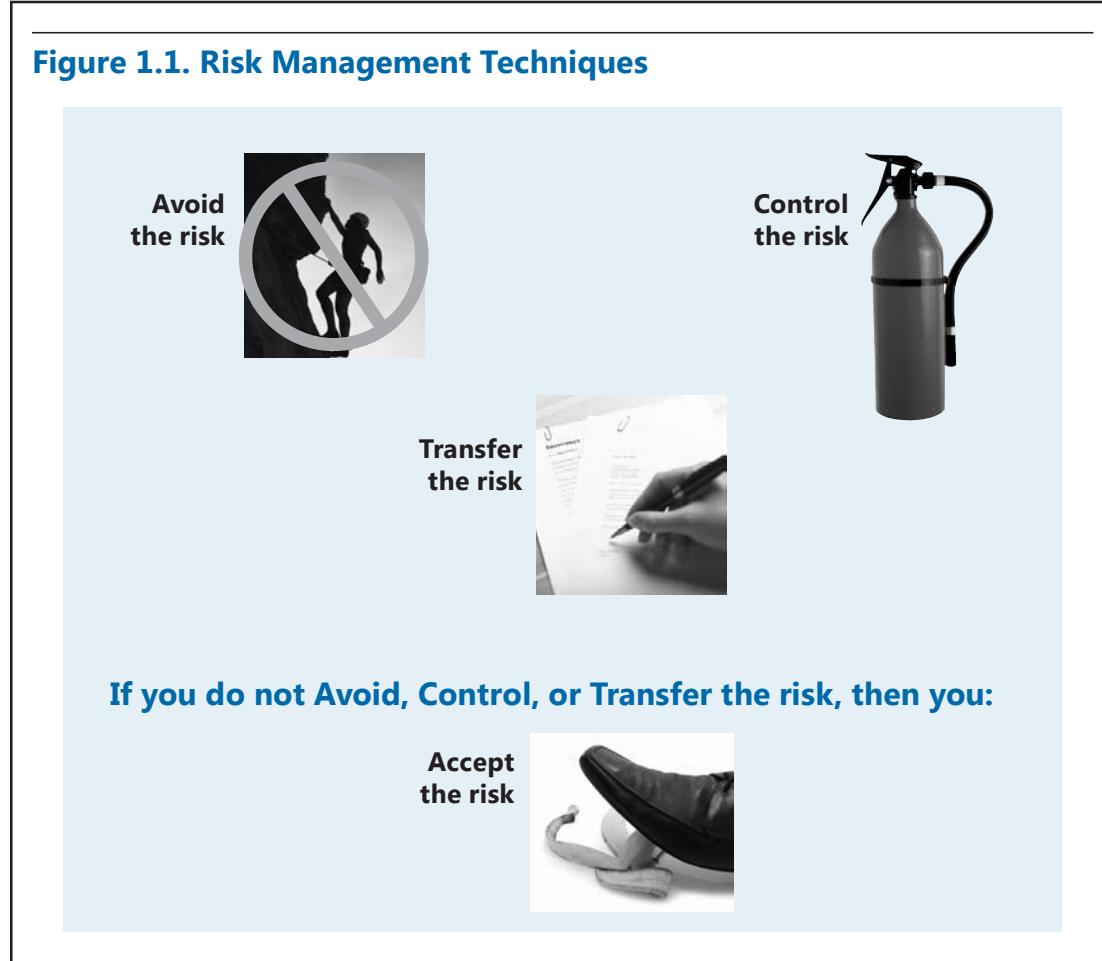
Individuals and businesses often use several risk management techniques in combination. For example, to reduce the risk of loss due to accidental injury, many people *avoid* certain hazardous activities such as sky diving. People also use safety devices, such as automobile seat belts, to help *control* the risk of accidental injuries. Finally, people purchase insurance to *transfer* their risk of financial loss resulting from any injuries they do receive. Figure 1.1 illustrates the four types of risk management techniques.

Insurance

Insurance is the most widely used risk management technique for both individuals and businesses. In simple terms, insurance is a method for transferring from an individual or entity to an insurer the risk of financial loss from events such as accident, illness, or death. The purpose of insurance is to compensate for financial loss, not to provide an opportunity for financial gain. For that reason, pure risk is the only kind of risk that can be insured; speculative risk cannot be insured.

A company that accepts risk and makes a promise to pay a policy benefit if a loss does occur is an *insurer* or *insurance company*. A *policy benefit* is a specific amount of money the insurer agrees to pay under an insurance policy when a specific loss occurs. An *insurance policy*, also known as a *policy* or *insurance contract*, is a written document that contains the terms of the agreement between

Figure 1.1. Risk Management Techniques



the insurer and the owner of the policy. The **premium** is the specified amount of money an insurer charges in exchange for agreeing to pay a policy benefit when a specified loss occurs. In 2008, insurance companies worldwide received almost \$4.3 trillion in premiums.¹

In general, individuals and businesses can purchase insurance policies to cover three types of risk: personal risk, property damage risk, and liability risk. **Personal risk** is the risk of economic loss associated with death, poor health, injury, and outliving one's economic resources. **Life and health insurance companies** issue and sell products that insure against financial losses that result from personal risks such as death, disability, illness, accident, and outliving one's savings. Figure 1.2 describes the primary types of products that life and health insurance companies sell.

Insurers issue life and health insurance products as either individual insurance policies or group insurance policies. An **individual insurance policy** is a policy that is issued to insure the life or health of a named person. Some individual policies also insure the named person's immediate family or a second named person. A **group insurance policy** is a policy that is issued to insure the lives or health of a specific group of people, such as a group of employees.

Property damage risk is the risk of economic loss resulting from damage to or loss of a person's property. **Property insurance** provides a benefit if insured items are damaged, destroyed, or lost because of various specific risks, such as fire, theft, or accident, that the policy describes.

Liability risk is the risk of economic loss resulting from a person being held legally responsible for harming others or their property. For example, if a customer slips and falls while in a store, the storeowner might be liable for any injuries the

Figure 1.2 Types of Life and Health Insurance Products

Life insurance: Insurance that pays a benefit upon the death of a named person.

Example: John Hendricks bought a \$500,000 insurance policy on his life from Able Life Insurance Company. If John dies while the policy is in force, Able will pay \$500,000 to John's wife Sally.

Annuity contract: A contract under which an insurer promises to make a series of periodic payments to a named individual in exchange for a premium or series of premiums.

Example: Luis Hernandez bought an annuity contract from Best Insurance Company. Once Luis reaches the age of 65, Best will pay Luis \$2,000 a month for the remainder of his life.

Health insurance: Insurance that provides protection against the risk of financial loss resulting from illness, injury, or disability.

Example: Mary Saunders bought a health insurance policy from Concerned Insurance Company. Concerned agreed to reimburse Mary for certain medical expenses she may incur if she becomes ill or injured while the policy is in effect.

customer suffers. *Liability insurance* provides a benefit payable on behalf of a covered party who is legally responsible for unintentionally harming others or their property. In the slip-and-fall case, the storeowner's liability insurance would pay for the injured customer's medical bills.

Property insurance and liability insurance (also referred to as *property and casualty insurance*) commonly are marketed together in one policy. Automobile insurance is an example of property and casualty insurance. In the United States, insurers that issue and sell insurance policies that cover property damage risk and liability risk are known as ***property/casualty (P&C) insurance companies*** or ***property and liability insurers***. In most countries other than the United States, insurance generally is classified as either *life insurance* or *nonlife insurance*.

A number of terms are commonly used to describe the people who are involved in the creation and operation of an insurance policy. The ***applicant*** is the person or business that applies for an insurance policy. Once a policy is issued, the person or business that owns the insurance policy is known as the ***policyowner***. In most cases, the applicant is also the policyowner. The ***insured*** is the person whose life, health, or property is insured under the policy. In some countries, the term ***assured*** is used to refer to the person insured.

The policyowner and the insured of a particular policy usually are the same person. If, for example, you purchase an insurance policy on your life, you are both the policyowner and the insured (sometimes called the *policyowner-insured*). However, if your spouse purchases a policy on your life, then she is the policyowner and you are the insured. A ***third-party policy*** is a policy purchased by one person or business on the life of another person.

If the person insured by a life insurance policy dies while the policy is in force, the insurer usually pays the policy benefit to the named beneficiary. The ***beneficiary*** is the person or party the policyowner names to receive the life insurance policy benefit. A request for payment under the terms of an insurance policy is called a ***claim***.

Example. Harold Finley applied to the Reliable Insurance Company for a \$100,000 life insurance policy covering his wife, Nancy. Reliable issued the policy as applied for. If Nancy dies while the policy is in effect, Reliable will pay \$100,000 to the Finleys' son, Stephen.

Analysis. Harold is the *applicant* and *policyowner* of this policy. Reliable is the *insurer*; Nancy is the *insured*; Stephen is the *beneficiary*. The policy is a *third-party policy*, because the policyowner, Harold, and the insured, Nancy, are two different people. After Nancy's death, Stephen can file a *claim* with Reliable for the *policy benefit* of \$100,000.

Managing Risks through Insurance

Insurers use a concept known as *risk pooling* that allows them to accept responsibility for the economic losses of their insureds. Many people are willing to pay a relatively small premium in order to transfer the risk of a much greater potential loss—for example, the loss of income due to disability—to an insurance company. Insurers issue policies to these individuals knowing that only a small percentage of the insureds actually will become disabled while their policies are in effect. By collecting premiums from all individuals and businesses that transfer the risk of

disability, insurers spread the cost of the relatively few losses that are expected to occur among all the insured persons.

Insurance thus protects against the risk of economic loss by applying a simple principle:

If the economic losses that actually result from a given peril, such as disability, can be spread across a large pool (or number) of people who are all subject to the risk of such losses *and* the probability of loss is relatively small for each person, then the cost to each person will be relatively small.

Characteristics of Insurable Risks

Insurance companies decide what types of risks they will insure. Unless a risk meets certain criteria, risk pooling may not be effective in regard to that risk. The business of insurance has developed in accordance with certain basic principles that insurers use to determine which risks are insurable. In general, for a risk—a potential loss—to be considered insurable, it must have the following basic characteristics:

- The loss must occur by *chance*.
- The loss must be *definite*.
- The loss must be *significant*.
- The loss rate must be *predictable*.
- The loss must *not* be *catastrophic* to the insurer.

The Loss Must Occur by Chance

For a potential loss to be insurable, the element of chance must be present. The loss must result either from an unexpected event or from an event that the insured person did not intentionally cause. For example, people generally cannot control whether they become seriously ill. As a result, insurers can offer health insurance policies to protect against financial losses caused by the chance event that an insured will become ill and incur medical expenses.

When this principle of loss is applied in its strictest form to life insurance, an apparent problem arises: death is certain to occur. The *timing* of a person's death, however, is usually out of one's control. Therefore, although the event being insured against—death—is a certain event rather than a chance event, the timing of that event usually occurs by chance.

The Loss Must Be Definite

For most types of insurance, an insurable loss must be definite in terms of *time* and *amount*. In other words, the insurer must be able to determine *when* to pay policy benefits and *how much* those benefits should be. In many cases, such as a death or property damage, the time of a loss is easy to determine. The amount of financial loss resulting from the occurrence, however, can be subject to interpretation.

The terms of the insurance policy determine the amount of policy benefit that is payable if a covered loss occurs while the policy is in force. Most insurance policies, other than life insurance policies, are contracts of indemnity. A **contract of indemnity** is an insurance policy under which the amount of the policy benefit payable for a covered loss is based on the actual amount of financial loss that results from the covered event, as determined at the time of the event. For example, many health insurance policies state that the amount of benefits payable due to a covered illness will be the total of certain types of expenses incurred, such as doctor and hospital bills. Other health insurance policies limit benefits payable to a stated maximum amount. The insurer will not pay any more than the maximum benefit, even if the insured has suffered a greater financial loss.

Calculating the monetary value of the financial loss resulting from the death of a loved one is not as simple as adding up medical and hospital bills. For that reason, most life insurance policies are valued contracts rather than contracts of indemnity. A **valued contract** specifies the amount of policy benefit that will be payable when a covered loss occurs, regardless of the actual amount of loss that was incurred. Most life insurance policies have a **face amount**, or **face value**, which is the amount of the policy benefit that is payable if the insured dies while the policy is in force. This benefit is called the face amount because it usually appears on the *face*, or first, *page* of the policy. For example, if a person buys a life insurance policy with a face amount of \$100,000 and dies while the policy is in effect, the beneficiary typically receives \$100,000, regardless of the actual amount of any loss suffered. The policy benefit of a life insurance policy often is referred to as the *death benefit*.

Some life insurance policies provide that the amount of the policy benefit may change over the life of the policy. For example, a policy may provide a policy benefit of \$25,000 if the insured dies within the first two years after policy issue and a benefit of \$50,000 if the insured dies at a later date while the policy remains in effect. Such policies are still considered valued contracts because changes in the amount of the policy benefit are based on factors that are not directly related to the amount of the actual loss that results from the insured's death.

The Loss Must Be Significant

Usually, people buy insurance only if the premium cost is relatively small in comparison to the amount of the potential loss. An insurer always incurs administrative expenses in connection with paying benefits under a policy, and those expenses are reflected in the premium. The administrative expense of paying benefits for a very small loss would, for most people, make the cost of insurance protection too great in relation to the amount of the potential loss.

On the other hand, more significant losses are considered to be insurable. For example, a person injured in an accident may lose a significant amount of income if she is unable to work, and insurance coverage is available to protect against such a potential loss. Even though the premium reflects the expenses incurred by the insurer in connection with paying policy benefits, the total cost of the premium is small enough in comparison to the potential loss that many people purchase the insurance.

The Loss Rate Must Be Predictable

As we discussed earlier, to be insurable, a loss must occur by chance. No one can predict the losses that a specific person will experience. We do not know when a specific person will die or if a person will become disabled or need hospitalization. However, insurers must have some way of predicting future losses so they can determine the proper premium amounts to charge policyowners.

Although individual losses cannot be predicted, insurers can provide a specific type of insurance coverage if they can predict the *loss rate*—the frequency of losses—that the insureds are likely to experience. To predict the loss rate for a given group of insureds, the insurer must be able to predict the number and timing of covered losses that will occur in that group of insureds.

Insurers can predict with a fairly high degree of accuracy the number of people in a given large group who will die, become disabled, or require hospitalization during a given period of time. These predictions are based on observations of past events and a concept known as the law of large numbers.

The **law of large numbers** states that, typically, the more times we observe a particular event, the more likely that our observed results will approximate the true **probability**—or likelihood—that the event will occur.

A classic example of the law of large numbers is the coin toss. If you toss a coin, there is a 50-50 probability that the coin will land with the head side up. If you toss the coin 10 times, you might not get an equal number of heads and tails. However, if you toss the coin 10,000 times, in approximately 50 percent of the tosses, the coin will land with the head side up and the other 50 percent of the tosses will land on tails. The more often you toss the coin, the more likely you will observe an approximately equal proportion of heads and tails.

Insurance companies rely on the law of large numbers when they make predictions about the covered losses that a given group of insureds is likely to experience during a given time period. Insurers collect specific information about large numbers of people so they can identify the pattern of losses that those people experienced. For many years, for example, U.S. life insurance companies have recorded how many of their insureds of each sex have died and how old they were when they died. Insurers also examine the general population records of the United States, noting the ages at which people of each sex in the general population died.

Using these statistical records, insurance companies have been able to develop charts—called **mortality tables**—that indicate with great accuracy the number of people in a large group (100,000 people or more) who are likely to die at each age. Mortality tables display the **mortality rates**, which are the rates at which death occurs among a specified group of people during a specified period, typically one year. Insurance companies have developed similar charts, called **morbidity tables**, which display the **morbidity rates**, or incidence of sickness and accidents, by age occurring among a given group of people. By using accurate mortality and morbidity tables, life and health insurers can predict the probable loss rates for given groups of insureds. Insurers use those predicted loss rates to establish premium rates that will be adequate to pay claims.

The Loss Must Not Be Catastrophic to the Insurer

A potential loss is not considered insurable if a single occurrence is likely to cause or contribute to catastrophic financial damage to the insurer. Such a loss is not insurable because the insurer could not responsibly promise to pay benefits for the loss and still meet its other obligations.

To prevent the possibility of catastrophic loss and ensure that losses occur independently of each other, insurers spread the risks they choose to insure. For example, major natural disasters such as hurricanes or earthquakes can damage or destroy a large number of properties in a concentrated area. In the past, some insurers failed because they were unable to pay claims following a disaster. For this reason, property insurance companies today usually limit the number of properties they will insure in any particular geographic area.

Alternatively, by purchasing reinsurance, an insurer can reduce the possibility that it will suffer catastrophic losses. **Reinsurance** is insurance that one insurance company—known as the *direct writer* or *ceding company*—purchases from another insurance company—known as the *reinsurer* or *assuming company*—to transfer all or part of the risk on insurance policies that the direct writer issued. For example, if Alpha Life Insurance Company (the direct writer) purchases reinsurance from Celtic Reinsurance Company (the reinsurer), then Celtic accepts some or all of the risk on insurance policies Alpha has issued. By entering into a reinsurance agreement with a reinsurer, an insurer can provide relatively large amounts of coverage without exposing itself to an excessive amount of risk.

Figure 1.3 summarizes the characteristics of insurable risks.

Figure 1.3. Characteristics of Insurable Risks

For a risk to be insurable:

The loss must occur by **chance**



The loss must be **definite**



The loss must be **significant**



The loss rate must be **predictable**

2001 CSO Table - Male - Smoker - 1000gr									
1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50
51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70
71	72	73	74	75	76	77	78	79	80
81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100

The loss must **not** be **catastrophic** to the insurer



Insurance Underwriting

Mortality and morbidity tables provide insurers with broad general statistics to help them predict how many people of a certain age and sex will die or become ill in the future. However, not all individuals of the same sex and age have an equal likelihood of suffering a loss. Insurance is sold on a case-by-case basis, and insurers cannot presume that each proposed insured represents an average likelihood of loss.

When an insurer receives an application for insurance, the company must assess the degree of risk it will be accepting if it issues the policy. The process of identifying and classifying the degree of risk represented by a proposed insured is called ***underwriting*** or ***risk selection***. Insurance company employees who are responsible for evaluating proposed risks are called ***underwriters***.

Proper underwriting is vital for an insurer's success and even its very survival. The premium rates that an insurance company establishes are based in large part on the amount of risk the company is assuming for the policies it issues. The greater the risk an insured represents, the higher a premium the insurer must charge. If the insurer consistently underestimates the risks that it assumes, its premium rates will be inadequate to provide the benefits promised to all its policyowners. On the other hand, if the insurer overestimates the risks it will be assuming, its rates may be considerably higher than those of its competitors, and potential customers will purchase insurance elsewhere.

Underwriting becomes more difficult because of antiselection, also known as ***adverse selection*** or ***selection against the insurer***. ***Antiselection*** is the tendency of individuals who believe they have a greater-than-average likelihood of loss to seek insurance protection to a greater extent than do other individuals. For example, people who believe they are in poor health are more likely to apply for life and health insurance—and also to apply for larger amounts of coverage—than people who believe they are in average or good health. The presence of antiselection requires an insurer to carefully review each application to assess the degree of risk the company will be assuming if it issues the requested policy.

Underwriting consists of two primary stages: (1) identifying the risks that a proposed insured presents and (2) classifying the degree of risk that a proposed insured represents.

Identifying Risks

Although predicting when a specific individual will die, become injured, or suffer from an illness is impossible, insurers have identified a number of factors that can increase or decrease the likelihood that an individual will incur a loss. The most important of these factors are physical hazards and moral hazards. A ***physical hazard*** is a physical characteristic that may increase the likelihood of loss. For example, a person with a history of heart disease possesses a physical hazard that increases the likelihood that the person will die sooner than a person of the same age and sex who does not have a similar medical history. A person's activities or lifestyle can also present a physical hazard. Cigarette smoking and alcohol or substance abuse are known to contribute to health problems, and those health problems may result in higher-than-average medical expenses and a lower-than-average life expectancy. Similarly, an occupation such as coal mining, which exposes a person to a significantly greater-than-average risk of health problems

or accidental injury, can present a physical hazard. Underwriters must carefully evaluate proposed insureds to detect the presence of such physical hazards.

Moral hazard is a characteristic that exists when the reputation, financial position, or criminal record of an applicant or a proposed insured indicates that the person may act dishonestly in the insurance transaction. For example, an individual who has a confirmed record of illegal or unethical behavior is more likely than an individual without this type of background to behave similarly in an insurance transaction. Therefore, an insurer must carefully consider that fact when evaluating the individual's application for insurance. The person may be seeking insurance for financial gain rather than as protection against a financial loss. Underwriters also evaluate the moral hazards presented by individuals who provide false information on their applications for insurance. In these cases, the applicants may be trying to obtain coverage that they might not otherwise be able to obtain. When underwriters evaluate applications, they take a variety of steps to identify proposed insureds who present moral hazards.

Classifying Risks

After identifying the risks that a proposed insured presents, the underwriter places the proposed insured into an appropriate risk class. A **risk class** is a grouping of insureds who represent a similar level of risk to the insurer. Classifying risks into classes enables the insurer to establish equitable premium rates to charge for the requested coverage. People in different risk classes are charged different premium rates, much the same as people of different ages are charged different rates. Without these premium rate variations, some policyholders would be charged too much for their coverage, while others would be paying less than the actual cost of their coverage.

Each insurer has its own **underwriting guidelines**, which are the general rules it uses when assigning proposed insureds to an appropriate risk class. Individual life insurers' underwriting guidelines usually identify at least four risk classes for proposed insureds: standard risks, preferred risks, substandard risks, and declined risks.

- Proposed insureds who have a likelihood of loss that is not significantly greater than average are classified as **standard risks**, and the premium rates they are charged are called **standard premium rates**. Traditionally, most individual life insurance policies have been issued at standard premium rates.
- Proposed insureds who present a significantly lower-than-average likelihood of loss are classified as **preferred risks** and are charged lower-than-standard premium rates known as **preferred premium rates**. Insurance company practices vary widely as to what qualifies a proposed insured as a preferred risk or a standard risk.
- Proposed insureds who have a significantly greater-than-average likelihood of loss but are still found to be insurable are classified as **substandard risks** or **special class risks**. For example, a proposed insured may have been diagnosed with a disease such as diabetes, which can lead to a shorter life expectancy. For individual life insurance, insurers typically charge substandard risks a higher-than-standard premium rate, called a **substandard premium rate** or **special class rate**.

- The **declined risk** category consists of those proposed insureds who are considered to present a risk that is too great for the insurer to cover. In addition to proposed insureds with a poor health history, those who engage in exceptionally risky activities, such as sky diving or mountain climbing, sometimes are classified as declined risks.

Because smoking represents a major health hazard, almost all insurers today take a proposed insured's smoking habits into account in their underwriting guidelines. Some insurers have established separate rate classes for smokers and nonsmokers, such as "standard smoker" and "standard nonsmoker." Other insurers place proposed insureds who smoke in a less favorable rate class than nonsmokers. For example, a smoker who might otherwise be classified as a preferred risk is instead classified as a standard risk.

Insurable Interest Requirement

As noted earlier, insurance is intended to compensate an individual or a business for a financial loss, not to provide an opportunity for gain. At one time, however, people used insurance policies as a means of wagering. In 18th-century England, for example, people frequently purchased life insurance on the lives of famous people, especially those who were reportedly ill, hoping to make a profit if the insured person died.

The practice of purchasing insurance as a wager is now considered against public policy. As a result, laws in the United States and many other countries require that a policyowner have an insurable interest in the risk that is insured at the time the policy is issued. An **insurable interest** means that the policyowner must be likely to suffer a genuine loss or detriment should the event insured against occur. For example, if a building is destroyed by fire, the owner would likely suffer an economic loss. Ownership of property is one means of establishing an insurable interest in the property for the purpose of purchasing property insurance.

To understand how insurable interest requirements are met, we need to consider two possible situations: (1) an individual purchases insurance on her own life and (2) an individual purchases insurance on another's life. In both cases, the applicant for life insurance must name a beneficiary.

All persons are considered to have an insurable interest in their own lives. A person is always considered to have more to gain by living than by dying. Therefore, an insurable interest between the policyowner and the insured is presumed when a person seeks to purchase insurance on her own life. Insurable interest laws do not require that the named beneficiary have an insurable interest in the policyowner-insured's life. In other words, the laws allow a policyowner-insured to name anyone as beneficiary.

Most insurance company underwriting guidelines, however, require that the beneficiary also have an insurable interest in the life of the insured when a policy is issued. As a result, life insurers typically inquire into the named beneficiary's relationship to the proposed insured and may refuse to issue the coverage if the beneficiary does not possess an insurable interest in the proposed insured's life. An exception exists in the state of California, where laws now prohibit insurers from declining to issue a life insurance policy solely because the named beneficiary has no insurable interest in the proposed policyowner-insured's life.

In the case of a third-party policy, laws in many countries and in most states in the United States require only that the policyowner have an insurable interest in the insured's life when the policy is issued. Most insurance company underwriting guidelines and the laws in some states, however, require both the policyowner and the beneficiary of a third-party policy to have an insurable interest in the insured's life when the policy is issued.

Certain family relationships are assumed by law to create an insurable interest between an insured and a policyowner or beneficiary. The natural bonds of affection and financial dependence that generally exist between certain family members make this a reasonable assumption. In these cases, even if the policyowner or beneficiary has no financial interest in the insured's life, the bonds of love and affection alone are sufficient to create an insurable interest. According to laws in most jurisdictions, the insured's spouse, mother, father, child, grandparent, grandchild, brother, and sister are deemed to have an insurable interest in the life of the insured.

An insurable interest is *not* presumed when the policyowner or beneficiary is more distantly related to the insured than the relatives previously described or when the parties are not related by blood or marriage. In these cases, a financial interest in the continued life of the insured must be demonstrated to satisfy the insurable interest requirement. For instance, assume that Mary Mulhouse obtained a \$50,000 personal loan from the Lone Star Bank. If Mary dies before repaying the loan, the bank could lose some or all of the money it lent her. Thus, the bank has a financial and, consequently, an insurable interest in Mary's life. Similar examples of financial interest can be found in other business relationships.

The insurable interest requirement must be met before a life insurance policy will be issued. After the life insurance policy is in force, the presence or absence of insurable interest is no longer relevant. Therefore, a beneficiary need not provide evidence of insurable interest to receive the benefits of a life insurance policy.

The insurable interest requirement also must be met when a health insurance policy is issued. For health insurance purposes, an applicant must demonstrate a genuine risk of economic loss should the proposed insured require medical care or become disabled. Because of the nature of health insurance, however, applicants rarely seek health insurance on someone in whom they have no insurable interest. Typically, people seek health insurance for themselves and their dependents.

Key Terms

risk	face amount
speculative risk	law of large numbers
pure risk	probability
risk management	mortality table
insurer	mortality rate
policy benefit	morbidity table
insurance policy	morbidity rate
premium	reinsurance
personal risk	direct writer
life and health insurance company	reinsurer
life insurance	underwriting
annuity contract	underwriter
health insurance	antiselection
individual insurance policy	physical hazard
group insurance policy	moral hazard
property/casualty (P&C) insurance	risk class
company	underwriting guidelines
applicant	standard risk
policyowner	standard premium rate
insured	preferred risk
third-party policy	preferred premium rate
beneficiary	substandard risk
claim	substandard premium rate
contract of indemnity	declined risk
valued contract	insurable interest

Endnote

1. Swiss Re, “World insurance in 2008: life premiums fall in the industrialized countries — strong growth in the emerging economies,” *sigma*, No 3/2009, 3, http://www.swissre.com/resources/c7f9f9004fbe0c3-ea67ffea7701fb964-sigma3_2009_e_rev4.pdf (8 March 2010).



Objectives:

After studying this chapter, you should be able to

- Distinguish among the three types of business organizations and explain why insurance companies must be organized as corporations
- Distinguish among stock insurers, mutual insurers, and fraternal benefit societies
- Describe the financial services industry and explain how insurance companies function within that industry
- Identify the two primary types of insurance regulation in most countries
- Describe the roles that the federal and state governments play in U.S. insurance regulation

Outline

Insurance Company Organization

- Types of Business Organizations
- Types of Insurance Company Organizations

Role of Government in Insurance

- Regulation of Insurance
- Social Insurance Programs
- Taxation

Insurance Companies as Financial Institutions

- Financial Intermediaries
- Evolution of the Financial Services Industry

Businesses produce goods or provide services and sell those goods or services, usually for a profit, to consumers who want or need them. *Profit* is the money, or revenue, that a business receives for its products or services minus the costs it incurs to produce the goods or deliver the services. Insurance companies are businesses that provide a valuable service to their policyowners—namely, the payment of policy benefits after an insured event occurs. To understand insurance, we need to understand more about insurance companies and the business environments in which they operate.

Insurance Company Organization

In some ways, an insurance company is organized the same as any other major business. In other important ways, however, it can be quite different.

Types of Business Organizations

In many countries, including the United States, businesses are structured in one of three basic ways: sole proprietorship, partnership, or corporation. A *sole proprietorship* is owned and operated by one person. The owner receives all profits and is personally responsible for all the debts of the business. If the business fails, the owner's personal property may be used to pay the debts of the business. If the owner becomes disabled or dies, the business often cannot continue to operate.

A *partnership* is a business that is owned by two or more people, who are known as the *partners*. The partners divide the profits, and generally each of them is personally responsible for all the debts of the business. For example, suppose George Simpson and Fred Tarver formed an equal partnership. At first, the business was successful, and each of the partners received one-half of the profits. However, the business eventually failed, and George was unable to pay his share of the losses. Fred was personally responsible for *all* the partnership's debts. If one of the partners dies or withdraws from the business, the partnership generally dissolves by operation of law. The remaining partners may form a new partnership and continue to operate the business.

In most countries, insurance companies and most other major businesses are organized as corporations. A *corporation* is a legal entity that is created by the authority of a governmental unit (through a process known as *incorporation*) and is separate and distinct from the people who own it. A corporation has two major characteristics that set it apart from a sole proprietorship and a partnership.

First, a corporation is a legal entity that is separate from its owners. As a result, a corporation can sue or be sued, can enter into contracts, and can own property. The corporation's assets and liabilities belong to the corporation itself, not to its owners. An **asset** is an item of value, such as cash, buildings, and investments, that a company owns. A **liability** is a company's debt or future obligation. The owners have no interest in the corporation's assets and are not personally responsible for the corporation's debts.

The second difference is that the corporation continues beyond the death of any or all of its owners. This second characteristic of the corporation provides an element of stability and permanence that a sole proprietorship and partnership cannot guarantee. Because an insurer's contractual obligations extend many years into the future, the corporation is the ideal form of business organization for an insurance company. Recognizing the importance of such stability and permanence, laws in the United States and many other countries require insurance companies to operate as corporations.

Types of Insurance Company Organizations

Unlike most other corporations, life and health insurance companies have some flexibility in how they are organized to do business. Typically, insurers are organized as stock insurance companies, mutual insurance companies, or fraternal benefit societies.

Stock Insurance Companies

Most corporations, including most life and health insurers, are stock corporations. A **stock corporation** is a corporation whose ownership is divided into units known as **shares** or **shares of stock**. A **stockholder**, or **shareholder**, is a person or organization that owns shares of stock in a corporation. The corporation's stockholders collectively are its owners. Insurers organized as stock corporations are known as **stock insurance companies**.

A corporation's stockholders own the business, but they do not directly manage it. Instead, they elect a group of individuals, known as the **board of directors**, who are responsible for overseeing the company's management. The board of directors typically selects the company's officers and other high-ranking employees who manage the business on a day-to-day basis. The laws that authorize incorporation generally impose requirements on matters such as the minimum number of directors a corporation must have, the duties of directors and officers, and the rights of stockholders.

If the business is profitable, from time to time the stockholders may receive a **stockholder dividend**, which is a portion of the corporation's earnings paid to the owners of its stock. The board of directors normally determines the frequency and amount of any dividends paid to stockholders. Many companies pay dividends on a quarterly or annual basis.

Mutual Insurance Companies

A **mutual insurance company** is an insurance company that is owned by its policyowners, who elect the company's board of directors. Because a mutual insurance company does not have stockholders, it does not pay stockholder dividends. Instead, a portion of the company's operating profits from time to time may be

distributed to its policyowners in the form of *policy dividends*. We discuss policy dividends in more detail in Chapter 9.

Approximately three-quarters of the life insurance companies in the United States in 2008 were stock companies.¹ However, even though stock insurers greatly outnumber mutual insurers, mutual insurers historically have been older and larger than stock insurers and thus provide a significant amount of the life insurance in force.

Fraternal Benefit Societies

A *fraternal benefit society* is a nonprofit organization that is operated solely for the benefit of its members and that provides social, as well as insurance, benefits to its members. The members of such societies often share a common ethnic, religious, or vocational background, although membership in some societies is open to the general public. The members of the society belong to local chapters or branches, usually referred to as lodges, which hold regular meetings. Only lodge members and their families may own the fraternal society's insurance. However, in a number of fraternal societies, applicants for insurance become lodge members automatically once the society issues them a policy. To issue insurance policies, the fraternal society must have a representative form of government—that is, the members must elect the officers of the fraternal society who manage its insurance and other operations.

Figure 2.1 depicts the total number of stock companies, mutual companies, and fraternal benefit societies operating in the United States in 2008, as well as the life insurance in force for each type of company.

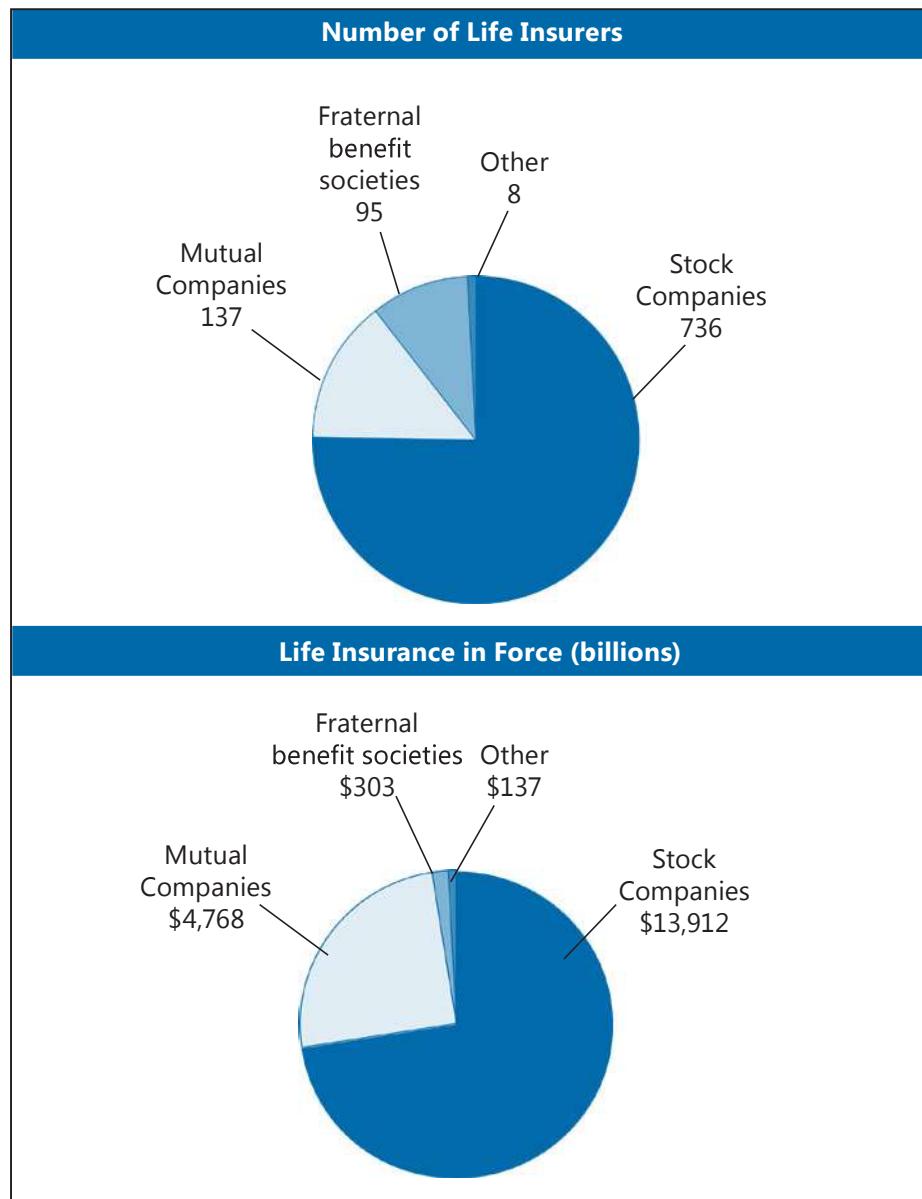
Insurance Companies as Financial Institutions

Insurance companies are financial institutions that function in the economy as part of the financial services industry.² A *financial institution* is a business that owns primarily financial assets, such as stocks and bonds, rather than fixed assets, such as equipment and raw materials. The *financial services industry* is made up of various kinds of financial institutions that help people, businesses, and governments save, borrow, invest, and otherwise manage money. The financial products that financial institutions provide help people manage income and debt, accumulate resources for their retirements, and protect themselves from financial losses resulting from unexpected occurrences such as disability, premature death, and natural disasters. In addition to insurance companies, financial institutions include

- **Depository institutions**, which accept deposits from and make loans to people, businesses, and government agencies. Commercial banks, savings and loan associations, and credit unions are examples of depository institutions.
- **Finance companies**, which specialize in making short- and medium-term loans to people and businesses.
- **Securities firms**, which specialize in the purchase and sale of securities. A *security* is a certificate that represents either an ownership interest in a business (for example, a share of stock) or a debt owed by a business, government, or agency (a bond, for example).

- **Mutual fund companies**, which operate mutual funds. A *mutual fund* is an investment vehicle that pools the funds of investors and uses the funds to buy a variety of stocks, bonds, and other securities.

Figure 2.1. Comparison of Stock Companies, Mutual Companies, and Fraternal Benefit Societies in the United States, 2008



Source: Adapted from ACLI, *Life Insurers Fact Book 2009* (Washington, DC: American Council of Life Insurers, 2009), 2–3.
Used with permission.

Financial Intermediaries

Financial institutions, including insurance companies, serve as financial intermediaries. A *financial intermediary* is an organization that collects funds from one group of people, businesses, and governments (suppliers) and channels them to another group (users). Insurers, for example, collect premiums from policyowners and pay claims to beneficiaries. In the process of moving funds from suppliers to users, financial intermediaries generate income for themselves.

As financial intermediaries, insurance companies take a substantial portion of the money that their customers pay for insurance and invest that money in other businesses and industries. The investments insurers make provide funds that these businesses need to operate and expand. For example, life insurance companies in the United States have been the largest single source of corporate bond financing since the 1930s.³ At the end of 2007, U.S. life insurers held approximately \$18 trillion in assets worldwide.⁴

Evolution of the Financial Services Industry

Nearly every business in the world depends on the financial services industry. The financial crisis of 2008, which originated largely in the financial services industry, illustrates the importance of the industry to the world economy. Much of the financial services industry's importance in today's global economy is the result of three major industry trends over the last several decades: convergence, consolidation, and globalization.

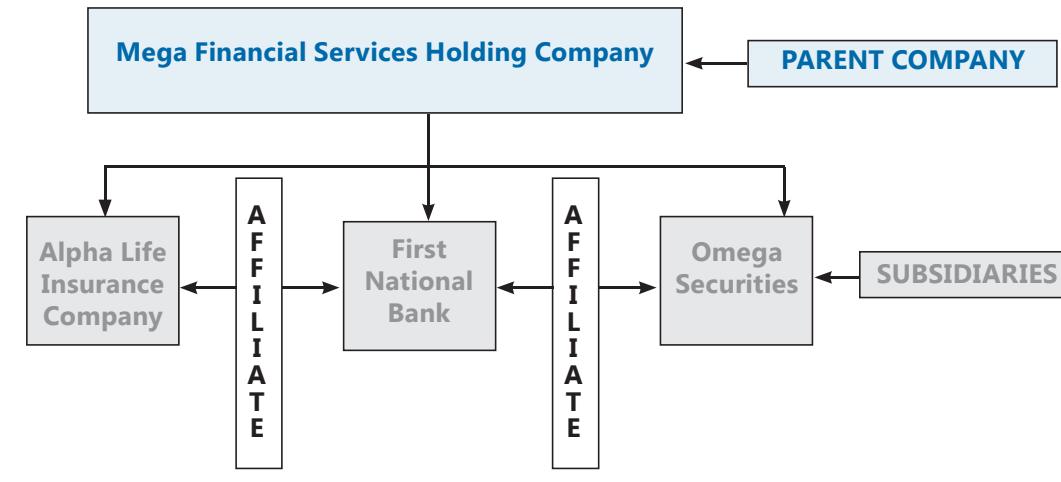
Convergence

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

Today, however, the financial services industry is characterized by *convergence*, which is the movement toward a single financial institution being able to serve a customer's banking, insurance, and securities needs. Financial services companies have entered into each others' traditional businesses, either through expansion of operations or through mergers and acquisitions. Thus, the distinctions have blurred among financial institutions based on the products they offer.

In the United States, financial services companies may affiliate by means of a financial holding company. A *holding company*, also known as a *parent company*, is a company that owns and controls another company or companies, which are referred to as *subsidiaries*. The various subsidiaries that are under the common control of the holding company are known as *affiliates* of each other because they are affiliated within a holding company system. A financial holding company is a holding company that conducts activities that are financial in nature or incidental to financial activities. Figure 2.2 illustrates a financial holding company structure.

Figure 2.2 Financial Holding Company



Affiliation in a financial holding company system allows companies to sell each others' products. For example, although banks in the United States still cannot issue—that is, accept the risk on—insurance products, an insurance company may design a product in accordance with a bank's specifications and issue a product that the bank can sell. Such affiliations increase the ability of insurance companies to offer a wider variety of noninsurance products, such as mutual funds.

Consolidation

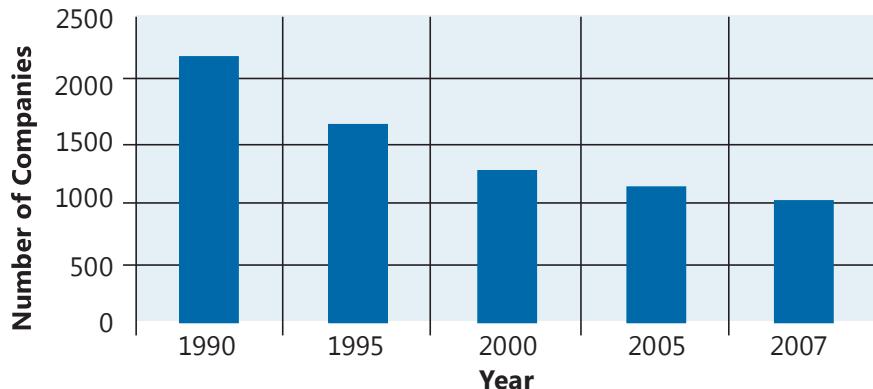
Consolidation, as the term is frequently used in the financial services industry, is the combination of financial services institutions within or across sectors. Consolidation in the financial services industry occurs primarily through mergers and acquisitions.

A *merger* is a transaction in which the assets and liabilities of two companies are combined into one company. One of the companies survives as a legal entity, and the other company ceases to exist. An *acquisition* is a transaction in which one corporation purchases a controlling interest in another formerly independent corporation; after the transaction, both corporations survive as separate legal entities.

Consolidation has decreased the number of traditional financial institutions within each sector of the financial services industry. As the number of financial institutions has decreased, many of the remaining institutions have grown in size. Figure 2.3 illustrates how the number of life insurance companies in the United States has decreased steadily since 1990.

Globalization

Financial institutions operate in a global environment. Large financial services enterprises, particularly those from Western Europe and North America, increasingly are expanding their customer bases worldwide. For example, in 2005,

Figure 2.3. Number of U.S. Life Insurance Companies, 1990–2007

Source: U.S. Bureau of the Census, "Table 1184. U.S. Life Insurance Companies—Summary: 1990 to 2007," *Statistical Abstract of the United States: 2010*, 129th ed. (Washington, DC: GPO, 2009), <http://www.census.gov/prod/2009pubs/10statab/banking.pdf> (9 March 2010).

U.S. insurers received \$94.4 billion of insurance premiums in other countries, an increase of nearly 50 percent since 2001.⁵ On the other hand, in 2008, nearly 11 percent of U.S. life insurers were foreign owned, and those companies held almost 23 percent of U.S. life insurance company assets.⁶

Role of Government in Insurance

For many people, insurance provides the only protection they and their families have against financial hardship or potential catastrophic losses resulting from death or illness. Because the insurance industry is so important to so many people, insurers occupy a special position of public trust. As a result, governments around the world regulate insurance companies to safeguard the public interest. In addition to acting as regulators, governments typically provide social insurance programs, and most governments influence spending and saving through taxation. In performing these roles, governments affect the supply and demand for insurance in the private sector.

Regulation of Insurance

Although insurance laws vary from one country to another, many insurance laws are similar in principle throughout the world. The United States has the most extensive insurance regulation in the world, and other countries often study U.S. laws as they develop their own laws. Thus, we describe some U.S. insurance laws to illustrate general principles of insurance regulation.

Insurance regulatory systems also vary from country to country. In many countries, insurance regulation is centralized and under the supervision of the national government. For example, in India, authority over insurance regulation

rests solely with the national Insurance Regulatory and Development Authority (IRDA). Some countries, including the United States and Canada, have **federal systems** of government in which a *federal government* and a number of lower-level governments, known as *state governments* in the United States or *provincial governments* in Canada, share governmental powers, including the power to regulate insurance. Figure 2.4 describes the U.S. insurance regulatory system.

To operate as an insurer, a company must incorporate in a particular jurisdiction. For example, in the United States, insurers must incorporate in one state. The jurisdiction in which a company incorporates becomes the company's **domicile**. The company then must obtain a certificate of authority from each jurisdiction in which it plans to conduct business. A **certificate of authority**, or **license**, grants an insurer the right to conduct an insurance business and sell insurance products in the jurisdiction that grants the certificate. An insurer must comply with all applicable laws in each jurisdiction in which it is licensed.

Figure 2.4. U.S. Insurance Regulatory System

The federal **McCarran-Ferguson Act** left insurance regulation to the state governments, as long as the Congress determines that regulation to be adequate.⁷ Thus, the states have primary authority to regulate insurance. Each state has its own laws, usually referred to as the **state insurance code**, that regulate insurance in that state. Each state also has an administrative agency, typically known as the **state insurance department**, that is responsible for making sure that companies operating in the state comply with applicable regulatory requirements. Each state insurance department is under the direction of an **insurance commissioner**, known in some states as the *superintendent of insurance* or *director of insurance*.



Although each state has its own set of laws and regulations governing insurance, these laws and regulations often are similar throughout the various states, because they are based on models developed by the National Association of Insurance Commissioners. The **National Association of Insurance Commissioners (NAIC)** is a nongovernmental association of the insurance commissioners of all the states. The NAIC's primary function is to promote uniformity of state insurance regulation by developing model laws and regulations as guidelines for the states. States are not required to adopt model laws and regulations as written; instead, states may either modify those models or choose not to adopt them at all.

The federal government has acted to regulate some aspects of the insurance industry. Most notably, businesses and individuals who sell securities must comply with federal securities laws. Variable life insurance and variable annuities are classified as securities that must comply with federal securities laws.

Insurance regulation has two primary focuses:

- To ensure that insurers remain ***solvent***—that they are able to meet their debts and to pay policy benefits when they come due. Solvency regulation is known as *prudential regulation* in many countries.
- To ensure that insurance companies conduct their businesses fairly and ethically. Such regulation is referred to as *market conduct regulation*.

Solvency Regulation

In most countries, insurance regulation focuses on making sure that insurance companies remain solvent. Each nation establishes the minimum criteria that insurers must meet to conduct business in that country. Most countries impose minimum financial requirements as a prerequisite to an insurer's obtaining a license to transact insurance; a company that is financially unsound cannot receive a license. In addition, governments have authority to act to protect the public interest if an insurance company becomes financially unsound.

A company's solvency is evaluated by applying the *basic accounting equation*, which states:

$$\text{Assets} = \text{Liabilities} + \text{Owners' Equity}$$

The ***owners' equity*** is the owners' financial interest in the company, which is the difference between the amount of the company's assets (what it owns) and the amount of its liabilities (what it owes). For a stock insurance company, owners' equity has two components:

- ***Capital*** is the amount of money that the company's owners invested in the insurer, usually through the purchase of company stock.
- ***Surplus*** is the remainder of the owners' equity, or the amount by which the company's assets exceed its liabilities and capital.

Because a mutual insurer does not issue stock, it has no capital; therefore, the owners' equity for a mutual insurer consists entirely of the company's surplus. Figure 2.5 illustrates the calculation of owners' equity for stock and mutual insurers.

Governments have established methods to oversee the financial condition of insurance companies operating within their jurisdiction. In the United States, the states oversee the financial condition of insurance companies by reviewing an accounting report, known as the ***Annual Statement***, which every insurer prepares each calendar year and files with the insurance department in each state in which it operates. The NAIC has developed an Annual Statement form that all states accept. An insurer can file the same Annual Statement form in all the states in which it operates. In addition, state regulators conduct an on-site financial condition examination of each insurance company every three to five years. In this examination, state regulators physically check the insurer's business records. State regulators may conduct more frequent examinations of companies that appear most likely to have financial difficulties.

Figure 2.5. Calculations of Owners' Equity

Stock Insurance Company

Friendly Insurance Company has assets of \$10 million and liabilities of \$6 million. The stockholders of Friendly have invested \$1 million in the company.

Basic Accounting Equation:

$$\$10 \text{ million (Assets)} = \$6 \text{ million (Liabilities)} + \text{Owners' Equity (Capital + Surplus)}$$

$$\begin{aligned}\text{Owners' Equity} &= \$10 \text{ million (Assets)} - \$6 \text{ million (Liabilities)} \\ &= \$4 \text{ million}\end{aligned}$$

$$\$4 \text{ million (Owners' Equity)} = \$1 \text{ million (Capital)} + \text{Surplus}$$

$$\begin{aligned}\text{Surplus} &= \$4 \text{ million (Owners' Equity)} - \$1 \text{ million (Capital)} \\ &= \$3 \text{ million}\end{aligned}$$

Therefore, the owners' equity is \$4 million, consisting of \$1 million capital and \$3 million surplus.

Mutual Insurance Company

Pleasant Mutual Insurance Company has assets of \$12 million and liabilities of \$7 million.

Basic Accounting Equation:

$$\$12 \text{ million (Assets)} = \$7 \text{ million (Liabilities)} + \text{Owners' Equity (Surplus)}$$

$$\begin{aligned}\text{Owners' Equity} &= \$12 \text{ million (Assets)} - \$7 \text{ million (Liabilities)} \\ &= \$5 \text{ million}\end{aligned}$$

Therefore, the owners' equity is \$5 million, all of which is surplus.

Market Conduct Regulation

Many countries have enacted **market conduct laws** that regulate how insurance companies conduct business. In the United States, each state regulates the market conduct of insurers operating in the state. All states and many countries have *unfair trade practices laws*, which prohibit insurers from engaging in a variety of practices that are considered unfair or deceptive. For example, insurers cannot misrepresent their financial condition or use a misleading name to describe their policies. Many market conduct laws are designed to ensure that customers are presented with fair and accurate information before they buy insurance. For example, laws require insurers to disclose specific information about a policy to a potential customer before selling the policy. Other laws regulate the form and content of insurance advertisements to make sure that consumers are not misled about the features or limitations in advertised insurance policies.

In the United States, the state insurance departments perform periodic market conduct examinations of insurers to ensure that the companies are complying with the state's market conduct laws. If the department determines that an insurer has violated state market conduct laws, it may impose sanctions against the insurer, including fines and, in severe cases, suspending or revoking the insurer's certificate of authority.

In addition to regulating insurance companies, the states regulate the conduct of the individuals who market and sell insurance. These individuals, commonly known as *insurance producers* or *insurance agents*, must be licensed by each state in which they conduct business. The licensing process helps ensure that insurance producers are reputable and knowledgeable about the insurance products they sell. In conducting business, insurance producers must comply with all applicable state and federal laws. A state insurance department may revoke or suspend the license of a producer who engages in unethical behavior that violates the state's laws.

Social Insurance Programs

A *social insurance program* is a welfare plan that is established by law and administered by a government and that provides the population with income security. Social insurance may provide cash payments to replace income lost because of old age, disability, death, occupational injuries, and unemployment. Social insurance also may provide services such as medical care.

In most countries, insurance companies cannot provide products that duplicate the coverage of social insurance programs. Instead, insurers create and sell products that fill in the gaps not covered by social insurance and that supplement the coverages social insurance provides.

Taxation

Many governments use taxation as a mechanism for accomplishing social, in addition to economic, goals. Through taxation, governments can influence populations to act or refrain from acting in certain ways. For example, some governments tax tobacco heavily not only to raise revenue, but also to discourage tobacco use. Governments also offer taxpayers reductions on taxable income for contributions made to qualified charities to encourage charitable giving.

Many governments also use tax policies to encourage people to purchase various types of private insurance and financial products. Governments, for example, provide tax benefits to encourage people to invest in and employers to provide retirement savings plans. Such tax incentives can be quite effective, and they have benefitted insurers and other financial services institutions because of the increased demand for private financial and insurance products.

Key Terms

profit	convergence
sole proprietorship	consolidation
partnership	federal system
corporation	McCarran-Ferguson Act
asset	state insurance code
liability	state insurance department
stock corporation	insurance commissioner
share	National Association of Insurance Commissioners (NAIC)
stockholder	domicile
stock insurance company	certificate of authority
board of directors	solvent
stockholder dividend	owners' equity
mutual insurance company	capital
fraternal benefit society	surplus
financial institution	Annual Statement
financial services industry	market conduct law
security	social insurance program
financial intermediary	

Endnotes

1. ACLI, *Life Insurers Fact Book 2009* (Washington, DC: American Council of Life Insurers, 2009), 1, <http://www.acli.com/NR/rdonlyres/0BFEABCA-1E2A-4F4C-A879-95CF104238AB/22602/FB0109Overview1.pdf> (8 March 2010).
2. This section is adapted from Mary C. Bickley, *Principles of Financial Services and Products* [Atlanta: LOMA (Life Office Management Association, Inc.), © 2004], 1–24. Used with permission; all rights reserved.
3. ACLI, “Assets and Investments in America’s Economy,” <http://www.acli.com/ACLI/Tools/Industry+Facts+Assets+and+Investments/> (25 June 2009).
4. Swiss Re Economic Research & Consulting, *Global insurance review 2008 and outlook 2009: Weathering the storm*, Special Report, 9 December 2008 (Zurich: Swiss Re, 2008), http://www.swissre.com/resources/9433b8004c3ac1698ca2bd32638cec3c-Special_Report_20081209.pdf (9 March 2010).
5. US. International Trade Commission, *Recent Trends in U.S. Services Trade: 2008 Annual Report* (Washington, DC: GPO, 2008), 4-13 – 4-14, <http://hotdocs.usitc.gov/docs/pubs/332/pub4015.pdf> (2 July 2009). The U.S. Government does not currently report international insurance transactions in this manner. The 2005 statistics are the most recent ones available.
6. ACLI, *Fact Book 2009*, 4, 20.
7. 15 U.S.C. §§ 1011–1015.



The title slide features a blue gradient background. On the left, the word "Chapter" is written vertically above the large number "3". To the right of the number, the words "The Insurance Contract" are written in a large, bold, blue sans-serif font.

Objectives:

After studying this chapter, you should be able to

- Explain the difference between a valid contract, a void contract, and a voidable contract
- Identify the four general requirements for the creation of a valid informal contract and describe how each of these requirements can be met in the formation of an insurance contract
- Distinguish between formal and informal contracts, bilateral and unilateral contracts, commutative and aleatory contracts, and contracts of adhesion and bargaining contracts, and identify the types of contracts an insurance contract represents

Outline

Requirements for an Informal Contract

- Mutual Assent
- Legally Adequate Consideration
- Lawful Purpose
- Contractual Capacity

Types of Contracts

- Bilateral and Unilateral Contracts
- Commutative and Aleatory Contracts
- Bargaining Contracts and Contracts of Adhesion

The fundamental basis of modern commerce is the *contract*, which is a legally enforceable agreement between two or more parties. The fact that a contract is legally enforceable means that the parties are bound to carry out the promises they made when entering into the contract. If a party does not carry out its promises, then that party has breached the contract, and the other party has legal remedies available to enforce those promises or to be compensated for the breach.

An insurance policy is a contract between an insurance company and the person or party that purchased the policy. The parties to the contract are the insurer that issued the policy and the policyowner. The insurance policy describes the terms of their agreement.

A contract that is enforceable at law because it satisfies all legal requirements is referred to as a *valid contract*. Because the law provides special protection to the parties to a valid contract, the law also imposes requirements that an agreement must meet to be enforceable. If those requirements are not met, then the contract is void or voidable.

- A *void contract* is a contract that does not meet one or more of the legal requirements to create a valid contract and, thus, is never enforceable.
- A *voidable contract* is a contract under which one party has the right to avoid his obligations under the contract. The other party, however, is bound by the terms of the contract.

The requirements to form a valid contract vary depending on whether the contract is a formal contract or an informal contract. A *formal contract*, sometimes referred to as a *contract under seal*, is a contract that is enforceable because the parties met certain formalities concerning the form of the agreement. To be enforceable, a formal contract typically must be in writing and contain some form of seal. For example, a contract for the sale of land is a formal contract.

An *informal contract* is a contract that is enforceable because the parties to the contract met requirements concerning the substance of the agreement rather than requirements concerning the form of the agreement. Life insurance contracts and most other contracts today are informal contracts.

A valid informal contract may be an oral agreement or a written document. Nevertheless, laws in some jurisdictions require insurance contracts to be in writing. Life insurance contracts typically are expressed in written form—even if not required by law—for some practical reasons. A written contract provides a permanent record of the agreement. Life insurance policies often remain in effect for many years. The memory of someone's oral promises made many years in the past may not be reliable, even under the best circumstances. Putting the contract in writing helps prevent misunderstandings between the parties as to the terms and conditions of their agreement.

Requirements for an Informal Contract

According to the laws in most of the United States and many other countries, an agreement must meet the following four general requirements to be a valid informal contract:

1. The parties to the contract must express mutual assent, or agreement, to the terms of the contract
2. The parties to the contract must exchange legally adequate consideration
3. The contract must be for a lawful purpose
4. The parties to the contract must have contractual capacity

Mutual Assent

To form a valid informal contract, the parties must express their ***mutual assent***, which is a meeting of the minds about the terms of the agreement. Mutual assent does not occur merely in the minds of the parties. All parties must clearly indicate that they intend to be bound by the terms of the agreement. One familiar method of expressing mutual assent is for the parties to sign a written contract that sets forth the terms of the agreement.

For life insurance policies, as well as for other types of contracts, mutual assent is expressed by means of an offer and an acceptance. An ***offer*** is a proposal to enter into a binding contract with another party. The party that makes the offer is the ***offeror***, and the party to whom the offer is made is the ***offeree***. An ***acceptance*** of the offer is the offeree's unqualified agreement to be bound to the terms of the offer. If an offer is accepted according to its terms, mutual assent has occurred.

Example. Mary Treadwell said to her neighbor Janet Morgan, "I will sell you my old television set for \$100." Janet replied, "I can use another television set. I will buy it."

Analysis. Mary's statement to Janet was an ***offer***, and Mary was the ***offeror***. Janet was the ***offeree***. Janet's reply was an ***acceptance*** of the offer. By their offer and acceptance, Mary and Janet expressed their ***mutual assent*** to the terms of a contract.

Legally Adequate Consideration

In order for an informal contract to be valid, the parties to the contract must exchange ***consideration***, which means that each party must give or promise something that is of value to the other party. In addition, the consideration exchanged must be ***legally adequate***. In general, consideration is legally adequate as long as it has *some* value to the parties.

Example. Mary Treadwell said to her neighbor Janet Morgan, "I will sell you my old television set for \$100." Janet replied, "I can use another television set. I will buy it." The television set was actually worth \$200.

Analysis. In exchange for \$100, Mary sold her television to Janet. The parties thus exchanged legally adequate consideration because they exchanged items that had value to them.

An applicant gives the application and the ***initial premium***—the first premium paid for an insurance policy—as consideration for a life insurance contract. The applicant gives this consideration in return for the insurer's promise to pay the policy benefit if the conditions stated in the policy occur. If the initial premium is not paid, then no contract has been formed, because the applicant has not provided the required consideration. ***Renewal premiums***, which are premiums payable after the initial premium, are a condition for continuance of the policy and are *not* consideration for the policy.

Lawful Purpose

No contract can be made for a purpose that is illegal or against the public interest—a contract is valid only if it is made for a lawful purpose. For example, all jurisdictions have laws that make certain acts punishable as crimes. An agreement between two parties to commit a criminal act, such as an agreement to kill an individual in exchange for money, is not legally enforceable.

As we discussed in Chapter 1, early insurance policies often were intended specifically as a form of gambling. As a result, many jurisdictions enacted insurable interest laws as a matter of public policy to prevent such gambling. The requirement that insurable interest be present when a policy is issued provides assurance that a life insurance contract is being made for the lawful purpose of providing protection against financial loss, rather than for an unlawful purpose, such as speculating on the life of another person for profit.

The requirement of lawful purpose in making an individual life insurance contract is met if an insurable interest is present when the policy is issued. If the insurable interest requirement is met when the policy is issued, a continuing insurable interest is not required for the contract to remain valid.

Example. Walter Caldwell purchased a life insurance policy insuring his wife, Sally. Walter and Sally divorced several years later.

Analysis. As Sally's spouse, Walter had an insurable interest in her life when the policy was issued. Thus, the policy remains valid and in effect as long as premiums continue to be paid even if Walter no longer has an insurable interest in Sally's life.

Contractual Capacity

In order for an informal contract to be binding on all parties, the parties must have ***contractual capacity***; they each must have the legal capacity to make a contract. Individuals and insurance companies can enter into binding contracts, but the criteria for determining contractual capacity are somewhat different for individuals than for insurers and other corporations.

Contractual Capacity of Individuals

Every individual is presumed to have the legal capacity to enter into a valid contract. The law, however, has established exceptions to that general rule in recognition of the fact that some people lack the ability to understand the consequences of their actions. In most jurisdictions, the majority of people who have limited contractual capacity either (1) are minors or (2) lack mental capacity.

Minors. The laws in nearly all jurisdictions establish a particular age, referred to as the *age of majority* or *age of maturity*, at which people are considered adults who are capable of managing their own affairs and are responsible for the legal obligations created by their actions. A **minor** is a person who has not attained the age of majority. In most countries and in most states of the United States, the age of majority is 18. Figure 3.1 lists the age of majority in some other countries.

Generally, a contract that a minor enters into is voidable by the minor.¹ A minor usually may reject a contract before reaching the age of majority or within a reasonable time afterwards.

Many jurisdictions have, by law, lowered the age of majority for the purpose of entering into life insurance contracts. These laws permit younger people (generally those who are at least 15 or 16) to purchase life insurance and to exercise some of a policy's ownership rights as though they were adults. In most such situations, however, the beneficiary of the life insurance policy must be a member of the minor's immediate family.

Figure 3.1. Age of Majority in Selected Countries

Jurisdiction	Age of Majority
Argentina	21
Brazil	21
Canada	18 or 19 (varies by province)
France	18
Germany	18
Hong Kong	18
India	18
Japan	18
Scotland	16
Singapore	21
South Africa	21
Turkey	18

If an insurance company sells an insurance policy to a person who is younger than the permissible age to purchase insurance, then the company is required to provide the promised insurance protection as long as premiums are paid. The minor, however, can sue to avoid the policy, and the insurance company will have to return the premiums the minor paid for the policy.

Example. Andrea Hazlett, age 17, purchased a life insurance policy from Resilient Life Insurance Company and paid the initial premium. The minimum permissible age to purchase life insurance in the jurisdiction in which Andrea lives is 18 years.

Analysis. Because Andrea was younger than the permissible age to purchase life insurance in the jurisdiction in which she lived, the policy is *voidable* by Andrea. She can reject the contract before she becomes 18 or within a reasonable time afterward, and Resilient must refund any premiums she has paid. By contrast, as long as premiums are paid, Resilient is bound by the contract.

Mental Capacity. Two situations arise in which a person's lack of mental capacity affects her contractual capacity.

- A court declares the person to be insane or mentally incompetent. A contract entered into by a person who has been declared insane or mentally incompetent is usually *void*.
- The person's mental competence is impaired, but she has not been declared insane or mentally incompetent by a court. For example, the person can be mentally impaired as a result of being intoxicated or mentally ill. Contracts entered into by someone whose mental competence is impaired are generally *voidable* by the mentally impaired person. If the person later regains mental competence, she may either reject the contract *or* require that it be carried out. The other party to the contract does not have the right to reject the contract and must carry out its terms if required to do so.

Contractual Capacity of Corporations

Corporations are generally presumed to have the contractual capacity of a mentally competent adult. A corporation that was created in accordance with the laws of the applicable jurisdiction has the contractual capacity to enter into a contract, including a contract to purchase insurance.

An insurer acquires the legal capacity to issue an insurance contract by being licensed or authorized to do business as an insurer by the proper regulatory authority. A company that is not licensed or authorized as an insurance company does not have the legal capacity to issue an insurance contract. Sometimes, however, a company that is not authorized as an insurer in a particular jurisdiction might mistakenly issue a policy—for example, as the result of a mistake in processing the address information contained in the application. If the policyowner is unaware of the insurer's lack of legal capacity, the policy may be enforceable against the insurer, depending on the laws of the jurisdiction. In some jurisdictions, the contract is *void*; in other jurisdictions, the contract is *voidable* by the policyowner.

Figure 3.2 summarizes the requirements for a valid informal contract.

Figure 3.2 Requirements for a Valid Informal Contract



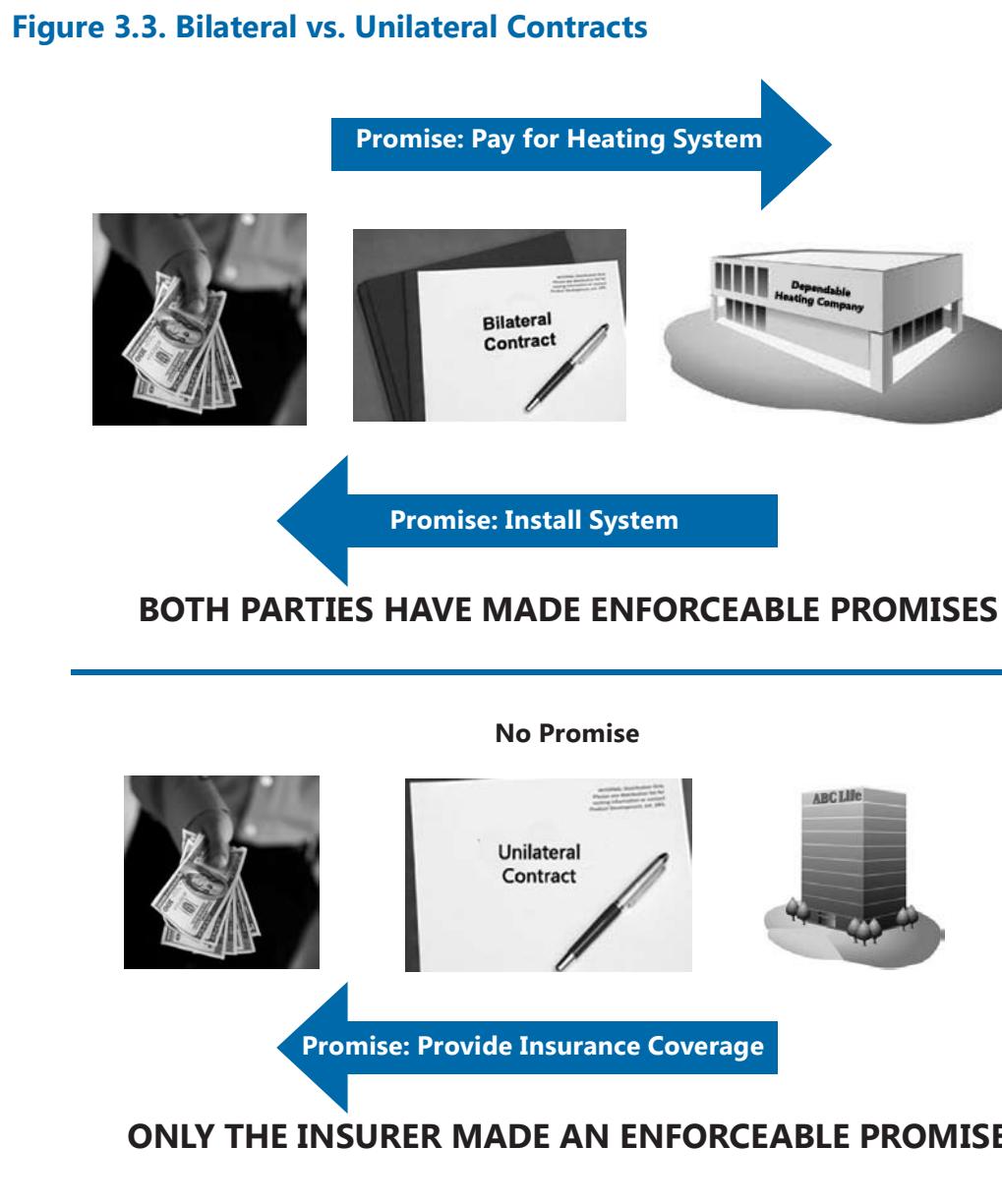
Types of Contracts

In Chapter 1, we described contracts of indemnity and valued contracts, noting that health insurance policies typically are contracts of indemnity and life insurance policies are valued contracts. Earlier in this chapter, we described formal contracts and informal contracts, noting that life insurance contracts are informal contracts. Contracts also may be categorized in several other ways.

Bilateral and Unilateral Contracts

A contract between two parties may be either bilateral or unilateral. As previously noted, contracting parties often exchange promises. A *bilateral contract* is one in which both parties make legally enforceable promises when they enter into the contract. For example, suppose Robert Garmond contracts with Dependable Heating Company for the company to install a heating system in his home for a mutually agreed-upon price. Dependable promises to perform the work, and Robert promises to pay a stated amount in exchange for the work. If either Robert or Dependable fails to perform its promise, the other party can take legal action to enforce the contract.

In some contracts, however, only one party makes a legally enforceable promise. A **unilateral contract** is one in which only one of the parties makes a legally enforceable promise when entering into the contract. Life insurance policies are unilateral contracts. The insurer promises to provide coverage in return for the required premiums. As long as premiums are paid, the insurer is legally bound by its contractual promises. The purchaser of the policy, on the other hand, does not promise to pay the premiums and is not legally required to pay the premiums. A policyowner has the right to stop paying premiums and cancel the policy at any time. Figure 3.3 illustrates the difference between a bilateral and a unilateral contract.



Commutative and Aleatory Contracts

The parties to many contracts specify in advance exactly what they promise to do. A *commutative contract* is an agreement under which the parties specify in advance the values that they will exchange. Moreover, the parties generally exchange items or services that they think are of relatively equal value. In the case of Robert Garmond and the Dependable Heating Company, both parties essentially agreed that the heating system and the price to be paid were of equal value. Contracts for the sale of goods or services usually are commutative contracts.

An *aleatory contract* is a contract under which one party provides something of value to another party in exchange for a conditional promise. A *conditional promise* is a promise to perform a stated act *if* a specified, uncertain event occurs. If the event does not occur, the promise will not be performed. Also, under an aleatory contract, one party may receive something of greater value than that party gave.

A life insurance policy is an aleatory contract. In a life insurance policy, the insurer's promise to pay the policy benefit is specified in advance and is contingent on the death of the insured while the policy is in force. The insured's death is an uncertain event because no one can say with certainty when the insured will die. If a life insurance policy is terminated prior to the death of the insured—for example, if the policyowner does not pay a particular renewal premium—the insurer is not obligated to pay the policy benefit, even though the policyowner may have paid a number of premiums for the policy. Conversely, death may occur soon after a life insurance policy is issued, and the policy benefit then becomes payable. The beneficiary would, in such a case, receive substantially more money than had been paid in premiums.

Bargaining Contracts and Contracts of Adhesion

Many contracts are the result of negotiation between the parties to the contract. Suppose, in the example involving the television earlier in the chapter, Mary and Janet had the following conversation:

Mary: I will sell you my television for \$100.

Janet: I like the television, but I will pay you only \$50 for it.

Mary: I can't sell you the television for \$50, but I will sell it for \$75.

Janet: All right, I will pay \$75 for the television.

This is an example of a **bargaining contract**, one in which both parties, as equals, set the terms and conditions of the contract. Many contracts between businesses are bargaining contracts involving lengthy negotiations covering a wide variety of terms and conditions.

By contrast, life insurance policies are contracts of adhesion. A **contract of adhesion** is a contract that one party prepares and that the other party must accept or reject as a whole, generally without any bargaining between the parties to the agreement. Applicants for life insurance have some choices regarding contract provisions. For example, an applicant for life insurance often has a variety of choices regarding the face value of the policy, with different premiums for each face value. However, the insurer drafts the insurance contract itself, and the applicant generally must accept or reject the contract as the insurance company has written it.

Because one party drafts a contract of adhesion and chooses the terms and wording that appear in the contract, if any contract provision is ambiguous, the courts usually interpret that provision in the manner that is most favorable to the other party. Thus, if any provisions of an insurance policy are ambiguous, the terms of the contract are construed against the insurance company that drafted the contract and in favor of the policyowner or beneficiary.

Figure 3.4 lists the various types of contracts and identifies which types characterize insurance contracts.

Figure 3.4. Types of Contracts

Type of Contract	Characterizes an Insurance Policy
Formal contract	
Informal contract	✓
Bilateral contract	
Unilateral contract	✓
Commutative contract	
Aleatory contract	✓
Bargaining contract	
Contract of adhesion	✓

Key Terms

contract	renewal premium
valid contract	contractual capacity
void contract	minor
voidable contract	bilateral contract
formal contract	unilateral contract
informal contract	commutative contract
mutual assent	aleatory contract
offer	conditional promise
acceptance	bargaining contract
consideration	contract of adhesion
initial premium	

Endnote

1. The general rule that a minor's contract is voidable by the minor has some exceptions. One important exception is that a minor's contract for *necessaries*, which are goods and services that a minor actually requires for her well-being, is valid and binding on both parties.



Chapter 4

Financial Design of Life Insurance Products

Objectives:

After studying this chapter, you should be able to

- Describe the legal reserve system, and explain how a product's financial design allows a life insurance company to meet its policy reserve requirements
- Identify and define the three primary elements in the financial design of a life insurance product, and explain how each element affects a product's financial design
- Explain how insurers use mortality tables in the financial design of products, and describe the effect that mortality rates have on the cost of benefits and the premium rate for a block of policies
- Describe the effect of compound interest on investment earnings, and calculate the amount of interest earned on a given sum of money
- Explain the purpose of using conservative values in the financial design of a life insurance product
- Define premium rate, and calculate the annual premium amount for a given life insurance policy
- Explain how the level premium system operates

Outline

The Legal Reserve System

Level Premium System

Elements of a Product's Financial

Design

- Cost of Benefits
- Investment Earnings
- Operating Expenses
- Conservative Values in Financial Design
- Premium Rates

Insurance companies have traditionally referred to the financial design of products as “pricing,” and many companies continue this usage. However, most life insurance products do not have a single feature that is a price. A premium for a life insurance policy is not a price, particularly when the policy has a cash value. (We describe cash values in Chapter 6.) The premium amount a policyowner pays to an insurance company has elements designed to support both cash values and the cost of benefits and operating expenses. Moreover, because most life insurance products include charges that are not premiums, premiums do not include all charges that policyowners pay to the insurer. In this chapter, we describe the many interrelated values in the financial designs of life insurance products.

A *financial design* for a life insurance product consists of a set of values for the numerous elements of the product. The financial design process involves, in part, setting premiums and other charges that policyowners pay. Although a financial design is detailed and includes values for many different aspects of a product, here we consider the most important product elements: payments from policyowners, benefit payments, investment earnings, and company operating expenses. To design a life insurance product, an insurer sets values for these elements for the period of years the product is expected to remain in force. In this context, the term *product* means all of those policies an insurer issues using a given financial design.

An insurer may be obligated to pay policy benefits for many years—even decades—after the life insurance policies are issued. An insurance company must design its life insurance products so that, over time, the company’s revenues from those products are adequate to fund the company’s financial obligations under those products. Employees from almost all operational areas of a company participate in the financial design of products. The employees who are most heavily involved in the financial design of products are specialists known as actuaries. An *actuary* is an expert in financial risk management and the mathematics and modeling of insurance, annuities, and financial instruments. In insurance companies, actuaries are responsible for ensuring that products are financially sound.

To operate on a sound basis, an insurer must make sure that the total of the premiums and other payments it receives from customers plus the investment earnings it makes by investing those funds is greater than the sum of the company’s operating expenses and its payments to customers. In other words, the amount of money coming in to the insurer—its revenues—must be greater than the amount of money the insurer pays out—its benefit payments and operating expenses.

We can summarize this concept with the following expression:

Financial stability requires revenues > expenses

The values of unknown future revenues and expenses over many years result from numerous factors, including economic conditions, the insurer's claims experience, and policy terminations. Companies cannot accurately forecast future financial conditions and developments; therefore, they study the potential effects of various potential future conditions on a product's financial design.

For this purpose, insurers use financial models. Generally, a *financial model* is a computer-based mathematical model that approximates the operation of real-world financial processes. These models produce projections of potential future financial values. These projected values are an important part of an insurer's financial design efforts. Companies use product development software that simulates the potential financial processes likely to occur over the time that a product is expected to remain in force. The assumed values used in the financial design of a product are known as *actuarial assumptions*. These assumptions are estimates of future values.

Example: Financial modeling can illustrate how changes in various actuarial assumptions could affect projected future revenues and expenses for a product.

The Legal Reserve System

The system insurers use to set financial values for life insurance products is generally known as the *legal reserve system*. The legal reserve system derives its name from legal requirements that apply to insurers in the United States and many other jurisdictions. Insurers are required by law to establish *policy reserves*, sometimes referred to as *legal reserves* or *statutory reserves*. These reserves are liabilities that represent the amount the insurer estimates it needs to pay future benefits.

Of all the terms used in the insurance industry, *reserves* is one of the most important and also one of the most easily misunderstood. In our everyday lives, we use the term *reserves* to mean something extra, something that is available in addition to our usual supply. For example, in a broad sense, people use the term *reserves* to refer to a sum of additional money that is put aside in case a special need arises. Used in this sense, a reserve fund is an asset.

In the insurance industry, however, reserves are not assets. Rather, reserves are liabilities representing the amounts of money an insurer estimates it will need to pay its future obligations. Policy reserves represent the largest portion of an insurer's total liabilities.

According to the basic accounting equation, an insurer's assets must equal its liabilities plus owners' equity. As the insurer issues policies, it establishes policy reserves for those policies. When the amount of the insurer's liabilities—which include its policy reserves—increases, then, to keep the accounting equation in balance, the insurer must make a corresponding increase in its assets or a corresponding decrease in its owners' equity. Accordingly, the financial design of a product must enable the company to meet its policy reserve requirements at all times.

The legal reserve system is based on the following premises:

- The amount of benefits payable should be specified or calculable in advance of the insured event.
- Companies should collect in advance the money needed to fund a policy reserve so that the insurer will have sufficient funds available to pay claims and expenses as they occur.
- The amounts a customer pays for a life insurance policy should be related to the amount of risk the insurance company assumes for that policy.

Elements of a Product's Financial Design

A product's financial design must incorporate many product elements, and the insurer must consider many variables and risk factors while creating that design. The primary elements in the financial design of a life insurance product are (1) the cost of benefits, (2) the insurer's investment earnings, and (3) the insurer's operating expenses. Keep in mind, however, that each of these elements can, in turn, have many components.

Cost of Benefits

The *cost of benefits*, sometimes known as the *cost of insurance*, is the value of all benefits under a product. A single life insurance product may offer numerous benefits, and the product's financial design must anticipate the costs of all of these benefits throughout the life of the product. Insurers calculate the projected cost of benefits for a product by multiplying all of the potential benefits payable under the product by the expected probability that each benefit will be payable.

$$\text{Cost of Life Insurance Policy Benefits} = \frac{\text{Total Potential Benefit Obligations}}{\times} \text{Probability that Potential Benefits will be Payable}$$

The primary benefit obligation under a life insurance policy is the death benefit payable if the insured dies while the policy is in force. Thus, to design a life insurance product, an insurer must be able to estimate the mortality rate for a given group of insureds, known as a *block of insureds*. Financial design calculations are based on calculations for a *block of policies*, which is a group of policies issued to insureds who are all the same age, the same sex, and in the same risk classification.

Example: A block of policies could be built with reference to a group of 100,000 male nonsmokers, age 35, with no significant medical history.

The cost of death benefits for a block of policies depends in part on the mortality rate. In general, the higher the mortality rate for a group of insureds of the same age and sex, the higher the cost of benefits and, thus, the higher the premium rate. Conversely, the lower the mortality rate for a group of insureds of the same age and sex, the lower the cost of benefits and the premium rate.

As we noted in Chapter 1, mortality tables show the mortality rates expected to occur among a specified group of people at each age. The mortality rates shown in a mortality table are known as **tabular mortality rates**. Insurers use tabular rates as a starting point to calculate the mortality rates that they use to project the cost of benefits for a block of policies.

One type of mortality table, known as a **mortality experience table**, is compiled from a company's own records, reflecting its insureds' actual mortality. To calculate the cost of benefits, many insurers use their own mortality experience tables, usually blended with mortality information from industry mortality tables. However, a wide variety of mortality tables are available from different sources and are used for different purposes. Because life expectancy and mortality rates vary widely from one country to another, insurers usually rely on mortality tables developed for use in a particular country. Figure 4.1 illustrates a portion of a mortality table.

Most mortality tables contain separate statistics for males and females. By contrast, some mortality tables, known as **unisex mortality tables**, do not show separate mortality rates for males and females.

Mortality statistics show that, at nearly all ages, females have a lower mortality rate than males of the same age. To reflect this difference, most insurers set lower life insurance premium rates for equivalent coverage for women than for men of the same age and underwriting risk. Figure 4.2 graphically illustrates the differences in the mortality rates of males and females.

Most mortality tables that insurers use in financial design divide the mortality rates into two additional categories: smokers and nonsmokers. In other words, gender-specific mortality tables often show mortality rates for four categories of people—male nonsmokers, male smokers, female nonsmokers, and female

Figure 4.1. Sample Mortality Table—Men

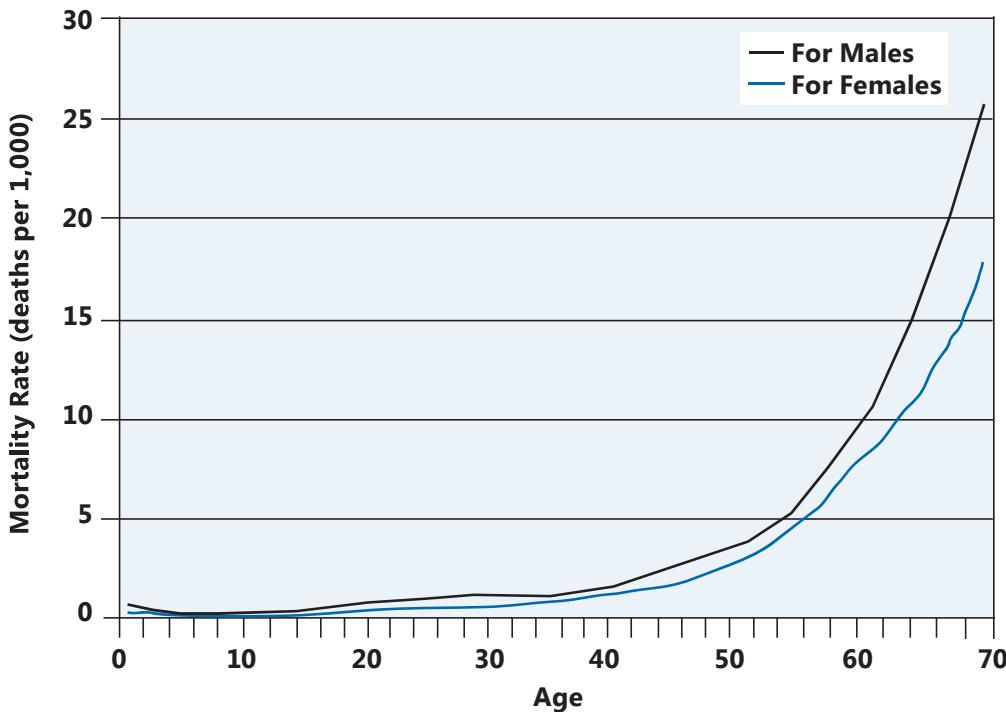
Age	Number Living	Number Dying	Mortality Rate per 1,000
59	100,000	1,100	11
60	98,900	1,200	12
61	97,700	1,300	13

The group of men age 59 begins the year with 100,000 members. During that year, 1,100 of the men are estimated to die. The mortality rate during that year is 11, calculated by dividing the number dying at age 59 by the number living at age 59 at the beginning of the year.

$$\frac{1,100}{100,000} = 0.011$$

According to this mortality table, 11 out of every 1,000 men will die after attaining age 59 but before attaining age 60.

Figure 4.2 Comparison of Mortality Curves for Males and Females



Source: Adapted from ACLI, *Life Insurers Fact Book 2009* (Washington, DC: American Council of Life Insurers, 2009), 131-132. Used with permission.

smokers. A mortality table that does *not* show separate mortality rates for smokers and nonsmokers is referred to as a *composite mortality table*. For the purpose of setting premium rates, mortality tables are also divided into even more categories, such as preferred, standard, and substandard risk classifications.

Investment Earnings

The financial design of a life insurance product must include a provision for **investment earnings**—the money the insurer earns from investing the funds it receives from customers. Many life insurance policies remain in force for a number of years before benefits become payable. During that time, the funds paid for those policies are available for the insurer to invest. The investment earnings allow insurance companies to charge policyowners less than if companies relied only on the premiums and charges that policyowners paid.

How Investments Create Earnings

Many investments earn money in the form of interest payments. **Interest** is a payment for the use of money. The rate of interest is expressed in terms of a percentage, such as 10 percent. The **principal** is the sum of money originally invested, loaned, or borrowed.

Simple interest is interest on the original principal only. Consider an example of a simple-interest loan. In such a transaction, the lender is considered to be the investor. A 10 percent interest rate on a loan indicates that the borrower must pay the lender the amount originally borrowed, plus an additional 10 percent of that amount.

Example. George Hanratty loaned Ned Barton \$1,000 for one year at an annual interest rate of 10 percent.

Analysis. At the end of one year, Ned owed George \$1,100, the \$1,000 George loaned Ned originally plus \$100 interest ($\$1,000 \times 0.10 = \100).

Calculating an interest amount on both the principal and the accrued interest is called **compounding**. Interest on both the principal and the accrued interest is called **compound interest**. Until a loan is repaid, the interest on a compound-interest loan continues to *accrue*—or accumulate. Under such circumstances, the investor usually earns interest on both the principal and on the accrued interest.

Example. Elaine Hamilton loaned Carla Monaghan \$1,000 at an annual interest rate of 10 percent. Carla did not repay any of the principal or interest on the loan for two years.

Analysis. At the end of the first year, Carla owed Elaine \$1,100, calculated as

$$\$1,000 \text{ principal} + (\$1,000 \text{ principal} \times 0.10)$$

At the end of the second year, Carla owed Elaine \$110 in interest, calculated as

$$\$1,100 \text{ principal and accrued interest} \times 0.10$$

Thus, at the end of the second year, Carla owed Elaine a total of \$1,210, calculated as

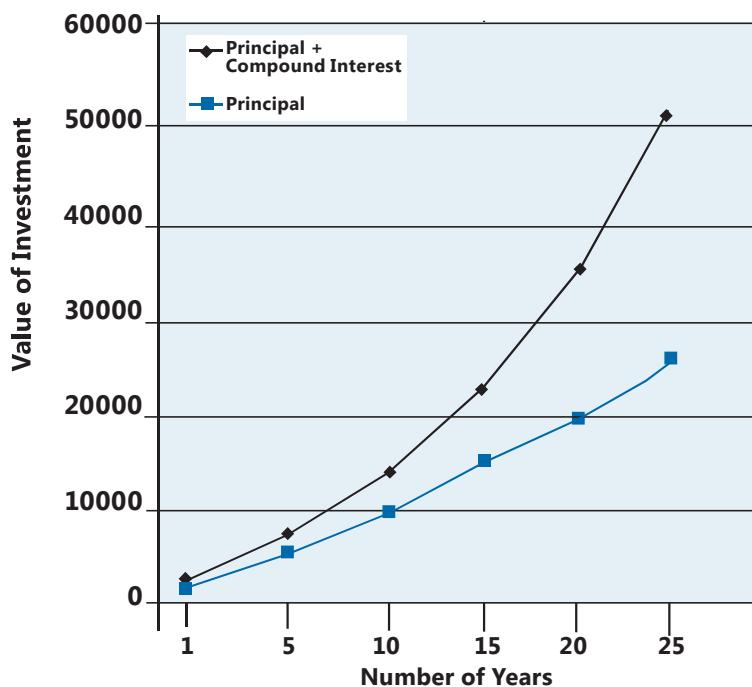
$$\$1,100 + \$110$$

The interest in this example was compounded annually. However, interest can be compounded with any frequency—quarterly, monthly, or daily, for example.

Although the additional \$10 earned by compounding interest in the example may seem small, over a long period of time, compounding interest has a dramatic effect on the total amount of interest that is earned. For example, many people earn interest on bank accounts. Suppose you deposit \$1,000 in a bank account that pays 5 percent interest. You make no other deposits and you spend the \$50 interest you earn each year. After 25 years, your account will have earned a total of \$1,250 simple interest ($\50×25). On the other hand, suppose you leave the interest earned each year in the account rather than spending it and that the interest is compounded annually. At the end of the 25-year period, your account will have earned a total of \$2,386 compound interest.

The example of the bank account shows how much money a single amount can earn over a long time. Many insurance policies require annual premium payments, which usually allow the insurer to invest an additional amount from premiums every year the policy remains in effect. Figure 4.3 shows the amount of money that can be earned over various periods of time by investing \$1,000 a year at 5 percent interest, compounded annually.

Figure 4.3. Value of \$1,000 Annual Investment at 5% Interest, Compounded Annually



Value of Investment						
1 year	Principal	\$1,000	Interest	\$50	Total	\$1,050
5 years	Principal	\$5,000	Interest	\$802	Total	\$5,802
10 years	Principal	\$10,000	Interest	\$3,207	Total	\$13,207
15 years	Principal	\$15,000	Interest	\$7,657	Total	\$22,657
20 years	Principal	\$20,000	Interest	\$14,719	Total	\$34,719
25 years	Principal	\$25,000	Interest	\$25,113	Total	\$50,113

For the sake of simplicity, we illustrated investment earnings in terms of an interest rate earned on a loan and on a bank account. However, companies can receive investment earnings from many other types of investments. For example, insurance companies invest money by buying stock in other companies. While an insurance company owns the stock, the company may collect dividend payments on that stock. In addition, the insurer might be able to sell the stock for more than it paid. In both instances, the insurer's investment earnings can be expressed as a **rate of return**, which is the investment earnings expressed as a percentage relative to the principal.

Example. Gala Insurance Company purchased stock in Mammoth Corporation for \$100,000. One year later, Gala sold the stock for \$110,000.

Analysis. Gala earned a return of \$10,000 on its investment (\$110,000 – \$100,000). The percentage rate of return on the investment was 10 percent [$\$10,000 \text{ return} \div \$100,000 \text{ principal} = 0.10 \text{ or } 10\%$].

How Investment Earnings Affect Financial Design

The effect of investment earnings on insurance companies and their policyowners becomes especially important in the financial design of insurance products. An insurer's investment earnings enable it to charge customers less than would be possible otherwise.

Earlier in this chapter, we said an insurer must charge customers enough in premiums and other fees so that the company will have enough funds available to pay benefits and other expenses. To pay benefits, the insurer uses (1) the premiums and charges it collects from customers and (2) its investment earnings. The greater the investment earnings, the less money the insurer needs to charge customers. In general, the longer a policy is in force, the greater the effect investment earnings will have on charges to customers.

Operating Expenses

When designing an insurance product, an insurer must consider its *operating expenses*, which are the expenses that arise in the normal course of the insurer's operations. Like any business, insurers have operating expenses such as payroll, office expenses, advertising, information technology costs, and taxes. In designing a product, an insurance company estimates the amount of all of its operating expenses over time.

In general, insurers spend considerably more on life insurance benefit payments than on their operating expenses. Figure 4.4 shows the typical portion of insurance company expenses that was attributable to paying policy benefits and the portion that was attributable to various operating expenses in recent years.

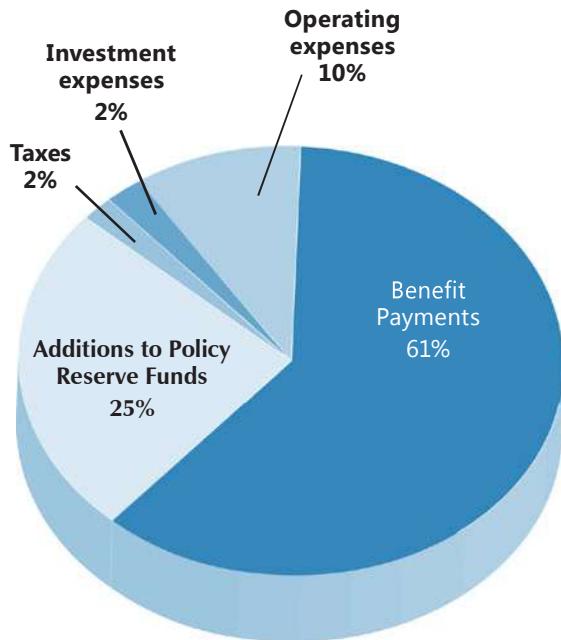
A significant risk associated with an insurer's operating expenses is that customers will terminate or reduce the value of a life insurance policy before the policy becomes profitable. During a policy's early years, the insurer incurs substantial product expenses. Underwriting and other costs are incurred when an insurer issues policies. For example, insurers often pay a substantial portion of a policy's initial premium as a commission to the producer who sold the policy. Thus, a policy generally must remain in force for several years for the policy to be profitable.

An example of a situation in which an insurer may lose money on a product is when the product's lapse rate exceeds the rate built into the product's financial design. The *lapse rate* is the percentage of a specified group of policies in force at the beginning of a specified period, such as a year, that are terminated by the end of that period for reasons other than the death of the insured. However, not all policy lapses cause the company to lose money.

Conservative Values in Financial Design

A financial design consists of projected values for payments from policyowners, mortality rates, benefit payments, company operating expenses, and investment earnings. In designing a product, insurers project the values of these elements over the years the product is expected to remain in force. Projected values, by their nature, are uncertain. Because insurers face a risk of unexpected financial outcomes, they must make sure they hold funds in an amount that will be more than adequate to protect policyowners and beneficiaries from unexpected outcomes

Figure 4.4. Distribution of U.S. Life Insurance Company Expenditures, 2008



Source: Adapted from ACLI, *Life Insurers Fact Book 2009* (Washington, DC: American Council of Life Insurers, 2009), 50. Used with permission.

that can cause adverse deviations from the projected values. Projections that are designed to be more than adequate are described as *conservative*. Conservative values for specific life insurance product elements generally take the form of

- Mortality rates that are higher than expected
- Investment earnings that are lower than expected
- Operating expenses that are higher than expected

Example: An insurer may project mortality rates 10 percent higher than expected in order to ensure that the financial design will be more than adequate.

Using conservative values in financial design provides a risk margin against adverse developments. A product's financial design also usually includes an amount to provide the company with some profit. Consistent profitability is important because it supports an insurer's long-term financial strength and stability.

Premium Rates

In financial design, actuaries do not determine the exact *premium amount* that each policyowner pays. Rather, as part of a product's financial design, companies establish various policy charges and *premium rates*. A **premium rate** is a charge

per unit of insurance coverage. For life insurance, a *coverage unit* usually equals \$1,000 of coverage. The premium rate for an individual life insurance policy typically is expressed as the rate per thousand per year. An annual premium amount for a policy is calculated by multiplying the premium rate by the number of coverage units.

Example. The annual premium rate for a \$500,000 life insurance policy is expressed as \$4 per \$1,000 of coverage.

Analysis. The annual premium amount for the policy is \$2,000, which is calculated as follows:

Premium Rate (Payment per Unit per Year)	×	Number of Units (\$1,000 of Coverage)	=	Annual Premium Amount (Customer's Annual Payment)
\$4	×	500 (\$500,000 ÷ \$1,000)	=	\$2,000

Actuaries consider many variables as they perform the calculations necessary to establish premium rates and other policy charges. In performing these calculations, actuaries seek to make sure that premium rates and other policy charges are

- **Adequate.** Adequate premium rates are high enough so that the insurer will have enough money available to pay policy benefits as well as operating expenses. Because most insurance companies operate for profit, their premium rates should be high enough to provide a reasonable profit as well.
- **Equitable.** Equitable premium rates ensure that each policyowner is charged a premium that reflects the degree of risk the insurer assumes in providing the coverage. Insureds who represent similar degrees of risk to the company should be charged similar rates.
- **Not excessive.** If an insurer's premium rates are too high, potential customers may instead purchase policies from competitors that offer lower premium rates. In addition, sales producers may prefer to represent other insurers that offer lower premium rates.

Level Premium System

The *level premium system* is a life insurance premium system that allows a policyowner to pay the same premium amount each year a policy is in force. An example of a type of life insurance that does not offer level premiums is the one-year term life insurance policy, because under one-year term life plans, the policyowner must purchase a new policy or pay an increasing premium for every year of coverage. We discuss term life insurance in chapter 5.

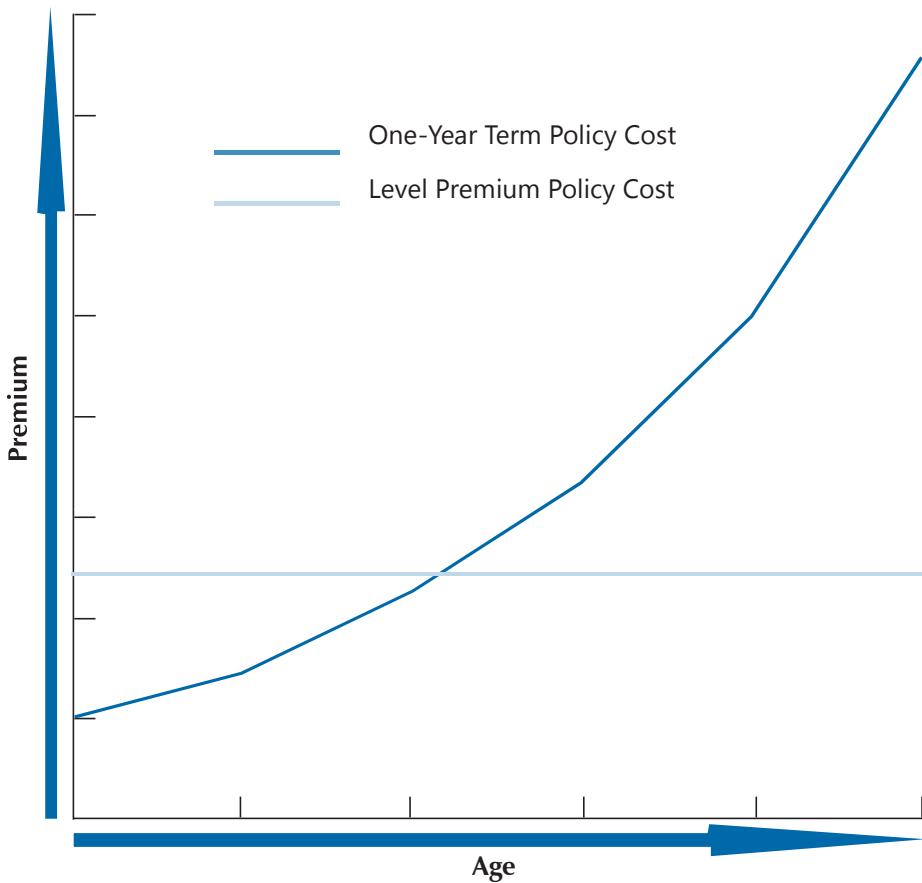
Because mortality rates increase with age, the company's cost of providing one-year term life insurance to aging individuals also must increase. Unfortunately, many people cannot afford the higher cost of one-year term life insurance in their later years when mortality rates are greater. To provide life insurance coverage for periods of more than one year at a premium rate that does not increase each year with the insured's age, the life insurance industry developed a level premium system.

Level premiums are possible because, in earlier policy years, premium rates for level premium policies are higher than needed to pay claims and expenses. Relatively few insureds will die during those early policy years, and few claims will be payable. The insurer can invest the premium dollars that are not needed to pay claims in those years.

As people insured under a block of level premium policies grow older, the insurer expects to receive an increasing number of death claims each year. Under a level premium system, the insurer uses premium dollars from the early policy years, plus the investment earnings, to help pay the increased number of death claims in the later years. Thus, the premium rate on any one of these policies can remain level throughout the duration of the policy. Figure 4.5 illustrates the difference between the premiums required for a level premium policy and the premium amounts required for a series of similar one-year term life policies.

As insureds age, the cost of providing benefits on a block of policies increases. The premium rate for a level premium policy, however, does not increase after the policy has been issued. Thus, the level premium system allows people to buy life insurance policies that protect them for many years at a steady cost even while their risk of death is increasing over the duration of the policy.

Figure 4.5. Level Premiums Contrasted with One-Year Term Life Premiums



Key Terms

financial design	interest
actuary	principal
financial model	simple interest
actuarial assumption	compounding
legal reserve system	compound interest
policy reserves	rate of return
cost of benefits	operating expenses
block of policies	lapse rate
tabular mortality rates	premium rate
mortality experience table	level premium system
investment earnings	



The title slide features a blue gradient background. On the left, the word "Chapter" is written vertically above the large number "5". To the right of the number, the words "Term Life Insurance" are written in a large, bold, blue font.

Objectives:

After studying this chapter, you should be able to

- Identify the common personal and business needs that life insurance can meet
- Describe the coverage provided by level term, decreasing term, and increasing term life insurance policies, and explain when the premium charged for term life insurance coverage may increase
- Describe renewable term life insurance and convertible term life insurance
- Describe the operation of a return of premium (ROP) term policy

Outline

Needs Met by Life Insurance

- Personal Needs
- Business Needs

Term Life Insurance

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

In this chapter, we describe various types of term life insurance products. However, before we examine particular products, you need to understand some of the reasons that people buy life insurance. People buy products to meet specific needs. However, many products—including life insurance—can meet different needs for different people. For example, some people use a cellular phone primarily to make or receive telephone calls when they are away from home. Others use a cellular phone as their primary telephone. Still others use a cellular phone to download and transmit information over the Internet. Before deciding which calling plan to purchase, people first consider what needs they are trying to meet and then determine the type of plan that is best suited to meet those needs. People buy life insurance to meet a variety of financial needs, and several types of life insurance products are available to meet these various financial needs.

Needs Met by Life Insurance

Life insurance provides for the payment of a benefit following the death of the insured. That benefit can be used for a range of purposes, including meeting some needs that do not arise until a person's death. Individuals and businesses both have needs life insurance can meet.

Personal Needs

People's needs for life insurance coverage vary greatly, but some of the reasons that people purchase life insurance are common to most buyers. Among the most common personal needs that life insurance can meet are dependents' support, estate planning, and paying debts and final expenses.

Dependents' Support

If a person who supports or helps support a family dies, the surviving dependents may face serious problems after the person's death. Household expenses go on; rent or mortgage payments must be made; utility bills must be paid; food and clothing must be purchased. The death may create additional expenses, such as the need to provide child care or daily household upkeep. The surviving family members often must make difficult financial decisions at a time when they also are coping with the emotional effects of the loss of a loved one.

Although many people save money for unexpected expenses, relatively few have sufficient funds to pay their usual expenses for an extended period of time if the regular family income ceases or is reduced substantially. Even those who do have sufficient savings may worry that using those savings to pay household

expenses at this time makes it more difficult for them to meet future financial needs, such as providing for retirement.

Life insurance can provide funds to support the family members until they obtain new methods of support or until they adjust to living on a lower income. In addition, the proceeds of a life insurance policy can be used to supplement the family's income. If the insured has dependents such as minor children or elderly parents, policy proceeds can provide funds to support those dependents. Policy proceeds also can fund the education of the insured's dependents.

In many jurisdictions, when the death benefit of a life insurance policy is paid in a lump sum to a named beneficiary following the death of the insured, that benefit usually is not considered taxable income to the beneficiary. In other words, a policy beneficiary who receives policy death benefits is not required to pay income taxes on the benefit. This favorable income-tax treatment given to life insurance is designed to encourage people to provide for their dependents' financial needs.

Estate Planning

People typically accumulate a variety of assets during their lifetimes. These assets may include cash, bank and investment accounts, real estate, personal possessions, and possibly ownership interests in a business. The accumulated assets that an individual owns when he dies are referred to as that person's *estate*. When the individual dies, his estate is distributed in an orderly manner according to the law.

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

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

Making sure that a deceased person's dependents and loved ones are provided for in accordance with the deceased's wishes can be complicated, especially if the person left a variety of assets and debts. In addition, the deceased person is not available to explain her wishes to the personal representative. An individual who wants to ensure that her estate will be settled in accordance with her wishes can develop a plan—called an *estate plan*—that considers the amount of assets and debts that she is likely to have when she dies and how best to preserve those assets so that they can be distributed as she desires.

A will is one component of an estate plan, but an estate plan generally involves a number of other components as well. Life insurance often is an important component of an estate plan. For example, life insurance can make it easier for an individual to divide her property among various people. Suppose an individual's primary asset is the family home, and she wants to divide her estate equally between her two children. If she owns a life insurance policy, she can leave the family

home to one child while the other child receives the proceeds of the life insurance policy.

Debts and Final Expenses

When a person dies, he often leaves a variety of debts, such as mortgage loans, educational loans, personal loans, credit accounts, and automobile loans. In addition, some expenses arise as a result of the person's death itself, such as doctor and hospital bills that are not covered by insurance, as well as funeral expenses. Furthermore, various taxes may be imposed on a deceased person's estate. In the United States, for example, the federal government imposes a tax on estates that exceed a specified amount.

A person's death generally does not extinguish his debts. Instead, the debts must be paid from the deceased's estate before any assets can be distributed to heirs. The personal representative may have to sell some or all of the deceased's assets to raise cash to pay the deceased's debts. Such a sale may result in harsh consequences. For example, an individual may want his spouse or children to own the family home after his death, but the personal representative may have to sell the home to pay the deceased's debts. In some cases, the deceased's estate is not large enough to pay his debts and final expenses.

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

In some cases, other people, such as a spouse or parent, may be personally liable for a particular debt of the deceased. For example, a spouse or parent may have co-signed a loan with the deceased and be jointly liable with the deceased for its repayment. Insurance benefits can help pay off any such debts so that the deceased's loved ones do not have to pay them.

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

Business Needs

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

Business Continuation Insurance

A **business continuation insurance plan** is an insurance plan designed to enable a business owner (or owners) to provide for the business' continued operation if the owner or a key person dies. A **key person** is any person or employee whose continued participation in the business is vital to the success of the business and whose death would cause the business to incur a significant financial loss. A business continuation insurance plan often includes key person life insurance or a buy-sell agreement.

Key Person Life Insurance. **Key person life insurance**, or **key employee life insurance**, is individual life insurance that a business purchases on the life of a key person. When a business purchases key person life insurance, the business owns,

Insight 5.1. How Much Life Insurance is Enough?

Many formulas are available to help people determine how much life insurance they should purchase. One of the simplest formulas focuses on the person's current income—the amount of insurance needed is a multiple of the amount of current income. For example, the formula might recommend that people purchase at least five times their current income in life insurance. Thus, a person who earns \$50,000 a year would be advised to purchase at least \$250,000 of life insurance. The specific multiple amount recommended varies widely.

Another common method to establish the amount of coverage needed is to evaluate all of the person's expenses, debts, savings, and family situation. This method is much more difficult than the multiple of current income formula and requires the person to develop a comprehensive picture of her financial situation and future financial needs. Fortunately, insurance companies and financial experts have software programs that allow people to determine quickly and reasonably accurately how much insurance they need to provide for their loved ones when they die. Many of these programs, commonly referred to as *life insurance needs calculators*, are available at no charge on insurers' or financial publications' Web sites.

The following is a sample life insurance needs calculator. An individual enters the appropriate information into the calculator concerning his assets, expenses, and the income he wishes to provide for his survivors. The calculator then determines the amount of additional life insurance the individual would need to purchase to meet all expenses and provide for his survivors. In the example shown, this particular individual would need \$489,249 of additional life insurance to meet all his expenses and provide an annual income of \$50,000 for 10 years to his survivors.

How Much Life Insurance Do I Need?

This tool gives you an idea of the amount of insurance you might need to protect and provide for your survivors. This tool assumes your home is not an asset you would choose to sell to provide for survivors.

Your Assets

Financial Assets (cash, securities, retirement accounts, etc.)	\$ 75,000
Personal Assets (vehicles, jewelry, etc., includes any assets you would be willing to sell to provide for survivors)	\$ 20,000
Non-financial Assets (business assets, real estate, etc.)	\$ 0
Total life insurance (personal, employer, mortgage insurance)	\$ 50,000

Expenses to Cover

Mortgage	\$ 80,000
Loan (credit card, line of credit, car loan)	\$ 5,000
Final expenses (can range from \$5,000 to \$20,000)	\$ 10,000
Emergency fund	\$ 20,000
Education fund	\$ 40,000
Other cash needs	\$ 20,000

Income needed for your survivors

Annual income to be left to survivors: **\$50,000** for **10** years.

Calculate

Your Results

Total expenses	\$ 175,000
Total income needed over 10 years	<u>+ \$ 459,249</u>
Total amount required	\$ 634,249
Total assets available	<u>- \$ 145,000</u>
Extra life insurance needed to meet survivors' needs	\$489,249

The additional life insurance needed is the amount of coverage suggested to bridge the gap between what you have today and what you need to meet all expenses and provide for all survivors.

Source: Sun Life Financial. Used with permission

pays the premiums on, and is the beneficiary of the insurance policy. If the key person dies, the business receives the policy proceeds.

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

The loss of a key person's expertise and services may seriously affect the company's earnings. During the period following the death of a key person, sales may drop off, and morale and productivity may decline. Creditors, customers, and suppliers may become uneasy. In addition, the business probably will incur the cost of finding or training a replacement for the key person.

The proceeds from a key person life insurance policy can provide a source of cash to supplement the company's earnings while it searches for and trains a replacement for the deceased individual. In addition, if the company's creditors, customers, and suppliers know that the business has protected itself by insuring the lives of its key people, they may be more confident about the company's future and agree to continue their business relationships with the firm on the same basis as before the key person's death.

Buy-Sell Agreements. The owner of a small business may want to ensure that the business can continue to operate under new ownership after his death. A *buy-sell agreement* is an agreement in which (1) one party agrees to purchase the financial interest that a second party has in a business following the second party's death and (2) the second party agrees to direct his estate to sell his interest in the business to the purchasing party. One or more of the parties to a buy-sell agreement often purchase life insurance to fund the buy-sell agreement. Life insurance can be used to fund buy-sell agreements for sole proprietorships, partnerships, or corporations with a small number of shareholders.

Example. John Davis is the owner of Quality Products, a sole proprietorship. John entered into a buy-sell agreement with one of his employees, Myron Kaufman. Under the terms of the agreement, Myron agreed to buy the business for \$1,000,000 at John's death. Myron purchased a \$1,000,000 life insurance policy on John's life, naming himself as beneficiary.

Analysis. After John's death, the proceeds of the life insurance policy will be paid to Myron, who can use the proceeds to purchase the business from John's estate.

Employee Benefits

Many businesses provide life insurance for their employees as an employee benefit. Businesses often pay for all or part of these employee benefits as part of the total package under which they compensate their employees. Providing such benefits enables businesses to attract and retain qualified employees. Many employers also provide health insurance and retirement plans for their employees. We describe these insurance and retirement plans later in the text.

Term Life Insurance

All life insurance policies provide for the payment of a benefit upon the death of the insured while the policy is in force. Therefore, all life insurance policies help individuals and businesses meet the needs we discussed earlier. However, the features and cost of life insurance policies vary depending on the type of policy. As we shall learn, in most cases, term life insurance is the least expensive plan of life insurance available. For that reason, individuals and businesses seeking to meet the needs we previously discussed often purchase term life insurance.

Characteristics of Term Life Insurance Products

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

The length of the policy term varies considerably from one policy to another. Some insurers issue policies that provide a death benefit only if the insured dies during a specified airplane trip, for example. Insurers also sell policies that cover a term of a specified number of years, such as 1 year, 5 years, 10 years, 20 years, or 30 years. For example, if George Stewart buys a 10-year term insurance policy, the policy will expire on its tenth policy anniversary, provided that all premiums have been paid. The **policy anniversary** generally is the anniversary of the date on which coverage under the policy became effective. Both the expiration date and the policy anniversary date are usually stated on the face—or first—page of the policy.

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

Example. Sandra Hardesty was born on November 1, 1975. She was issued a term to age 65 policy, effective October 1, 2009. Under the terms of the policy, coverage expires on the policy anniversary *closest to* her 65th birthday. Sandra paid all renewal premiums as they were due.

Analysis. Sandra's policy will expire on October 1, 2040, the anniversary date closest to her 65th birthday. If Sandra's policy instead provided that coverage expires on the policy anniversary *immediately after* her 65th birthday, her policy would expire on October 1, 2041.

Term life insurance is one of the most popular forms of life insurance currently being sold. In 2008, term insurance policies represented 43 percent of the individual life insurance policies sold in the United States. These policies had a combined

face amount of over \$1.3 trillion, which was 73 percent of the face amount of all individual life policies issued in the United States that year.¹

Plans of Term Life Insurance Coverage

The amount of the benefit payable under a term life insurance policy usually remains the same throughout the term of the policy. Term life insurance, however, also may be purchased to provide either a benefit that decreases over the policy's term or a benefit that increases over the policy's term.

Level Term Life Insurance

By far, the most common plan of term insurance is ***level term life insurance***, also known as ***level face amount term life insurance*** or ***guaranteed level premium term insurance***, which provides a policy benefit that remains the same over the term of the policy. For example, under a 10-year level term policy that provides \$250,000 of coverage, the insurer agrees to pay \$250,000 if the insured dies at any time during the 10-year period that the policy is in force.

The amount of the initial premium and each renewal premium payable for a level term policy remains the same throughout the stated policy term. For example, if the initial premium for a guaranteed level premium 10-year term policy is \$500, then each renewal premium also will be \$500 throughout the policy term. However, some level term policies provide for renewal premiums that may increase during the policy term, although the policy benefit remains the same.

Decreasing Term Life Insurance

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

The amount of each renewal premium payable for a decreasing term insurance policy usually remains level throughout the policy term. The renewal premium for a decreasing term policy typically is less than the renewal premium for an equivalent level term policy having the same policy benefit as the initial policy benefit for the decreasing term policy.

Decreasing term policies usually are sold to meet specific needs that decrease over a period of time. For example, many people borrow money to purchase houses or cars, and, as they repay those loans, their liabilities decrease. Similarly, as children grow up and move away from home, a family's expenses decrease as well.

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

Mortgage Life Insurance. The largest debt that many people owe is the mortgage loan on their homes. Under the terms of a typical home mortgage loan, a borrower makes equal monthly payments for a period of time, usually either 15 or 30 years. Each payment the borrower makes on a mortgage loan consists of both principal and interest on the loan. The amount of the outstanding principal balance

owed on the mortgage loan gradually decreases over the term of the mortgage, although initially the decrease is fairly slow.

Mortgage life insurance, sometimes referred to as *mortgage redemption insurance*, is a plan of decreasing term insurance designed to provide a benefit amount that corresponds to the decreasing amount owed on a mortgage loan.² If the borrower purchases mortgage life insurance, the amount of the policy benefit payable at any given time generally equals the amount the borrower then owes on the mortgage loan. The term of a mortgage life policy is based on the length of the mortgage. Renewal premiums payable for mortgage life insurance are generally level throughout the term. Figure 5.1 illustrates the declining benefit amount payable on a typical mortgage life insurance policy.

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

Sometimes, a mortgage lender, as a condition for making a mortgage loan, requires the borrower to purchase mortgage life insurance naming the lender as beneficiary, and to maintain that coverage throughout the mortgage term. If the borrower dies during the mortgage term, the mortgage lender receives a policy benefit equal to the remainder due under the mortgage loan. The insurance company is not a party to the mortgage loan contract. Its only obligation is to carry out its duties under the mortgage life insurance policy.

Example. When Gary Watkins purchased his house, he also bought a mortgage life insurance policy from Steadfast Life Insurance Company. Gary named his wife, Janice, as beneficiary.

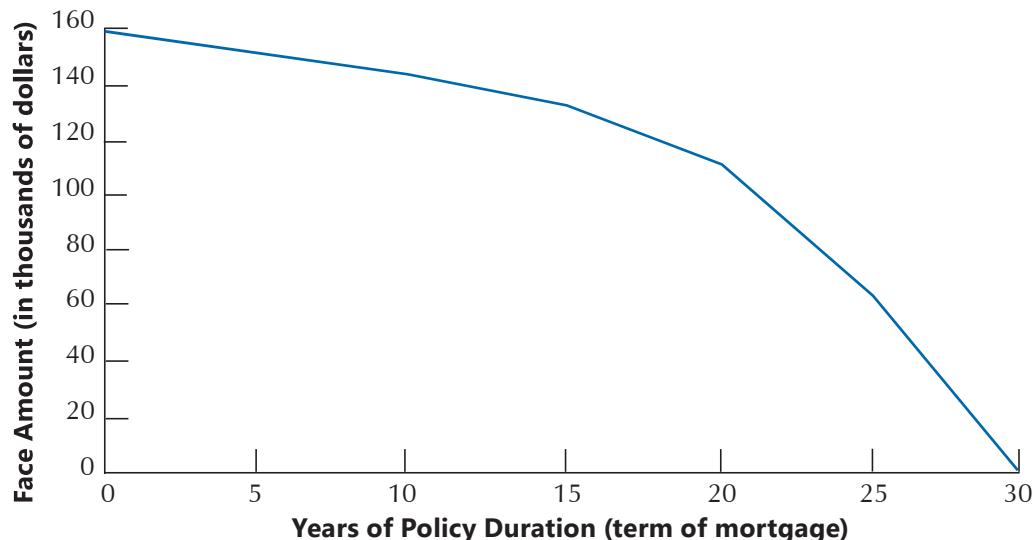
Martin Sanderson purchased a house at the same time and applied for a mortgage loan from First Line Mortgage Company. As a condition of the loan, First Line required Martin to purchase a mortgage life insurance policy naming First Line as beneficiary and to maintain the coverage during the mortgage term. Martin purchased a mortgage life insurance policy from Steadfast Life.

Five years later, both Gary and Martin died, and the policy benefit on each of their mortgage life insurance policies was \$150,000.

Analysis. In both cases, Steadfast Life was obligated to pay the \$150,000 to the named beneficiary. As beneficiary of Gary's policy, Janice could use the policy benefit to pay off the balance due on the mortgage or for other purposes—for example, by investing the proceeds to help pay for their children's education. As the beneficiary of Martin's policy, First Line used the policy benefit to pay off Martin's mortgage.

Many mortgage loans are obtained jointly by two people, both of whose incomes are required to make the monthly mortgage payments. For that reason, insurers offer **joint mortgage life insurance**, which provides the same benefit as a mortgage life insurance policy except the joint policy insures the lives of two people. If both insureds survive until the end of the policy term, the joint mortgage life policy expires. But if one of the insureds dies while the policy is in force, the insurer pays the policy benefit to the beneficiary, who typically is the surviving

Figure 5.1. The Declining Benefit Amount of a Mortgage Life Insurance Policy



insured. Note that the beneficiary is not required to use the policy benefit to pay off the mortgage.

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

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

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

Family Income Coverage. **Family income coverage** is a plan of decreasing term life insurance that provides to the beneficiary a stated monthly income benefit amount if the insured dies during the term of coverage. Monthly income benefits continue until the end of the term specified when the coverage was purchased.

Family income coverage is a form of decreasing term life insurance because the longer the insured remains alive during the term of coverage, the shorter the length of time over which the insurer is required to pay monthly income benefits and the smaller the total amount of benefits the insurer will pay out. The beneficiary of family income coverage typically is the insured's surviving spouse.

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

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

Analysis. If Marvin dies 2 years after buying the family income coverage, the insurer will pay a total of \$96,000 in monthly income benefits ($\$1,000 \times 12 \text{ months} \times 8 \text{ years}$) to Karen. If he dies 6 years after buying the coverage, the monthly income benefit will be paid for 4 years; thus, the insurer will pay Karen a total of \$48,000 ($\$1,000 \times 12 \text{ months} \times 4 \text{ years}$). If, however, Marvin dies 9 years after purchasing the coverage, then the income benefit will continue for the specified 3-year minimum, for a total of \$36,000 ($\$1,000 \times 12 \text{ months} \times 3 \text{ years}$). If he dies 11 years after purchasing the coverage, no monthly income benefit would be paid because the coverage expired 1 year before his death.

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

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

Increasing Term Life Insurance

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

Increasing term insurance often is purchased as a rider to a life insurance policy and usually is just for a limited time to meet a specific need, such as providing

funds for a child's education. The premium for increasing term insurance generally increases as the amount of coverage increases. Increasing term insurance is fairly uncommon, in part because other options are available that allow policy-owners to increase the amount of their policy coverage at a later date.

Features of Term Life Insurance Policies

Term life insurance provides only temporary protection; at the end of the stated term, the policy expires. A policyowner who wants to maintain insurance coverage after the policy expires must apply for a new policy. However, the new policy must be underwritten, and if the insured's health has declined during the policy term, the insured may no longer be insurable or may be insurable only at a sub-standard premium rate. To meet this customer need to continue life insurance coverage, insurers include renewability and convertibility features for some term life insurance policies.

Renewable Term Insurance

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

Example. Five years ago, Martine Lambert purchased a five-year renewable term policy from Tandem Insurance Company. Since then, Martine has suffered a number of heart attacks and undergone open-heart surgery.

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

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

Many renewable term insurance policies place limits on the policyowner's right to renew. The most common limitations are that (1) the coverage may be renewed only until the insured attains a stated age or (2) the coverage may be renewed only a stated maximum number of times. For example, the renewal provision of a policy

may specify that the coverage is not renewable after the insured has reached the age of 75. Another policy may specify that the coverage is renewable no more than three times. Such restrictions exist to minimize antiselection.

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

Example. Allen Padred, age 33, purchased a 10-year term life insurance policy on his own life. The policy gives Allen the option to renew his policy until the policy anniversary date nearest his 65th birthday without having to submit evidence of his insurability. The policy's annual premium is \$220.

Analysis. On the policy anniversary at the end of the 10-year term, Allen has the right to renew his coverage. The coverage will be for the same face amount as the original policy and for the same 10-year term. The new premium amount, however, will increase to reflect Allen's *attained age* at the time of renewal. Allen will pay this higher premium each year during the 10-year renewal period. At the end of the second 10-year period and subsequent 10-year periods until the policy anniversary date nearest his 65th birthday, Allen again will have the option to renew the policy at a premium rate based on his attained age.

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

Most one-year term insurance policies and riders are ***yearly renewable term (YRT) insurance*** or ***annually renewable term (ART) insurance***, which means they are renewable for a stated number of years. YRT policies typically are renewable for periods of 10 to 30 years, depending on the age of the insured. As the insured ages, however, the renewal premiums for YRT coverage can become considerably more expensive than premiums for comparable 5- or 10-year term policies. For that reason, most renewable term insurance policies sold today have policy terms of from 5 to 30 years. Figure 5.2 illustrates the difference in premium costs between a YRT policy, a 5-year term policy, and a 30-year term policy as an insured ages.

Convertible Term Insurance

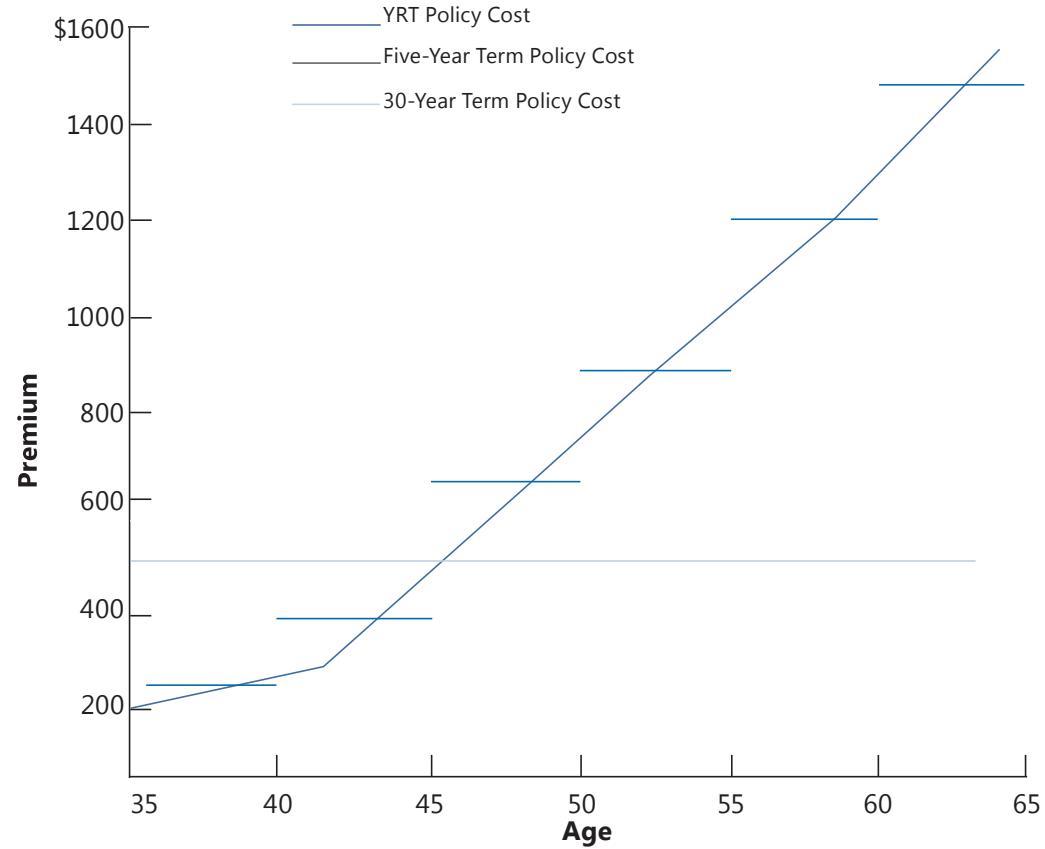
Younger people often purchase term insurance because of the lower premium cost, but they may want cash value insurance later, when they can better afford the higher premium cost. A ***convertible term insurance policy*** gives the policyowner the right to convert the term policy to a cash value life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

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

The specific amount of the premium charged for the cash value insurance coverage provided following conversion depends on the effective date of the cash value life insurance policy. Usually, the effective date of the cash value policy is the date the term policy is converted to a cash value policy. Under such a conversion, known as an *attained age conversion*, the premium rate for the cash value policy is based on the insured's age at the time the policy is converted. For example, suppose Henrik Swenson bought a convertible term life policy at age 35 and converted it to a cash value policy at age 39, using an attained age conversion. The insurer would charge Henrik the same premium it was then charging 39-year-old men for a comparable cash value policy.

Alternatively, under an *original age conversion*, the premium rate for the cash value policy is based on the insured's age when the original term policy was issued.

Figure 5.2 Relative Premium Costs of a YRT Policy, a 5-Year Term Policy, and a 30-Year Term Policy



In the foregoing example, assume that Henrik Swenson bought his term policy at age 35 and converted the policy to a cash value policy at age 39 using an original age conversion. The premium the insurer would charge Henrik for the cash value policy would be the same as it charges for a comparable cash value policy issued to a 35-year-old man.

The renewal premium rate charged for cash value insurance is lower under an original age conversion than under an attained age conversion because the premium rate is based on a younger age (in Henrik's case, age 35 as opposed to age 39). For that reason, it would seem that a policyowner would always select an original age conversion rather than an attained age conversion, if both are available. However, the policyowner also must pay an additional lump sum at the time a policy is converted under an original age conversion. The lump sum is based on the difference between the lower premiums the policyowner actually paid for the term insurance policy and the higher premiums that the policyowner would have paid if he had purchased a cash value policy originally. This lump sum can be substantial, and, as a result, attained age conversion is much more common than original age conversion.

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

Return of Premium Term Insurance

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

Example. Samantha Taggart, age 40, purchased a \$500,000 30-year ROP term policy from Great Future Insurance Company at an annual premium of \$1,100. Samantha paid all required premiums and was alive when the policy expired.

Analysis. Great Future would return to Samantha the premiums she has paid for the coverage, a total of \$33,000 ($\$1,100 \times 30$ years).

Some ROP term policies provide a partial return of premiums if the policy is kept in force for a stated period of time but then canceled before the end of the term; the longer the policy is kept in force, the greater the percentage of premium that is returned. Under such a policy, if the insured dies during the policy term, the

beneficiary receives the death benefit only; there is no additional partial return of premiums. Most insurers offer ROP term policies for terms of only 15 years or longer. The premium for an ROP term policy is usually more than 25 percent higher than for a comparable term policy without a return of premium feature.

Renewability, convertibility, and return of premium features are of obvious potential value to the policyowner, but they also are of value to the insurance company. Most policyowners renew or convert their term life insurance policies, not because they are in poor health, but because they want to continue their insurance protection. The return of premium feature also gives policyowners substantial motivation to keep a policy in effect. Therefore, insurance companies are able to keep insurance policies that have these features in force without the expense of initiating new sales.

Key Terms

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

Endnotes

1. ACLI, *Life Insurers Fact Book 2009* (Washington, DC: American Council of Life Insurers, 2009), 68.
2. The term “mortgage insurance” is sometimes used to refer to a type of property/casualty insurance more commonly referred to as *private mortgage insurance (PMI)* or *lenders mortgage insurance (LMI)*. PMI is insurance that pays the lender if the borrower fails to make mortgage payments as required. PMI is **not** a form of life insurance.
3. As an alternative to a family income policy, some insurers offer a *family maintenance policy*, which is a cash value life insurance policy with a level term monthly income benefit rider. If the insured dies during the term of the monthly income benefit rider, the beneficiary receives monthly income payments for a fixed number of years. For example, assume that an insured purchased a family maintenance policy with a 10-year term that provides for \$1,000 monthly payments. If the insured dies during that 10-year term, the beneficiary would receive both the policy death benefit and a \$1,000 monthly benefit for a total of 10 years, regardless of whether the insured dies in the first year or the 10th year of the policy. If the insured dies after the 10-year term expires, no monthly benefits are payable, but the beneficiary still receives the death benefit, as long as the policy remains in force.
4. The *Consumer Price Index (CPI)* measures the change in the price of a fixed list of items (a “basket of goods”) bought by a typical consumer. The goods included in the CPI include food, transportation, housing, utilities, clothing, and medical care.



Chapter
6

Cash Value Life Insurance and Endowment Insurance

Objectives:

After studying this chapter, you should be able to

- Define cash value life insurance and distinguish it from term life insurance
- Identify the common characteristics of whole life insurance, modified whole life insurance, and joint whole life insurance, and describe the features that differentiate these types of whole life insurance
- Explain how universal life insurance differs from whole life insurance in terms of its separate policy elements and its flexible premiums, face amount, and death benefit
- Describe how variable life insurance allows policyowners to decide how their premiums and cash values are invested
- Describe the features that variable universal life insurance products share with universal life insurance and variable life insurance products
- Describe the characteristics of endowment insurance

Outline

Whole Life Insurance

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

Universal Life Insurance

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

Variable Life Insurance**Variable Universal Life Insurance****Endowment Insurance**

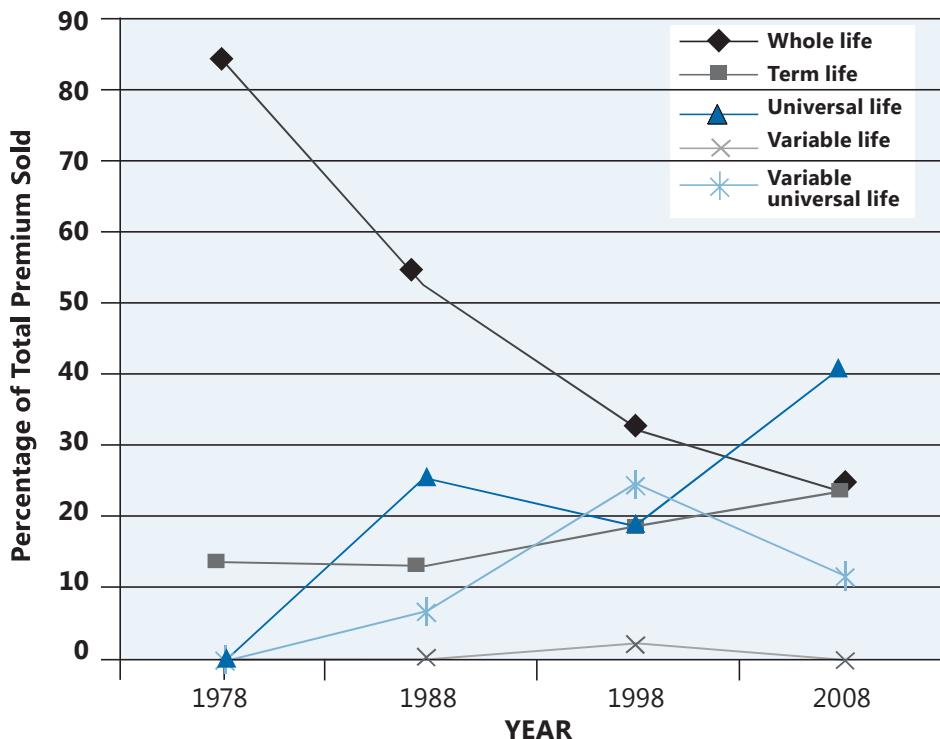
In addition to offering term life insurance products, insurance companies offer a range of life insurance products that contain a savings element. **Cash value life insurance**, sometimes referred to as *permanent life insurance*, provides life insurance coverage throughout the insured's lifetime and provides a savings element, known as the **cash value**. Cash value life insurance has two characteristics that distinguish it from term life insurance. First, cash value life insurance provides protection for the *entire* lifetime of the insured, as long as the policy remains in force. Second, cash value life insurance provides both insurance coverage and a savings element that a policyowner can use to meet financial needs during the insured's lifetime.

The various types of cash value life insurance accounted for three-quarters of the individual life insurance premiums sold in the United States in 2008.¹ Figure 6.1 shows the trends in recent years in U.S. life insurance sales among the various types of insurance by premium dollars.

Whole Life Insurance

Whole life insurance is a type of cash value life insurance that provides lifetime insurance coverage usually at a level premium rate that does not increase as the insured ages. As we noted in Chapter 4, life insurers use the level premium pricing system so that premium rates do not increase as insureds' mortality rates increase. An insurer collects more in early policy years than it needs to pay claims in those years. The insurer invests the excess premium dollars collected during the early policy years and accumulates assets that are at least equal to the amount of the policy reserve liability the insurer has established for those policies.

The terminology used to describe insurance products is not consistent throughout the insurance industry. The term *whole life* is often used in a number of contexts. Sometimes, *whole life* refers to the broad classification of insurance products that are considered to be cash value insurance. In this context, some of the newer products we discuss later in this chapter, such as universal life insurance, variable life insurance, and variable universal life insurance, are forms of whole life insurance. However, *whole life* also is used to refer to a specific type of cash value insurance product. This text uses *whole life* in this last sense to refer to a specific type of cash value insurance product.

Figure 6.1. U.S. Individual Life Insurance Sales, 1978-2008

- 1978: Whole life – 85%, Term life – 15%, Universal life, Variable life, Variable universal life – 0%
- 1988: Whole life – 53%, Term life – 13%, Universal life – 26%, Variable Life – 1%, Variable universal life – 7%.
- 1998: Whole life 33%, Term life 19%, Universal life – 20%, Variable Life – 3%, Variable universal life – 25%
- 2008: Whole life 24%, Term life 23%, Universal life – 41%, Variable Life – less than 1/2%, Variable universal life 12%.

Source: Adapted from Ashley Durham, *U.S. Individual Life Insurance Sales Trends 1975–2008* (Windsor, CT: LIMRA International, 2009), <http://www.limra.com/members/abstracts/reports/1746.pdf> (30 October 2009). Used with permission.

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

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

The owner of a whole life or other policy that has accumulated a cash value has the right to receive the policy's cash value and can use the policy as security for a loan. The policyowner can receive a loan, known as a **policy loan**, from the insurance company itself, or the policyowner can use the cash value of the policy as collateral for a loan from another financial institution. If the insured dies before a policy loan is repaid, however, the unpaid amount of the loan—plus any interest outstanding—is subtracted from the policy benefit.

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

End of Policy Year	Cash Value
1	-----
2	-----
3	\$ 400
4	1,400
5	2,400
6	3,500
7	4,500
8	5,600
9	6,800
10	8,000
11	9,300
12	11,000
13	12,900
14	14,800
15	16,700
16	18,700
17	20,700
18	22,700
19	24,800
20	26,900
Age 60	32,300
Age 65	41,700

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

Source: Adapted from Harriett E. Jones, *LOMA's Handbook of Insurance Policy Forms* [Atlanta: LOMA (Life Office Management Association, Inc.), ©1999], L29. Used with permission; all rights reserved.

If for some reason a cash value life insurance policy does not remain in force until the insured's death, the insurer agrees to refund the cash value—less any surrender charges and outstanding policy loans—to the policyowner. Because the policyowner generally has the right to surrender—or terminate—a cash value life insurance policy for its cash value during the insured's lifetime, the amount of the cash value that a policyowner is entitled to receive upon surrender is referred to as the ***cash surrender value***, also known as the *surrender value* or *surrender benefit*. Cash surrender values and policy loans are discussed in more detail in Chapter 8.

Premium Payment Periods

Although whole life insurance policies provide insurance coverage for the entire lifetime of the insured, the time period over which the policyowners pay premiums can vary. Most whole life policies are classified as either (1) continuous-premium policies or (2) limited-payment policies. The length of a policy's premium payment period directly affects both the amount of the premium required for the policy and the pace at which the policy's cash value builds.

Continuous-Premium Policies

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

Limited-Payment Policies

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

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

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

Example. Nora Stapleton, who was born on September 1, 1966, purchased a paid-up-at-age-65 whole life policy with an effective date of November 1, 2010. According to the terms of Nora's policy, premiums are payable until she reaches the policy anniversary nearest her 65th birthday.

Analysis. Nora's last premium payment will be due on November 1, 2031, the policy anniversary nearest her 65th birthday. At that time, if Nora has made all required premium payments, she will have a paid-up policy that requires no further premium payments but will provide life insurance coverage for the rest of her life.

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

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

Modified Whole Life Insurance

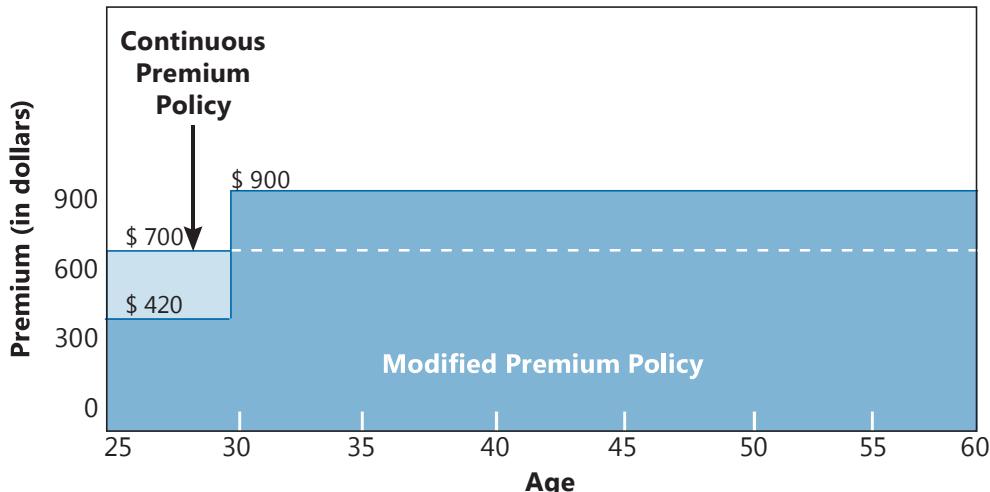
The traditional whole life insurance products we have described provide a constant face amount of life insurance coverage in exchange for a series of level premiums or a single premium. Some insurers offer whole life insurance policies under which either (1) the amount of the premium payments required changes at some point in the life of the policy or (2) the face amount of coverage changes during the life of the policy.

Modified Premiums

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

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

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



The primary advantage of a modified-premium whole life policy is that it allows a person to purchase a larger amount of life insurance than he otherwise could afford. The chief disadvantage of a modified-premium whole life policy is that the cash value builds more slowly under a modified-premium policy than under a continuous-premium whole life policy.

Some insurers issue whole life policies for which premium payments are modified even more frequently. Generally known as *graded-premium policies*, these policies call for three or more levels of annual premium payment amounts, increasing at specified points in time—such as every three years—until reaching the amount to be paid as a level premium for the rest of the life of the policy. For example, the premium for a \$100,000 graded-premium policy for a 25-year-old man might be \$450 a year for the first three years, \$600 a year for the next three years, and \$900 a year thereafter. As in other modified-premium plans, the face amount of insurance remains level throughout the life of the policy.

Modified Coverage

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

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

Whole Life Insurance Covering More Than One Insured

The whole life insurance policies we have discussed so far provide insurance coverage on the life of only one person. However, insurers also offer whole life insurance policies that provide coverage on the lives of more than one person.² Some common types of such policies are joint whole life insurance, last survivor life insurance, and family policies.

Joint Whole Life Insurance

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

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

Last Survivor Life Insurance

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

Family Policies

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

the insured's whole life insurance coverage. For example, a family with two children might purchase a family policy that provides \$100,000 of whole life insurance coverage on the primary insured, \$25,000 of term insurance coverage on the insured's spouse (one-fourth of the amount of the coverage on the primary insured), and \$20,000 of term insurance coverage for each child (one-fifth of the amount of coverage on the primary insured). Thus, a total of \$165,000 of life insurance would be provided by one family policy.

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

Universal Life Insurance

Universal life (UL) insurance is a form of cash value life insurance that is characterized by its flexible premiums, its flexible face amount and death benefit amount, and its separation of the three primary policy elements. Most term and whole life insurance policies feature premiums, face amounts, death benefits, and—in the case of whole life policies—cash values that are fixed at the time the policy is issued. Universal life insurance differs from traditional term and whole life insurance by featuring a far more flexible structure.

Separation of Policy Elements

All of the policies that we have described until now—both term insurance and whole life insurance policies—state a single periodic premium amount that the policyowner must pay to keep the policy in force. Universal life insurance policies, however, list the policy elements separately. Each universal life policy specifies (1) the mortality charges that the insurer will apply, (2) the interest rate that the insurer will credit to the policy's cash value, and (3) the expense charges that the insurer will apply.

Mortality Charges

The insurer periodically deducts a mortality charge from a universal life insurance policy's cash value. The mortality charge is the amount needed to cover the risk the insurer has assumed in issuing the policy. In other words, the mortality charge pays the cost of the life insurance coverage.³ For this reason, some universal life policies refer to the mortality charge as the *cost of insurance*. The amount of the mortality charge usually is based on the insured's age, sex, and risk classification, and this charge typically increases each year as the insured ages. Universal life policies guarantee that the mortality charge will never exceed a stated maximum amount. In addition, these policies usually provide that the mortality charge will be less than the specified maximum if the insurance company's mortality experience is more favorable than expected.

Interest Rate

A universal life insurance policy guarantees that the insurer will pay at least a stated minimum interest rate on the policy's cash value each year. The policy also provides that the insurer will pay a higher interest rate if economic and competitive conditions warrant. Some policies state that the interest rate to be paid on the cash value will be tied to the rate paid on a standard investment, such as a specific type of government bond. Usually, however, the insurer determines the current interest rate for universal life policies based on the return that its own investments are earning.

Expenses

Each universal life insurance policy lists the expense charges that the insurance company will impose to cover the costs it incurs to administer the policy. The following types of expense charges commonly are imposed:

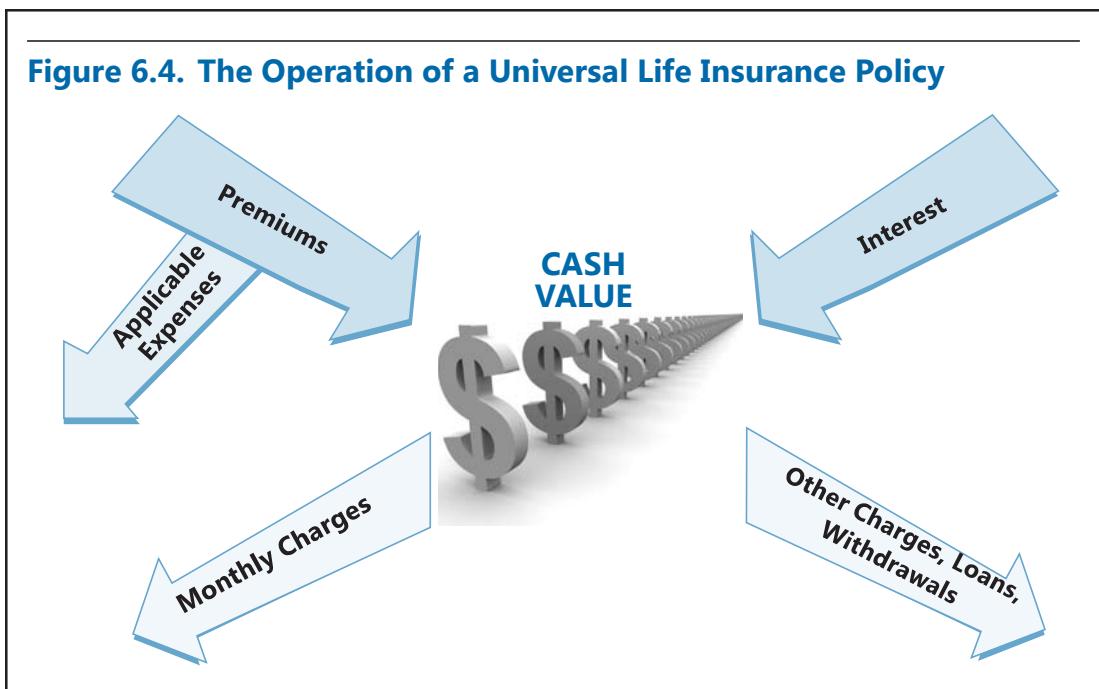
- A flat charge during the first policy year to cover sales and policy issue costs
- A percentage of each annual premium (such as 7 percent) to cover expenses
- A monthly administration (management) fee, sometimes referred to as a policy fee
- **Surrender charges**, which are specific charges imposed if the owner surrenders the policy for its cash surrender value⁴
- Specific charges for other services such as coverage changes or policy withdrawals

Operation of a Universal Life Insurance Policy

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

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

Figure 6.4. The Operation of a Universal Life Insurance Policy



If the cash value of any universal life policy is not sufficient to pay the periodic mortality and expense charges, the policy will lapse, unless the policyowner takes action to keep the policy in force. A *lapse* is the termination of a life insurance policy for nonpayment of premium. The insurer gives the policyowner a stated amount of time—usually 60 days—in which to take action to prevent the policy from lapsing. To prevent a policy from lapsing, the policyowner must either (1) pay additional premiums, or (2) reduce the policy's face amount.

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

Flexibility Features

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

Face Amount and Death Benefit

When a person buys a universal life policy, he specifies the policy's face amount and decides whether the amount of the death benefit payable will remain equal to the face amount (as with most traditional whole life policies) or will vary with

changes in the policy's cash value. After the policy has been in force for a specified minimum time—often one year—the policyowner can request an increase or decrease in the policy's face amount. The insurer typically requires the policyowner to provide evidence of the insured's continued insurability when a proposed increase in the policy's face amount exceeds a certain amount. Before approving a decrease in a policy's face amount, the insurer must make sure that the decrease would not cause the policy to lose its status as an insurance contract and instead be classified as an investment contract. Insight 6.1 describes the regulatory requirements that a life insurance policy must meet to be classified as an insurance product rather than an investment product.

Premiums

A universal life policy may be either a flexible premium policy or a fixed premium policy. A *flexible premium universal life insurance policy* allows the policyowner to alter the amount and frequency of premium payments, within specified limits. The policyowner can determine, within certain limits, how much to pay for the initial premium and for each renewal premium. The insurer requires payment of at least a stated minimum initial premium, and for administrative purposes, the insurer may also impose a minimum limit on the size of any renewal premium payment. The insurer also imposes maximum limits on the amounts of the initial and renewal premiums to ensure the policy meets the regulatory requirements described in Insight 6.1. The policyowner has great flexibility to decide when to pay renewal premiums. As long as the policy's cash value is large enough to pay the periodic mortality and expense charges the insurer imposes, the policy remains in force even if the policyowner does not pay renewal premiums.

Insight 6.1. Effects of Regulatory Requirements on Universal Life Policies

Life insurance receives favorable income tax treatment in many countries. For example, a beneficiary who receives policy proceeds following an insured's death typically is not taxed on those proceeds. Similarly, the increase in the cash value of a life insurance policy is not taxable as current income. Because a universal life policyowner can pay much more in premiums than is needed to fund the cost of insurance, the amount of the policy's cash value can be much greater in relation to the face amount of the policy than is possible with a whole life insurance policy. The larger the cash value is in relation to the policy's face amount, the more a policy resembles an investment product, such as a bank account, rather than an insurance product.

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

A **fixed premium universal life insurance policy** requires a series of scheduled premium payments of a specified amount for a specified length of time (typically 8 to 10 years) or until the insured's death, whichever comes first. However, the owner of a fixed premium universal life policy does *not* have a paid-up policy at the end of the premium payment period. Sometimes, a product's actual experience is less favorable than the insurer projected when it created the financial design of a product. For example, the insurer's investments may earn a lower rate of return than the insurer projected, which reduces the current interest rate the insurer pays on the product's cash values. If that occurs, a fixed premium universal life policy's cash value will be lower than projected and may not be large enough to pay the periodic mortality and expense charges. If the cash value is not large enough to pay the periodic charges, the policyowner must take action or the policy will lapse.

Periodic Reports

Because so many aspects of a universal life insurance policy change over the course of a year, insurers send each policyowner an annual, semiannual, or quarterly report giving the policy's current values and benefits. Generally, this report includes the following types of information:

- The amount of the death benefit payable
- The amount of the policy's cash value
- The amount of the cash surrender value, if different from the cash value
- The amount of interest earned on the cash value
- The amount of the mortality charges deducted
- The amount of the expense charges deducted
- The amount of premiums paid during the reporting period
- The amount of policy loans outstanding
- The amount of any cash value withdrawals

Figure 6.5 shows a sample universal life insurance policy annual report. Note that this sample report illustrates a policy earning interest at a rate of 7 percent. Interest rates vary over time with changes in the economy, and rates being paid on such policies as this edition is being written tend to be considerably lower than the illustrated rate. Nevertheless, the sample report contains the types of information that are provided to universal life insurance policyowners.

Figure 6.5. Sample Annual Report for a Universal Life Insurance Policy

ABC Life Insurance Company
 Universal Life
 Policy Number 000-000-00
ANNUAL NOTICE OF YOUR POLICY'S STATUS FOR YEAR ENDING

JANUARY 19, 2011

INSURED: James E. Doe
 200 Spring Street
 Anytown, Anystate 10000

Date	Payments (Withdrawals)	Expense Charges	Cost of Insurance	Interest Credited	Unpaid Loans	Ending Cash Value
01/19/10						\$ 826.66
02/19/10	\$ 100.00	\$ 11.50	\$ 11.91	—	—	903.25
03/19/10	100.00	11.50	11.90	\$ 4.68	—	984.53
04/19/10	100.00	11.50	11.90	5.15	—	1,066.28
05/19/10	100.00	11.50	11.89	5.58	—	1,148.47
06/19/10	100.00	11.50	11.88	6.04	—	1,231.13
07/19/10	100.00	11.50	11.87	6.48	—	1,314.24
08/19/10	100.00	11.50	11.86	6.95	—	1,397.83
09/19/10	100.00	11.50	11.85	7.40	—	1,481.88
10/19/10	100.00	11.50	11.85	7.85	—	1,566.38
11/19/10	100.00	11.50	11.84	8.32	—	1,651.36
12/19/10	100.00	11.50	11.83	8.78	—	1,736.81
01/19/11	100.00	11.50	11.82	9.58	—	\$ 1,823.07
TOTALS	\$ 1,200.00	\$ 138.00	\$ 142.40	\$ 76.81	0	

Death Benefit as of February 6, 2011	\$ 100,296.00
Cash Value Balance as of January 19, 2011	\$ 1,823.07
Interest to Be Earned, February 6, 2011	+ \$10.07
Total Cash Value, February 6, 2011	\$ 1,833.14
Surrender Value as of February 6, 2011	\$ 1,731.98*

*The total cash value has been reduced by the surrender charge of \$101.16 to arrive at the surrender value.

The cash value currently earns 7%, except the cash value equal to any policy loan earns 6%. From February 6, 2010, to December 5, 2010, the current interest rate was 6.75%. The interest rates are effective annual interest rates.

Continued planned payments of \$100 each month will provide coverage until February 6, 2061, based on guaranteed rates.

If no further payments are made, your policy will provide coverage until January 6, 2023, based on current rates, and until January 6, 2018, based on guaranteed rates.

Variable Life Insurance

Variable life (VL) insurance is a form of cash value life insurance in which premiums are fixed, but the death benefit and other values may vary, reflecting the performance of investment subaccounts that the policyowner selects. A **subaccount** is one of several alternative pools of investments to which a variable life insurance policyowner allocates the premiums she has paid and the cash values that have accumulated under her policy.

The subaccounts in which variable insurance premiums and cash values are invested are part of an insurer's separate account. The **separate account**, also known as a **segregated account**, is an investment account the insurer maintains separately from its general account to isolate and help manage the funds placed in its variable products. The **general account** is an undivided investment account in which an insurer maintains funds that support its contractual obligations to pay benefits under its guaranteed insurance products, such as whole life insurance and other nonvariable products. The funds in the general account are placed in relatively secure investments so that the insurer is assured of having funds available to pay the benefits it has guaranteed to pay policyholders.

Most variable life insurance policies permit the policyowner to allocate premium payments among one or more subaccounts. The insurer follows a different investment strategy for each subaccount in its separate account. For example, some subaccounts concentrate on investing in high-growth stocks, other subaccounts concentrate on investing in stocks that pay high dividends, and still other subaccounts may concentrate on investing in bonds.

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

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

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

Variable Universal Life Insurance

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

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

Figure 6.6 illustrates how variable universal life insurance products combine the features of universal life and variable life insurance products.

Figure 6.6. How VUL Products Combine Features of UL and VL Products

Features of Universal Life Insurance	Features of Variable Universal Life Insurance	Features of Variable Life Insurance
Policy elements are listed separately	Policy elements are listed separately	Policy elements are not listed separately
Flexible premiums	Flexible premiums	Fixed premiums
Flexible face amount	Flexible face amount	Flexible face amount
Flexible interest rate with a guaranteed minimum	Variable investment earnings	Variable investment earnings
Not subject to U.S. securities laws	Subject to U.S. securities laws	Subject to U.S. securities laws

Source: Adapted from Deborah Bellange and Dani L. Long, *Intro to Variable Universal Life Insurance* [Atlanta: LOMA (Life Office Management Association, Inc.), ©2000], 11. Used with permission; all rights reserved.

Endowment Insurance

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

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

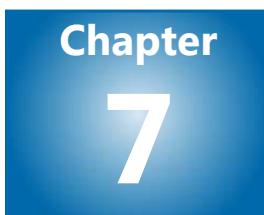
Because endowment policies build cash values rapidly and because the cash value of an endowment policy is quite large in relationship to the face amount of the policy, endowment policies generally do not satisfy the requirements to receive the same favorable federal income tax treatment in the United States as do most other life insurance policies. That unfavorable tax treatment has resulted in dwindling sales of endowment insurance in the United States. Endowment insurance remains a popular product in insurance markets in many other countries, however. For example, in Taiwan, endowment insurance premium volume in 2006 was twice as much as the premium volume for term life insurance and whole life insurance combined.⁵

Key Terms

cash value life insurance	universal life (UL) insurance
cash value	surrender charge
whole life insurance	lapse
policy loan	flexible premium universal life insurance
cash surrender value	fixed premium universal life insurance
continuous-premium whole life policy	variable life (VL) insurance
limited-payment whole life policy	subaccount
paid-up policy	separate account
single-premium whole life policy	general account
modified-premium whole life policy	variable universal life (VUL) insurance
graded-premium policy	endowment insurance
modified coverage policy	maturity date
joint whole life insurance	
last survivor life insurance	
family policy	

Endnotes

1. Ashley Durham and Ken Isenberg, *U.S. Individual Life Insurance Sales Trends: Second Quarter 2009* (Windsor, CT: LIMRA International, 2009), <http://www.limra.com/members/abstracts/other/10173.pdf> (25 September 2009). Used with permission.
2. Some insurers also offer joint term life insurance and last survivor term life insurance.
3. The primary risk the insurer assumes is the risk of the insured's dying while the policy is in force, which is referred to as the *mortality risk*. However, as we shall see in Chapter 7, many life insurance policies offer supplemental benefits in addition to the death benefit. The mortality charge covers the cost of providing all benefits that may be payable under a particular policy.
4. Surrender charges usually decline over time and typically are not imposed after the policy has been in effect for a stated period of time, such as 15 years.
5. Lori L. Chester, *Bancassurance in Asia—Part 2: Country Information* (Windsor, CT: LIMRA International, 2007), 41, <http://www.limra.com/members/abstracts/reports/5917.pdf#search=%22endowment%22> (11 June 2010). Used with permission.



Chapter 7

Supplemental Benefits

Objectives:

After studying this chapter, you should be able to

- Identify and describe three types of supplemental disability benefits that life insurance policies may provide
- Explain the coverage that an accidental death benefit rider provides and give examples of common exclusions
- Identify three types of accelerated death benefit riders and describe the differences among those riders
- Describe three types of insurance riders that expand a life insurance policy's coverage to insure more than one individual
- Identify two types of insurability benefit riders and explain how they allow a life insurance policyowner to purchase additional insurance coverage

Outline

Supplemental Disability Benefits

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

Accident Benefits

Accelerated Death Benefits

- Terminal Illness Benefit
- Dread Disease Benefit
- Long-Term Care Insurance Benefit

Benefits for Additional Insureds

- Spouse Insurance Rider
- Children's Insurance Rider
- Second Insured Rider

Insurability Benefits

- Guaranteed Insurability Benefit
- Paid-Up Additions Option Benefit

All life insurance policies provide a benefit if the insured dies while the policy is in force. However, a number of other benefits can be added to individual life insurance policies. We refer to these benefits as *supplemental benefits*. The insurance company usually charges an additional premium amount for each supplemental benefit that is added to a policy; the additional premium charge typically ends when the supplemental benefit expires or is cancelled.

Supplemental benefits are sometimes provided by a policy provision, but usually such benefits are provided by adding riders to a life insurance policy. Policy riders benefit both the policyowner and the insurer because they give both parties flexibility. An insurer issuing a policy can include riders to customize the basic insurance plan for the policyowner. If the policyowner later wants to adapt the policy to better meet his needs, the insurer can drop or add riders to the policy. Thus, the policyowner and the insurer need not enter into a new contract when the policyowner desires customized or additional coverage.

Supplemental Disability Benefits

Although disability benefits are a type of health insurance, such benefits can be added to the coverage provided by a life insurance policy. We describe three types of disability benefits that a life insurance policy or policy rider can provide: the waiver of premium for disability benefit, the waiver of premium for payor benefit, and the disability income benefit.

Waiver of Premium for Disability Benefit

One of the most common supplemental benefits that may be added to nearly all individual life insurance policies is the **waiver of premium for disability (WP) benefit**. Under a WP benefit, the insurer promises to give up—to waive—its right to collect premiums that become due while the insured is totally disabled. The insurance company actually pays the premiums that are waived under a WP benefit. Therefore, if the policy is one that builds a cash value, the cash value continues to increase just as if the policyowner paid the premiums. In the case of a participating policy, the insurance company continues to pay policy dividends as if the policyowner were paying premiums.

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

Disabilities resulting from certain causes typically are excluded from coverage. For example, disabilities resulting from intentionally self-inflicted injuries and injuries the insured suffered while committing a crime are typically excluded. In addition, most WP benefits contain a three- to six-month waiting period before the insurer will waive the payment of premiums. In other words, the insured must be totally disabled for three to six months before the insurer will waive premium payments. The policyowner must continue to pay premiums that come due during the waiting period, although some WP benefits provide that these premiums will be refunded if the insured is still disabled when the waiting period ends.

Example. Daniel Hederle purchased a whole life insurance policy with a waiver of premium for disability benefits rider that had a six-month waiting period. One month before his first semiannual renewal premium was due, Daniel became totally disabled.

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

Because universal life insurance policies and variable universal life insurance policies typically have variable premiums, the standard WP benefit usually is not offered. Instead, universal life and variable universal life policies may have a *waiver of cost of insurance benefit*, sometimes referred to as a *monthly deduction waiver benefit*, that waives most of the periodic charges of the policy if the insured meets the policy's definition of disability. The exact charges that are waived vary depending on the terms of the WP benefit rider.

Waiver of Premium for Payor Benefit

The WP benefit provides a waiver of premium if the insured becomes totally disabled. Most individual life insurance policies are issued to a policyowner who also is the policy's insured, and the WP benefit was designed for such policies. By contrast, the waiver of premium for payor benefit was designed for third-party policies. The *waiver of premium for payor benefit* provides that the insurance company will waive its right to collect a policy's renewal premiums if the *policyowner*—the person responsible for paying premiums—dies or becomes totally

disabled. The policyowner generally must provide satisfactory evidence of his own insurability—in addition to providing evidence of the insurability of the insured—before the insurer will add this benefit to a life insurance policy.

A waiver of premium for payor benefit often is included as a rider to a ***juvenile insurance policy***, a policy that is issued on the life of a child but owned and paid for by an adult, usually the child's parent or legal guardian. When the benefit is added to a juvenile life insurance policy, the policy or rider usually states that the insurance company will waive the premium payments only until the insured reaches a specified age, such as 18 or 21, when ownership and control of the policy typically passes to the insured.

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

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

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

Waiver of Premium for Disability Benefit	Waiver of Premium for Payor Benefit
Policy premiums are waived if the insured becomes totally disabled.	Policy premiums are waived if the policyowner dies or becomes totally disabled.
The benefit was designed for policies issued to a policyowner who also is the policy's insured.	The benefit was designed for third-party policies, such as juvenile insurance policies, in which the policyowner is not the policy's insured.
Total disability is defined as the insured's inability to perform the essential duties of her own occupation or any other occupation for which she is reasonably suited by education, training, or experience.	During the first two years of disability, the policyowner is considered totally disabled if she is unable to perform the essential duties of her own occupation. After that two-year period, the policyowner is considered totally disabled if she is unable to perform the essential duties of any occupation for which she is reasonably suited by education, training, or experience.

Disability Income Benefit

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

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

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

Accident Benefits

An ***accidental death benefit*** is a supplemental life insurance policy benefit that provides a death benefit in addition to the policy's basic death benefit if the insured dies as a result of an accident. For example, a policy might provide a basic death benefit of \$100,000 and a supplemental accidental death benefit of \$100,000. If the insured dies as a result of an accident while the coverage is in force, the beneficiary receives a total benefit of \$200,000.

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

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

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

Analysis. If the accident itself caused the insured's death, then the \$250,000 accidental death benefit is payable in addition to the policy's \$250,000 basic death benefit. On the other hand, the insured may have died from a heart attack while driving, causing her to lose control of the automobile. If so, then her death did not result from an accident, and only the policy's \$250,000 basic death benefit is payable to the named beneficiary.

Accidental death benefit riders usually contain several exclusions and limitations. Some riders require that the insured's death occur within a specified time period after the accident, such as within 90 days of the date of the accident, in order for the benefit to be payable. In addition, the riders typically exclude payment of the accidental death benefit if the insured's death results from certain stated causes, including

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

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

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

Accelerated Death Benefits

As a result of medical advances, people today live longer than ever before and often require costly medical care late in their lives. However, traditional life insurance benefits typically are payable only after the insured's death. An **accelerated death benefit**, also known as a *living benefit*, provides that a policyowner may elect to receive all or part of the policy's death benefit before the insured's death

if certain conditions are met. The payment of an accelerated death benefit reduces the death benefit that will be paid to the beneficiary at the insured's death by the amount of the accelerated death benefit paid.

To keep administrative costs down, life insurers usually offer accelerated death benefit coverage only on policies with larger face amounts, such as \$100,000 or \$250,000 and above. Some insurers also require that before they pay any accelerated death benefit, the beneficiary must sign a release acknowledging that the policy's death benefit will be reduced by the amount paid to the policyowner under the accelerated death benefit rider.

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

Terminal Illness Benefit

The most common type of accelerated death benefit is the terminal illness benefit. The **terminal illness (TI) benefit** is a benefit under which the insurer pays a portion of the policy's death benefit to a policyowner-insured who suffers from a terminal illness and has a physician-certified life expectancy of less than a stated time, generally 12 or 24 months. A statement by an attending physician establishes evidence of the terminal condition and certifies that the insured is likely to die within the time period specified in the rider.

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

The insured is not required to use accelerated death benefits for medical care or any other purpose. Figure 7.2 provides some common examples of how insureds have used the funds they received in the form of accelerated death benefits.

Figure 7.2 Using Accelerated Death Benefits

The following are a few examples of how an insured might use money received as accelerated death benefits:

- Payment of medical expenses
- Payment of outstanding debts and living expenses
- Payment of home health care costs
- Payment of travel expenses for himself or his family



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

Dread Disease Benefit

A **dread disease (DD) benefit**, also known as a *critical illness benefit*, is an accelerated death benefit under which the insurer agrees to pay a portion of the policy's face amount to the policyowner if the insured suffers from one of a number of specified diseases. Although the dread disease benefit usually is paid in a lump sum, some insurers pay the benefit in monthly installments over a period of 6 to 12 months. The remainder of the death benefit is paid to the beneficiary following the insured's death.

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

- Life-threatening cancer
- Coronary artery bypass surgery
- Myocardial infarction (heart attack)
- Stroke
- End-stage renal (kidney) failure
- Acquired immune deficiency syndrome (AIDS)

Some DD benefits also include vital organ transplants and Alzheimer's disease as insurable events. In some countries, considerably more diseases and medical procedures—sometimes more than 30 in total—are included as insurable events. In those countries, insurers sometimes offer two different DD benefit riders, a less expensive basic rider that covers a limited number of diseases and procedures, and a more expensive comprehensive rider that covers a greater number of diseases and procedures.

Long-Term Care Insurance Benefit

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

The amount of each monthly LTC benefit payment generally is equal to a stated percentage of the policy's face amount. For example, the benefit may state that 2 percent of the policy's face amount will be paid each month if the insured requires

long-term care. If the policy has a \$100,000 face amount, the policyowner would receive a monthly long-term care benefit of \$2,000. The insurer usually pays monthly benefits until a specified percentage of the policy's basic death benefit has been paid out. This percentage typically falls between 50 and 100 percent of the policy's face amount. Any remaining death benefit is paid to the beneficiary after the insured's death.

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

Benefits for Additional Insureds

Riders may be added to an individual life insurance policy to provide benefits if someone other than the policy's insured dies. The most common of these riders are the spouse insurance rider, the children's insurance rider, and the second insured rider.

Spouse Insurance Rider

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

Children's Insurance Rider

A *children's insurance rider* is a supplemental life insurance policy benefit that provides term life insurance coverage on the insured's children. Like the spouse insurance rider, coverage is sold on the basis of coverage units, although the amount of insurance coverage per unit typically is only \$1,000 or \$2,000. A married insured with children may purchase either a spouse insurance rider or a children's insurance rider or both. Some insurers combine spouse and children's insurance coverage into one rider, which is referred to as a *spouse and children's insurance rider* or a *family insurance rider*.

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

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

Second Insured Rider

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

Insurability Benefits

Sometimes, a policyowner would like to increase the amount of his life insurance coverage, but the insured may no longer be insurable at that time. Insurers offer two types of supplemental benefits that allow policyowners to purchase additional insurance without the insured providing evidence of insurability at the time of purchase. These benefits are the guaranteed insurability benefit and the paid-up additions option benefit.

Guaranteed Insurability Benefit

The **guaranteed insurability (GI) benefit**—sometimes referred to as a *guaranteed insurability option (GIO)*—is a supplemental life insurance policy benefit that gives the policyowner the right to purchase additional insurance of the same type as the basic life insurance policy—for an additional premium amount—on specified option dates (typically every three years) during the life of the policy without supplying evidence of the insured's insurability. The GI rider also may permit the purchase of additional life insurance coverage when certain events occur, such as when the insured marries or at the birth of a child. Thus, the GI rider guarantees that the policyowner will be able to purchase additional life insurance even though the insured may no longer be in good health. The premium for the additional coverage is based on the insured's attained age when the additional insurance is purchased.

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

Although the right to purchase the additional coverage is automatic, the actual purchase is not. A policyowner who desires the extra coverage must take positive action (such as filing an appropriate application form) to purchase the new coverage. Most GI riders specify that if the policyowner does not exercise the option on one of the specified dates, that option is lost forever, though the policyowner is permitted to exercise the next option when it comes due.

Paid-Up Additions Option Benefit

The **paid-up additions option benefit** is a supplemental life insurance policy benefit that allows the owner of a whole life insurance policy to purchase single-premium paid-up additions to the policy on stated dates in the future without providing evidence of the insured's insurability. For example, many paid-up additions option riders allow the policyowner to purchase paid-up additional whole life insurance on each policy anniversary. Because the additions are whole life insurance, the paid-up additions also have their own cash values.

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

Key Terms

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



**Chapter
8**

Individual Life Insurance Policy Provisions

Objectives:

After studying this chapter, you should be able to

- Describe the free-look provision of an insurance policy
- Identify the documents that make up the entire contract between the owner of a life insurance policy and the insurer
- Explain the purpose and operation of the contestability provision
- Apply the terms of the standard grace period provision in a given situation to determine whether a life insurance policy has lapsed for nonpayment of premium
- Identify situations in which a life insurance policy can be reinstated and the conditions the policyowner must meet to reinstate the policy
- Determine the action an insurer likely will take if it discovers a misstatement of the age or sex of the person insured by a life insurance policy
- Describe the rights provided by a policy loan provision and a policy withdrawal provision, and explain the differences between a policy loan and a commercial loan
- Identify and describe the nonforfeiture options typically included in cash value life insurance policies
- Identify the exclusions that insurers sometimes include in individual life insurance policies

Outline

Standard Policy Provisions

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

Provisions Unique to Cash Value Policies

- Policy Loans and Policy Withdrawals
- Nonforfeiture Provision

Life Insurance Policy Exclusions

As noted in Chapter 3, an individual insurance policy is a contract between the insurance company and the policyowner. The provisions included in the written policy set forth the terms of the agreement between the two parties and describe the operation and effect of the contract. Policy provisions also define the rights and obligations of the parties to the insurance contract.

Many policy provisions are standard in principle—though not in exact wording—throughout the life insurance industry worldwide. Some standard provisions are found in all types of life insurance policies. Other standard provisions, however, are unique to cash value life insurance policies.

Standard Policy Provisions

All types of individual life insurance policies typically include a free-look provision, an entire contract provision, an incontestability provision, a grace period provision, a reinstatement provision, and a misstatement of age or sex provision. The specific wording of standard provisions in individual life insurance policies varies from policy to policy, from insurer to insurer, and from jurisdiction to jurisdiction. Although these provisions may vary in wording, they are similar in principle because insurance laws in many jurisdictions require insurers to include certain provisions in individual insurance policies. Even in jurisdictions that do not require these provisions, insurers tend as a standard industry practice to include the same basic provisions. The required provisions are designed to protect policyowners and beneficiaries. Insurers generally have the right to include provisions that are more favorable to policyowners than those required by law.

Free-Look Provision

An individual life insurance policy generally includes a *free-look provision*, sometimes referred to as a *free-examination provision* or a *cooling-off provision*, that gives the policyowner a stated period of time—usually at least 10 days—after the policy is delivered in which to examine the policy. In practice, this period of time ranges from 10 to 30 days in most jurisdictions. Note that the free-look period runs from the date the policy is delivered to the policyowner, not from the date of issue. During the free-look period, the policyowner has the right to cancel the policy and receive a refund of the initial premium payment. Insurance coverage is in effect throughout the free-look period or until the policyowner rejects the policy, whichever occurs first.

Example. Yuri Malenkov applied for an individual insurance policy on his life and paid the initial premium. The insurer issued the policy, which contained a 10-day free-look period, and delivered it to Yuri. Two days later, Yuri changed his mind about purchasing the policy. Before he could contact the insurer to cancel the policy, Yuri died in an accident.

Analysis. During the free-look period, Yuri had the right to cancel the policy and receive a full premium refund. However, because the policy was in force when Yuri died, the insurer is obligated to pay the policy death benefit to the named beneficiary.

Entire Contract Provision

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

The specific wording of the entire contract provision varies depending on whether the policy is a closed contract or an open contract. A *closed contract* is a contract for which only those terms and conditions that are printed in—or attached to—the contract are considered to be part of the contract. Most individual life insurance policies are closed contracts. The entire contract provision in these policies typically states that the entire contract consists of the policy, any attached riders, and the attached copy of the application for insurance. The entire contract provision ensures that policyowners have access to all of the terms of the contractual agreement. Thus, advertising materials are not part of the contract, nor are the insurer's governing corporate documents.

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

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

Incontestability Provision

Applications for life insurance policies contain questions designed to provide the insurance company with relevant information so that it can decide whether the proposed insured is an insurable risk. Under the general rules of law that govern contracts, an insurance company has the right to avoid its obligations under an otherwise enforceable insurance contract if the applicant misrepresented any facts in the application for insurance.

Insurance laws in many jurisdictions, however, impose two important limits on an insurer's right to avoid an insurance contract on the basis of misrepresentation. First, only certain misrepresentations—referred to as *material misrepresentations*—give the insurer the right to avoid an insurance contract. Second, the insurer has only a limited amount of time in which to avoid an insurance contract. As a result, life insurance policies contain an ***incontestability provision***, which describes the time limit within which the insurer has the right to avoid the contract on the ground of material misrepresentation in the application.

Material Misrepresentation

A false or misleading statement in an application for insurance is known as a ***misrepresentation***. Some statements contained in the application are more important to the insurer's decision to issue a policy than are other statements. A misrepresentation that is relevant to the insurance company's evaluation of the proposed insured is called a ***material misrepresentation***. A misrepresentation is considered material if, had the truth been known, the insurer would not have issued the policy or would have issued the policy on a different basis, such as with a higher premium or a lower face amount. A misrepresentation in an application for life insurance gives the insurer grounds to avoid the contract only if it was a material misrepresentation.

Example. Albert Whitney's application for life insurance contained the statement that he had been treated by a doctor for a sprained left ankle, when he actually had been treated for a sprained right ankle.

Analysis. The insurer's decision as to whether Albert is an insurable risk would not have changed as a result of the misstatement as to which ankle Albert had sprained. This misrepresentation, therefore, is not a material misrepresentation and the insurance company cannot use it to avoid the contract.

Example. Gina Montaigne's application for life insurance contained the statement that she had visited a doctor on July 10 for a regular physical examination when, in fact, the reason for the visit was that she was being treated for heart disease.

Analysis. The purpose of a proposed insured's visit with a doctor may be very relevant to the insurance company's evaluation of the application for insurance. To evaluate her application properly, the insurance company would have needed to know that Gina suffered from heart disease. As a result, the misrepresentation about the purpose of the doctor visit is a material misrepresentation if the insurance company would have made a different decision about issuing the life insurance policy had it known the truth.

Operation of the Incontestability Provision

If an insurance company issues a life insurance policy and later discovers a material misrepresentation in the application, the terms of the incontestability provision usually determine whether the insurer can avoid the contract. The language of the incontestability provision varies from jurisdiction to jurisdiction depending on the governing insurance laws. In the United States, a typical incontestability provision states that the policy is incontestable after it has been in force during the lifetime of the insured for two years from the date the policy was issued. The two-year contestable period is the maximum contestable period permitted by law in most states.¹ A period shorter than two years is permitted because a shorter contestable period would be more favorable to the policyowner, and some policies limit the contestable period to one year. Figure 8.1 lists the maximum contestable period allowed by law in various countries.

As a general rule, after a policy's contestable period has ended, the insurer cannot avoid the contract. Laws in many jurisdictions, however, contain an exception—an insurer may contest a policy at any time if the application for insurance contained a fraudulent misrepresentation. A *fraudulent misrepresentation* is a

Figure 8.1. Maximum Contestable Period for Life Insurance Policies Allowed by Law in Selected Countries

Luxembourg	1 year
Canada	2 years
China	2 years
India	2 years
New Zealand	3 years
South Africa	3 years
Sweden	5 years

misrepresentation that was made with the intent to induce the other party to enter into a contract and that did induce the innocent party to enter into the contract. In reality, insurers seldom exercise their right to avoid a life insurance contract on the basis of a fraudulent misrepresentation. Obtaining sufficient evidence to prove that a misrepresentation was fraudulent usually is quite difficult.

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

In the United States and some other jurisdictions, the application for insurance generally is not considered part of the policy unless a copy of the application is attached to the policy when the policy is issued and delivered to the applicant. For that reason, an insurer has the right to use a material misrepresentation in the application as the basis for avoiding a life insurance contract only if a copy of the application for insurance was attached to the policy the insurer issued and delivered to the applicant. Other jurisdictions permit an insurer to avoid an insurance contract during the contestable period on the basis of a material misrepresentation in the application even if a copy of the application is not attached to the policy.

The purpose of the incontestability provision is to assure policyowners and beneficiaries that, after the contestable period has ended, the insurer cannot avoid the policy on the basis of a material misrepresentation in the application for insurance. The provision allows the beneficiary to know with certainty that if all required premiums are paid and the policy has been in force for at least the stated period, the insurer will pay the policy proceeds following the insured's death.

Example. In the previous example, Gina Montaigne did not disclose the true reason for her visit to the doctor. Gina died five years after the policy was issued. In evaluating the death claim, the insurer discovered the material misrepresentation.

Analysis. Because the policy's contestable period had expired by the time the insurer discovered the misrepresentation, the insurer does not have the right to contest the validity of the contract. As a result, the insurer must pay the policy proceeds to the named beneficiary.

Grace Period Provision

The **grace period provision** specifies a length of time following each renewal premium due date within which the premium may be paid without loss of coverage. The specified time, known as the **grace period**, typically is 30 or 31 days, and the coverage remains in force throughout that period. If the insured dies during the

grace period, then the insurer will pay the policy proceeds to the named beneficiary. The insurer, however, usually deducts the amount of any unpaid renewal premium from the amount of the policy proceeds.

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

Example. Michael Ettinger was the policyowner-insured of a \$100,000 term life insurance policy. The policy's annual renewal premium of \$400 was due on March 21 of each year. His policy contained a typical 30-day grace period provision. Michael died on April 10, 2010, without having paid the renewal premium then due.

Analysis. Because Michael died during his policy's grace period, the insurer was liable to pay the policy proceeds to the named beneficiary. The insurer may deduct the unpaid premium from the policy proceeds and pay the policy beneficiary a benefit of \$99,600 ($\$100,000 - \400).

Example. Assume that Michael Ettinger died on June 15, 2010, without having paid the renewal premium due on March 21, 2010.

Analysis. The insurer would not be obligated to pay the policy benefit to the named beneficiary because the policy lapsed for nonpayment of premium on April 21, 2010—following the expiration of the policy's grace period.

Some types of life insurance policies, such as universal life insurance policies and variable universal life insurance policies, do not require scheduled premium payments. The grace period provision contained in a universal life policy applies when the cash value is insufficient to meet the policy's monthly mortality and expense charges. The date on which the grace period begins can vary among universal life policies. Some universal life insurance policies provide that the grace period begins on the date on which the policy's cash value is insufficient to cover the policy's entire monthly mortality and expense charges. For those policies, the grace period will continue for 61 or 62 days after that date. Other universal life policies provide that the grace period begins on the date that the cash value is zero and continues for 30 or 31 days after that date. The grace period provision in these policies also requires the insurer to notify the policyowner at least 30 or 31 days before the coverage expires that coverage will terminate if the policyowner does not make a premium payment large enough to cover the policy charges. If the insured dies during the policy's grace period, then the insurer will pay the policy death benefit, but it will deduct from those proceeds the amount required to pay the overdue mortality and expense charges.

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

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

Reinstatement Provision

Individual life insurance policies typically include a *reinstatement provision*, which describes the conditions that the policyowner must meet to reinstate a policy. **Reinstatement** is the process by which a life insurance company puts back into force a life insurance policy that either has been terminated because of non-payment of renewal premiums or has been continued under the extended term or reduced paid-up insurance nonforfeiture option. (We discuss these nonforfeiture options later in this chapter.) Most insurers do not permit reinstatement if the policyowner has surrendered the policy for its cash surrender value. When an insurer reinstates a policy, the original policy is again in effect; the insurer does not issue a new policy.

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

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

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

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

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

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

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

Misstatement of Age or Sex Provision

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

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

Insurers adjust the face amount of the policy when they discover a misstatement of age or sex *after* the death of the insured. If the misstatement is discovered *before* the death of the insured, however, the insurer may give the policyowner the option to pay—or receive as a refund—any premium amount difference caused by the misstatement instead of having the insurer adjust the policy's face amount.

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

Example. Larry Dietrich purchased a life insurance policy from Galactic Life Insurance Company. On the application, Larry listed his age as 30. In fact, Larry was 33. Larry died five years later, after the policy's contestable period had expired, and Galactic discovered the misstatement of age while processing the benefit claim.

Analysis. Galactic will reduce the policy's face amount to the amount that the premiums paid would have purchased for Larry at age 33 and will pay that amount to the policy beneficiary.

Example. While processing a death claim, the insurance company discovered that when Alice Langston purchased a life insurance policy on her 50-year-old mother, Denise, she mistakenly stated on the application that the proposed insured was male instead of female.

Analysis. When it calculates the amount of policy proceeds payable upon Denise's death, the insurer will increase the face amount of the policy to the amount that the premiums paid would have purchased for a female age 50.

Provisions Unique to Cash Value Policies

Cash value life insurance policies typically contain several provisions in addition to those described in the previous section. The provisions that are unique to cash value life insurance policies relate to policy loans and withdrawals and to nonforfeiture options.

Policy Loans and Policy Withdrawals

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

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

Example. At the time of her death, Sylvia Cortina was insured under a \$250,000 whole life insurance policy. The policy had an unpaid policy loan in the amount of \$10,000.

Analysis. The insurance company will deduct the amount of the unpaid policy loan from the policy proceeds. As a result, the named beneficiary will receive \$240,000 ($\$250,000 - \$10,000$).

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

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

For some insurance policies, the interest rate charged on policy loans is stated in the policy. Other policies state that the policy loan interest rate can vary from year to year according to current economic conditions. Laws in many jurisdictions specify the maximum interest rate that insurers can charge on policy loans.

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

Nonforfeiture Provision

The **nonforfeiture provision** sets forth the options available to the owner of a cash value policy if the policy lapses or if the policyowner decides to surrender—or terminate—the policy. Most nonforfeiture provisions give the policyowner the right to select from among several nonforfeiture options if a renewal premium is unpaid when the grace period expires. These nonforfeiture options include the cash pay-

ment nonforfeiture option, two continued insurance coverage options—reduced paid-up insurance and extended term insurance—and the automatic premium loan option. Most policies include an ***automatic nonforfeiture benefit***, which is a specific nonforfeiture benefit that becomes effective automatically when a renewal premium for a cash value life insurance policy is not paid by the end of the grace period *and* the policyowner has not elected another nonforfeiture option. The most typical automatic nonforfeiture benefit is the extended term insurance benefit.

Cash Payment Nonforfeiture Option

The ***cash payment nonforfeiture option*** states that a policyowner who discontinues premium payments can elect to surrender the policy and receive the policy's cash surrender value in a lump-sum payment. Following the surrender of a policy, all coverage under the policy terminates.

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

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

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

Continued Insurance Coverage Nonforfeiture Options

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

Reduced Paid-Up Insurance. Under the ***reduced paid-up insurance nonforfeiture option***, the policy's net cash surrender value is used as a net single premium to purchase paid-up life insurance of the same plan as the original policy. The premium charged for the paid-up insurance is based on the insured's attained age when the option goes into effect. The amount of paid-up insurance that can be purchased under this option is smaller than the face amount of the original policy—thus the name *reduced* paid-up insurance. For example, if the policyowner of a \$500,000 whole life insurance policy exercises this option, he can purchase a paid-up whole life insurance policy with a face amount lower than \$500,000.

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

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

Extended Term Insurance. Under the *extended term insurance nonforfeiture option*, the insurance company uses the policy's net cash surrender value to purchase term insurance for the full coverage amount provided under the original policy, for as long a term as the net cash surrender value can provide. For example, if the owner of a \$500,000 whole life insurance policy exercises this option, she can purchase \$500,000 of term life insurance for as long a term as the net cash surrender value can provide. As with reduced paid-up insurance, the premium charge for extended term insurance is based on the insured's attained age when the option goes into effect.

Life insurance policies that contain the extended term insurance option typically contain a chart showing the length of time the original face amount of the policy will be continued in force under the extended term option for each of the first 20 policy years. Figure 8.2 shows a sample table of guaranteed values for a whole life policy, including the amount of reduced paid-up insurance available and the duration of extended term insurance available at the end of specified policy years.

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

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

Automatic Premium Loan Option

Under the *automatic premium loan (APL) option*, the insurer will automatically pay an overdue premium for the policyowner by making a loan against the policy's cash value as long as the cash value equals or exceeds the amount of the premium due. The use of the automatic premium loan keeps the original policy in force for the full amount of coverage, including all supplemental benefits. Some jurisdictions require by law an automatic premium loan provision, and it is widely used in policies issued in many other jurisdictions.

Figure 8.2. Sample Table of Guaranteed Nonforfeiture Values

Table of Guaranteed Values

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

Alternatives to Cash Value

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

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

Life Insurance Policy Exclusions

Life insurance policies sometimes contain **exclusions**—provisions that describe circumstances under which the insurer will not pay the policy proceeds following the death of the insured. For example, individual life insurance policies typically include a **suicide exclusion provision**, which states that policy proceeds will not be paid if the insured dies as the result of suicide as defined by the policy within a specified period following the date of policy issue. Laws in many jurisdictions specify the maximum allowable length of a suicide exclusion period, usually one or two years. A typical suicide exclusion provision follows.

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

If the insured dies as a result of suicide within the policy's suicide exclusion period, the exclusion provision typically requires the insurer to return all premiums paid, less any unpaid policy loan, to the named beneficiary. The suicide exclusion provision in some policies states that the insurer will pay the larger of (1) the policy's cash surrender value or (2) the premiums paid for the policy if the insured commits suicide during the suicide exclusion period.

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

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

- A *war exclusion clause*, which states that the insurer will not pay the policy proceeds if the insured's death results from war or an act of war. The policy defines the terms "war" and "act of war." Similarly, some policies include a *military service exclusion clause* which states that the insurer will not pay the policy proceeds if the insured's death results from his military service during time of war. Policies containing these clauses typically are issued only during periods of war or threats of war.
- A *hazardous activities exclusion provision*, which states that the insurer will not pay the policy proceeds if the insured's death results from specified dangerous activities such as mountain climbing, sky diving, or scuba diving.

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

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

Key Terms

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

Endnote

1. A one-year contestable period is the maximum allowed by law in some states.

Chapter
9

Life Insurance Policy Ownership Rights

Objectives:

After studying this chapter, you should be able to

- Distinguish between primary and contingent beneficiaries and between revocable and irrevocable beneficiaries
- Describe the premium payment modes that insurers typically offer on individual life insurance policies
- Identify the policy dividend options that most commonly are included in participating life insurance policies, and describe the characteristics of each option
- Identify the methods by which ownership of a life insurance policy can be transferred
- Identify the person in a given situation who is entitled to receive the proceeds of a life insurance policy following the insured's death
- Describe the general rule stated in a simultaneous death act, and explain how that rule is affected if a policy contains a survivorship clause
- Calculate the proceeds payable under a given life insurance policy following the death of the insured
- Identify the settlement options that typically are included in life insurance policies, and describe the features of each option

Outline

Naming the Beneficiary

- Primary and Contingent Beneficiaries
- Changing the Beneficiary

Mode of Premium Payment

Policy Dividends

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

Transfer of Policy Ownership

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

Right to Receive Policy Proceeds

- Identifying Who Is Entitled to Policy Proceeds
- Calculating the Amount of the Benefit Payable
- Paying Policy Benefits under a Settlement Option

An insurance policy is a contract between the insurer and the policyowner and is subject to the rules of contract law. An insurance policy also is a type of property and, thus, is subject to the principles of property law. In legal terminology, **property** is defined as a bundle of rights a person has with respect to something. In most countries, including the United States, property is characterized as either real property or personal property. **Real property** is land and whatever is growing on or attached to the land. **Personal property** is all property other than real property.

Personal property can be classified as tangible or intangible. **Tangible property** is property that has physical form, such as automobiles, jewelry, or clothing. **Intangible property** is property that represents ownership of a legal right, such as a contractual right. An insurance policy is intangible personal property; it represents legal rights that have value and that can be enforced by the courts.

Ownership of property is the sum of all the legal rights that exist in that property. Typically, the owner of an insurance policy—rather than the insured or the beneficiary—holds the ownership rights in an insurance policy. Most of the ownership rights are set out in the policy, and some ownership rights vary depending on the type of policy.

Naming the Beneficiary

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

Primary and Contingent Beneficiaries

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

Example. At the time of her death, Madeleine Altman owned an insurance policy on her life. Madeleine's three children—Anna, Bernard, and Charles—were named as the policy beneficiaries, and all three children survived Madeleine.

Analysis. Unless Madeleine indicated otherwise, the policy proceeds would be divided equally among the three beneficiaries.

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

Example. Morton Navinsky was the policyowner-insured of a life insurance policy that named his wife, Sonia, as primary beneficiary and his sons, Boris and Dimitri, as equal contingent beneficiaries. At Morton's death, he was survived by his wife and both sons.

Analysis. The policy proceeds are payable to the primary beneficiary, Sonia.

Example. Marisol Bonilla owned an insurance policy on her life and named her husband, Carlos, as primary beneficiary and her sons, Alfredo and Ramon, as equal contingent beneficiaries. Both Carlos and Alfredo predeceased Marisol.

Analysis. As the sole surviving contingent beneficiary, Ramon is entitled to receive the policy proceeds.

Example. Craig Reilly owned an insurance policy on his life and named his sons, Stan and Tom, as equal primary beneficiaries and his wife, Anne, as contingent beneficiary. When Craig died, he was survived by only Tom and Anne, as Stan had died several years earlier.

Analysis. As the sole surviving primary beneficiary, Tom is entitled to receive the policy proceeds.

Insurers usually prefer that policyowners name at least a primary and a contingent beneficiary. Most insurers permit the designation of additional levels of contingent beneficiaries. Contingent beneficiaries at any given level typically have a right to the policy proceeds only if all beneficiaries in the preceding levels have predeceased the insured. For example, assume that a policyowner-insured named his wife as primary beneficiary, his daughter as first contingent beneficiary, and his sister as second contingent beneficiary. The policyowner-insured's sister is entitled to the policy proceeds *only* if both the policyowner-insured's wife and daughter predeceased him. Naming additional levels of contingent beneficiaries helps the policyowner to be certain that the proceeds are paid to the desired party.

Changing the Beneficiary

Life insurance policies usually give the policyowner the right to change the beneficiary designation any time during the insured's lifetime. This right to change the beneficiary designation is known as the ***right of revocation***. A beneficiary designation is said to be ***revocable*** if the policyowner has the unrestricted right to change the designation during the life of the insured. Most insurers refer to any beneficiary so designated as a ***revocable beneficiary***. On the other hand, a beneficiary designation is said to be ***irrevocable*** if the policyowner has the right to change the beneficiary designation only after obtaining the beneficiary's consent. Insurers refer to any beneficiary so designated as an ***irrevocable beneficiary***. As a general rule, a beneficiary designation is revocable unless the policyowner voluntarily gives up the right to change the beneficiary and makes the designation irrevocable.

Revocable Beneficiary

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

Note that a beneficiary change can be made only during the insured's lifetime. Once the insured dies, the named beneficiary has a vested interest in the policy proceeds, and the policyowner cannot deprive the beneficiary of that interest. A ***vested interest*** is a property right that has taken effect and cannot be altered or changed without the consent of the person who owns the right.

Irrevocable Beneficiary

A policyowner may at any time designate a beneficiary as an irrevocable beneficiary. After making such a designation, the policyowner gives up the right to change the beneficiary designation unless the irrevocable beneficiary consents to such a change. An irrevocable beneficiary has a vested interest in the proceeds of the life insurance policy even during the lifetime of the insured.

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

Under certain circumstances, a policyowner may be able to name a new beneficiary, even if the original beneficiary designation is irrevocable. For example, the policyowner may change the beneficiary designation if he obtains the written consent of the irrevocable beneficiary. Most life insurance policies contain a provision stating that the rights of any beneficiary, including an irrevocable beneficiary, will terminate if the beneficiary should die before the insured dies. This provision prevents the automatic payment of the proceeds to the estate of the irrevocable beneficiary and permits the policyowner to designate a new beneficiary following the death of an irrevocable beneficiary.

Example. Frederick Weltner purchased an insurance policy on his own life and named his mother, Caroline, as irrevocable beneficiary. Several years later, while the policy was still in effect, Caroline died.

Analysis. Upon Caroline's death, Frederick is permitted to designate a new beneficiary without having to obtain anyone's consent.

Mode of Premium Payment

Most individual life insurance policyholders pay periodic renewal premiums to keep their policies in force. A policy's **premium payment mode** is the frequency at which renewal premiums are payable. Each insurance company determines which premium payment modes it will make available to its policyholders. Most insurers offer to accept renewal premiums for individual life insurance policies on an annual, semiannual, quarterly, or monthly basis. The applicant selects one of these premium payment modes during the application process. Typically, the policyholder also may change the mode of premium payment after the policy has taken effect.

Renewal premiums for an individual life insurance policy generally are stated as an annual premium amount due. Insurers incur administrative costs to receive and process renewal premiums. The more frequent the renewal premium payments, the greater the insurer's administrative costs. To cover some of those administrative costs, an insurer usually charges more than the annual premium amount when a policyholder chooses to pay premiums more frequently than once

a year. For example, suppose the annual renewal premium for a particular policy is \$1,200 a year. If the policyowner elects to pay on a monthly basis, the insurer probably will increase the monthly renewal premium payable from \$100 (\$1,200 annual premium ÷ 12 monthly payments) to a greater amount, such as \$108, to cover the insurer's administrative costs.

Insurers also seek to keep their administrative costs down by requiring scheduled renewal premium payments to be at least equal to a stated minimum amount. Typically, a policyowner may not select a premium payment mode that results in a premium less than the required minimum amount. For example, the insurance company may require a minimum monthly premium payment of at least \$20 for a policyowner to choose a monthly premium payment mode. If the monthly premium amount were less than that minimum, then the policyowner would be required to choose a less frequent mode of payment, such as quarterly or semiannually.

Policy Dividends

Insurance policies may be issued on either a participating or nonparticipating basis. A **participating policy**, sometimes referred to as a *par policy*, is a type of policy under which the policyowner shares in the insurance company's divisible surplus. A **nonparticipating policy**, also known as a *nonpar policy*, is a type of policy in which the policyowner does not share in the insurer's surplus. Remember from Chapter 2 that a company's surplus is the amount by which its assets exceed its liabilities plus its capital. Surplus results from a company's profitable operations. Some insurance companies set aside a portion of this surplus, called the **divisible surplus**, specifically for distribution to owners of participating policies. A policyowner's share of the divisible surplus is called a **policy dividend**. A policy dividend is considered a refund of part of the premiums a participating policyowner paid in a policy year.

Each element involved in the financial design of an insurance product is a potential source of divisible surplus. If the people insured by a company experience a more favorable mortality rate than the company expected, fewer claims will be paid. If a company earns a higher rate of return on investments than anticipated, it will receive more investment income. And if a company spends less money on expenses than was estimated, additional funds will be available.

In 2007, approximately 79 percent of the individual life insurance policies issued in the United States were nonparticipating policies.¹ Stock insurance companies can offer both participating and nonparticipating policies. In the past, mutual insurance companies tended to offer only participating policies. Today, however, many mutuals offer both participating and nonparticipating policies.

Generally, the premium rates for nonparticipating policies are lower than the premium rates for equivalent participating policies because insurers issuing non-participating policies often use less conservative assumptions regarding mortality, investment earnings, and expenses. However, determining in advance which type of policy—participating or nonparticipating—ultimately will be less expensive is difficult because any policy dividends received by the owner of a participating policy in effect reduce the amount of the policy's actual cost to the owner.

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

The owner of a participating life insurance policy may receive policy dividends in a number of different ways, called ***dividend options***. Common dividend options for participating life insurance policies include (1) the cash dividend option, (2) the premium reduction option, (3) the policy loan repayment option, (4) the accumulation at interest option, (5) the paid-up additional insurance option, and (6) the additional term insurance option. An applicant for a participating policy usually selects a dividend option during the application process. Over the life of a participating policy, the policyowner may change the dividend option at any time, although, as we discuss, some changes are subject to certain restrictions. Each participating life insurance policy also specifies an ***automatic dividend option***, which is the dividend option that the insurer will apply if the policyowner does not choose an option. Most cash value policies specify the paid-up additional insurance option as the automatic dividend option. Most term insurance policies specify the accumulation at interest option as the automatic dividend option.

Cash Dividend Option

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

Premium Reduction Option

Under the ***premium reduction dividend option***, the insurer applies policy dividends toward the payment of renewal premiums. Unless a policy has been in force for many years, the annual policy dividend usually is not large enough to pay an entire annual renewal premium. If a policyowner is paying premiums more often than annually, the dividend may cover one or more of the installments. The insurer notifies the policyowner of the amount of the policy dividend and bills the policyowner for the difference, if any, between the premium amount due and the amount of the policy dividend. If the amount of an annual policy dividend exceeds the amount of the annual renewal premium, the policyowner can select another dividend option to receive the remainder of the dividend, or the insurer will apply the automatic dividend option.

Policy Loan Repayment Option

Under the ***policy loan repayment dividend option***, the insurer applies policy dividends toward the repayment of an outstanding policy loan. The amount of the policy dividend usually is applied first to repay any outstanding interest on the loan

and then to repay the loan principal. If the amount of the annual policy dividend exceeds the amount of the policy loan and any outstanding interest, the policy-owner can select another dividend option to receive the remainder of the dividend, or the insurer will apply the automatic dividend option.

Accumulation at Interest Option

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

During the life of the policy, the policyowner typically has the right to withdraw part or all of these dividends and accumulated interest at any time. If the policyowner surrenders the policy, the amount the insurer pays the policyowner includes the accumulated value of the policy dividends. Any policy dividends that are on deposit with the insurer when the insured dies usually are payable to the named beneficiary rather than to the policyowner.

Paid-Up Additional Insurance Option

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

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

Although the face amount of the paid-up additions purchased each year under this option may be relatively small, over the life of a policy, the total additional insurance available can be substantial. Figure 9.1 illustrates how the paid-up additional insurance option increases the total death benefit payable under a policy. In this illustration, the insured was 40 years old when he purchased a \$100,000 participating whole life insurance policy and selected the paid-up additional insurance option. After the policy had been in force for two years, the insurer declared a dividend of \$5 for his policy. The insurer automatically applied the \$5 dividend to purchase a paid-up whole life addition of \$16, the amount of paid-up whole life insurance that the \$5 premium would purchase at the insured's attained age. As a result, the total death benefit payable under the policy increased to \$100,016. The next year, the insurer used the \$21 policy dividend to purchase another paid-up whole life addition—this time for \$65—and the total death benefit payable under the policy increased to \$100,081. As you can see from the illustration in Figure 9.1, when the insured reached age 65, the total amount of paid-up additions purchased with policy dividends totaled \$49,357, thus increasing the total death benefit payable under the policy to \$149,357.

Figure 9.1. Illustration of Paid-Up Additional Insurance Option

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

Additional Term Insurance Option

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

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

- Insurers often limit to the amount of the policy's cash value the maximum amount of one-year term insurance that can be purchased each year. If the annual policy dividend is larger than the premium required to purchase the maximum amount of one-year term insurance permitted, then the insurer applies the remaining amount under one of the other dividend options.
- Before a policyowner is permitted to change from another dividend option to the additional term insurance option, insurers usually require evidence of the insured's insurability. This requirement is designed to prevent antiselection because a policyowner is more likely to change to this dividend option if the insured is in poor health rather than to apply dividends to purchase the more expensive paid-up additions.

Transfer of Policy Ownership

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

Transfer of Ownership by Assignment

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

The right to assign a life insurance policy is subject to some restrictions.

- To make a valid assignment of an insurance policy, the policyowner must have contractual capacity. As a result, if the policyowner is a minor or, for some other reason, lacks contractual capacity, any attempt by the policyowner to assign the policy is invalid.
- The assignment of a life insurance policy may not infringe on the vested rights of an irrevocable beneficiary. An assignment made without such a beneficiary's consent is invalid. Note that when the beneficiary is a revocable beneficiary, the policyowner has an unlimited right to assign the policy without obtaining the beneficiary's consent.
- An assignment that is made for illegal purposes, such as speculating on a life, is invalid.

Types of Assignment

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

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

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

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

1. **The collateral assignee's rights are limited to those ownership rights that directly concern the monetary value of the policy.** The policyowner retains all ownership rights that do not affect the policy's value. For example, the right to name the policy beneficiary and the right to select a settlement option remain with the policyowner. The policyowner-assignor, however, is not permitted to take out a policy loan or surrender the policy for its cash surrender value while a collateral assignment is in effect unless the assignee consents. This limitation is imposed to protect the assignee's right to the policy's value because a policy loan and a policy surrender both diminish that value.
2. **The collateral assignee has a vested right to the policy's monetary values, but that right is limited.** The assignee's rights to the policy's values are limited to the amount of the assignor's indebtedness to the assignee. Consequently, if the policy proceeds become payable, the assignee is entitled to receive only the amount of the indebtedness; any remaining amount must be paid to the policy's beneficiary. The assignee can receive this amount only in a lump sum and cannot select a settlement option.

Example. Calvin Hastings was the policyowner-insured of a \$100,000 life insurance policy. Calvin collaterally assigned the policy to Steadfast Bank as security for a loan he received from Steadfast. When Calvin died, he owed Steadfast \$20,000.

Analysis. The insurer will pay Steadfast \$20,000 and the remaining \$80,000 of the policy proceeds to the named beneficiary.

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

Assignment Provision

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

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

An assignment is an agreement between the assignor and the assignee. The insurance company is not a party to the agreement. Therefore, the policy's assignment provision states that the insurer is not responsible for the validity of any

assignment. When an insurance company receives written notice of an assignment, the company presumes that the assignment is valid. The insurance company, however, has no control over the validity of the assignment and usually cannot be held liable for having acted in accordance with an assignment that is later determined to be invalid.

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

Example. Talia Silvestri collaterally assigned the insurance policy she owned on her life to Consolidated Bank as security for a loan. When Talia died, the insurance company had not been notified of the assignment, and, thus, it paid the policy proceeds to the named beneficiary. Consolidated later claimed the policy proceeds.

Analysis. Because the insurer was not notified of the assignment before it paid the policy death benefit, it has no liability to pay the proceeds again to Consolidated.

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

Transfer of Ownership by Endorsement

Many life insurance policies issued today specify a simple, direct method of transferring all the policy's ownership rights. Under this method, known as the *endorsement method*, policy ownership is completely transferred without requiring the policyowner to enter into a separate assignment agreement. The endorsement method is commonly used when a policy is given as a gift, such as the gift of a policy from a parent to a child.

The right to change the policy's owner is generally specified in the *change of ownership provision* in the policy. Typically, to change the ownership of the policy, the policyowner must notify the insurer, in writing, of the change. However, the insurer usually has the right to require that the ownership change be endorsed in the policy. In such a case, the policyowner sends the policy to the insurance company, and the insurer adds to the policy an endorsement that states the name of the new owner. The transfer of ownership provision usually states that the insurance company is not responsible for any payments it made to the owner of record before it received written notice of an ownership change and recorded that change.

Right to Receive Policy Proceeds

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

Identifying Who Is Entitled to Policy Proceeds

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

No Surviving Beneficiary

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

Example. Cynthia Riessen was the policyowner-insured of a life insurance policy that named her husband as the primary beneficiary and her two children as contingent beneficiaries. No named beneficiary survived Cynthia.

Analysis. Because no named beneficiary survived the insured, the policy proceeds are payable to the policyowner's—in this case, Cynthia's—estate.

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

Insured and Beneficiary Die in a Common Disaster

A beneficiary is entitled to receive the policy proceeds only if he survives the insured. Sometimes, however, the insured and the beneficiary die in the same accident. This situation is referred to as a *common disaster*, because the accident or disaster was common to more than one person. Under such circumstances, the insurer may be unable to determine whether the insured or the beneficiary died first.

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

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

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

Example. Darren Alexander and his wife, Natalie, died in an airplane crash, and the evidence did not show which of them died first. Darren was the policyowner-insured of a policy that named Natalie as the primary beneficiary. Darren's father, Norman, was named as the contingent beneficiary. Norman was still living at the time of the plane crash.

Analysis. Because no evidence exists as to the order in which Darren and Natalie died, the insurer would apply the general rule stated in the simultaneous death act. Darren is deemed to have survived the primary beneficiary, Natalie. Thus, the policy proceeds are payable to the contingent beneficiary, Norman.

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

The policyowner, however, may prefer that the proceeds be paid to someone other than the beneficiary's estate if the beneficiary survives the insured by only a short time. Some life insurance policies include a survivorship clause to address this potential problem. A ***survivorship clause*** states that the beneficiary must survive the insured by a specified period, usually 30 or 60 days, to be entitled to receive the policy proceeds. If the beneficiary does not survive the insured by the stated amount of time, then the policy proceeds are paid as if the beneficiary pre-deceased the insured. As a result of the survivorship clause, the policy proceeds are more likely to be distributed as the policyowner had intended. The survivorship clause is not limited to cases involving a common disaster. It applies in all situations in which the beneficiary dies within the stated period of time after the insured's death.

Example. Melinda Vincent was insured under a life insurance policy that included a survivorship clause requiring the beneficiary to survive the insured by 30 days. Her husband, Timothy, was the policy's primary beneficiary, and her mother, Deanna, was the contingent beneficiary. Melinda and Timothy died as the result of an automobile accident. Melinda died within a few minutes of the accident, and Timothy died 10 days later.

Analysis. Because the beneficiary survived the insured, the policy's survivorship clause governs the situation. Timothy died only 10 days after Melinda died and, thus, did not survive her by the required 30 days. Thus, the proceeds are payable to the contingent beneficiary, Deanna.

Beneficiary Wrongfully Kills the Insured

Permitting someone to profit from the wrongful killing of another person is not in the public interest. As a result, laws in many countries disqualify a beneficiary from receiving the policy proceeds if the beneficiary wrongfully and intentionally killed the insured.³ In most cases in which a beneficiary is disqualified from receiving policy proceeds, the life insurance contract is valid, and the insurer is liable to pay the policy proceeds to someone, such as the contingent beneficiary. If, however, the policy was purchased with the intention to profit from the insured's death, then the life insurance contract is void because the lawful purpose requirement was not met when the contract was created.

Calculating the Amount of the Benefit Payable

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

- The amount of the **basic death benefit payable**. In most cases, the basic death benefit is the policy's face amount. However, if the policy was in force under the reduced paid-up insurance nonforfeiture option when the insured died, then the amount of the basic death benefit payable is less than the face amount.
- The amount of any **accidental death benefits payable**.
- The amount of any **declared but unpaid policy dividends**.
- The amount of any **accumulated policy dividends**, including interest, left on deposit with the insurer.
- The face amount of any **paid-up additions**.
- The amount of any **unearned premiums paid in advance**. Policyowners sometimes pay premiums before those premiums are due. For example, a policyowner might pay a renewal premium a month before the premium due date. If the insured dies shortly before the renewal premium is payable, the insurer usually refunds the amount of the renewal premium because the insurer has not earned that premium.

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

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

The result of this calculation is the total benefit amount payable.

Example. When Samir Gupta died, he was insured under a \$250,000 life insurance policy. At that time, \$450 in accumulated policy dividends were on deposit with the insurer, and Samir had paid \$500 in advance premiums. Samir also had an outstanding policy loan of \$5,300.

Analysis. The insurer was liable to pay the policy beneficiary a total policy benefit of \$245,650. That amount was calculated as follows.

\$250,000	Face amount of policy
+ 450	Accumulated policy dividends
+ 500	Premium paid in advance
<u>-5,300</u>	Outstanding policy loan
\$245,650	Total policy benefit payable

Paying Policy Benefits Under a Settlement Option

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

The policyowner may select a settlement option at the time of application or at any time while the policy is in force. The policyowner also has the right to change to another settlement option at any time during the insured's lifetime. A policyowner who selects a settlement option for the beneficiary may choose to make the settlement mode *irrevocable*, in which case the beneficiary will not be able to change to another option when the policy proceeds become payable. If the selected settlement option is not irrevocable, then the mode is considered to be *revocable*, and the beneficiary has the right to select another settlement option when the proceeds become payable. Further, if the policyowner has not chosen a settlement option when the policy proceeds become payable, then the beneficiary has the right to choose a settlement option.

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

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

Interest Option

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

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

Fixed Period Option

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

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

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

Fixed Amount Option

The **fixed amount option** is a settlement option under which the insurance company pays equal installments of a stated amount until the policy proceeds, plus the interest earned, are exhausted. For example, the policyowner might elect for the insurer to pay \$1,000 a month to the payee until the policy proceeds are exhausted. As with the fixed period option, the fixed amount option states the minimum guaranteed interest rate that the insurer will pay on the policy proceeds it holds.

The number of installments that the insurer will pay depends on the amount of the policy proceeds, the interest rate, and the fixed amount selected. The larger the amount of the proceeds, the longer the period for which the insurer will make installment payments of the fixed amount.

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

Life Income Option

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

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

Insurance companies offer several types of life annuities. Therefore, insurance companies also give the policyowner or beneficiary who chooses the life income option the right to select from among several types of life annuities. In Chapter 10, we discuss the various types of life annuities that insurers offer.

The settlement options provision also guarantees that each periodic annuity income payment will be at least as large as a stated amount. Policies typically contain charts that list the amount of the guaranteed minimum income payments that will be available under each of the life income options. If the insurer's annuity rates in effect at the time of settlement would result in larger payment amounts, then the insurer typically provides the larger amounts, rather than the guaranteed amounts.

Key Terms

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

Endnotes

1. ACLI *Life Insurers Fact Book 2009* (Washington, DC: American Council of Life Insurers 2009), 64, <http://www.acli.com/NR/rdonlyres/0BFEABCA-1E2A-4F4C-A879-95CF104238AB/22608/FB0709LifeInsurance1.pdf> (16 March 2010).
2. In some jurisdictions, the simultaneous death act applies if the insured and beneficiary die within a stated amount of time—often 120 hours—of each other. Under such a law, if the beneficiary dies within 120 hours of the insured, then the insured is deemed to have survived the beneficiary, unless the policy provides otherwise.
3. In many jurisdictions, the beneficiary's unintentional wrongful killing of the insured also disqualifies her from receiving the policy proceeds. For example, the beneficiary might have driven a car while intoxicated and unintentionally caused an accident that resulted in the death of the insured, who was a passenger in the car.

The logo consists of a blue rectangular background. On the left side, the word "Chapter" is written vertically above the number "10". To the right of the number "10", the word "Annuities" is written in a large, bold, sans-serif font.

Chapter 10

Annuities

Objectives:

After studying this chapter, you should be able to

- Define the terms *annuity contract, annuitant, payee, maturity date, and payout period*
- Distinguish between immediate and deferred annuity contracts, single-premium and flexible-premium annuity contracts, and fixed and variable annuity contracts
- Explain standard contract provisions included in individual annuity contracts
- Describe the guaranteed benefits included in some variable annuity contracts
- Explain the fees and charges typically paid by annuity contract owners
- Identify and distinguish among the types of payout options available under annuity contracts
- List the factors that affect the amount of an annuity's periodic income payments and describe the effect of each factor
- Describe two types of favorable income tax treatment for annuities in various jurisdictions, and compare the income tax treatment of traditional IRAs and Roth IRAs

Outline

Introduction to Annuities

Types of Annuity Contracts

- Immediate and Deferred Annuities
- Single-Premium and Flexible-Premium Annuities
- Fixed and Variable Annuities

Annuity Contract Provisions

- Deferred Annuity Contract Provisions
- Guaranteed Benefits
- Fees and Charges
- Payout Options

Factors Affecting Amount of Periodic Income Payments

Taxation of Annuities

Individual Retirement Arrangements

The life insurance products we have discussed in this text provide protection against the risk of economic loss associated with death. However, *personal risk* includes the risk of outliving one's financial resources. As a result of medical advances and increasing life expectancy, many people now live for a number of years or even decades after they retire or are no longer able to work. Even people who have accumulated a substantial amount of assets may require more money than they have saved to meet their expenses in their later years. Annuities often can protect people against the financial risk of outliving their financial resources.

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

In the United States and many other countries, annuities are considered to be life insurance products, and only life insurance companies are permitted to issue annuities. In the United States, therefore, annuities must comply with state insurance laws and regulations. However, in some countries, such as Argentina, companies that issue life insurance policies and annuity contracts must be different legal entities.

Introduction to Annuities

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

Insurers issue both individual and group annuities. Thus, the contract owner can be either an individual or an organization that purchases the annuity on behalf

of a group of individuals. In this chapter, we describe only individual annuities; we discuss group annuities later in the text.

As part of the contractual agreement between the parties to an annuity, the contract owner pays a single premium or a series of premiums to the insurer. Premiums that insurers receive for annuities sometimes are referred to as *annuity considerations*. The insurer pools the premiums it receives from a large group of individual contract owners and invests those pooled funds. The insurer uses the pooled funds and investment earnings on those funds to make periodic annuity income payments as they come due according to the terms of the contract.

The terminology insurers use to describe the operation of an annuity differs somewhat from the terminology used in connection with insurance policies. The *payee* is the person or entity who receives the periodic income payments according to the terms of the annuity contract. The contract may name a *contingent payee*, who will receive any remaining annuity payments upon the death of the payee. The annuity contract may specify an *annuitant*, whose lifetime is used to determine the amount of benefits payable under the contract. In most cases, the contract owner, the payee, and the annuitant are the same person.

The date on which the insurer begins to make the periodic income payments is the *maturity date*, also known as the *annuity date* or the *income date*. The period during which the insurer makes periodic income payments is known as the *payout period* or *liquidation period*. An *annuity period* is the time span between each of the payments in the series of periodic annuity payments. The annuity period is typically either one month or one year; other options, such as quarterly or semiannual payments, are also available. An annuity contract that provides for a series of annual income payments has an annuity period of one year and is referred to as an *annual annuity*. An annuity contract that provides for a series of monthly income payments has an annuity period of one month and is referred to as a *monthly annuity*.

Types of Annuity Contracts

As noted earlier, annuity contracts may be issued either as individual or group contracts. Annuity contracts can be categorized in a number of other ways, such as

- When periodic income payments begin
- How often premiums are paid
- How annuity premiums are invested

As we will discuss, all of the categories overlap one another.

Immediate and Deferred Annuities

An annuity can be classified as either an immediate annuity or a deferred annuity, depending on when the insurer begins making periodic income payments. An *immediate annuity* provides periodic income payments that generally are scheduled to begin one annuity period after the date the contract is issued. The owner of an immediate annuity selects the date on which periodic income payments are to begin. For example, if a contract owner purchased an annual immediate annuity on March 1, 2010, he would begin to receive annual income payments on the

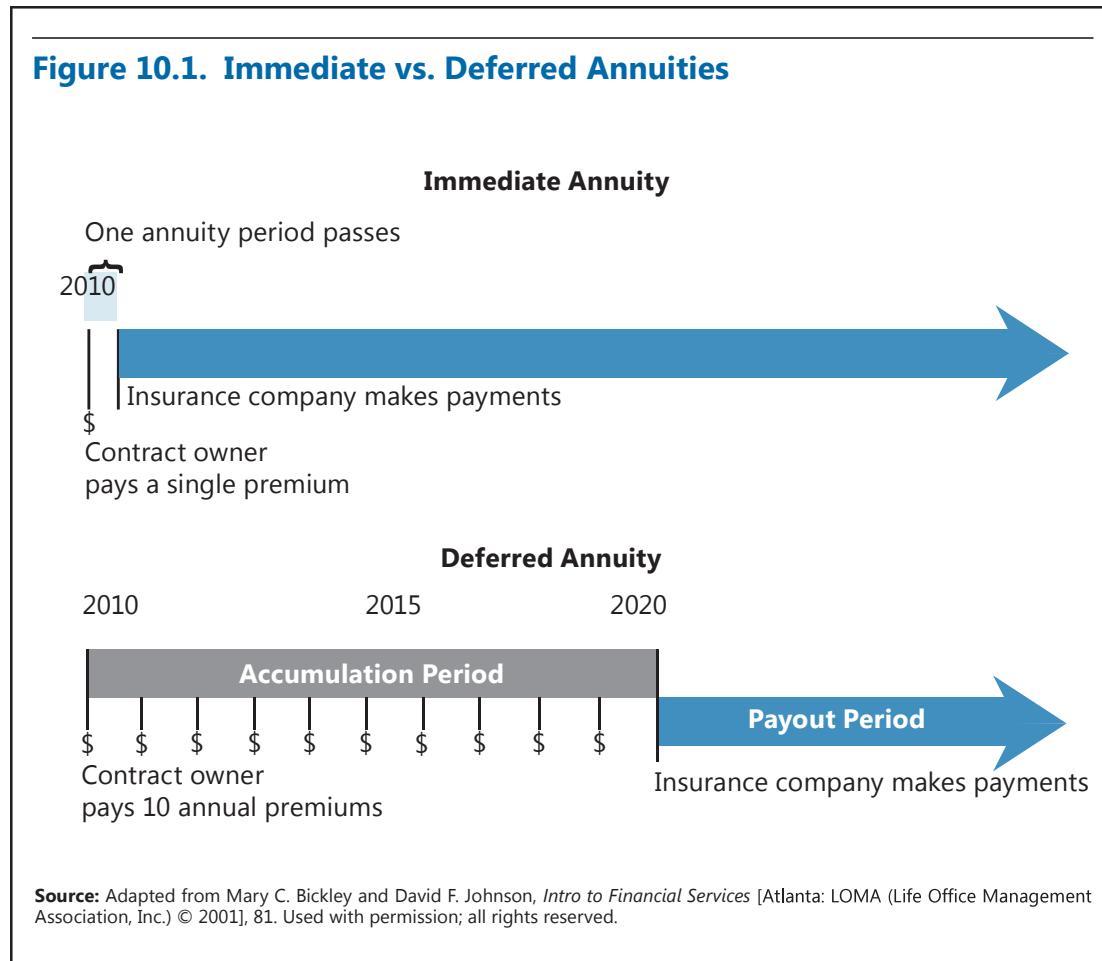
annuity's maturity date of March 1, 2011. On the other hand, if a contract owner purchased a monthly immediate annuity on March 1, 2010, he would begin to receive monthly income payments on the annuity's maturity date of April 1, 2010.

A contract owner often uses an immediate annuity to convert a lump-sum payment into an income stream. For example, a person who receives an inheritance might use that money as the premium for an immediate annuity that will provide her with a monthly income.

A **deferred annuity** is an annuity under which periodic income payments are scheduled to begin more than one annuity period after the date on which the annuity was purchased. The period between the contract owner's purchase of a deferred annuity and the beginning of the payout period is known as the **accumulation period**. During a deferred annuity's accumulation period, the insurer invests the premiums paid by the contract owner, and the annuity builds an accumulated value. A deferred annuity's **accumulated value**, also known as the **accumulation value** or **contract value**, is equal to the amount paid for the annuity, *plus* the investment earnings, *minus* the amount of any withdrawals and fees.

People often purchase deferred annuities during their working years in anticipation of the need for retirement income later in their lives. In addition to being a vehicle for accumulating savings, a deferred annuity gives the contract owner the right to receive periodic income payments at some time in the future. Figure 10.1 illustrates the difference between an immediate annuity and a deferred annuity.

Figure 10.1. Immediate vs. Deferred Annuities



Single-Premium and Flexible-Premium Annuities

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

- A ***single-premium immediate annuity (SPIA) contract*** is purchased with a lump-sum premium payment and provides periodic income payments that begin one annuity period after the annuity is purchased. All immediate annuities are single-premium annuities.
- A ***single-premium deferred annuity (SPDA) contract*** is purchased with a lump-sum premium payment and provides periodic income payments that begin more than one annuity period after the annuity is purchased.

Deferred annuities can be purchased with a series of periodic premiums as well as with a single premium. A ***flexible-premium annuity*** is an annuity that is purchased by the payment of periodic premiums that can vary between a set minimum amount and a set maximum amount. Because every annuity purchased with flexible premiums is a deferred annuity, most insurers refer to the flexible-premium annuities they issue as ***flexible-premium deferred annuity (FPDA) contracts***. Typically, the minimum amount required for the initial premium of an FPDA is larger than the minimum amount allowed for subsequent premiums. For example, an FPDA might require the contract owner to pay an initial premium between \$1,000 and \$20,000, and then allow the contract owner to pay subsequent premiums between \$250 and \$20,000 each year. The contract owner also can choose not to pay any premium in a given year; the only requirement is that any premium amount paid each year must fall within the stated minimum and maximum amounts.

Figure 10.2 illustrates how different types of annuities can be used.

Fixed and Variable Annuities

An annuity contract can be classified as a fixed annuity or a variable annuity, depending on how premiums are invested. People who purchase annuities have different goals in mind for the funds they place in an annuity. Annuity contract owners also differ in the amount of risk they are willing to assume when they place money in their annuities. Thus, many insurers offer two general options to annuity purchasers, depending on the method of investing the annuity premiums: (1) the insurer will guarantee to pay at least a stated interest rate on the annuity funds it holds, or (2) the insurer will not guarantee any rate of return on the annuity funds; instead, the rate of return will vary according to the earnings of certain investments held by the insurer.

Fixed Annuities

A ***fixed annuity*** is an annuity contract under which the insurer guarantees the minimum interest rate that will be applied to the annuity's accumulated value during the accumulation period and the minimum amount of the periodic income payments that will be made during the payout period. Most fixed annuities state that once the insurer begins making periodic income payments, the amount of

Figure 10.2 How Annuities Can Be Used

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

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

Example 3. Francis Gilbert, age 30, is employed and wants to save money for his retirement. Francis purchased a *flexible-premium deferred annuity*. Francis paid an initial premium of \$1,000 and paid subsequent monthly premiums of \$100 for three months before experiencing a financial emergency. Six months later, after resolving the financial emergency, Francis resumed making monthly premium payments.



each payment will not change. Some fixed annuity contracts, however, provide that periodic income payments may increase if the insurer's investment earnings exceed those the insurer expected when it calculated the periodic income payment amount.

If the fixed annuity is an *immediate annuity*, then the amount of the periodic income payments is known when the insurer issues the contract. The insurer calculates the amount of the periodic income payments based on the amount of the single premium paid for the contract and the guaranteed interest rate.

If the fixed annuity is a *deferred annuity*, then the accumulated value earns interest throughout the accumulation period. When the annuity is purchased, the insurer typically guarantees that the accumulated value will be credited with a stated interest rate for at least a stated period of time, usually from 1 to 10 years. Such an annuity also specifies that, after that initial period, the interest rate credited will not fall below a minimum stated rate. For example, the annuity contract might provide that the accumulated value will earn 4 percent interest for a period of 3 years and a minimum guaranteed interest rate of 2 percent for the remainder of the accumulation period. The actual interest rate that the insurer applies after the initial period, however, may be greater than the guaranteed rate depending on the insurer's actual investment experience.

A fixed deferred annuity's accumulated value on the maturity date determines the amount of the periodic income payments. The annuity contract contains a payout schedule that specifies the minimum periodic income payment amount that

is guaranteed for each \$1,000 of accumulated value. The insurer bases the payout schedule on the annuity contract's minimum guaranteed interest rate. However, if the insurer's actual investment experience as of the maturity date has been better than originally anticipated, the insurer typically provides a larger periodic income payment than the minimum guaranteed in the contract.

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

Insurers also issue hybrid types of annuity products, such as equity-indexed annuities (EIAs) and market value adjusted (MVA) annuities. Figure 10.3 describes these hybrid annuities.

Variable Annuities

A **variable annuity** is an annuity under which the amount of the accumulated value and the amount of the periodic income payments fluctuate in accordance with the performance of one or more specified investment funds. In general, insurers make

Figure 10.3 Hybrid Annuities

Equity-Indexed Annuities

An **equity-indexed annuity (EIA)** is a type of annuity that offers certain principal and earnings guarantees, but also offers the possibility of additional earnings by linking the contract to a published index. EIAs typically are classified as fixed annuities because of the guarantees they offer. However, like variable annuities, EIAs offer the potential for higher returns depending on investment performance.

Market Value Adjusted Annuities

A **market value adjusted (MVA) annuity**, also known as a *modified guaranteed annuity*, is an annuity that offers multiple guarantee periods and multiple fixed interest rates. Rather than being "locked in" with fixed earnings for the life of the contract, contract owners can move or withdraw premium deposits at certain times stipulated in the contract to take advantage of prevailing market interest rates.

To be issued as fixed annuities in the United States, EIAs and MVA annuities must meet certain regulatory requirements. Those EIAs and MVA annuities that do not meet regulatory requirements are considered variable products, which must be registered as securities.

Source: Mary C. Bickley, *Principles of Financial Services and Products* [Atlanta: LOMA (Life Office Management Association, Inc.), © 2004], 269. Used with permission; all rights reserved.

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

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

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

During a variable annuity's accumulation period, the annuity's accumulated value will fluctuate directly with the investment performance of the chosen subaccounts. At the beginning of the payout period, the variable annuity contract owner typically has the option of receiving income payments that

- Are fixed in amount from a fixed subaccount
- Fluctuate as the result of the investment performance of specified variable subaccounts
- Are based on the results of a combination of fixed and variable subaccounts, so that a portion of the periodic income payments will be stable and another portion will fluctuate

Figure 10.4 summarizes the major classifications of annuities.

Figure 10.4 Major Classifications of Annuity Contracts

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

Source: Mary C. Bickley, *Principles of Financial Services and Products* [Atlanta: LOMA (Life Office Management Association, Inc.), © 2004], 263. Used with permission; all rights reserved.

Annuity Contract Provisions

Many of the provisions that typically are included in individual life insurance policies also are included in individual annuity contracts. The following provisions generally are included in all types of individual annuity contracts:

- An *entire contract provision*, which states that the entire contract consists of the annuity contract, the application if it is attached to the contract, and any attached riders.
- A *free-look provision* or *free-examination provision*, which gives the contract owner a stated period of time—usually 10 to 30 days—after the contract is delivered in which to examine the policy. During the free-look period, the contract owner has the right to cancel the contract and receive a full refund of the initial premium.
- An *incontestability provision*, which describes the insurer's right to contest the validity of the annuity contract. Generally, the application for an annuity does not contain questions relating to the insurability of the applicant, and the applicant does not make representations on which the insurer bases its decision to issue the annuity. As a result, the incontestability provision in an annuity contract typically states that, once the contract becomes effective, the insurer may not contest the validity of the contract. However, some insurers offer supplemental benefit riders, such as a waiver of premium for disability benefit rider. The applicant for such a rider generally must provide evidence of insurability, and the annuity's incontestability provision in such cases gives the insurer a specified period, usually one or two years, in which to contest the validity of the coverage provided by the rider on the basis of a material misrepresentation in the application. The annuity contract itself remains in force.
- A *misstatement of age or sex provision*, which states that if the annuitant's age or sex was misstated in the application, then the periodic income payments will be those that the premiums paid would have purchased for the correct age or sex.
- Like participating individual life insurance policies, participating individual annuity contracts must include a *dividends provision*, which describes the contract owner's right to share in the insurer's divisible surplus, if any, and the dividend payment options available to the contract owner.

Deferred Annuity Contract Provisions

Deferred annuity contracts generally include a number of provisions that govern the rights of the contract owner during the annuity's accumulation period. For example, the *withdrawal provision* gives the contract owner the right to withdraw all or part of the contract's accumulated value during the accumulation period. Most contracts allow the contract owner to withdraw up to a stated percentage of the annuity's accumulated value each year without charge. If the contract owner withdraws more than that stated percentage in one year, then the insurer generally imposes a *withdrawal charge*. Withdrawals of less than a stated minimum amount typically are not permitted.

Throughout the accumulation period, the contract owner also has the right to surrender the annuity for its *surrender value*—the accumulated value *less* any surrender charges included in the policy. A *surrender charge* is a fee typically imposed if the annuity contract is surrendered within a stated number of years after it was purchased. The amount of any surrender charge that is imposed usually declines over time. An insurer usually imposes a surrender charge during the early years of an annuity contract as a way to recover the costs it incurred in issuing the contract.

Example. Cynthia Quincy owned a fixed deferred annuity contract. The contract imposed a surrender charge of 5 percent of the accumulated value if the annuity was surrendered during the first contract year, 3 percent of the accumulated value if the annuity was surrendered during the second contract year, and 1 percent of the accumulated value if the annuity was surrendered during the third contract year. After the third contract year, the contract owner could surrender the contract without any surrender charge. Cynthia surrendered the contract 18 months after she purchased it. At that time, the contract had an accumulated value of \$100,000.

Analysis. The insurer imposed a 3 percent surrender charge and paid Cynthia the surrender value of \$97,000 ($\$100,000$ [accumulated value] – $\$3,000$ [surrender charge]).

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

Guaranteed Benefits

Some people are reluctant to deposit funds into a variable annuity because they fear losing their money as a result of market fluctuations. Insurers have responded to such concerns by adding enhanced benefits to variable annuity contracts. A variable annuity contract may contain none, some, or all of these features. The most common of these enhanced benefits include:

- The *guaranteed minimum death benefit (GMDB)* is a variable annuity contract feature which guarantees that, if the annuitant dies before periodic income payments begin, the beneficiary will receive at least a stated amount, regardless of the contract's accumulated value at that time. Depending on the terms of the annuity contract, the guaranteed benefit amount may be the total amount of annuity considerations paid, less any withdrawals, or it may be a larger amount.

- The **guaranteed minimum withdrawal benefit (GMWB)** is a variable annuity contract feature which guarantees that up to a certain percentage of the amount paid into the contract will be available for withdrawals annually during the accumulation period, even if subaccount investments perform poorly. Some GMWBs guarantee annual withdrawals for a fixed period, such as 20 years, or until the owner receives the total amount of premiums paid; others guarantee annual withdrawals as long as the contract owner is alive. A GMWB that guarantees withdrawals for the contract owner's lifetime sometimes is referred to as a *guaranteed lifetime withdrawal benefit (GLWB)*.
- The **guaranteed minimum income benefit (GMIB)** is a variable annuity contract feature that guarantees a minimum periodic income payment regardless of the annuity's investment performance if the contract remains in force for a specified period of time—typically 7 to 10 years.
- The **guaranteed minimum accumulation benefit (GMAB)** is a variable annuity contract feature which guarantees that the accumulated value will be at least a minimum amount if the contract remains in force for a specified period of time—typically 7 to 10 years. For some annuities, the guaranteed amount equals the total amount of premiums paid; for other annuities, the insurer guarantees a larger amount.

Because these guarantees increase risk for the insurer, insurers usually charge contract owners extra for these benefits.

Fees and Charges

Insurers can incorporate a variety of fees and charges into annuity contracts to cover their expenses. The types and amounts of these fees and charges depend on the type of annuity. Insurers generally include one or more of the following fees and charges:

- A **front-end sales charge**, which is an amount charged to the contract owner at the time she pays for the annuity. The front-end charge compensates the insurer for sales commissions and other expenses associated with acquiring the business. The charge is expressed as a percentage of the annuity premium.
- A **back-end sales charge**, also known as a *surrender charge*, which is an amount charged to the contract owner when she withdraws money from the product. In variable annuities, a back-end sales charge is known as a *contingent deferred sales charge (CDSC)*. The back-end sales charge/CDSC is expressed as a percentage of the withdrawal and typically decreases over time. Eventually the contract owner can withdraw funds without incurring a charge. Insurers typically do not impose both a front-end charge and a back-end charge on an annuity, as both charges are designed to offset commission costs.
- A **periodic fee**, also known as a *maintenance fee*, which is an amount payable at predetermined intervals—for example, every year or every month. A periodic fee typically compensates the insurer for its administrative expenses. The fee can be either a flat amount or a percentage of the accumulated value.

- A **service fee**, which is a one-time fee charged for specific services. For example, an insurer might impose a service fee of \$20 per additional withdrawal if a contract owner makes more than two withdrawals from the annuity's accumulated value in any calendar year.

Insurers charge the following additional fees on variable annuities:

- A **mortality and expense risk (M&E) charge**, which covers various risks and expenses assumed by the insurer, including the risk involved in providing the annuity death benefit and certain other guarantees. The M&E charge generally is expressed as a percentage of the accumulated value. Insurers generally state charges for guaranteed benefits separately from the M&E charge.
- An **investment management fee**, also known as an *asset management fee*, which covers the costs of managing and operating the investment funds underlying the variable subaccounts. This fee usually is expressed as a percentage of the accumulated value.

Payout Options

When a deferred annuity reaches the payout period, all provisions relating to the policy's accumulated value—including the withdrawal provision and the death benefit provision—become inoperable. At that time, the contract owner decides how the insurer will distribute the accumulated value. In the case of an immediate annuity, the applicant decides when she applies for the annuity how the insurer will distribute the annuity funds.

Every annuity contract includes a **payout options provision** that lists and describes each of the payout options from which the contract owner may select. **Payout options**, also known as *settlement options*, are the choices a contract owner has as to how the insurer will distribute the funds in an annuity during the payout period. The terms of the payout option provision govern the parties' rights and obligations under the contract during the payout period. An annuity in the payout period is commonly called a **payout annuity**.

Lump-Sum Distribution

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

Fixed Period Option

Under the **fixed period option**, the insurer makes annuity payments for a specified period of time. At the end of the specified period, periodic income payments cease. For example, the contract owner might elect to receive monthly income payments for a 10-year period. The fixed period option also guarantees that all of the accumulated value of the annuity will be distributed. If the payee dies before the end of the period certain, the contingent payee becomes entitled to receive the remaining

periodic income payments. An annuity that is payable for a stated period of time, regardless of whether the annuitant lives or dies, is referred to as a *period certain annuity* or an *annuity certain*. The stated period over which the insurer will make periodic income payments is called the *period certain*.

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

Example. Miko Yamata plans to retire at age 60. However, she will not receive pension benefits from her employer-sponsored pension plan until she reaches age 65. Miko purchased a 5-year period certain deferred annuity with a maturity date when she reaches age 60.

Analysis. When Miko reaches age 60, she will begin receiving periodic income payments from her annuity for 5 years. At the end of the 5-year period, periodic income payments will cease, but Miko will begin receiving pension benefits from her employer-sponsored pension plan.

Fixed Amount Option

Under the *fixed amount option*, the insurer provides periodic income payments of at least a specified minimum amount for as long a period as the annuity's accumulated value will provide, regardless of whether the annuitant lives or dies. Once the total accumulated value has been paid out, periodic income payments end and the insurer has no further liability under the annuity contract. For example, the contract owner might elect to receive monthly income payments of \$1,000 for as long a period as the accumulated value will provide. An annuity that guarantees the payment of periodic income payments of a specified minimum dollar amount for as long a period as the annuity's accumulated value will provide, regardless of whether the annuitant lives or dies, is known as a *fixed amount annuity*.

Life Annuity

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

The most basic form of life annuity is the *straight life annuity*, also known as a *single life annuity* or a *life only annuity*, which provides periodic income payments for only as long as the annuitant lives. Upon the death of the annuitant, the insurer has no further liability under the annuity contract. If the annuitant dies shortly after periodic income payments begin, the purchaser of a straight life annuity may have paid a great deal more in premiums than the amount the insurer distributes in periodic income payments. For this reason, many people are unwilling to purchase straight life annuities. Instead, they purchase other forms of life annuities that contain more guarantees than a straight life annuity contains.

A *joint and survivor life annuity*, sometimes referred to as a *joint and survivor annuity*, provides periodic income payments to two or more annuitants, and those payments continue until both or all of the annuitants die. The terms of a joint and

survivor annuity contract determine whether the amount of each periodic income payment remains the same after the death of one of the annuitants or decreases by a stated amount, such as 50 percent, following the death of the first annuitant. A married couple might purchase a joint and survivor annuity to provide income for the remainder of both of their lives.

A **life annuity with period certain** guarantees that the insurer will make periodic income payments throughout the annuitant's life and guarantees that the payments will be made for at least a certain period, even if the annuitant dies before the end of that period. The contract owner selects the guaranteed period, which is often 5 or 10 years, and—assuming the annuitant is the payee—names a contingent payee. If the annuitant dies before the period certain has expired, then the contingent payee becomes entitled to receive the periodic income payments throughout the remainder of the period certain. If the annuitant dies after the expiration of the period certain, periodic income payments cease.

Example. Yvonne Wilkinson purchased a life annuity with a 10-year period certain. She named herself as the annuitant and the payee. She named her husband, Dexter, as contingent payee. Yvonne died 7 years after periodic income payments began.

Analysis. Dexter will receive the periodic income payments throughout the remainder of the 10-year period certain—for 3 years. After the expiration of the 10-year period certain, no more payments will be made. If Yvonne had lived 15 years after periodic income payments began, she would have received payments throughout her life, and Dexter would have received no payments after her death.

The **life with refund annuity**, also known as a *refund annuity*, provides periodic income payments throughout the lifetime of the annuitant and guarantees that at least the purchase price of the annuity will be paid out. This guarantee means that if the annuitant dies before the total of the periodic income payments made equals the purchase price, a refund will be made to a contingent payee whom the contract owner has designated. The amount of the refund is equal to the difference between the purchase price of the annuity and the amount that has been paid out in income payments.

Example. Harry Benedict paid a single premium of \$150,000 for a refund annuity that would provide an income payment of \$10,000 per year during his lifetime. He named his wife, Dorothy, as the contingent payee. Harry died 6 years after income payments began; at the time of his death, he had received periodic income payments totaling \$60,000.

Analysis. Dorothy will be entitled to a refund of \$90,000, which is the difference between the \$150,000 purchase price and the \$60,000 paid in periodic income payments during Harry's lifetime. If Harry had lived for 20 years after periodic payments began, he would have received more in income payments than he paid for the annuity ($20 \text{ years} \times \$10,000 \text{ per year} = \$200,000$). In that case, Dorothy would not have received a refund payment following Harry's death.

Factors Affecting Amount of Periodic Income Payments

An insurer determines the dollar amount of periodic income payments for a fixed annuity at the maturity date.¹ Although the exact method of calculating these payments is beyond the scope of this text, every calculation is based on the following basic mathematical principle:

A sum of money, known as the *principal*, that is invested at a stated *rate of interest* for a certain *period of time* can be paid out in a series of periodic income payments over a stated *period of time*.

This mathematical principle contains four variables:

1. **The amount of the principal invested.** Premiums increase principal. Fees, charges, and withdrawals decrease principal.
2. **The time over which the principal grows at interest.** For annuity contracts, this time period is the accumulation period. The longer the time period, the greater the interest earnings will be.
3. **The interest rate that represents investment earnings.** Fixed annuities earn a minimum guaranteed rate of interest. In many cases, the insurer applies a higher interest rate, depending on the company's investment experience. For variable annuities, the interest rate fluctuates depending on the performance of the annuity's subaccounts. The higher the interest rate, the larger the periodic income payments will be.
4. **The number and timing of periodic income payments.** The frequency of payments and the total length of the payout period determine the number of periodic income payments. For all types of life annuities, the number and timing of periodic income payments also depends on mortality experience. The longer the annuitant is expected to live, all other factors being equal, the more payments the insurer expects to make and the smaller each periodic income payment will be. Similarly, the shorter the time period the annuitant is expected to live, all other factors being equal, the fewer payments the insurer expects to make and the larger each periodic income payment will be.

Figure 10.5 summarizes the relationships among the important factors that affect periodic income payments.

Taxation of Annuities

In some countries, such as the United Kingdom, Switzerland, Chile, and the United States, annuity premiums represent a substantial portion of overall life insurance premium receipts.² Insurers in the United States received \$328 billion in annuity considerations in 2008, which represented more than 51 percent of all life insurance sales premiums.³ In the first six months of 2009, annuity sales in Chile represented 34 percent of overall life insurance sales premiums.⁴

The popularity of annuities in some countries, including the United States, is in part the result of income tax laws that provide certain tax advantages to annuity purchasers. These income tax laws generally take one of two forms.

Figure 10.5 Factors Affecting Periodic Income Payments

In an annuity contract, if—while keeping all other factors unchanged—we increase the following value:

Then the dollar amount of the contract's periodic income payments will:

Principal	Increase
Time (accumulation period)	Increase
Investment earnings or interest rate	Increase
Number of periodic income payments	Decrease

Source: Adapted from Mary C. Bickley, *Principles of Financial Services and Products* [Atlanta: LOMA (Life Office Management Association, Inc.), © 2004], 279. Used with permission; all rights reserved.

- Some countries, such as Switzerland and the United States, allow tax deferral for investment earnings of all annuities. In other words, the investment income the contract owner earns on his premium payments generally is not subject to taxation until the investment income is actually paid out to the named recipient. By contrast, tax laws in many countries, including Canada, do not provide this favorable treatment for annuities. In these countries, investment earnings from an annuity generally are taxable as income throughout the life of the annuity unless the annuity is used to fund a retirement plan that qualifies for special tax treatment.
- Many countries, including Canada and the United States, provide other income tax advantages to certain individuals who deposit funds into specified types of retirement savings plans. These tax advantages are designed to encourage taxpayers to establish savings plans for their retirement.

Individual Retirement Arrangements

Tax laws in the United States allow individuals to establish and contribute to certain retirement plans that provide income tax savings in addition to the tax deferral of investment earnings. A person with earned income may deposit a portion of that income in a retirement savings plan known as an ***individual retirement arrangement (IRA)***, which is a tax-deferred savings arrangement that an individual establishes and that meets certain requirements specified in the U.S. federal tax laws. An IRA may take the form of an annuity. An ***individual retirement annuity*** is an individual deferred annuity that qualifies for favorable federal income tax treatment because it meets the requirements specified in the federal tax laws for individual retirement arrangements.

The financial services industry uses the acronym *IRA* to refer to any form of individual retirement arrangement in general, as well as to an individual retirement annuity and to another form of individual retirement arrangement known as an individual retirement account.⁵ To avoid confusion in terminology, we use the acronym *IRA* where appropriate to refer to both an individual retirement arrangement and an individual retirement annuity.

The tax treatment of an IRA varies depending on whether it is a traditional IRA or a Roth IRA.

- A **traditional IRA**, also known as a *regular IRA*, is an IRA in which contributions may be tax-deductible and investment earnings are tax-deferred until the funds are withdrawn. If an individual meets certain criteria, the amounts that she contributes to a traditional IRA—up to a stated maximum—usually are deductible from her gross income in the year in which those funds were contributed to the IRA. In addition, the investment earnings on a traditional IRA are tax deferred. When the owner of a traditional IRA does withdraw the funds from the IRA during retirement, she will pay federal income tax at that time on the entire amount withdrawn. Presumably, the withdrawal will be taxed at a lower rate than the tax rate she would have paid on that amount during her working years.
- A **Roth IRA** is an IRA in which contributions are not tax-deductible, but qualified withdrawals are tax-free. In other words, contributions are not taxed when they are withdrawn because they were taxed previously. In addition, investment earnings accumulate and are distributed on a tax-free basis (with certain exceptions beyond the scope of this text).

Figure 10.6 compares the income tax treatment of traditional IRAs and Roth IRAs.

Figure 10.6 Comparison of Income Tax Treatment of Traditional IRAs and Roth IRAs

	Traditional IRA	Roth IRA
Contributions deductible from current taxable income?	Yes (up to specified amounts)	No
Withdrawals taxable?	Yes	No (certain exceptions apply)
Annual contribution limits?	Yes	Yes

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

Other countries also allow individuals to establish retirement savings plans that qualify for income tax advantages.

- In Canada, any gainfully employed person may establish a qualified retirement account known as a *registered retirement savings plan (RRSP)*.⁶ Contributions to an RRSP are tax-deductible, subject to a stated maximum amount. The permitted contribution amount varies depending on whether the person is also covered by a registered pension plan, which is a pension plan that receives favorable tax treatment. A person who is not covered by a registered pension plan may deduct a larger contribution amount than can an individual who does participate in a registered pension plan. The investment income earned on the funds in an RRSP is not taxed until the funds are withdrawn. Individuals who establish RRSP accounts must begin withdrawing the accumulated funds by the time they reach age 71.
- In Germany, most individuals with earned income may establish a retirement plan known as a *Riester pension*.⁷ A Riester pension may take the form of an annuity or of a variety of other investment plans. An individual may contribute a percentage of his earned income, subject to a stated maximum amount, to the Riester pension, and the federal government also contributes certain stated amounts to the pension. Individual and government contributions are tax-exempt, and earnings are tax-deferred. Individuals may begin making taxable withdrawals from a Riester pension at age 60.
- In Brazil, certain individuals may establish a retirement plan known as a *PGBL*.⁸ In simple terms, a PGBL is a deferred annuity to which an individual may contribute a percentage of her annual income, up to a stated maximum amount. Contributions are tax-deductible, and earnings are tax-deferred. Periodic income payments are taxable. Individuals also may establish a retirement plan known as a *VGBL*.⁹ In simple terms, a VGBL is a deferred annuity whose tax treatment is similar to that of most annuities in the United States. Contributions are not tax-deductible, but earnings are tax-deferred. An individual with a PGBL may also establish a VGBL, and there is no limit to the annual contribution an individual may make to a VGBL.

Key Terms

annuity	guaranteed minimum income benefit (GMIB)
contract owner	guaranteed minimum accumulation benefit (GMAB)
payee	front-end sales charge
contingent payee	back-end sales charge
annuitant	periodic fee
maturity date	service fee
payout period	mortality and expense risk (M&E) charge
annuity period	investment management fee
immediate annuity	payout options provision
deferred annuity	payout option
accumulation period	payout annuity
accumulated value	lump-sum distribution
single-premium annuity	fixed period option
single-premium immediate annuity (SPIA) contract	period certain annuity
single-premium deferred annuity (SPDA) contract	period certain
flexible-premium annuity	fixed amount option
fixed annuity	fixed amount annuity
equity-indexed annuity (EIA)	straight life annuity
market value adjusted (MVA) annuity	joint and survivor life annuity
variable annuity	life annuity with period certain
fixed subaccount	life with refund annuity
withdrawal provision	individual retirement arrangement (IRA)
withdrawal charge	individual retirement annuity
surrender value	traditional IRA
surrender charge	Roth IRA
death benefit	
guaranteed minimum death benefit (GMDB)	
guaranteed minimum withdrawal benefit (GMWB)	

Endnotes

1. For variable annuities, the amount of periodic income payments may vary according to the performance of the annuity's subaccount investments after the maturity date. The calculation of variable annuity payouts is beyond the scope of this text.
2. Swiss Re Economic Research & Consulting, *Annuities: a private solution to longevity risk, sigma* No. 3/2007, (Zurich: Swiss Re, 2007), http://media.swissre.com/documents/sigma3_2007_en.pdf (3 May 2010).
3. ACLI, *Life Insurers Fact Book 2009* (Washington, DC: American Council of Life Insurers, 2009), 37–38.
4. M. Machua Millett, “Brazil: Latin American Insurance And Reinsurance 2009 In Review: Liberalization, Development And ‘Reform’ In The Face of the Global Economic Downturn,” Mondaq, 12 February 2010, <http://www.mondaq.com/article.asp?articleid=91994> (3 May 2010).
5. An *individual retirement account* is a trust account established with an organization such as a bank, investment company, stock brokerage, or similar organization for the exclusive benefit of an individual and her beneficiaries. An individual retirement account must meet certain requirements specified in federal income tax laws in order to qualify for favorable income tax treatment. A detailed discussion of individual retirement accounts is beyond the scope of this text.
6. In Canada, any individual over age 18 may also establish a tax-advantaged savings plan known as a *tax-free savings account (TFSA)*. Contributions to a TFSA are limited to a stated maximum annual amount. Contributions are not tax-deductible, but earnings and withdrawals are tax-free. Individuals may make withdrawals from a TFSA in any amount and at any age.
7. Self-employed individuals may establish a similar type of retirement plan known as a *Rurup pension*.
8. PGBL is an acronym for *Plano Gerador de Beneficio Livre* (Free Benefit Generator Plan).
9. VGBL is an acronym for *Vida Gerador de Beneficio Livre* (Living Free Benefit Generator).



Chapter 11

Principles of Group Insurance

Objectives:

After studying this chapter, you should be able to

- Identify the parties to a group insurance contract, and distinguish between contributory and noncontributory group insurance plans
- Describe the operation of the probationary period and the actively-at-work requirement
- Compare group underwriting with individual underwriting, and identify the risk characteristics that group underwriters consider
- Identify the common types of insurable groups
- Describe the purpose and operation of benefit schedules in group life insurance policies
- Explain the method insurers use to calculate group insurance premiums
- Define self-administered group plans and insurer-administered group plans

Outline

Group Insurance Contracts

- Formation of the Contract
- Certificates of Insurance
- Eligibility Provisions

Group Insurance Underwriting

- Reason for the Group's Existence
- Size of the Group
- Flow of New Members into the Group
- Stability of the Group
- Participation Levels
- Determination of Benefit Levels
- Nature of the Business

Group Insurance Premiums

- Premium Amounts
- Premium Refunds

Group Plan Administration

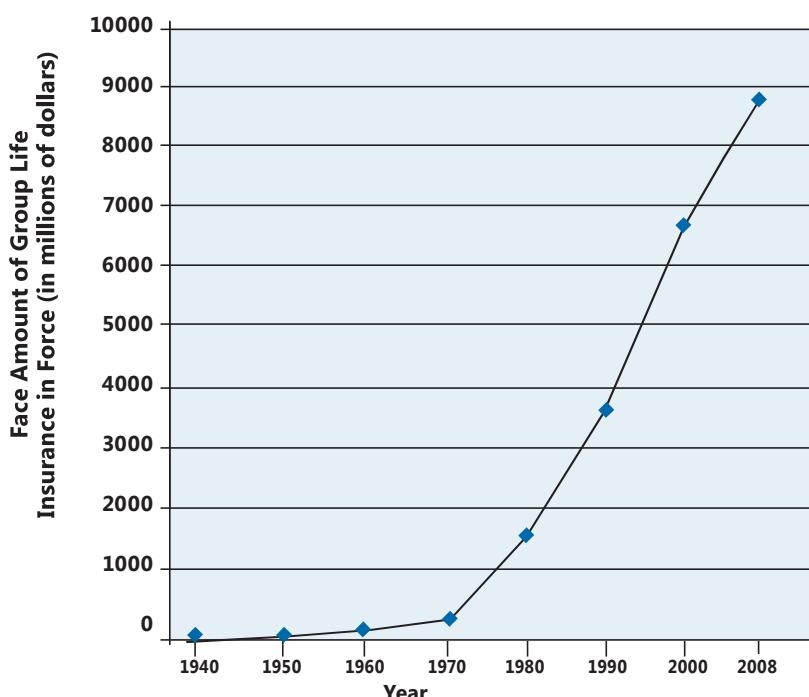
In previous chapters, we focused on individual life insurance. In this chapter, we turn our attention to group insurance. **Group insurance** is a method of providing life or health insurance coverage for a group of people under one insurance contract. In several parts of the world, group insurance represents a substantial portion of the overall life insurance market. For example, in the 21st century, Brazilian insurers have sold approximately nine times as much group life insurance, by premium volume, as individual life insurance. In Mexico, group life insurance sales, by premium volume, represent approximately 20 percent of the total annual sales for all types of insurance, including property/casualty insurance.¹ In China, group life insurance sales, by premium volume, represent approximately 20 percent of total life insurance sales.² Figure 11.1 illustrates the growth of group life insurance coverage in the United States.

Group Insurance Contracts

Although individual insurance and group insurance are similar in many ways, these insurance products also differ in many ways. For example, an individual insurance policy typically insures one person or one family. On the other hand, a group insurance plan insures a number of people, such as a group of employees, under a single insurance contract, called a **master group insurance contract**.

The parties to a master group insurance contract are the insurance company and the *group policyholder*, which is the entity or organization that decides what types of group insurance coverage to purchase for the group members, negotiates the terms of the group insurance contract with the insurer, and purchases the group insurance coverage. The term *policyholder* is used rather than the term *policyowner* because the group policyholder does not have the same ownership rights in the group insurance policy that a policyowner has in an individual insurance policy. Instead, some of these rights are granted to the insured group members. For example, each group member insured under a group life insurance policy generally has the right to name the beneficiary who will receive the benefit payable upon that group member's death.³ By contrast, an individual life insurance policy gives that right to the policyowner.

Figure 11.1. Group Life Insurance in Force in the United States



Source: ACLI, *Life Insurers Fact Book 2009* (Washington, DC: American Council of Life Insurers, 2004), 73. Used with permission.

In the United States, the individuals covered by a group insurance policy are referred to as the **group insureds**, and we use that term in this text. Terminology varies from country to country. In Canada, for example, an individual insured under a group life insurance policy is referred to as a *group life insured*; an individual insured under a group health insurance policy is known as a *group person insured*.

Many businesses purchase group life and health insurance for their employees as an employee benefit. Although insurers issue group insurance policies covering other types of groups, which we will discuss, most group insurance policies insure a group of employees. For that reason, this text concentrates on employer-employee group insurance policies. We sometimes refer to the group policyholder as the *employer* and to the group insureds as the *employees*.

The group policyholder usually is responsible for handling some of the administrative aspects of the group insurance plan. For example, the group policyholder typically handles the enrollment of new group members into the plan. The group policyholder also is responsible for making all premium payments to the insurer, although the insured group members may be required to contribute some or all of the premium amount. If insured group members are not required to pay any part of the group insurance premium, the group plan is a **noncontributory plan**. If insured group members must pay part or all of the premium for their coverage, the group insurance plan is a **contributory plan**. A contributory plan usually requires covered employees to pay their portion of the premium through payroll deductions.

Formation of the Contract

As we described in Chapter 3, an insurance contract is an informal contract that must be formed in accordance with the rules of contract law. Thus, to form a valid group insurance contract, the group policyholder and the insurer must

- Mutually agree to the contract's terms
- Both have contractual capacity
- Exchange legally adequate consideration
- Form the contract for a lawful purpose

The parties to a group insurance contract meet the first three of these requirements in much the same manner as do the parties to an individual insurance contract. However, the last requirement—the lawful purpose requirement—is met somewhat differently.

For individual life insurance policies, the lawful purpose requirement is met by the presence of insurable interest. The insurable interest requirement prevents the insurance contract from being used as a means of wagering. A group insurance contract does not induce wagering because the group insureds or the beneficiaries—not the group policyholder—usually receive the insurance benefits. For that reason, insurance laws typically exclude group life and health insurance contracts from the insurable interest requirement. The lawful purpose requirement is met for a group insurance contract because the policyholder enters into the contract to provide a benefit to covered group members.

Certificates of Insurance

The group insureds are not parties to a master group insurance contract, do not participate in the formation of the contract, and do not receive individual copies of the contract. However, as we discussed, insured group members have certain rights under the contract. Insurance laws typically require the insurer to provide the group policyholder with written descriptions of the group insurance plan; the group policyholder then delivers a written description to each group insured. This document, known as the *certificate of insurance*, describes (1) the coverage that the group insurance contract provides and (2) the group insured's rights under the contract. As a result, an insured group member often is referred to as a *certificate holder*. Many policyholders describe the group insurance coverage in a special benefit booklet. In such cases, the benefit booklet contains the information that would be included in a certificate, and the benefit booklet serves as the group insurance certificate.

Example. Sturdy Manufacturing Company purchased from Constellation Life Insurance Company a group life insurance policy covering its employees.

Analysis. Sturdy and Constellation are the parties to the *master group insurance contract*. Sturdy is the *group policyholder*. Sturdy's employees who are covered under the policy are the *group insureds*. Each group insured receives a *certificate of insurance* describing the coverage provided under the group insurance contract and his rights under the contract.

Eligibility Provisions

When an insurance company and a group policyholder enter into a master group insurance contract, the insurer issues a policy that contains the terms of the contractual agreement. An important term found in every group insurance policy is a description of the individuals who are covered by the policy.

A group policy often defines the individuals who are eligible for coverage as those employees in a specified class or classes. These classes typically are defined by requirements that are related to conditions of employment, such as salary, occupation, or length of employment. For example, many group insurance policies state that all full-time employees are eligible for coverage; thus, at those companies, part-time workers are excluded from the class of eligible employees.

Many group insurance policies also impose requirements that new group members must meet to be eligible for coverage. The most common of these eligibility provisions are the actively-at-work provision and the probationary period.

An **actively-at-work provision** states that, in order to be eligible for coverage, an employee must be actively at work—rather than ill or on leave—on the day the insurance coverage is to take effect. If the employee is not actively at work on the day the coverage is to take effect, then the employee is not covered by the group insurance policy until he returns to work. For example, under an actively-at-work provision, if an employee who otherwise would become eligible for coverage on March 1 is absent due to illness on that date, coverage does not begin until the day the employee returns to work.

A **probationary period** is the length of time—typically, from one to six months—that a new group member must wait before becoming eligible to enroll in the group insurance plan. A probationary period requirement can reduce a plan's administrative costs by avoiding the cost of enrolling new employees who work for only a short period before terminating their employment. Under a noncontributory group insurance plan, a new employee who has met all other eligibility requirements is automatically covered at the end of the probationary period. By contrast, if the plan is contributory, then an eligibility period typically follows the probationary period.

An **eligibility period**, also called an *enrollment period*, is a specified period of time, usually 31 days, during which a new group member may first enroll for group insurance coverage. As part of the enrollment process, the employee must sign a written authorization allowing the employer to make payroll deductions from her salary to cover the amount of her premium contributions. Coverage under a contributory group insurance plan will not become effective until the employee completes such an authorization.

Example. John Talbot and Enrique Ramirez both began work on September 1. John and Enrique are both eligible for coverage under group life insurance policies that their employers provide. Both policies have a 30-day probationary period. John's employer has a noncontributory plan, and Enrique's employer has a contributory plan.

Analysis. Both John and Enrique became eligible for life insurance coverage on October 1, the first day following the end of their probationary periods. John's coverage under a noncontributory plan was automatically effective on that date. Because Enrique's plan was contributory, his group coverage will become effective when he enrolls and signs the payroll deduction authorization form during the eligibility period.

An employee who declines group insurance coverage under a contributory plan when she first becomes eligible for coverage or who drops out of the plan ordinarily must submit satisfactory evidence of insurability before she is allowed to join the plan at a later date. However, many contributory group insurance plans feature an ***open enrollment period***, which is a period of time—typically a specified 30 or 31 days per year—during which eligible people who did not join the group insurance plan at the first opportunity subsequently may join the plan without providing evidence of insurability.

Some group insurance policies provide coverage both for eligible group members and the dependents of covered group members. Group insureds who are covered as dependents typically do not have the same rights as do members of the insured group, such as the employees who are covered by an employer-employee group policy. For example, a covered dependent typically does not have the right to name the beneficiary of his group life insurance coverage. Instead, the beneficiary of any dependent group life coverage usually is either (1) the insured group member himself or (2) a beneficiary selected by the insured group member. Further, if dependent coverage is optional, then the insured group members—not their dependents—have the right to elect or reject that coverage. Because of such differences in the rights of group insureds, we use the term *insured group members* to refer to the individuals who are covered as members of the insured group to distinguish those insureds from individuals who are covered as dependents.

Group Insurance Underwriting

Individual and group insurance policies both require underwriting to determine whether the proposed insured or group presents an acceptable degree of risk for the insurer. However, individual life and health insurance underwriting requires that the proposed *individual* insured meet the insurer's underwriting requirements. By contrast, group insurance underwriting generally focuses on the characteristics of the *group* and, with the exception of very small groups, usually does not require each proposed group insured to provide individual evidence of insurability. Each insurance company establishes its own underwriting guidelines that define the types of groups it will insure.

In general, group insurance underwriting has the following objectives:

- To determine whether the proposed group is an acceptable risk
- To prevent antiselection
- To keep administrative costs involved in providing the insurance coverage as low as possible
- To determine the appropriate premium rates to charge for the group insurance

Group underwriters consider a number of specific characteristics of a group when evaluating whether that group is an acceptable risk. These risk characteristics include the reason for the group's existence, the size of the group, the flow of new members into the group, the stability of the group, the required percentage of eligible group members who must participate in the plan, the way in which benefit levels will be determined, and the activities of the group. In any given situation, however, the group underwriter may need to consider a variety of other characteristics of the group.

Reason for the Group's Existence

Group underwriting guidelines usually require that, for a group to be eligible for insurance coverage, the group must have been formed for a reason other than obtaining insurance. Antiselection would be likely in a group formed solely for the purpose of obtaining group insurance. People who believe they are uninsurable individually would be more likely to join such a group than would individuals who believe they can qualify for individual insurance. In general, groups that are eligible for coverage can be placed into one of the following categories:

- A **single-employer group** consists of the employees of a single employer. Most group insurance policies insure the employees of a single employer.
- A **labor union group** consists of workers who are members of a *labor union*, which is an association that promotes the welfare, interests, and rights of its members.
- A **multiple-employer group** consists of the employees of (1) two or more employers in the same industry, (2) two or more labor unions, or (3) one or more employers *and* one or more labor unions.
- An **association group** consists of individuals who share a common bond. For example, group members may work in a specific industry or may share a common characteristic, such as individuals who are alumni of a specific college. An association group is eligible for group insurance only if it was formed for a purpose other than obtaining group insurance. Figure 11.2 describes some of the types of association groups that are eligible for group insurance coverage.
- A **debtor-creditor group** consists of persons who have borrowed funds from a lending institution, such as a bank.
- A **credit union group** consists of the members of one or more *credit unions*, which are cooperative associations that pool the savings of their members and use those funds to make loans to members.
- A **discretionary group** consists of the members of any other type of group that qualifies for group insurance coverage according to applicable insurance laws.

Underwriting guidelines vary somewhat for each of the preceding types of groups. For example, group underwriting guidelines typically require the employer in an employer-employee group insurance plan to pay at least a portion of the group insurance premium. This requirement, which is imposed by law in many jurisdictions, gives the employer a financial interest in the operation of the plan. By contrast, other group policyholders usually are not required to pay a portion of the group insurance premium.

Some underwriting guidelines are more stringent for some types of groups than others. For example, antiselection by individual group members is much more likely to occur in association groups in which group membership is voluntary than in employer-employee groups. As a result, insurance companies often impose more stringent underwriting requirements on association groups than on employer-employee groups. An insurer might be willing to issue an employer-employee group insurance policy to a group with as few as 10 members, but it might refuse to issue an association group policy covering fewer than 50 association members.

Figure 11.2 Types of Association Groups

Trade association. An association of firms that operate in a specific industry.

Professional association. An association of individuals who share a common occupation, such as an association of medical doctors, attorneys, or engineers.

Public employee association. An association of individuals employed by a governmental entity.

Common interest association. An association of individuals who share a common bond, background, or interest. Examples include associations of retired persons, participants in a specific sport, or alumni of a specific college. Sometimes referred to as an *affinity group*.



Size of the Group

One of the group underwriter's goals is to predict the loss rate that the group will experience. The size of the group has a strong impact on the underwriter's ability to predict the group's probable loss rate. In general, the larger the group, the more likely that the group will experience a loss rate that approximates the predicted loss rate.

The underwriting process varies depending on the size of the group. For very small groups, such as groups with fewer than 15 members, group underwriting guidelines often require each individual member of the group to submit satisfactory evidence of insurability.⁴ When calculating the anticipated loss rate of a slightly larger group, such as a group with between 15 and 50 members, the underwriter often pools several groups that are of the same approximate size and are in the same business sector. By considering the expected experience of several small groups, the underwriter can expect the experience of those small groups taken as a whole to approximate the experience of a single large group.

Most insurers establish minimum size requirements for groups they are willing to insure. Minimum group sizes typically range from 3 to 50, depending on the insurer. Insurers do not offer insurance to groups with fewer than the required minimum number of members.

Flow of New Members into the Group

Another important group underwriting requirement is that a sufficient number of new members enter the group periodically. Ideally, underwriters seek a steady flow of young, new members to replace those members who leave the group. A steady flow of new members into the group means that both the group's size and

its age distribution remain stable. If a group did not add young, new members for a number of years, then the increasing age of the group's original members would adversely affect the group's age distribution, and the group's loss rate and premium rate would increase as a result. But if young, new members are continually joining the group, the age distribution of the group should remain more stable, as should the expected loss rate.

Stability of the Group

Despite the generally favorable results of changes in group membership, the insurance company also must be able to expect that the group will remain a group for a reasonable length of time and that its composition will remain relatively stable. Otherwise, the costs of administering the plan, such as the costs of enrolling new members in the plan, would become prohibitively high. Therefore, underwriters avoid issuing coverage to groups that anticipate excessive changes in group membership. For example, a group of seasonal or temporary workers generally would not be considered an insurable group.

Participation Levels

Group insurance underwriting requirements set limits as to the minimum percentages of eligible group members that a group insurance plan must cover. Note that these requirements relate to participation by *eligible group members*. Minimum participation requirements minimize antiselection. Employees who believe themselves to be in good health are less likely than other employees to choose to participate in group insurance plans. Without minimum participation requirements, an insurance company could not rely on the group underwriting process because an unusually large percentage of group members might be individuals who were uninsurable on an individual basis.

Minimum participation requirements vary depending on whether the group insurance plan is a noncontributory plan or a contributory plan. Typically, a noncontributory plan requires 100 percent participation of all eligible employees; to do otherwise would be discriminatory. Because participation in a contributory plan is voluntary, however, some employees may decide not to enroll in the plan. Most insurers require that at least 75 percent of the eligible employees in a contributory group insurance plan participate in the plan.⁵ A higher percentage of employees may participate in the plan, but a participation level lower than 75 percent would cause the group to lose its eligibility for coverage.

Determination of Benefit Levels

The group policyholder typically works with the insurer to establish a fair and nondiscriminatory method to determine the benefit levels—that is, the types and amounts of coverage offered to the group insureds. Group life insurance policies typically include a schedule, known as a *benefit schedule*, that defines the amount of life insurance the policy provides for each insured. Including benefit amounts in the master group contract prevents group insureds from selecting their own coverage amounts and, thus, helps prevent antiselection. Otherwise, those group members who are in poor health and unable to secure individual insurance would probably select larger benefit amounts than healthy members would select.

Some group life insurance plans offer the same benefit amount to all group members. A more common method is to vary the benefit amount according to specific objective criteria, such as salary, job classification, or length of employment. For example, a benefit schedule might provide life insurance coverage to all eligible employees in an amount equal to one year's salary. In another benefit schedule, the amount of life insurance coverage might vary depending on whether the employee is a senior executive, a manager, or a nonmanagement employee. Figure 11.3 provides some illustrations of the types of benefit schedules that might be included in group life insurance policies.

Some group life insurance policies allow covered group members to purchase additional coverages—under certain conditions—from a schedule of optional coverages. For example, a covered employee might receive group life insurance coverage in an amount equal to one year's salary and also have the option to purchase additional coverage in the same amount. To avoid antiselection in such situations, the group insurer may (1) limit the optional coverages that the group plan can offer or (2) require the insured group member to provide satisfactory evidence of insurability if the optional coverage selected exceeds a certain amount.

Figure 11.3 Examples of Group Life Insurance Policy Benefit Schedules

Benefit Schedule Based on Standard Amount	
Salary	Amount of Life Insurance
Any	\$50,000 per group insured
Benefit Schedule Based on Annual Salary	
Salary	Amount of Life Insurance
Less than \$50,000	1 × salary
\$50,000 to \$100,000	2 × salary
Over \$100,000	3 × salary
Benefit Schedule Based on Length of Employment	
Length of Employment	Amount of Life Insurance
Less than 5 years	1 × annual salary
5 years to 10 years	2 × annual salary
Over 10 years	3 × annual salary
Benefit Schedule Based on Job Classification	
Job Classification	Amount of Life Insurance
Nonmanagement personnel	\$30,000
Supervisors	\$50,000
Managers	\$100,000
Officers	\$250,000

If a group life insurance policy provides coverage for dependents, then the policy includes a separate benefit schedule that defines the amount of coverage provided for each covered dependent. Such a benefit schedule may specify a flat amount of coverage for all covered dependents, or the benefit schedule may specify one amount for the group member's spouse and a lower amount of coverage for each covered dependent child. Insurance company requirements and the laws of some jurisdictions require that the amount of coverage provided on the dependents of an insured group member be less than the amount provided for the group member.

Nature of the Business

The type of work that group members perform affects the degree of risk a group presents to an insurer. For example, a group of coal miners has a higher probability of being injured or killed on the job than a group of office workers. To develop appropriate group insurance underwriting guidelines, insurers use claim experience data concerning the likelihood of people in certain jobs to incur covered losses.

If the insurer determines that, due to the nature of its group members' work, a group can be expected to have a higher-than-average loss rate among its members, the insurer charges the group more than the standard premium. Some insurers increase their standard premium rate by a certain percentage to account for the greater risk that a group in a particular occupation presents. Other insurers charge a flat extra premium for certain types of coverage for groups that work in hazardous occupations, such as logging. If a group's occupation is extremely dangerous, some insurance companies decline the group for coverage. For example, many insurers would decline to issue group life insurance coverage to a group consisting solely of race car drivers.

Group Insurance Premiums

Insurance companies typically establish group insurance premium rates on a case-by-case basis. The insurer evaluates each group and establishes a premium rate that is adequate to pay the group's claims and will be equitable to the policyholder. To establish premium rates that meet these criteria, the insurer must determine what costs it will incur (1) in providing the benefits promised by the group insurance policy and (2) in administering the group insurance plan.

Unlike individual insurance level-premium rates, the premium rate for a group insurance policy usually is recalculated every year that the policy remains in force. The insurer generally guarantees the group's premium rate for only one year. However, some group life insurance policies guarantee rates for a longer period of time, such as two or three years. An insurer that is allowed to change a group's premium rate may do so at the beginning of a policy year or on any premium due date. The insurer may not, however, change the premium rate more than once in any 12-month period.

Insurance companies generally use one of three methods to calculate the premium rate to charge for group coverage.

- **Manual rating** is a method of establishing group insurance premium rates that are based on the experience of a broad class of groups rather than on a particular group's claims and expense experience. The insurer uses its own past experience and also may use information from industry or governmental associations to estimate the group's expected claims and expense experience. Insurance companies typically use manual rating to set the initial premium rates to charge groups that have not been previously insured and to set both initial and renewal premium rates for small groups. In both cases, the groups have no reliable claims experience that the insurer can use to set the premium rate. The claims experience of a small group generally is unreliable because the group is not large enough for the insurer to determine whether the group's prior experience is a result of chance or actually reflects the group's average experience.
- **Experience rating** is a method of setting group insurance premium rates under which the insurer considers the particular group's prior claims and expense experience. Insurance companies typically use experience rating to set renewal premium rates for large groups. In many cases insurers also use experience rating to set the initial premium rate to charge a large group that is currently insured by another insurance company. In such a case, the insurer is able to obtain information about the group's prior experience.
- **Blended rating** is a method of setting group insurance premium rates under which the insurer uses a combination of manual rating and experience rating. Insurers typically use blended rating for groups that are too small for an insurer to rely fully on experience rating, yet large enough for the insurer to consider their claims and expense experience to be significant. The larger the group is, the more the insurer relies on the group's own experience and the less the insurer relies on manual rating.

Setting a group's premium rate often is a complicated process. In addition to determining whether or to what extent a group's own experience can be used, an insurer also must consider a number of other factors when setting premium rates. For example, the insurer must consider the specific benefits provided by a particular group plan. In addition, the amount of administrative expense an insurer incurs in connection with group insurance coverage varies widely from one group to another and depends, to a great extent, on how much of the plan's administration the group policyholder will handle. We discuss group insurance administration later in this chapter.

Premium Amounts

Group insurance premiums typically are payable monthly. The insurer establishes the premium rate for a group insurance policy at the beginning of each policy year. That premium rate usually is calculated on the basis of a stated benefit unit. For example, the premium rate for group life insurance usually is stated as a rate per \$1,000 of death benefit provided by the policy.

Although the *premium rate* for a group insurance policy generally is guaranteed for one year, the *premium amount* payable each month varies, depending on the amount of insurance in force that month. A group life insurance policy, for example, requires a monthly premium amount that is equal to the premium rate per \$1,000 of coverage multiplied by the number of benefit units (\$1,000 of coverage) in force that month. If additional employees become eligible for coverage during the policy year, the number of benefit units in force increases, and the premium amount the employer pays to the insurer each month increases. The premium rate per \$1,000 of coverage, though, does not change during the year.

Example. The Hastings Company provides \$50,000 of noncontributory group life insurance coverage for each of its full-time employees. The current monthly premium rate for this coverage is \$0.40 per \$1,000 of coverage. In January, Hastings had 10 full-time employees. In March, Hastings hired 2 new full-time employees, who became eligible for group life insurance coverage in April.

Analysis. In January, February, and March, Hastings provided \$50,000 of group life insurance coverage to 10 employees. Thus, the premium amount payable in each of those three months was \$200, calculated as

$$\begin{array}{r} \$50,000 \text{ Coverage per employee} \\ \times 10 \text{ Number of employees} \\ \hline \$500,000 \text{ Total group coverage} \\ \\ \$ 0.40 \text{ Monthly premium rate} \\ \times 500 \text{ Number of coverage units } (\$500,000 \div \$1,000) \\ \hline \$200 \text{ Monthly premium amount payable} \end{array}$$

In April, Hastings provided \$50,000 of group life insurance coverage to 12 employees. Thus, the premium amount payable in April was \$240.

$$\begin{array}{r} \$50,000 \text{ Coverage per employee} \\ \times 12 \text{ Number of employees} \\ \hline \$600,000 \text{ Total group coverage} \\ \\ \$ 0.40 \text{ Monthly premium rate} \\ \times 600 \text{ Number of coverage units } (\$600,000 \div \$1,000) \\ \hline \$240 \text{ Monthly premium amount payable} \end{array}$$

Premium Refunds

At the end of each policy year, a portion of the group insurance premiums paid during the year may be refunded to the group policyholder. Group insurance premium refunds are similar to the policy dividends provided for individual participating life insurance policies. These refunds usually are called *dividends* by those companies that also issue individual participating policies. Companies that do not issue participating policies generally call premium refunds for group insurance *experience refunds*.

The insurer determines the amount of a premium refund by evaluating the group's claim experience and expense experience during the policy year. If the group incurred fewer claims or if the insurer incurred lower administrative expenses than anticipated when the prior year's premium rate was established, then the insurer may refund a portion of the premium paid for the coverage.

All premium refunds are payable to the group policyholder, even if the plan is contributory. If the amount of the refund to the policyholder of a contributory plan is greater than the portion of the group premium that was paid out of the policyholder's funds, then the excess amount must be used for the benefit of the individual participants in the plan. For example, when an employer receives a premium refund that is larger than the amount the employer paid out of its own funds, the employer may apply the excess refund to pay a portion of the employees' contributions during the next policy year or to pay for additional benefits for covered employees.

Group Plan Administration

Group insurance enables a number of people to be insured at a cost that is relatively low compared to the cost of individual insurance. Insurers are able to provide relatively low-cost group coverage because of the expense savings inherent in the operation of group insurance policies. These savings result from the fact that the expenses an insurer incurs in administering a group insurance policy are lower than those incurred in administering a number of individual insurance policies. For example, the underwriting costs are generally lower for group insurance because the insurer usually underwrites the group as a whole rather than each individual member. Policy issue costs are lower because the insurer issues a master policy rather than many individual policies. In addition, the sales costs are much lower for one group policy than for a number of individual policies.

Group policyholders can reduce an insurer's administrative expenses further—and reduce their premium rates as a result—by performing much of the necessary administrative work themselves. The administration of a group insurance policy is primarily a matter of recordkeeping. For example, some of the necessary records for a group life insurance plan include the name and address of each group insured, the amount of coverage for each group insured, and the name of each beneficiary. Many group policyholders maintain these records and provide all needed reports to the insurer. A ***self-administered group plan*** is a group insurance plan for which the group policyholder is responsible for handling the administrative and recordkeeping aspects of the plan. Alternatively, an ***insurer-administered group plan*** is a group insurance plan for which the insurer is responsible for handling the administrative and recordkeeping aspects of the plan.

Key Terms

group insurance	eligibility period
master group insurance contract	open enrollment period
group insured	benefit schedule
noncontributory plan	manual rating
contributory plan	experience rating
certificate of insurance	blended rating
certificate holder	self-administered group plan
actively-at-work provision	insurer-administered group plan
probationary period	

Endnotes

1. Benfield Group Limited, *Latin America Insurance Market Review: Focus on Brazil and Mexico*, February 2007 (London: Benfield Group, 2007), 17–18, <http://www.benfieldgroup.com/SiteCollection-Documents/Benfield/Research%20and%20Publications/LAMarketReview2007.pdf> (5 May 2010).
2. Benfield Group Limited, *China Insurance Market Review: Major Changes, Rapid Growth*, September 2006 (London: Benfield Group, 2006), 36, <http://www.benfieldgroup.com/SiteCollectionDocuments/Benfield/Research%20and%20Publications/ChinaInsuranceMarketReview.pdf> (5 May 2010).
3. The same rules and restrictions that apply to individual life insurance beneficiary designations also apply to group life insurance beneficiary designations. In addition, a group insured may *not* name the group policyholder as beneficiary unless the group life insurance plan is a group creditor life plan (which we discuss later).
4. Group life insurance underwriting requirements may vary according to the amount of coverage on an individual. For example, some insurers may require evidence of insurability from group insureds with coverage in excess of a certain amount. In addition, in the United States, various state and federal laws limit the ability of insurers to require evidence of insurability for health insurance under certain circumstances.
5. In determining minimum participation percentages, insurers typically do not consider employees who decline coverage because they have other coverage available to them, such as through another employer or a spouse's employer.

Chapter
12

Group Life Insurance and Group Retirement Plans

Objectives:

After studying this chapter, you should be able to

- Identify and describe typical provisions contained in a group life insurance policy and compare these provisions with similar provisions contained in individual life insurance policies
- Identify the features of group term life insurance plans, group accidental death and dismemberment plans, group cash value insurance plans, and group creditor life insurance plans
- Explain the tax benefits generally provided to group retirement plans that meet applicable government requirements
- Identify the components of a group retirement plan and describe the types of provisions that a plan document contains
- Identify and describe four general types of employer-sponsored retirement plans

Outline

Group Life Insurance

- Group Life Insurance Policy Provisions
- Group Life Insurance Plans

Group Retirement Plans

- Components of a Retirement Plan
- Types of Retirement Plans
- Government-Sponsored Retirement Plans

Many of the insurance products we have discussed in this text are issued as group insurance policies as well as individual insurance policies. In this chapter, we discuss group life insurance and group retirement plans.

Group Life Insurance

We begin our discussion of group life insurance by describing some of the provisions that group life insurance policies typically include. Then we describe various types of group life insurance policies.

Group Life Insurance Policy Provisions

Group life insurance policies usually include a number of standard provisions, many of which are similar to provisions found in individual life insurance policies. In Chapter 11, we described typical provisions relating to eligibility for group insurance coverage. In this chapter, we describe some other provisions typically found in group life insurance policies.

Grace Period Provision

Group life insurance policies typically contain a 30- or 31-day grace period provision. As in the case of an individual insurance policy, the insurance coverage provided by a group insurance policy remains in force during the grace period. If the group policyholder does not pay the premium by the end of this period, the group policy terminates. Unlike the grace period provision in an individual insurance policy, the grace period provision in a group insurance policy specifies that if the policy terminates for nonpayment of premiums, then the group policyholder is legally obligated to pay the premium for the coverage provided during the grace period.

Incontestability Provision

Group life insurance policies include an incontestability provision that limits the period during which the insurance company may use statements in the group insurance application to contest the validity of the master group insurance contract. Generally, the incontestability provision in a group life insurance policy limits the period during which the insurer may contest the contract to two years from the date of issue. Material misrepresentation occurs much less frequently in group insurance applications than in individual insurance applications. As a result, insurance companies rarely contest the validity of group insurance contracts.

The contestability provision also allows an insurer to contest an individual group member's coverage without contesting the validity of the group insurance contract. Individuals insured under a group life insurance policy usually are not required to provide evidence of insurability to be eligible for group coverage. Sometimes, however, group insureds are required to provide such evidence. If a group insured makes material misrepresentations about his insurability in a written application, then the insurance company can contest the individual group member's coverage on the grounds of material misrepresentation without contesting the validity of the master group contract itself. The contestability provision of a group life insurance policy typically states that the insurer cannot contest the insurance coverage of any group insured after the coverage has been in effect for a period of one or two years during the lifetime of the insured.

Example. Janice Minter was required to fill out a medical questionnaire to be eligible for group life insurance coverage. In completing the questionnaire, Janice made material misrepresentations about her health. Janice died six months after her coverage became effective. While investigating the claim, the insurance company discovered Janice's material misrepresentations. The group policy contained a two-year contestable period.

Analysis. Janice died while her group insurance coverage was contestable. Thus, the insurer had the right to contest the validity of Janice's coverage on the basis of the material misrepresentations in her medical questionnaire. Janice's material misrepresentations did not affect the validity of the master group contract.

Beneficiary Designation

Under the terms of a group life insurance policy—*unless* it is a group creditor life policy—each insured group member has the right to name a beneficiary who will receive the insurance benefit that is payable when that group insured dies. (We describe group creditor life policies later in the chapter.) The insured group member also has the right to change the beneficiary designation.

If the policy provides for dependent coverage, then the insured group member also has the right to designate the beneficiary of such coverage; alternatively, the group policy may specify that the insured group member is automatically designated as the beneficiary of any coverage provided on the group member's dependents.

Example. David Hewitt works for Trident Enterprises, which purchased a group life insurance policy to insure its employees and their dependents. The group policy provides \$100,000 of life insurance coverage on David and \$25,000 of life insurance coverage on both David's wife and his son.

Analysis. According to the requirements of most insurance companies, David has the right to name the beneficiary who is entitled to receive any group life insurance benefits following his own death. In addition, depending on the terms of the group policy, either David is the named beneficiary who is entitled to receive any benefits payable following the death of his wife or son, or David has the right to name someone else as the beneficiary entitled to receive those benefits.

The beneficiary designation rules and restrictions that apply to individual life insurance beneficiary designations also apply to group life insurance beneficiary designations. In addition, the insured group member may *not* name the group policyholder as beneficiary *unless* the plan is a group creditor life plan.

Portability Provision

Many group life insurance policies contain a ***portability provision***, which allows a group insured whose coverage terminates for certain reasons to continue her coverage under the group plan, typically without presenting evidence of insurability. Group insurance coverage that can be continued if an insured employee leaves the group is known as ***portable coverage***. Continued coverage usually is term insurance coverage.

To continue coverage under the portability provision, a group insured generally must complete an application and pay the initial premium within a stated time—usually 31 days or less—after her group eligibility terminates. For example, a group insured's eligibility for group coverage terminates when the insured terminates her employment. The maximum amount of continued coverage available under the portability provision may be less than the amount of coverage the group insured had under the group plan. The premium rate for continued coverage is based on the insured's attained age when continued coverage begins.

Some group life insurance policies include a ***conversion privilege***, which allows a group insured whose coverage terminates for certain reasons to convert her group life insurance coverage to an individual life insurance policy, usually without presenting evidence of her insurability. The group insured usually can purchase any type of individual life insurance policy that the insurer is then issuing, but the amount of coverage the group insured can purchase is limited. The premium rate for converted coverage typically is higher than for an equivalent amount of continued coverage. Some group insurance policies contain both a portability provision and a conversion privilege, but the eligibility requirements and amounts of coverage available may vary depending on the type of coverage.

Misstatement of Age

The misstatement of age or sex provision included in individual life insurance policies specifies that the insurer will adjust the amount of the death benefit payable to reflect a misstatement of the insured's age or sex. By contrast, the amount of the benefit payable following a group insured's death is specified in the group life insurance policy's benefit schedule. As a result, the misstatement of age provision in most group life insurance policies specifies that, if the amount of the premium required for the plan is incorrect as the result of a misstatement of a group member's age, then the insurer will retroactively adjust the amount of the premium required for the coverage to reflect the group insured's correct age. The amount of the death benefit payable remains unaffected. Because group life insurance premium rates typically do not vary according to the sex of the insured, such policies typically do not include a misstatement of sex provision.

Settlement Options

When a person insured under a group life insurance policy dies, the beneficiary of the group insured's coverage usually receives the death benefit in a lump sum. Sometimes settlement options also are available. If so, the group life insurance policy gives the group insured and/or the beneficiary the right to choose a settlement option. All of the usual settlement options for individual life insurance policies described in Chapter 9 are generally made available. However, for a group insured or beneficiary to select the life income option, the death benefit payable usually must be at least a stated minimum amount.

Group Life Insurance Plans

The majority of all group life insurance policies are yearly renewable term (YRT) insurance plans. Group accidental death and dismemberment policies are also commonly issued, either as separate plans or in addition to other group life insurance coverage. Some insurers issue group cash value life insurance plans, but they are less common than group term life insurance plans.

Group Term Life Insurance

The YRT insurance coverage under group life insurance policies is similar to YRT coverage under individual policies. Evidence of insurability is not required from the group insureds each year when the coverage is renewed. Group term life insurance policies do not build cash values, and the insurer typically has the right to change the premium rate each year.

When employers pay the premiums to provide their employees with group term life insurance, the employees receive a financial benefit. The income tax treatment of employer-paid group term life insurance coverage for employees varies from jurisdiction to jurisdiction. In some countries, including the United States and Canada, some or all of the premiums paid by the employer for group term life insurance coverage for employees are considered taxable income to the employee. In other countries, including the United Kingdom, such premiums are not considered taxable income to the employee.

Accidental Death and Dismemberment Insurance

Accidental death and dismemberment (AD&D) benefits may be part of a group life insurance policy, or an insurer may issue them under a separate group insurance policy. The low cost of AD&D benefits makes them an attractive addition to group insurance plans, especially to employer-employee group plans. When the accidental death benefit is added to a group term life insurance plan, the accidental death benefit amount usually is equal to the amount of the death benefit provided under the basic group term insurance plan. For example, assume that a group insured has \$50,000 of basic group life insurance coverage and a \$50,000 AD&D benefit. If the group insured dies as the result of an accident, the beneficiary would be entitled to receive \$100,000.

Many AD&D plans provide an additional travel accident benefit that covers only accidents occurring while the employee is traveling for the employer. In other words, an employee may die as the result of an accident that occurs while he is traveling. If the accident occurs while the employee is on vacation, his beneficiary will receive benefits under the AD&D coverage only; if the accident occurs while the employee is on a business trip, his beneficiary will receive benefits under the AD&D coverage plus an additional accident benefit because he was traveling for the employer.

Example. Ashley Henderson is covered under the group life insurance plan her employer provides. The group insurance policy provides \$100,000 of group term life insurance, \$50,000 of group accidental death and dismemberment insurance, and \$25,000 of business travel accident insurance.

Analysis. If Ashley dies in an accident while she is traveling on business for her employer, then her beneficiary would be entitled to receive \$175,000 in benefits (\$100,000 + \$50,000 + \$25,000). If Ashley dies in an accident while she is on a vacation trip, then her beneficiary would be entitled to receive \$150,000 in benefits (\$100,000 + \$50,000).

Group Cash Value Life Insurance

Employers use group cash value life insurance plans to help employees purchase life insurance coverage that will continue after their retirement, when their group term insurance coverage typically ends. Covered employees usually are required to pay a significant portion of the premium for group cash value life insurance plans. Therefore, participation levels in group cash value life insurance plans generally are much lower than the participation levels that insurers require under other contributory group insurance plans.

The specific characteristics of group cash value life insurance coverage vary from plan to plan. The three most commonly offered group cash value life insurance plans are (1) group paid-up plans, (2) level premium whole life plans, and (3) group universal life plans.

Group Paid-Up Plans. Group life insurance purchased under a group paid-up plan combines paid-up whole life insurance with decreasing amounts of term life insurance. Each year, the employee's premium contribution is used to purchase single premium paid-up whole life insurance. The employer's contribution then is used to purchase group term life insurance in an amount that brings the employee's total coverage up to a predetermined amount. The total amount of paid-up whole life insurance on each participating employee increases each year, and the amount of the employee's group term insurance decreases each year. If the employee retires or leaves the group for any reason, the amount of paid-up coverage he has purchased remains in force for his lifetime.

Level Premium Whole Life Plans. Some insurance companies make level premium whole life insurance available on a group basis. Level premium coverage usually is written on a limited-payment whole life plan, such as whole life paid-up at age 65. Because group whole life insurance policies build cash values, employers often use them to provide retirement income benefits for employees. If the employee leaves the group prior to her planned retirement age, her group whole life insurance coverage typically terminates. Whether the employee has a right to the cash value that has built up depends on whether the group insurance plan is contributory or noncontributory. If the plan is a noncontributory plan, the accumulated cash value generally belongs to the employer. If the plan is a contributory plan, a portion of the cash value belongs to the employee, depending on the portion of the premium that the employee paid. For example, if the employee paid 25 percent of the premium, then, 25 percent of the accumulated cash value would typically belong to the employee.

Group Universal Life Plans. Some insurers offer group universal life (UL) plans and/or group variable universal life (VUL) plans. In many ways, group UL and VUL plans function much more like individual insurance policies than like typical group insurance policies. The employer typically does not pay any portion of the premium. Instead, each employee chooses the amount of premium she wishes to pay; the amount of the policy's cash value depends on the amount of the premiums paid. As with individual VUL insurance, the participants in a group VUL plan are given a choice of different subaccount options for investing their cash values.

Group Creditor Life Insurance

Group creditor life insurance is insurance issued to a creditor, such as a bank, to insure the lives of the creditor's current and future debtors. Group creditor life insurance differs from other forms of group life insurance policies in a number of respects. For example, unlike other group life insurance policies, group creditor life policies designate the policyholder—the creditor—as the beneficiary to receive the benefit payable when a group insured dies. At any given time, the amount of insurance on each group insured is equal to the amount of the outstanding debt that person owes to the policyholder-creditor. The premium for group creditor life insurance coverage usually is paid by the debtor, although it may be paid entirely by the creditor or paid by both the creditor and the debtor.

Group Retirement Plans

People often purchase individual annuities to provide themselves with an income after they retire. Individual annuities are not the only source of retirement income, however. Often, people receive retirement income from various government programs and from private retirement plans sponsored by employers and unions. Life insurance companies are involved in the funding and administration of many private retirement plans.

In the United States and a number of other countries, those private retirement plans that meet the applicable government requirements are granted special income tax benefits. Laws in these jurisdictions contain incentives that provide economic benefits both to the *plan sponsors*—the employers and unions that establish plans—and the *plan participants*—the employees and union members the plans cover.

The income tax benefits provided for sponsors and participants who deposit funds into retirement plans that meet the applicable government requirements vary from one jurisdiction to another and from one type of retirement plan to another. When establishing a retirement plan, employers and unions usually want to ensure that the plan qualifies for favorable income tax treatment. To meet this customer need, life insurance companies design their group retirement products to meet applicable regulatory requirements.

Components of a Retirement Plan

A group retirement plan consists of three components: (1) the plan, which describes how benefits are funded and paid to participants; (2) a method for administering the plan; and (3) the funding vehicle into which the plan assets are invested. Insurance companies are involved in activities related to all three of these components—designing and developing retirement plans, administering retirement plans, and providing retirement plan funding vehicles.

The Plan

The plan sponsor determines the type of plan to establish and the terms of that plan, which are described in a plan document. A **plan document** is a detailed legal agreement that establishes the existence of an employer-sponsored retirement plan and specifies the rights and obligations of various parties to the plan. Among other things, the plan document describes the individuals whom the plan covers, the benefits that are the plan provides, and the method for funding the plan. Plan participants typically receive a summary plan description that informs them of their rights under the plan.

Coverage, Eligibility, Participation, and Vesting Requirements. The plan document describes which group members the plan covers. The covered group typically is defined in terms of job class, location of the work site, salary, and/or occupation. For example, a plan may cover all non-union employees.

The plan document specifies the requirements group members must meet to be eligible to participate in the plan. The most common eligibility requirement is a service requirement, which states a minimum length of employment a group member must have to be eligible to participate in the plan. Some plans also impose an age requirement that states the minimum age a group member must be to be eligible to participate. For example, the plan document may specify that only employees who are 21 years of age or older and who have at least one year of employment are eligible to participate in the plan. Eligibility requirements are limited by law in some jurisdictions. In the United States, for example, a retirement plan may not set a maximum age for participation.

The plan document also specifies when employee participation in the plan becomes effective. Under an employer-sponsored retirement plan, an employee's participation in the plan typically becomes effective on the first day of the month or the first day of the calendar year following the person's completion of the plan's eligibility requirements. Participation in an employer-sponsored retirement plan can be automatic or voluntary.

- If participation is *automatic*, all eligible group members are automatically enrolled as plan participants. Typically, noncontributory plans are automatic plans.
- If participation is *voluntary*, eligible group members have a choice between participating or not participating in the plan. Typically, contributory plans are voluntary plans. Under some voluntary plans, known as *opt-out plans*, eligible group members are automatically enrolled as plan participants unless they notify the employer that they do not want to participate in the plan.

The plan document also specifies the plan's *vesting* requirements that define when a plan participant is entitled to receive partial or full benefits under the plan even if he terminates employment prior to retirement. A plan participant's right to receive benefits funded by his own contributions typically vests immediately in the participant because those contributions belong to the participant. Statutory requirements often impose time limits within which the participant's right to receive benefits funded by employer contributions must vest.

Benefit Formulas. A retirement plan's *benefit formula* describes the calculation of the plan sponsor's financial obligation to plan participants. Two types of benefit formulas are common.

- A *defined benefit formula* specifies the amount of retirement benefit a plan sponsor promises to provide to each plan participant. A retirement plan structured according to a defined benefit formula is referred to as a *defined benefit plan*.
- A *defined contribution formula* specifies the level of contributions that the plan sponsor promises to make to the plan. The benefit that a participant will receive is not determined in advance of the participant's retirement but depends on the investment performance of the funds in the plan. A retirement plan structured according to a defined contribution formula is referred to as a *defined contribution plan*.

In recent years, the defined contribution plan has become increasingly popular among plan sponsors establishing retirement plans. The reason for this rise in popularity is that when an employer establishes a defined contribution plan, it knows in advance what it will cost to fund the plan each year. By contrast, an employer that is funding a defined benefit plan must rely on actuarial estimates of what it will cost each year to fund the plan. The employer also has no guarantee that its costs will remain at or below the estimated amount.

Figure 12.1 illustrates the differences between defined benefit plans and defined contribution plans.

Figure 12.1. Comparison of Defined Benefit Plans and Defined Contribution Plans

Plan	Amount of Sponsor's Contributions	Amount of Participant's Retirement Benefits
Defined Benefit	<ul style="list-style-type: none"> ■ Uncertain, not specified ■ Can only be estimated 	<ul style="list-style-type: none"> ■ Specified ■ Reasonably certain
Defined Contribution	<ul style="list-style-type: none"> ■ Specified ■ Reasonably certain 	<ul style="list-style-type: none"> ■ Uncertain, not specified ■ Can only be estimated

Plan Administration

The plan sponsor usually names a *plan administrator* who becomes responsible for a variety of aspects of the plan's operation. Although the plan administrator usually is a named individual, the administrator may be the sponsoring employer or it may be a board or committee that the employer establishes. The plan administrator, who is responsible for maintaining accurate records on all participants, uses these records to determine the amount of benefits payable to plan participants and to provide the participants with information about the plan. The plan administrator also may need to obtain the services of other professionals, such as accountants, actuaries, and attorneys.

Life insurers often provide administrative services for retirement plans. In some cases, a life insurer provides only administrative services to a plan. In other cases, the insurer provides administrative services and a funding vehicle for the plan.

Funding Vehicles

The sponsor of a retirement plan must choose a funding vehicle for the plan. A *funding vehicle*, also known as an *investment vehicle* or *funding instrument*, is an arrangement for investing a retirement plan's assets as those assets are accumulated. Life insurers offer a variety of products that are designed as retirement plan funding vehicles, including group annuities. Insurers are quite flexible in tailoring their products to meet the specific needs of a plan sponsor.

Types of Retirement Plans

The laws of each jurisdiction determine the types of retirement plans that qualify for special tax benefits. The distinctions among the various types of plans in any jurisdiction are important because the regulatory requirements imposed on retirement plans often vary somewhat depending on the type of plan. In any case, the specific provisions of a given retirement plan govern the operation of that plan. In the United States, four general types of employer-sponsored retirement plans are: (1) defined benefit pension plans, (2) savings plans, (3) profit sharing plans, and (4) stock bonus plans.

Defined Benefit Pension Plans

Under a defined benefit pension plan, an employer agrees to provide its employees with a *pension*—a lifetime monthly income benefit that begins at retirement. The employer obligates itself to fund, in advance, at least a portion of the pension plan's promised benefits each year. Although defined benefit pension plans typically provide other types of benefits to covered employees, the primary goal of a defined benefit pension plan is to provide plan participants with periodic retirement income benefits in the form of a life annuity. Defined benefit pension plans in the United States generally are noncontributory, although some defined benefit pension plans do permit or require contributions from plan participants.

Defined benefit pension plans are common in a number of countries, including the United Kingdom. However, in many countries other than the United States, the term *pension plan* generally refers to a type of defined contribution plan under which an employer agrees to make periodic contributions of a stated amount on behalf of each plan participant. For example, an employer might agree to contribute 5 percent of each participant's salary to the plan on a monthly basis. Under such a pension plan, employees often are permitted or required to make additional contributions to the plan. In some countries, the government contributes to the plan as well.

Savings Plans

A *savings plan* is a retirement plan to which a plan sponsor may make contributions on behalf of a plan participant if the participant makes contributions to the plan. A savings plan is a defined contribution plan; the amount of an employer's contribution usually is equal to the amount contributed by the employee or is a percentage of that amount, subject to a specified maximum. For example, the plan document often specifies that an employee may contribute a percentage of his salary to the plan, subject to specified minimums and maximums, and that the employer will match that contribution up to a stated maximum percentage of the employee's salary.

Example. Northside Enterprises sponsors a savings plan that allows full-time employees to participate by contributing from 1 to 10 percent of their monthly salaries. Northside will match any employee contribution up to a maximum of 3 percent of the employee's salary. Teri Chang, Jonathan Walters, and Marisa Santiago all are full-time employees of Northside, each earning \$3,000 a month. During the month of April, Teri made no plan contribution; Jonathan contributed 2 percent of his monthly salary, and Marisa contributed 10 percent of her monthly salary.

Analysis. Jonathan's 2 percent contribution (\$60) will be credited to his account, and Northside will make a matching contribution of \$60. Marisa's 10 percent contribution (\$300) will be credited to her account, and Northside will make a matching contribution of 3 percent of Marisa's monthly salary (\$90). Because Teri made no contribution to the plan, Northside will make no contribution on her behalf.

One popular type of savings plan in the United States is a **401(k) plan**, which is a savings plan that allows employees to make contributions on a pre-tax basis. In other words, when an employee contributes to a 401(k) plan, the amount of her contribution is not included in her current taxable income. For example, if an employee earning \$50,000 a year contributes \$3,000 to a 401(k) plan, the contribution reduces her taxable income to \$47,000. The employee is taxed later when she withdraws funds from her 401(k) plan. To participate in a 401(k) plan, an employee must enter into a salary reduction arrangement that permits the employer to deduct the amount of the employee's plan contribution from her salary.

Some countries require certain employers to establish savings plans for eligible employees. For example, employers in Australia are required to contribute a stated percentage of eligible employees' wages into a savings plan. The contributions are invested in a government-approved fund that the employee chooses. Employees also may make voluntary contributions to the plan up to a stated maximum amount.

Profit Sharing Plans

A **profit sharing plan** is a retirement savings plan that is funded primarily by cash contributions payable from the employer's profits. Because employer contributions to such plans are based on company profits, and profits can fluctuate, the amount of contributions varies from year to year. If conditions warrant, the employer may not make any contribution in some years. Although a profit sharing plan accumulates retirement assets on behalf of plan participants, the plan does not promise to provide monthly retirement income benefits. Although most profit sharing plans are noncontributory plans, some plans in the United States allow employee contributions.

Stock Bonus Plans

A **stock bonus plan** is a retirement plan into which a plan sponsor that is a stock company makes contributions on behalf of plan participants in the form of the corporation's stock. A **stock option plan** is regarded as a type of stock bonus plan. Contributions to a stock bonus plan are not dependent upon company profits. The

value of the stock shares, however, fluctuates. Stock bonus plans accumulate retirement assets on behalf of participants, but such plans do not promise to provide a monthly retirement income benefit.

Government-Sponsored Retirement Plans

The governments of many countries have established plans that provide periodic retirement income benefits to qualified residents. Many employer-sponsored retirement plans determine the amount of plan benefits by factoring in the amount of benefits that will be payable under government-sponsored plans. For most people in the United States, government retirement income benefits are provided under the Old Age, Survivors, Disability and Health Insurance (OASDHI) Act, or, as it is better known, Social Security. **Social Security** is a federal program that provides specified benefits, including monthly retirement income benefits, to people who have contributed to the plan during their income-earning years. The program also provides a benefit to qualified disabled individuals, as well as to the surviving spouses and dependent children of qualified deceased workers. Nearly all people employed in the United States, including those employed by the armed forces, are covered under Social Security. Benefits are funded by mandatory contributions from covered workers and their employers.

Social Security provides a monthly income benefit to people who have contributed to the program during their income-earning years. Social Security retirement benefits are available to covered persons who are age 62 or older, although people retiring before their full retirement age of 65 or older typically receive a lower monthly benefit amount than they would receive if they retired at age 65 or older. The federal government administers the Social Security program and makes frequent changes in the program's funding and benefits.

Many other countries have government-sponsored retirement plans; however, the exact provisions vary widely from country to country.

- In Canada, the federal *Old Age Security (OAS) Act* is a universal pension plan that provides a pension to virtually all Canadian residents who are age 65 or older, regardless of preretirement wages. Each person who has reached age 65 and has met certain residency requirements receives the same pension amount. However, individuals whose incomes exceed certain amounts must repay part or all of the pension amount received. The money to fund these pensions is taken from federal government general tax revenues. In addition, the *Quebec Pension Plan (QPP)*—for residents of Quebec—and the *Canada Pension Plan (CPP)*—for residents of all other provinces—provide pensions for wage earners who have contributed money into the plans during their working years. Participation is mandatory for employees covered by the plans, and benefits are funded through compulsory contributions from employees, their employers, and self-employed persons. The amount of the monthly benefit paid following retirement is related to the amount contributed to the plan by or on behalf of the person.

- In Japan, the National Pension is a universal pension plan that provides a pension to residents who are age 65 or older. Residents of Japan who are age 20 to 59 pay a flat monthly premium. Each person who has reached age 65 and paid premiums for at least 25 years receives a monthly benefit based on the total amount of premiums paid. In addition, the Employees' Pension Insurance plan provides pensions for most wage earners who have contributed money into the plan during their working years. Participation is mandatory for employees covered by the plan, and benefits are funded through compulsory contributions from employees and their employers. The amount of the monthly benefit paid following retirement is related to the amount contributed to the plan by or on behalf of the person.

Key Terms

portability provision	defined contribution formula
portable coverage	defined contribution plan
conversion privilege	plan administrator
group creditor life insurance	funding vehicle
plan sponsor	pension
plan participant	savings plan
plan document	401(k) plan
vesting	profit sharing plan
benefit formula	stock bonus plan
defined benefit formula	Social Security
defined benefit plan	

**Chapter
13****Health Insurance****Objectives:**

After studying this chapter, you should be able to

- Identify some common types of basic medical expense coverage, and describe the benefits that each provides
- Identify the purpose of expense participation features in major medical expense policies, and give examples of commonly used expense participation methods
- Identify and describe common types of medical expense coverage other than basic and major medical expense coverage
- Describe the techniques that managed care plans use to manage access to health care services and the costs of health care services
- Identify the various definitions of *total disability* that have commonly been included in disability income insurance policies, and distinguish among those definitions
- Identify the criteria used to classify disability income coverage as either short-term coverage or long-term coverage
- Explain the purpose of including an elimination period in a disability income insurance policy, and identify the length of the typical elimination period
- Identify and describe some supplemental benefits that may be included in a disability income insurance policy
- Identify the causes of disability that a disability income insurance policy may exclude from coverage
- Identify two types of specialized disability coverage that are designed to meet the needs of closely held businesses for disability coverage of owners, partners, and key people
- Describe the benefit triggers for long-term care insurance policies
- Describe the methods insurers use to pay long-term care benefits

Outline

Medical Expense Coverage

- Traditional Medical Expense Insurance
- Managed Care Plans
- Government-Sponsored Medical Expense Coverage

Long-Term Care Coverage

- Benefit Triggers
- Long-Term Care Benefits

Disability Income Coverage

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

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

Medical Expense Coverage

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

Medical expense insurance coverage in the United States is available in three basic forms: (1) traditional medical expense insurance policies, which offer indemnity benefits; (2) managed care plans; and (3) government-sponsored health care programs.

Traditional Medical Expense Insurance

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

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

Basic Medical Expense Coverage

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

- **Hospital expenses**, which include charges for specific inpatient and outpatient hospital services, such as room and board, medications, laboratory services, and other fees associated with a hospital stay
- **Surgical expenses**, which include charges for inpatient and outpatient surgical procedures
- **Physicians' expenses**, which include charges associated with physicians' visits both in and out of the hospital

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

Major Medical Expense Coverage

Today, rather than offering basic medical expense coverage, most health insurers offer *major medical expense coverage*, which provides substantial benefits for (1) basic hospital, surgical, and physicians' expenses, (2) additional medical services related to illness or injuries, and (3) preventive care.

Two types of major medical coverage are commonly available.

- A *supplemental major medical policy* is a policy issued in conjunction with an underlying basic medical expense insurance policy. The supplemental policy is designed to provide benefit payments for expenses that exceed the benefit levels of the underlying basic plan and, often, for expenses that are not covered by the underlying plan.

- A **comprehensive major medical policy** is a single policy that combines the coverages provided by both a supplemental major medical policy and an underlying basic medical expense policy. A comprehensive major medical policy provides substantial medical expense coverage under one policy, and that policy covers most of the medical expenses the insured may incur. Today, the majority of medical expense insurance policies are issued as comprehensive major medical policies.

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

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

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

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

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

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

Example. Elizabeth Cater is covered by a comprehensive major medical expense policy that specifies a \$500 calendar-year deductible. During 2009, Elizabeth incurred a total of \$400 in allowable expenses. In 2010, she incurred a total of \$800 in allowable expenses.

Analysis. Because Elizabeth's allowable expenses for 2009 did not meet the \$500 calendar-year deductible specified in her policy, she was required to pay the entire \$400 in expenses she incurred that year. In 2010, she was required to pay \$500 of the \$800 in allowable expenses she incurred to satisfy the policy deductible, but she was eligible to receive reimbursement from the insurer for at least a portion of the remaining \$300.

Coinurance is an expense participation requirement imposed by many medical expense plans; the requirement generally is a specified percentage of all allowable expenses that remain after the insured has paid the deductible and that must be paid by the insured. Most major medical expense policies set the coinsurance amount at 10, 20, or 30 percent of allowable expenses that remain after the insured has paid the deductible amount.

Example. Wendell Ford is covered by a comprehensive major medical expense policy that specifies a \$400 calendar-year deductible and a 20 percent coinsurance requirement. In 2010, Wendell incurred \$1,000 in allowable expenses.

Analysis. Wendell was responsible for paying the \$400 deductible. In addition, he was responsible for paying coinsurance in the amount of 20 percent of the remaining \$600, or \$120 ($0.20 \times \$600$). Wendell's total out-of-pocket costs, therefore, were \$520 ($\$400 + \120). The insurer paid the remaining \$480 ($\$1,000 - \520).

Most major medical expense policies limit the amount of money the insured must pay under the coinsurance provision by including a maximum out-of-pocket provision. The **maximum out-of-pocket provision**, also known as the **stop-loss provision**, specifies that the policy will cover 100 percent of allowable medical expenses after the insured has paid a specified amount out-of-pocket to satisfy deductible and coinsurance requirements.

Example. Susan Young is covered by a comprehensive major medical expense policy that specifies a \$500 calendar-year deductible, a 20 percent coinsurance requirement, and a \$5,000 maximum out-of-pocket provision. Susan incurred a total of \$2,500 in allowable expenses in January when she was hospitalized for treatment of an illness. In May of that same year, Susan incurred an additional \$30,000 in allowable expenses when she underwent surgery.

Analysis. Of the \$2,500 in allowable expenses Susan incurred in January, she was required to pay \$500 to meet the policy's calendar-year deductible and an additional \$400 ($0.20 \times \$2,000$) in coinsurance. The insurer paid the remaining \$1,600. Because she had satisfied her deductible in January, Susan was required to pay only coinsurance on the allowable expenses she incurred in May. The amount of this coinsurance was \$6,000 ($0.20 \times \$30,000$). However, the maximum out-of-pocket provision in her policy requires Susan to pay only \$5,000 of her expenses for the year. Because she had already paid \$900 in deductible and coinsurance amounts in January, Susan paid only \$4,100 of her May expenses ($\$5,000 - \900). The insurer paid the remaining \$25,900.

Exclusions. Although major medical expense policies cover most medical expenses, they commonly exclude from coverage any medical expenses that result from the following treatments:

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

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

Other Medical Expense Coverages

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

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

- **Prescription drug coverage**, which provides benefits for the purchase of drugs and medicines that are prescribed by a physician and are not available over-the-counter. Prescription drug coverage usually requires the insured to pay part of the cost of the prescription out-of-pocket at the time of purchase. Benefit levels and expense participation requirements for prescription drug coverage usually vary according to the type of drugs. For example, some policies require insureds to pay one out-of-pocket amount for generic drugs and a higher amount for brand-name drugs. Prescription drug costs are a covered expense under many major medical expense policies, but prescription drug coverage can also be provided under a stand-alone policy.
- **Vision care coverage**, which provides the insured with benefits for expenses incurred in obtaining eye examinations and corrective lenses. Vision care coverage generally provides benefits to cover one routine eye examination per year for each insured. Policies also specify the maximum benefit amount the insurer will pay for eyeglass lenses and frames or contact lenses.

Managed Care Plans

Today, most insureds in the United States are covered by some type of managed care plan. **Managed care** is a method of integrating the financing and delivery of health care services within a system that manages the access to health care services and the cost of those services. A **managed care plan** is an arrangement that integrates the financing and management of health care with the delivery of health care services to a group of individuals who have enrolled in the plan. Figure 13.1 describes some common types of managed care plans.

Managing Access to Health Care Services

Managed care plans manage access to health care services through the use of provider networks. A **network** is a group of physicians, hospitals, and ancillary services providers that a specific managed care plan has contracted with to deliver health care services to plan members. Ancillary, or supplemental, services providers include laboratories, radiologists, home health care providers, and physical, speech, and occupational therapists. Provider contracts specify how the managed care plan will pay the providers.

Managed care plans typically require plan members to choose providers from within the network or offer financial incentives to members who choose network providers. Some managed care plans also encourage plan members to use a **primary care provider (PCP)**, also referred to as a *primary care physician*, who is a network member who coordinates members' medical care and treatment. In a PCP-based system, a plan member selects a PCP from among the network of providers and receives basic medical care, preventive care, and wellness care directly from the PCP, without obtaining authorization from the plan. To receive specialized care, however, the plan member usually must obtain authorization or a referral from the PCP. The PCP thus serves as a plan member's point of entry into the

Figure 13.1. Types of Managed Care Plans

A **health maintenance organization (HMO)** is a health care financing and delivery system that provides comprehensive health care services to plan members—often referred to as *subscribers*—in a particular geographic area. HMOs typically require subscribers to gain access to services through a primary care provider, and subscribers must use in-network providers; benefits generally are not provided for services rendered by non-network providers. Subscribers are required to pay a small copayment at the time of service, but they do not pay deductibles or coinsurance, and they are not required to file claims for benefits.

A **preferred provider organization (PPO)** is a health care benefit arrangement that provides incentives for plan members to use network providers, but also provides at least some coverage for services rendered by non-network providers. PPOs do not provide health care directly to plan members; instead, they act as brokers or middlemen by contracting with health care providers to deliver medical services at discounted fees to a specific group of covered individuals. PPOs resemble traditional indemnity plans in that they typically reimburse in-network health care providers on a fee-for-service basis, though network providers agree to discount those fees for plan participants.

A **point-of-service (POS) plan** is a managed care plan that combines features of HMOs and PPOs. A plan member generally must select a primary care provider who is responsible for coordinating the member's medical care within the plan's network of providers. Plan members who need medical care choose, at the point of service, whether to seek care in-network or out-of-network. The plan, however, provides a much lower level of coverage for services received from non-network providers.

managed care system and as a gatekeeper to additional services. Plans typically encourage members to obtain services through PCPs by requiring lower out-of-pocket costs for PCP-based care.

Managing the Cost of Health Care Services

Managed care plans seek to manage health care costs by requiring plan members and medical care providers to share the cost of health care services. In most managed care plans, plan members receive comprehensive health care in exchange for payment of a fixed, periodic—usually monthly—premium. This premium covers the cost of most health care services, no matter how often the member uses those services. In addition, when a plan member receives services from a network provider, the plan member generally pays a specified, fixed amount, known as a *copayment*, to the provider.

Example. Stephen Burdette is a member of a managed care plan that requires a \$25 copayment for physician office visits and a \$20 copayment for prescription drugs. On February 1, Stephen visited his PCP for treatment of a sprained ankle. During the office visit, X-rays were taken of Stephen's ankle. The PCP also wrote Stephen a prescription for pain medication.

Analysis. Before leaving the PCP's office, Stephen paid a \$25 copayment to cover the office visit. The remaining charges for the office visit, including the X-rays, were covered by the managed care plan. When Stephen took his prescription to the pharmacy, he paid a \$20 prescription copayment. The pharmacy billed the managed care plan for the remaining cost of the prescription.

Although copayments are significantly lower than deductibles and coinsurance requirements included in traditional medical expense insurance policies, they provide an incentive for plan members to manage the utilization, and therefore the cost, of health care services.

Managed care plans also encourage medical care providers to deliver necessary care in a cost-effective way by requiring them to share in the financial risk of providing medical care. Managed care plans achieve risk sharing by negotiating fee arrangements with medical care providers and making other contractual arrangements that encourage cost-effective care. Negotiated fee arrangements for in-network providers can include plan member copayments, fee schedules, and fee caps. If the costs of medical services exceed the provider's negotiated fee, the provider must absorb the loss. Out-of-network providers typically are reimbursed on a fee-for-service basis.

Managed care plans also manage health care costs by providing a variety of additional services designed to reduce the amount of medical care that plan members will require. Managed care plans typically offer

- Extensive preventive care programs, including prenatal and well-baby care, routine physical examinations, screening programs, 24-hour telephone line access to a nurse, and childhood immunizations
- Access to wellness programs, including smoking cessation, weight management, and stress management programs
- Patient education programs, including seminars, newsletters, and medical self-help booklets

Government-Sponsored Medical Expense Coverage

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

In Canada, for example, the provincial governments each have established medical expense insurance plans that meet the conditions set out in the federal *Canada Health Act* to qualify to receive federal funding for their plans. Each province and territory provides a medical expense insurance plan that provides basic health care benefits to qualified residents. These benefits vary somewhat from province to

province. In addition, commercial insurers can offer medical expense coverage to supplement the benefits provided by the provincial plan. For example, commercial insurers typically offer coverage for the added cost of a private hospital room. Many employers offer supplemental health care coverage to their employees under group health insurance policies issued by traditional health insurance companies. Individual health insurance policies also are available.

In the United Kingdom, the *National Health Service (NHS)* is a publicly funded health care system available to nearly all residents. Residents receive basic medical and hospital services at no cost. Residents pay copayments and coinsurance for certain prescription drugs, dental care, and vision care. Residents can purchase private medical expense insurance that covers treatment in privately owned hospitals and provides expedited access to medical treatment.

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

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

Disability Income Coverage

Disability income coverage provides income replacement benefits to an insured who is unable to work because of sickness or injury. When a person is unable to work because of disability, the financial effect on the individual's family is potentially much greater than if the individual had died. When a wage earner dies, the family is left without a source of income. When a wage earner is disabled, the family not only loses a source of income, but the family also faces additional expenses resulting from the disability. To help relieve the financial stress created by disability, insurance companies offer income replacement benefits in the form of disability income coverage. In addition, in many countries, including the United States and Canada, government programs provide certain benefits to individuals who become disabled.

Types of Disability Income Insurance

Insurance companies issue both individual and group disability income insurance policies. The coverage provided by such policies is classified as either short-term or long-term coverage, depending on the length of the benefit period. The **benefit period** is the time during which the insurer agrees to pay income benefits to the insured. The criteria used to classify the benefit period are different for individual and group coverages. Individual disability income coverage is seldom offered with a maximum benefit period of less than one year.

- **Short-term individual disability income coverage** provides a maximum benefit period ranging from one to five years.
- **Long-term individual disability income coverage** provides a maximum benefit period of five years or more. The maximum benefit period provided by individual long-term coverage for illnesses commonly extends until the insured reaches age 65. However, for accidents, benefits often are provided for the insured's lifetime.

Group disability income coverage generally specifies shorter benefit periods than those included in individual policies.
- **Short-term group disability income coverage** provides a maximum benefit period of one year or less; such coverage commonly specifies a maximum benefit period of 13, 26, or 39 weeks.
- **Long-term group disability income coverage** provides a maximum benefit period of more than one year. Many policies extend the maximum benefit period to the insured's normal retirement age or to age 70.

To receive periodic income benefits under a disability income insurance policy, an insured person must meet the policy's definition of total disability. In addition, the insured person generally must be disabled for a certain period of time—known as the elimination period—before benefits become payable.

Definitions of Total Disability

Each disability income policy specifies the definition of ***total disability*** that the insurer uses to determine whether a covered person is entitled to receive disability income benefits. Although the definition of ***total disability*** varies from policy to policy, we describe the definitions that insurance companies have most commonly included in disability income policies.

Any Occupation

At one time, disability income policies defined total disability as a disability that prevented the insured from performing the duties of ***any occupation***. Because a strict interpretation of this definition would prevent most people from ever qualifying for disability income benefits, most insurers now define ***total disability*** more liberally.

Current Usual Definition

Most disability income policies issued today use a two-part definition of ***total disability***. An insured is considered totally disabled if at the start of disability, the disability prevents her from performing the essential duties of her ***regular occupation***. At the end of a specified period after the disability begins, usually two to five years, an insured is considered totally disabled only if the disability prevents her from working at ***any occupation for which she is reasonably fitted by education, training, or experience***.

Example. Howard Beauchamp, a surgeon, is insured under a disability income policy that contains the current usual definition of total disability; the policy's definition of total disability changes after the insured has been disabled for two years. Howard was involved in an accident and lost his left arm. Although Howard is unable to perform surgery, he has been hired to teach in a medical college.

Analysis. Because Howard's injury prevents him from working as a surgeon, he meets the policy's initial definition of total disability and, thus, will be eligible to receive disability income benefits for up to two years. At the end of that time, Howard will no longer be considered totally disabled because his disability does not prevent him from working at an occupation for which he is reasonably fitted by his education and training.

Some policies that use this definition of total disability also state that the insured is not considered to be totally disabled if he is working in a gainful occupation. Thus, no total disability income benefits are payable if the person insured by such a policy voluntarily returns to work at any occupation.

Own Previous Occupation

Some insurers have further liberalized the definition of *total disability* included in certain disability income policies. This definition, which is included more often in individual policies than in group policies, specifies that *total disability* is the inability to perform the essential duties of the insured's *own previous occupation*. In fact, policies using this "own previous occupation" definition specify that benefits will be paid even while the insured is gainfully employed in another occupation, as long as she is prevented by disability from engaging in the essential duties of the occupation specified in the policy. Policies containing this definition of total disability often are sold to people who are employed in certain professional occupations.

Example. Suppose that Howard Beauchamp from the last example is insured under a disability income policy that contains this "own previous occupation" definition of total disability. Because of his accident, Howard is unable to perform surgery and has begun teaching at a medical school.

Analysis. Howard is unable to perform surgery and, thus, will never be able to work in his own previous occupation. Therefore, the insurance company will pay Howard the full disability income benefit until the end of the policy's benefit period.

Presumptive Disabilities

Some disability income policies classify certain conditions as presumptive disabilities. A *presumptive disability* is a stated condition that, if present, automatically causes the insured to be considered totally disabled. An insured with a presumptive disability receives the full income benefit amount provided under the policy, even if he resumes full-time employment in a former occupation. Presumptive disabilities include total and permanent blindness, loss of the use of any two limbs, and loss of speech or hearing.

Elimination Period

Although some forms of disability income coverage are designed to provide benefits beginning on the first day of an insured's disability, most policies specify an elimination period. An *elimination period*, often referred to as a *waiting period* or a *benefit waiting period*, is the specific amount of time that the insured must be disabled before becoming eligible to receive policy benefits.

Like the deductible amount found in medical expense policies, the purpose of the elimination period is to reduce the cost of coverage. By specifying an elimination period, the insurer can substantially reduce the expenses involved in processing and paying claims for disabilities that last for only a very short time. This expense savings is reflected in the cost of the coverage; the longer the elimination period, the lower the cost for otherwise equivalent disability income coverage.

The length of the elimination period included in both short-term and long-term individual disability income policies is typically from 30 days to 6 months. The elimination period in a group policy is typically related to the length of the maximum benefit period.

- *Group short-term disability income policies* typically specify no elimination period for disabilities caused by accidents and an elimination period of one week for disabilities caused by sickness.
- *Group long-term disability income policies* typically specify an elimination period of from 30 days to 6 months, though such plans also typically coordinate their short-term and long-term coverages. That is, the length of the elimination period before long-term benefits are payable is designed to ensure that short-term coverage ends at the same time that long-term benefits become payable.

Benefit Amounts

As a general rule, the benefit amount provided by disability income coverage is not intended to fully replace an individual's pre-disability earnings. Instead, disability income benefits are limited to an amount that is lower than the individual's regular earnings when not disabled. Without restrictions on the income amounts available through disability income coverage, a disabled insured could receive as much income as he received when working. In such a case, the disabled insured has no financial incentive to return to work.

Disability income benefit amounts, however, should not be so low that a disabled insured suffers a drastic reduction in income and lifestyle; the purpose of disability insurance is, after all, to provide protection against the economic consequences of income loss. Therefore, the benefit amount paid to a disabled insured should bear a relationship to the amount of the individual's income before disability.

Disability income insurance providers use two methods to establish the amount of disability income benefits that will be paid to a disabled person: (1) an income benefit formula or (2) a flat benefit amount. The method used generally depends on whether the coverage is provided by a group or an individual policy and on whether the coverage is short-term or long-term.

Income Benefit Formula

Group disability income policies typically include an income benefit formula that the insurer uses to determine the amount of the periodic benefit that is payable to a disabled insured. An income benefit formula usually expresses the disability income benefit amount as a stated percentage of the insured's pre-disability earnings and considers all sources of disability income that the disabled insured receives.

The amount of the stated percentage in the formula varies from policy to policy. The percentage typically included in group long-term disability income policies ranges from 60 to 75 percent. For example, the formula may specify that the insured will receive a disability income benefit amount equal to 75 percent of her pre-disability earnings and that the benefit amount will be reduced by the amount of any disability income benefit she receives from other sources. Group short-term policies often specify a higher percentage than do group long-term policies, and it is not uncommon for group short-term policies to provide from 90 to 100 percent income replacement benefits.

Flat Amount

Individual disability income policies usually specify a flat benefit amount that the insurer will periodically pay to an insured who becomes totally disabled. The specified benefit amount is based on the amount of the insured's income when the policy was purchased. Unlike the benefit paid under group disability income policies, the specified benefit amount typically is paid to a disabled insured regardless of any other income benefits she receives during the disability. The income benefit amount that an individual disability income policy provides is lower than the amount of income the insured earned before becoming disabled. Insurers limit the maximum amount of disability income benefit that an applicant can purchase.

Supplemental Disability Benefits

A variety of supplemental benefits are available in connection with disability income policies. These supplemental benefits—which include partial disability benefits, future purchase option benefits, and cost-of-living adjustment (COLA) benefits—may be automatically included with the basic coverage or may be available on an optional basis for an additional premium amount.

Partial Disability Benefits

Some disability income policies provide benefits for periods when the insured person has a *partial disability*—a disability that prevents the insured either from performing some of the duties of his usual occupation or from engaging in that occupation on a full-time basis. The amount of the disability income benefit paid when an insured has a partial disability is described in the policy. The benefit amount is either a specified flat amount or an amount established according to a formula specified in the policy. Under the formula method, the amount of the income benefit will vary according to the percentage of income that the insured has lost because of the partial disability.

Future Purchase Option Benefit

Some disability income policies that specify a flat benefit amount contain a *future purchase option benefit*, which grants the insured the right to increase the benefit amount in accordance with increases in the insured's earnings. This benefit provision generally specifies that benefit increases can be made only if the insured can prove a commensurate increase in income; further, the amount of such increases generally is limited to a specified maximum. The insured, however, usually is permitted to increase the benefit amount without providing evidence of insurability.

Cost-of-Living Adjustment Benefit

A *cost-of-living adjustment (COLA) benefit* provides for periodic increases in the disability income benefit amount that the insurer will pay to a disabled insured; these increases usually correspond to increases in the cost of living. When a policy or rider provides a COLA benefit, it usually defines an increase in the cost of living in terms of a standard index, such as the Consumer Price Index (CPI), that measures changes in the prices of goods and services.

Exclusions

Disability income policies often specify that income benefits will not be paid to a disabled insured if the insured's disability results from certain causes. The causes of disability that typically are excluded from coverage include the following:

- Injuries or sicknesses that result from war, declared or undeclared, or any act of war
- Intentionally self-inflicted injuries
- Injuries received as a result of active participation in a riot or the commission of a crime
- Occupation-related disabilities or illnesses for which the insured is entitled to receive disability income benefits under a government program

Specialized Types of Disability Coverage

In addition to disability income coverage, insurers market specialized types of disability coverage. These specialized coverages are designed to provide benefits for

specific expenses—other than loss of income—that may result from an insured's disability. Businesses are subject to certain financial risks if an owner, partner, or key person dies. Likewise, such businesses could suffer a financial loss if an owner, partner, or key person becomes unable to work because of a disability.

Key Person Disability Coverage

Just as businesses that rely on the work of a key person may need to purchase key person life insurance, businesses also may need **key person disability coverage**, which provides benefit payments to the business if an insured key person becomes disabled. When a key person is unable to work because of disability, the business loses the person's services and, thus, loses money. Such losses can be offset by key person disability benefits.

Disability Buyout Coverage

In Chapter 5, we described buy-sell agreements and how they can be funded by life insurance policy death benefits. A buy-sell agreement also may include provisions concerning the purchase of a partner's or owner's interest in the business should the partner or owner become disabled. **Disability buyout coverage** provides benefits designed to fund the buyout of a partner's or owner's interest in a business should he become disabled.

Long-Term Care Coverage

Long-term care (LTC) coverage provides benefits for medical and other services to insureds who need care for an extended period in their own homes or in a qualified facility. With the increased life expectancy and better medical treatment in many parts of the world, increasing numbers of people may require long-term care. Because the costs of long-term care can deplete savings quickly, many people are turning to long-term care insurance to provide for that care. Insurance companies issue both individual and group long-term care policies. In addition, some insurers offer long-term care coverage as a rider to life insurance policies, disability income policies, or annuities.

Benefit Triggers

Long-term care insurance policies typically contain **benefit triggers**, which are requirements specifying the conditions that establish an insured's eligibility to receive long-term care benefits. Long-term care benefits generally are payable if an insured either loses his physical functional capacity to perform at least a specified number of the activities of daily living without assistance or has a severe cognitive impairment.

- The **activities of daily living (ADLs)** are the activities of eating, bathing, dressing, continence, toileting, and transferring into or out of a bed, chair, or wheelchair. A licensed health care practitioner must certify that the insured requires assistance with at least the specified number of ADLs.

- A **cognitive impairment** is a reduction in a person's ability to think, reason, or remember. Alzheimer's disease and dementia are common types of cognitive impairment. Cognitive impairment severe enough to require regular supervision or assistance to protect the insured and others around the insured triggers LTC benefits. LTC policies generally treat severe cognitive impairments as a benefit trigger even if the insured can perform all of the ADLs without assistance.

Long-Term Care Benefits

Long-term care insurance provides coverage for medical or other health-related services required in a qualified facility or, for most policies, in an insured's home. Qualified facilities may include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, hospices, assisted living facilities, and adult day care centers. Care paid for by LTC coverage may include diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services. LTC policies vary as to the facilities and services covered. For example, some group LTC policies provide home health care and adult day care as options, rather than as standard features of the policy. The benefit period for LTC insurance can be set for any length of time—from one year to a maximum of lifetime coverage.

Long-term care insurance policies generally state a **daily benefit amount**, which is the maximum amount of benefits payable for each day of an insured's long-term care at a care facility or in the patient's home.¹ Daily benefit amounts typically range from \$50 to \$500. Many LTC policies provide a lower daily benefit amount for certain types of facilities. For example, an LTC policy may provide a daily benefit amount of \$200 a day for care in a nursing home, \$150 a day for care in an assisted living facility, and \$100 a day for home care.

Long-term care policies generally determine the amount of benefits payable according to either the indemnity method or the reimbursement method.

- Under the **indemnity method**, the insurer pays the insured the daily benefit amount regardless of the actual expenses for long-term care of the insured. For example, if an insured enters a nursing home costing \$150 per day and the policy provides a daily benefit amount of \$200, then the insured will receive the daily benefit amount of \$200, even though the benefit is \$50 greater than the actual cost of nursing home care.
- Under the **reimbursement method**, the insurer pays the insured the amount of covered LTC expenses per day up to the stated maximum daily benefit amount. Under the reimbursement method, if an insured enters a nursing home costing \$150 per day and the policy provides a daily benefit amount of \$200, then the insured will receive a benefit of \$150 per day, the actual cost for nursing home care. However, if an insured enters a nursing home costing \$250 per day, and the policy provides a daily benefit amount of \$200, the insured will receive a benefit of \$200 per day, which is the maximum daily benefit amount for care in a nursing home.

Some LTC insurance policies contain an **inflation protection provision**, which either automatically increases the benefit amount each year by a specified percentage or allows the insured to opt for a higher daily benefit amount at specified intervals during the lifetime of the policy without having to show evidence of

insurability. Inflation protection also may be provided by means of a rider to an LTC policy.

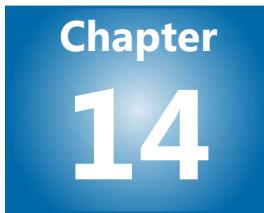
Many LTC policies have an *elimination period*, also known as a *waiting period* or *deductible period*, which is the number of days after long-term care begins that an insured must wait before benefit payments under the policy begin. Almost all insurers permit a person applying for an individual LTC insurance policy to select the desired elimination period from choices typically ranging from 0 to 100 days. However, group LTC policies have a set elimination period, which typically is 90 days.

Key Terms

medical expense coverage	Medicare
indemnity benefits	Medicaid
basic medical expense coverage	disability income coverage
hospital expenses	benefit period
surgical expenses	short-term individual disability income coverage
physicians' expenses	long-term individual disability income coverage
first-dollar coverage	short-term group disability income coverage
major medical expense coverage	long-term group disability income coverage
supplemental major medical policy	total disability
comprehensive major medical policy	presumptive disability
usual, customary, and reasonable (UCR) fee	elimination period
deductible	partial disability
calendar-year deductible	future purchase option benefit
coinsurance	cost-of-living adjustment (COLA) benefit
maximum out-of-pocket provision	key person disability coverage
dental expense coverage	disability buyout coverage
prescription drug coverage	long-term care (LTC) coverage
vision care coverage	benefit trigger
managed care	activities of daily living (ADL)
managed care plan	cognitive impairment
health maintenance organization (HMO)	daily benefit amount
preferred provider organization (PPO)	indemnity method
point-of-service (POS) plan	reimbursement method
network	inflation protection provision
primary care provider (PCP)	
copayment	

Endnote

1. Some LTC insurance policies instead state a *monthly benefit amount*, which is the maximum amount of benefits payable for each month of an insured's long-term care at a care facility or in the patient's home.



Chapter **14**

Health Insurance Policies

Objectives:

After studying this chapter, you should be able to

- Identify and describe the provisions that individual health insurance policies typically include
- Explain how differences between health insurance and life insurance affect the financial design of health insurance products
- Describe the factors that insurers consider in the financial design of individual health insurance products
- Identify and describe the provisions that group health insurance policies typically include
- Calculate the amount of benefits payable when an insured is covered by two group health insurance policies that contain a coordination of benefits (COB) provision
- Distinguish between fully insured plans and self-insured plans
- Explain why an employer might decide to self-insure a group health insurance plan
- Describe the operation of a self-insured group health insurance plan, including the use of stop-loss insurance and plan administration

Outline

Individual Health Insurance Policies

- Individual Health Insurance Policy Provisions
- Individual Health Insurance Underwriting
- Financial Design of Individual Health Insurance Products

Group Health Insurance Policies

- Group Health Insurance Policy Provisions
- Group Health Insurance Underwriting
- Funding Mechanisms

Individual and group health insurance policies both provide the health insurance coverages—including medical expense, disability income, and long-term care coverages—we described in the previous chapter. In this chapter, we describe the features of individual and group health insurance policies issued by commercial insurance companies. Remember that the term health insurance includes medical expense, disability income, and long-term care coverage. Throughout the chapter, we point out ways in which medical expense insurance policies, disability income policies, and long-term care policies differ.

Individual Health Insurance Policies

An individual health insurance policy is an enforceable contract between an insurance company and the policyowner. The policy describes the coverages provided, the benefits payable, and the premium amounts and their due dates. A copy of the insurance application the policyowner completed typically is attached to the policy when it is issued. The policyowner and the insured usually are the same person, although individual health insurance policies can provide coverage for the policyowner's family as well. The insurer typically pays benefits directly to the policyowner or to a health care provider on behalf of the insured.

To create a valid health insurance contract, the applicant must submit an application for insurance and pay the initial premium for the contract. The policyowner then must pay periodic renewal premiums to keep the policy in force.

Individual Health Insurance Policy Provisions

Individual health insurance policies include a number of provisions that are the same as provisions included in individual life insurance policies. For example, both types of policies include an *entire contract provision* that specifies the documents that constitute the insurance contract. With the exception of open contracts issued by fraternal insurers, the entire contract consists of the policy and any policy riders or other documents attached to the policy, including the attached application for insurance.

Some provisions are included in both individual life and individual health insurance policies, but the provisions contain some differences. In addition, individual health insurance policies contain some provisions that are not found in individual life insurance policies. In this section, we describe some of the provisions typically included in individual health insurance policies.

Grace Period Provision

Like individual life insurance policies, individual health insurance policies contain a *grace period provision* that allows the policyowner to pay a renewal premium within a stated grace period following the premium due date. Coverage remains in force during the grace period. If the premium is not paid by the end of the grace period, the policy lapses and all coverage ends.

The length of the grace period included in individual health insurance policies varies, depending on how frequently renewal premiums are payable. For example, policies for which renewal premiums are paid monthly typically contain a 10-day grace period. The grace period is usually 30 or 31 days if premiums are payable less often than monthly, although many insurers provide a 30- or 31-day grace period even when premiums are payable monthly.

Incontestability Provision

Individual health insurance policies include an incontestability provision that, like the incontestability provision included in individual life insurance policies, limits the time during which the insurer has the right to avoid the contract based on material misrepresentations made in the application. However, the policy provisions included in individual medical expense policies, individual disability income policies, and individual long-term care policies are not identical.

The incontestability provision included in most individual medical expense policies states that after the policy has been in force for a stated period of time—usually two or three years—the insurer cannot use a material misrepresentation in the application to contest the policy, *unless* the misrepresentation is fraudulent. In the United States, once an individual medical expense insurance policy is in force, insurers are prohibited from denying any claim on the basis of a material misrepresentation in the application, *unless* the misrepresentation is fraudulent or intentional. The incontestability provision specifically notes that the insurer retains the right to deny a claim on the basis of another policy provision. For example, the insurer may deny a claim on the basis that the expenses are specifically excluded from coverage.

The incontestability provision included in individual disability income policies is the same as the provision included in individual life insurance policies. The insurer cannot contest the disability income policy's validity on the ground of material misrepresentation in the application after a stated period—typically one or two years from the date the policy was issued. Note that, unlike the provision included in individual medical expense policies, the incontestability provision included in individual disability income policies does not include a reference to fraudulent misrepresentations.

According to the incontestability provision included in long-term care policies an insurer's right to avoid the insurance contract on the basis of a material misrepresentation in the application typically varies depending on the length of time the policy has been in force.

- If the individual long-term care policy has been in force for a period of at least six months but less than two years, the insurer cannot use a material misrepresentation in the application to contest the policy or deny a claim, unless the misrepresentation pertains to the condition for which benefits are sought. For example, suppose Nathan Morrison, a person with a history of heart disease,

indicated on his application for long-term care insurance that he had not been treated for heart disease. One year after the policy's effective date, Nathan was severely injured as a passenger in an automobile accident and, as a result, required long-term care. Although the insurer would have declined Nathan's application initially if it had known of his heart condition, the misrepresentation contained in the application did not pertain to the condition for which benefits were sought, namely, the injuries Nathan suffered in the automobile accident. Therefore, the insurer could not deny Nathan's claim for long-term care benefits on the basis of the misrepresentation in the application.

- If the individual long-term care policy has been in effect for more than two years, the insurer cannot contest the policy or deny a claim on the basis of misrepresentation in the application unless the insured knowingly and intentionally misrepresented relevant facts relating to his health.

Claims Provisions

Individual health insurance policies typically include provisions that define both the insured's obligation to provide timely notification of loss to the insurer and the insurer's obligation to make prompt benefit payments to the insured. For example, the policy may require the insured to notify the insurer of a claim in writing within 30 days from the date the claim arose and to furnish the insurer with proof of the loss within 90 days from the date the claim arose. Similarly, the policy may require the insurer to pay benefits within 60 days of receipt of proof of loss for a medical expense claim and within 30 days of receipt of proof of loss for a disability income or long-term care claim.

Legal Actions Provision

Individual health insurance policies typically include a **legal actions provision**, which limits the time during which a claimant who disagrees with the insurer's claim decision has the right to sue the insurer to collect the amount the claimant believes she is owed under the policy. The length of this time period varies from jurisdiction to jurisdiction, but it typically ranges from one to three years after the claimant provides the insurer with proof of the loss.

Overinsurance Provision

To prevent an insured from profiting from an illness or injury, many individual health insurance policies contain an **overinsurance provision**, which states that the benefits payable under the policy will be reduced if the insured is overinsured. An **overinsured person** is one who is entitled to receive either (1) more in medical expense benefits than the actual costs incurred for treatment or (2) a greater income amount during disability than the amount that would have been earned from working.

An overinsurance provision takes effect *only* if the insurer was not notified of the other existing coverage at the time of application. In cases of overinsurance, the insurer reduces the amount of the benefits that would otherwise be payable under the policy and refunds any premium amount paid for the excess coverage.

Physical Examination Provision

Individual disability income insurance policies usually include a **physical examination provision**, which states that the insurer has the right to have an insured who has submitted a claim examined by a physician of the insurer's choice, at the insurer's expense. Such an examination allows the insurer to verify the validity of disability income claims. The provision also gives the insurer the right to require that a disabled insured undergo medical examinations at regular intervals so that the insurer can verify that the insured is still disabled.

Individual Health Insurance Underwriting

Underwriting of applications for individual health insurance focuses on determining the degree of morbidity risk that a proposed insured represents. As noted in Chapter 1, morbidity risk refers to the risk of illnesses and injuries. Various factors affect the degree of morbidity risk a proposed insured presents. The primary factors that affect the degree of morbidity risk a proposed insured presents include the following:

- **Age.** Morbidity rates generally increase with age. As people grow older, they are more likely to become ill, and the average duration of each illness generally increases.
- **Health.** An individual's health history and current health are both important factors in determining morbidity risk. Many illnesses have a tendency to recur, and an individual's future health is strongly affected by her past and current illnesses and injuries.
- **Sex.** Because females generally experience a higher morbidity rate than males of the same age, the cost of providing health insurance coverage to females generally is higher than the cost of providing coverage to males.
- **Occupation.** A person's occupation may affect his morbidity risk. Occupational factors that affect the degree of morbidity risk include the hazards inherent in the occupation, the stability of the occupation, and the amount of recovery time people usually need to resume their normal job duties.
- **Avocations.** Engaging in certain sports or hobbies may expose an individual to an increased chance of injury or disease.
- **Work history.** A proposed insured's work history is especially important for disability income coverage. A person with a number of gaps in his work record or who has a history of only temporary jobs may be a poor risk for disability income coverage because he may lack the incentive to recover from a disability or the incentive to return to work.
- **Habits and lifestyle.** A person's habits and lifestyle can lead to a higher risk of accidental injury or illness. For example, a person who has a recent criminal record may present a higher degree of risk than does a person with no criminal record. Individuals who smoke or have alcohol or drug-related problems also are more likely to present health insurance claims than are people who do not use those substances.

In many jurisdictions, various laws limit the factors an insurer can consider in determining the degree of morbidity risk that a proposed insured represents. Laws in some jurisdictions place limits on the extent to which an insurer may consider an individual's health history or current health in determining morbidity risk for medical expense coverage. In addition, many jurisdictions have enacted antidiscrimination legislation to prevent health insurers from considering certain aspects of an applicant's lifestyle, such as the applicant's sexual orientation, during the underwriting process.

Financial Design of Individual Health Insurance Products

The fundamental principles underlying the financial design of health insurance products are the same as those underlying the financial design of life insurance products. Health insurance premiums must be adequate to provide the promised benefits and must be equitable to all policyowners. Nevertheless, life insurance and health insurance products have significant differences, and most of these differences affect how insurance companies create the financial design of these two products.

First, let's look at some of these differences between life insurance and health insurance.

- The amount payable for a life insurance claim is specifically defined by the policy, but the amount payable for a health insurance claim often is much less definite. For example, medical expense claims range from fairly small to very large amounts, depending on the severity and duration of the covered illness or injury.
- An insurer is likely to pay a number of covered claims for each person insured by a health insurance policy, but it will pay only one death claim for each person insured by a life insurance policy.
- Inflation, changes in the economy, and changes in medical practice affect the amount of benefits paid for health insurance claims much more dramatically than such factors affect life insurance claims.
- Medical costs may vary considerably in different geographic areas; as a result, the amount of benefits payable for a particular claim can vary by geographic location. By contrast, the amount of a life insurance policy death benefit does not vary by geographic location.

In creating the financial design of a health insurance product, an insurance company uses information about morbidity rates to calculate the product's *claim costs*—the costs the insurer predicts that it will incur to provide the policy benefits promised. For example, medical expense insurance typically provides benefits to pay various types of medical and hospital expenses. The insurer estimates the claim costs for each type of benefit provided.

The premium amount a customer pays for an individual health insurance policy varies depending on the choices the applicant makes concerning the coverage the policy provides. For example, an applicant is permitted to make some choices concerning the benefit levels that an individual health insurance policy includes.

Also, insurers usually offer an applicant for an individual medical expense policy several choices concerning the amount of the policy's deductible; the larger the deductible, the lower the amount of premium required. Insurers generally offer an applicant for an individual disability income policy or long-term care policy several possible combinations of elimination periods and maximum benefit periods.

A number of jurisdictions require an insurer's loss ratio to be at least a minimum stated percentage. The *loss ratio* is the ratio of benefits an insurer paid out for a block of policies to the premiums the insurer received for those policies. The loss ratio generally is stated as the percentage of premiums paid out in benefits for a block of policies. The loss ratio is calculated by dividing the total amount the insurer paid out in policy benefits for a block of policies by the total premiums the insurer received for that block of policies. For example, if an insurer received \$1,000,000 in premiums for a block of policies and paid out \$900,000 in policy benefits for those policies, then that block of policies has a loss ratio of 90 percent ($\$900,000 \text{ benefits paid} \div \$1,000,000 \text{ premiums received}$). Note that even if the loss ratio for a block of policies remains level over a period of time, the amount of premiums required for those policies will increase if policy benefit costs increase.

Group Health Insurance Policies

Most health insurance policies that commercial insurers issue are group health insurance policies. A group health insurance policy is an enforceable contract between an insurer and the group policyholder that purchased the group insurance coverage. The insured members of the group are not parties to the insurance contract and are not given individual policies. Instead, each insured group member is given a certificate of insurance or benefit booklet that provides information about the terms of the group health insurance coverage and the insured's rights under the policy.

If a group policyholder purchases different types of group health insurance, an insurer generally issues separate master policies to the group policyholder for each type of coverage provided. For example, an insurer could issue both a group medical expense policy and a group disability income policy to the group policyholder. In addition, a group policyholder can choose to purchase various types of health insurance coverage from one or more providers.

Group Health Insurance Policy Provisions

Many policy provisions are substantially the same in all group life and group health insurance policies. For example, every group health and group life insurance policy contains an eligibility provision that describes the eligibility requirements for coverage under the policy.

Similarly, group life and group health insurance policies both contain grace period provisions, providing a 30- or 31-day grace period following the premium due date during which insurance coverage remains in force even if the premium is not paid. If the required premium is not paid by the end of the grace period, the group life insurance or group health insurance policy terminates, and the group policyholder is legally obligated to pay the premium for the coverage provided during the grace period.

Some group health insurance policy provisions vary depending on the type of health insurance coverage the policy provides.

- Group medical expense insurance policies specify the types of medical expenses they cover, the benefit maximums (if any), the deductible amount, and the coinsurance features.
- Group disability income policies specify the definition of total disability, the length of the elimination period, the method of determining the amount of the disability income benefit payable, and the length of the maximum benefit period.
- Group long-term care policies specify the types of care covered, the benefit triggers, the daily benefit amount, the length of the maximum benefit period, and the length of the elimination period.

Many employer-employee group health insurance policies provide dependent coverage, but the availability of dependent coverage varies depending on the type of health insurance coverage a group policy provides.

- Most group medical expense policies provide that an insured employee's family and dependents are eligible for group insurance coverage. Such dependent coverage is generally available at the option of the insured group member, who usually must pay an additional premium amount for dependent coverage.
- Most group disability income policies do not provide coverage for dependents of group members.
- Many group long-term care policies provide optional coverage for certain dependents and family members of the insured employee. Depending on the policy, dependent coverage may be available for the insured employee's spouse, parents, or grandparents. Group long-term care policies typically do not provide dependent coverage for the insured employee's children.

Many of the provisions that typically are included in individual health insurance policies also are included in group health insurance policies. For example, both individual and group health insurance policies include a claims provision, an contestability provision, and a legal actions provision. Individual disability income policies and group disability income policies both include a physical examination provision.

Coordination of Benefits Provision

People often are eligible for coverage under more than one group medical expense plan. For example, spouses who both work often are eligible for coverage under their own employers' group policy and under their spouses' group policy. If an insured receives full benefits from both policies, he might receive benefit amounts that are greater than the amount of medical expenses actually incurred and, consequently, would profit from an illness or injury. The ***coordination of benefits (COB) provision*** is designed to prevent a group insured who is covered under more than one group medical expense policy from receiving benefit amounts that are greater than the amount of medical expenses the insured actually incurred. The COB provision prevents duplicate benefit payments by defining the group health plan that

is the primary provider of benefits and the plan that is the secondary provider of benefits for group insureds who have duplicate group medical expense coverage.

A plan defined in the COB provision as the primary provider of benefits is the plan that is responsible for paying the full benefit amounts promised under the plan. When the plan designated as the primary plan has paid the full benefit amounts promised, then the provider of the secondary plan determines the amount payable for the claim in accordance with the terms of the secondary plan.

A plan's COB provision may take one of several approaches to determining the amount of benefits payable when the plan is functioning as the secondary provider of benefits. Under the most common approach, the secondary provider first calculates the amount of the insured individual's total allowable expenses and the amount of those expenses that the insurer would pay if it were the primary provider. **Allowable expenses** are those reasonable and customary expenses that the insured incurred and that are covered under the insured's group medical expense plans. The secondary provider then looks at the amount the primary provider paid. If payment of the full benefit amount provided by the secondary plan would result in the insured receiving more in benefit payments from both plans than the total amount of allowable medical expenses, then the secondary plan pays only the difference between the amount of allowable expenses incurred and the benefit amount the insured already received from the primary plan. Under this type of COB provision, the insured individual typically pays no portion of her covered medical expenses; the primary plan pays all allowable expenses in excess of the deductible and coinsurance requirements, and the secondary plan pays the portion of allowable medical expenses not paid by the primary plan, including reimbursing the insured for any deductible and coinsurance amounts paid by the insured.

Example. Brad Metcalf is covered by two group medical expense plans; both plans include a coordination of benefits provision. Each plan also specifies a \$500 deductible and a 20 percent coinsurance requirement. Brad was hospitalized and incurred \$4,500 in allowable medical expenses. He submitted a claim for his expenses to the plan designated as his primary plan. Brad later submitted the claim, along with a description of the benefit paid by the primary plan, to his secondary plan.

Analysis. The plan designated as the primary plan is paying benefits equal to \$3,200. The calculations used to determine this benefit amount are as follows.

\$4,500	Total allowable expenses
– 500	Deductible
\$4,000	
– 800	Coinurance ($0.20 \times \$4,000$)
\$3,200	Amount payable by the primary plan

Because both plans contain the same deductible and coinsurance features, Brad's secondary plan normally also would pay him \$3,200 in benefits. Under the COB provision, however, the secondary plan will pay Brad only \$1,300; that is, the secondary plan will pay the difference between the total allowable expenses (\$4,500) and the amount the primary plan paid in benefits (\$3,200). Brad incurs no out-of-pocket costs.

Some group medical expense insurance policies contain another type of coordination of benefits provision, generally called a nonduplication of benefits provision, that limits the amount payable if the plan is defined as the secondary plan. A **nonduplication of benefits provision** is a COB provision that, if included in a secondary provider's plan, limits the amount payable by the secondary plan to the difference, if any, between the amount paid by the primary plan and the amount that would have been payable by the secondary plan had that plan been the primary plan. A nonduplication of benefits provision requires the insured individual to pay a portion of the cost of covered medical expenses and, thus, more strictly limits the amount of benefits payable than does the COB provision we discussed previously.

Example. Assume that Brad Metcalf from the previous example is covered under two group medical expense plans that contain the same deductible and coinsurance features as described. In this example, however, assume that Brad's secondary plan contains a nonduplication of benefits provision.

Analysis. As in the earlier example, Brad's primary plan would pay a \$3,200 policy benefit. Under the nonduplication of benefits provision, however, the secondary plan would pay no benefit because the primary plan had already paid the full \$3,200 benefit amount to which Brad was entitled under the secondary plan.

Most COB provisions include rules for determining which plan is the primary provider of benefits. First, most COB provisions state that when an insured also is covered by another group plan that does not include a COB provision, the plan without a COB provision is the primary provider of benefits; the plan with the COB provision is the secondary plan. In addition, if more than one group plan covering an individual includes a COB provision, then the primary plan is usually defined as the plan under which the insured is covered as an employee rather than as a dependent.

Example. Lori and Tom Calloway are married. Both Lori and Tom work full time for employers that provide group medical expense coverage to employees and their spouses and dependents.

Analysis. If only one plan covering the Calloways includes a COB provision, then the plan without the COB provision is considered the primary provider of benefits for both Lori and Tom. Alternatively, if both plans contain a COB provision, then Lori's primary provider is her employer's plan, and her secondary provider is the plan provided by Tom's employer. Tom's primary provider is his employer's plan, and his secondary provider is the plan provided by Lori's employer.

Insurers use a variety of methods to define which plan is the primary provider of benefits if an individual is covered as a dependent under more than one group plan. A common method, known as the *birthday rule* or the *earlier birthday method*, states that the plan covering the employee whose birth date falls earlier in the calendar year will be considered the primary provider of benefits for a dependent.

Note that the employees' actual ages are not a factor in determining the primary provider under the birthday rule.

Example. Assume that Lori and Tom Calloway from the previous example have a son, Jake, who is covered as a dependent under both of their group plans. Lori Calloway was born on March 1, 1980, and Tom Calloway was born on September 1, 1975.

Analysis. According to the birthday rule, the plan provided by Lori's employer would be considered the primary provider of benefits for Jake because Lori's birthday falls *earlier in the year* than Tom's birthday. The actual year in which Lori and Tom were born is not a factor in determining which plan is considered the primary provider of benefits for Jake.

Conversion Provision

Insurers often include a conversion provision in their group medical expense policies. The **conversion provision** gives an insured group member who is leaving the group a limited right to purchase an individual medical expense policy without presenting evidence of insurability. The right is limited in that the insurer can refuse to issue the individual policy if the coverage would result in the insured group member becoming overinsured. For example, an employee who is changing jobs and will be eligible for group medical expense insurance from her new employer would probably be overinsured if she were also issued an individual medical expense policy.

Many individuals who lose their group medical expense coverage cannot afford the cost of an individual medical expense policy. To protect such individuals, laws in some jurisdictions require certain group insurance plans that provide medical expense benefits to allow eligible covered employees the right to continue their group insurance coverage for a limited time in specified situations—such as the termination of employment—in which their group coverage would otherwise terminate. A person who elects to continue group medical expense coverage typically pays the full cost of continuation coverage, including any portion of the premium that the employer had paid.

Group Health Insurance Underwriting

When an insurer evaluates a group for group health insurance coverage, the insurer applies the group underwriting principles we described in Chapter 11. Usually, the group as a whole—rather than the individual members of the group—must meet the insurer's underwriting requirements. Underwriters evaluate a proposed group's expected morbidity rate, which reflects a number of factors such as the industry in which the group members work, the age distribution of the group, and the distribution of males and females in the group.

Funding Mechanisms

The way in which a group insurance plan's claim costs and administrative expenses are paid is known as the plan's **funding mechanism**. A number of funding mechanisms are available for group insurance plans. At one extreme is a **fully insured plan** for which the group policyholder makes periodic premium payments to an

insurance company, and the insurance company bears the responsibility for all claim payments. At the other extreme is a ***fully self-insured plan***, also known as a ***fully self-funded plan***, for which the group policyholder—usually an employer—takes complete responsibility for all claim payments and related expenses. Between these extremes are a number of alternative funding mechanisms.

Fully Insured Plans

A fully insured plan is the traditional funding arrangement for a group health insurance plan. The insurer issues the group health insurance policy on a one-year renewable term basis, and each year's premium pays for just that year's coverage. New premium rates are charged each year based on the attained ages of the insured members of the group and the group's claim experience. These group health insurance premium rates are typically guaranteed for 12 months. At the end of the policy year, the insurance company may establish new premium rates for the group. Most group long-term disability income and group long-term care insurance plans are fully insured.

Premiums for group health insurance policies usually are payable monthly and can be paid by the group policyholder, the individuals insured under the group policy, or both. As noted in Chapter 11, if the group policyholder pays all of the premiums without requiring the individual insureds to pay anything, the group insurance plan is said to be *noncontributory*. If individual insureds pay any part of the premium, the plan is said to be *contributory*. Individual insureds' contributions generally are paid to the group policyholder, which then makes monthly premium payments to the insurer. For most employer-sponsored group health insurance plans, the employer collects required premium contributions from covered employees through payroll deductions.

The insurer bears all risk under a fully insured plan. If the dollar amount of the claims submitted exceeds the dollar amount of premiums collected, the insurer must absorb the loss. On the other hand, if the group experiences lower claim expenses than anticipated and the dollar amount of the claims submitted is less than the dollar amount of premiums collected, the insurer retains the difference as profit.

Self-Insured Plans

As noted in Chapter 1, individuals and businesses sometimes decide to accept responsibility for a given financial risk rather than purchasing insurance to cover the risk. ***Self-insurance*** is a risk management technique by which a person or business accepts financial responsibility for losses associated with specific risks. Many employers choose to partially or fully self-insure, or self-fund, the medical expense or disability income coverage they provide for their employees. As a result, the employers bear some or all of the risk of paying claims and the risk that claims may be excessive.

Many employers, for example, fully self-insure short-term disability income coverage for their employees by means of a salary continuation plan. A ***salary continuation plan*** typically provides 100 percent of the insured employee's salary, beginning on the first day of the employee's absence resulting from illness or injury and continuing for a specified period.

Alternatively, many group medical expense insurance plans are partially self-insured. Under such an arrangement, the employer is financially responsible for

paying a certain level of claims, and the risk for claims above that level is transferred to a traditional health insurance provider. For example, an employer might self-insure the plan's basic medical expense benefits and purchase supplemental major medical insurance coverage from an insurance company.

Many employers believe that self-insuring can help them better control increasing health care costs by allowing them to avoid some of the costs that are built into traditional insurance premium rates. For example, a self-insured employer can avoid paying sales producer commissions and the insurer's operating expenses. Another benefit an employer may receive from self-insuring is an improved cash flow because the employer retains the money it would have paid in premiums and can earn interest on that money.

Stop-Loss Coverage. If a self-insured group experiences several catastrophic medical claims in one year, the employer may not have the financial resources to pay all of the claims. For this reason, many employers that self-insure purchase from an insurance company ***stop-loss insurance***, which enables employers to place a maximum dollar limit on their liability for paying health insurance claims. Several forms of stop-loss coverage are available.

- Under ***individual stop-loss coverage*** or ***specific stop-loss coverage***, the stop-loss insurer reimburses the employer for all claims paid for any individual that exceed a stated amount in a stated period of time. The ***individual deductible***, or ***specific deductible***, is the dollar amount of claims that an employer must pay for any individual in a stated period of time before the stop-loss insurer reimburses the employer for any excess amount. Note that the insurer reimburses the employer whenever the ***total amount of claims*** paid for any individual in a stated period of time exceeds the individual deductible, not merely when any particular claim exceeds the deductible. For example, suppose an employer has individual stop-loss coverage with an individual deductible of \$10,000 in a specified 12-month period. During that period, the employer pays three separate claims of \$4,000 each for one insured group member. The stop-loss insurer would reimburse the employer \$2,000, the amount by which the claims paid ($\$4,000 \times 3 = \$12,000$) exceed the individual deductible.
- Under ***aggregate stop-loss coverage***, the stop-loss insurer begins to reimburse the employer for claims when the employer's total claims exceed a stated dollar amount within a stated period of time. The ***attachment point***, sometimes referred to as the ***aggregate deductible***, is the total dollar amount of claims that the employer must pay within a stated period of time before the stop-loss insurer begins to reimburse the employer. For example, an employer might purchase aggregate stop-loss coverage with an attachment point of \$250,000 in a specified 12-month period. If the employer paid a total of \$300,000 in claims during that period, the insurer would reimburse the employer \$50,000.

Many employers purchase both individual and aggregate stop-loss coverage. Stop-loss coverage typically is provided under a contract between the stop-loss insurer and the employer. The contract defines the relationship between the insurer and the employer and includes a schedule of benefit payments for which the insurer will reimburse the employer. The agreement is typically for a 12-month period. Note that the stop-loss insurer does not make benefit payments directly to the insured group members; instead, the insurer reimburses the employer, which retains responsibility for making claim payments to insureds.

Plan Administration. Self-insured plans are administered by a variety of methods. Some employers that self-insure their plans are able to fully administer their own plans. For other employers, having an outside organization provide some or all administrative services for the plan is more cost-effective. These employers usually purchase an ***administrative services only (ASO) contract*** from an insurance company or other organization, such as a third-party administrator (TPA). A ***third-party administrator (TPA)*** is an organization other than an insurance company that provides administrative services to the sponsors of group benefit plans. Under an ASO contract, the employer pays a fee in exchange for the administrative services provided by the insurer or TPA.

Key Terms

legal actions provision	fully insured plan
overinsurance provision	fully self-insured plan
overinsured person	self-insurance
physical examination provision	salary continuation plan
claim costs	stop-loss insurance
loss ratio	individual stop-loss coverage
coordination of benefits (COB) provision	individual deductible
allowable expenses	aggregate stop-loss coverage
nonduplication of benefits provision	attachment point
conversion provision	administrative services only (ASO) contract
funding mechanism	third-party administrator (TPA)