Texas

Life & Health

Insurance School of Texas

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Study and Testing

1. **How to Pass Your Exam:**
   a. **Read the book before attending class.**
   b. Your practice exams are online at https://www.insuranceschooloftexas.com.
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      ii. Your Password is Valid for 90 days from the date of purchase.
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   b. Bring the required forms of ID as required by testing center (see website: www.pearsonvue.com or phone 888-754-7667)
   c. For most of you the license to sign up for will be these. Please check with your company before you select the license exam.
      1.General Lines Life, Accident and Health (Ins TX-LAH05)
      2.General Lines Property & Casualty (Ins TX-PC06)
   d. When you are seated you will have a sheet and marker pen. Before beginning test write down on the sheet things you want to remember and refer to during test.
   e. **Read the whole question and all answers carefully.** Don't assume you know what they are asking for.
      1. Be aware of words such as: NEVER, ALWAYS, ONLY, and EXCEPT
   f. Use the process of elimination – Eliminate the answers you know are wrong and then select the BEST answer.
   g. NEVER change your first choice unless you are absolutely sure it is wrong.

OUR OBJECTIVE IS YOUR SUCCESS!!

HOUSTON	ABILENE
450 N. Sam Houston Pkwy. E. East Hall, Suite 130 Houston, TX 77060	See your receipt for class location

TEST BREAKDOWN

2021 -2022

Life & Health		Life Only	
2 ½ Hours		2 Hours	
Chapters 1-13	**State Law**	**Chapters 1-7**	**State Law**
115 Questions	**35 Questions**	**60 Questions**	**35 Questions**
100 Count	**30 Count**	**50 Count**	**30 Count**
Must score 70% overall		**Must score 70% overall**	
Can miss 39 and still pass		**Can miss 24 and still pass**	

INSURANCE SCHOOL OF TEXAS

Table of Contents

TEXTBOOK LEGEND

Wherever you see:

This is a universal truth. No matter where you are on the test, this information is <u>always true.</u>

This is Texas state specific and will be found in Section 2 of your exam.

This is information regarding taxation.

INSURANCE SCHOOL OF TEXAS

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OF TEXAS

Life Insurance

Chapter 1 - Insurance 101

SUMMARY
This chapter discusses Texas insurance law and the basics of insurance setting the foundation for the rest of the course.

I. General Definitions

A. Insurer – the insurance company or carrier

B. Insured – the person upon whom the insurance is written and rated

1. NOTE: The only difference between A. and B. is one letter!

C. Policyowner - the person with ownership rights in the policy.

1. This may or may not be the insured.

D. Beneficiary - the person designated to receive death benefits in a life or health policy.

E. Insurability

1. The acceptability of an applicant for an insurance policy from an insurer at a given rate.

F. Underwriting

1. Underwriting is the process of classifying a risk for the purpose of issuing insurance coverage.

G. Insurable Interest

1. Insurable interest is a principle that requires the purchaser of life insurance to suffer financially in the event of a loss (death of the insured) to obtain insurance and collect claim payment.

2. In life & health insurance, insurable interest must exist at the time of application.

a) For example, a newly married couple have insurable interest on one another upon their marriage. They take out a life insurance policy on each other. Ten years later, the couple is divorced and neither remembers to change the beneficiary on their life insurance policies. When one of them dies, the policy will still pay to the other because the insurable interest existed at the time the policy was purchased. It is not necessary at the time of the loss.

H. Cancellation

1. Cancellation is the discontinuation of a policy prior to the expiration date of the policy if any.

I. Non-Renewal

1. This is the discontinuation of a policy at the end of its term.

J. Rider

1. A rider is a policy form used to add or revise coverage in a life or health policy.

a) Also, known as an endorsement.

K. Exclusion

1. This is a cause of loss or situation not covered by the policy.

II. The Commissioner of Insurance

A. The Commissioner of Insurance is appointed by the Governor to be the Department of Insurance's chief executive and administrative officer.

B. The Commissioner's powers are stated in the Insurance Code as:

Commissioner Can	Commissioner Cannot
Enforce insurance rules and law	Make insurance law or any law
Issue Subpoenas, hold hearings, administer oaths, take testimony, assess and enforce penalties	Prosecute non-insurance related crimes (not a public prosecutor)
Sets Continuing Education Requirements	Sentence anyone to jail or prison
Ensure the fair treatment of consumers	
Administers the Workers' Compensation system	
Approves producer licenses and insurer's Certificate of Authority	
Approves insurers policy and endorsement forms	

C. The Commissioner of Insurance, an insurer, the district attorney and legal entities such as the local police or FBI can investigate and request information about fraudulent claims.

1. The insured cannot request information about fraudulent claims.

III. Examination of Records

A. The Department of Insurance will, at least once every five years, examine the books and records of each domestic and admitted insurer to determine their financial stability.

IV. Investigation/Notice of Hearing

A. The department may examine and investigate the affairs of a person engaged in the business of insurance in this state to determine whether the person has or is engaged in an unfair method of competition or unfair or deceptive act.

B. When the department has reason to believe that a person engaged in the business of insurance in this state has engaged or is engaging in this state in an unfair method of competition or unfair or deceptive act or practice defined by Subchapter B and that a proceeding by the department regarding the charges is in the interest of the public, the department shall issue and serve on the person:

1. a statement of the charges; and

2. a notice of the hearing on the charges, including the time and place for the hearing.

a) The department may not hold the hearing before the sixth day after the date the notice is served.

V. Cease and Desist Orders

A. On determining that a person committed a violation the department shall:

1. make written findings; and

2. issue and serve on the person an order requiring the person to cease and desist from engaging in the method of competition or act or practice determined to be a violation.

VI. Penalties

A. ADMINISTRATIVE PENALTY

1. A person who violates a cease and desist order is subject to an administrative penalty.

2. An administrative penalty imposed under this section may not exceed:

a) $1,000 for each violation; or $5,000 for all violations.

3. An order of the department imposing an administrative penalty under this section applies only to a violation of the cease and desist order committed before the date the order imposing the penalty is issued.

B. CIVIL PENALTY FOR VIOLATION OF CEASE AND DESIST ORDER

1. A person who is found by a court to have violated a cease and desist order is liable to the state for a penalty. The state may recover the penalty in a civil action.

a) The penalty may not exceed $50 unless the court finds the violation to be willful, in which case the penalty may not exceed $500.

VII. Reinsurance Reserves

A. A reinsurance reserve is a required fund set up by the insurer for the protection of its policyholders.

B. The funds are utilized in the event the insurer becomes insolvent (bankrupt), unable to pay off outstanding claims.

C. The Department of Insurance is responsible for computing the amount of reinsurance reserves necessary for all policies of all insurers in the state, with certain policies excepted.

D. The Department does not have the right to tell an insurer when to release the funds.

VIII. Domicile of Insurer

A. Domicile means the jurisdiction under which an insurer is formed, incorporated, or has its' home-office.

1. Where is the insurer from?

B. There are 3 categories of domicile:

1. Domestic – an insurer that was formed, incorporated, and has its home office in Texas.

a) Examples: Texas Life's home office is in Waco; American National's home office is in Galveston.

2. Foreign – an insurer that was formed, incorporated, and has its home office in any state in the United States, except Texas.

a) Examples: Farmer's home office is in California, Allstate and State Farm's home office are in Illinois, AFLAC's home office is in Georgia.

3. Alien – an insurer that was formed, incorporated, and has its home office in another country.

a) Examples: Sun Life of Canada's home office is in Canada; Zurich's home office is in Switzerland.

IX. Admission

A. Is the insurer allowed to sell insurance in Texas?

B. Admission has nothing to do with domicile!

C. Admitted Insurer

1. An admitted insurer is an insurer that has sought permission from the Commissioner of Insurance and been granted authority to sell insurance policies in Texas.

a) Simply put, they're allowed to sell policies (conduct business) here.

b) Where the insurer is from (domestic, foreign, or alien) doesn't matter!

2. Certificate of Authority

a) Admitted insurers receive a Certificate of Authority.

b) Think of this as an insurance license for the insurer.

3. Sanctions and Penalties

a) If an insurer fails to meet admission requirements or breaks the rules of the Commissioner, the Commissioner may suspend or revoke the Certificate of Authority.

b) The Commissioner must provide the insurer 10 days' notice before revoking the insurer's Certificate of Authority.

c) If the Commissioner denies an application for or revokes a Certificate of Authority, the insurer can request a hearing which must be held within 30 days of the request.

d) We call this the 10/30 rule.

(1) If you kick someone out, you want them gone *fast!* So, 10 days' notice to get out.

(2) If a hearing is to be held then everyone's schedule must line up. A longer period is needed to coordinate schedules.

(a) Hearings are always 30 days!

X. Guaranty Associations

1. The Texas Life and Health Insurance Guaranty Association:

2. Is a non-profit legal entity that provides protection, for life, health, and annuity policies owned by Texas residents if a member insurance company is found to be insolvent and is ordered liquidated by a court.

3. The Association either continues the insurance policy coverage, including paying the claims and other policy benefits, or transferring the policies to another insurance company.

XI. Types of Insurers

A. Stock Insurer

1. A stock insurer is owned by its stockholders also known as shareholders.

2. The shareholders elect a Board of Directors to guide the company.

3. Shareholders receive taxable dividends as a return of profit.

4. Dividends are not guaranteed!

B. Mutual Insurer

1. A mutual insurer is owned by its policyholders.

2. The policyholders elect a Board of Directors to guide the company.

3. Policyholders receive non-taxable dividends as a refund of premium.

4. Dividends are not guaranteed!

C. Fraternal Benefit Society

1. A Fraternal Benefit Society provides insurance only to their members.

2. An individual must be a member of the organization to obtain insurance.
    a) Examples would include Woodmen Life and USAA.

XII. Transacting Insurance

A. The transaction of insurance includes all the following:
- **1.** Collecting a premium, commission, or other fee
- **2.** Issuing or delivering a proposal or policy
- **3.** Receiving an application for insurance
- **4.** Directly or indirectly acting as a producer

B. Setting up appointments, selling mutual funds, and paying claims are not transacting insurance.

XIII. Advertising Insurance

A. For an advertisement to be legal the insurer must use the full or complete corporate name in any form of advertisement.

B. Advertisements cannot use solely:
- **1.** Trade name of an insurer
- **2.** Parent company name
- **3.** Logo only of the insurer

XIV. License Types

A. General Lines Life, Accident, & Health License

1. This is the standard license type.

Required to License	NOT Required to License
Be at least 18 years' old	Be at least 21 years' old
Be honest, fair and in good standing with the state	Have a high school diploma, GED, or college degree
Submit the application and fees	Be a U.S. Citizen
Pass the exam within the last 12 months	

2. A person who has a Chartered Life Underwriter (CLU) designation is not required to test to obtain a Life & Health license.
    a) Certified Financial Planners (CFP), Chartered Financial Consultants (ChFC), and Certified Public Accountants (CPA), would be required to test to obtain their insurance license.
    b) Remember that someone with a CLU designation has a CLUe about insurance, so they do not need to test!

B. Temporary License

- **1.** A temporary license is issued to individuals being considered for appointment by a producer or insurer.
- **2.** The license is valid for 90 days and cannot be renewed more than once in any 6-month period.
- **3.** The individual must complete 40 hours of supervised training.

4. No exam is required to obtain this license.

C. Life and Health Insurance Counselor

1. A Life and Health Insurance Counselor's license is issued to a person who is available to the public to examine and evaluate risks for a person obtaining life or health insurance.

2. Insurance Counselors give advice for a fee on how much and what kind of insurance to buy. MGA's and Financial Advisors charge fees for advice as well.

3. Limited Lines licensees **cannot** charge a fee for advice.

XV. Appointment

A. A person wishing to sell insurance must have an insurance license and an appointment from an insurer selling policies in Texas.

B. If a producer appointed with one company wishes to sell for a second company, that producer need only request appointment.

1. This is how independent agencies sell through multiple companies.

C. Canceling the appointment allows insurers terminate their relationship with a producer.

XVI. Continuing Education

A. Insurance licenses in Texas expire after 2 years (24 months).

B. To maintain a license, a producer must complete the continuing education requirements set forth by the state before the expiration date of the license:

1. 24 total hours

2. 50% of the total hours must be completed in a classroom or classroom equivalent - 12 hours

3. 2 hours of the total 24 must cover ethics.

C. Those who have maintained their license for 20 consecutive years are exempt from continuing education requirements.

D. The requirement is the same regardless of the number of insurance licenses held by the person.

E. A penalty of $50 for every hour not properly completed will apply. If a licensee does not complete the 24 hours of CE before the expiration date of the license, the licensee will have 90 days to complete the deficient number of hours and pay a fine of $50 per deficient hour. If these two conditions are not met within 90 days of the license expiring, the license will be inactivated, and the licensee will have to apply for a new license. A new license will not be granted until the deficient CE hours are completed, and the fine is paid.

XVII. Records Maintenance

A. Licensees and adjuster applicants must provide evidence of completion of courses to TDI or its designee upon request. Each licensee must maintain evidence of each course completed for a period of at least four years from the date of completion of the course for the purpose of investigation or audit. Licensees must continue to maintain evidence of compliance during any period in which the licensee has been notified by TDI or its designee that the records or the licensee's compliance is the subject of an investigation or audit.

B. Types of course completion evidence of compliance may include:

1. a certificate of completion from a provider;
2. a college transcript;
3. a passing grade report from a national designation program;
4. a certificate or report of completed continuing education hours issued by a professional licensing authority or a provider of a course certified by a professional licensing authority; or
5. a letter from the program sponsor's representative stating the number of hours the licensee taught.

XVIII. Notification to Department of Certain Information

A. An individual licensed as a producer shall notify the department on a monthly basis of:

1. a change of the license holder's mailing address;
2. a felony conviction of the license holder; or
3. an administrative action taken against the license holder by a financial or insurance regulator of this state, another state, or the United States.

XIX. Producer Responsibilities

A. Insurance producers are in a unique position between the insurer and the insured where they represent both, although technically they only represent the insurer.

B. As such they have certain responsibilities to each party, such as:

1. Fiduciary Duty
   a) Keeping premium funds in an account separate from your personal funds. Forwarding premiums promptly to insurer.
   b) Producers have a fiduciary responsibility to insureds, insurers, applicants but not to other producers.
2. Report material facts to underwriting.
3. Understanding all the applicant’s insurance needs.
4. Only recommend appropriate policies to applicants and not the most profitable coverage for the producer.

XX. Unfair Business Practices

A. Boycott, Coercion, Intimidation

1. These are deliberate and forceful actions intended to unreasonably restrain an individual or organization.
2. **Boycott –** refusing to do business with someone.
3. **Coercion** – compelling someone to act against their own interest
   a) For example, telling a claimant that they must sign a release before they will receive aid in handling the claim would be coercion.
4. **Intimidation** – causing someone to fear harm or injury

B. Commingling

1. Insurance producers are prohibited from commingling premiums collected with their own personal funds.
2. Life insurance policy proceeds received by a trustee may be commingled with any other assets properly coming into a trust.

C. Controlled Business

1. Controlled business is selling only to friends, family, employer or neighbors.
2. Texas requires producers write insurance for the general public.

D. Defamation

1. Defamation is defined as any written or spoken statement about a person or organization that is both false and maliciously critical of a person or company with the intent to injure that person or company engaged in the business of insurance.
   a) For example, a producer lying to a client by advising them not to shop their insurance with a certain producer because that producer is a racist or steals premiums.

E. Discrimination

1. Discrimination is the unfair or illegal treatment of rights to a person purely on the arbitrary basis of characteristics such as:
   a) Age, Race, Gender, Note: Age and sex can determine rates
   b) Religion
   c) Marital Status
   d) Sexual Orientation
   e) National Origin

F. False Advertising

1. False advertising is a publicly made statement that is deceptive or untrue or aimed to mislead the public about a person working in insurance or about the industry itself.
2. This statement must be published and placed before the public in print, on television, radio, or the internet, or any other manner.

3. An insurer who misleads the public about its assets, corporate structure, financial standing or age is guilty of false advertising.
4. A statement in print that future dividends are guaranteed, or exaggerated dividend payments are examples of false advertising.

G. Rebating

1. Rebating is offering anything of any value or returning or offering to return a portion of initial premium or commission to an applicant to induce the purchase of insurance from that producer.
2. Also, qualifying as rebating is offering anything of any value as a reward of any kind for a referral of business if the reward is based upon policy purchase.
3. Nothing can be given as a thank you for purchase of a policy, except what is listed in the policy!
4. **Commission Sharing** is allowed between two producers who have the same license type where one referred a customer to the other and are or are not appointed by the same company.

H. Unfair Discrimination

1. An insurer must not make or permit with respect to a life insurance or life annuity contract an unfair discrimination between individuals of the same class and equal life expectancy regarding:
   a) the rates charged;
   b) the dividends or other benefits payable; or
   c) any of the other terms and conditions of the contract.

XXI. Unfair Claim Settlement Practices Act

A. The following are defined as unfair claim practices, and are prohibited under Chapters 541 and 542 of the Texas Insurance Code:

1. Misrepresenting to a claimant a material fact or policy provision relating to coverage at issue.
   a) Lying to a claimant.
2. Failing to acknowledge pertinent communications relating to a claim within 15 business days.
3. Failing to attempt to seek a prompt and fair settlement when liability is clear.
4. Failing to promptly provide a reasonable explanation for the denial of a claim.
5. Failing to affirm or deny coverage within a reasonable time.
6. Attempting to enforce a full release of a claim from a policyholder when only a partial payment has been made.

7. Failing to provide claims forms within a reasonable time.
8. Failing to adopt reasonable standards for investigation of claims.
9. Refusing to pay claims without first conducting a reasonable investigation.

B. If, upon reviewing a consumer complaint, the Department determines further action is required, then it will set a date for a hearing.
1. The Department must give the accused insurer 30 days' advance notice of the hearing.

C. If the Department finds the insurer violated the act, the Department will issue a cease and desist order and may revoke or suspend the insurer's Certificate of Authority.

XXII. Disciplining A Licensee

A. If any of the Unfair Business Practices or Claims Practices above are committed the Department may discipline an individual licensee.

B. Additionally, a licensee or license applicant can have their license non-renewed or be disciplined for the following:
1. Intentionally violating insurance law.
2. Obtaining a license by fraud or misrepresentation.
3. Withholding funds belonging to an insurer or insured.
4. Been convicted of a felony.
a) But not a misdemeanor.
5. Engaging in Controlled Business. Selling insurance to family only.

C. A licensee or license applicant cannot be denied a license if they've filed for bankruptcy.

D. If a licensee or license applicant is found guilty, the Department can take the following actions:
1. Deny an application for original license or renewal.
2. Suspend the license.
3. Assess a financial penalty.

E. An individual whose license was denied, suspended, or revoked, must wait 5 years before reapplying which does not guarantee that a license will be issued.

XXIII. Federal Laws Affecting Insurance

A. Fair Credit Reporting Act

1. This act is intended to promote the fairness, accuracy, and protection of private information contained in consumer reports, such as a credit report.

2. It created legal requirements to ensure the protection of the public from overly intrusive information collection practices by making sure the data collected on an applicant is kept confidential, accurate, and used for a proper purpose.

3. At the time of application, the applicant must be notified that a credit report will be obtained, and the producer must obtain the applicant's signed permission to do so.
4. The credit report can be used to determine the financial and moral status of an applicant for insurance.
5. If there are any inaccuracies on a credit report, the producer and insurer cannot correct them.
    a) The applicant must contact the consumer reporting agency that provided the report to make the correction.

B. USA Patriot Act (Financial Anti-Terrorism Act)

1. This act which was enacted after 9/11 imposed recordkeeping and reporting requirements on financial institutions, including insurers, to aid in monitoring criminal acts like, laundered money for drug trafficking or money being used to finance terrorism.
    a) An example of a red flag would be a potential client trying to pay for a policy upfront in full, with a duffle bag full of cash.

XXIV. Risk Management

A. Risk - is uncertainty concerning the potential for a loss.

1. **Types of Risk**
    a) **Speculative Risk**
        (1) A risk where the circumstances provide the opportunity for loss, gain or neither.
            (a) For example, while gambling someone could lose money, break even, or win money.
            (b) For example, investments in the stock market can be a loss, gain or breakeven on any given day.
        (2) Speculative risk is not insurable because of the opportunity for gain.
    b) **Pure Risk**
        (1) A situation where there is no chance for gain; the options are nothing occurs, or a loss occurs.
            (a) For example, the potential for financial loss as the result of death. Either the insured dies or they don't.
        (2) It must be pure to insure!

B. Methods of Risk Management

1. **Transfer -** risk transfer is the shifting the burden of the risk onto another party.
    a) For example, insurance transfers the risk of loss from the insured and to the insurer.

2. **Avoid -** risk avoidance is the elimination of the risk.
    a) Insurance cannot do this.
3. **Reduce -** risk reduction is minimizing risk but not eliminating it.
    a) For example, eating a healthy diet and exercising or taking medications appropriately.
4. **Retain -** risk retention is self-insuring meaning not carrying insurance for the risk.
    a) For example, parents often neglect to purchase life insurance on themselves until older or on their children.

XXV. Contracts

A. Insurance policies are legal contracts and must meet certain specifications to qualify as a legal contract.

B. The Four Elements of a Legal Contract

1. Legal Purpose

a) A contract can only be entered for a legal purpose.
b) The contract cannot violate public policy or law.
    (1) For example, no one can knowingly insure a drug dealer with a life insurance policy.

2. Competent Parties

a) Each party to the contract must have the legal capacity to enter the contract.
b) Restricted parties:
    (1) Minors - persons under the age of majority which in Texas is 18.
    (2) Intoxication - persons under the influence of legal or illegal drugs or alcohol.
    (3) Incapacitation - persons with a mental defect or disorder.
c) Old age alone is not sufficient to bar someone from entering into a contract.

3. Agreement

a) One party must make an offer to the other which must be accepted, thus forming an agreement.
b) **Offer** - In insurance, the offer is the applicant submitting the application and the initial premium.
c) **Acceptance** - The acceptance in insurance is when the insurer accepts the offer by issuing a policy.

4. Consideration (4P's)

a) Consideration is the exchange of values by both parties. **P**remium **p**ayment for **p**romise to **p**ay.
b) The insured's consideration is their premium payment.

c) The insurer's consideration is their promise to pay the claim.

Note: Negotiation is not one of these elements!

C. Contract Terms & Definitions

1. Contract of Adhesion

a) A contract offered to the first party, the insured, by the second party, the insurer, requiring the first party to accept or reject the contract in total without having the opportunity to negotiate.

b) This type of contract could be called "take it or leave it".

(1) If the first party does not like a condition set forth in the contract (the policy), they cannot make changes.

c) No negotiation is required to contract.

d) Insurance policies are contracts of adhesion and, as such, are construed strictly against the party writing them (i.e., the insurer) if there is any ambiguity in the wording of the contract. Only the insurer can make changes in the contract.

2. Aleatory Contract

a) An agreement that allows the unequal transfer of value between the parties.

b) Insurance policies are aleatory contracts because an insured can pay premiums for years without filing a claim for a loss.

c) On the other hand, an insured's total premium payments are potentially less than the benefit received at the time of loss.

3. Unilateral Contract (one-sided)

a) An agreement where only one party makes a promise of future performance.

b) Most insurance policies are unilateral contracts in that only the insurer makes a legally enforceable promise to pay covered claims.

c) By contrast, the insured is not required to maintain the policy.

4. Conditional Contract

a) An agreement where both parties to the contract fulfill certain conditions to keep the contract enforceable.

(1) As in the above example, the insured must pay premiums on time and report losses to be paid.

5. Representation

a) representation is a statement made by an applicant in the application that is believed to be true or substantially true to the best of the applicant's knowledge.

(1) For example, an applicant can only make a representation that they are in good health.

6. **Warranty**
   a) A warranty is a statement made by an applicant or a stipulation in the policy that guarantees something is true in all respects.
      (1) For example, an applicant can warrant their name, social security number, mailing address, etc.
      (2) They rhyme! Warranties are guarantees!
7. **Misrepresentation**
   a) A misrepresentation is a false statement made by an applicant on the application or claim form.
   b) A false statement made by a producer regarding coverage, terms, or conditions of the policy.
   c) Simply put, a misrepresentation is a lie. If material it voids the policy.
      (1) For example, an applicant stating that they are not a smoker when they actually are.
8. **Concealment**
   a) Concealment is the deliberate withholding or hiding information important to issuing the policy, even if the applicant was not directly asked about the subject.
   b) Concealment is secrets.
      (1) For example, an applicant not mentioning on the application how a family member died.
9. **Waiver**
   a) A waiver is the surrender of a right or privilege.
      (1) Such as the right to sue or to collect for a loss.
      (2) An insurer waives their rights to use any information from unanswered questions on an application. If the insurer issues the policy, they must honor it as it is.
   b) If a waiver is signed, then the signer has waived their rights.
      (1) Think they waved good-bye to the right to sue or to collect for a loss.

Say out loud: "I WILL PASS MY TEST!"

Chapter 2 - Life Insurance 101

SUMMARY

This chapter discusses the basics of life insurance and the life of a life insurance application as it goes through the underwriting process.

I. Definitions

A. Application - a form providing the insurer with certain information necessary to underwrite the intended policy.

B. Applicant - a person who completes the application.

C. Insured - the person(s) upon whose life the policy is based.

D. Policyowner - the person who has ownership rights in a policy.

1. The only person who can request and sign for any changes to an insurance contract.

2. This person is usually the insured but not necessarily.

3. For example, the insured could be a child and the policyowner would be the parent.

E. Third-Party Ownership - a policy owned by someone other than the insured as in the above example.

1. Insurer is the 1st party, the insured/applicant is the 2nd party and when the insured is not the owner, the policyowner becomes the 3rd party in the contract.

F. Beneficiary - the person or persons designated to receive the claim payout upon the insured's death.

G. Death Benefit - the amount of coverage payable on the policy, sometimes called the face amount.

1. The death benefit in life insurance is always received income tax free.

2. Any interest received on the death benefit is income taxable.

3. Premiums paid on individual policies are not tax deductible.

H. Cash Value - the money accumulated within permanent types of life insurance from which the policyowner may take a loan from or surrender the policy and receive if the policy is cancelled by the policyowner.

1. The cash value in life insurance is not taxed if withdrawn, but the interest in the cash value is income taxable upon withdrawal.

I. Estate - the sum of all assets minus any debts of a person at the time of their death; their net worth.

II. Why Do People Get Life Insurance?

A. Life insurance can serve various purposes in the individual market, summarized below:

B. **Survivor Protection** - is usually the first reason people pursue life insurance, to protect their dependents in the event of their death.

1. First-time buyers

C. **Cash Accumulation** - is available within certain policies allowing the policyowner to surrender the policy or borrow funds as a loan.

D. **Estate Conservation** - is using life insurance to pay estate taxes thus preserving the entirety of the estate for the insured's heirs.

E. **Estate Creation** - is using life insurance to provide large sums of money for beneficiaries.

F. **Liquidity** - is the immediate availability of funds upon the insured's death to pay any expenses.

G. **Pre-Need Plan** - is a type of coverage purchased to pay the funeral expenses of the insured.

III. The Application Phase

A. It is the producer's responsibility to ensure that the applicant fills out the application completely and to the best of his/her knowledge.

B. Both the producer and the applicant/insured must sign the application. If the insured a minor, the applicant/policyowner signs.

1. The applicant is representing, not warranting, that the statements they made on the application are true.

C. If a change needs to be made to the application, such as in the case of a mistake, the applicant/insured needs to initial the change.

1. **NOTE:** At this point, the applicant has all the control, not the policyowner because there is no policy yet to own.

D. If any questions are left unanswered, the producer is responsible for obtaining those answers from the applicant before submitting the application to underwriting.

1. The producer should not do any of the following:

a) Fill in the answers themselves
b) Submit the application as is
c) Mail the application to the applicant to complete
d) Call and complete by phone

2. The producer **should** go back to the applicant or have the applicant return to complete the application in person. Face to Face.

a) Test questions like this are best answered keeping this in mind: Whatever causes the producer the most work and the biggest headache is the correct answer! Face to Face.

E. The producer should also attempt to collect an initial premium payment to submit with the application.

1. A policy will not go into effect until payment is received.

F. If no premium is collected, then the application will be considered a **trial application** and the policy will not go into effect until the premium is paid at time of policy delivery.

G. If premium is paid at time of application, then the receipt included with the application is issued:

1. Binding Receipt - is unconditional; coverage begins immediately and lasts until the applicant is either approved or rejected by the insurer.

2. Conditional Receipt - has conditions for temporary coverage; coverage will begin the **date of application** or the **date of the medical exam**--whichever happens last.

a) If the application is a **non-medical application** with a conditional receipt, then coverage would begin the date the application is completed because no medical exam is required.

3. Acceptance Conditional Receipt - is conditional upon the application being approved by the insurer.

a) There is no temporary coverage provided by this receipt, coverage begins when the policy is issued.

IV. The Underwriting Phase

A. Information Sources for Underwriting

1. The underwriter has multiple sources of information available.

2. Application

a) The application itself contains the basic information that an underwriter needs to get started.

(1) Part 1 asks for information such as name, social security number, gender, marital status, date of birth.

(2) Part 2 is current and past medical information; immediate family members causes of death and ages when deceased.

3. Medical Exam

a) The medical exam is completed by a physician or a paramedic and provides the insurer with a current summary of the applicant's health to check insurability.

b) It is paid by and performed at the request of the insurer.

4. **AIDS Testing Requirements**
    a) An insurer may ask an applicant if they have ever tested positive or were diagnosed for HIV/AIDS.
    b) Insurers cannot discriminate so testing must be kept to the underwriting guidelines for an amount of coverage and the test results must be kept confidential.
    c) Insurer's must have a signed-written approval to test for HIV/AIDS.
5. **Attending Physician's Statement**
    a) An APS is the applicant's medical records and a review of their medical history provided by their treating physician providing an in-depth analysis of their medical status.
6. **Medical Information Bureau**
    a) The Medical Information Bureau operates as a coded information exchange keeping a secure record of applicant medical histories and other important information.
    b) The MIB obtains its information from other member insurers and is regularly utilized by member insurers who can only access an individual's data with that individual's signed consent. Allowing insurers to share medical information.
    c) This organization helps prevent fraud and any other intentional or unintentional omissions on an application.
7. **Consumer Investigative Report**
    a) This an inspection report containing information about the applicant's finances, work history, habits, character and morals.
    b) This information is protected by the Fair Credit Reporting Act.

B. Once all these information sources have been reviewed, the underwriter will approve this risk at a preferred, standard, or substandard rate or they will deny the application.
1. An applicant can be denied life insurance for height, weight and health issues. Not Gender.

C. The premium will be based on the rate and is available to be paid in multiple formats called modes.

D. **Mode** is the frequency of payments, such as monthly, quarterly, semiannually, or annually.
1. The more frequent the payment the greater the cost as the insurer adds surcharges to offset the increased expenses of having to handle the account more than once a year.
2. Over a 12-month period, the cheapest mode of premium is annual.

3. For example:

Mode	Example Amount
Annual	$1000 x 1 payment = $1000
Semi-Annual	$520 x 2 payments = $1040
Quarterly	$265 x 4 payments = $1060
Monthly	$100 x 12 payments =$1200

V. Policy Delivery

A. Once the policy is issued, it is sent to the producer for delivery.

B. It is the producer's responsibility to deliver the policy either in person or by certified mail with signed receipt of delivery.

C. The producer is also responsible for explaining the policy to the policyowner ensuring they understand all the terms and conditions as well as any riders added or exclusions. Face to Face.

D. If no initial premium was collected at the time of application, the producer must also collect those funds (consideration) at the time of policy delivery. Face to Face.

1. A transmittal notice is often required notifying the insurer that the premium has been collected.

2. Example: If a premium check is made out to the name of the producer instead of the name of the insurer, the producer should collect a new check made out properly. Face to Face.

a) They should not send that check to the insurer, deposit it into their own account and write a check to the insurer, or scratch their name out and write the insurer's name in.

b) This is another example of a test question that is answered best by whatever causes the producer the most work and the biggest headache.

3. Additionally, a statement of good health is required from the insured that they have not been ill or injured since the application.

4. If an insured has suffered injury or illness, the producer is required to return the policy to underwriting.

a) Yet another example of the correct answer being what causes the producer the most work and the biggest headache.

SAY OUT LOUD: "GOOD BLESSINGS ARE CHASING ME DOWN!"

Chapter 3 - Policy Provisions

SUMMARY

This chapter discusses the standard provisions found in most life insurance policies and how they protect the policyowner, insured, or insurer.

I. Standard Provisions

A. Entire Contract Clause - states that the policy, the application, and the riders all combined complete the contract

1. An easy way to remember what makes up the entire contract is to remember a good score in golf is P.A.R: **p**olicy, **a**pplication, and **r**iders.
2. This clause also stipulates that only the insurer can make changes the policyowner requests. Once the policy is issued, only the policyowner can request changes which must be approved by an executive officer of the insurer and attached in writing to the entire contract.

B. Assignment - the transfer of ownership in a policy. The policyowner has the right to give the policy away as if it were property. The policyowner loses the rights to obtain a loan, cash surrender or cancel the policy. There are two types of assignment:

1. **Absolute** - the original policyowner, called the assignor, transfers full ownership rights to a new owner, called the assignee.
   a) This transfer is 100% and permanent.
   b) For example, upon reaching a certain age, a parent might absolutely assign a life insurance policy they took out on their child to the name of the now adult child, so they can control the policy.
2. **Collateral** - the assignor assigns a portion of the policy death benefit typically as a means of paying the balance of a debt.
   a) If the insured dies before the debt is repaid, the debt is paid to the creditor out of the death benefit prior to any beneficiary receiving death benefit.
   b) This is a partial transfer and can be temporary.

C. Ownership Clause - designates the owner of the policy when owner is someone other than the insured.

1. The policyowner's rights would include but are not necessarily limited to the following:

a) The right to name and sign to change beneficiaries
b) The right to borrow against the policy
c) The right to receive dividends
d) The right to assign the policy
e) The responsibility to make premium payments.

2. The insured, if not the policyowner, has no rights in the policy.

D. Changes - any change to the policy must be made in writing and approved by the insurer and signed by the policyowner.

1. A producer cannot make changes to a policy.

E. Insuring Clause - establishes the purpose of the policy itself.

1. It identifies the parties to the life insurance contract (the insured and the insurer) and how much death benefit will be paid upon death of the insured to the beneficiary.

2. It is the insurer's promise to pay.

3. Think of the insuring clause as what the insurer cares about:

a) Who are we, who are we insuring, and how much money are we paying to whom?

F. Consideration Clause - establishes the amount of **P**remium to be paid per **P**ayment as well as how often payments are to be made in exchange for the Insuring Clause (the **P**romise to **P**ay made by the insurer). **The 4 P's**.

1. Think of the consideration clause as what the client (policyowner) cares about:

a) How much do I have to pay and how often to maintain the coverage?

G. Incontestability Clause - states that during the first two years of the policy, the insurer may void the policy upon proof of a material misrepresentation or fraud.

1. After two years have expired, the insurer cannot contest or void the policy for any reason--even fraud.

H. Suicide Clause - states that if the insured commits suicide within the first two years of the policy, the insurer is only obligated to refund premiums paid into the policy.

1. After two years, the full death benefit will be paid to the beneficiary if the insured commits suicide.

2. This discourages individuals from purchasing life insurance while considering suicide.

I. Misstatement of Age or Gender - is a provision that allows for the insurer to adjust the death benefit according to the correct age or gender of the insured if, upon the death of the insured, they find that one or both of these were misstated.

1. Age and gender are not considered material to policy issuance.
2. So, if at the time of death, the insurer finds the insured was older than stated on the policy, the insurer will reduce the death benefit to fit the premiums paid over the course of the policy.
3. Gender alone cannot be used to deny a life insurance policy.

Free Look (Right to Examine) Period - is a period of time allowing the policyowner the right to examine or look over the policy.

1. If they no longer want the policy, they can return it for a full refund.
2. This period lasts 10 days from the date of delivery to the owner.
3. Annuities have a 15-day free look period.

K. Legal Action - states that if someone wishes to sue the insurer for denial of a claim, they must do so within 2 years of the claim being denied.

L. Policy Loans - can be acquired from the policy's cash value by the policyowner only if there is sufficient cash value to borrow against.

1. The policyowner may obtain a loan if:
   a) the policy is in force;
   b) the premiums for the policy have been paid for at least three full years; and
   c) the policy is properly assigned.
2. A life insurance policy may provide that a policy loan may be deferred for a period not to exceed six months after the date the application for the loan is made.
3. Unpaid loans will eat away at the cash value because the loan will have interest charged and accumulating annually until the cash value runs out and the policy is terminated.
4. If the insured dies with an unpaid loan, the death benefit is paid minus the amount of the loan due back to the insurer plus any interest that accumulated on the loan.

M. Grace Period - is the period of time provided after the due date but before the policy lapses during which time coverage remains in effect.

1. The grace period in Texas for all life insurance policies is 31 days.
2. For example, if the premium was due December 1, the policyowner has 31 days to make the premium payment.
3. If the insured dies during the grace period, the death benefit is paid minus the premium amount due and any loans on the policy.

N. Automatic Premium Loan - is an optional provision that allows the insurer to borrow from the policy's cash value to cover a premium payment that is past due and prevent the policy from lapsing.

1. This loan would apply after the grace period has expired and no payment has been received. Not available on term policies.

2. This is treated as any other loan and will be deducted from the death benefit if the insured dies with the loan outstanding.

O. Reinstatement - allows the policyowner to put the policy back in force after it has lapsed due to nonpayment of premiums.

1. Most insurers allow reinstatements up to 5 years after the lapse date.

2. In order to reinstate the policy, think of PIE.

a) Pay back **P**remiums

b) Plus, any **I**nterest

c) Provide **E**vidence (proof) of insurability

P. Replacement

1. Purpose – Insurers and producers are regulated with the respect to the replacement of life and annuity contracts so that the purchasers are protected by establishing minimum standards of conduct in the replacement. To:

a) ensure that purchasers receive information with which a decision in the purchaser's best interest may be made;

b) reduce the opportunity for misrepresentation and incomplete disclosure; and

c) establish penalties for failure to comply with the requirements.

2. Definitions

a) When an insurer or producer contacts a person through mail, telephone, the Internet, or other mass communication media for the purpose of purchasing a policy this is called Solicitation.

b) Financed purchase means the purchase of a new policy that involves the actual or intended use of funds to pay all or part of any premium due on the new policy obtained by:

(1) the withdrawal or surrender of an existing policy; or

(2) borrowing from values of an existing policy.

c) Illustration means a presentation or depiction that includes nonguaranteed elements of a life insurance policy over a period of years.

d) Replacement means a transaction under which a new policy or contract is to be purchased, and for which it is known or should be known to the proposing producer or proposing insurer that, by reason of the transaction, an existing policy or contract has been or is to be:
   (1) lapsed, forfeited, surrendered or partially surrendered, assigned to a replacing insurer, or otherwise terminated;
   (2) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
   (3) amended so as to affect a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
   (4) reissued with any reduction in cash value; or
   (5) used in a financed purchase.

3. Exemptions – The following are not protected by replacement rules and laws.

a) credit life insurance; group life insurance or group annuities for which there is no direct solicitation of individuals by a producer; life insurance and annuities used to fund prepaid funeral contracts.

b) An application to:
   (1) exercise a contractual change or a conversion privilege made to the insurer that issued the existing policy or contract;
   (2) exercise a term conversion privilege among corporate affiliates.

c) Life insurance proposed to replace life insurance under a binding or conditional receipt issued by the same insurer.

d) A policy or contract used to fund:
   (1) an employee pension benefit plan or employee welfare benefit plan;
   (2) a plan described as a Section 401(a), 401(k), or 403(b), established or maintained by an employer;
   (3) a government or church plan, described as a Section 414, a government or church welfare benefit plan, or

a deferred compensation plan of a state or local government or tax-exempt organization described as a Section 457; or

(4) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

e) New coverage provided under a life insurance policy or contract if the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

f) an existing life insurance policy that is a nonconvertible term life insurance policy scheduled to expire in five years or less and that cannot be renewed;

g) immediate annuities purchased with proceeds from an existing contract; or structured settlements.

h) Direct solicitation does not include a group meeting held by an insurance producer solely for the purpose of:

(1) educating or enrolling individuals; or

(2) if initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual.

4. DUTIES OF PRODUCER; NOTICE.

a) A producer who initiates an application for a life insurance policy or annuity contract shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts.

b) If the applicant states that the applicant does not have existing policies or contracts, the producer's duties with respect to replacement are complete.

c) If the applicant states that the applicant does have existing policies or contracts, the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements.

d) The notice required by this section must be given in a form adopted or approved by the commissioner. The notice shall be signed by both the applicant and the producer attesting

that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud, in which case the producer is not required to read the notice aloud. The notice must be left with the applicant unless it is presented to the applicant by electronic means and signed electronically, in which case the insurer shall mail the applicant a copy of the notice not later than the third business day after the date the application is received by the insurer. The notice must list all life insurance policies or annuities proposed to be replaced, properly identified by the name of the insurer, the name of the insured or annuitant, and the policy or contract number if available, and include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, must be listed.

e) Commissioner approval of a notice is not required if a notice adopted or approved by the commissioner is used and amendments to that notice are limited to the omission of references not applicable to the product being sold or replaced.

f) In connection with a replacement transaction, the producer shall leave with the applicant, at the time an application for a new policy or contract is completed, the original of all sales material or a copy of that material. Electronically presented sales material must be provided to the policy or contract owner in printed form not later than the date that the policy or contract is delivered.

g) In connection with a replacement transaction, the producer shall submit to the insurer to which an application for a policy or contract is presented:
   (1) a copy of each document required by this section;
   (2) a statement identifying any preprinted or electronically presented insurer-approved sales materials used; and

(3) copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

5. DUTIES OF REPLACING INSURANCE COMPANY

a) The replacing insurer shall verify that the required forms are received and are in compliance.

b) The replacing insurer shall:

(1) notify any existing insurer that may be affected by the proposed replacement not later than the fifth business day after:

(a) the date of receipt of a completed application indicating replacement; or

(b) the date that replacement is identified if it is not indicated on the application; and

(2) mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract to the existing insurer not later than the fifth business day after the date of a request from the existing insurer.

c) The replacing insurer must be able to produce copies of the notification regarding replacement until the later of:

(1) the fifth anniversary of the date of the notification; or

(2) the date of the replacing insurer's next regular examination by the insurance regulatory authority of the insurer's state of domicile.

d) The replacing insurer shall provide to the policy or contract owner notice of the owner's right to return the policy or contract within 30 days of the delivery of the policy or contract and to receive an unconditional full refund of all premiums or considerations paid on the policy or contract, including any policy fees or charges.

e) In transactions in which the replacing insurer and the existing insurer are the same or are subsidiaries or affiliates under common ownership or control, the replacing insurer shall allow credit for the period that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract.

Q. Exclusions - are causes of loss not covered by the policy.

1. **Hazardous Occupation** - no coverage is provided if death is related to a hazardous occupation.
2. **Hazardous Hobby -** no coverage is provided if the death is related to a hazardous hobby or avocation (side job) stated in the policy.
3. **Status Clause** - no coverage is provided for individuals with military status since they have government coverage.
4. **Results/War Clause** - no coverage is provided for death as a result of any type of war.
5. **Aviation** - no coverage is provided to student pilots or those with limited flying experience.
   a) This exclusion does not apply to passengers on commercial flights.

II. Non-Forfeiture Options

A. If a policyowner wishes to cancel a permanent life insurance policy that has cash value accumulated in it, they will not lose that money.

1. That's why these are called Non-Forfeiture options as the policyowner does not forfeit (or give up) everything that accumulated in the policy up to that point.

B. There are three options to choose from called **REC**:

1. **Reduced Paid-Up** - is an option that takes the existing cash value and purchases a single premium permanent policy with a lower death benefit.
   a) The benefit in this option is that the new coverage is permanent with no more payments required.
   b) The drawback in this option is that the death benefit is not as high as the original death benefit.
   c) For example, if the original death benefit was $230,000 and after 15 years the policyowner wishes to take the reduced paid-up option, the $29,900 of cash value would purchase about $106,000 in death benefit.
2. **Extended Term** - is an option that takes the existing cash value and purchases a single premium term policy for as long a term as can be bought.
   a) The benefit in this option is that the death benefit remains the same as the original policy.
   b) The drawback in this option is that the coverage is only temporary.

   For example, if the original death benefit was $230,000 and after 15 years the policyowner wishes to take the extended term

option, the $29,900 of cash value would purchase $230,000 of death benefit lasting about 24 years and 311 days. If the insured lives beyond this period, the policy is terminated.

3. **Cash Surrender** - is simply cancelling the policy and receiving a check for the cash value amount minus the fees associated with the cancellation, if any.
   a) For example, after 15 years a policy could have $29,900 of cash value. The policyowner would receive a check for approximately that amount and all coverage would cease.

Guaranteed Values for $230,000 Death Benefit

Age	Policy Year	Cash Value	Reduced Paid-Up	Extended Term Years	Extended Term Days
34	1	$0	$0	0	0
35	2	$0	$0	0	0
36	3	$838	$4,899	3	55
37	4	$2,835	$15,396	8	351
38	5	$4,908	$25,659	13	67
39	6	$7,057	$35,457	16	132
40	7	$9,288	$44,787	18	214
41	8	$11,598	$53,885	20	111
42	9	$13,987	$62,283	21	205
43	10	$16,453	$70,680	22	181
44	11	$18,993	$78,611	23	83
45	12	$21,609	$86,076	23	297
46	13	$24,301	$93,307	24	101
47	14	$27,073	$100,072	24	227
48	15	$29,900	$106,000	24	311
49	16	$32,911	$112,902	24	361
50	17	$35,990	$119,200	25	17

III. Dividends

A. When a mutual company issues a dividend to its policyowners, those policyowners have several options available to them.

1. Remember that <u>dividends are never guaranteed.</u>

B. The dividend itself is not income taxable because it's essentially a refund of the policyowner's overpaid premiums.

1. <u>Any interest that accumulates on the dividend is income taxable because interest is always taxable.</u>

C. Dividend Options

1. Cash - the policyowner receives the dividend annually by check.

2. **Premium Credit** - the dividend is applied toward the next premium payment due.
3. **Accumulation** - the dividend is left with the insurer to accumulate with interest in the policy and can be withdrawn by the policyowner at any time.
4. **Paid-Up Additions** - the dividend is used to purchase additional totally paid for life insurance on the policy. This additional insurance would use all of these to determine how much additional death benefit is purchased with the dividend.
   a) Insured's age
   b) Amount of dividend
   c) Type of policy
5. **Paid-Up Option** - the dividend is used to pay off the policy faster.
6. **One-Year Term** - the dividend is used to purchase a 1-year term policy.

SAY OUTLOUD: "I HAVE UNDERSTANDING, I KNOW THIS MATERIAL, AND I WILL PASS MY EXAM!"

Chapter 4 - Types of Policies

SUMMARY

This chapter discusses the types of life insurance policies and the characteristics common to each. Available riders will be discussed at the end of this chapter.

I. Term Insurance

A. Term insurance provides life insurance for a temporary time.
   1. Test Key keep your "T"s together: **T**erm means **T**emporary.

B. A policy can be a 1-year term, 10-year term, 20-year term, 30- year term, or to age 65 or term to age as examples.

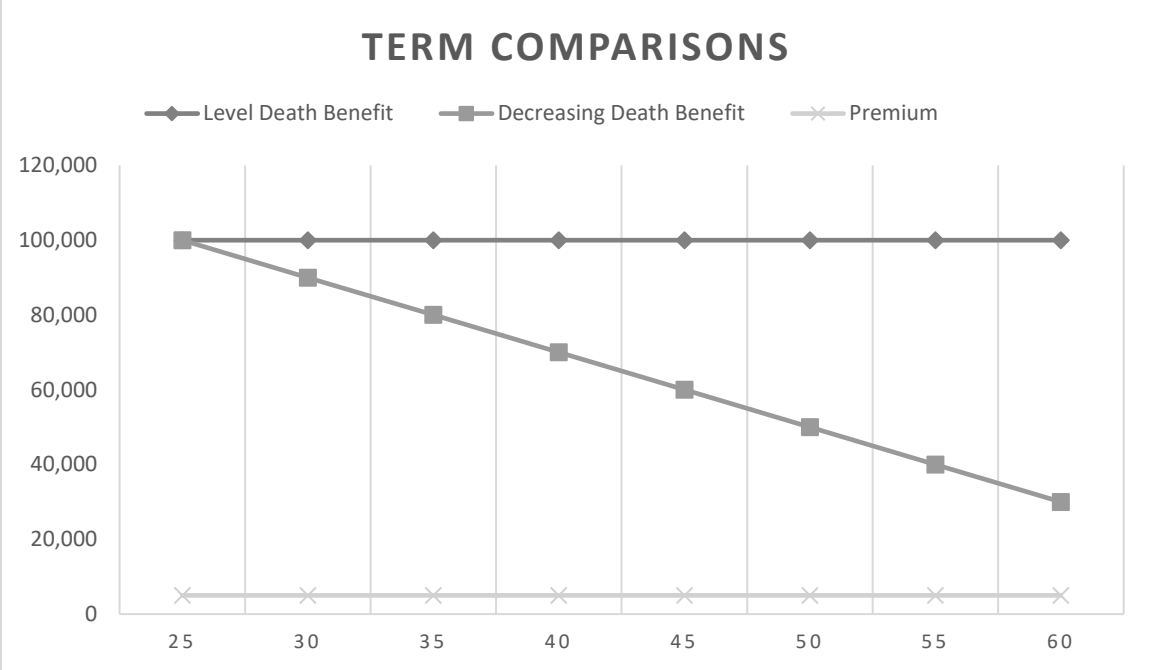
C. This coverage is initially cheaper than other kinds of life insurance because of the low risk associated with the term.

D. Term provides the most amount coverage for the least amount of money. Term does not build cash value.

E. The longer the period of coverage, the more expensive the premium.
   1. For example, a 30-year term is more expensive than a 10-year term because the insured is more likely to die in the next 30 years than they are the next 10 years.

F. Types of Term Policies
   1. Level Term - the death benefit and the premium remain unchanged through the policy term.
   2. Decreasing Term - the death benefit decreases over time, but the premium remains level.
      a) Often this policy is used to pay off debts like mortgages.
   3. NOTE: The only difference between the two is how the death benefit behaves over the life of the policy.

Policy Name	Death Benefit Amount	Premium Amount
Level Term	Level	Level
Decreasing Term	Decreasing	Level



4. **Annual Renewable Term -** the death benefit remains level, but the premium increases each year as the insured gets older. Each year the policy renews at the insured's current age.
5. **Return of Premium Term Insurance –** the death benefit remains level for the length of term selected as well as the premiums.
   a) Should the insured die during the length of the term the policy pays the full face amount (death benefit).
   b) If the insured lives to the end of the benefit period selected, the policy is terminated with all premiums then refunded to the policyowner.
   c) Usually the refund of premiums does not apply to any riders selected on the base policy.

G. Term Options

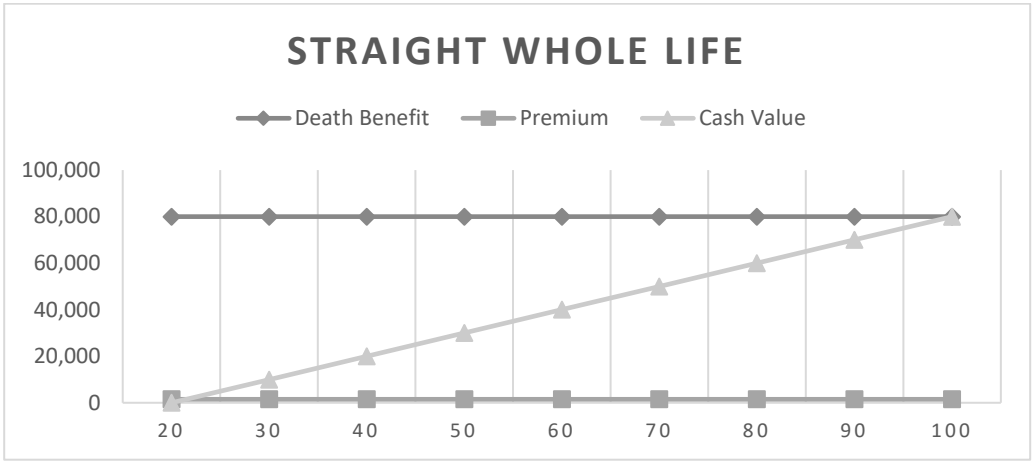
1. **Convertible** - <u>the right to change the term (temporary) policy into a permanent policy without the insured having to provide evidence of insurability.</u>
   a) The policy is being changed from term to permanent. So, the converted policy will cost more but lasts for entire life.
   b) Test key, conversion only works in one direction so remember **t**erm to **p**ermanent, **t** to **p** like **t**oilet **p**aper.

2. **Renewable -** the right to renew (continue) the term policy at the end of the policy term without the insured having to provide evidence of insurability.
    a) The policy remains a term policy, but the insured does not have to prove they are healthy to renew it.

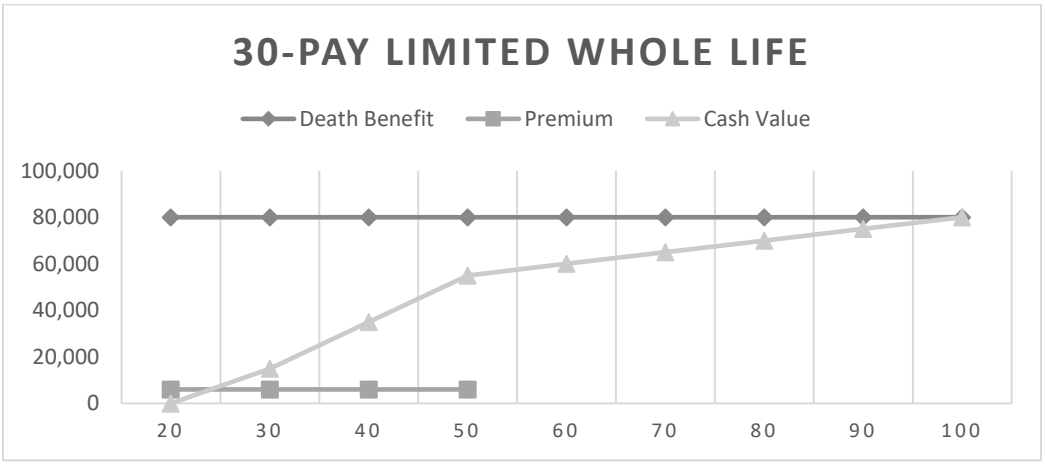
II. Permanent Insurance

A. Permanent insurance, also called Whole Life, provides life insurance protection for the duration of the insured's life.

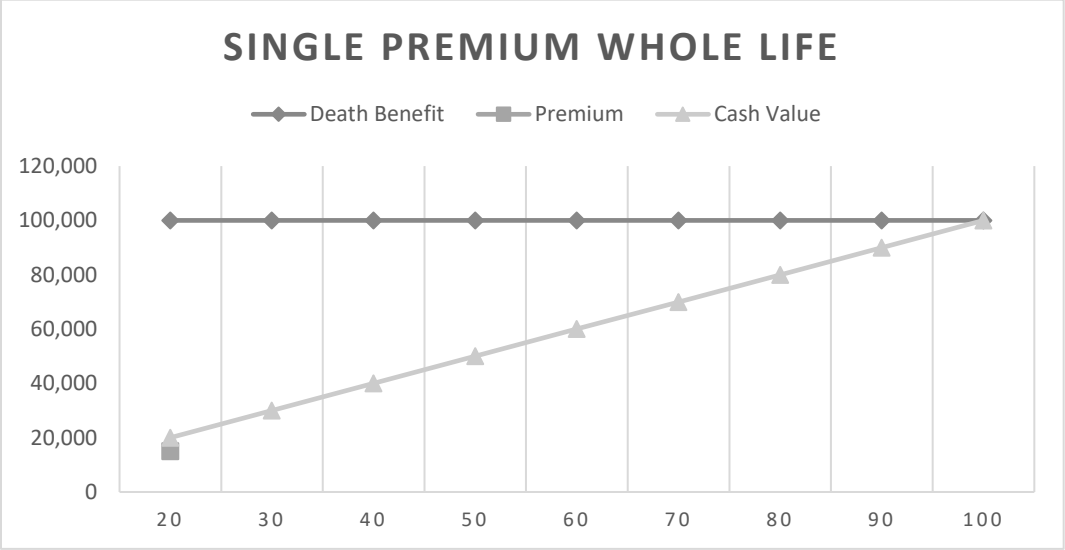
1. **Straight Whole Life** - the policy premiums and death benefit remain level until the death of the insured. Pays insured if they live to age 100, called endowment.
    a) Guaranteed interest rate on the cash value accumulation.



2. **Limited Payment Whole Life** - the policy premiums are paid for a limited period of time while the death benefit remains level until the death of the insured or age 100. These policies have higher cash value accumulation than the straight whole life.
    a) For example, a 30-pay whole life would be paid for 30 years then the policy would be totally paid for.
    b) Guaranteed interest rate on the cash value accumulation.



3. **Single Premium Whole Life** - the policy premium is paid up front, so the entire cost is paid at the time of purchase. The death benefit remains level until the death of the insured.
   a) Guaranteed interest rate on the cash value accumulation.
   b) Single Premium policies have unique tax consequences; they are classified as MEC's **Modified Endowment Contracts** since they are funded very quickly.
      a) Any policy with premiums paid less than 7 years is considered a Modified Endowment Contract because it is over funded.
      b) MEC rules impose penalties to discourage the use of life insurance as a short-term savings vehicle.



4. **NOTE:** The only difference between these three is the premium structure.

Policy Name	Death Benefit	Premium Payment
Straight Whole Life	Level to age 100	Payments made until death or age 100
Limited Pay Whole Life	Level to age 100	Payments made for a limited period of time
Single Premium Whole Life	Level to age 100	One payment, you own it

B. Interest-Sensitive Whole Life

1. Interest-Sensitive policies have 2 interest rates, a guaranteed rate like a traditional whole life and a current interest rate which is based upon current money market rates.

2. The policy's cash value is credited with which one is the highest.

3. The interest rate being credited to the cash value can change based on the fluctuations in the market.

C. Equity-Indexed Whole Life

1. Equity-Indexed policies take 80%-90% of the premium and invest the funds in traditional fixed income securities.

2. The other 10%-20% of the premium is invested in a stock market exchange like, New York Stock Exchange, or the S&P 500 index.

D. Universal Life

1. Universal Life is a type of adjustable whole life insurance that allows the policyowner more control. The death benefit is term.

2. The premiums in this policy have a recommended minimum payment to maintain the cash value, however the policyowner can skip a payment if needed or can dump large sums of money into the policy at any time.

3. The death benefit amount can also be increased with evidence of insurability or decreased without evidence of insurability from the insured.

E. Variable Life

1. Variable Life has two accounts for the cash value in the policy:

a) The General Account provides a guaranteed minimum death benefit.

b) The Separate Account is invested in securities chosen by the policyowner.

a) The securities can be stocks (equities), bonds, or, most commonly mutual funds; purchased as units.

b) Cash values in this account will fluctuate based on the performance of the securities in the separate account with the opportunity to achieve higher investment returns.

c) However, this is no guaranteed minimum return in the Separate Account.

c) To sell a Variable Life policy, a producer must have an insurance license and a FINRA securities license Series 6 or 7 license.

a) All Variable products require two licenses to sell!

b) Make a 'V' with your fingers, that's the number 2!

d) A document called a prospectus must be provided to the applicant which explains the various accounts available for them to invest in and their historical performance.

F. Variable Universal Life

1. Variable Universal Life combines the adjustable features of Universal Life with the investment features of Variable Life where the owner selects the investment choices.

2. Again, this a "V" product and requires two licenses to sell.

3. Like the Universal policy, it has adjustable death benefits and adjustable premiums (the death benefit is a type of term).

G. Juvenile Life

1. Juvenile Life is life insurance written on the life of a minor.

2. Jumping Juvenile is a type of insurance that is issued at one death benefit and multiplies upon reaching a certain age, usually 18 to 25.

a) For example, the policy would be issued at $10,000 then upon reaching the appropriate age the death benefit would "jump" to $50,000 without evidence of insurability required.

3. Life insurance cannot be issued on a child until they are 14 or 15 days old, at the discretion of the insurer.

H. Joint Life

1. Joint Life is a type of whole life insurance written on the lives of two people; whose ages are averaged together for a joint premium which will be cheaper than 2 individual policies.

2. This policy pays out the death benefit when the first person of the two or more listed on the policy dies.

3. The life insurance policy no longer provides coverage for the surviving person.

I. Joint Survivor Life

1. Called Survivor Life on the exam, is similar to Joint Life in that it is written with multiple insureds.

2. This policy pays out the death benefit when the **S**econd or last person listed as an insured on the policy dies. Test key, **S**urvivor = **S**econd to die.

3. Upon the death of the first, there is no death benefit paid.

III. Life Insurance Riders

1. Child Term Rider

a) This rider allows the addition of level term insurance coverage on the lives of all the insured's children after 14 or 15 days old including adopted children.

b) The coverage remains in place until age 18-25, most typically to age 21 at which point the coverage can be converted to a permanent life policy without evidence of insurability.

2. Spouse Term Rider

a) Like the Child Term Rider, this rider allows the addition of level term insurance coverage of the life of the insured's spouse.

b) Conversion will typically be available either at the end of the term or upon the death of the insured.

B. Affecting Death Benefit

1. Accidental Death Benefit

a) If the insured dies as the result of an accident, this rider pays double or triple the death benefit.

b) It is important to note that death due to sickness, such as from cancer, a heart attack or stroke, no matter how sudden will not be considered an accident.

2. Guaranteed Insurability

a) This rider allows the purchase additional amounts of insurance without having to prove good health every 3 years either by reaching a stated age or upon certain qualifying events, such as marriage or the birth of a child.

3. Return of Premium

a) This rider adds increasing term insurance that equals the amount of all premiums paid into the policy.

b) If the insured dies during the term, the beneficiary would be paid the death benefit plus all premiums refunded.

4. Accelerated Death Benefit aka (Living Benefit)

a) If the insured becomes terminally ill with less than two years to live, this rider allows the early payment of the death benefit usually between 50%-90%.

b) Upon death, the remainder will be paid to the beneficiary.

5. Long-Term Care Rider

a) Provides up to 100% of the policy benefits if the insured qualifies for long-term care benefits as defined in the rider.

b) Any payout is an acceleration of the life insurance death benefit, meaning it will reduce the death benefit payable to the beneficiary.

c) Benefits must be paid no less than monthly and are received income tax free.

C. Due to Disability

1. Waiver of Premium

a) This rider states that if the insured becomes totally disabled, the insurer waives premiums for the duration of the disability.

b) The rider will typically drop off at age 65.

c) This keeps the policy in force when the insured cannot pay due to being disabled, it has no negative effect on any of the policies values.

d) There is usually an Elimination Period of six months where the insured continues paying premiums and after that time the insurer will make payments for the duration of the disability and return the six months the insured paid.

e) For example, Tony the roofer has fallen off a second story roof and is in the hospital. His wife, Judy, is worried about keeping up with all the bills and calls to cancel his life insurance. With this rider on Tony's policy, the producer would tell Judy not to cancel the policy and instead pay premiums for the next six months. Six months later if Tony is still disabled the insurer returns the six months of premium paid and pays all future premiums for the duration of the disability. Tony ended up being disabled for 18 months, but his life insurance policy remained in force.

2. Waiver of Cost of Insurance

a) A rider that waives the deduction of the monthly cost of insurance and expense charges (known as pure cost or the minimum premium) associated with a Universal Life policy while the insured is totally disabled.

3. Waiver of Payor Premium aka **(Payor Benefit)**

a) Similar to Waiver of Premium, this rider would waive premium payment if the premium payor/owner dies or becomes disabled not the insured.

b) This rider is commonly offered on a policy for a minor since the minor does not pay their own premium, the parent does.

   a) Example: If the parent becomes disabled, like Tony the roofer did, then Tony Junior's policy would be paid for as Tony the roofer is the policyowner/payor.

IV. Viatical Settlements

A. A viatical settlement is an agreement between a viatical settlement provider and the policyowner, called a viator.

B. These arrangements are only available when the insured has been diagnosed with terminal illnesses and less than two years' life expectancy.

C. The settlement provider purchases the life insurance policy from the viator at a percentage of the death benefit. Usually 60%-80% of the death benefit.

1. For example, the policy may have a death benefit of $100,000 but the agreement will be to purchase the policy for $60,000. Upon the death of the insured, the policy would pay to the settlement provider the full $100,000 death benefit and the provider will profit $40,000 minus premiums paid by the provider from time of purchase until the insured's death.

V. Life Settlements

A. A life settlement is the sale of an existing policy to a third party for more than the cash value but less than the death benefit.

B. The purchaser would profit upon the insured's death.

C. Stranger Originated Life Insurance (STOLI) & Investor Originated Life Insurance (IOLI)

1. These terms describe a life settlement situation where an investor or broker has absolutely no connection with a person who induces that person to buy a life insurance policy to sell it to the investor for quick profit. The new owner thus benefits from the death of the insured.

2. Since a life insurance policy is considered one's property, this is perfectly legal in Texas.

Congratulations you have finished the hardest chapter. Say out loud: I am smart, I understand what I read, I will pass my test!

Chapter 5 - Group & Business Markets

SUMMARY

This chapter discusses the structure of group life insurance as well as other uses businesses have for life insurance to ensure the stability of their business.

I. Group Life Insurance Overview

A. Group Life insurance is an arrangement between a group sponsor (employer) and the group participants (employees).

B. The sponsor or employer receives the **Master Policy.**

C. The participants or employees receive **Certificates of Insurance.**

II. Eligible Group

A. A group policy can be written in this state only if the group is a legal and eligible group.

Eligible Groups	Ineligible Groups
A natural group formed for purposes other than to obtain insurance Employers	Select group of employees, such as only the salespeople and not the service people or executives only
Stockholders	Family, blood relatives, adopted
Labor Unions	Friends
Board of Directors	Neighbors

III. Group Underwriting

A. Group insurance requires no evidence of insurability meaning there is no medical underwriting or medical exams, assuming the employee enrolled during the enrollment period.

1. However, the underwriter must avoid **adverse selection** which is the tendency for high risk individuals to pursue life insurance that requires no medical questions or exams.

B. Two Payment Arrangements

1. Contributory Plans

a) Requires employees to pay for part of the premium payments.

b) 75% of eligible employees must participate.

2. Non-Contributory Plans

a) The employer pays all the premiums.

b) 100% of eligible employees must participate.

(1) That's free insurance!

C. Group life insurance is written as, annual renewable term.

D. A small employer group in Texas would have a minimum of 2 employees and a maximum of 50.

E. An eligible employee must work a minimum of 30 hours per work week.

F. Waiting Period - is the period of time new employees must wait before they can enroll in the group plan.

1. For most employers, this is somewhere between 0 to 90 days.

G. After the waiting period has expired, the employee will then have 30 days to enroll in the plan.

1. Annually thereafter an open enrollment period will allow participants to make any necessary changes.

H. Taxation

a) Employee paid premiums are not tax deductible by the employee.

b) The employer can tax deduct the portion of premiums they pay as ordinary and necessary business expenses.

c) The portion of premium paid for by the employer providing death benefit over $50,000 is income taxable to the employee. Any death benefits $50,000 or less has no taxes.

d) Death benefits in group life are always received income tax free because the benefits are received as a lump sum.

I. Conversion Privilege

1. If an employee loses eligibility, some insurers offer the right to convert the group term policy to an individual permanent policy.

a) Remember, it is term to permanent, T to P, like toilet paper!

2. If available, the conversion period is 31 days.

J. Coverage for Dependents

1. The employee can purchase life insurance through the group on their spouse for up to 1/2 the death benefit on themselves.

a) If the group plan provides the employee with $50,000 of life insurance, then a spouse can be covered up to $25,000.

2. Coverage for children can be added at amounts that vary by insurer.

IV. Buy-Sell Agreements

A. Buy-Sell Agreements are life insurance arrangements between the partners in a business designed to transfer ownership in the business by providing a buyout of the deceased partner and their heirs. One is called a **Cross Purchase Plan.**

B. Each partner owns a policy on the other partners.

C. These policies are an example of Third-Party Ownership.

D. Due to the legal statutes of partnerships, a deceased partner's spouse is entitled to step into the business and assume their share.

1. This can be detrimental if the spouse acts as a silent partner which is a party that takes their share of profit but does none of the work.

E. A Buy-Sell Agreement put in place would pay upon the death of one partner the death proceeds of a policy or policies on the deceased partner to the other partners and then the partners give that money to the deceased partner's spouse or heirs thus buying them out of the business.

F. For example, Adam, Brian, and Claire are partners in a business together. Adam has a policy on Brian and Claire. Brian has a policy on Adam and Claire. And Claire has a policy on Adam and Brian. Upon Adam's death, Brian's policy on Adam and Claire's policy on Adam would pay out to Brian and Claire. Then Brian and Claire pay that money to Adam's spouse buying her out of the business.

V. Key Employee Plans

A. <u>These plans are purchased by the employer on the life of a valuable employee, such as a vice president, highly compensated employee, or top salesperson.</u>

B. <u>The death benefit pays the employer</u> to offset lost income in the business plus the cost of hiring and training a new employee and smoothing over any problems with customers created by the death of the key employee.

1. These policies <u>do not</u> benefit the Key Employee's family!

C. <u>The employer is the premium payor, policyowner and beneficiary.</u>

D. This is another example of Third-Party Ownership.

VI. Credit Life Insurance

A. <u>Credit Life is sold as a decreasing term policy</u> with the death benefit proceeds satisfying the amount of the debt or <u>loan owed by a debtor</u> to an individual or organization.

B. Example: A person buys a car with a loan the loan provider offers a policy which pays off the loan in the event of the car buyer's (debtor's) death.

Woohoo an easy chapter!
Say out loud: I am wise, I am disciplined, and I am focused!

Chapter 6 - Beneficiaries & Settlement Options

SUMMARY

This chapter discusses the types of beneficiaries and the beneficiary provisions found in life insurance policies that apply upon the death of the insured. Additionally, the various settlement options available to the policyowner or beneficiary will be explored at the end.

I. Beneficiary Succession

- **A. Primary Beneficiary** - is the **first** in line to receive death benefit upon the death of the insured.
- **B. Contingent Beneficiary** – is the **second** in line to receive the death benefit if the primary beneficiary dies before or at the same time as the insured.
  1. If you have a contingency plan, you have a backup plan.
  2. This beneficiary is the backup plan.
- **C. Tertiary Beneficiary** – is the **third** in line to receive the death benefit only if both the primary and the contingent beneficiaries die before the insured. Another test key keep your T's together.
  1. At this point, most insurers designate the tertiary beneficiary as the estate of the insured.
  2. For example, Adam is the insured. His wife Brenda is the primary beneficiary. His adult son Charlie is the contingent beneficiary. Two minor children, Dana and Erin, are not listed on the policy. Brenda and Charlie both die before Adam, then Adam dies. A good way to solve test questions like this are to write them out:
     a) Adam - insured
     b) Brenda - primary beneficiary
     c) Charlie - contingent beneficiary
     d) Estate of Adam - tertiary beneficiary
     e) Dana and Erin are not listed on the policy so do not consider them in solving the question.
     f) Since Brenda and Charlie are both deceased prior to Adam dying, the only remaining option is the tertiary beneficiary which is the estate of Adam.

II. Beneficiary Designations

- **A. Revocable Beneficiary** – means changeable; this beneficiary can be changed at any time by the policyowner.
  1. This is the one most commonly used in life insurance policies.

B. Irrevocable Beneficiary - cannot be changed without this beneficiary's consent.

1. Irrevocable beneficiaries have what is called a "vested interest" in the policy proceeds, meaning they have a personal stake in the death benefit.

2. The policyowner cannot change this beneficiary, cancel the policy, take a loan from the policy, or do anything that might affect the death benefit or any other values of the policy.

a) The policyowner can, however, change the mode of premium as the irrevocable beneficiary doesn't care how often the policyowner pays.

3. For example, Mary and Bob have a child together and are divorced. Mary has custody of the child. The court settlement requires Bob to have a life insurance policy on himself with Mary named as the irrevocable beneficiary. In the event of his death, child support payments continue. Upon the child reaching a certain age, Mary is legally obligated to sign her consent to release the policy and Bob can then change the beneficiary to whomever he pleases.

C. Named Individual - is the most specific designation naming the beneficiary by their full name to avoid any confusion or probate proceedings.

D. Class - is broader and names beneficiaries by type or grouping, such as "the insured's spouse" or "the insured's children".

1. Per Stirpes - is a type of class designation that pays all beneficiaries equally even if one beneficiary is deceased; then his or her heirs would receive their share, but only if the deceased beneficiary has heirs.

a) For example, a policy designates all my children per stirpes as the beneficiary. If one of the children had already died, the deceased beneficiary's children would receive their parent's portion.

2. Per Capita - is a class designation that pays only to surviving beneficiaries.

a) For example, a policy designates all my children per capita as the beneficiary. If one of the children has already died, their spouse or children would not receive any death benefit proceeds. Death benefit would be paid only to surviving children of the insured.

E. Trust - is an arrangement set up when the death benefit proceeds are not to be paid directly to the beneficiary, for example to minor children. Minors cannot receive the money until age of majority.

1. The proceeds will be distributed as per the insured's direction set forth in the trust agreement.
2. If no trust was set up, the insurer will set up a trust for the minor children the money will be in trust until the child or children turn legal age to release the contract. It will earn taxable interest.

III. Uniform Simultaneous Death Act aka (Common Disaster Clause)

A. This act states that if the insured and the primary beneficiary die as the result of the same accident, then the primary beneficiary will always be deemed to have died prior to the insured allowing the insurer to pay the contingent or tertiary beneficiaries.

B. For example, the insured and the primary beneficiary both die in a car accident. The insurer will say that the primary beneficiary died prior to the insured to preserve the order of succession even if the primary beneficiary died after the insured.

C. In Texas, the death of both parties must occur within 120 hours of the accident for this rule to apply.

IV. Settlement Options

A. Settlement options answer the question of "how the death proceeds are paid to the beneficiary after death of the insured?"

B. The settlement option chosen by the policyowner at application or by the beneficiary at the time of the claim tells the insurer how to distribute the death benefit.

C. Lump Sum - is the payment of the entire death benefit at once.

1. This option is entirely income tax free as death benefit is always paid income tax free and lump sum does not include any interest.

D. Fixed Amount - is when payments are made at specified amounts at regular intervals until the death benefit and the interest are both consumed.

1. For example, the insurer would pay the beneficiary $3,000/month.
2. A portion of the payment is non-taxable death benefit and a portion is the earned interest which is income taxable.

E. Fixed Period - makes payment for a specified period of time consuming both the death benefit and the earned interest by the end of the specified time.

1. For example, the insurer would pay the beneficiary for 20 years.
2. A portion of each payment is non-taxable death benefit and a portion is the income taxable interest.

F. Interest Only - pays only the accumulated interest on the death benefit while the death benefit itself remains held in trust with the insurer for a specified period of time.

1. The entirety of each payment made to the beneficiary is income taxable because the entire payment is composed of interest only.
2. At the end of the stipulated period, the death benefit is then paid per the instructions set forth by the policyowner or the beneficiary.

G. Life Income Only - allows the insurer to set up an annuity for the beneficiary from which payments from the death benefit and interest will be made for the **rest of the beneficiary's life ONLY**.

1. The interest portion of each payment is taxable.
2. If the beneficiary dies before receiving the entirety of the death benefit, the insurer keeps the remaining funds.
3. If the beneficiary outlives the original death benefit amount, payments will continue to the beneficiary until their death regardless of how much the insurer ultimately ends up paying.

H. Life Income Period Certain - is exactly like Life Income Only but, with a built-in guarantee.

1. The period certain would be set, for example; a 20-year guarantee, so that if the beneficiary dies prior to the end of 20 years, what's left of the remaining 20 years of payments is paid to another beneficiary.
2. If the beneficiary lives beyond the 20-year guarantee period certain, then payments continue to be paid until that beneficiary dies, at that point all payments cease.
3. Only the interest portion of each payment is taxable.

I. Life Refund - is exactly like Life Income Only however if the beneficiary dies prior to receiving all the funds, the remaining funds are granted to the contingent beneficiary.

1. Only the interest portion of each payment is taxable.

J. Joint and Survivor Life Income - pays Life Income to two beneficiaries and, when the first one dies, payments continue to the survivor at 50%, 66%, or 100% of the original payments.

K. Joint Life Income - pays Life Income to two beneficiaries and, when the first one dies, all payments are discontinued.

Options are challenging but you are a winner! Say it out loud!

Chapter 7 - Annuities & Retirement

SUMMARY

This chapter discusses the different types of annuities and retirement plans that can be purchased through an insurer. The taxation of each plan will also be discussed.

I. What Are Annuities?

A. Whereas life insurance answers the question of "what happens if you die too soon?", annuities answer the question of "what happens if you live too long?"

1. Basically, they are the reverse of life insurance.

B. Annuities are policies designed to provide a steady stream of income paid to an individual upon reaching a certain age, usually 65, retirement age. The systematic liquidation of funds for retirement.

1. Annuities have the following roles:

a) Policyowner - the person with ownership rights in the contract.

(1) Determines the beneficiary, the payout date called annuitization, settlement option selected, etc.

b) Annuitant - the person upon whose life the annuity is based.

c) Beneficiary - the person designated to receive the benefits if the annuitant dies.

II. Types of Annuities

A. Fixed Annuity - has a fixed interest rate and pays a guaranteed fixed payout amount to the annuitant.

B. Equity-Indexed Annuity - has interest rates tied to a stock market exchange like, New York Stock Exchange, or the S&P 500 index.

C. Variable Annuity - Like Variable life. Payments are made in units.

1. Requires an insurance license and a securities license to sell.

a) Make a 'V' with your fingers, that's the number 2!

2. Also requires a prospectus be delivered to the applicant at the time of application giving them the opportunity to review the historical performance of their investment account options.

III. Annuity Mechanics

A. Immediate

1. Immediate annuities are designed to pay benefits to the annuitant within 12 months of the issue date. Only single premium payment plans can be immediate.

B. Deferred

1. Deferred annuities are designed to pay benefits to the annuitant at a stipulated date in the future more than 12 months from the issue date.

IV. Accumulation Period

A. The Accumulation Period is the period of time from the first premium payment, where the owner is depositing funds in the account plus the account is accumulating interest. Called the Pay-In Period.

1. Immediate annuities do not have an accumulation period.

V. Premium Payment Options

A. Single Premium - the account is funded in a lump sum payment with no more payments allowed.

B. Flexible Premium - the account is funded with continuous payments at the owner's discretion with minimum amounts accepted by the insurer.

Payment & Mechanics Combined

	Single Premium	**Flexible Premium**
Immediate	Lump sum deposit; benefits withdrawn 1 year or less	Does not exist
Deferred	Lump sum deposit; benefits withdrawn sometime after 1 year	Periodic deposits; benefits withdrawn sometime after 1 year

VI. Annuitization Period

A. The Annuitization Period is the period of time when benefits are paid to the annuitant, called the Pay-Out Period. Typically happens at retirement.

B. Settlement Options

1. Just like in life insurance, the insurer must be advised how and when the money is to be distributed.

2. Unlike life insurance, the funds are meant to go to the annuitant, not the beneficiary. But can go to beneficiary at death of annuitant dependent upon the option selected or if death occurred before annuitization.

3. **Life Income** – Pays the most, it provides the annuitant with income for rest of their life and, upon their death, all payments cease.
    a) If the annuitant dies prior to exhausting the funds within the annuity, the insurer retains the money in the account.
4. **Life Income Period Certain** - provides the annuitant with lifetime income or provides that, upon their death, payments continue to the beneficiary for the number of years remaining.
    a) For example, an annuity might have a 20-year period certain which means that if the annuitant dies before 20 years have passed, the remaining years get paid to the beneficiary either in lump sum or installments.
5. **Life Income with Refund** - pays the annuitant for the rest of their life and if, upon their death, the account funds are not exhausted, the remainder of the money invested by the annuitant is refunded to the beneficiary.
    a) However, the accumulated interest is not given to the beneficiary.
6. **Life Income Joint and Survivor** - pays two annuitants while both live then, upon the death of the first, payments continue to the survivor either at 50%, 66% or 100% of the original payments. Test key, **S**urvivor = **S**econd to die.
7. **Joint Life** - pays two annuitants while both are living then, upon the death of the first, all payments cease.

VII. Investment Retirement Plans

A. The following plans are similar to annuities in that they provide retirement income. Some are established by employers while others can be opened by individuals.

B. Profit-Sharing 401(k)

1. 401(k) plans are set up by employers as a benefit to eligible employees.
2. Employees make contributions to the plan via pre-tax salary reduction.
3. Employers can voluntarily make contributions on a matching basis.

C. Individual Retirement Accounts (IRAs)

1. Individual Retirement Accounts or IRAs are set up by individuals to help them plan their own retirement, even if they have a retirement plan available through work.

2. **Traditional IRA**
    a) The account owner deposits funds on a tax-deferred basis, meaning the money will not be income taxed until withdrawn.
    b) Anyone can contribute to an IRA if you are still working and have sufficient earned income.
    c) The contributions can be tax deductible unless gross income exceeds certain amounts.
    d) Annual contributions are limited by the IRS.
    e) Catch up contributions are allowed for people 50 and over.
    f) IRA's may be funded with mutual funds, common stocks, certificates of deposit, and annuities. NOT life insurance.
3. **Roth IRA**
    a) The account owner deposits funds with after tax dollars. When they retire, no taxes are owed on the withdrawn amount even the interest, as long as the account has been open for at least 5 years.

D. Tax-Sheltered Annuities

1. TSAs are accounts set up for 403(b) public school employees or employees of a 501(c)3 non-profit organization. Employers put money into the TSA pretax from the employee's earnings. Earnings grow tax deferred.
2. These accounts are owned by the employees.

E. KEOGH Plans

1. KEOGH Plans, also called (SEP) Self-Employed Plans, are set up for unincorporated business owners and their employees.
2. If an employer contributes money into their own account, it is mandatory for the employer to contribute to the employees' accounts as well.

F. Savings Incentive Match Plan for Employees (SIMPLE)

1. SIMPLE Plans can be either 401(k)s or IRAs and are only available to employers with 100 employees or less.
2. The advantage of these plans is low administrative costs.

VIII. Taxation

A. Most annuities and retirement accounts are income taxable.
1. The exception is the Roth IRA.

B. The IRS imposes a 10% penalty tax on any withdrawals taken prior to age 59½ from any of these accounts.

Done with Life and Life Law, great job! Have you scheduled your exam? YOU WILL PASS!

INSURANCE SCHOOL

OF TEXAS

Health Insurance

Chapter 8 - Health Insurance 101

SUMMARY

This chapter discusses the basics of health insurance and the life of a health insurance application as it goes through the underwriting process.

I. Definitions

A. Accident - is an unplanned and unforeseen event that occurs suddenly and from which injury results.

B. Sickness – is an illness manifesting after the policy is in force.

C. Preexisting Condition – is a health or physical condition that existed prior to the effective date of the policy.

D. Probationary Period – a period of time stated in the policy after the effective date and before coverage applies for pre-existing conditions.

1. Keep your P's together! Pre-existing condition goes with Probationary period.

E. Deductible – is the initial amount of expense paid by the insured before the insurer pays the benefits of the policy. Example: $500.

1. The higher the deductible, the lower the premium.

F. Coinsurance – is the percentage split of cost-sharing between the insurer and the insured after deductible has been paid by insured. Example: 80%/20%.

G. Copayment – is the specified dollar amount that applies per claim. Example: $30 per visit to the doctor.

H. Subrogation – transfers an insured's legal right of recovery to the insurer that has paid a claim.

1. This prevents the insured from collecting twice for the same loss and holds the responsible 3rd party accountable for the loss.

II. The Application Phase

A. It is the producer's responsibility to ensure that the applicant fills out the application completely and to the best of his/her knowledge.

B. Both the producer and the applicant must sign the application.

1. The applicant is representing, not warranting, that the statements they made on the application are true.

C. If a change needs to be made to the application, such as in the case of a mistake, the applicant needs to initial the change.

1. NOTE: At this point, the applicant has all the control, not the policyowner because there is no policy yet to own.

D. If any questions are left unanswered, the producer is responsible for obtaining those answers from the applicant before submitting the application to underwriting. Face to Face.

1. The producer should not do any of the following:

a) Fill in the answers themselves
b) Submit the application as is
c) Mail the application to the applicant
d) Call and complete by phone

2. The producer **should** go back to the applicant or have the applicant return to complete the application in person. Face to Face.

a) Questions like this are best answered keeping this in mind: Whatever causes the producer the most work and the biggest headache is the correct answer! Face to Face.

E. The producer should also attempt to collect an initial premium payment to submit with the application.

1. A policy will not go into effect until payment is received.

F. If premium is paid, then a receipt is issued.

1. Conditional Receipt - has conditions for temporary coverage; coverage will begin the date of application or the date of the medical exam--whichever happens last. If both of these conditions are not met coverage does not exist.

III. The Underwriting Phase

A. Information Sources for Underwriting

1. The underwriter has multiple sources at their disposal to underwrite a policy.

2. Application

a) The application itself contains the basic information that an underwriter needs to get started such as name, social security number, sex/gender, marital status, date of birth, and medical information.

3. Medical Exam

a) The medical exam is completed by a physician or a paramedic and provides the insurer with a current summary of the applicant's health.

4. AIDS Testing Requirements

a) An insurer may ask an applicant if they ever tested positive or were diagnosed for HIV/AIDS.
b) Insurers cannot discriminate so testing must be kept to the underwriting guidelines and the test results must be kept confidential.
c) Insured's must sign for consent to be tested for HIV/AIDS.

5. **Attending Physician's Statement**
   a) An APS is a review of the applicant's medical history provided by their treating physician providing an in-depth analysis of their medical status. Simply put, your doctor's records.
6. **Medical Information Bureau**
   a) The Medical Information Bureau operates as a coded information exchange between insurers, keeping a secure record of applicant and insureds medical histories and other important information.
   b) The Bureau is utilized only by member insurers who can only access an individual's data with that individual's signed consent.
   c) This organization helps prevent fraud and any other intentional or unintentional omissions on an application.
7. **Consumer Investigative Report**
   a) This an inspection report containing information about the applicant's finances, work history, habits, character and morals and is protected by the Fair Credit Reporting Act.
8. **HIPAA Law - 1996**
   a) The Health Insurance Portability and Accountability Act (HIPAA) privacy rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the privacy rule is balanced so that it permits the disclosure of personal health information (PHI) needed for patient care and other important purposes. Texas state laws and legislation strengthen the protection to include an individual's sensitive personal information (SPI).
   b) As a covered entity, contracted providers are mandated to follow the HIPAA and privacy laws, as well as state legislation. Legislation requires that a covered entity:
      (1) Ensures the security and safeguard of protected personal health information (PHI) and sensitive personal information (SPI).
      (2) Provides HIPAA and privacy training to employees, contract employees and volunteers.
      (3) Requires an employee, contract employee, volunteer or manager to report a potential violation incident to the covered entity's management or Privacy Office.
      (4) Requires the covered entity to assess the validity of an incident and provide notification if required.

(5) Reports HIPAA violations and findings to the federal secretary of Health and Human Services (HHS), as required.

B. Once all these information sources have been reviewed, the underwriter will take one of the following actions:

1. Issue Preferred – a lower premium rate for an ideal applicant

2. Issue Standard – is the standard premium rate quoted

3. Issue Substandard – is the premium rate issued higher than quoted or:

a) With Exclusions – the insurer uses a rider to limit the insurer's obligation to pay.

b) **Impairment Rider** – is an attachment to the policy that eliminates coverage for a particular condition, also called an **Exclusion Rider.**

IV. Policy Delivery

A. Once the policy is issued, it is sent to the producer.

B. It is the producer's responsibility to deliver the policy either in person or by certified mail, obtaining a signed receipt of delivery.

C. The producer is also responsible for explaining the policy to the policyowner ensuring they understand all the terms and conditions, including a probation period, until coverage begins. Face to Face.

D. If no initial premium was collected at the time of application, the producer must also collect those funds (consideration) at the time of policy delivery. Face to Face.

1. A transmittal notice is often required notifying the insurer that the premium has been collected.

2. Example: If a premium check is made out to the name of the producer instead of the name of the insurer, the producer should collect a new check made out properly.

a) They should not send that check to the insurer, deposit it into their own account and write a check to the insurer, or scratch their name out and write the insurer's name in.

b) This is another example of a test question that is answered best by whatever causes the producer the most work and the biggest headache.

3. Additionally, a statement of good health is required from the insured that they have not been ill since the application.

4. If an insured has suffered injury or illness, the producer is required to return the policy to the insurer for further underwriting.

a) Yet another example of the correct answer being what causes the producer the most work and the biggest headache as the producer cannot simply hand over the policy.

V. Payment Structures

A. Health insurance policies pay the health care providers in different ways dependent upon the policy type.

B. Pre-Paid – provides health care with payments made to the provider on a monthly basis.

C. Fee-for-Service – pays directly to the health care provider.

D. Reimbursement – pays directly to the insured.

E. Blanket – maximum overall limit with no itemization of costs.

F. Scheduled – itemized listing of the amount payable for each expense.

G. Usual, Customary, and Reasonable – pays benefits based upon the average fee charged by providers within a certain geographical area; any amounts above the UCR amount are billed to the insured.

1. This is a way for insurers to limit what they pay of the medical expenses.

H. Taxation - The benefits paid by medical expense policies are not taxable as income.

Say out loud: "I HAVE A CLEAR MIND AND A GOOD MEMORY, SO I WILL PASS MY TEST!"

Chapter 9 - Policy Provisions

SUMMARY
This chapter discusses the standard provisions found in most health insurance policies and how they protect the policyowner, insured, or insurer.

I. Mandatory Provisions

A. Entire Contract Clause - states that the policy, the application, and the riders all combined complete the contract.

1. An easy way to remember what makes up the entire contract is to remember a good score in golf is P.A.R: **p**olicy, **a**pplication, and **r**iders.
2. This clause also stipulates that the insurer cannot make arbitrary changes which would surprise the policyowner. Once the policy is issued, only the policyowner can request changes which must be approved by an executive officer of the insurer and attached in writing to the entire contract.
3. Producers cannot make changes in contracts.

B. Time Limit on Certain Defenses – states that all statements made in the application are incontestable after 2 years.

1. Except in cases of fraud, no time limit applies to fraud in health insurance.

C. Free Look (Right to Examine) Period - is a period of time allowing the policyowner the right to examine or look over the policy.

1. If they no longer want the policy, they can return it for a full refund.

2. This period only lasts for 10 days from the date of delivery to the owner.
3. The Medicare Supplement and Long-Term Care policies provide 30-day free look, discussed in the Senior Needs chapter.

D. Grace Period – is the period of time provided after the policy due date where coverage remains in effect before the policy lapses.

1. Premiums paid weekly have a 7-day grace period.
2. Premiums paid monthly have a 10-day grace period.
3. Premiums paid quarterly, semi-annually, or annually have a 31-day grace period.
4. If payment is not made on time the policy lapses. If a claim is made after the policy lapses it will be denied.

E. Reinstatement – allows the policyowner to put the policy back in force after it has lapsed due to nonpayment of premiums.

1. In order to reinstate the policy, think of PIE.

a) Pay back **P**remiums

b) Plus, any **I**nterest

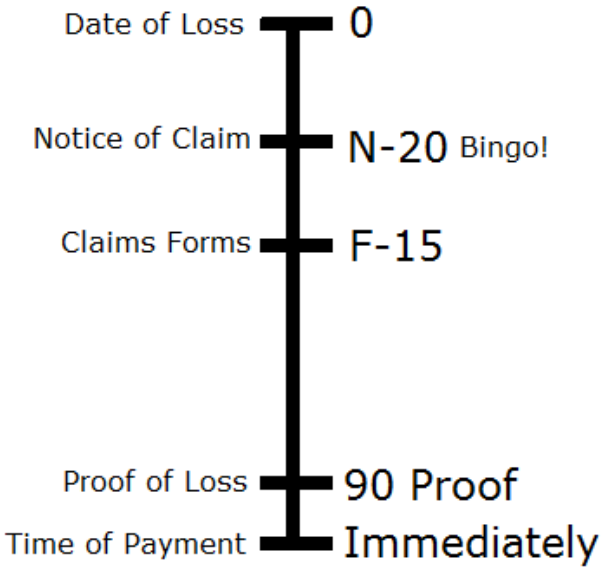
c) Provide **E**vidence (proof) of insurability

F. Notice of Claim Provision – requires that the policyowner/insured notify the insurer of a claim within 20 days of the date of loss.

G. Claim Form Provision – requires that the insurer furnish forms to the insured within 15 days after the notice of claim is received.

H. Proof of Loss Provision – requires the insured send the proof of loss back to the insurer within 90 days of the day of loss.

I. Time of Payment of Claims Provision – requires the insurer pay claims immediately upon receiving the proof of loss.



J. Payment of Claims – states who receives the claim payments. The policyowner does unless assigned to the provider of care.

K. Change of Beneficiary – allows the policyowner to change the beneficiary unless the beneficiary is irrevocable.

L. Legal Actions – requires the insured/claimant to wait 60 days and no more than 3 years to bring a lawsuit against the insurer for denial of claim.

1. Requiring the insured/claimant to wait 60 days gives the insurer time to review the claim and policy coverages.

M. Physical Exam and Autopsy – is the right of the insurer to have a physical exam or autopsy conducted upon an insured when not prohibited by law.

N. Insuring Clause – states the names of the insured, the insurer, the amount of insurance, covered losses, and the policy period.

1. It is the insurer's promise to pay.

2. Think of the insuring clause as what the insurer cares about:

a) Who are we, who are we insuring, and how much money are we paying to whom?

O. Consideration Clause – states the amount of premium, payment of the initial premium, premium mode, and the statements in the application are the insured's consideration while the insurer's consideration is given in the Insuring Clause.

1. Think of the consideration clause as what the client (policyowner) cares about:

a) How much do I have to pay and how often to maintain the coverage?

II. Optional Provisions

A. Change of Occupation – states that if the insured moves to a more hazardous occupation then the premiums will be automatically increased, or the benefit reduced.

1. If the insured changes to a less hazardous occupation, they must apply for a rate reduction.

a) The excess premium will not automatically be applied to the next premium payment or claim.

B. Misstatement of Age – states that if the age of the insured was misstated on the application then the benefit will pay adjusted to fit the insured's correct age.

C. Relationship of Earnings to Insurance – is used in Disability Income policies and limits the loss of time benefits (aka lost income) to no more than what the insured was earning on average for the 2 years prior to the disability. Prevents someone from buying multiple policies to be paid more from being disabled than working.

D. Unpaid Premiums – will be deducted by the insurer if a claim is received near the end of the grace period without a payment being received. This prevents the policy from lapsing.

E. Illegal Occupation or Act – allows the insurer to deny payment to any insured injured while committing or attempting to commit an illegal occupation or act.

Say out loud: "I AM INCREASING IN WISDOM AND FAVOR; THUS, I SHALL PASS MY EXAM!"

Chapter 10 - Medical Expense Policies

SUMMARY

This chapter discusses the different payment options, types of health insurance providers, and the major classifications of health insurance programs and plans.

I. Types of Providers

A. Service Providers – are insurers who pay benefits to the providers of healthcare.

1. These would include (HMOs) Health Maintenance Organizations, (POSs) Point of Service plans, (PPOs) Preferred Provider Organizations and (BC/BS) Blue Cross / Blue Shield.

B. Indemnity Providers (Reimbursement) – are insurers who reimburse (pay) the insured for paying their healthcare costs up front.

C. Self-Insured Providers – are employers who pay claims themselves instead of through an insurer.

II. Preferred Provider Organizations (PPO)

A. Preferred Provider Organizations are groups of independent healthcare providers who agree with the insurer to provide discounted services to insureds who are subscribers to the PPO.

B. Healthcare providers in these arrangements are paid on a discounted fee-for-service basis.

C. If an insured chooses to use a healthcare provider that is not in the network, the insurer will not pay as much of the medical expenses and the insured will pay more.

III. Health Maintenance Organizations (HMO)

A. Health Maintenance Organizations are managed healthcare systems, many that are contained within their own facilities.

B. HMO offers prepaid medical services to members called subscribers.

C. Subscribers called enrollees must receive an Evidence of Coverage:

1. means any certificate, agreement, or contract, that:

a) is issued to an enrollee; and

b) states the coverage to which the enrollee is entitled.

D. A health maintenance organization may cancel or nonrenew the coverage of a subscriber only for:

1. failure to pay the charges for the coverage.

E. One of the ways some HMOs keep costs down is by a compensation system known as "capitation".

1. Under a capitated system, a doctor is given a set amount of money for each patient. The doctor will then have to pay for each patient's tests, treatments and referrals to specialists out of that pool of money. The doctor keeps what is left at the end of the policy year.

F. A health maintenance organization shall provide to an enrollee on request information on:

1. whether a physician or other health care provider is a participating provider in the health maintenance organization's network;

2. whether proposed health care services are covered by the health plan; and

3. what the enrollee's personal responsibility will be for payment of applicable copayment or deductible amounts.

G. If a subscriber chooses to use a healthcare provider that is not in the network, the insurer will pay none of the medical expenses.

H. A gatekeeper or primary care physician (PCP) is chosen by the subscriber at the time of application and may be changed up to 4 times per policy year. If not selected at time of application or within 30 days of enrollment the HMO may assign one to you. This health care professional oversees and manages a person's medical care.

1. The gatekeeper authorizes most medical services, including referrals to other specialists.

2. The gatekeeper also orders laboratory work and medical tests and prescribes medical treatments.

3. If the person is admitted to the hospital, the gatekeeper may manage the case.

I. HMOs have low co-payments for office visits and higher co-payments for emergency rooms to discourage the unnecessary use of medical resources.

1. For example, going to the emergency room when it's not an emergency.

2. HMOs place strong emphasis on preventive visits, so the co-pay is lower for office visits than the emergency room to encourage the insured to visit the doctor if they feel unwell.

a) They would rather pay for a cold now than for pneumonia later.

J. **Non-Emergency Hospital Pre-Authorization Admissions** – is a provision in HMOs requiring the insured to obtain authorization prior to checking into a hospital, unless it's an emergency.

1. In other words, an insured can't just go admit themselves into the hospital because they feel like it.

K. While other insurers have their Certificate of Authority approved by the Texas Commissioner of Insurance, HMOs must be approved by the Managed Care Quality Assurance office (MCQA) first, then by the Texas Commissioner of Insurance.

L. HMO's must be in operation for 24 months before they can enroll insureds.

M. Open enrollment must be 31 days (1 month) long.

N. Group HMO's must offer conversion of coverage to the enrollee no less than 30 days before the end of the 6-month period during which they would be eligible for conversion to an individual plan under the Texas Health Insurance Risk Pool.

IV. Point of Service Plans (POS)

A. Point of Service plans combine HMO and PPO benefits.

B. At the 'point of service', the insured can choose to pay benefits out of the HMO portion if the doctor is in-network.

1. Gatekeeper referrals will apply.

C. If the Doctor is out of network, the plan will pay like a PPO paying some of the cost where an HMO doesn't pay out of network costs.

V. Basic Health Insurance

A. Basic Health Insurance policies cover a variety of expenses typically on a scheduled payment basis or could say (less than the full charge) with no deductible.

B. Basic Medical Expense

1. Pays for office visits, lab charges, diagnostic scans, ambulance, and professional nursing when *not* hospitalized. Doctor's visit.

C. Basic Hospital Expense – pays the room, board and miscellaneous hospital expenses while hospitalized, such as a semi-private room, food, and incidentals.

1. Think of this as paying for the building.

D. Basic Surgical Expense – pays surgeon's fees, anesthesiologist's fees, and operating room charges.

1. Think of this as paying for people.

VI. Major Medical Insurance

A. Major Medical policies offer better coverage than Basic policies and for a broader range of medical expenses that an insured may incur with fewer gaps in coverage as well as higher limits. Does not pay for work related injuries, workers compensation pays work related injuries.

B. These policies have several common features:

1. **Deductible** – the amount the insured must pay per year before the policy will pay covered expenses.
2. **Coinsurance** – is the cost sharing feature that applies after the deductible is paid by the insured. It is stated as a percentage of sharing, typically 80%/20% with the insurer paying the higher amount.

Example: An insured has $1200 of medical bills. Their Major Medical Policy has a $100 deductible and an 80%/20% coinsurance.

Insure**r** pays:	
Total bill:	$1,200
Deductible:	-$100
Remaining:	$1,100
Coinsurance:	x 0.80
ANSWER:	$880

Insure**d** pays:	
Total bill:	$1,200
Deductible:	-$100
Remaining:	$1,100
Coinsurance:	x 0.20
One more step!	$220
Deductible:	+$100
ANSWER:	$320

3. **Stop Loss Limit** – <u>is a maximum amount stipulated in the policy that states the insured no longer has to pay their medical expenses once this limit is reached, per policy year.</u>

Example: An insured has $6,000 in medical bills. Their Major Medical Policy has a $250 deductible and an 80%/20% coinsurance <u>up to a maximum of</u> $5,000 then the insurer pays 100% after that.

Insure**r** pays:	
Total bill:	$6,000
Deductible:	-$250
Remaining:	$5,750
Stop loss above $5,000	-$750
Remaining:	$5,000
Coinsurance:	x 0.80
Insurer share:	$4,000
Add the stop loss back in:	+ $750
ANSWER:	$4,750

Insure**d** pays:	
Total bill:	$6,000
Deductible:	-$250
Remaining:	$5,750
Stop loss above $5,000	-$750
Remaining:	$5,000
Coinsurance:	x 0.20
Insured share:	$1,000
Add deductible back:	+ $250
ANSWER:	$1,250

4. **Carryover Provision** – allows expenses incurred in the last 3 months of the previous year that did not meet the deductible to be applied toward satisfying *this* year's deductible.

Example: An insured had $50 of medical expenses in November 2015 and had no other medical expenses for that year. In March 2016, he sustains $3,000 of medical expenses. His policy has a $100 deductible, 80%/20% coinsurance, and a 90-day carryover provision.

FIRST, you must establish the new deductible:

Deductible:	$100
Last year's applicable expenses:	-$50
New deductible:	$50

Then solve the question as usual

Insure**r** pays:	
Total bill:	$3,000
Deductible:	-$50
Remaining:	$2,950
Coinsurance:	x 0.80
ANSWER:	$2,360

Insure**d** pays:	
Total bill:	$3,000
Deductible:	-$50
Remaining:	$2,950
Coinsurance:	x 0.20
Insured pays:	$590
Add deductible:	+ $50
ANSWER:	$640

C. There are two additional types of Major Medical policies:

1. **Comprehensive Major Medical**
   a) A Comprehensive Major Medical policy provides the most complete coverage available as it combines the Basic Health Insurance benefits with virtually any other medical expenses into this one single policy.
   b) The insured has greater choices in choosing their healthcare providers and pays a single deductible before benefits are paid by the insurer subject to the coinsurance.
2. **Supplemental Major Medical**
   a) A Supplemental Major Medical policy supports (supplements!) the Basic Health Insurance plans by paying benefits after the Basic plan is exhausted.
   b) The Basic plans do not have a deductible.
   c) Instead the insured will pay a deductible after exhausting the Basic plan and before the Supplemental Major Medical plan will begin to pay.
   d) As this deductible is between the two plans, it is called a corridor deductible.

VIII. Benefits & Provisions

A. Newborn Infant Coverage

1. All health plans providing coverage for dependents must provide coverage for an insured's newborn from the moment of birth.
   a) No insurer can exclude coverage for any period of time.
   b) Adopted children can be covered from the date adoption proceedings begin.
2. The plan must cover routine care and care for congenital defects and birth abnormalities.
3. The insured must notify the insurer within 31 days of birth or adoption and pay the required premium.

B. Dependent Child Coverage

1. Any policy that provides coverage for dependent children must provide that coverage until the dependent turns 26, according to the Affordable Care Act (ACA).
2. Even if the child is married or has other insurance available, they can remain on the plan.

IX. Limited Policies

A. Accidental Death and Dismemberment

1. These plans pay the principal sum for the accidental death, loss of sight in both eyes, or loss of two limbs and pays a lesser amount called the capital sum for loss of sight in one eye or loss of one limb.
2. A limb qualifies as anything above the wrist or ankle.
3. For example: if an insured cut their toes off with a lawn mower, the AD&D policy would not pay anything as this loss does not qualify as a limb.
4. Benefits received income tax free.

B. Critical Illness/Dreaded Disease

1. Critical Illness plans provide lump sum cash benefits for certain diseases
   a) Heart Attack plans, Stroke plans,
   b) Cancer Plans covers all the following:
      (1) Immunotherapy
      (2) Physical therapy
      (3) Chemotherapy

C. Dental Insurance

1. Dental insurance is highly specialized and includes the following:
   a) Endodontics – covers care for the interior of the tooth such as pulp care and root canals
   b) Oral Surgery – is surgical treatment for dental disease or injury
   c) Orthodontics – covers teeth alignment such as braces

d) Periodontics – is treatment for gum disease and injury
e) Prosthodontics – bridgework and dentures
f) Restorative Care – restores the use of natural teeth, by putting in a filling or a crown. Making the tooth functional.

D. Hospital Income

1. Hospital Income plans pay benefits to the insured whatever dollar amount is stated in the policy while they are hospitalized.

2. The benefit could be used for whatever the insured wants, for example, to pay someone to walk their dog while they're hospitalized.

I. Short-Term Medical - Short-term health insurance is a temporary plan designed for people who don't currently have health insurance and are waiting for longer term, major medical insurance coverage.

1. Short-term insurance is also <u>not</u> considered minimum essential coverage under the Affordable Care Act (ACA).

2. Purchasing a short-term plan will make the insured ineligible for any guaranteed-issue individual health plans commonly referred to as HIPAA plans.

E. Vision Care

1. Vision Care benefit provides payment for the cost of an annual examination, the cost of lenses, frames, or contact lenses.
a) However, it will not pay the cost to replace glasses that are lost or broken.

2. <u>This benefit does not pay for disease or injury to the eye, such as cataract removal or treatment for glaucoma.</u>
a) Even if the insured sees the eye doctor for this treatment, their health policy pays for these claims.
b) Vision care is purely for correcting vision.

F. Prescription Drugs

1. The prescription drug benefit is most often found in group health insurance, but some individual policies offer it as a rider. This benefit is written requiring a small copayment for each prescription.

X. Exclusions

a. Intentional self-inflicted injuries or injuries due to any act of war.
b. Elective cosmetic surgery.
c. Military service, overseas residence, or expenses payable by Workers Compensation.
d. Injuries sustained in the commission or attempt of a felony crime.
e. Duplicate or replacement glasses, dentures or prosthetic devices.

Say out loud: "I AM NOT WORRIED; I AM CONFIDENT I WILL PASS MY TEST!"

Chapter 11 - Group Health & Benefits

SUMMARY

This chapter discusses the structure of group health insurance as well as other benefits available to employees of employers who offer group benefits.

I. Group Health Insurance Overview

A. Group Health insurance is an arrangement between a group sponsor and the group participants.

B. The sponsor or policyowner is typically an employer who receives the **Master Policy**.

C. The participants would be the employees who receive a **Certificate of Insurance** and their benefits are found in the **Policy Summary**.

II. Eligible Groups

A. A group policy can be written in this state only if the group is a legal and eligible. Eligible groups would include:

Eligible Groups	Ineligible Groups
A natural group formed for purposes other than to obtain insurance. Employers	Select group of employees, such as only the salespeople and not the service people or executives only
Stockholders	Family, blood relatives, adopted children
Labor Unions	Friends
Board of Directors	Neighbors

B. Employee Eligibility

1. To be eligible for group coverage, the employee must be working full time with a minimum of 30 hours per week, according to the Affordable Care Act.

C. Dependent Coverage

1. If coverage is offered to dependents, then the group plan will cover the insured employee's spouse and their children, natural or adopted, married or unmarried, up to age 26.

D. Coordination of Benefits

1. If an insured employee has coverage through their employer and is also insured as a dependent on their spouse's plan, then the employee's plan is primary for the employee with the spouse's plan acting as secondary.

a) For example, J works for ABC Engineering. J and his wife M are both insured on his group health plan. They are also insured on M's group health plan with her employer, XYZ Pharmaceuticals.
b) If J has a $10,000 hospital bill then the group insurance from his employer, ABC Engineering, would pay their 80% coinsurance obligation. Without considering the deductible, that amount is $8,000. The remaining $2,000 of expenses can be filed under M's group insurance through her employer, XYZ Pharmaceuticals.

	ABC Engineering	**XYZ Pharmaceuticals**
Primary	J	M
Secondary	M	J

2. If children are covered on both parents' plans, then the parent whose birthday is first in the year will be the primary coverage.
a) J is 37 and his birthday is December 12 and M is 34 and her birthday is August 8. Their daughter L is 5 and her birthday is February 2.

	ABC Engineering	**XYZ Pharmaceuticals**
Primary	J	M, L
Secondary	M, L	J

E. Conversion Privilege

1. If available, the conversion privilege allows an insured employee to convert the group coverage to an individual plan when they quit, retire, or are fired.
2. This requires no proof of insurability.
3. The insured employee must submit the conversion request within 31 days of separation from their employer.

F. Small Employer

1. Small employers are those that employ a minimum of 2 and no more than 50 employees.

III. Group Underwriting

A. Group insurance requires no evidence of insurability meaning there is no medical underwriting or medical exams. The employee must sign the enrollment card to obtain benefits.
B. However, the underwriter must avoid **adverse selection** which is the tendency for high risk individuals to pursue health insurance that requires no medical questions or exams.
C. Waiting Period - is the period of time new group members must wait before they can enroll in the group plan.
1. For most employers, this is somewhere between 0 to 90 days.

D. After the waiting period has expired, the employee will then have 30 days to enroll in the plan.

1. Annually thereafter an open enrollment period will allow participants to make any necessary changes.

E. Two Payment Arrangements

1. Contributory Plans

a) Requires employees contribute to premium payments.

b) 75% of the eligible employees must participate.

2. Non-Contributory Plans

a) Requires the employer pay all the premiums.

b) 100% of the eligible employees must participate.

3. Taxation – the benefits paid under Group Health arrangements are not income taxable to the employer or the employee.

a) However, the employer can deduct the portion of premium they pay for these plans from their business taxes.

IV. COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

A. COBRA is a federal act that requires employers with 20 or more employees provide the option to continue health coverage.

B. The ex-employee or dependents pay up to 102% of the premium cost to the employer to be allowed to remain on the ex-employer's group health plan without having to provide proof of good health.

C. Eligibility for COBRA:

Employees & Dependents	**Dependents Only**
18 months	**36 months**
• Termination of employee	• Death of employee
• Reduction of employee's hours so they are no longer full-time	• Divorce or legal separation
29 months	• Employee becomes entitled to Medicare (age 65)
• Employee qualifies for Social Security Disability	• Loss of dependent status (age 26)

D. Within 14 days of the above qualifying events, the employee (or their dependent) must be notified of the right to continue coverage.

1. The employee (or their dependent) must notify the employer of their choice within 60 days.

E. The employer must notify the Health Insurer within 30 days of one of the above qualifying events.

F. No proof of insurability is required because this is still a group plan.

G. COBRA coverage will be terminated in the following circumstances:

1. Non-payment of premium

2. Employer terminates all group coverage

3. Employee becomes eligible for a new group coverage
4. Employee converts to an individual plan

V. Worksite Plans

A. Worksite Plans are voluntary plans offered in conjunction with group health benefits and are optional to the employees.

1. Vision Care
2. Dental Care
3. Disability Income
4. Critical Illness

B. Typically, the employee pays 100% of the premium for these benefits however some employers will contribute to payment or they can pay with pre-tax income under a Section 125 Cafeteria Plan.

VI. Consumer-Driven Health Plans

A. Consumer-driven health plans help individuals fund the cost of healthcare that they must pay out-of-pocket.

B. Flexible Spending Account (FSA)

1. FSAs are set up by the employer to allow employees to set aside up to $2,750 of pre-tax income into an account to pay for unreimbursed medical expenses.
2. Eligible expenses would be the cost of glasses, deductibles, coinsurance, copayments, prescription drugs, and elective surgery such as LASIK.
3. Contributions into the account are "use it or lose it" meaning the employee needs to spend the entirety of the funds over the course of the year (sometimes rolling over into the first quarter of the next year) or else the employer retains the unused funds.

C. Health Reimbursement Arrangement (HRA)

1. HRAs are accounts set up to reimburse employees for their medical expenses, similar to an FSA plan.
2. However, these plans are 100% employer funded.
   a) Think of Human Resources or HR as the ones who fund the plan. HR funds the HRA.

D. Health Savings Account (HSA)

1. HSAs are accounts that can be funded by either the employee, the employer or both.
2. The only individuals eligible to have these plans are those with a high deductible health plan. Usually offered by the employer to help pay the high deductible.
   a) Remember that to pay that high deductible, you need a lot of money in savings, so they offer you a health savings account.

3. Say out loud: "I AM FOCUSED, I AM CONFIDENT, I WILL PASS THIS TEST!"

Chapter 12 - Disability Income Policies

SUMMARY

This chapter discusses the Disability Income policy, the definitions of a disability, how these policies work for individuals and businesses, and the available riders to supplement the coverage.

I. What is Disability Income Insurance?

A. Disability Income Insurance pays lost earnings when the insured becomes disabled due to an illness or injury.

B. **Premiums** paid by individuals are not tax deductible for the individual, but should the individual become disabled the benefits received are income tax free.

C. **Occupational** – is a type of policy that covers disability due to illness or injury that occurs on or off the job.

1. Ideal for someone who does not have Workers Compensation available to them from their employer.

D. **Non-Occupational** – is a type of policy that covers disability due to illness or injury that occurs off the job only.

1. Ideal for someone who has Workers Compensation available.

II. Definitions

A. Total Disability

1. **Own Occupation** - to qualify as 'totally disabled' under this definition the policy requires the insured to be unable to perform the duties of the occupation they were engaged in when they became disabled.

2. **Any Occupation** – to qualify as 'totally disabled' under this definition the policy requires the insured to be unable to perform the duties of any occupation that they are reasonably suited and trained for.

OWN OCCUPATION	ANY OCCUPATION
Can you work in you your own job?	Can you work in your own job?
	Can you work in *any* job that you are reasonably trained for?

B. Partial Disability – to qualify as 'partially disabled' the policy requires the insured to be unable to perform some of the duties of their occupation.

C. Temporary Disability – is a disability from which the insured is expected to recover.

D. Permanent Disability – is a disability from which the insured is not expected to recover.

E. Residual Disability – only pays benefit when the insured returns to work after a total disability, but their earnings are reduced because they are unable to perform the entirety of their previous job duties.

F. Recurrent Disability – is a disability that happens again after the insured is presumed to have recovered but sustains the same disability within a certain period of time from the recovery.

G. Presumptive Disability – means that the insurer will not require the insured to submit to periodic medical exams to prove that they are still disabled, such is in the event of blindness or amputation.

H. Malingering – faking illness or injury to escape duty or work.

III. Policy Structure

A. Elimination Period – is the period of time after a disability begins but before the policy pays out.

1. Think of this as a time deductible.

2. Instead of how much money must be paid before the policy pays, this is how much time must pass before the benefit pays.

B. Benefit Period – is the period of time the benefit pays.

1. The benefit period could be a certain number of years (3, 5, 10, or 20 years) or to a stipulated age (to age 65) or for life.

C. Benefit Amount – is the amount of income per month the policy will pay which is not taxable as income.

D. For example, a policy could have a $3,000 benefit amount and a 10-year benefit period.

1. This means the policy will pay $3,000 per month for up to 10 years after the insured becomes disabled.

E. The elimination period the insured chooses will affect the premium.

1. If they choose a short elimination period, then premium goes up.

2. A 30-day elimination period would be $127 per month.

3. A 90-day elimination period would be $99 per month.

4. A 150-day elimination period would be $65 per month.

IV. Disability Underwriting Factors

Factor	Meaning	How it affects premium	How it affects benefit
Income	How much the insured made prior to the disability.	The higher the income, the higher the premium.	The benefit amount will be 66 $^{2}/_{3}$% of the insured's average income.
Occupation (Vocation)	How likely was the insured to become disabled from their job?	The more hazardous the job, the higher the premium.	The more hazardous the job, the lower the benefit.
Avocation	How likely was the insured to become disabled due from their side job?	The more hazardous the side job, the higher the premium.	The more hazardous the side job, the lower the benefit.
Hobbies	How likely was the insured to become disabled due to their hobbies, such as sky diving, racing, etc.	The more hazardous the hobby, the higher the premium or it could be excluded.	The more hazardous the hobby, the lower the benefit or the hobby could be excluded.
Age	How old the insured was at the time of application.	The older the insured, the higher the premium	
Gender	Men are more likely to become disabled than women.	Women have a higher premium because they are more likely to file a claim.	Gender cannot be used to determine benefit level as this is discrimination
Health History	Someone with poor health is more likely to become disabled.	Poor health history would result in higher premiums.	

A. Once all the information has been reviewed, the underwriter will decide if the applicant is insurable.

B. If the applicant is considered 'substandard' then the underwriter can adjust the requested coverages to make them insurable by increasing the premium, increasing the elimination period, shortening the benefit period, reduce the benefit amount, or excluding certain conditions that will likely result in a loss.

1. For example, a prior back injury will likely be excluded if it seems likely to recur.

V. Group Disability

A. Underwriting group disability income policies is much less detailed because the group is viewed as an averaged individual.

B. Remember, all group policies will have no proof of insurability required during an enrollment period!

C. Group disability income insurance is usually offered only on a nonoccupational basis, meaning it doesn't cover work-related disabilities. Work-related disabilities are covered under Workers' Compensation Insurance.

D. Group disability income benefits are income taxable to the employee if the premium was paid by the employer. If the employee paid the premiums for the group disability the benefits are received income tax free.

E. **Short Term Disability** – these group policies pay 80% – 100% of their income for short periods of time usually 2 – 26 weeks but no more than 2 years.

F. **Long Term Disability** – these group policies pay 66 2/3% of their income after the short-term disability runs out, usually up to age 65.

VI. Business Disability

A. Other than providing group insurance to their employees, businesses can utilize Disability Income insurance in other ways.

B. **Disability Buyout** – is used in partnership arrangements to buy out a totally disabled partner's interest in the business.

1. Benefits are paid to the disabled partner tax free.

C. **Key Person Disability** – pays benefits to the employer to hire and train a new employee or replace lost revenue due to a disabled employee's inability to work.

1. The benefit received is income tax free.

D. **Business Overhead Expense** – pays benefits to cover the expenses of a business, such as rent and payroll, when the owner of the business becomes disabled.

1. The benefit payment on this policy is income taxable. The premium is tax deductible.

2. A Business Expense policy pays a monthly benefit based on actual expenses, not on anticipated expenses and profits.

E. **Disability Reducing Term** – pays long term benefits such as a loan with the benefit amount remaining the same and the benefit period shortening per payment.

VII. Optional Riders

A. **Change of Occupation** – If an insured change their occupation from a less dangerous to a more dangerous occupation they should inform their insurer of the new occupation and pay the premium for

the change of risk. If the insurer is not informed and later a claim occurs the insurer will, pay the claim according to the benefit that would have been paid had the insurer known the correct job classification.

B. Cost of Living Rider – will increase the benefit amount in accordance with the Consumer Price Index (CPI) which measures inflation on an annual basis allowing the insured's purchasing power to remain level.

C. Guaranteed Purchase Option – allows the insured to purchase additional benefit amounts without proof of insurability based upon certain dates or qualifying events, such as marriage, birth of a child, promotion, etc.

D. Impairment Rider – also known as an **Exclusion Rider**; this eliminates coverage for conditions that would otherwise make the insurance unobtainable for an insured.

1. Allows the insurer to offer a policy they wouldn't normally offer by not covering the specific impairment.

E. Waiver of Premium Rider - if the insured becomes totally disabled, the insurer waives premiums for the duration of the disability.

Say out loud: "I AM EXCITED ABOUT MY FUTURE I'M ALMOST THERE, A LICENSED INSURANCE PRODUCER, AND A GOOD ONE TOO!"

Chapter 13 - Government Plans & Supplements

SUMMARY
This chapter discusses the various types of insurance provided by the federal or state government for the disabled, the elderly, or the poor. Also discussed in this chapter are policies designed to supplement these government-run plans. And finally, the Affordable Care Act will be addressed at the end.

I. Social Security offers medical-Medicare, retirement, and disability benefits-OASDI.

II. Social Security Disability – OASDI (Old Age Survivors and Disability Insurance)

- **A.** Social Security disability is available to those of any age who qualify by having worked and paid into Social Security for a certain amount of time.
  - **1.** Fully insured is 40 credits which is a quarter (3 months) 20 of which were in the last 10 years.
  - **2.** Currently insured is based upon age starting with 6 credits in the last 13 quarters.
  - **3.** Both must wait 5 full months before receiving benefits.
- **B. Primary Insurance Amount (PIA)** – determines the Social Security Disability Income benefit paid based on the employee's average indexed monthly earnings upon which Social Security taxes were collected.

III. Medicare (Care for the Elderly)

- **A.** Medicare was originally designed for American citizens 65 and over and was later expanded to cover people of any age diagnosed with kidney failure or ALS who are insured under Social Security.
- **B.** Those on Social Security disability are also eligible if they have received benefits for at least 24 months regardless of age.
  - **1.** Someone receiving Social Security disability benefits is covered first by Medicare.
- **C.** If someone turns 65, continues to work, and remains on their employer's group health plan, then the group health plan is primary to Medicare.
  - **1.** The group health plan must have at least 20 employees for this rule to apply.

D. Medicare has 4 parts (A, B, C and D):

1. Part A – Hospital Insurance (Inpatient)

a) Part A is provided by the federal government and is premium free to citizens 65 and over who paid into Social Security for at least ten years (40 quarters).

b) Those who did not can pay monthly premiums to obtain Part A coverage.

c) Part A covers most medically necessary hospital, skilled nursing, home health, and hospice care.

d) It also covers blood transfusions but has a 'blood deductible' requiring the insured to pay for the first 3 pints of blood per year. Medicare pays after the first 3 pints.

2. Part B – Medical Insurance (Physicians, Surgeons, Outpatient)

a) Part B is provided by the federal government and enrollees must pay a monthly premium for this coverage.

b) Part B covers 80% of Medicare approved doctors' visits, preventive care, durable medical equipment, outpatient lab services, mental health, home health, and ambulance services. Blood after the first 3 pints.

c) Part B does not cover prescription drugs, care in another country, dental or vision care, routine physicals, cosmetic surgery.

3. Part C – Medicare Advantage

a) Part C is sold by insurers and is not a separate benefit.

b) Instead, it allows insurers to enhance the Medicare benefits that are found in Part A and B. Insureds must have both parts A and B to obtain part C.

c) Medicare Advantage plans are HMOs or PPOs and are more familiar to insureds than managing their insurance directly through Original Medicare.

4. Part D – Prescription Drugs

a) Part D is sold by insurers and covers prescription drugs administered on an outpatient basis.

b) This pays for medications from the pharmacy.

IV. Medicare Supplement

A. Medicare Supplement plans require a Life & Health insurance license to be sold. The licensed producer is an employee of the insurer. Producers sell them to help people 65 and over with their medical bills.

B. They are designed to supplement Original Medicare by filling in the gaps of coverage by paying for deductibles and copays.

1. A person with excessive medical bills on Medicare would benefit by having a Medicare Supplement policy to pay some of the costs Medicare doesn't pay.

C. There are several Plans available, but Plan A is the basic plan that must be offered and is the foundation of all Medicare Supplements.

1. Plan A – Core Benefits pays the following:
   a) Part A Coinsurance of Original Medicare
   b) Part B Coinsurance of Original Medicare
   c) Hospital Costs, an additional 365 days
   d) 1st 3 pints of blood
   e) Part A Hospice Care copay

D. Policy Requirements

1. These policies must have a 30-day free look period.
2. An Outline of Coverage and Buyer's Guide must be provided to the insured at the time of application.
3. These policies must be guaranteed renewable meaning the policy will renew without regard to health status.
4. Insurers cannot cancel except for non-payment of premium or fraud was committed.
5. If a replacement is involved in the selling of a plan the insured must sign a notice of replacement that shows the insured understands that their current plan is being replaced by the new one. One copy signed by the producer and insured is given to the insured and one copy must be retained by the insurer.

V. Long-Term Care

A. Long-Term Care insurance is a policy designed to provide payment for skilled nursing care type facility for at least 12 months, rehabilitation care, and some offer home health care.

1. This policy does not pay for hospitalization.
2. Think about where you want to be long term: at the hospital or in a home setting?

B. Benefits received income tax free.

C. Available in these forms:

1. Individual – the most common sold.
2. Group – Some employers offer as a voluntary benefit.
3. Life Insurance Rider- some insurers offering the benefits to be paid out of the life insurance death benefit prior to death.

D. Benefit Triggers

1. The policy must be 'triggered' to pay, meaning the insured can't decide spontaneously to check into a nursing home and expect the policy to pay.

2. **Activities of Daily of Living**
    a) Bathing
    b) Continence – the ability to 'hold it'
    c) Dressing
    d) Eating
    e) Toileting – the ability 'to go without assistance'
    f) Transferring – getting from one place to another
    g) If the insured is unable to perform 2 or more of these, they are considered functionally impaired and the policy is triggered.
3. **Cognitive Impairment**
    a) The loss of memory
    b) The loss of deductive or abstract reasoning
    c) Due to a mental illness, such as dementia or Alzheimer's, stroke, or blunt force trauma.
        (1) Note: Cognitive Impairment does not require inability under the Activities of Daily Living.
4. **Physician Certification**
    a) A certification from a Doctor, Nurse Practitioner or Social Worker that the insured needs Long Term Care.

E. Policy Requirements

1. These policies must have a 30-day free look period.
2. An Outline of Coverage must be provided to the insured.
3. These policies must be guaranteed renewable meaning the policy will renew without regard to health status so long as the premium was paid, and no fraud was committed.
4. The reimbursement LTC policy pays actual cost of care up to a daily maximum such as $200 per day.

ATTENTION: ONLY MEDICARE SUPPLEMENT AND LONG-TERM CARE POLICIES HAVE THESE REQUIREMENTS:

1. These policies must have a 30-day free look period.
2. An Outline of Coverage must be provided to the insured.
3. These policies must be guaranteed renewable meaning the policy will renew without regard to health status so long as the premium was paid, and no fraud was committed.

II. Medicaid (Aid for Low Income Individuals)

A. Medicaid is a federally funded program that is also funded and administered by each state in partnership.

B. It provides medical insurance to low-income individuals as well as those on public assistance who are:

1. Blind or disabled
2. Medically needy refugees

3. Pregnant women
4. Children under age 21

III. Affordable Care Act

A. The Affordable Care Act (ACA) initiated a web exchange where individuals and businesses can shop for and compare health insurance options.

1. This exchange is called the Health Insurance Marketplace.
   a) The Marketplace used to enroll a person is the one in their state of residence, not the state of their employment if different.
2. **Open Enrollment Period**
   a) If a person misses the Open Enrollment Period, they must wait for the next Open Enrollment Period to apply.
3. **Special Enrollment Period (SEP)**
   a) A time outside the yearly Open Enrollment Period when you can sign up for health insurance. You qualify for a Special Enrollment if you have had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.
   b) If you qualify for a SEP, you have up to 60 days following the event to enroll in a plan. IF you miss that window, you must wait until the next Open Enrollment Period to apply.

B. Types of Plans

1. **Bronze Plan** – pays 60% of covered expenses
2. **Silver Plan** – pays 70% of covered expenses
3. **Gold Plan** – pays 80% of covered expenses
4. **Platinum Plan** – pays 90% of covered expenses

C. Essential Health Benefits-

1. Benefits shall include at least the following general categories and the items and services covered within the categories:
   a) Ambulatory patient services.
   b) Emergency services.
   c) Hospitalization.
   d) Maternity and newborn care.
   e) Mental health and substance use disorder services, including behavioral health treatment.
   f) Prescription drugs.
   g) Rehabilitative and habilitative services and devices.
   h) Laboratory services.
   i) Preventive and wellness services and chronic disease management.
   j) Pediatric services, including oral and vision care.

D. Eligibility

1. Self-employed people or people without health care.

2. Certain individuals are exempt from this requirement:

a) Undocumented immigrants called illegal residents
   (1) Legal residents are eligible for ACA
b) Incarcerated persons
c) Members of a federally recognized Indian tribe
d) Members of a religion opposed to health care benefits
e) Those whose household income doesn't require a tax return
f) Those eligible for hardship exemptions
   (1) Homeless, victims of eviction, victims of human or natural disasters
g) Those who pay more than 9.5% of their income for health insurance after employer contributions and tax credits

E. Minimum Coverage

1. People under the age of 30, or who have a hardship exemption, or who can't qualify for Medicaid are eligible to purchase catastrophic plans that pay only in the event of medical emergencies.

a) Eligibility does not include, not being able to afford insurance. The government offers assistance for low and moderate-income Americans to afford health insurance. The cost-sharing reduction program reduces the out-of-pocket spending for health services.

Say out loud: "MY PATH BEFORE ME IS BRIGHT, I CAN SEE THE END AND IT SAYS, CONGRATULATIONS YOU PASSED YOUR EXAM!"