Life Insurance - Basics

Accurate underwriting depends heavily on an application that is complete and representative of the potential risks. This chapter focuses on the producer's first major role as a field underwriter: completing the application and delivering the policy. This section discusses the specific steps of the application process, which includes completing the form itself, collecting the premium, and delivering the policy. In general, this chapter helps you build a foundation of insurance concepts that make it easier for you to master the rest of the material in this course.

TERMS TO KNOW

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

A. Uses Of Life Insurance

In life insurance, an insured pays a premium to an insurance company, and in return, the insurance company assumes the risk of that person dying prematurely. The premium (a small certain loss) is exchanged for a large uncertain loss. The insurance company is insuring many lives, so it is spreading the risk of premature death among a large group of lives.

While life insurance is not usually thought of as property in the same way as real estate and other personal property, it has value like other property in the following ways:

- It can be a valuable part of an individual's estate, providing immediate cash to pay debts and providing financial security to the insured's survivors;
- Like land or buildings, the cash value of a life insurance policy can be used as collateral to secure a loan; and
- Life insurance may be paid for in manageable installments called **premiums.**

Insureds who are the breadwinners of their families will have different income needs at various stages of their lives. The needs that are protected with insurance

can be divided into 3 different income periods. Today, with the wide variety of types of policies and riders available, it is possible to structure an insurance program to satisfy all of these needs. As an insurance producer, it is your responsibility to assist the insured in developing such a program. The 3 income periods that most insureds are exposed to are the following:

1. Family Dependency Period — This is the period when, should the insured die prematurely, the surviving spouse will have dependent children to support. The family's income need will be greatest during this period.
2. Preretirement Period — This is the period after the children are no longer dependent upon the surviving spouse for support, but before the surviving spouse qualifies for Social Security survivor benefits ("Blackout Period"). The income needs of the surviving spouse lessen during this period; however, until the surviving spouse reaches age 60, Social Security benefits are not available.
3. Retirement Period — During this period, the surviving spouse's working income ceases and his or her Social Security benefits begin. Since the surviving spouse's standard of living does not lessen, he or she will require an income comparable to the Preretirement Period during this time.

1. Personal Financial Planning

Educational Objective:
II.A.2. Be able to identify the elements of the personal insurance planning process:

a. Overall financial objectives
b. Development and implementation of an insurance plan to accomplish the objectives

The type of information that needs to be gathered falls under 4 categories:

1. Debt;
2. Income;
3. Mortgage; and
4. Expenses.

These costs would take into account the final medical expenses of the insured, funeral expenses, and day to day expenses of maintaining the family including rent or mortgage payments, car payments, utilities, groceries, etc.

Other needs and objectives would include estate taxes, day care, insurance premiums, and similar expenses.

Debt Cancellation — Insurance may be used to create a fund to pay off debts of the insured such as home mortgage or auto loans.

Emergency Reserve Funds — Insurance proceeds may be used to assist in paying for sudden expenses following the death of the insured, such as travel expenses and lodging for family members coming from a distance.

Education Funds — Insurance proceeds may be used to pay for children’s education expenses so they can remain in school, or sometimes a surviving

spouse who has worked in the home caring for children will need to receive education or training in order to re-enter the job market.

Retirement Fund — Insurance proceeds may be used as a source of retirement income.

Bequests — An insured may wish to leave funds to their church, school, or other organization at the time of their death.

Unless funded by insurance, the surviving spouse who was the caregiver of the children may have to train to enter the job market. If they do work outside the home, expense for day care needs to be considered.

Selling assets, or liquidation, is a method of raising capital. Retention is the retaining of assets. If the principal asset is the home, selling the home would require that the survivors then pay rent. Under the retention of capital approach, enough insurance is purchased so that when added to other liquid assets, there is enough to pay income benefits without invading the principal.

2. Life Insurance Creates an Immediate Estate

Educational Objective:
II.A.9. Be able to identify the meaning of the statement "Life insurance creates an immediate estate."

A person may create an estate through earnings, savings, and investments, but all of these methods require disciplined action and a significant period of time. The purchase of life insurance **creates an immediate estate**. Estate creation is especially important for young families that are getting started and have not yet had time to accumulate assets. When an insured purchases a life insurance policy, they will have an estate of at least that amount the moment the first premium is paid. There is no other legal method by which an immediate estate can be created at such a small cost.

Life insurance may be used to accumulate specific amounts of monies for specific needs with guarantees that the money will be available when needed. *For example*, some life policies (those that provide permanent protection, such as whole life) accumulate cash value that is available to the policyowner during the policy term.

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

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

3. Determining the Amount of Life Insurance

Educational Objective:
II.A.3. Be able to identify the two approaches used to determine life insurance amounts:

a. Human life value approach, or
b. Needs approach

Human Life Value Approach

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

Example:

Let's assume that a 40-year-old insured earns $50,000 a year and is expected to earn the same amount until he retires at age 65. Out of his annual income, $40,000 is spent on family needs, and the remaining $10,000 goes to the insured's personal expenses. This means that the human life value of this insured to his family is $1,000,000 ($40,000 a year spent on family needs x 25 years to retirement). Based on this assumption, and taking interest and inflation into consideration, the insurance company will determine the right amount of insurance to produce the same annual amount of income for the family if the insured were to die.

Needs Approach

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

4. Business Uses of Life Insurance

Educational Objective:
II.A.5. Be able to identify the following business funding uses of life insurance:

a. Key person insurance
b. Buy-sell agreements
c. Other uses (e.g., split dollar, deferred compensation, business overhead, salary continuation)

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

The most common use of life insurance by businesses is as an employee benefit, which serves as a protection for employees and their beneficiaries. There are also

other forms of life insurance that can serve business owners and their survivors, and even protect the business itself. These include funding business continuation agreements, compensating executives, and protecting the business against financial loss resulting from the death or disability of key employees.

Key Person Insurance

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

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

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

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

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

Buy-Sell Insurance

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

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

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

Example:

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

Other Uses
Business Overhead Expense

Business overhead expense (BOE) insurance is a unique type of policy that is sold to small business owners who must continue to meet overhead expenses, such as rent, utilities, employee salaries, installment purchases, or leased equipment, following a disability. The business overhead expense policy reimburses the business owner for the actual overhead expenses that are incurred while the business owner is totally disabled. This policy does not reimburse the business owner for their salary, compensation, or other form of income that is lost as a result of disability. There is usually an elimination period of 15 to 30 days and benefit payments are usually limited to one or two years. The benefits are usually limited to covered expenses incurred or the maximum monthly benefit stated in the policy. The premiums paid for BOE insurance are tax deductible to the business as a business expense. However, the benefits received are taxable to the business as received.

Executive Bonuses

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

Business Continuation

Business continuation plan is an arrangement between business owners that provides for shares owned by any one of them who dies or becomes disabled to be sold to, and purchased by, the other co-owners or the business.

5. Limit of Liability

The **limit of liability** is the face value/amount or death benefit of an individual life insurance policy, subject to any exclusions or riders as applicable, minus any outstanding policy loans and interest payments due to the insurer.

Face Amount - (Outstanding Policy Loan + Loan Interest) = Limit of Liability

B. Process Of Issuing A Life Insurance Policy

1. Solicitation and Sales Presentations

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

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

Educational Objective:
II.E.2. Be able to identify the life insurance disclosures (CIC 10509.950, .955, and .970-.975):

a. Requirements for using illustrations
b. Buyer's guide
c. Cost indexes
d. Surrender charges
e. Surrender period

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

Illustrations

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

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

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

An illustration used in the sale of a life insurance policy must contain the following basic information:

- Name of insurer;

- Name and business address of producer or insurer's authorized representative, if any;
- Name, age, and sex of proposed insured, except when a composite illustration is permitted under this regulation;
- Underwriting or rating classification upon which the illustration is based;
- Generic name of policy, the company product name (if different), and form number;
- Initial death benefit;
- Dividend option election or application of nonguaranteed elements, if applicable
- Illustration date; and
- A prominent label stating “Life Insurance Illustration.”

When using an illustration in the sale of a life insurance policy, an insurer or its producers **may NOT do** any of the following:

- Represent the policy as anything other than a life insurance policy;
- Describe nonguaranteed elements in a manner that could be misleading;
- Use an illustration that depicts policy's performance as being more favorable than it really is;
- Provide an incomplete illustration;
- Claim that premium payments will not be required for each year of the policy in order to maintain the illustrated death benefits, unless that is the fact;
- Use the term "vanish" or "vanishing premium," or a similar term that implies the policy becomes paid up; or
- Use an illustration that is not self-supporting.

If an interest rate used to determine the illustrated nonguaranteed elements is shown, it may not be greater than the earned interest rate underlying the disciplined current scale.

Buyer's Guide

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

Policy Summary

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

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

Cost Indexes

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

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

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

The Commissioner may, by regulation, adopt a term life insurance monetary value index (similar to the Life Insurance Surrender Cost Index) to be disclosed in all advertisements and policies of term life insurance for individuals 55 years of age or older. In developing a term life insurance monetary value index, the Commissioner must consider actual premiums and policy benefits and the manner in which they are affected with the passage of time. Any term life insurance monetary value index must assume that the insured would want to retain coverage for at least 10 years.

2. Underwriting

Educational Objectives:
II.I.1. Be able to identify the purpose of underwriting: prevention of adverse selection, properly classifying risks (be able to differentiate between *preferred, standard*, and *substandard* risk classifications), and underwriting responses to substandard risks.

II.I.2. Be able to identify the process of underwriting:

a. The responsibility of the agent as a field underwriter
b. Completing the application
c. Know that additional information may be required if an application reveals certain health conditions or other risk exposures

Educational Objective:
II.C2.2. With regard to the underwriting of applicants and/or insureds, be able to:

a. Identify a producer's responsibilities
b. Understand the insurer's requirements

Underwriting is the risk selection process. The underwriter's responsibilities include selecting only those risks that are considered insurable and meet the insurer's underwriting standards. The purpose of underwriting is to protect the insurer against **adverse selection** (risks which are more likely to suffer a loss).

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

Field Underwriting

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

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

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

Application

Educational Objective:
II.E.1. Regarding life insurance application, be able to identify:

a. The types of information required on the application
b. A nonmedical application and why a medical examination may be required
c. Required signatures
d. Changes to the application
e. Why insurers attach the application to a life policy
f. Conditional receipt vs. binding receipt
g. Temporary insurance agreement and the insurer's conditions for a temporary insurance agreement to be in effect

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

Part 1 - General Information of the application includes the general questions about the applicant, such as name, age, address, birth date, gender, income, marital status, and occupation. It will also inquire about the existing policies and if the proposed insurance will replace them. Part 1 identifies the type of policy applied for and the amount of coverage, and usually contains information concerning the beneficiary.

Part 2 - Medical Information of the application includes information on the prospective insured's medical background, present health, any medical visits in recent years, medical status of living relatives, and causes of death of deceased relatives. If the amount of insurance is relatively small, the agent and the proposed insured will complete all of the medical information. That would be considered a *nonmedical* application. For larger amounts, the insurer will usually require some sort of medical examination by a professional.

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

Attachment of Application to Policy

If an application is taken at the time of purchase and a policy is then issued, the application must be attached to the policy. The policy and the application constitute the *entire contract* between the parties, and no additional documents may be incorporated into the contract unless endorsed and attached to the policy. Any statements made by the insured in the application are considered representations and not warranties.

Agent's Report

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

Required Signatures

Both the agent and the proposed insured (usually the applicant) must sign the application. If the proposed insured and the policyowner are not the same person, such as a business purchasing insurance on an employee, then the policyowner

must also sign the application. An exception to the proposed insured signing the application would be in the case of an adult, such as a parent or guardian, applying for insurance on a minor child.

Know that the **applicant's signature attests to the accuracy of the information** in the application.

Changes on the Application

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

Consequences of Incomplete Applications

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

Premiums with the Application

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

Conditional vs. Binding Receipt

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

Example:

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

be refunded to the beneficiary, and the insurer is not required to pay the death benefit.

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

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

The **unconditional (binding) receipt** is rarely used in life insurance. Binders are more commonly found in property insurance. When the agent issues a binding receipt, coverage begins immediately for a specific length of time, even if the applicant is later found to be uninsurable. Binding receipts usually stipulate that coverage is effective from the date of the application for only a specified period of time, such as 60 days, or until the company either issues or declines coverage, whichever occurs first.

Note that written binders are deemed to be valid insurance policies for the purpose of proving that the insured has coverage. This does not apply to life insurance. Binders are prohibited in life and disability policies.

Temporary Insurance Agreement

The underwriting process may often require a considerable amount of time. To bridge the gap between the applicant's request for an immediate coverage and the insurer's need for thorough underwriting, insurance companies offer their customers a **Temporary (or Interim) Insuring Agreement**. This agreement requires payment of the first premium at the time of application, but does not guarantee that a policy will be issued.

There are three types of Temporary Insuring Agreements:

- Conditional Receipt (most commonly used);
- 30-day Interim Term Receipt; and
- Acceptance Form of Receipt.

The **temporary term** is the protection period offered by binding receipts. During this time period, an insurance company is liable for the maximum amount guaranteed under the binding receipt/temporary insurance agreement.

Nonmedical Application and Required Medical Examinations

A **nonmedical application** is the medical portion of an application which accepts a health questionnaire completed and signed by the applicant and the agent and does not require a medical examination.

If the amount of insurance is relatively nominal, the agent and insured will complete all of the medical information. For larger amounts, the insurer will usually require some sort of medical examination by a professional.

Limitations on Pre-Selection and Post-Selection Activities

Pre-selection – The agent or broker is able to accomplish good pre-selection by a complete, accurate and thorough completion of the insurance application. The application will ask for all of the legally allowed information which an insurer may gather in order to do effective **post-selection** underwriting.

During the application process, the agent is in a position to terminate at any time if he finds that the client poses an untenable risk to the insurance company, or to explain to the clients why their risk may be higher than normal. Forewarning clients of a possible premium rating can help them overcome "sticker shock" later.

For example, if an applicant is morbidly obese, the application could still be submitted to the insurer, but the producer should warn the applicant that since his height/weight ratio is out of the standard range, that he can expect to pay a significantly higher premium. The same applies to smokers, extreme sports enthusiasts, skin divers, and similar risk individuals.

The producer is not allowed to collect information which is not asked for on the application, but can seek details for those items which do appear. This can include dosages and frequency of use of medications, extent of involvement in hazardous activities, specifics regarding employment duties, etc.

It is also necessary to emphasize the responsibility of the producer to not withhold from the principal any information which may be negative in regard to the client's risk.

Post-selection – Once the producer has elected to complete and submit an application, the in-house underwriters begin the post-selection process.

Using the application as a springboard, the underwriter begins an investigation of the client's complete risk profile. Federal and state law delineates the types and extent of information which can be acquired and considered, which we will see below. After considering all of the information legally available, the underwriter will label the client as **standard**, **substandard** or **uninsurable**.

If the client is sub-standard, she will be offered the opportunity to obtain coverage under a higher than standard premium. The client can, of course, decline to be insured under the stated conditions.

After the agent receives a signed authorization for disclosure of information, the underwriter can begin an investigation using the following sources of information:

- **MIB** — The Medical Information Bureau is a centralized information database into which insurers provide information from applications and claims. Subscribing insurers are then able to search the MIB database for information regarding any applicant for insurance.
- **Department of Motor Vehicles** — Since statistically half of all accidental deaths in the United States occur as the result of traffic collisions, insurers are very interested in the driving records of their applicants. A poor driving record can result in a rating or even a declination.
- **Physician/medical facility records** — The APS (attending physician statement) enables the insurer to receive the complete medical treatment history of the client.
- **Additional medical testing /Current physical** — The insurer can request that the applicant be examined by a physician and the results submitted for consideration.

It is also common to require examination by a paramedical company and the use of blood, urine or saliva samples to check for nicotine or other drug use and the presence of HIV. An EKG (electrocardiogram) may also be required.
- **Financial reports** — Using financial inspection reports and/or information from major credit reporting agencies, the insurer can detect whether the client has a history of financial malfeasance.
- **Personal interviews** — The underwriter may contact persons with information about the applicant by telephone. These may include coworkers, neighbors, relatives or other acquaintances.
- **Hazardous activity questionnaire** — The insurer may also ask the applicant to fill out a separate hazardous activity questionnaire to determine the applicant's risk classification. The questionnaire may include questions regarding hobby aviation, skydiving, scuba diving, and auto, boat, motorcycle racing, or mountain climbing.

Company Underwriting

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

Information Sources and Regulations
Application

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

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

Agent's Report

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

Investigative Consumer Report (Inspection)

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

Fair Credit Reporting Act

The **Fair Credit Reporting Act** established procedures that consumer-reporting agencies must follow in order to ensure that records are confidential, accurate, relevant, and properly used. The law also **protects consumers** against the circulation of inaccurate or obsolete personal or financial information.

The acceptability of a risk is determined by checking the individual risk against many factors directly related to the risk's potential for loss. Besides these factors, an underwriter will sometimes request additional information about a particular

risk from an outside source. These reports generally fall into 2 categories: Consumer Reports and Investigative Consumer Reports. Both reports can only be used by someone with a legitimate business purpose, including insurance underwriting, employment screening, and credit transactions.

Consumer reports include written and/or oral information regarding a consumer's credit, character, reputation, or habits collected by a reporting agency from employment records, credit reports, and other public sources.

Investigative Consumer Reports are similar to consumer reports in that they also provide information on the consumer's character, reputation, and habits. The primary *difference* is that the information is obtained through an investigation and interviews with associates, friends and neighbors of the consumer. Unlike consumer reports, these reports cannot be made unless the consumer is advised in writing about the report within **3 days** of the date the report was requested. The consumers must be advised that they have a right to request additional information concerning the report, and the insurer or reporting agency has **5 days** to provide the consumer with the additional information.

Know This! Insurance applicants must be notified in writing whenever insurers request investigative consumer reports.

The reporting agency and users of the information are subject to civil action for failure to comply with the provisions of the Fair Credit Reporting Act. A person who knowingly and willfully obtains information on a consumer from a consumer reporting agency under false pretenses may also be fined and/or imprisoned for up to 2 years.

An individual who **unknowingly** violates the Fair Credit Reporting Act is liable in the amount equal to the loss to the consumer, as well as any reasonable attorney fees incurred in the process.

An individual who **willfully** violates this Act enough to constitute a general pattern or business practice will be subject to a penalty of up to $2,500.

Under the Fair Credit Reporting Act, if a policy of insurance is declined or modified because of information contained in either a consumer or investigative report, the consumer must be advised and provided with the name and address of the reporting agency. **The consumer has the right to know what was in the report**. The consumer also has a right to know the identity of anyone who has received a copy of the report during the past year. If the consumer challenges any of the information in the report, the reporting agency is required to reinvestigate and amend the report, if warranted. If a report is found to be inaccurate and is corrected, the agency must send the corrected information to all parties to which they had reported the inaccurate information within the last 2 years.

Consumer reports cannot contain certain types of information if the report is requested in connection with a life insurance policy or credit transaction of less than $150,000. The **prohibited information** includes bankruptcies more than 10 years old, civil suits, records of arrest or convictions of crimes, or any other negative information that is more than 7 years old. As defined by the Act, *negative*

information includes information regarding a customer's delinquencies, late payments, insolvency or any other form of default.

Medical Information and Consumer Reports

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

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

Medical Information Bureau (MIB)

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

The MIB is a membership corporation owned by member insurance companies. It is a **nonprofit trade organization** the purpose of which it is to collect, maintain, and make available to insurance companies important underwriting information on applicants for life and health insurance. It is a systematic method for companies to compare the information they have collected on a potential insured with information other insurers may have discovered. The MIB can be used only as an aid in helping insurers know what areas of impairment they might need to investigate further. An applicant cannot be refused simply because of some adverse information discovered through the MIB.

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

Medical Examinations and Lab Tests Including HIV

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

It is common among insurers to require an HIV test when an applicant is applying for a large amount of coverage, or for any increased and additional benefits. To ensure proper obtaining and handling of results, and to protect the insureds' privacy, when an insurer requires an applicant to submit to an HIV test, they must do the following:

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

Unfair Underwriting for the Risk of HIV or AIDS

The following are guidelines to help insurers avoid unfair underwriting for the risk of HIV/AIDS:

- If tests were performed correctly, insurers may decline a potential insured for coverage if his/her medical sample comes back "positive for HIV/AIDS" after 2 different tests have been performed. The applicant can also be declined if he/she has already been diagnosed with AIDS/HIV by another medical professional.
- These tests must be paid for by insurer, not insured.
- If an insurer tests for HIV, it must first obtain from the insured informed, written consent. This often entails a separate disclosure form signed by all insureds and the agent. A copy of this duplicate form should then be left with the client. The information includes written details on the tests performed, their purposes and uses, and how results will be returned to the insured. The form often asks for a physician's name and address so that the client's doctor can get involved should a positive result come back. If the client has no physician, the insurer should urge the client to consult a physician or government health agency.
- Informed consent also includes supplying the client with information concerning AIDS/HIV counseling from third-party sources.
- The information that is gathered must be handled correctly and in compliance with confidentially requirements by authorized personnel.
- If an insured correctly obtains coverage, but later dies due to AIDS or AIDS-related conditions, coverage cannot be limited or denied.

From an ethical and nondiscrimination standpoint, no insurer or its agents may consider the individual's gender, sexual orientation, marital status, living arrangements, occupation, zip code, or other such related demographic characteristic in determining whether to take an application, provide coverage, or perform any medical testing. The insurers cannot ask if the insured has been tested before, unless it was for insurance purposes. None of this information should be either on the application or implied. This is so the underwriter can make a clearly unbiased determination and avoid overt or apparent discrimination. The only allowable criterion that a company may use to determine whether to test for HIV is the amount of insurance the applicant has applied for at certain age ranges.

Negligently disclosing confidential results or underwriting information to unauthorized third parties may result in a civil fine of up to $1,000 plus court costs. The fine may go up to $5,000 plus costs for willful violations. If the violation causes economic, bodily, or psychological harm to the other party, the penalty may include a **misdemeanor** charge, one year in jail, and/or a fine of up to $10,000.

Genetic Testing

Genetic characteristics means any scientifically or medically identifiable gene or chromosome that is known to be a cause of a disease or disorder, and that is determined to be associated with a statistically increased risk of development of a disease or disorder. Examples of genetic conditions include Tay-Sachs, sickle cell, and X-linked hemophilia.

Insurers cannot require a test of the presence of a genetic characteristic for the purpose of determining insurability (except in policies that are contingent on testing for other diseases or medical conditions). Whenever a genetic characteristic test is conducted, the insurer must first obtain the applicant's

written consent. The insurer must also notify the applicant of a test result directly or through a designated physician.

HIPAA

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

Use and Disclosure of Insurance Information

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

Risk Classification

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

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

Standard

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

Preferred

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

Substandard

Substandard (High Exposure) risk applicants are not acceptable at standard rates because of physical condition, personal or family history of disease, occupation, or

dangerous habits. These policies are also referred to as "rated" because they could be issued with the **premium rated-up**, resulting in a higher premium.

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

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

3. Premium Determination

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

Factors in Premium Determination

Educational Objectives:

II.A.8. Be able to identify the term *mortality*, and the term *mortality table*, including how it is developed.
II.I.4. Be able to identify the following rate-making components: *mortality, insurer expenses,* and *investments*.
II.E.5.c. Regarding the life insurance policy, be able to identify premium payment mode (annual, semiannual, quarterly, and monthly).

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

Mortality

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

Interest

Because premiums are paid before claims are incurred, insurance companies invest a large portion of the premiums in an effort to earn interest on these

funds (invested in bonds, stocks, or mortgages). The interest earnings help insurers reduce the premium rates for policyowners.

Expense

The expense factor, also known as the *loading charge,* also affects premium rates. Insurers have various operating expenses, so each premium must carry a proportionate share of these operating costs. The insurer's largest expense is the commissions paid to its agents. Other ongoing expenses include payroll, rent, and taxes.

Premium Payment Mode

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

Higher Frequency = Higher Premium

Monthly > Quarterly > Semi-Annual > Annual

If the insured dies during a period of time for which the premium has been paid, the insurer must **refund any unearned premium** along with the policy proceeds.

Single premium — The policyowner makes one lump-sum payment to the insurance company to create a policy. A single premium whole life policy will generate immediate cash value due to the size of the lump sum payment that is made to the insurance company. Most companies require a minimum premium of $5,000 or more for a single premium policy.

Limited pay — A level annual premium. The policy is designed so premiums for the coverage will be completely paid up before age 100. Some of the more common versions of limited-pay life are 20-pay life whereby coverage is completely paid for in 20 years, and life paid-up at 65 (LP-65) whereby the coverage is completely paid for by the insured's age 65. Obviously when the premium-paying period is condensed (all other things being equal) to a shorter duration, a higher annual premium is required.

Modified pay — A lower premium is charged in the first few policy years, usually the first three to five years, and then a higher level premium is paid for the remainder of the insured’s life. These policies were developed to make the purchase of whole life insurance more attractive for individuals who, for example, are just starting out and have limited financial resources.

Level — Most life insurance policies have a level premium, which means that the premium remains the same throughout the duration of the contract.

Fixed vs. flexible — With a fixed premium, the same amount is paid periodically; with a flexible premium, the policyowner is allowed to pay more or less than the planned premium.

Guaranteed at Initial Level vs. Initial and Maximum Premiums — Depending on the type of policy, premiums can either remain the same for the entire policy period, or can increase and decrease at different times.

Term policies and most permanent policies have premiums **guaranteed at initial levels** (or level premium for the life of the policy). The insurer "overcharges" the insured in the policy's early years, and applies that excess in the later years to fund the increased mortality costs.

Insurers use **premium tables** to determine the cost of insurance based on the insured's age and other underwriting factors. These tables can also be used to compare the *initial premiums* and *maximum premiums* charged by 2 types of policies for a specific class of insured.

Below is a sample premium table that shows estimated initial and maximum premiums for 2 types of policies for the same insured:

Premium Estimates for $500,000 of Term Life Insurance Coverage

Year	Level Premium Term	Annually Renewable Terms
1	$400	$300
2	$400	$315
3	$400	$325
4	$400	$345
5	$400	$380
6	$400	$455
7	$400	$525
8	$400	$600
9	$400	$725
10	$400	$850
11	$400	$1,000
12	$400	$2,225
13	$400	$2,350
14	$400	$2,540
15	$400	$2,625
TOTAL	**$6,000**	**$15,560**

These rates are calculated for a 35-year-old male, nonsmoker.
These are sample rates only; actual rates may vary due to other underwriting factors

4. Policy Issue and Delivery

Educational Objectives:

II.E.6. Regarding policy delivery, be able to identify:

a. The acceptable methods for delivery of a life policy to the policyowner (CIC 10113.6)
b. The purpose of a delivery receipt

II.E.5.b. Regarding the life insurance policy, be able to identify that there is no "standard" life policy (unlike property and casualty insurance).

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

Methods for Policy Delivery and Delivery Receipt

Basic to all contract law, life and/or disability insurance policies must be signed and dated to remain valid and avoid conflict.

More specifically, the California Code requires that all life/disability contracts issued or delivered in this state must be signed and dated by the policyowner the day the owner/client receives the policy. Nothing added to the policy after this date will be considered as a part of the *entire contract* by any ruling judge, unless agreed upon by both parties to the contract. These additions must be signed by each party and attached to the original contract. Any statements made and incorporated into the policy are considered representations.

The following are acceptable methods of delivery:

- Personal delivery with a signed and dated written receipt of delivery;
- Registered or Certified Mail (requires a signature);
- First Class Mail with a signed and dated written receipt of delivery; or
- Any other reasonable means (as determined by the Commissioner).

Note: Without written and signed proof of delivery, the burden of proof of delivery falls on the insurer and its agent in any legal dispute. Without a signature and date, it is difficult to establish when the appropriate free-look period or right of rescission started. If a loss should occur during this time, it needs to be clear whether a claim should be paid and whether the client accepted or rejected the policy. It is also good practice to get a signed and dated receipt/note when a client rejects a policy in case he/she passes away shortly thereafter (and the family expects an incorrect death benefit).

The following are **advantages of personal delivery**:

- It is another opportunity to explain to the policyowner (insured) what he or she has purchased and why;
- It reinforces the personal relationship with the agent and the company that the agent represents. The policyholder is more likely to give referrals to those agents they trust and with whom they have a personal relationship;

- It gives the agent the opportunity to assess future needs of additional insurance or provide other needed products; and
- If the paperwork or information gathered in underwriting was incomplete or contradictory, the insurer may require the agent to revisit the client when delivering a policy to also get a signed confirmation that a condition does or does not exist in order to properly cover the client.

Explaining the Policy

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

Information on Policy Title Page

The **policy title (specification) page** is the first page of a life insurance policy. This page contains a summary of the benefits and coverages the policy will provide. In addition, the following information is provided on the title page:

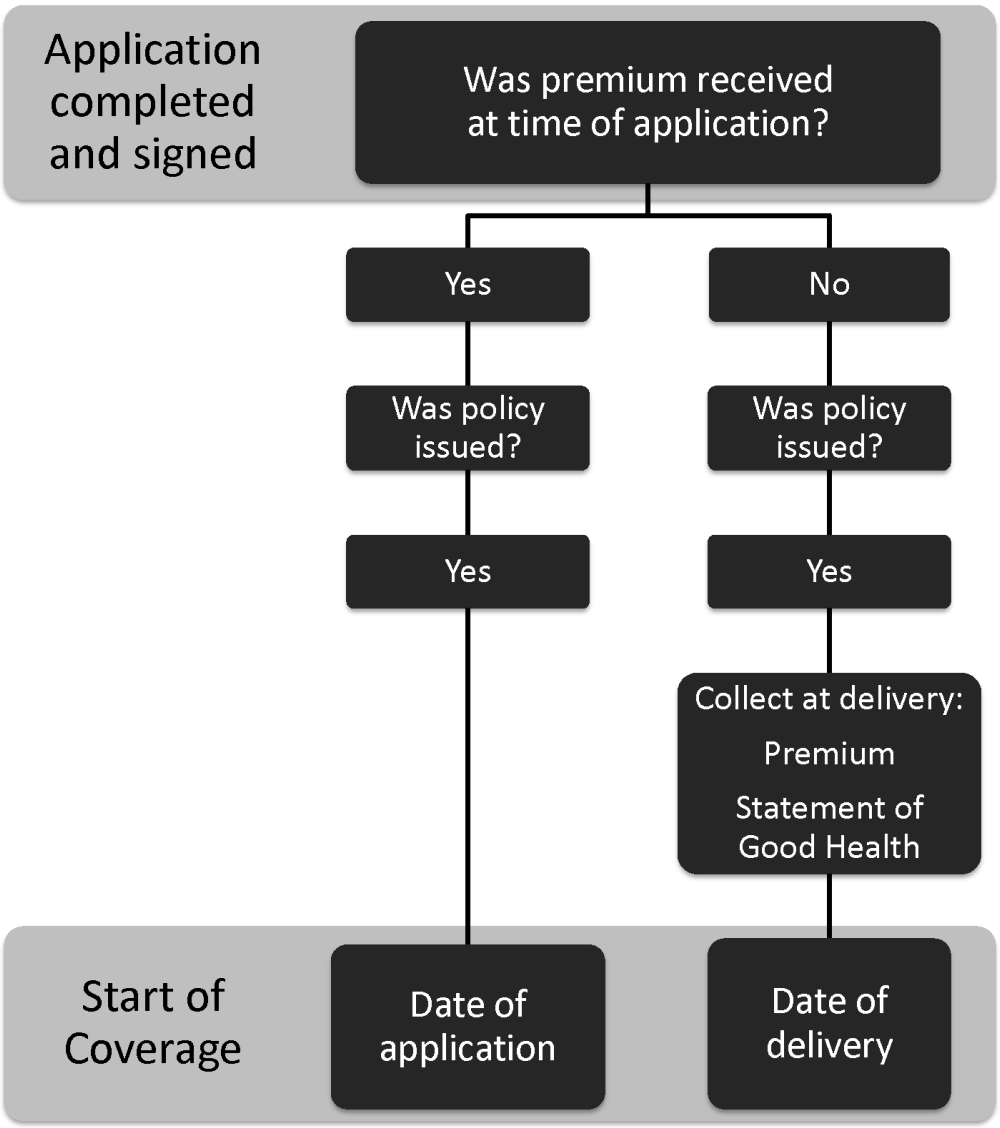
- The type of policy purchased, the amount of coverage it provides, and the premium amount and modal to be paid by the insured;
- The name of the insured, his/her age and gender, and the name of the policyowner;
- The date the policy will be effective and the date of termination;
- The premium payment period;
- If the policy is a term policy, the "renewability" of the policy; and
- Any optional provisions or riders attached to the policy and the amount of premium to be paid for each.

Effective Date of Coverage

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

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

Know This! NO premium, NO coverage.



No "Standard" Life Policy

Unlike with property and casualty policies that use standard policy forms, there are NO **"standard"** life insurance policies.

C. Life Settlements

Educational Objective:
II.E.3. Be able to define a life settlement contract and know what its purpose and suitability are. Be able to identify:

a. Possible alternatives to life settlements;
b. The owner's rescission rights;
c. Fraudulent life settlements (including Stranger-Originated Life Insurance);
d. Know that a life agent must also be licensed as a life settlement broker in order to transact life settlements on behalf of a policy owner.

The term **life settlement** refers to any financial transaction in which the owner of a life insurance policy sells a life insurance policy to a third party for some form of compensation, usually cash. A life settlement would require an absolute assignment of all rights to the policy from the original policyowner to the new policyowner.

Policyowners may choose to sell their policies because they feel they no longer need their coverage, or the premium costs have grown too high to justify continuation of the policy. In many cases, however, life settlement transactions are offered to senior citizens who may have a life-threatening illness and a short life expectancy. In these situations, the owner may elect to sell the policy to a life settlement provider for an amount greater than what they would receive if they surrendered the policy for cash value.

Example:

A person, age 70, owns a $1,000,000 life insurance policy. He recently sold his business for $5,000,000 and decided he no longer needed the insurance coverage. The cash value is $390,000, which the insurance company would give the policyowner if he cashed in the policy. A life settlement provider may offer him, after reviewing his medical records, $575,000 for the policy. Once ownership is transferred and the policyowner has received the funds, the life settlement company will assume premium payments until the insured dies, at which time the life settlement company will receive the proceeds of the policy - $1,000,000.

Know This! In a life settlement, the owner sells an existing life policy to a third party.

1. Disclosures

To help the owner understand the benefits and consequences of a life settlement transaction, at a minimum, the following information must be included in the disclosure:

- An explanation of possible alternatives, including accelerated benefits offered by the insurer;
- That some or all of the proceeds of a life settlement contract may be taxable;
- The proceeds of a life settlement contract may be subject to the claims of creditors;
- Receipt of the proceeds may adversely affect the recipient's eligibility for public assistance;
- That the proceeds will be sent to the owner within 3 business days after the life settlement provider has received acknowledgement that ownership of the policy has been transferred and the beneficiary has been designated according to the terms of the life settlement contract;
- That entering into a life settlement contract may cause other benefits under the policy, such as conversion or waiver of premium, to be forfeited by the owner;
- The total amount paid by the life settlement provider, as well as the net amount to be paid to the owner;
- The date by which the funds will be available;
- That the life settlement provider is required to furnish to the owner a consumer information booklet;
- That the insured may be contacted by either the provider or the broker to determine the insured's health status or to verify the address (the provider or broker must also disclose that the contact will be limited to once every 3 months

if the insured's life expectancy is more than 1 year, and no more than once a month if the insured is expected to live 1 year or less); and
- The life settlement provider's name, business and email address, and phone number.

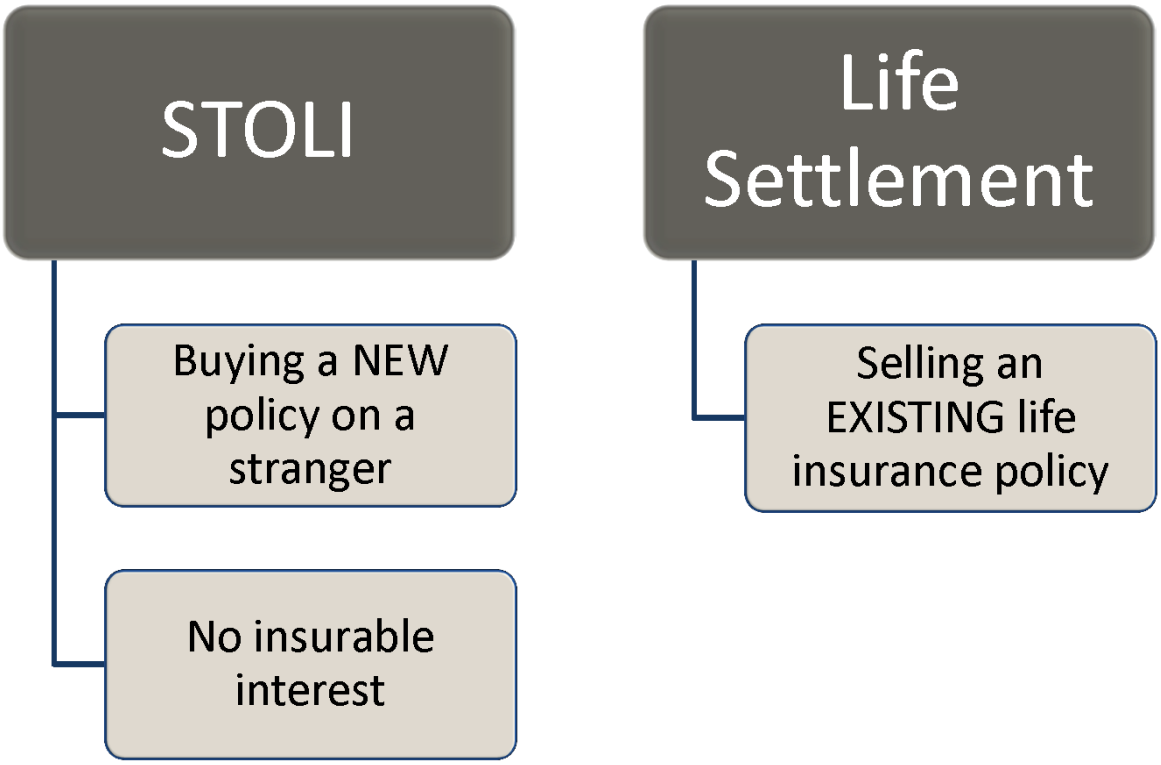
A life settlement licensee or provider is also required to disclose that the owner has the **right to rescind** a life settlement contract within **30 days** after the contract is executed by all parties and the owner has received all the disclosures, or within **15 days** of the receipt of the life settlement proceeds by the owner, whichever is sooner. Rescission by the policyowner is effective only if both notice of rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the **insured dies** during the rescission period, the contract will be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

2. Fraudulent Life Settlements

Stranger-originated life insurance (STOLI) is a life insurance arrangement in which a person with no relationship to the insured (a "stranger") purchases a life policy on the insured's life with the intent of selling the policy to an investor and profiting financially when the insured dies. In other words, STOLIs are financed and purchased solely with the intent of selling them for life settlements.

STOLIs **violate the principle of insurable interest**, which is in place to ensure that a person purchasing a life insurance policy is actually interested in the longevity rather than the death of the insured. Because of this, insurers take an aggressive legal stance against policies they suspect are involved in STOLI transactions.

Note that lawful life settlement contracts do not constitute STOLIs. Life settlement transactions result from existing life insurance policies; STOLIs are initiated for the purpose of obtaining a policy that would benefit a person who has no insurable interest in the life of the insured at the time of policy origination.



Under the California law, anybody purchasing life insurance on another individual **must have an insurance interest** in that person. If there is no insurable interest, the insurer has a basis for declaring the policy void. The state law also prohibits issuing insurance policies as wagers on people's lives. **STOLI arrangements violate these rules and are illegal in this state.**

D. Chapter Recap

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

PURCHASE OF LIFE INSURANCE	
Personal Use	• *Survivor protection* - planning for survivor needs • *Cash accumulation* - permanent policies have living benefits • *Estate creation* - life insurance creates an immediate estate • *Estate conservation* - using life insurance proceeds to cover estate taxes
Amount of Insurance	• *Human life value approach* - potential earnings of the insured (considering salary, years to retirement, inflation) • *Needs approach* - predicted needs of the surviving family (considering debt, income, Social Security blackout, expenses)
Business Uses of Life Insurance	• *Key person* - third-party ownership - business is the owner; employee is the insured • *Buy-sell funding* - not really insurance, but a business continuation agreement

- *Executive bonuses* - employer gives the employee a wage increase in the amount of insurance premium; employee is the policyowner

PROCESS OF ISSUING A LIFE INSURANCE POLICY

Solicitation and Sales Presentations

- *Advertisements* - must be truthful and not misleading
- *Illustrations* - presentation of nonguaranteed elements
- *Buyer's guide* - *g*eneric information about life policies; must be provided at the time of application
- *Policy summary* - description of features and benefits of the policy being issued; must be provided when the policy is delivered

Underwriting

Field underwriting (by agent)

- *Application* - completed and signed
- *Agent's report* - agent's observations about the applicant that can assist in underwriting
- Premiums with application and conditional receipts

Company underwriting

- Multiple sources of information (e.g. application, consumer reports, Medical Information Bureau)
- *Selection criteria* - cannot discriminate unfairly
- *Risk classification* - 3 types of risks: standard, substandard, and preferred

Premium Determination

- 3 key factors for life insurance: mortality, interest and expense
- Premium payment mode - the higher the frequency, the higher the premium

Policy Issue and Delivery

- Effective date of coverage - policy is delivered and the premium is paid
- If the premium not paid with the application, the agent must obtain the premium and a statement of continued good health at the time of policy delivery

LIFE SETTLEMENTS

Process

- Owner of a life insurance policy sells the policy that is no longer needed to a third party
- Absolute assignment of all rights to the policy to the new policyowners

Rescission Rights

- Within 30 days after the contract is executed or within 15 days of receipt of life settlement proceeds, whichever is sooner
- If the insured dies during the rescission process, the contract will be deemed to have been rescinded

Stranger-Originated Life Insurance (STOLI)

- A person with no insurable interest originates a life insurance contract on another person;
- STOLIs are prohibited because they violate the concept of insurable interest
- Life settlement contracts are not STOLIs