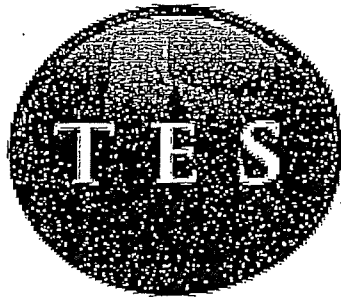


LIFE AND HEALTH INSURANCE

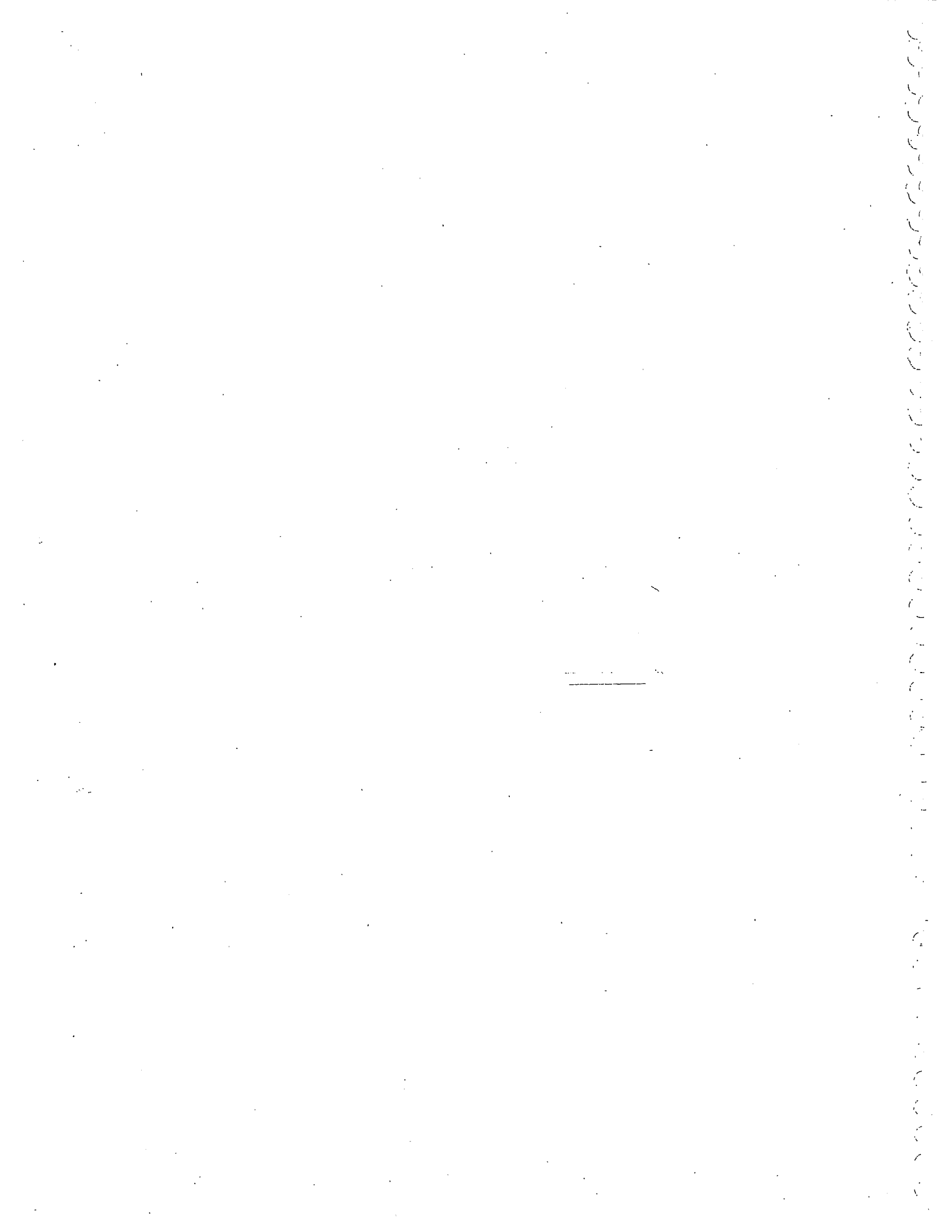
B.J. Sims, Ph.D.



T E X A S

E D U C A T I O N A L
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Introduction

The Texas Department of Insurance (TDI) has contracted with a national testing organization to give the exam for life and health agents in Texas. The test is comprehensive, thorough and difficult. Success requires a high level of preparation and an understanding of insurance. A prospective agent must learn about different types of policies, policy riders, provisions and Texas laws that apply to life and health insurance.

It is no longer possible to take a one or two day cram course and pass the test. These cram courses, successful in the past, often taught students little or nothing about insurance. They taught memory gimmicks designed to pass the test.

We at Texas Educational Services, Inc. are glad to be a partner in your success. Our materials are up-to-date and have been developed with feedback from many students.

Complete study guides are enclosed that cover every area of the test. This material is being revised and updated every six months. Following the study guide in each area are practice questions with a key. These questions are in the same format that you will find on the state exam.

An appendix includes a comprehensive glossary, a valuable reference for every student. Also enclosed is a section entitled *Numbers that Might Appear on the Exam* that allows a convenient review of the many numbers used in the exam.

In addition to the enclosed material, we have developed a complete audio CD training program that parallels this book and can add another dimension to your preparation. Thousands of students have attributed their success to the use of these materials.

I am indebted to so many who have helped make this program successful. Many students have attended our classes and generously shared their reactions to these materials and have made so many helpful, timely suggestions.

The organization of these materials and the interpretations found in them belong to me. Any mistakes that might be found here are mine.

Finally, this book is dedicated to my wife, Olivia, my partner in life as well as business. Without her unfailing optimism, gentle spirit and encouragement, this book would not have been completed.

B.J. Sims, Ph.D.
President
Texas Educational Services, Inc.

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By Marybeth Peters, Register of Copyrights, United States of America

CONTENTS

| | |
|---|------------------------------|
| Passing the Exam..... | i |
| Insurance Regulation | 1 |
| Insurance Regulation Practice Exam | 19 |
| General Insurance | 30 |
| General Insurance Practice Exam | 42 |
| Life Insurance | 52 |
| Life Insurance Federal Tax Considerations | 56, 68, 77, 79, 89, 92-94 |
| Life Insurance Practice Exam | 96 |
| Health Insurance, Including Affordable Care Act | 118 |
| Health Insurance Practice Exam | 145 |
| Health Maintenance Organization (HMO) Basics | 167 |
| Health Maintenance Organization (HMO) Practice Exam | 171 |
| Numbers that Might Appear on the Exam | 179 |
| Glossary..... | 187 |

PASSING THE EXAM

The Texas Department of Insurance has been given the statutory authority to contract with a testing agency to administer the examination. There are currently two main companies that administer the examination in the various states.

The exam for the General Lines, Life, Accident, Health and HMO license consists of questions divided into separate categories. All sections of the exam are averaged for one, overall score. Seventy (70) percent is required for a passing grade.

A student who makes less than seventy (70) percent is required to retake the entire exam. An applicant may retake the test an unlimited number of times. The exam score report given after each exam will show the areas where the student needs remedial study. All areas covered on the exam are given full and complete explanation in this text.

You can pass the exam the first time! Thousands of students have used our program and have been successful. You may visit our web site at www.texaseducatorialservices.com to read comments of some of these students who have used our materials successfully and have given us their enthusiastic endorsement. There are three steps to take in achieving success.

- STEP ONE:** Build your vocabulary. Every profession has its own specialized words and definitions and insurance is no exception. In the back of the text is a *Glossary/Index*, a vital tool to consult in your studies. *Mastering the vocabulary in the glossary will lay a strong foundation for your success! I recommend using flash cards that you make of the glossary.*
- STEP TWO:** Learn to understand all life and health policies, annuities, provisions, and riders. Learn what every policy will do and will not do. Keep asking yourself, "who would buy this specific policy and why?"
- STEP THREE:** Learn to apply what you know by solving problems. Apply information to solve hypothetical problems. Presented with a given scenario or situation, what policy would you recommend?

Follow these points in your preparation:

1. You must have up-to-date study materials that cover all areas of the test. These materials should include a glossary that gives attention to Texas laws and regulations. Practice questions should also be included that are in the multiple-choice format used on the exam.
2. Allow yourself adequate time to prepare and pretest your preparation before taking the exam. Time is required to master a large body of information for an important, professional license.

3. READ SLOWLY AND CAREFULLY THE ENTIRE QUESTION AND ALL OF THE CHOICES BEFORE YOU ANSWER! Even though all questions are multiple choice, they may be arranged in several different ways. The answer is on the screen in front of you. Don't mark the first choice that you see that is "correct." Even though the answer is "correct," it may not be the proper way to mark that question for credit. There may be other choices that are also "correct." It is extremely important that you read all of each question and the choices before you answer. Read every question at least twice before answering.

EXAMPLE: (The correct answer is in bold print)

A woman applied for a life insurance policy on her husband's life and made their son the beneficiary. Who is required to sign the application?

1. The applicant.
2. The insured.
3. The beneficiary.
4. **The applicant and the insured.**

Multiple-choice questions can be arranged in different formats. You will see three formats on the exam. **EXAMPLES:**

THE DIRECT QUESTION

When must an insurable interest be shown?

1. At the time of the insured's death.
2. **At the time the insurance is applied for.**
3. When the policy is changed in any manner.
4. Whenever the insurer makes a request.

THE INCOMPLETE SENTENCE

When a conditional receipt is given, it means:

1. The insurer will pay more than the amount of insurance applied for.
2. No premium was paid at the time of application.
3. The maximum amount the insurer will pay is a refund of premium.
4. **The insurer may pay an amount up to the limits stated in the receipt.**

ALL OF THE FOLLOWING EXCEPT

All of the following require a license EXCEPT:

1. Selling a travel policy.
2. Selling credit life in an automobile agency.
3. Selling mortgage cancellation policies.
4. Selling an accident only policy.

Many answers will be determined by a key word or phrase. Look for these key words and phrases.

EXAMPLE: Notice the keyword, "elective."

An individual A&H policy would pay for all of the following losses EXCEPT:

1. Losses following an automobile accident.
 2. Losses arising from complications of pregnancy.
 3. Losses arising from complications following an elective abortion.
 4. Losses caused by heart attack
5. Don't read information into the question. Take the question that is asked and use the information that is given. There are no perfect questions and there are no perfect answers. You should choose the BEST choice that you are given.

EXAMPLE:

L works at a manufacturing plant that has installed a contributory group medical plan. L has chosen to cover dependent daughter, O, under the plan by paying for O's premium. O goes into the hospital with an illness and has a medical bill for \$4,500. The insurance company would send a check to which of the following?

1. Hospital
2. Doctor.
3. L.
4. O.

The question gives no information about L signing an assignment authorizing the insurance company to pay directly to the hospital or doctor. You cannot add this type of information to questions. Work with what is given.

6. Be especially cautious in reading "Allness" choices. "Allness" statements refer to extreme statements such as "always," "never," "in every case," "in no case," etc. Normally, these responses are wrong choices.

EXAMPLE:

"All policies sold by stock companies are nonparticipating policies." This is a false statement because most policies sold by stock companies are nonparticipating, but not "all". When statements are absolute or extreme, they are usually false choices.

There are at least two allness statements on the exam that are correct choices.

EXAMPLE:

Under NO circumstances can an agent EVER change, alter, or modify a contract of insurance.

How many companies can an agent legally be appointed to represent when they have a permanent insurance license in Texas? ANSWER: No limit.

7. Watch out for questions on the exam that contain time-framed material. When specific dates are used or specific periods of time, the answer will be decided by these dates or times.

EXAMPLE:

A woman purchased an individual health policy and later allowed the policy to lapse. She reinstated the policy on June 1 and went into the hospital on June 8 with pneumonia. What would be the insurer's obligation to pay? ANSWER: None because there is a ten day waiting period before a reinstated individual policy would pay for sickness (illness).

8. When you read a question completely and you have considered all of the choices carefully and still don't know the answer, mark it so that you can return to it later. The computer will allow you to "Mark" a question that you wish to look at again. The "Mark" key is a time saving device. You must answer the question on the screen before you can advance. If you do not know the answer, you must guess, mark the answer and move on. The computer will store your marked questions and allow you to look at them again and reconsider your choice after you have answered all of the questions on the test. It is a simple matter to mark the questions you are unsure about so that you can return to them later. Three things can happen. First, something may jog your memory and you can remember the correct answer, return to the question and make your choice. Don't make changes in questions that you have already answered without a good reason. Your first response to a question is usually your best response. Second, some of the questions you are reading will give you the answer to other questions. All multiple choice tests do this. Take advantage of the opportunity. Third, if you finish the exam and have questions you have marked because you were not certain of the answer, go back and do some informed guessing. Eliminate the obviously wrong choices, narrowing the selection down to two, if possible, and guess. You will get half of them right and this could be helpful. Remember, you don't have to know the answer to everything. You only have to make 70%, not 100% or 90%. You may be asked a question about something that you never heard of and they may not grade several of the questions on your test.

9. Pretest yourself. At the end of each section there are practice questions. *It is crucial to your success that you use these practice questions wisely! Do not memorize the answers to these questions!* Concentrate on studying the text. Do not study the questions. **REMEMBER:**
- a. These are not actual questions you will have on the exam. These questions will allow you to practice taking a multiple choice test.
 - b. When you are taking the exam, don't write in your book. Use the score sheet provided for you at the beginning of each exam. You might wish to make extra copies of the score sheets so that you can take the practice exams several times.
 - c. Don't rely on these practice tests as your sole or major preparation.
 - d. Get your scores up to 95% and above. Then, you will know that you are ready to pass their exam.
10. Keep in mind that there are two things that you must do to be successful on the exam. First, you must **UNDERSTAND** insurance. In addition to understanding insurance, you must practice being a good test taker. For this exam, it is not good enough to simply know the subject. You must also be skilled in test taking.

All of us at Texas Educational Services wish you the best of luck!

INSURANCE REGULATION

I. INTRODUCTION

- A. Insurance is subject to public regulation because it is "affected with a public interest."
- B. Insurance is primarily regulated by the individual states.
 - 1. In 1944, the United States Supreme Court ruled in the *Southeastern Underwriters* case that insurance sales were in interstate commerce. The Court held that insurance, therefore, came under the regulatory power of the U.S. Congress.
 - 2. To establish a policy different from the *Southeastern Underwriters* case, Congress passed the *McCarran-Ferguson Act* (Public Law 15) in 1945. This gives states the right to regulate insurance. The Act provides that "States may regulate where the Congress has not acted."
 - 3. *McCarran-Ferguson* is probably the most important single piece of legislation regulating insurance in the history of the United States. The reason there are fifty separate Departments of Insurance within the fifty states and there is no United States Department of Insurance is *McCarran-Ferguson*. When an applicant is issued an insurance license in any state, it will be mailed to the applicant from the Insurance Department of that state, not from Washington, D. C. This is due to *McCarran-Ferguson* that established that the primary, day to day regulation of insurance would be left, by Congress, to the individual states. Congress does regulate insurance, but the major responsibility for regulation is left to the states by *McCarran-Ferguson*.

II. LICENSING REQUIREMENTS

A. General Provisions

The examination required for any insurance license may be given by the Texas Department of Insurance (hereinafter referred to as TDI) or by a testing service.

1. Who are agents?

Any person, who solicits insurance on behalf of any insurance company, takes or transmits any application for an insurance policy, examines any risk, receives any premium, must comply with the requirements of the State of Texas. Failure to comply makes the person acting as an agent personally liable to the holder of any policy of insurance for any loss covered by that policy.

2. Application for License.

A person who seeks to sell insurance in Texas must comply with the following application requirements:

- a. Must be at least eighteen (18) years of age.
- b. File a completed application with the Commissioner of Insurance on forms approved and furnished by the Commissioner.
- c. The form must include the applicant's full name, residence, age, occupation and place of business for five (5) years preceding the date of application.
- d. Any previous insurance experience, including licenses held and companies represented, must be stated in the application. Any indebtedness to a company or agency and any previous licenses denied, suspended or revoked must be included.
- e. The applicant must be fingerprinted in order for a criminal background to be conducted.
- f. A nonrefundable filing fee (currently \$50) must accompany the application.
- g. The applicant must state whether they intend to be a full time agent or a part time agent. A license is not to be denied because the applicant will be a part time agent.

NOTE: Letters of recommendation are not required by the State of Texas.

B. Persons Who Can Be Licensed

Any person(s) wishing to sell insurance for a Legal Reserve Life Insurance Company must hold a valid Life and Health license from the State of Texas. It is a broad license, allowing the holder to sell almost all types of life and health products. There is no Brokers license in insurance in Texas.

1. Individuals. An individual holding this Life and Health license is called a "Legal Reserve Life Insurance Agent."
2. Limited Corporations. Two or more agents may seek a Corporation Life and Health license for tax advantages or other benefits. Every officer,

director and shareholder of the corporation must be individually licensed, making the group a type of Limited Corporation.

3. Limited Partnerships. Partners may seek a Partnership Group Life and Health license but each partner must be individually licensed and named in the Partnership License.
4. Nonresident Agents. A person who is not a resident of Texas may obtain a nonresident license to sell insurance in Texas without taking an examination if
 - a. The state where the agent resides will accord the same privilege to a citizen of Texas (reciprocity).
 - b. The state where the agent has a resident license requires a written examination.
 - c. The agent can produce a recent original Letter of Clearance from their home state showing that they hold a valid resident license in good standing.

C. Types of Licenses

1. Legal Reserve Insurance Agent. This agent would hold a license to sell almost all types of life and health policies for a Legal Reserve Life Insurance Company. The TDI refers to this license as a General Lines License with a description: *Life, Accident, Health & HMO*.
2. Stipulated Premium Insurance Agent. This agent represents a company that is not organized as a Legal Reserve Company. These companies sell low face amount life insurance policies and Accident and Health policies. The TDI refers to this license as a General Lines License with one of the three following descriptions: *Stipulated Premium — Life Only; Stipulated Premium — Accident & Health Only, Stipulated Premium — Life, Accident & Health*.
3. Accident and Health Insurance Agent. An Accident and Health insurance agent holds a license that restricts sales to only accident and health policies. The TDI refers to this license as a General Lines License with a description: *Accident & Health*.
4. Life and Health Insurance Counselor. A special license issued by the state, entitled *Life and Health Insurance Counselor*, allows the agent to receive a fee for advice and counsel. It is illegal to use the term counselor or any similar word unless the agent has taken a special examination and received the license. An applicant for a Life and Health Insurance Counselor's license must have held an agent's license for at least three (3) years. A Counselor is prohibited from dual compensation. A Counselor can sell insurance and make a commission as an agent and can also charge for advice and counsel but is prohibited from doing both at the same time. A bank officer who is administering a trust is allowed to act as a Counselor without obtaining the license.

D. Maintenance and Duration (Renewing your License)

Licenses are valid for two (2) years following issue. Licenses which have not expired, been suspended or revoked, may be renewed by filing, with the TDI, a

completed renewal application and paying a nonrefundable fee not later than the expiration date of the license. The TDI is required to send a renewal application form not less than thirty (30) days before the expiration date. The TDI now allows agents to renew on-line. Agents can renew on-line if they have received their renewal notices and are within 90 days of their renewal dates. To renew on-line an agent must access the state website by typing in their search engine, "Texas Department of Insurance" and clicking on "Insurance License Search and Renewal Application."

1. Ninety (90) days to renew. If a license has gone past the expiration date for not more than ninety (90) days, it can be renewed, but a penalty of 50% of the original license fee is charged. (The penalty would be \$25).
2. After ninety (90) days - no renewal. If a license is beyond the expiration date more than ninety (90) days, it cannot be renewed. A new license may be obtained without examination within one year after expiration by completing a new application and paying the required license fee.

E. Temporary License

Texas allows agents to apply, with company sponsorship (appointment), for a temporary license. The license allows agents to sell without an examination for ninety (90) days with the one company sponsoring them. There are several requirements and restrictions.

1. Pre-license training.
Forty (40) hours of pre-license training must be completed within fourteen (14) days of application. Ten (10) of these hours must be in a classroom setting. The training should provide an agent with the basic knowledge of insurance principles and the duties of agents. A certificate attesting to the completion of the forty (40) hours must accompany the application.
2. Limited number of temporary licenses. A company is limited to the issuance of 250 temporary licenses during a calendar year.
3. Fee charged.
A nonrefundable fee of \$100 must accompany the application.
4. When license is valid
A temporary license is considered valid within seven (7) days of the mailing of the application to the TDI, unless notified otherwise.
5. Nonrenewable.
No temporary license can be renewed. At the end of the ninety days and the temporary has expired, another one can be applied for, after waiting three months. Only one can be held in any one six months.
6. Must sell to the public.
An agent selling on a temporary license must not sell to themselves, any relative by blood or marriage, persons in family employment or those in a

business relationship presently or for six (6) months prior to the date of the application for the temporary license.

7. Replacement rules.

No existing life insurance policy or annuity contract can be replaced by a temporary licensee. This restriction does not apply to the replacement of accident and health policies.

F. Continuing Education Requirements

State approved continuing education must be completed for license renewal

1. Thirty hours are required in each two year renewal period; at least fifteen (15) of these hours must be in a classroom setting. Agents must have two (2) hours of ethics in each two year renewal period.
2. The Department of Insurance has authority to grant an extension of time for agents to comply but the request must be in writing and must be for illness, medical disability or circumstances beyond an agent's control.
3. Failure to complete continuing education requirements will result in refusal of license renewal. Another license cannot be applied for within one year.
4. Courses for continuing education credit must be approved by the state and must increase the licensee's knowledge of insurance principals, processes of insurance, etc. Courses that are not acceptable include: pre-licensing courses, general accounting, speed reading, computer skills, sales meeting, communications, motivational skills, etc.
5. Agents must keep their own continuing education records for four (4) years. The records and their accuracy are subject to an audit at any time.
6. There are two possible exemptions from the continuing education requirement. If an agent has held a resident Texas license for twenty (20) consecutive years or if an agent is not selling insurance but wishes to keep a license in order to receive renewal commissions, an exemption may be requested from the Department of Insurance.

G. Disciplinary Actions

The TDI may impose disciplinary actions against agents in a variety of ways. These include:

1. Denial of license. A license may be denied, suspended or revoked if an agent or applicant for a license has:
 - a. Willfully violated any provision of the insurance laws.

- b. Intentionally made a material misstatement in the application for a license.
- c. Obtained, or attempted to obtain, a license by fraud or misrepresentation.
- d. Misappropriated or converted money to their own use (commingling) or illegally withheld money belonging to an insurer, insured or beneficiary. Agents must act as responsible *fiduciaries*.
- e. Been guilty of fraudulent or dishonest practices.
- f. Materially misrepresented the terms and conditions of policies.
- g. Misrepresented or made incomplete comparisons of policies for the purpose of replacing insurance (twisting) when it is not in the client's best interest.
- h. Obtained a license, not for the purpose of holding themselves out to the general public as an agent, but primarily for the purpose of selling insurance on themselves, family or business associates (controlled business).
- i. Been convicted of a felony.
- j. Failed to have the qualifications required for a license.

NOTE: If the Commissioner intends to deny a license, he or she must notify the person by registered mail and set a date for a hearing not less than twenty (20) days from the date of the mailing.

2. Cease and Desist Orders.

The Commissioner may issue emergency cease and desist orders to any authorized person engaging in the insurance business that is believed to be in violation of insurance laws. The order may also be issued to unauthorized persons engaging in insurance business in Texas. Cease and desist orders may be appealed to a hearing before the Commissioner.

3. Surrender of license.

The surrender of an agent's license will not negate any offense that might have been committed while the license was in effect. The surrender of a license will not affect any pending disciplinary proceedings against the agent.

4. Suspension.

An agent's license may be suspended by the TDI during the time the agent fails to hold a valid appointment with an insurance company. The suspension would end when a new appointment is sent to the TDI.

5. Revocation.

An agent may have his or her license revoked if they violate an insurance law such as knowingly deceiving or defrauding any insured or failing to promptly turn over premiums collected on any policy of insurance. An

agent whose license is revoked cannot receive another certificate of authority (license) for one year following the revocation. Any new application for a license after one year following revocation may be refused by the Commissioner.

6. Penalties.

The following penalties may be applied to any officer of a corporation who violates an insurance law:

- a. \$500 fine per violation and/or six months in jail.
- b. Any insurance license held by the person being penalized would be revoked.

7. It is an offense that could land anyone in prison if they wrote a threatening letter to the Commissioner of Insurance.

III. STATE REGULATION

- A. Under the authority of *McCarran-Ferguson*, the Texas legislature has passed laws creating the Texas Department of Insurance (TDI). The Chief Executive Officer over the TDI is the Commissioner of Insurance (hereinafter referred to as Commissioner). The Commissioner has complete regulatory power of the TDI.

- B. Commissioner's General Duties and Powers
 - 1. The Commissioner is the Chief Executive Officer over the TDI and has the responsibility of administering, enforcing and carrying out the provisions of the Texas Insurance Code.
 - 2. The Commissioner is appointed by the Governor, with the "advice and consent" of the State Senate. He or she has a two (2) year term of office that expires on February one of odd-numbered years. The Commissioner must have at least ten years experience as an executive in the administration of business or government, or as a practicing attorney or certified public accountant, with at least five years experience in the field of insurance or insurance regulation. The Commissioner is not required to be a resident of the state of Texas at the time of appointment.

- C. Company Regulation
 - 1. Certificate of authority: No individual, group or corporation can sell insurance in Texas (unless exempted by law) without holding a Certificate of Authority from the TDI. Regulations of these companies include:
 - a. They must file an annual statement according to law.
 - b. All fees collected from the companies by the state are deposited in the State Treasury to the credit of the TDI's operating fund.
 - c. The TDI may inquire into the competency, fitness and reputation of the officers and directors of each insurance carrier.
 - d. If the TDI refuses to issue a Certificate of Authority or revokes an existing one, they must provide a hearing not sooner than ten (10) days or more than twenty (20) days after the notice is given.

 - 2. Financial requirements.
 - a. An annual examination by an independent certified public accountant is required of all companies, unless exempted by law. This examination includes checking company *reserves*.
 - b. An exemption may not be granted if a company has been placed under supervision, conservatorship or receivership during the five years preceding the application for an exemption.
 - c. A foreign or alien insurer may use the same audited financial report required by their own state if the requirements are substantially the same.

3. Examination of Records

- a. Newly organized or incorporated companies will have their financial condition examined once a year for the first three (3) years. After that, once every three (3) years or more often if the Commissioner deems it necessary.
- b. In making examinations, the TDI may use its own examiner or may employ any independent public accountant. Exams shall cover the period of time requested by the Department and the companies being examined will pay for the examination. The companies will receive credit for such payment on their premium taxes or other taxes paid to the state.

4. Unfair Claims Settlement Practices.

- a. Insurers are prohibited from engaging in the following practices:
 - 1) Misrepresenting policy coverage.
 - 2) Failing to be reasonably prompt in replying to claims inquiries. A response within fifteen (15) days is presumed to be reasonably prompt.
 - 3) Failure to have reasonable standards for the prompt investigation of claims.
 - 4) Not attempting to settle claims equitably and in good faith when their liability is clear. Death claims should be settled not later than two (2) months following proof of death.
 - 5) Forcing a claimant to file a lawsuit to recover losses when a legitimate, properly supported claim has not been paid by the insurer.
 - 6) Forcing a claimant to pay for an investigative (inspection) report.
 - 7) Failing to maintain records of all complaints received during the past three (3) years or since the date of their last state examination.
 - 8) Failing to provide promptly claim forms that are required for settlement.
 - 9) Failing to provide to the policyholder a reasonable explanation for the denial of a claim.
 - 10) Attempting to settle a claim for less than the amount required in the policy.
 - 11) Seeking a release from the obligation to pay when, in fact, only a partial payment has been made.

NOTE: If an insurer offers to go to a *conciliation meeting, or a settlement conference, or to arbitration*, these are not considered to be Unfair Practices.

b. Insurers must be prepared to file periodic reports that provide the following information accumulated during the past twelve (12) month period or since the last state report.

- 1) The number of written claims that have been filed.
- 2) The total number of written claims denied.
- 3) The total number of written claims settled and the settlement amounts.
- 4) The total number of claims for which lawsuits have been filed.
- 5) The total number of complaints and their disposition.

D. Agent Regulation

1. One agent, one license.

- a. A person can hold only one license of the same type. The license must be issued in the agent's true name.
- b. Any licensed agent may have additional offices or conduct business under assumed names provided that all such names are furnished to the TDI.
- c. An agent is not allowed to use any name that implies a capability beyond the license held. No name may imply that the agent is an insurer or guarantor. No name can imply a sponsorship by federal, state or local governments.
- d. The name an agent uses must make clear that he or she is in the insurance business.

2. Acting without a license.

Any person who acts as a life or accident and health agent without holding a valid license and a valid appointment with an authorized company will be guilty of a misdemeanor and, upon conviction:

- a. Shall be fined any sum not to exceed \$500, and
- b. Shall be barred from receiving an insurance license for at least two (2) years.

3. Unfair trade practices.

a. Rebates.

- 1) Offering "anything of any value whatsoever" that is not in the contract of insurance as an inducement to purchase or continue an insurance contract. Both parties to rebating are violating the laws and are subject to punishment.
- 2) Examples of rebating would include an offer of the agent to return a part of the premium, offer or an implication of an offer to make a donation from the proceeds of a sale,

give a television set to a client, give a membership in a health club, etc.

- 3) Actions not considered rebating would include anything that is stated in the contract of insurance, giving a policy wallet when delivering a policy, sending a calendar costing five dollars to all clients, etc.

b. Unlawful inducement.

- 1) No advertisement can state or imply a pecuniary offer outside of the express terms of the contract.
- 2) No guarantee of premium refund can be made unless required by law or stated in the policy.
- 3) No offer can state or imply a preference that would violate public policy.
- 4) No deviation in normal or usual cost may be stated or implied that is not legally allowable.
- 5) An advertisement may not state or imply an advantage by purchase of insurance to be gained by an organization because of past or prospective donations to be made by an insurer or agent out of proceeds of purchase.

c. Disparagements.

- 1) An advertisement may not directly or indirectly unfairly disparage competitors, their policies, services or business methods.
- 2) An advertisement may not contain statements that are untrue in fact or that are misleading by implication about another insurer's assets, financial standing, age, etc.

d. Misrepresentations and false advertising.

Misrepresentations and false advertising of policy contracts are illegal. These would include:

- 1) Making any statement of a material fact that is untrue or misleading about policy benefits.
- 2) Any omission of a material fact or a failure to disclose that is required to be disclosed.
- 3) Any statement or implication that future dividends are guaranteed.

e. Defamation of insurer.

An advertisement may not directly or indirectly unfairly disparage competitors, their policies, services or business methods.

f. Unfair discrimination.

- 1) Sexual orientation.
No inquiries may be made concerning an applicant's sexual orientation. Sexual orientation is not to be used in the underwriting process. No investigation is to inquire into sexual orientation either directly or indirectly.
- 2) Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) questions and tests.
Questions are permissible concerning HIV and AIDS as long as they deal with factual medical history and not with sexual orientation. Any proposed HIV test must be made known to the proposed insured as to its purpose and use. All results should be regarded as confidential. The results can only be released to the proposed insured, a physician designated by the proposed insured, a re-insurer if they are involved in the underwriting process and outside legal counsel representing the insurer.
- 3) Rate discrimination.
It is unfair discrimination for an insurer to charge different rates for individuals of the same class and equal life expectancy.

g. False use of statistics.

All advertisement that uses statistics must identify the source of the statistics and must contain factual, accurate information relevant to the policies advertised.

h. Testimonials.

All of the following guidelines must be followed in the use of testimonials.

- 1) They must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced.
- 2) No advertisement may state or imply an endorsement by any government agency, including the TDI.
- 3) If an endorser is owned or controlled by an agent or insurer, this must be stated.
- 4) If an endorser has any financial interest in the insurer or agent, this must be stated.
- 5) If a person is being compensated for a testimonial or endorsement, this fact must be disclosed by the words, "Paid Endorsement" or "Controlled by Insurer."

i. Unfair competition.

Any advertisement that compares policies with another company must make fair and complete comparisons and must state that the information was not furnished by the competing company.

j. False financial statements.

Unfair and deceptive acts include filing any false financial report with a state official, making a false entry in a record book or report or willfully omitting to make a true entry into a financial record.

4. Sharing Commissions

An agent can share commissions with another person only if that person holds a valid license. Nothing of any value can be paid directly or indirectly to any individual or corporation unless such person or corporation holds a currently valid license. The requirement for holding a valid license also applies to anyone receiving override commissions on someone else's sales.

5. Controlled Business

Every person who seeks or receives an insurance license must hold themselves out in good faith to the general public as an insurance agent. A person cannot seek or hold a license to limit sales exclusively to controlled business such as family or a family controlled company.

6. Concurrent Managing General Agent's (MGA) License and Other Licenses

A person who holds an agent's license may also hold an MGA license as long as the qualifications are met for both licenses.

7. Joint Advertising by Similarly Licensed Agents

Two or more agents holding active licenses may jointly advertise as long as they clearly identify the specific agency making the offer to the public. No agent can offer to represent a company unless the agent is properly appointed to represent that company.

8. Reporting Change of Address

An agent is required to keep the TDI informed of his or her current address at all times. If the agent moves to a new address he or she should notify the TDI immediately.

9. Illegal Conversion of Funds

Any agent who receives funds on behalf of an insurance company and embezzles or fraudulently converts (commingles) such funds will be punished as if he or she had stolen the funds.

10. Probation Due to Disability

- a. The TDI, after a notice and hearing, may place an agent on disability probation if the TDI feels that the agent is suffering from a disability.
- b. The agent would not be placed on disability probation unless the disability can be successfully arrested and no harm could come to the public.
- c. The TDI can order regular reports to be made and may order specific tests and a course of treatment.

B. Company and Agent Regulation

Companies and agents must observe the following in licensing and appointments:

1. Agents may represent more than one insurer if they so desire. The agent and the company must give notice to the Commissioner of the appointment.
2. An agent must hold a valid appointment with every company he or she represents.
3. An insurance company shall not furnish applications and other supplies to an agent unless the agent is duly licensed and appointed for the sale of that type of insurance.
4. Appointments are not required to be renewed but may be terminated by the company. The company is required to explain to the TDI why they are terminating an agent's appointment and the agent must be sent a copy of the explanation given to the TDI.
5. When an agent's license is renewed the agent is authorized to represent all companies where the agent holds a valid appointment.

F. Life, Accident, Health and Hospital Service Insurance Guaranty Association

1. The legislature created the Guaranty Association in order to give limited protection to policy-owners in the event an insurance company fails financially.
2. All companies that are admitted to do business in Texas are required to be members and must contribute to the fund, based upon premiums collected. The maximum contribution per year is \$100,000.
3. If a resident of Texas purchases a policy from a company that is incorporated in another state and the company fails financially, the Guaranty Fund in Texas would not be responsible. The Guaranty Fund in the state where the company is incorporated would be responsible.

4. An agent cannot use the Guaranty Fund in any manner in the sale of insurance. Such use would constitute unfair competition and unfair practices.
5. If an agent is asked for any information about the Guaranty Fund in a sales situation, it would be advisable to inform their prospect that they can call the TDI at 1-800-599-7467 and request a free brochure entitled, "*If My Insurance Company Fails ...*"

NOTE: Do not confuse the Guaranty Fund with the reserves an insurance company is required to have in order to meet their financial obligations. The Guaranty Fund is controlled by the State. The reserves are owned and controlled by the insurance company. These reserves are evaluated by the Texas Department of Insurance annually.

EXAMINATION

SCORE _____

SCORE SHEET: Circle the correct answer

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

PRACTICE EXAMINATION

Insurance Regulation

1. The reason insurance is primarily regulated by the individual states is because of
 1. *Southeastern Underwriter* case.
 2. *Nebbia v. New York* case.
 3. *McCarran-Ferguson Act* (Public Law 15).
 4. *Paul v. Virginia* case.

2. The Commissioner of Insurance is chosen by
 1. The National Association of Insurance Commissioners (NAIC).
 2. The State Senate.
 3. The Governor with the "advice and consent" of the State Senate.
 4. The Association of Life Underwriters.

3. The term of office for the Commissioner is
 1. Six (6) years.
 2. Four (4) years.
 3. Two (2) years.
 4. Serves at the pleasure of the Governor.

4. The Commissioner is required to have all of the following qualifications EXCEPT:
 1. Be a competent, experienced administrator.
 2. Be well informed about insurance.
 3. Have ten (10) years of business, administrative, governmental experience or as a practicing attorney, or CPA, and have five (5) years experience in insurance.
 4. A resident of Texas for at least one year.

5. The term of office for the Commissioner will expire
 1. January 1 s' of even-numbered years.
 2. When they lose the Governor's confidence.
 3. When the State Senate disapproves of them by a two-thirds vote.
 4. February 1 of odd-numbered years.

6. Which of the following is considered an unfair claims settlement practice?
 1. The insurer requires the insured to pay the cost to document a loss.
 2. The claimant and the insurer go to mediation.
 3. The insurer requires the insured to pay the cost of an investigative (inspection) report.
 4. The claimant and the insurer go to arbitration.

7. New companies admitted to do business in Texas will have their records examined
 1. Once every three years.
 2. Every other year.
 3. Once a year for the first three years.
 4. Once every two years.

8. After a company has been in business for three years, their records will be examined
 1. Only as needed.
 2. Once every year.
 3. Once every three years.
 4. Once every two years.

9. All of the following are required in the application for an insurance license EXCEPT:
 1. An application form approved by the state.
 2. A nonrefundable deposit.
 3. Employment history for the previous five years.
 4. A letter of recommendation from an insurance agent.

10. If an agent's license is revoked, the agent may not apply for another license for
 1. Six months.
 2. One year.
 3. Two years.
 4. Five years.

11. Which one of the following is the best definition of an agent?
1. An advocate for the insured to negotiate a policy.
 2. A person under contract with an insurer to solicit and sell insurance.
 3. A person who searches for the lowest premium available.
 4. A representative of the insurance industry.
12. How many times will an applicant for an insurance license be allowed to take the examination?
1. An unlimited number of times during a twelve month period.
 2. Three times.
 3. Only one repeat exam is allowed.
 4. Six times.
13. When an agent is taking an application for life insurance, the agent must go over all of the following with the applicant EXCEPT:
1. The protections in the Guaranty Fund.
 2. Fair Credit Reporting Act.
 3. Benefits of the policy.
 4. Surrender Value Comparison Index.
14. An agent selling insurance while holding a temporary license is prohibited from selling to all of the following EXCEPT:
1. Themselves.
 2. Their brother.
 3. Their business partner.
 4. Their neighbor.
15. Which one of the following statements best describes the Continuing Education requirement?
1. The hours are optional.
 2. Courses that enhance sales techniques are preferred.
 3. Thirty hours are required every two years and they must increase an agent's knowledge of insurance.
 4. Failure to complete the required hours will not affect an agent's license.

16. Which one of the following statements is the best definition of controlled business?
1. Any business the agent can be confident of receiving, as family members or a family owned business.
 2. Renewal business.
 3. Business that will come to an agent because the products sold by the agent are very competitive.
 4. Referral business.
17. Which one of the following statements best states the responsibilities of the Commissioner of Insurance?
1. To promote insurance sales.
 2. To see that all insurance laws are faithfully executed.
 3. To serve as a clearinghouse for consumer information.
 4. To work with the legislature to improve insurance laws.
18. All of the following would be regarded as Unfair Claim Settlement Practices EXCEPT:
1. Misrepresenting policy coverage's to avoid paying a claim.
 2. Failing to be reasonably prompt in settling a claim.
 3. A company seeking to settle a disputed claim by agreeing to arbitration.
 4. Failing to provide claim forms on a timely basis.
19. All of the following would be regarded as Unfair Claim Settlement Practices EXCEPT:
1. The insurer requests that the two parties agree to a settlement conference.
 2. Failing to provide to a policyholder an explanation for the denial of a claim.
 3. Seeking a release from paying a claim when, in fact, only a portion of the claim had been paid.
 4. Seeking to settle a claim for less than the policy provides.
20. How often must the TDI value the reserve liabilities of a company?
1. Every 4 years.
 2. Every 3 years.
 3. Every year.
 4. When a complaint arises.

21. How many hours of pre-license training is required for a temporary license?
1. 10 hours.
 2. 20 hours.
 3. 30 hours.
 4. 40 hours.
22. How long will a temporary license be considered valid?
1. 31 days.
 2. 45 days.
 3. 60 days.
 4. 90 days.
23. If an agent receives a permanent license, how many insurance companies would they be allowed to represent?
1. Only the one company that originally appointed them.
 2. Five (5) companies.
 3. Ten (10) companies.
 4. An unlimited number.
24. All of the following statements are accurate concerning continuing education requirements EXCEPT:
1. Four hours of ethics must be taken as a one-time classroom requirement.
 2. Thirty (30) hours are required during the two year renewal cycle.
 3. No more than fifteen (15) hours can be required in any one year.
 4. Continuing education credits must be kept on file for four (4) years.
25. A permanent insurance license is renewed every
1. 2 years.
 2. 4 years.
 3. 3 years.
 4. 5 years.

26. Records of Continuing Education credits must be kept for how many years?
1. 1 year.
 2. 2 years.
 3. 3 years.
 4. 4 years.
27. If an agent told a prospect if they purchased a policy, the agent would make up the difference between any projected dividends and actual dividends, the agent is guilty of which of the following?
1. Conversion.
 2. Defamation.
 3. Intimidation.
 4. Rebating.
28. All of the following, as an offering to a prospect to buy, is an example of rebating EXCEPT:
1. A return of unearned premium.
 2. Free membership in a Country Club.
 3. Agent to pay part of premium.
 4. Agent to buy a car from prospect.
29. What is an agent guilty of if he or she makes false statements about a competing agent or company?
1. Rebating.
 2. Coercion.
 3. Intimidation.
 4. Defamation.
30. When a company fails to respond to claim inquiries within 15 days, they have committed a violation described as a(n)
1. Misrepresentation.
 2. Boycott.
 3. Discrimination.
 4. Unfair Claim Settlement Practice.

31. A proper example of advertising under the Texas Insurance Code is
1. "In house" communications.
 2. Codes known only to underwriters.
 3. Agent training manuals.
 4. Information in a policy outline of coverage.
32. If an agent has his or her license revoked, all of the following would be applicable to the situation EXCEPT:
1. The agent has the right to an administrative hearing.
 2. The license will be reissued upon application.
 3. Application for a new license can be made after one year.
 4. The license may not be reissued.
33. All of the following statements are true concerning an agent license EXCEPT:
1. A person can hold only one license of the same type.
 2. An agent can operate a business under an assumed name as long as the name has been approved by the TDI in advance of its use.
 3. If an agent operates a business under an assumed name, the name does not have to indicate it is insurance business.
 4. An agent cannot choose a name that implies an endorsement by state or federal governments.
34. Before being eligible to apply for a Counselor's license, an applicant must have practiced selling insurance for how many years?
1. 1 year.
 2. 2 years.
 3. 3 years.
 4. 5 years.
35. With which of the following circumstances can an agent split a commission with another person?
1. If the other person gave the agent some leads.
 2. If the other person purchased more than one policy.
 3. If both the agent and the other person are licensed with the state.
 4. If the other person has been a client for more than three years.

36. All of the following statements are true concerning a Cease and Desist Order EXCEPT:
1. Emergency Cease and Desist Orders carry no right of appeal.
 2. May be issued to prevent Unfair and Deceptive acts.
 3. May be issued because of a hazardous financial condition.
 4. May be issued if the safety of the public is at risk.
37. If an agent renews a license within 90 days following the renewal date a penalty of what percent is assessed?
1. 10% of the original license fee.
 2. 25% of the original license fee.
 3. 50% of the original license fee.
 4. 100% of the original license fee.
38. Which of the following is the main consideration under which the Texas Department of Insurance approves Continuing Education courses?
1. Study courses that prepare students for the state licensing exam.
 2. Courses on general business and office practices.
 3. Courses that specialize in insurance practices.
 4. Courses that teach sales techniques.
39. What is required for a resident agent in a state other than Texas to receive a nonresident license in Texas?
1. The only requirement is that the agent must be in good standing in the resident state.
 2. All that is required is a non-resident license fee.
 3. The agent must prove to be in good standing in the resident state and the resident state must extend to Texas agents the same privileges that they are requesting (reciprocity) in Texas.
 4. Any valid insurance license issued by a state is automatically recognized by other states.
40. Which of the following actions would be regarded as an unlawful inducement?
1. The agent promises that if the mutual company makes a profit, there may be a dividend paid.
 2. An agent advertises in the home town newspaper.
 3. The agent is a member of a prominent civic club.
 4. An advantage will be given to an organization in the purchase of insurance because the agent had made a contribution to the organization.

INSURANCE REGULATION

Key

| | | | |
|-----|---|-----|---|
| 1. | 3 | 21. | 4 |
| 2. | 3 | 22. | 4 |
| 3. | 3 | 23. | 4 |
| 4. | 4 | 24. | 1 |
| 5. | 4 | 25. | 1 |
| 6. | 3 | 26. | 4 |
| 7. | 3 | 27. | 4 |
| 8. | 3 | 28. | 1 |
| 9. | 4 | 29. | 4 |
| 10. | 2 | 30. | 4 |
| 11. | 2 | 31. | 4 |
| 12. | 1 | 32. | 2 |
| 13. | 1 | 33. | 3 |
| 14. | 4 | 34. | 3 |
| 15. | 3 | 35. | 3 |
| 16. | 1 | 36. | 1 |
| 17. | 2 | 37. | 3 |
| 18. | 3 | 38. | 3 |
| 19. | 1 | 39. | 3 |
| 20. | 3 | 40. | 4 |

GENERAL INSURANCE

I. CONCEPTS

A. Risk Management

Risk Management is the process of identifying, measuring, and treating exposures to potential loss.

1. Key terms.

Understanding the key terms is vital to the understanding of risk management.

- a. Risk - The uncertainty of financial loss. The term is used to designate the insured or a peril insured against. Example: Because we live we are at risk of dying. A *pure risk* is where there is no possibility of gain; only a loss or no loss. Insurance is considered a *pure risk* purchase. A *speculative risk* allows possible gains or possible losses.
- b. Exposure - The possibility of loss. There are three types of exposures: property, liability and personal. This book deals only with personal exposures.
- c. Peril - A cause of loss, such as an accident or an illness that causes death or disability. (Sometimes called a *hazard*)
- d. Loss - A risk manager involved in planning the proper type and amount of insurance must consider the probabilities of loss in health, life and employment.

2. Methods of handling risk.

- a. Avoidance - Avoiding a risk altogether as when parents decide not to purchase an automobile for a college student. A party could also avoid a risk by signing a *hold harmless agreement*
- b. Retention - Retaining some of the risk as in having a deductible and/or coinsurance.
- c. Sharing - Sharing the risk. Example: A sole owner of a company takes on an equal partner.
- d. Reduction - Reducing risk. Example: A company might have an exercise program for workers and reduce the risk of heart attacks.
- e. Transfer - Transferring the risk to another party as in the purchase of insurance. In purchasing life insurance the risk of economic loss by premature death is transferred to the insurance company.

B. Elements of Insurable Risks

Risk selection involves the elements that help an insurer to determine whether or not to accept a risk.

Risk classification involves the considerations determining premium rates.

1. Age - Usually important only at the very young ages and the advanced ages.
2. Health - Crucial to both risk selection and premium classification.
3. Occupation - Important in risk selection and premium classification.
4. Sex - Not used in risk selection; used in premium classification.
5. Residence - A factor in risk selection and premium classification.

C. Law of Large Numbers

Life insurance companies must have accurate data from which to draw conclusions about mortality risks. If the data is accurate, the larger the sample used, the more accurate the conclusions will be. The principle is used to predict losses; it has nothing to do with causing losses. Mathematicians called *actuaries* work with this data.

D. Reinsurance

Reinsurance is a process of one life insurance company choosing to transfer all or a portion of a risk to another company. A company may wish to keep their exposure to loss at a lower level or they may desire to reduce the amount of reserves they are required to hold. The original company that first accepted the risk is called the direct-writing or ceding company. The company that assumes the risk is called the re-insurer or the assuming company. In Texas an insurance company is allowed to reinsure 100% of their business.

II. INSURERS

A. Types of Insurers

1. Stock Companies.

Stock companies are owned by the stockholders. The profits of the company belong to the stockholders. Most of their policies do not pay dividends to the policy-owners and are called nonparticipating ("nonpar") policies. Stock companies write some participating policies but most of their sales are in nonpar policies.

2. Mutual Companies.

Mutual companies have no stockholders. They are owned by the policy-owners. When they make profits, the profits are distributed to the policy-owners in the form of dividends. Since the insurance policy allows the policy-owner to participate in the profits of the company, the policy is called a participating or "par" policy. All mutual company products are participating products. These dividends are regarded by the IRS as a return of unearned (surplus) or unused premium; essentially an overcharge of premium. Because of this definition, there is no tax liability on dividends.

Dividends are based on the profits of a company. Since these profits cannot be foretold with accuracy, the agent is strictly prohibited from guaranteeing a dividend or implying a guarantee. If dividends are illustrated, the current dividend must be used.

A special type of mutual company is called an Assessment Mutual Company. These companies are allowed to charge a proportional share of any losses back to the policy-owners. Examples: *Germania* and *Hoheim*.

3. Fraternal Associations

Fraternal Associations, sometimes called Fraternal Benefit Societies or Fraternal, started originally as ethnic and religious societies. Early in their development, they began selling burial insurance to their members. Presently, Fraternal are allowed to sell all types of insurance to their members. Their agents are required to be licensed by the state to sell insurance. In order to buy insurance from a Fraternal Association the buyer must be a member of the organization. They have the following characteristics:

- a. They are nonprofit societies, organized on the mutual principle, with no capital stock.
- b. They must be organized in lodges with rituals.
- c. They must be democratic. The leaders must be elected by the membership.

4. Reciprocal exchanges.

A reciprocal exchange is an unincorporated association with each insured insuring the other insured's in the organization. Individuals, partnerships and corporations are allowed to exchange these reciprocal contracts. Each participant is both an insured and an insurer. An attorney-in-fact administers the exchange, collecting premiums, paying losses, etc. Members share profits and losses to the proportion of their insurance purchase.

5. Lloyd's associations.

Lloyd's of London insurance facility is composed of many different insurance syndicates, each specializing in a particular risk, for example the risks of ship hulls. Lloyd's provides coverage primarily for jumbo risks. They also offer reinsurance. Membership in a syndicate is limited to individuals with a large personal net worth, and each member may belong to more than one syndicate depending upon his or her net worth. Although much of the publicity Lloyd's receives involves insuring exotic risks such as an actress' legs, this represents only a small portion of its total business, most of which involves reinsurance.

B. Private versus Government Insurers

There is an ongoing debate over the relative merits of private insurance versus social (government sponsored) insurance. Many citizens have come to rely on social insurance such as:

1. Social Security.
2. Workers' Compensation.
3. Unemployment compensation.
4. Medicaid.
5. Medicare

C. Admitted versus Non-admitted Companies.

1. Admitted companies have been authorized by the Texas Department of Insurance to engage in the insurance business in Texas. They have been issued a Certificate of Authority that is their license to do business in the state.
2. Non-admitted companies have not been authorized to engage in the insurance business in Texas. It is illegal for them to sell insurance in Texas unless it is through a Surplus Lines Agent. This agent has a license to place business with an unauthorized company because no admitted company could handle the business. The Surplus Lines Agent is required to file a statement with the Commissioner of Insurance that they were unable to find an authorized company to accept the risk they are placing with an unauthorized company.

It is possible for a person in Texas to have a policy from a non-admitted company. They might have brought the policy from another state where the company was authorized. They may have purchased it from a Surplus Lines Agent. If a citizen of Texas comes into the possession of a policy with a company not authorized to do business in Texas, the law in Texas is clear: The Texas Department of Insurance has authority over that company in order to protect the residents of Texas.

D. Domestic, Foreign, and Alien Companies.

An insurance company is considered a *Domestic* company in Texas if the company is chartered (incorporated) in Texas. If this Texas based company sells in one of the other 49 states, it would be considered a *Foreign* company in those states. A company is considered a *Foreign* company, in Texas, if it is incorporated in some other state. It is considered an *Alien* company in Texas if it comes from another country.

EXAMPLES:

1. If an insurance company is incorporated in Texas if is considered a *domestic* company only in Texas and a *foreign* company in all of the other 49 states.
2. If a company is incorporated in Oklahoma it is a *foreign* company in Texas and a *domestic* company only in Oklahoma.
3. If a company is incorporated in London, England (as Lloyd's of London) it is considered an *alien* company in any of the 50 United States.
4. Therefore, New York Life is a *domestic* company in New York, a *foreign* company in Texas and an *alien* company in Canada, Mexico, etc.

E. Financial Status (Independent Rating Services)

Because of the complexity of insurance finances, the average consumer would have difficulty evaluating the financial strength of an insurance company. Consumers rely on several different rating services for this purpose.

1. A. M. Best has been the dominant company that has rated insurance companies over the past century. Incorporated in 1899, they have been publishing *Best's Insurance Reports* since 1906. Most insurance companies purchase as short summary rating sheet from A. M. Best for their agents to distribute to their prospects. They maintain a web page which allows anyone to access certain limited information about any of the companies they rate. The web page address is www.ambest.com. In the late 1980s three other companies emerged to challenge A. M. Best.
2. Standard and Poors began rating insurance companies both in solvency ratings and claims paying ratings.
3. Moody's used ratings that coincided with their ratings of corporate bonds.
4. Duff & Phelps also rates companies on their claims paying ratings.

F. Marketing (Distribution) Systems

The life and health insurance sales divide into two distinct distribution systems:

1. Direct response - The company makes a direct sale to the customer without using a salesperson.
2. Agency system - The agency system uses agents in the selling of insurance and may take the form of either an agency building system (using a General Agent) or a non-agency building system. Agents are paid commissions on the sale of insurance. In some cases commissions may be paid even after the agent is no longer contracted with the company if the agent's renewals had been vested in the contract with the company. Some contracts are not vested, some are partially vested and some are 100% vested. Normally, vested contracts would be issued to independent agents where the insurance company was not furnishing any additional support to the agent beyond commissions on sales. Captive agents who might receive office support, company training, training allowances, company group benefits, etc. would not be expected to receive a vested contract.

III. PRODUCERS

A. Law of Agency

1. In law, agency is a relationship between two parties against all others. The relationship is created by the *principal*, which is the insurance company. An *agent* is the *principal's* representative. In most life and health insurance transactions, the agent is the legal representative of the insurance company.
2. *Insurance service representatives* are salaried employees of insurance agents who give support and assistance to the agent.
3. Insurance counselor - Holds a special license that allows them to be compensated for advice and counsel.

B. Authority

1. Express - Authority clearly spelled out in specific language in the contract between the agent and the insurance company he or she represents. Sometimes called *actual authority*.
2. Implied - Authority associated with certain duties. If the agent collects premium to send in with an application, authority to do so is implied with the duty or responsibility to transmit premium.
3. Apparent - Sometimes called *perceived authority*, apparent authority is that perceived by a third party because the insurer has given the agent the vestiges of authority, like sample policies, sales brochures, etc. Apparent authority is often linked with the contract principle of estoppel. If an agent exercises apparent authority, the company would be estopped (legally stopped) from denying the agent's action.

C. Responsibilities

1. To the insurer - The agent is obligated to abide by the contract between the agent and the company and to demonstrate high ethical values at all times.
2. To the applicant/insured - The agent should place the interests of the client first, have current knowledge of insurance and give continuing service. Sometimes the terms *due diligence* or *due care* are used to describe an agent's responsibility to know the financial strength of the company the agent represents and to understand fully the policy coverage he or she recommends.
3. In order to protect both the agent and a client, the agent should carry E&O (Errors and Omissions Insurance.) This insurance would protect the agent (and their client) in the event the agent mistakenly overlooks or inadvertently fails to complete an action that they should have taken. Example: Accidentally failing to send a policy change form to an insurer.
NOTE: E&O Insurance will not protect an agent if the agent commits a deliberate act that is illegal or fraudulent.

IV. CONTRACTS

A. Elements of a Legal Contract

1. Offer and acceptance.

The applicant makes the offer to the insurance company. The company may accept the risk, decline or ask for another offer (as in requesting additional premium).

2. Consideration. (Premium).

Consideration refers to the statements made in the application plus the premium.

- a. If no premium is collected when an application is taken, there is no coverage if a loss occurs.
- b. If no premium is collected when an application is taken and the insurer agrees to issue a policy, coverage will be conditioned on the collection of premium. The date of the execution of the contract will be the date the premium is paid if all of the other requirements have been met.
- c. If any time has elapsed between the taking of an application and the premium payment, the insured must sign a statement of "continued good health" when the premium is paid. This will become part of the contract.
- d. If an agent collects no premium at the time of application and later discovers a deterioration of health when delivering the policy, the

policy must not be delivered. No premium should be collected and the policy should be returned to the company.

NOTE: If premiums had been paid at the time of application, health changes after that would not affect the life contract.

3. Competent parties.

All parties to a contract must have legal capacity. This includes age and mental state. A person who is below legal age, is intoxicated or is mentally incompetent would lack the legal capacity to sign a contract.

4. Legal purpose.

A contract must have a legal purpose or object. A contract cannot be in violation of public policy. It also means a contract cannot call for an illegal activity.

B. Distinct Characteristics of an Insurance Contract

1. Contract of adhesion.

The insurance company writes the entire contract because of the highly specialized and technical language required. Because the insured must accept or reject the contract, as written, it is referred to as a "take it or leave it" contract.

2. Aleatory.

Equal value is not given in the contract. A small premium may result in large benefits being paid. By the same token, premiums may be paid and no benefits result. Contracts that give approximately equal value, like a real estate contract, are called *commutative* contracts.

3. Personal contract.

A life or health insurance contract involves a person's life and health rather than property.

4. Unilateral contract.

"Uni" means one. This is a one sided contract because only the insurance company can be legally forced to abide by the contract. A policy-owner is only promising to pay premiums and cannot be legally forced to do so.

5. Conditional contract.

A life and health contract is conditional because the company's payment of a claim will depend upon the insured's meeting certain conditions, like paying the premiums, furnishing proof of loss, etc.

C. Legal Interpretations Affecting Contracts

1. Ambiguities in a contract of adhesion.

Because the insurer writes the contract *en totale*, if there are disagreements in the language, the courts will favor the insured rather than the insurer. The courts have ruled that an applicant may have *reasonable expectations* based on an agent's promise or a company's advertisement. The courts may hold that the insurer is estoppel (legally stopped) from denying a promise that an agent made to an applicant even if the promise seems at odds with the contract.

2. Indemnity.

Under a contract of indemnity an insured is not entitled to recover more than the actual economic loss.

3. Utmost good faith.

All parties to an insurance contract are expected to show utmost good faith. All are under an obligation not to deceive or withhold material information that affects the contract.

a. Representations/misrepresentations.

An applicant is expected to give accurate information to the best of his or her knowledge and memory (representations). An applicant should not give information that he or she knows is not accurate (misrepresentations).

b. Warranties.

A warranty is a statement that is absolutely and literally true. Insurance companies give warranties; applicant statements are defined by law as representations.

c. Concealment.

If the applicant fails to disclose a fact that would materially affect the contract, he or she is guilty of concealment. A material fact would be any fact that would have caused the company to have declined the risk, issued the policy on a less favorable basis or charged a higher premium had the fact(s) been known.

d. Fraud.

Any effort to defraud an insurance company is grounds for the denial of a claim and the cancellation of the policy.

4. Waiver.

A waiver is exercised when a company gives up a right. A waiver of premium is an example of a company giving up the right to collect the premium if the insured becomes disabled.

5. Estoppel

Any legal prohibition against an insurance company's action or inaction is generally called an estoppel. It would be issued by a court of authority with instructions for the company to "stop" failing to live up to the promises they had made in the contract.

EXAMINATION

SCORE _____

SCORE SHEET: Circle the correct answer

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

PRACTICE EXAMINATION

General Insurance

1. All of the following are considered elements of risk selection EXCEPT:
 1. Age.
 2. Occupation.
 3. Sex.
 4. Residence.

2. Which one of the following statements best describes an insurance contract?
 1. Equal value is given.
 2. Equal value is not given.
 3. Both parties contribute to the wording of the contract.
 4. All parties can be legally forced to abide by the contract.

3. A person whose occupation is to identify, measure and treat exposures to potential loss would be called a
 1. Actuary.
 2. Risk manager.
 3. Agent.
 4. Underwriter.

4. If an Insurance company voluntarily gave up a right in an Insurance policy contract, it would be called a
 1. Waiver.
 2. Surrender.
 3. Estoppel.
 4. Subrogation.

5. If a person chooses a high deductible and a coinsurance amount when buying a major medical policy it would be an example of
 1. Risk retention.
 2. Risk sharing.
 3. Risk avoidance.
 4. Risk reduction.

6. An unincorporated association where members insure each other and share in profits and losses would be a
 1. Fraternal Association.
 2. Stock company.
 3. Mutual company.
 4. Reciprocal exchange.

7. A company incorporated in New York and admitted to do business in Texas is considered, in Texas, to be
 1. A foreign company.
 2. A domestic company.
 3. A mutual company.
 4. A stock company.

8. When an employer has decided to set up an exercise room for employees because the employer is concerned with losses due to the risk of heart attacks, the employer is engaging in
 1. Risk transfer.
 2. Risk reduction.
 3. Risk avoidance.
 4. Risk retention.

9. Which one of the following contract principles in an insurance policy illustrate that the contract is a "take it or leave it" contract?
 1. Adhesion.
 2. Aleatory.
 3. Unilateral.
 4. Personal.

10. Under the "offer and acceptance" rule of insurance contracts, which one of the following statements is the most accurate?
 1. The insurer offers and the agent change's the contract to fit the prospect's needs.
 2. The insurer offers, the prospect accepts or declines.
 3. The prospective insured offers, the insurer accepts or declines.
 4. The insurer offers and the applicant offers and the agent mediates.

11. If an applicant signed an application while under the influence of narcotics, the contract might be invalid because of the rule of
 1. Competency.
 2. Implied waiver.
 3. Estoppel.
 4. Failure to pay a premium.

12. The Law of Large Numbers would be most accurately described as:
 1. A mathematical concept that causes losses to occur.
 2. A way of predicting what losses an insurance company might face.
 3. A concept that is useful in assessing agent authority.
 4. An accurate way for an insurance company to tell when an individual will die.

13. The majority of the policies sold by a stock company could be described as
 1. Participating policies.
 2. Dividend paying policies.
 3. Fraternal policies.
 4. Nonparticipating policies.

14. If an agent waived a provision of a contract at the time of sale, the insurance company would
 1. Ignore the action.
 2. Be estopped from enforcing the provision.
 3. Not be bound by an agent's action.
 4. Revoke the policy and refund the premium.

15. All of the following statements are true about the practice of reinsurance in Texas EXCEPT:
 1. The company that originally sold the insurance is called the "ceding" company. Those who handle the transfer do not have to be licensed agents.
 2. The company that takes over a risk from the original selling company is called the "assuming" company and those handling the transaction do not have to be licensed agents.
 3. A company may reinsure 100% of their business with the approval of the Commissioner of Insurance.
 4. All of the employees of insurance companies involved in the reinsurance process are required to be licensed agents.

16. A good definition of an unauthorized company is one
1. Admitted to do business in Texas but still considered to be under the TDI's authority.
 2. Not admitted to do business in Texas and not under TD1 authority.
 3. Not admitted in Texas but under TDI authority.
 4. Admitted in Texas but not under TDI authority.
17. An agent filled out an application and mailed it, with premium to a life insurance company. In a few weeks the agent received a policy with an accompanying letter of instruction. The agent was to collect an additional premium and have the applicant sign that he or she was willing to pay the additional premium because the company had rated up the premium due to substandard health. Which statement best describes what the company has done?
1. The company has decided to leave coverage up to the decision of the agent.
 2. The company has declined the original offer and is asking the applicant to make a counter-offer.
 3. The company has declined the original offer and is making a counter-offer.
 4. The company has accepted the original offer and is amending the contract.
18. All of the following are descriptive of Fraternal Associations EXCEPT:
1. Nonprofit groups.
 2. Organized in lodges.
 3. For profit groups.
 4. Members choose their leaders.
19. When an insurance company is drawing actuarial conclusions based on millions of pieces of data collected over decades, the company would be applying
1. Reasonable expectations.
 2. Reinsurance
 3. The law of large numbers.
 4. Due diligence.
20. A company that sells only participating policies would be a
1. Stock company.
 2. Mutual company.
 3. Domestic company.
 4. Foreign company.

21. An agent who is allowed to place business with a non-admitted company must hold which of the following licenses?
1. Insurance Counselor.
 2. Surplus Lines.
 3. General Managing Agent.
 4. Account representative.
22. If an insurance company is incorporated in a country in Europe and does business in one of the states in the United States, it is a(n)
1. Foreign company.
 2. Domestic company.
 3. Fraternal Association.
 4. Alien company.
23. A type of marketing system where an insurance company sells to the consumer without the services of an agent is known as a(n)
1. Agency system.
 2. Direct response system.
 3. Indirect system.
 4. Brokerage system.
24. If an agent shows a prospect company sales brochures and sample policies and the prospect concludes that the agent is speaking for the insurance company, this would be an example of
1. Implied authority.
 2. Apparent or perceived authority.
 3. Express authority.
 4. Insubordination.
25. If an agent sells insurance to a client and it later becomes obvious that the agent had inadequate knowledge about the company and the policies being sold, the agent would have failed to show
1. Preparation.
 2. Pre-license training.
 3. Continuing education.
 4. Due diligence or due care.

26. An applicant gives information on an application for insurance that is known as representations whereas the information supplied by an insurance company is called a(n)
1. Representation.
 2. Offer.
 3. Warranty.
 4. Waiver.
27. Which one of the following is involved in the rating of insurance companies?
1. A. M. Best.
 2. Coopers and Lybrand.
 3. Smith and Barney.
 4. ITC.
28. Which one of the following terms would best apply, in life and health insurance, to the presence of a deadly and contagious virus?
1. Risk.
 2. Exposure.
 3. Peril.
 4. Loss.
29. A woman is the sole proprietor of a business. She decides to sell half of her interest, making the business a partnership. She is engaging in risk
1. Avoidance.
 2. Retention.
 3. Reduction.
 4. Sharing.
30. If an insurance agent fills out an application for life insurance and mails the application to the insurance company without premium attached, what must the applicant do when the policy is delivered at a later date and the premium is paid?
1. Submit to a physical examination.
 2. Answer additional health questions.
 3. Pay an additional amount of premium as a penalty for delay of payment.
 4. Sign a statement of "continued good health."

31. Insurance companies make their premium decisions on a number of factors including mortality and morbidity. Because these conclusions are based on extremely high figures, we call this
1. The law of large numbers.
 2. Representative sampling.
 3. Subrogation.
 4. Adverse selection.
32. Which one of the following groups or associations is characterized by the members sharing profits or losses and is administered by an attorney-in-fact who collects premiums and pays losses?
1. Reciprocal exchange.
 2. Fraternal Benefit Society.
 3. Stock company.
 4. Mutual company.
33. If a person wishes to cancel a current insurance policy, they should:
1. Telephone the agent and request cancellation.
 2. Write the agent and request cancellation.
 3. Write the insurance company and request cancellation.
 4. Telephone the insurance company and request cancellation.
34. A person had a health policy in effect and decided to cancel the policy. Eight days after the company cancelled the policy at the policy-owner's request, a loss was sustained. The company would do which of the following?
1. Nothing, because there is no insurance in force.
 2. Pay the claim because of the grace period.
 3. Pay the claim because of the free look period.
 4. Reinstate the policy, and then pay the claim.
35. If a company issues a policy when no premium has been paid and the agent is instructed to collect the premium, what would happen if a loss occurred before the premium could be collected?
1. There is coverage under a free look provision.
 2. There is no coverage because no premium has been paid.
 3. There is coverage under a grace period provision.
 4. The company will pay only a portion of a claim.

36. All of the following could void an insurance contract EXCEPT:
1. One of the parties withheld material information.
 2. Equal value was not exchanged in the contract.
 3. One of the parties was shown to be incompetent at the time of contract signing.
 4. The contract called for an illegal activity.
37. Most life and health policies will be underwritten in the home office of the insurance company by a trained evaluator of risks, known as an underwriter. Which one of the following would be an advantage that a field underwriter would have over a home office underwriter?
1. Training in evaluating risks.
 2. Access to additional information not in the application.
 3. The opportunity to visually observe the person applying for insurance.
 4. Time to thoughtfully weigh all of the risk factors.
38. If an applicant fails to reveal information of a material nature to the insurance company, even though not asked, the failure to reveal would be
1. Misstatement of age.
 2. Incompetency.
 3. Misrepresentation.
 4. Concealment.
39. If a court ordered an insurance company to cease their failure to observe contract requirements, the court would be applying the legal concept of
1. Waiver.
 2. Estoppel.
 3. Adhesion.
 4. Aleatory.
40. When a company gives up the right to enforce some part of an insurance contract, they are applying a(n)
1. Waiver.
 2. Exclusion.
 3. Estoppel.
 4. Adhesion.

GENERAL INSURANCE

Key

| | | | |
|-----|---|-----|---|
| 1. | 3 | 21. | 2 |
| 2. | 2 | 22. | 4 |
| 3. | 2 | 23. | 2 |
| 4. | 1 | 24. | 2 |
| 5. | 1 | 25. | 4 |
| 6. | 4 | 26. | 3 |
| 7. | 1 | 27. | 1 |
| 8. | 2 | 28. | 3 |
| 9. | 1 | 29. | 4 |
| 10. | 3 | 30. | 4 |
| 11. | 1 | 31. | 1 |
| 12. | 2 | 32. | 1 |
| 13. | 4 | 33. | 3 |
| 14. | 2 | 34. | 1 |
| 15. | 4 | 35. | 2 |
| 16. | 3 | 36. | 2 |
| 17. | 2 | 37. | 3 |
| 18. | 3 | 38. | 4 |
| 19. | 3 | 39. | 2 |
| 20. | 2 | 40. | 1 |

LIFE INSURANCE

I. INTRODUCTION

A. Insurable Interest

A contract of life insurance must be based upon an insurable interest. Even though the term insurable interest is imprecise, a person is considered to have an insurable interest in another person's life if he or she can reasonably be expected to benefit economically from that person's continued life. The death of that person, the insured, would cause them, the beneficiary, to have an economic loss. The absence of an insurable interest would cause a life insurance contract to be unenforceable. Several important points should be observed about insurable interest.

1. Insurable interest in one's own life. Every person possesses an insurable interest to an unlimited extent in his or her own life and he or she can make the insurance payable to whomever he or she wishes. In these circumstances, the issue of insurable interest does not arise. The issue arises when an applicant is applying for insurance on someone else's life and making themselves (applicant) the beneficiary. The insurance company will insist that the insurable interest of the beneficiary in the life of the insured is clear at the time of application.
2. Insurable interest in another person's life.
 - a. Family and Marriage Relationships. The relationship of husband and wife create an insurable interest on behalf of either party in the other's life. The courts have extended the relationship of parent and child, grandparent and grandchild, brothers and sisters, but have generally refused to go further. In-laws, for example, would not have an insurable interest. It is sometimes said that an insurable interest can be "blood, business or bucks."
 - b. Creditor-Debtor relationships. A creditor has an insurable interest in the life of his or her debtor.
 - c. Business relationships. Many types of business relationships other than creditor-debtor establish insurable interest. Examples would include employer-employee, business partners, corporations and officers in the corporation, etc.
3. The interest is established when the application for the life insurance is made. The insurable interest is not required to exist at the time of the death of the insured, only at the time of application. For example, a fiance might purchase insurance on his or her intended spouse. If the marriage did not take place and the insurance was kept in force, the insurance would be valid and would pay the beneficiary upon the death of the insured because an insurable interest did exist at the time of application.

4. The beneficiary must show the insurable interest because the beneficiary is the person who would receive the money upon the death of the insured. At the time the application is being filled out, following the naming of the beneficiary, the next question on the application is, "what is the relationship between the beneficiary and the insured?" This is the time and the place the beneficiary shows they he or she has an insurable interest in the life of the insured.

II. HOW MUCH LIFE INSURANCE IS NEEDED?

- A. The unique quality about life insurance is that it creates an *immediate* estate. Although estates can be developed in a number of other ways, they all require many years to accomplish. Only life insurance creates an estate *immediately*.
- B. There are two ways to evaluate how much life insurance a person needs.
 1. **Human Life Value (HLV).** If a person is seeking to replace income that would be lost because of a premature death, this is called the *Human Life Value* approach. This concept was developed by the late Solomon S. Huebner of the American College in Bryn Mawr, PA. (The American College awards the prestigious Chartered Life Underwriter (CLU) and Chartered Financial Consultant (ChFC) designations.)
 2. **Need Analysis.** If a person is concerned with how much money a beneficiary would need to pay the mortgage, feed, clothe and educate the children, etc., in the event of a provider's premature death, the approach is called *Need Analysis*.

This widely used approach is sometimes called Life Insurance Programming. It is also called the "Total Approach" to assess needs. It is the application of the risk management process to the sale of life insurance. The steps include:

- a. **Gathering of information.**

This includes identifying assets, liabilities, income, savings and investments and "lump-sum" needs for postmortem expenses. Postmortem expenses include the costs of funeral expenses, medical expenses, and probating an estate.
- b. **Establishing objectives.**

A "lump-sum" need for debt cancellation, emergency reserve funds, education funds, retirement funds and bequests. Objectives also include planning for the income needs of the family by replacing the lost salary of the deceased. The "blackout" period of Social Security must be taken into account. (The "blackout" period is the time when a surviving spouse is not receiving Social Security benefits.)

- c. **Analyzing information.**
Post-death financial objectives usually fall into two groups: Cash and income. Cash requires a single sum to fulfill. Income objectives required the adoption of either a capital liquidation method or a capital retention method. Naturally, a capital liquidation would require a lower amount of life insurance.
- d. **Developing a plan.**
The agent would identify one or more policies that would accomplish the objectives already developed.
- e. **Implementing the plan.**
Taking the application and required first premium.
- f. **Monitoring and reviewing the plan periodically.**
Significant changes in a client's life, such as: marriage, divorce, buying a home, birth of children, etc. Requires making the needed changes in an insurance program.

TEN HELPFUL QUESTIONS ON CASH VALUES IN WHOLE LIFE POLICIES

1. Whole life policies must begin to cash values after what period of time? After the policy has been in effect for two years.
2. Why do insurance companies charge interest on a policy loan if the money "belongs to the owner of the policy"? Because when the policy was purchased the company quoted a premium for the policy based on the fact that they could invest the money and earn interest. If the owner borrows the money, the company has to charge interest to replace the interest they were earning on the money before it was borrowed from the policy.
3. What collateralizes a policy loan? The death benefit of the policy. This means when the insured dies any outstanding loan and interest due would be subtracted from the amount paid to the beneficiary.
4. If a person had a \$100,000 whole life policy and borrowed \$10,000 from the cash values with a simple annual interest rate of 8% and died one year after the loan was taken out, how much money would be paid to the beneficiary? You would subtract the \$10,000 loan from the \$100,000 face amount (death benefit) and then deduct the \$800.00 simple annual interest making the payment to the beneficiary \$89,200.00
5. What is an automatic premium loan? If a person has a whole life policy and fails to pay the premium, the insurance company can borrow the cash values in the policy to pay the premium. This will make the insurance policy "lapse proof" and is only available on whole life policies, since term policies have no cash values to borrow.
6. When does the cash values of a whole life policy equal the face amount of the policy? When the insured reaches 100 years old.
7. When does a whole life policy endow? When the insured reaches age 100.
8. What is a cash surrender? When the owner of a whole life policy decides to cash the policy in and take the cash. In a whole life policy we call that a "total surrender". Partial surrenders are only found in universal life policies and in annuities.
9. What is a reduced paid up option? It is when the owner of a whole life policy asks the insurance company to take the cash values and purchase a single premium whole life

policy. It is called a reduced amount policy because the owner is still paying premiums on the first policy, so it was not paid up.

10. What is an extended term option? It is when the owner of the policy uses the cash values to have the company change the policy into a term policy with the same face amount as the whole life policy. It is called extended term because it will be in effect for the amount of time stated in the Table of Values page.

III. TYPES OF WHOLE LIFE

A. Whole Life vs. Term Life

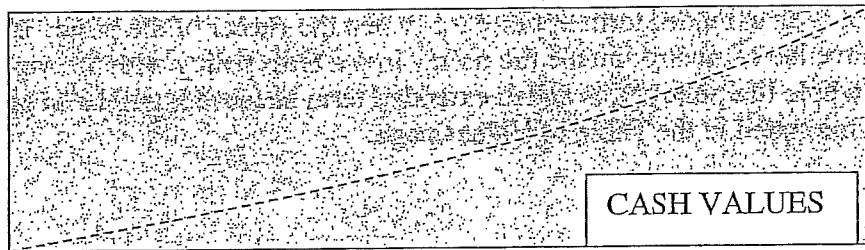
| WHOLE LIFE (Permanent) | TERM (Temporary) |
|--|---|
| <ol style="list-style-type: none"> 1. Will be in force all of one's life, that is "whole life". 2. Guaranteed cash values build in the policy. Since the cash value can be used in different ways, these policies have "living benefits". Living benefits include: Non-Forfeiture Options, Automatic Premium Loan, etc. 3. Almost always have a level premium. (This is the policy recommended for children because a low premium can be locked in for their lifetime). | <ol style="list-style-type: none"> 1. Always in force for a specific period of time. Example: One Year Term, Five Year Term, Term to 65, etc. 2. No cash values. Pure death protection. No living benefits. Whatever a policy-owner can do with cash values (Example: pay the premium) <i>cannot</i> be done in a term policy. 3. Premiums will increase when the policy is renewed. A Five Year Renewable Term policy would have a premium increase, for example, at the 6th, 11th, 16th, and 21st year of the policy's life. |

B. Whole Life Policies

1. Continuous Premium Whole Life. Premiums are payable throughout the insured's lifetime and coverage continues until the insured's death. Insured is considered statistically dead at age 100 and the cash value equals the face amount at age 100 and the policy endows. Sometimes called Ordinary or Straight Life.

EXAMPLE: Pat buys a \$100,000 Continuous Premium Whole Life insurance policy at age 20.

Face Amount (Level Death Benefit) for \$100,000



AGE 20 (Original Age - The age when a policy is purchased.)

AGE 100

a. If Pat dies, the beneficiary would receive \$100,000 income tax free as a death benefit payment. Income taxes are not paid because the IRS code treats life insurance favorably when paid as a death benefit and Pat paid the premiums with after tax dollars. Individuals cannot deduct life insurance premiums from their income taxes. A useful rule of thumb is that "if premiums are not deductible, benefits are not taxable." Example: personal life insurance. "If premiums are deductible, benefits are taxable." Example: Contributions to a 401k by an employer; deductible for the employer, taxable to the employee.

b. Pat will pay level premiums throughout his/her lifetime and coverage continues until death.

c. Pat will be considered statistically dead at age 100 and the policy will endow. The insurance company will send Pat \$100,000 at age 100 and an income tax liability will be assessed on the difference between premiums paid and the face amount. The amount will be taxed as ordinary income, due in the taxable year it was received.

d. All Whole Life insurance policies build cash values. They build slower in Continuous Premium Whole Life policies than in other types of Whole Life policies because Pat is spreading the premium payments over an entire lifetime, causing the premiums to be lower. In all Whole Life policies, cash values will equal the face amount of the policy at age 100.

2. Limited Payment Life.

A policy that limits the premium payment period. A higher premium is collected doing a shorter period of time, causing the cash values to rise faster. The cash values will still not equal the face amount until age 100 and the policy will endow at age 100.

- a. Life paid up at 65. Premiums are paid only until the insured reaches age 65. Premiums stop but the policy remains in force until the insured dies or reaches age 100. Premiums are higher than Continuous Premium Whole Life and cash values rise faster than Continuous Premium Whole Life.
- b. 30 Pay Life, 20 Pay Life, 15 Pay Life or 10 Pay Life. Premium paying times are limited to the period chosen. At the end of the period chosen, premiums stop and the insured has a paid up policy. The shorter the period, the higher the premiums and the faster the rise in cash values.
- c. Single Premium Life Policies. The ultimate limited pay. Premiums are paid with one payment when the policy is purchased. The policy has immediate cash values but the cash values will not equal the face amount until age 100. After the initial premium is paid, no premiums are ever due. Therefore, the policy has no grace period and is lapse proof

3. Indeterminate Premium Policies.

Policies may be sold that allow a re-determination of premium periodically, usually on an annual basis. The maximum premium must be stated.

4. Endowment Policies.

An endowment policy is a life insurance policy plus a vehicle to accumulate funds at the end of the policy period. A 20 year endowment policy gives life insurance protection for 20 years for the face amount. If the insured died during the endowment period, the death benefit would be paid, as in Whole Life, without tax liabilities. If the insured lives to the end of the 20 years, the face amount would be paid to the owner. The gain (face amount minus premiums) would be taxed as ordinary income. Endowments are sold in various time periods and are often used to accumulate funds for a child's education. However, they can be used to build a lump sum payment for any purpose. In all endowment policies, the cash value accumulations will equal the face amount at the end of the endowment period.

5. Modified Whole Life. (Modified Premium Whole Life)

A form of Whole Life when the premiums are lower at the beginning of the policy, usually for five years, and then advances, in one jump, to a higher level and remain there throughout the insured's life. The starting premium is called the "initial" premium and the higher premium is called the "ultimate" premium. The purpose of the policy is to allow individuals with limited income to buy permanent life insurance. Cash values are low in the initial premium phase of the policy but the premiums are not much higher than term insurance during the early period. When buying this policy, the insured should have the income potential to absorb the one time premium increase.

6. Graded Premium Whole Life.

This policy is similar to Modified Whole Life except the premium advances from initial to ultimate in five annual steps or "grades" rather than one, single increase.

7. Adjustable Life.

Adjustable Life policies combine term insurance and whole life insurance into a single plan. The buyer chooses how much face amount they wish to purchase and how much premium they want to pay. The insurer then selects the appropriate plan. The result will be a mix of term and whole life depending on the ratio between premium and the face amount that is chosen. A higher face amount and lower premium produces term insurance coverage either primarily or completely. A higher premium and a low face amount produce whole life primarily or completely. Adjustments can be made.

- a. The insured can raise or lower premium and/or the premium paying period.
- b. The insured can raise or lower the face amount and/or the period of protection.

NOTE: In theory an insured could adjust the face amount up while lowering the premium but such a move would require a previously high premium for a previous low face amount.

Many Adjustable Life policies have restrictions such as minimum premium requirements, minimum face amount requirements, insurability requirements when the face amount is raised and limits on how often changes can be made.

8. Joint Life (first-to-die).

Two people are insured in one policy. The policy is usually purchased because the premium is lower than it would be for two separate policies. The ages of the two insured's are "averaged" according to each company's formula and one premium is charged for both lives. It is whole life insurance and pays the face amount when the first insured dies. The survivor will be offered a new policy (same face amount) without evidence of insurability but will be charged at their *attained* age. In the event both insured's die at the same time, the face amount is paid to the beneficiaries on each life. For example, a face amount policy of \$50,000 would pay a total of \$100,000 in the case of simultaneous death.

9. Joint Life and Survivorship (second-to-die).

A variation of the Joint Life policy is the Survivorship policy, sometimes called the Last Survivor Policy or "Second-to-Die" Policy. This policy insures two lives but the death benefit is paid only upon the death of the second insured. Often, these survivorship policies are purchased to help the children pay estate taxes after the death of the second parent. This policy is especially useful in *Estate Planning*.

10. Indexed Whole Life.

A policy where the face amount increases as the Consumer Price Index (CPI) increases. When the policy is purchased the buyer may choose to pay a higher premium that remains level and thereafter receive increases in the face amount with no additional premium increases or they may pay a lower initial premium and agree to pay premium increases when the CPI calls for a higher face amount. Any failure to pay for an increased amount of insurance would void the agreement that calls for face amount increases. In all cases no evidence of insurability would be required for any increases in the face amount. This policy was designed to offset the impact of inflation upon a person's life insurance.

C. Interest-Sensitive Whole life Products

1. Universal Life.

Universal Life is an annual renewable term contract with an investment fund like a fixed annuity. The cash value fund has a minimum guaranteed interest, but it pays a higher interest rate if the economy so justifies.

Unlike Whole Life, face amounts are adjustable, premiums are flexible and the buyer can withdraw all or part of the cash values (partial surrender).

This policy is sometimes referred to as "unbundled life insurance" because the following three basic elements are separately identified in the policy and in an annual statement to the policyholder.

- a. The costs of the insurance protection. (Annual term insurance.)
- b. Earnings on the excess premium that the company is investing for the insured. A low, minimum interest rate is guaranteed but the current interest rate is paid if it is higher than minimum.
- c. Periodically, the insurer withdraws an amount from the cash values to cover expenses and to pay premiums for the annually renewable term coverage.

The insured has no investment options; the policy's cash values are invested by the company like a blind trust.

Face amount of insurance can be changed up or down. Of course, a minimum amount must be maintained in the cash values to fund the amount of life insurance protection desired.

Unlike a Whole Life policy, a Universal Life policy allows partial withdrawals from the cash values.

A Whole Life policy will pay the face amount to a beneficiary, but not the cash values. A Universal Life policy pays both the face amount *and* the cash value account.

NOTE: Because the policy-owner has no investment choices in Universal Life policies, the agent is not required to have additional training or licenses beyond the Life and Health License.

2. Variable Life.

A variable life insurance policy is a whole life policy with an attached investment fund like a variable annuity. The buyer assumes responsibility for making investment choices. The policy has fixed premiums and a guaranteed minimum death benefit which is the face amount of the policy. The higher the return on the investments made, the higher the death benefit or surrender value of the policy. Because the cash values are at risk, Texas law limits the amount that can be borrowed at 75%.

Even though a Variable Life policy is a life insurance contract, the U.S. government considers it a securities instrument because there is an investment risk to the buyer. It is regulated by both state and national governments. The federal Securities and Exchange Commission (SEC) regulates Variable Life Policies. In addition to state regulation, the life insurance agent must be a registered representative of the Financial Industry Regulatory Authority (FINRA). This is accomplished by passing the series 6 exam administered by the FINRA. The licensee must also pass the series 63 exam administered by Texas.

Any variable product sold in insurance, whether it is life insurance or an annuity contract will contain the three elements: **SECURITIES, OPTIONS, LICENSE REQUIREMENTS**. Remember:

Securities

Options

Licensing Requirements

3. Variable Universal Life – See chart on page 61.
4. Current Assumption Whole Life – May pay higher returns on cash values if interest rates rise. (Sometimes called Interest-Sensitive Whole Life).

THREE INTEREST-SENSITIVE POLICIES COMPARED TO A WHOLE LIFE POLICY

| | WHOLE LIFE | UNIVERSAL LIFE | VARIABLE LIFE | VARIABLE UNIVERSAL LIFE |
|---------------------------------|--|---|--|--|
| FACE AMOUNT | Fixed | Adjustable | Fixed | Adjustable |
| PREMIUM | Fixed | Flexible | Fixed | Flexible |
| DEATH BENEFIT | Face Amount Only | Face Amount Plus Guaranteed Minimum Cash Values | Face Amount As A Minimum - Cash Values Are At Risk | Face Amount As A Minimum - Cash Values Are At Risk |
| CASH VALUES | Guaranteed Source of Non-forfeiture Values and Options | Guaranteed Minimum Plus Current Interest Earnings | No Guarantee - Variable | No Guarantee - Variable |
| INVESTMENT OPTIONS | No Conservative Low Risk Investments | No Typical Conservative Investments like Real Estate, Mortgages, etc. | Yes Common Stocks Money Market Accounts, Equity Type Securities | Yes Stocks and other Equity Type Securities |
| PARTIAL SURRENDERS | No Loans of Cash Values or Total Cash Surrender | Yes | No | Yes |
| GOVERNMENT REGULATES AS: | Insurance | Insurance | Insurance And Securities | Insurance And Securities |
| LICENSE REQUIRED | Only The General Lines Life and Health License | Only The General Lines Life and Health License | General Lines Life and Health Plus Variable Contract License (Series 6 & 63) | General Lines Life and health Plus Variable Contract License (Series 6 & 63) |

D. Term Life

1. Level Term - A life insurance policy that provides the same amount of protection for a specific period of time. At the end of the period, the policy expires.

20 Year Level Term

Death Benefit Remains the Same

\$200,000



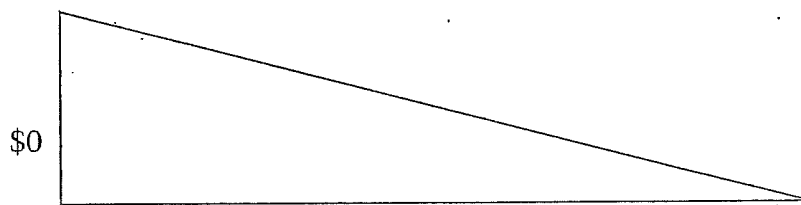
AGE 35

AGE 55

2. Decreasing Term - A life insurance policy where the face amount decreases over the life of the policy. An excellent plan to provide coverage for a loan being amortized over a specified number of years, as a home mortgage. Sometimes called "mortgage cancellation" insurance. The premiums are level.

20 Year Decreasing Term

\$200,000



AGE 35

AGE 55

NOTE: The premiums for level and decreasing term policies remain the same (level) throughout the life of the policies.

3. Credit Life Insurance. Credit Life Insurance is a specialized type of Decreasing Term Life Insurance. It is insurance on the life of a debtor that would pay what is owed on the loan in the event the debtor dies (sometimes disability is included). The amount of the credit life insurance may not, at any time, exceed the amount of the debt. If credit life is a requirement for a loan, the debtor must be allowed to substitute current insurance they own and/or choose their own insurer. Credit life may be issued as:
 - a. Individual policies. These are policies issued to the debtor on the decreasing term plan. The creditor is the beneficiary and the debtor pays the premiums.
 - b. Joint policies. Unlike joint life insurance, joint credit life policies may be issued only on spouses or business partners.
 - c. Group policies. These are issued to creditors, providing insurance on the lives of debtors on the decreasing term plan. The group credit life policy is owned by the creditor and the premiums are paid by the debtor. Premiums for group credit life policies are usually based on a flat rate unrelated to the borrower's age.

4. Term policies may be:
 - a. Renewable. If a term policy is renewable, the policy-owner has the option to renew before the expiration date and no evidence of insurability is required. A One Year Term policy, sometimes called Yearly Renewable Term (YRT) or Annual Renewable Term (ART) may be renewed at the end of each year. ART policies are the most popular of all term policies sold. The premium will increase each time it is renewed because the renewal premium will be based on attained age. A Five Year Renewable Term policy would have a premium increase at the sixth, eleventh, sixteenth and twenty-first year of the policy's life.
 - b. Convertible. If a term policy is convertible, the policy-owner can change the coverage to permanent insurance with *no evidence of insurability required*. The insured may convert part or all of the term coverage. Premiums will usually be based on *attained age* at the time of conversion. If the insurer allows the use of *original age* at the time of conversion, an additional premium may be assessed as a one time makeup charge. Conversion options usually specify the time frame in which the conversions must be made.

E. Family Policy and Family Income Policy

A Family Policy is any life insurance policy that insures the provider with whole life and the spouse and/or children with term riders.

The Family Policy insures all members of the family under one policy. It is usually packaged in units: a certain amount of permanent insurance is chosen on the *primary insured* (provider or breadwinner). This amount will determine the amount of term coverage on the spouse and on each child.

One premium is collected for the combined coverage's in the policy. The *primary insured* will have permanent insurance (usually Whole Life) and the spouse and each child will have term insurance. All children are covered under one premium. New born children are added to the policy after living fourteen days with no increase in the premium. The family must notify the insurer, in writing, to add a new born or adopted child.

The death benefits are paid *lump sum* immediately following the death of an insured. It is possible for the spouse and/or child to die after their term insurance has expired and no benefits would be paid.

A Family Income Policy (or Rider on a family policy) is designed to provide monthly income to the family upon the death of the *primary insured*. It is usually purchased for a certain number of years, like 20 years for example. In the event the *primary insured* dies 10 years after purchasing the policy, there would only be 10 years of payments left at the time of death. The full benefit of the policy (20 years in our example) would only be paid if the *primary insured* died during the first year after the policy was purchased.

F. Juvenile Insurance

Life insurance on children 15 years of age or younger is called Juvenile Insurance. (Some states, including Texas, define the age as 14 and under.)

1. Applicants and premium payers would be:
 - a. Parents.
 - b. Grandparents.
 - c. Legal Guardians.
2. The purpose of Juvenile Insurance is to:
 - a. Protect the insurability of children. Insurance must be written on children before they develop health problems that would make them uninsurable. Options are usually placed in the policy that would enable the insured to purchase additional insurance at specified times regardless of bad health.
 - b. Provide for postmortem expenses in the event of the child's death.
3. Juvenile Policies often have a Payor Provision (Rider) attached. This provision stipulates that, if the adult premium payer dies or is disabled before the child reaches a certain age (usually 21), the premiums are waived until the child reaches that certain age or until the policy matures.

4. Jumping Juvenile.

A special type of Juvenile Insurance is called "Jumping Juvenile" or "Junior Estate Builder." The policies have three characteristics:

- a. They are sold in \$1,000 units and when the child reaches age 21 the original face amount advances (Jumps") five times the original amount purchased. A policy sold on a three year old child with a \$2,000 face amount would automatically become a \$10,000 policy at age 21. The one-time advance ("jump") is at age 21, but the "jump" is a multiple of five. 5 X \$2,000 equal \$10,000.
- b. When the policy jumps in the face amount of insurance, no evidence of insurability is required.
- c. When the policy jumps in face amount of insurance, premiums remain the same.

G. Industrial Life Insurance

1. Face amount of \$1,000 or less.
2. Premiums are collected weekly by the agent.
3. The words "Industrial Policy" must appear on the face of the policy.
4. The agent is usually assigned an area to service, called a "debit."
5. Agents are sometimes called *Home Service Agents*.

H. Annuities

1. Principles and concepts.
 - a. The traditional definition of an annuity: *the scientific liquidation of an estate*. When a person purchases an annuity contract from an insurance company, the person agrees to give the company money to invest on his or her behalf. Later, the company will convert the accumulated sum into periodic income payments that are actuarially calculated to extend for either a certain period of time or for the rest of the person's life.
 - b. The period in which the premiums are being paid and invested is the accumulation period.
 - c. Annuity period. When the money is being paid out to the annuitant or to a beneficiary, this is the annuity period. The contract *annuitizes* at the time when the payout begins.
 - d. Owner - The person who buys the annuity. The owner is sometimes called the *contract-holder*.
 - e. Annuitant - The person who receives the income, usually the owner, but not always.
 - f. Beneficiary - The person who receives the funds if the owner dies before the payout period begins. In certain cases the beneficiary may receive payments if the annuitant dies during the payout period.

- g. Insurance aspects of annuities. Like life insurance, annuities use the law of large numbers and mortality tables. However, the focus is on how long a person will live rather than when a person will die. Because some annuity payout periods extend as long as a person lives, this life insurance principle requires that only life insurance companies sell annuities because they have the information and expertise to guarantee a life income based upon mortality factors, etc.
2. Immediate versus Deferred Annuities.
- a. Single Premium Immediate Annuity (SPIA). All the premium is paid when the annuity is purchased. Immediate means the payout begins from one month up to one year following purchase. A single premium must be used and there is no accumulation period.
 - b. Deferred Annuities.
The purchaser of an annuity may choose to begin the payout period many years after the purchase date. If a deferred annuity is chosen, the premium payment may be either a:
 - 1.) Single Premium Deferred Annuity (SPDA) or a
 - 2.) Flexible Premium Deferred Annuity (FPDA).
 - c. Non-forfeiture values. The funds that are in an annuity account belong to the owner of the annuity. These funds are guaranteed to the owner and may be withdrawn (surrendered) at any time.
 - d. Surrender charges. A charge may be made for a withdrawal from or the surrender of an annuity contract before the payout period starting date. The charges often scale down over a period of time.
 - e. Death benefits. If the owner dies during the accumulation period, the beneficiary would be paid the amount of the fund minus surrender charges.
3. Annuity (benefit) payout options
- a. Life contingency options. On life contingency options three factors, other than the payout option chosen, would influence the monthly income the annuitant would receive: Age, sex and the amount of money accumulated in the fund. The older the person or persons are when the fund is annuitized, the more monthly income would be paid, all other factors being equal. Women would receive less than a man if all other factors were equal because they outlive men.
 - 1.) Pure life versus life with guaranteed minimums. A pure life income option will give the annuitant the largest monthly income if all other factors are equal. In exchange for a life income guarantee, the annuitant agrees that upon his or her death, the insurance company keeps whatever funds are left in the annuity account. It is obvious that a life income option, during the payout period, can have no beneficiaries.
 - 2.) A guaranteed minimum could be achieved with either a life income with period certain or a refund life income. The period

certain refers to the beneficiary receiving money if the annuitant died before he or she lives through the period they had selected. For example, if an annuitant chooses a life income with a period certain of ten years, the beneficiary would receive payments following the death of the annuitant if the annuitant died during the ten years of the payout. If the owner chooses a life income for themselves with a period certain of ten years for their beneficiary and died after receiving payments for five years, the beneficiary would then receive payments for five years after which all payments would cease.

- 3.) A refund life annuity will guarantee that, in the event the annuitant dies before the premiums they have paid to the company are paid back to them, any premiums held by the company at the time of the annuitant's death would be paid to the beneficiary either in installments or as a lump sum payment.

b. Single life versus multiple lives.

The annuitant can be an individual person or an annuity can be paid out to two or more (joint) persons.

- 1). Joint Life and Survivorship Option. This option will pay income as long as either one of the annuitants live. Ideal for husband and wife because payments would continue throughout both lives, guaranteeing the surviving spouse an income for life. When the survivor dies, no further payments are made. The amount of income would be lower per payment than the Joint Life Option because payments continue on two lives rather than one. Companies offer several variations on this option, including a one-half or a two-thirds payment to a survivor. The survivor's income would be reduced to this fraction of the original joint income.
- 2). Joint Life Option. A Joint Life Annuity pays until the death of the first of two or more annuitants. Monthly benefits are higher than with some other options because payments cease upon the first death. Not suitable for a husband and wife retirement plan if their sole or principal income is from the annuity.

c. Temporary annuities.

A temporary annuity is one that does not provide a lifetime income. Installments can be paid for a fixed period or for a fixed amount. Some annuities combine these, paying a fixed amount for a fixed period. Many awards, sweepstakes winnings and state sponsored lotteries are often funded by annuities. These are usually temporary annuities.

4. Fixed versus Variable annuities.

a. Fixed annuities.

When a fixed interest rate is chosen, the funds are placed by the insurance company in a general account and the company guarantees that the interest payments will not fall below the guarantee. Frequently, the fixed guarantee interest is a "worst case scenario" with companies paying a higher current interest. Fixed rates are usually set at three or four percent. A fixed annuity would perform well during a period of deflation.

b. Variable annuities.

Variable annuity premiums are placed in a special variable annuity account by the insurance company. It is a mutual type fund within an annuity contract. Because the variable account is a securities type of investment, it is regulated by the Securities and Exchange Commission (SEC) in the same manner as variable life insurance contracts. In order to sell variable annuities an agent must pass an exam administered by the National Association of Securities Dealers (NASD) and apply for a variable license from the state of Texas. Variable annuities perform well during periods of inflation because they are directly influenced by the stock market.

5. Tax Sheltered Annuity (TSA). (Covered under Qualified Plans)

6. The Advantages of Annuities

- a. Safety. The insurance industry has gone to great lengths to protect the safety of annuity purchases. Although not insured by the FDIC, there are many safeguards for annuities.
- b. Tax Deferral. All annuities have the tax on their interest accumulations deferred until the money is withdrawn. This gives annuities an advantage over traditional investments like savings accounts and CDs where the income tax must be paid annually. A Tax Sheltered Annuity (TSAs, also called 403b) all pre-tax dollars to be invested. In TSAs both the principal and interest are tax-sheltered until withdrawal.
- c. Probate Avoidance. Annuities are paid to a beneficiary directly without going through probate, avoiding publicity and delays.
- d. Adverse Civil Litigation. Annuities, like life insurance, are beyond the reach of a civil judgment as long as the funds are kept separate.

IV. POLICY PROVISIONS, OPTIONS, AND RIDERS

A. Entire Contract. The Entire Contract provision, placed in the beginning of the policy, states that the policy itself, a copy of the application attached to the policy, and any attached papers constitute the Entire Contract. This means that there are no outside documents that are part of the contract. The company could not claim that they have a special form on file in the home office that could change their liability to pay. Before the contract of insurance is in effect, the company may require the policy-owner to agree to changes. When the policy is effective, these changes are attached to the policy and are part of the Entire Contract. These changes may come in one of these forms:

1. Rider. A revision in the wording of the policy that changes the coverages. It can expand benefits or exclude certain conditions from coverage.
2. Endorsement. A change made directly on the policy form by the insurer. It can be stamped, written, or typed.
3. Amendment. A change made by the company usually by adding an additional page to the contract.

NOTE: If a policy is issued by the company with a rider, endorsement, or amendment, it is the responsibility of the agent to explain the changes to the policy-owner and have them accept the changes in writing. Any changes must be in the insured's copy of the contract. All papers relating to coverage's in the home office of the insurance company must be identical with the policy-owner's papers. This is the concept and purpose of the Entire Contract.

B. Insuring, Consideration and Execution Clauses

1. Insuring Clause. The Insuring Clause states the basic promise of the insurance company to pay benefits upon the death of the insured. It is usually one paragraph on the front (cover or face) page of the policy. The cover page is the *Declaration* (Dec) page.
2. Consideration Clause. The Consideration Clause tells what the insured promises - to pay the premium. No contract is effective in life and health insurance until the premium is paid.
3. Execution Clause. The execution clause states that the contract is in force (executed) when both parties have met the conditions of the contract.

C. Free Look (Sometimes called Free Examination or Right of Refusal)

The Free Look is the time a policy-owner has to decide to return the policy for a full refund. No reasons need to be given and notifying the agent is the same as notifying the company. The standard Free Look time is ten (10) calendar days from the time the policy is in the possession of the owner. Companies can always be more liberal than the standard, but can never be more restrictive. A thirty (30) day Free Look must be given for all Medicare Supplement Policies and all Long Term Care policies in health insurance. A Free Look period is not "free insurance."

D. Policy Ownership

When an application for life insurance is completed, the applicant will automatically be the owner unless someone else is designated. If someone else is designated the owner, that person will have complete control of the policy once the contract is in force. The owner of a life insurance policy is the person who can make changes, borrow the cash values, make a policy assignment, choose a settlement option, etc.

E. Beneficiaries

The word beneficiary shares the same root word meaning as the word benefit. Someone benefits economically when a person dies and the beneficiary has been named in the policy to receive the death benefit.

Beneficiary designations should be made with great care. The language should be clear and unambiguous. Specific names, in full, should be used with the relationship to the insured clearly designated. Minors should not be used because of the necessity of appointing a guardian, which can be time consuming. "Estate" should be avoided as a beneficiary designation because it requires that the proceeds go through probate which is time consuming and expensive. Trusts have some advantages and some disadvantages. A trust designation allows more precise and detailed instructions on the disbursement of funds but do not have the guarantees that an insurance company can give under a settlement option where the death benefit and the interest are both guaranteed. Settlement options are discussed fully under a separate heading. (See "Settlement Options" in the Glossary/Index).

1. Revocable or Irrevocable Beneficiaries.

Revocable beneficiaries (the most common type) can be changed without their knowledge or consent; irrevocable beneficiaries cannot. An irrevocable beneficiary is actually a co-owner of the policy. When a policy has an irrevocable beneficiary, the owner cannot make any change that would diminish the rights of the irrevocable beneficiary without that person's written permission. Irrevocable beneficiaries are used in life insurance purchased for charitable giving and would be appropriate wherever the rights of the beneficiary need to be protected.

2. Primary, Contingent (Secondary), and Tertiary Beneficiaries.

A Primary beneficiary is first in line to receive the death benefits of a policy when the insured dies. If the Primary beneficiary has already predeceased the insured, the Contingent (Secondary) beneficiary would receive the benefit. Some companies also include a third level beneficiary, a Tertiary ("Third") to receive the money if both the Primary and Contingent beneficiaries have predeceased the insured. Whenever possible, death proceeds of life insurance should be kept out of the estate. Placing life insurance in someone's estate causes delays and could raise the costs of settling the estate.

3. Per Capita and Per Stirpes Beneficiary Designations.
Beneficiary designations involving a group, as "all my children," would be considered Per Capita if no additional instructions are given. This would mean, upon the death of the insured, the children who are living would divide the death benefits equally and any deceased children would be removed from any participation. Per Stirpes would allow grandchildren to step up and take their deceased parent's place as beneficiaries. Five children as Per Stirpes beneficiaries would mean five divisions of money, even if only three children were living. The children of each deceased child would divide one-fifth of the death benefit that would have gone to their parent, if living.
4. Uniform Simultaneous Death Act.
This Act protects the contingent beneficiary in the event the insured and the primary beneficiary die at the same time, as in an automobile accident. The proceeds are paid as if the primary beneficiary died first. The purpose of this Act is to keep the insured's proceeds out of the primary beneficiary's estate and pay them directly to the contingent beneficiary.
5. Common Disaster Provision
The Common Disaster Provision addresses the problem of the primary beneficiary clearly outliving the insured, but by only a few days. The policy-owner must request that this provision be in the policy. It is usually in the policy itself or made a part of the beneficiary designation. The number of days chosen is usually 10, 15 or 30. If the primary beneficiary dies within the time specified following the death of the insured, the contingent beneficiary would receive the death benefit.
6. Spendthrift Clause.
The Spendthrift Clause protects the death proceeds from a life insurance policy from legal seizure for the debts of the insured and/or the beneficiary. The clause best applies when the benefits are being paid under a settlement option and not lump sum.

F. Incontestable Clause

Insurance companies can contest the accuracy and completeness of information in the application within the first *two years*. If the company cancels the policy, they must refund the premium. After *two years*, the information is incontestable, except for fraud. (Called "time limit on certain defenses.")

G. Suicide Clause

If the insured commits suicide within the first *two years* of a life insurance policy, the insurer will refund (pay) the premiums to the beneficiary. After two years, the insurer must pay full benefits. Some companies will pay after one year.

H. Misstatement of Age Clause

If a company discovers a misstatement of age, they will adjust the face amount of the policy to fit the premium collected. If the age had been overstated (applicant said the age was 31 when it was actually 29) the benefits would be raised. If the age had been understated (applicant said the age was 29 when it was actually 31) benefits would be lowered. In all cases there will be no change in the premiums. This clause is not subject to the two year time limit on certain defenses that insurance companies have under life and health contracts. (Contestable Clause)

I. Grace Period

A grace period is when a life or health policy is still in force, but a premium is due. If a loss arises during the grace period, the insurer would pay according to the policy provisions, deducting the earned premium from the payment. The length of the grace period is determined by the mode of premium payment: 7 days, 10 days, or 31 days. 7 days for weekly collected premiums; 10 days for a monthly direct premium. All others would have a 31 day grace period. This would include annual, semi-annual, quarterly, and monthly bank drafts. HMOs are an exception to the mode of premium payment and grace period. All HMOs must have a 30 day grace period as a federal requirement, regardless of the way the premium is paid.

J. Reinstatement Clause

Life insurance policies may be reinstated up to three years following their lapsation. The reason a person would seek reinstatement rather than purchase a new policy would be to save their original age for premium savings. Individual companies may be more liberal than the industry standards for reinstatement, but the basic requirements when applying for reinstatement includes:

1. Pay all back premiums.
2. Pay the interest on all back premiums.
3. Give evidence of insurability. The requirements to prove insurability may be different and more stringent than the original application because the insured is older.

NOTE: Reinstatement should not be confused with replacement of insurance. Reinstatement is when someone buys a policy from Company A and the policy lapses. The same policy is put back into force through the reinstatement procedures. Replacement is when a person buys a policy from company A and an agent from company B sells them a different policy and they cancel the policy with company A. Replacement is carefully regulated by all state insurance departments.

K. Automatic Premium Loan

Permanent insurance policies allow for a loan to be made to pay premiums. The loan would be against the cash values and is designed for an *unintentional* failure to pay the premium. It is obviously not available in term policies. The insured *does not pay* any additional premium for this benefit.

L. Policy Assignment

The owner of the policy might "assign" the proceeds to a third party. This is usually done when money is borrowed and a bank requires the assignment. The assignment would be a collateral assignment; the bank would only collect to the extent of the loan balance. An absolute assignment gives all control and rights to a third party.

M. Policy Exclusions

Circumstances under which the policy would not pay. Historically, life insurance policies have sometimes included these exclusions:

1. War or Military Service Exclusion - Excluded two separate areas: Service in the military and/or death as a result of a declared war.
2. Aviation Exclusion - The policy will not pay if death results from private aviation activities. The exclusion does not apply to commercial aviation licenses. The exclusion does not apply to death resulting from being a fare paying passenger on a commercial flight.
3. Hazardous Occupation or Hobby Exclusion - Will not pay if death results from a dangerous job or pastime. An insurance company may simply decline to cover some occupations that are hazardous. If they decide, for example, to issue coverage for a firefighter, then firefighting would not be exclusion in the policy. Parasailing, parachuting and sky jumping are examples of hazardous hobbies that would be excluded.

V. RIDERS

Riders in this section are special policy provisions that, in life insurance, add benefits to the policy. These benefits must be specifically requested by the applicant at the time of application and an extra premium is charged. The provisions are attached to or "ride" the policy.

A. Waiver of Premium

A common rider added to most, but not all, life insurance policies that protect the policy from lapsing in the event the insured is ever disabled. If the insured is totally and permanently disabled, the company will pay the premiums. The disability must be total and permanent. There is usually a waiting period from three to six months to establish disability. If disability is established, the company refunds those premiums to the insured. Most Waiver of Premium riders will not apply if a disability arises after the insured reaches age 60.

NOTE: For Universal, Variable, and Variable Universal Life policies, only the premium for the death benefit would be paid by the company under the Waiver of Premium rider.

B. Disability Income (Covered under Health Insurance)

C. Accidental Death Benefit (ADB)

This rider will pay double, triple, or quadruple the face amount if the insured's death is caused by an accident. Triple and quadruple benefits are usually limited to accidental death while traveling on a common carrier such as a scheduled airliner, franchised taxi, etc. This rider is sometimes called a Multiple Indemnity rider.

NOTE: For the Accidental Death Benefit to pay, the death must occur within 90 days following the accident. The 90 day rule does not apply if the insured is permanently disabled between the accident and death.

D. Accidental Death and Dismemberment

This rider pays for accidental death and also pays for the loss of limbs and eyes. A scheduled amount is given in the rider for the loss of hands, arms, legs, etc. Blindness is almost always included in dismemberment losses. Sometimes loss of speech is included, and more rarely, loss of hearing

E. Payor Benefit

This rider is almost always associated with Juvenile Insurance because the rider is on the premium payor, not the insured. The rider provides a waiver on the premiums of a child's policy if the premium payor dies or is disabled before the child reaches a certain age, usually 21. Some companies use age 25.

F. Guaranteed Insurability

This rider allows the insured to purchase additional insurance regardless of their health. The rider specifies how many options the insured has and when the options can be exercised. The options start at age 21 and end at age 40. The insured is limited to the amount of insurance originally purchased and must wait until the options mature. Premiums for the additional insurance will always be based on attained age. Two events in the life of the insured will allow them to exercise an option before they reach it: getting married or having (or adopting) a baby. The strength of this rider is that it protects the policyholder's insurability.

G. Term Insurance

This rider is often added to a base policy of permanent insurance. This allows the insured to have a higher death benefit than the permanent insurance alone would give. The Term rider should have no more than five times the amount of insurance in the base policy. The rider can be level, decreasing, or increasing.

H. Cost of Living Adjustment (COLA)

In order to prevent insurance coverage from falling behind due to inflation, a Cost of Living rider is used. This rider will cause the amount of insurance to go up as the Consumer Price Index advances. It is sometimes called an Inflation benefit or Indexing rider. A relatively new type of Whole Life policy is Indexed Whole Life. The face amount automatically increases as the Consumer Price Index (CPI) increases.

I. Exchange Privilege

This rider allows a person to be taken off of a policy and a new person takes their place. This rider is used in business insurance, like Key Person insurance. The new person will be medically underwritten and premium adjustments will be made according to age, etc.

J. Accelerated Death Benefit

This rider is the newest rider in the life insurance industry. It allows a company to pay all or a portion of the death benefit prior to death if the insured is terminally ill or facing a long-term disability (two years or longer.) If Accelerated Death Benefits are paid, they are paid to the insured, assuming that the insured is the policy-owner. Following death, the remainder of the death proceeds would be paid to the beneficiary. The benefit is now being placed in many life policies, but it can also be added to a policy as a rider.

NOTE: People who own life insurance policies without an Accelerated Death Benefit provision may elect to make a *Viatical* settlement or enter a *Life Settlement agreement*. See glossary, P. 216

VI PREMIUMS

A. Computing premiums. Three factors determine premiums in all insurance companies. Because these factors vary from company to company, premiums also differ.

1. Mortality. In life insurance, companies pay a benefit when an insured dies. Even though company's use the standard mortality tables (Commissioners Standard Ordinary) based on millions of figures collected over decades, the company's own mortality experience will depend upon their underwriting skills. In health insurance, these losses are called the morbidity factor. In property and casualty (P&C) insurance, the word claims is used. Overall, the claims experience of any insurance company influences the premiums they charge.
2. Interest Assumptions. Insurance companies invest the premiums they collect. The returns on their investments influence premiums. The interest insurance companies make on their investments vary according to the investment skills found in each company.
3. Loading. The operating expense of insurance is a factor in determining premiums. What businesses generally call "overhead", insurance companies call "loading". Commissions, salaries for employees, printing costs, etc. are examples of loading factors that differ from one company to another.
4. Net premium is the mortality factor minus the assumed interest.
5. Gross premium is the net premium with the loading charge added. This is the premium quoted in a company's rate book.

B. Mode of Premium Payment

Insurance companies offer a range of premium choices to fit different budgets. Premiums are calculated as if the insured is paying an annual premium. Since most people choose a different mode of payment, companies charge a small administrative fee for paying more frequently than annually. Premium modes range from weekly, monthly direct billing, monthly bank draft (referred to frequently as a *Check-0-Matic* plan), quarterly, semi-annually, annually to single premium. Annual premiums would be the least expensive way to pay for insurance from the mode choices usually selected.

VII. NONFORFEITURE VALUES AND OPTIONS

The cash values in a permanent life insurance policy are guaranteed. These values are placed in the policy on the "Table of Values" page or a "Table of Guaranteed Values" page. These values are not subject to the annual profit history of the company and are found in all permanent life insurance policies and endowment policies, whether the company is a stock company or a mutual company. These guaranteed cash values should never be confused with dividends, which are based on the annual profits of a company and can never be guaranteed.

Because these cash values are guaranteed, they are called *non-forfeiture* values. The policy-owner is entitled to receive these at any time. They can be borrowed (not a forfeiture option) or the policy can be ended and one of the following choices (options) can be exercised.

A. Cash Surrender

The policy is returned to the company and the company gives the policy-owner the cash values minus any outstanding loan and interest due on the loan. The policy is terminated and cannot be reactivated. A cash surrendered policy cannot be reinstated.

Most states require that cash values accrue in whole life policies after a certain period (two years in Texas). Most policies build cash values in one year.

Many states, including Texas, allow companies to delay cash surrender (or a policy loan) for six months following the request. The law was written to protect companies during an economic crisis and is almost never invoked.

If the amount of money the policy-owner received in cash surrender exceeds the premium paid, the gain or "profit" is taxed as interest income.

B. Reduced Paid-Up Insurance

The policy-owner asks the company to take the cash values and use them to purchase a single premium life insurance policy at the insured's attained age. By choosing this option, the policy-owner ends the premium but still retains a reduced amount of permanent life insurance.

The new policy must be the same type of policy as the original policy. If the original policy was a participating whole life policy, the reduced paid-up policy would be the same type. The premium is paid up and the reduced face amount remains the same for the rest of the insured's life.

The policy-owner will continue to have access to the cash values in the new, lower face amount policy.

C. Extended Term Insurance

This option takes the cash values in the original policy and purchases a new term policy for the same face amount as the original policy. The new term policy will continue (extend) as long as stated in the policy's Table of Values page.

All additional benefits attached to the original policy like accidental death benefit, term riders, etc., are dropped.

VIII. DIVIDENDS AND DIVIDEND OPTIONS

- A. There are two types of life and health insurance companies: Stock companies and Mutual companies. Most of the insurance sold by a stock company is nonparticipating insurance. All of the insurance sold by Mutual companies are participating policies.
- B. When a company sells a participating policy, the owner is allowed to choose one of the following dividend options:
1. Cash.
Each year the company pays the dividend directly to the policy-owner. There is no tax liability.
 2. Accumulate With Interest.
The dividend is left with the company to invest and an accounting is made to the policy-owner. The interest earned on the dividend would be taxed as ordinary interest income; the dividend itself (now the principal) would not be taxed.
 3. Paid-Up Additions.
The dividend is taken by the company and used as a single premium to purchase more permanent insurance. This is the most popular dividend option because it raises the amount of life insurance on the insured and also increases the cash values. To achieve its maximum value it requires a relatively long period of time. This option must be used if an Enhanced Ordinary Life (Economatic) policy is purchased.
 4. Reduce Premium.
The dividend is applied to the premium.
 5. One Year Term. The dividend is used each year as a single premium to purchase a one year term policy.

IX. SETTLEMENT OPTIONS

Most life insurance proceeds are paid lump sum, meaning that the insurance company issues one check for the full face amount of the policy to settle the contract. Lump sum payment is not one of the settlement options. When the amount of insurance is very high, a settlement option might be chosen by the owner of the policy. The owner can choose an option and change an option as long as the insured is living. Once the insured dies, whatever settlement option the owner has chosen will be carried out by the insurance company. By choosing a settlement option the Spendthrift Clause protections are automatically in force. This clause, in most state laws, including Texas, protects the money being held by the insurance company from legal seizure for the debts of either the insured or the beneficiary. Once the money is paid lump sum and commingled with the money of the beneficiary, it has no Spendthrift Clause protection. If an owner does not choose a settlement option and the insured dies, the beneficiary would be allowed to choose one of the following options. If the owner has chosen an option, the beneficiary could not make any changes.

A. Interest Options

The company is asked to keep the proceeds, invest them, and pay them out to the beneficiary according to the policy-owner's wishes. This option has great flexibility.

1. The owner (or beneficiary) could choose an *interest only* option. The purpose of this option would be to allow the beneficiary an interest income from the death benefit that the company was investing and still pass the death benefit to other beneficiaries following the primary beneficiary's death. The interest payed would be subject to income taxes.
2. *Interest option with right of withdrawal.* The owner could stipulate that the interest was to be paid monthly to the beneficiary and the beneficiary could be given the right of withdrawal of the original death benefit. The right of withdrawal could be a limited right or an unlimited right.

B. Fixed Period Option

The death proceeds are turned into an annuity type payout where the principal and interest are liquidated to the beneficiary over a selected number years. The death proceeds are guaranteed to be paid along with a guaranteed minimum interest rate.

C. Fixed Amount Option

A certain amount is selected to be paid periodically to the beneficiary and this amount is paid until the principal and interest have been liquidated.

D. Life Income Option

The life income option provides payments to the beneficiary as long as they live. In essence, the insurance company purchases a single premium immediate annuity for the beneficiary. Based upon all of the actuarial considerations, the company guarantees a lifetime income for the beneficiary. At the death of the beneficiary any funds left are absorbed by the insurance company. This is the only settlement option where the insurance company might possibly pay out more money to a beneficiary than the total of the death proceeds and interest combined.

X. POLICY LOANS, WITHDRAWALS AND PARTIAL SURRENDERS

All permanent life insurance policies are required by state laws to have a policy loan provision. This allows the policy-owner, within some limits, to borrow the cash values in the policy. Interest is charged on the loan. The company cannot force repayment of the loan or interest but repayment can be made anytime the owner chooses. A company may delay making a loan for up to six months following a loan request, but this is rarely done.

A. Irrevocable Beneficiaries and policy Changes

If there is an irrevocable beneficiary, no change can be made in the policy that would diminish their interests, including a policy loan, without their written permission.

B. Outstanding Loans and Death claims

If an insured dies while there is a policy loan in effect, the amount of the loan and any interest due would be deducted from the face amount paid to the beneficiary. Thus, the death benefit of the policy is the collateral the insurance company uses for any policy loan.

C. Cash Values Used as Collateral

Cash values can be assigned to a third party (usually a bank) as collateral for a loan. An irrevocable beneficiary must agree. At the death of the insured, any loan and interest owed would be paid first; the balance going to the beneficiary.

D. Partial Surrenders

In the traditional Whole Life policies the policy may be surrendered in order that the owner can have the cash values. This is a total surrender that ends the policy. Universal Life and Variable Universal Life policies allow the owner to withdraw a part of the cash value account and continue the policy. This is called a "partial surrender." It is not available in traditional Whole Life policies and in Variable Life policies.

XI. THE APPLICATION

The application provides much of the essential information an insurance company will use to evaluate a risk and determine whether or not that risk will be assumed by the company. It should be filled out carefully, accurately and completely.

A. Four separate individuals may be involved in the application for insurance

1. The applicant must always sign the application in all the required places. An agent must witness the signature(s). Failure to sign in any required place will result in the company's returning the application to the agent. The agent must secure another appointment and witness the applicant's signature(s).
2. If the insured is an adult and they are not the applicant, they must also sign the application in all required places in the presence of an agent.
3. If someone other than the applicant or insured is designated as the owner of the policy, they must sign the application in the presence of the agent.
4. If an irrevocable beneficiary is named in the policy, they must sign a special irrevocable beneficiary form in the presence of the agent.

B. Corrections on the Application

Corrections should be made by lining through the wrong information and having the applicant initial the inserted corrected information. Correction fluid cannot be used.

C. Incomplete Applications

If an application is sent to any insurance company with incomplete information it will be returned to the agent and issuance will be delayed.

If an insurance company issues a policy with incomplete information in the application the company has waived the right to contest that part of the application. (If a policy is issued without a copy of the application, the company cannot later void the policy because of misrepresentation.)

D. Backdating of Applications

Life insurance applications can be backdated in most states, including Texas, for up to six (6) months to save age. The premiums for the months the application is backdated must be paid.

E. Conditional Receipt.

In life insurance, an applicant is given a conditional receipt when the premium is paid at the time of application. The conditional receipt states that, if the person to be insured dies before the company can decide whether or not they will accept the risk, the company will pay (up to the limits stated in the receipt) conditioned on the fact that they would have issued the policy if they had only had the time to do so.

XII. UNDERWRITING AND POLICY DELIVERY

A. Underwriters

Home Office Underwriters are professionals who work in the home office of insurance companies and are trained and experienced in evaluating risks for the company. Some companies allow their agents to act as Field Underwriters in some restricted cases involving limited coverage policies. The Field Underwriter can visually observe the applicant.

B. Factors used by underwriters in evaluating risks include: Age, sex, marital status, occupation, health, medical history, moral character (a person convicted of fraud and embezzlement would not be a good risk), financial state, income and residence.

C. Attending Physicians Statement (APS)

One of the basic sources an underwriter uses in evaluating a risk is the information supplied by an attending physician regarding the health history of the applicant. Many regard the APS as the most important single source of underwriting material.

D. Medical Information Bureau (MIB)

The MIB is a nonprofit organization owned by insurance companies that serves as a clearinghouse of information on applicants for insurance. The MIB collects information from applications for insurance and shares it by code to member companies.

The purpose of the MIB is to prevent over-insurance and check against erroneous information and misleading information that might be fraudulent.

All members share in a common code that includes:

1. Applicants for life insurance must be informed in writing that the information given to a company might be shared with the MIB.
2. Applicants must sign an "Authorization to Obtain Information" form before a company can share the applicant's file.3. If a company declines to issue a policy to an applicant, they must inform the applicant if information in the MIB files was used. The applicant then has the right to have the MIB disclose the contents of the file. The information is disclosed by the MIB to the applicant's physician who can interpret the information to the applicant.

E. The Fair Credit Reporting Act of 1974 (The Privacy Act)

The requirements of the Act are extensive and apply to insurance companies. The requirements include:

1. Permission must be given by an applicant before information can be released.
2. Applicants must be notified (usually within three days) if an investigative report has been requested by an insurance company.
3. If the application for insurance is denied and an investigative report has been used, the insurance company must furnish the applicant with the name and address of the agency that did the investigation.
4. If requested, the investigative agency - not the insurance company - must disclose the information in their report to the applicant.
5. If the applicant disagrees with something in a report, they have the right to place their statement of the difference in the file and it must be included in any later use of the file.

F. Substandard Risk

When a life insurance company concludes that a person is in substandard health, they may issue a policy and charge an extra premium. This called a "rated" policy. If the insured dies, the beneficiary receives the full face amount because there is no exclusion. The extra premium compensates the insurance company for the additional risk. There are generally three levels of risk classifications:

1. *Preferred risks* would only be assigned to persons with excellent health, non-tobacco users with low risk occupations.
2. *Standard risks* would be assigned to those in average health, average occupations, etc.
3. *Substandard risks* are those who are judged to have some health issues that could allow them to be insured by paying an additional premium.
4. *Declined risks*. Those applicants who fail to meet the underwriting standards established by the insurer are declined for coverage.

NOTE: Group Life Insurance will be covered under Group Health Insurance.

XIII. BUSINESS AND LIFE INSURANCE

A. Three types of businesses:

1. Sole Proprietorship - Owned by one person. Their personal assets and business assets are not separated.
2. Partnerships - A legal relationship has been established between the owners.
3. Corporations - They are legal *persons* existing legally and separately from owners.

B. Life Insurance Contracts Used In Business

1. The Entity Purchase Buy-Sell Agreement.
The business entity (partnership or corporation) buys life insurance on partners or stockholders so that the entity can purchase the share of business owned by a deceased partner or stockholder.
2. The Cross Purchase Buy-Sell Agreement.
The owners agree to a Buy-Sell contract drafted by an attorney so that, when a partner dies, the survivors can purchase the deceased partner's share of the business.

The purchase is often financed through life insurance. The value of the business must be determined (and periodically reviewed) and each partner buys life insurance on the other partner's lives. If there are three partners and the business is valued at \$300,000, each partner will purchase a \$50,000 policy on each of the other partners. If there are three partners, a total of six policies will be needed to finance the agreement. To figure the number of policies needed, subtract one from the total number of partners and multiply that number by the original number. Three partners equals six policies, four partners equals twelve, etc.

Each partner is both the *beneficiary* and the *owner* of the policies he or she purchases on the other partners.

3. Section 303 Redemption.
The IRS allows a corporation to purchase part of the stock from an owner's estate to help pay death taxes and funeral expenses. This can be funded by life insurance.

4. Key Employee Insurance.

Life insurance is purchased on a valuable employee and, in case of death; the company receives the death benefit of the life insurance to compensate them for their loss. The premiums are not tax-deductible to the company and the company is not liable for taxes on the death proceeds they receive.

5. Deferred Compensation.

An incentive plan to pay funds at a later date, usually during retirement. The plan can be funded by life insurance and is sometimes called "executive compensation."

8. Split-Dollar Insurance.

Split-dollar life insurance is an arrangement for providing funds for individually issued cash-value life insurance. It is a funding method, not a type of policy. The arrangement divides (splits) the death benefit, the living benefits and possibly the premium between two parties. The idea behind this plan is to bring together two parties, one having a need for insurance and the other having the ability to pay premiums. Usually, the employee's spouse is the beneficiary but the employer would be reimbursed for the share of premiums they had paid.

XIV. TAXES AND LIFE INSURANCE

The U.S. Government has recognized that it is good public policy to encourage the sale of life insurance for the protection of families in the event a provider dies prematurely.

A. Premiums that are *not* deductible

Almost all premiums for life insurance are not deductible.

1. Personal life insurance.
2. Business life insurance purchased on a key employee.

B. Premiums that *are* deductible

1. Premiums paid for life insurance owned by a qualified charity.
2. Premiums paid by an ex-husband as part of court ordered alimony.
3. Premiums paid by a *creditor* to secure a debt.
4. Group term life insurance paid by an employer can be deducted by the employer under certain conditions. The employer must not be the beneficiary of the insurance.

C. Proceeds of Life Insurance

1. When an insured dies and the proceeds are paid to a beneficiary lump-sum, the funds are not subject to income taxes.
2. If the proceeds are held by the company and paid out in installments, the *interest* is taxable; the original death benefit is not.
3. Dividends left to accumulate with interest will have the interest taxed; not the original dividend.
4. When there is a *Transfer of Benefits* in the proceeds to life insurance for a valuable consideration, the death proceeds lose their income tax exempt status.

D. Life Insurance and Estate Taxes

Upon an insured's death, the amount of life insurance is part of the insured's gross estate for *federal estate tax* purposes. The proceeds are not subject to federal income taxes, however.

E. Third-Party Ownership of Life Insurance

When life insurance is owned by someone other than the insured, it is called Third-Party ownership. The insured and insurance companies are the first two parties. This could be a Juvenile policy, a corporation taking out a life insurance policy on their president, or a husband making his wife the owner of the policy that insures his life. The husband would be keeping the life insurance out of his estate for a possible estate tax savings. Third-Party ownership may be established when the insurance is applied for or may be accomplished at a later time by assignment.

Life insurance proceeds are usually paid to the beneficiary income tax free. One exception to this is the *transfer of value rule*. If person A sells their life insurance policy to person B for \$2,000 and person B agrees to pay the premiums, upon the death of person A person B would receive only the \$2,000 and the amount of premiums B paid income tax free. The remaining death benefit would be taxable.

F. Modified Endowment Contract (MEC)

Modified Endowment Contracts are Whole Life policies (or annuities) that have been penalized by the Internal Revenue Code, since 1988, because they accumulate cash values too quickly within the first seven (7) years they are in effect.

1. The first seven (7) years of cash accumulations determines whether or not the policy is, in fact, a MEC rather than a regular whole life policy. This is called, by the IRS, the "*seven pay test*". If after the policy has been in force for seven years, a material change is made in the investment plan, the policy could enter another seven pay test period.
2. If a policy is considered a MEC by the IRS, it will be considered one "forever."
3. Whenever a MEC is cash surrendered, the penalty is ten (10) percent.
4. One way for the insured to escape the tax and the penalty is to die. The beneficiary would receive the face amount of the policy without any taxes or penalty being due.

XV. SOCIAL SECURITY

Social Security was established in 1935 to provide a minimum floor of protection to all working citizens who face financial problems caused by death, disability and old age. The official title, "Old Age Survivors and Disability Insurance" expresses much of its intent. The purpose was not to replace, but to assist sound financial planning. It is not welfare, but a social insurance plan for all working Americans who meet minimum requirements.

A. Most Americans who are employed or self-employed are covered. Exceptions:

1. Most federal employees hired before 1984 who are covered under a different plan.
2. Some state and local government employees who have chosen to be covered under state pension plans.
3. Railroad workers covered under a separate federal plan called the Railroad Retirement System.

B. Eligibility Requirements

1. Social Security is funded by payroll taxes. As a person works and pays taxes, "credits" are earned toward Social Security eligibility. A maximum of four credits can be earned each year.
2. Forty credits (10 years of work) are needed to qualify for benefits.

C. Types of Social Security Benefits

1. Death Benefit - When an eligible worker dies, a lump sum death benefit (maximum of \$255) is paid to a surviving spouse or children.
2. Widow or Widower's Benefit - A surviving spouse is entitled to a monthly life income equal to the worker's PIA at death.
3. Child's Benefit - A child under the age of 18 may receive a benefit equal to 75% of the worker's PIA upon the death of the parent. The benefit will be paid until the child reaches 18 (or 19 if still in high school).
4. Retirement Benefits - Benefits are payable at full retirement age (with reduced benefits available as early as age 62) for anyone with enough Social Security credits. The full retirement age is 65 for persons born before 1938. The age gradually rises until it reaches 67 for persons born in 1960 or later. People who delay retirement beyond full retirement age get special credit for each month they don't receive benefits until age 70.
5. Disability Benefits - Eligible workers may receive disability benefits, regardless of age, if they are disabled following a five month waiting period. The disability must be expected to last for twelve months and they must be disabled for five months before benefits would begin.

XVI. QUALIFIED RETIREMENT PLANS

Qualified retirement plans meet the guidelines in the Internal Revenue Code for important tax considerations. The rules include requirements that the plan be written, provide for vesting and be nondiscriminatory. A plan is considered "Top-Heavy" (discriminatory) if benefits going to key employees exceed 60 percent of values going to other employees. Vesting refers to the employee having ownership of funds contributed by the employer. Under the Tax Reform Act of 1986, vesting must be either full vesting (100%) after a participant completes five (5) years of service with an employer or vesting of 20% after the completion of three (3) years of service with an employer, increasing by 20% each year of service thereafter, until 100% vesting is achieved at the end of seven (7) years of service. If an employee leaves a company when he/she is only 40% vested, they could not take the 60% of the funds with them that had been contributed by their employer. The employer may invest the funds but is not allowed to use the funds for operational business expenses.

A. Examples of qualified plans include:

1. 401(k). Employers may contribute to a 401(k) plan and deduct their contributions from their taxes as a business expense. Employee elective contributions are tax deferred, up to a limit. The earnings in the fund (interest) are tax deferred. As in all qualified plans, the income tax will be paid on the principal and the interest by whomever (original employee or a beneficiary) receives the funds when they are paid out. 100% is taxable.
2. 403(b) Tax Sheltered Annuity (TSA). This qualified annuity was originally planned for public school employees. It was later extended to churches and certain other tax exempt organizations in section 501(c)(3) of the Internal Revenue Code. An employee of an authorized organization purchases the annuity. Funds can be withheld from the employee's salary as a *voluntary salary reduction* up to a certain limit and be tax sheltered until the money is paid out at retirement. Both the principal and the interest are tax sheltered until retirement.
3. Keogh (HR-10). Keogh plans are special retirement plans for self employed persons. New laws have brought these plans under the same general rules as regular pension plans.
4. Simplified Employee Pension (SEP). After 1978 employers were allowed to establish a Simplified Employee Pension (SEP). These are sometimes referred to as SEP-IRAs because they use an IRA funding vehicle. A SEP is a written plan where an employer, based on an IRS formula, contributes funds into an IRA for the employee's pension. Contributions are tax deductible as a business expense to the employer, employee contributions are tax sheltered and the interest earned is tax deferred.

5. Individual Retirement Accounts (IRAs). A traditional IRA is an account established by an individual who has *earned income*. The contributions are deductible from taxable income and the interest accumulations are tax deferred. Guidelines:
 - a. Maximum annual contribution is \$5,500 for the 2014 tax year (\$6,500 if age 50 or older), or up to 100% of earned income, whichever is less.
 - b. A *separate* Spousal IRA can be established for a spouse who has no earned income. This IRA contribution is subject to the same limits stated above. Therefore a married couple where only one spouse has earned income could establish two separate IRAs.
 - c. No contributions after age 70½.
 - d. A Roth IRA may be opened with after tax dollars (no income tax deduction taken), allowing the funds to grow with no income tax liability ever being attached. Qualified distributions may be taken after the account is five years old under the following conditions: upon the death of account holder, paid to the designated beneficiaries; upon the disability of the account holder; first time home purchase subject to a \$10,000 lifetime cap.

B. Principles in most Qualified Retirement Plans

1. Most qualified funds would have taxes due on 100% of the fund in the taxable year the money was withdrawn because all of the principal and interest had been deferred.
2. There is a penalty for withdrawing most qualified funds before age 59½. The penalty is 10% in added to whatever taxes are due. The penalty is not applied in cases of death, disability and some annuitized payouts. Additional exceptions to the penalty allows IRA holders to take penalty free distributions from their IRA to pay for:
 - a. Medical expenses exceeding 7.5% of adjusted gross income.
 - b. Health insurance if an individual has been receiving unemployment compensation for more than twelve (12) weeks.
3. There is a penalty for failing to withdraw qualified funds after age 70½. The IRS requires a certain amount, based on mortality tables, be withdrawn each year. Failure to withdraw the funds results in a 50% penalty on the funds that are not withdrawn. If a person is required to withdraw \$10,000 annually and only withdraws \$5,000 the penalty would be \$2,500 (50% of the amount that was not withdrawn).

- C. Section 457 of the Internal Revenue Code allows employers to set up a plan of deferred compensation for employees. It is mutually agreed that compensation is reduced during the working years so that the money, with interest, can be paid to the employee during retirement. Since the fund is owned and controlled by the employer, the plan is sometimes referred to as "golden handcuffs."
- D. Section 1035 of the Internal Revenue Code governs how qualified funds can be rolled over from one company to another. The transfer should be with the same type of contracts. For example, a variable life insurance account should be transferred to another company into a variable life insurance contract. The exchange (rollover) must be completed within 60 days and the owner should not take control of the funds. The IRS calls such controls *constructive receipt* and could bring penalties and loss of tax-deferred status for the funds. The IRS will regard the exchange as a *no gain-no loss* transaction, meaning that any gain will not be taxed in the year the transaction takes place and no loss could be deducted.
- E. Nonqualified Plans

Nonqualified plans do not contain the tax deferral advantages of the qualified plans. Nonqualified plans are financed with after tax dollars. Most annuities are nonqualified. Only the interest accumulations on these plans are tax deferred. An example would be a nonqualified fixed annuity. Only the interest would be tax deferred. The interest income would be taxable as the benefits are paid to the annuitant and based upon the amount of interest in each payment. The principal would not be subject to taxes because after tax dollars were used.

EXAMINATION

SCORE _____

SCORE SHEET: Circle the correct answer

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

PRACTICE EXAMINATION

Life Insurance

1. If all factors are equal, which pair of the following co-annuitants would receive the highest monthly amount on a joint annuity with a one hundred percent survivorship option?
 1. Ages 48 and 72.
 2. Ages 66 and 71.
 3. Ages 65 and 68.
 4. Ages 70 and 65.

2. How many years does the IRS code use to determine if a life insurance or an annuity contract is, in fact, a Modified Endowment Contract (MEC)?
 1. Two (2) years.
 2. Three (3) years.
 3. Five (5) years.
 4. Seven (7) years.

3. If the IRS considers an insurance contract or annuity to be a Modified Endowment Contract (MEC), how long would it be considered such?
 1. Forever.
 2. Seven (7) years.
 3. Until the cash values fall below a certain corridor.
 4. Ten (10) years.

4. An Automatic Premium Loan would be possible in all of the following policies EXCEPT:
 1. Term.
 2. Endowment.
 3. Whole Life.
 4. Life Paid-up at 65.

5. A young man who is twenty years old is considering buying one of the following policies and each would have a face amount of \$100,000. Which one of these policies would accumulate cash value the fastest?
 1. Five year term.
 2. Whole Life.
 3. Endowment at 65.
 4. 20 Pay Life.

6. If a person buys a life insurance policy that allows an increase in the face amount as the Cost Price Index (CPI) rises with no evidence of insurability required, they have purchased
 1. Indexed Whole Life.
 2. Enhanced Ordinary Life.
 3. Current Assumption Life.
 4. Modified Life.

7. If an individual were seeking to buy a Whole Life policy that would allow the cash values to increase above the guaranteed levels if the company's profits exceed expectations, which of the following would they choose?
 1. Economatic.
 2. Indeterminate Premium.
 3. Current Assumption.
 4. Graded Premium.

8. All of the following statements are required of Indeterminate Premium policies EXCEPT:
 1. If the non-guaranteed rate is used in advertising, the magnum premium must be equally displayed.
 2. It must be stated clearly that the premium may be changed.
 3. The frequency of possible changes need not be stated.
 4. Premium changes may not be made more than once in a policy year.

9. Kim owns an annuity. She has it on John. Several years after she purchased the annuity, she made Terry the beneficiary. What is John?
 1. Owner.
 2. Beneficiary.
 3. Payer.
 4. Annuitant.

10. Which one of the following statements best describes a Graded Premium life insurance policy?
 1. The premium will make one increase during the life of the policy.
 2. The premium remains the same, the benefits are graded according to the age at death.
 3. The premium increases each year for five years and then levels off.
 4. The premium goes up every year but the benefits are level.

11. In order to change an insurance policy, the agent must
 1. Have the client initial the changes.
 2. Discuss the changes with the client by phone and make certain the changes are understood.
 3. Submit a request for any change on a change form that is sent to the home office of the insurance company.
 4. Have the client sign an addendum to the policy.

12. Which of the following is an example of Limited Pay Life policy?
 1. Whole Life.
 2. Variable Life.
 3. Adjustable Life.
 4. 30 Pay Life.

13. All of the following statements are true concerning Joint Life policies EXCEPT:
 1. Covers two lives on one policy.
 2. The survivor's policy is cancelled.
 3. The survivor's policy is automatically reissued without any proof of insurability required.
 4. Pays only on one life if the two insured's die simultaneously.

14. Which of the following policies has a fixed premium?
 1. Adjustable Life.
 2. Universal Life.
 3. Variable Life.
 4. Variable Universal Life.

15. The statement that best describes the Free Look provision:
 1. An agent should deliver the policy before the "free look" period expires.
 2. The "free look" is a period of free insurance.
 3. If the premium is not paid during this period, the policy expires.
 4. The purchaser does not have to give a reason for canceling.

16. If a person purchases a life insurance policy with a \$100,000 face amount, pays the premium for eighteen (18) months, then commits suicide, the insurer will pay
1. \$100,000.
 2. \$50,000.
 3. The face amount, less premiums paid.
 4. A refund of the premiums collected.
17. If an insurance company declines to pay a death benefit because the insured's death was caused by an act of war, they would be applying which policy provision?
1. Consideration.
 2. Accidental Death Benefit.
 3. Exclusion.
 4. Reinstatement.
18. An individual purchases a Whole Life policy and allows the policy to lapse. It may be reinstated unless
1. A policy loan had not been paid.
 2. The premium was over 180 days late.
 3. The policy was surrendered for its cash values.
 4. The policy was still in the Contestable Period.
19. A buyer submits an application for life insurance with the first month's premium. The next day the buyer dies. All of the following statements are true EXCEPT:
1. The company may decline to pay.
 2. The company may pay the full face amount.
 3. The company may pay less than the face amount.
 4. The company will pay a Capital benefit.
20. The best description of a Conditional Receipt would be that the company had a responsibility to pay
1. Pending company approval.
 2. If no premium was involved.
 3. Because there is temporary insurance.
 4. If the agent had bound coverage.

21. Which of the following has a premium payment period longer than the term riders?
1. Family policy.
 2. 20 Pay Life.
 3. Whole Life.
 4. Jumping Juvenile.
22. H purchased a life insurance policy and made M sole beneficiary. M died before H. When H dies, the death benefit would be paid to
1. M's three children, per capita.
 2. Probate court.
 3. H died intestate; the Probate Court would escheat the death benefit to M's estate.
 4. H's estate.
23. John withdrew \$15,000 from a 403(b) Tax Sheltered Annuity into which he had contributed \$12,000. Which of the following amounts would be liable for income taxes?
1. \$12,000
 2. \$15,000
 3. \$8,000
 4. \$3,000
24. A term rider can be added to a Family policy on
1. The primary insured only.
 2. A beneficiary.
 3. A nephew not being supported by the primary insured.
 4. A dependent child until he/she reaches a certain age.
25. A woman who is 60 years of age withdrew money from her 401k account and several months later rolled it over into another account. What would be her tax liability?
1. The money is subject to taxation.
 2. There is no tax liability.
 3. There is a ten percent penalty.
 4. The money is subject to taxes and penalties.

26. Which of the following circumstances would allow a person to apply for benefits under an accelerated death benefit clause of a life insurance policy?
1. A policy owner decides to sell their life insurance to a third party.
 2. An insured is planning to undergo cosmetic surgery and borrows the cash values from their life insurance policy.
 3. An insured has an automobile accident and will be on crutches for two months.
 4. An insured has back surgery and will be laid up for two years.
27. L buys a \$10,000 life policy on February 1st and pays a \$200.00 annual premium. The following February, L fails to pay the premium. L dies on February 28th. The beneficiary would receive a minimum of
1. Nothing.
 2. \$200.00.
 3. \$9,800.00.
 4. \$10,000.00.
28. All of the following statements are correct concerning the waiver of premium on a life insurance policy EXCEPT:
1. For the rider to pay the disability must be total and permanent.
 2. The rider will not apply if a disability arises after the insured reaches age 60.
 3. There is a waiting period between three to six months to establish disability..
 4. All life insurance policies have waiver of premium in them.
29. If an insurer requires a blood test from an applicant, which of the following would be required?
1. That the applicant sign a written consent form.
 2. That the applicant pay for the test
 3. That the applicant sign a waiver of privacy rights.
 4. That the applicant agrees the insurer can share the information with others.
30. An Adjustable Life policy would be the best suitable policy for
1. A 62 year old retiree who wants to accumulate funds to pay estate taxes.
 2. A 44 year old government employee who wants additional retirement funds.
 3. A 36 year old real estate agent with fluctuating income.
 4. An eight year old child who wants funds for college.

31. M purchases a \$50,000 Level Term to 70 policy at 28 years of age. Six years later, M changed the policy to Whole Life. Which of the following terms best describes the original policy?
1. Adjustable.
 2. Modified.
 3. Flexible.
 4. Convertible.
32. When a policyholder borrows from the cash value, the money comes from
1. The insurance company's funds.
 2. The policy.
 3. The Guaranty Association.
 4. General Fund of the Texas Department of Insurance (TDI).
33. If an agent makes a mistake on an application, the proper procedure would be to
1. Use white-out.
 2. Start over with a new application.
 3. Line through the incorrect information and have the applicant initial the changes.
 4. Ignore the mistake and continue.
34. In a qualified retirement plan, money must be withdrawn after age 70½ or a penalty must be paid. How much is the penalty?
1. 10%.
 2. 20%.
 3. 50%.
 4. There is no penalty after age 70½.
35. Under the "offer and acceptance" rule of insurance contracts, which one of the following statements is the most accurate?
1. The prospective insured offers, the insurer accepts or declines.
 2. The insurer offers, the prospect accepts or declines.
 3. The insurer offers and the agent changes the contract to fit the prospect's needs.
 4. The insurer offers and the applicant offers and the agent mediates.

36. All of the following would have an insurable interest EXCEPT:
1. Son-in-law.
 2. Wife.
 3. Business partner.
 4. Creditor.
37. Postmortem expenses include all of the following EXCEPT:
1. Funeral expenses.
 2. Medical expenses associated with dying.
 3. Current bills upon death.
 4. Mortgage payments.
38. N purchased a life insurance policy that had a premium increase in the twenty-first year of the policy's life. N had purchased
1. Twenty Pay Life.
 2. Five Year Term.
 3. Twenty Year Endowment.
 4. Whole Life.
39. What is an advantage in purchasing a flexible premium annuity?
1. The owner can change premiums as his or her income changes.
 2. The owner can begin an immediate payout period.
 3. The owner can determine, at time of purchase, how much money will be accumulated in the fund at their projected retirement age.
 4. There are no advantages, only disadvantages.
40. The tax liability on Endowment policies is for
1. The full face amount of the policy.
 2. The premiums paid.
 3. The difference between the premiums and the face amount.
 4. The premiums only.

41. N is a successful stock broker who has held a securities license for many years. N wishes to purchase a life insurance product that would allow the use of N's knowledge of securities. N's agent would recommend
1. Variable Life.
 2. Universal Life.
 3. Adjustable Life.
 4. Graded Premium Life.
42. If a company purchases a Key Person life insurance policy on a valuable employee and that employee later dies, what would be the company's income tax liability on the death proceeds they received?
1. The company would be liable for taxes on the amount exceeding their costs.
 2. The company would be liable for taxes on whatever they received.
 3. Since the company would not have deducted the premiums from their income taxes, there would be no tax liability.
 4. Taxes would be shared between the company and the employee's estate.
43. The main reason agents are concerned that a Term policy be renewable and convertible is
1. Persistency is better.
 2. Commissions are higher.
 3. A good selling point.
 4. Insurability is not an issue.
44. Life insurance premiums are not deductible tax items for individual buyers. For this reason, how are the proceeds viewed for tax purposes?
1. They are taxable.
 2. They are not taxable.
 3. The difference in premiums and face amount is taxable.
 4. The face amount minus the cash value is taxable.
45. If a Whole Life insurance policy is cash surrendered
1. All of the amount received is taxable.
 2. None of the amount received is taxable.
 3. The amount that exceeds the premium is taxable.
 4. Only the dividends are taxable.

46. If a policy has a face value of \$1,000 or less and the agent collects the premium weekly, it is
1. Modified Premium.
 2. Industrial Life insurance.
 3. Jumping Juvenile.
 4. Graded Premium.
47. Which of the following statements best describes an annuity?
1. Creates an estate.
 2. Designed to give death benefits.
 3. Has no tax advantages.
 4. Liquidates an estate.
48. If an annuitant wishes for payments by the company to begin immediately, the premium choice would have to be
1. Single.
 2. Level.
 3. flexible.
 4. Modified.
49. If money placed in a Tax Sheltered Annuity is taken out before retirement, a penalty could result. The cut-off age is
1. 59½.
 2. 62.
 3. 65.
 4. 70½.
50. W is a sales clerk in a department store. W wishes to purchase an annuity to supplement retirement income. W seeks a minimum of risk and desires to place various amounts of premium in the annuity, depending upon commissions earned on their job. Which annuity should W purchase?
1. Single premium, immediate, variable.
 2. Flexible premium, deferred, fixed.
 3. Level premium, deferred, fixed.
 4. Tax-Sheltered Annuity (TSA).

51. Which one of the following statements best describes the Entire Contract?
1. Contains the company's promise to pay.
 2. States the insured's promise to pay.
 3. All riders, endorsements and amendments.
 4. The policy plus a copy of the application and all attached papers.
52. T purchased a life insurance policy on a monthly bank draft and the agent delivered the policy to T on the first day of June. T's Free Look period would be up on
1. June 30th.
 2. July 11th.
 3. June 11th.
 4. June 8th.
53. An irrevocable beneficiary might be used in
1. Most life policies.
 2. Group life insurance.
 3. Life insurance used for charitable giving.
 4. States where it is legal.
54. Wilma Rudd purchased a life insurance policy on her life. She wishes her husband Sam to be the first one to receive the money, her daughter Toni to be second in line and her sister Harriet to be next.
1. Sam is primary, Toni tertiary, Harriet contingent.
 2. Toni is primary, Sam tertiary, Harriet contingent.
 3. Sam is primary, Toni is contingent, Harriet tertiary.
 4. Harriet is primary, Toni contingent, Sam tertiary.
55. If an insured names "all my children" as beneficiaries, they may designate the beneficiaries in the following way if they wanted the grandchildren to step up and take a deceased parent's place.
1. Per stripes.
 2. Per capita.
 3. Irrevocable.
 4. Tertiary.

56. When the death proceeds are held by the company under a settlement option, the money is protected from lawsuits by creditors because of the
1. Spendthrift clause.
 2. Incontestable clause.
 3. Ownership provision.
 4. Beneficiary designation.
57. The clause in a life insurance policy that prohibits an insurance company from denying payment of a death claim after the policy has been in force a specified period of time is called
1. Insuring clause.
 2. Misstatement of age clause.
 3. Incontestability clause.
 4. Reinstatement clause.
58. A person bought a life insurance policy and misstated their age on the application. After paying premiums for five years, they died. Because the company discovered a misstatement of age, it would pay the beneficiary
1. The amount of insurance the premiums he had paid the company would have purchased at the correct age.
 2. The full face amount since he had paid on the policy more than two years.
 3. A return of the premium.
 4. Nothing.
59. If Mary purchases an annuity and Betty is the beneficiary and Paul and Greg are co-annuitants, on whose life or lives would the payout be underwritten?
1. Mary and Betty.
 2. Mary.
 3. Betty.
 4. Paul and Greg.
60. Grace periods are determined by
1. The choice of the company.
 2. The mode of premium payment.
 3. The choice of the applicant.
 4. The numbers of riders on the policy.

61. The reason an insured might reinstate a life policy that had been lapsed up to three years is
1. Sentimental attachment to the policy.
 2. To avoid proving insurability.
 3. To help the agent's persistency.
 4. To save age.
62. An automatic premium loan provision is permission by the policy-owner for the company to make a loan from the cash values to pay a premium accidentally overlooked and is available on which of the following policies?
1. Accident only.
 2. Term to 65.
 3. Five year term.
 4. Whole life.
63. Gerald Wilson has a \$100,000 life insurance policy. To cover a \$20,000 loan, Gerald makes a collateral assignment to the bank. If Gerald dies, his beneficiary would receive
1. \$20,000.
 2. \$80,000.
 3. \$100,000.
 4. \$50,000.
64. If an insured becomes disabled, the insurer would waive collection of premium if the policy had which one of the following riders?
1. Waiver of premium rider.
 2. Payor rider.
 3. Disability income rider.
 4. Guaranteed insurability rider.
65. A person purchased a life insurance policy with a \$10,000 face amount with a triple indemnity for accidental death. After having the policy for five years, they were in a bus accident and died four months later. The policy would pay
1. \$30,000.
 2. \$10,000.
 3. \$20,000.
 4. Nothing.

66. A payor rider is associated with
1. Disability of the insured.
 2. Guaranteeing insurability.
 3. Juvenile insurance.
 4. Group life policies.
67. Guaranteed Insurability Riders could best be described as
1. The option to buy specified amounts of life insurance at any time.
 2. The option to buy as much life insurance as you wish.
 3. The option to buy specified amounts of life insurance at designated times if you prove insurability.
 4. The option to buy specified amounts of life insurance at designated times regardless of your health.
68. A life insurance policy that might be purchased by parents to help their children pay estate taxes is
1. Joint Life.
 2. Adjustable Life.
 3. Joint Life and Survivorship.
 4. Single Premium Immediate Annuity.
69. Which one of the following annuities would have no accumulation period?
1. Variable.
 2. Deferred.
 3. Fixed.
 4. Immediate.
70. The maximum amount an individual may deduct from income taxes annually in an IRA for the taxable year 2009:
1. \$2,250.
 2. \$3,000.
 3. \$5,000.
 4. Three percent of annual income.

71. The maximum amount that can be tax deducted annually in a joint tax return where one spouse has an IRA and the other spouse has no earned income but also has an IRA is
1. Six percent of combined annual income.
 2. \$2,000.
 3. \$10,000
 4. \$2,500.
72. Which one of the following dividend options would increase the cash value in a life insurance policy?
1. Cash.
 2. Accumulate with interest.
 3. Paid-up additions.
 4. One year term.
73. If an insurance company orders an inspection report on an applicant, all of the following statements are true EXCEPT:
1. The applicant must sign an authorization before information can be collected.
 2. The applicant can get a copy of the report from the insurance company.
 3. The insurance company must tell the applicant the source of the information.
 4. The applicant can get a copy of the report from the company that developed the inspection report for the insurance company.
74. Which of the following non-forfeiture options will continue to give the owner access to cash values?
1. Extended term insurance.
 2. Paid-up additions.
 3. Reduced paid-up insurance.
 4. Cash surrender.
75. A person owned a Whole Life policy with \$10,000 of accumulated cash values. The face amount of the policy was \$100,000. The cash values of \$10,000 were borrowed, and an annual simple interest of eight percent was charged. One year after the loan was made, the person died. None of the loan or interest had been repaid. The beneficiary would receive
1. \$100,000.
 2. \$ 89,200.
 3. \$ 90,000.
 4. \$ 50,000.

76. A mother purchases a Jumping Juvenile life insurance policy on her three-year-old daughter with a face amount of \$2,000. When the child reaches 21 years of age, all of the following statements are true about the policy EXCEPT:
1. The face amount will jump to \$10,000.
 2. There will be no increase in premium.
 3. Evidence of insurability is required.
 4. No evidence of insurability is required.
77. Which of the following statements is true concerning dividends?
1. Stock companies never pay them.
 2. They are usually guaranteed.
 3. They are the cash values in the policy.
 4. The IRS regards them as a refund of premium.
78. An insurable interest must be shown
1. When the insurance is applied for.
 2. When the insured dies.
 3. On any anniversary of the policy.
 4. When an insurance company requests that it be shown.
79. When does a Joint Life Insurance Policy pay the death benefit?
1. When the second person dies.
 2. When the first person dies.
 3. When there has been a simultaneous death.
 4. When the policy endows.
80. A Joint Credit Life would allow which of the following to be on the policy?
1. Husband and wife.
 2. Neighbors.
 3. Father and son.
 4. Mother and daughter.

81. If three business partners decide to enter into a buy-sell agreement funded by life insurance, how many total life policies would be required?
1. One.
 2. Two.
 3. Three.
 4. Six.
82. If a business agrees to help an employee buy life insurance on the employee's life and upon the employee's death, the company would be refunded premiums paid and allow the employee's family to receive the death benefit it is called
1. Deferred compensation.
 2. Key person insurance.
 3. Qualified Retirement Plan.
 4. Split-dollar insurance.
83. Which one of the following is the most accurate definition of net premium?
1. Mortality costs plus assumed interest.
 2. Mortality costs minus assumed interest.
 3. Mortality costs plus loading.
 4. Mortality costs minus loading.
84. A settlement option that would allow a primary beneficiary to receive a monthly income and yet preserve the full death benefit for the contingent beneficiaries upon the primary beneficiary's death is called
1. Fixed period.
 2. Fixed amount.
 3. Interest only.
 4. Life income with no refund.
85. All of the following are characteristic of Fraternal Benefit Societies EXCEPT:
1. They have a representative form of government.
 2. They are organized into lodges.
 3. They are nonprofit.
 4. They issue Capital stock.

86. When is the interest income taxable on a deferred fixed annuity?
1. Contributions are not deductible but the interest is never taxable.
 2. Contributions are deductible and interest is taxable only when withdrawn.
 3. Contributions are not deductible and the interest is taxed when withdrawn.
 4. Interest is taxable each taxable year the interest accumulates.
87. Who purchases a tax sheltered annuity (TSA)?
1. A third party assigned by the authorized organization as an agent.
 2. The authorized organization.
 3. The beneficiary of the annuity.
 4. An employee of an authorized organization.
88. Which one of the following life insurance policies allows a partial surrender?
1. Variable life.
 2. Universal life.
 3. Whole life.
 4. Group term.
89. Premiums for Group Credit Life are usually based on
1. A flat rate unrelated to the borrower's age.
 2. The borrower's age at the date of final debt repayment.
 3. The borrower's age at the time the debt is incurred.
 4. The borrower's average age while the debt is being repaid.
90. If an annuitant chooses a payment option that has a guaranteed minimum of payments, as for example, fifteen years, which of the following was chosen?
1. Joint Life option.
 2. Straight Life Income option.
 3. Period Certain option.
 4. Installment Refund option.

91. Which one of the following statements best describes gross premium?
1. Net premium with loading charges added.
 2. Mortality plus assumed interest and loading charges.
 3. Mortality minus loading.
 4. Mortality plus loading.
92. The least expensive way to pay for life insurance would be
1. Annually.
 2. Semi-annually.
 3. Quarterly.
 4. Monthly.
93. If an agent submitted an application to the home office of an insurance company and the underwriter discovered that the applicant had failed to sign the application in one of the required places, what would the company do?
1. Issue the policy and ask the agent to get the signature when the policy is delivered.
 2. Mail the application back to the agent and have the agent make an appointment with the applicant and obtain the signature.
 3. Mail a copy of the application to the applicant and ask them to sign.
 4. Mail the application to the applicant and ask them to sign it and return to either the company or the agent.
94. Life insurance applications can be backdated up to
1. One month.
 2. Two months.
 3. Three months.
 4. Six months.
95. Who is required to show an insurable interest?
1. Applicant.
 2. Insured.
 3. Agent.
 4. Beneficiary.

96. In a Group Credit Life policy, who is the owner of the policy?
1. The creditor.
 2. The debtor's beneficiary.
 3. The debtor.
 4. The group.
97. Who pays the premiums for a Group Credit Life policy?
1. The creditor.
 2. The beneficiary.
 3. The debtor.
 4. The group.
98. A widely used rating service for insurance companies is
1. IBM
 2. Insider Reports.
 3. A.M. Best.
 4. NASDAQ.
99. A type of qualified retirement plan that allows an employee of a public school to choose a reduction in their current salary by deferring amounts into a retirement plan is called a
1. 401(k) Plan.
 2. Simplified Employee Pension (SEP) Plan.
 3. Keogh (HR-10) Plan.
 4. 403(b) Plan.
100. If a person is planning to exchange an existing policy for a new one and wishes to comply with the federal tax code to avoid any tax liability, which section of the IRS Code would they consult?
1. 403(b).
 2. 1035.
 3. 2035.
 4. 401(k).

LIFE INSURANCE

Key

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

HEALTH INSURANCE

I. INTRODUCTION

- A. The term "health insurance" refers to different types of coverage
 - 1. Hospital, medical and surgical expenses caused by illness or accident.
 - 2. Accidental death and/or dismemberment.
 - 3. Disability (sometimes called loss of income or loss of time caused by accident or illness).
- B. "Accident and Health" (A & H) and "Accident and Sickness" (A & S) are terms that are used interchangeably.
- C. It is important to concentrate on what type of health policy will pay for what type of loss. For example, a disability income policy will not pay for the health costs involving a diagnosis of disability. The policy is designed to pay monthly income benefits when the insured is disabled, cannot work and has lost their income.
- D. Principal Types of Losses and Benefits
 - 1. Loss of income from disability.
 - 2. Medical expense.
 - 3. Dental expense.
 - 4. Long-term care expense.
- E. Classes of Health Insurance Policies
 - 1. Individual versus group.
 - 2. Private versus government.
 - 3. Limited versus comprehensive.

II. TYPES OF HEALTH POLICIES

A. Limited Policies

Limited policies refer to the coverage being limited to a narrowly defined area. An Accident Policy would limit payment to a loss caused by an accident. The policy would not pay for a heart attack. Other examples of limited policies include Dread Disease, Travel, Dental, Cancer and Blanket policies (for students, sports teams, traveling groups, etc.)

B. Accident Policies

Coverage is limited to losses caused by an accident. Accident is defined as an event that is unforeseen and unexpected, causing traumatic damage to the body.

1. "Accidental bodily injury" is a broad definition of accident found in most policies. It is sometimes referred to as the "results" definition. Benefits would be paid if the injury resulting from an accident was unintentional. The policy would pay if someone jumped from a bus and broke their ankle. The jump was intentional, the break was not.
2. "Accidental means" is a more restrictive definition. Benefits would be denied if the insured intentionally does something that causes a loss. A "means" definition requires that both the cause and the results of an accident be unintentional.
3. Accident policies usually pay for accidental loss of life (Accidental Death Benefit - ADB), hospital expenses, surgical expenses required because of an accident and medical expenses.

C. Accidental Death and Dismemberment Policies (AD&D)

AD&D policies have the same basic benefits found in Accident Policies. In addition, they add benefits for dismemberment. Dismemberment is defined as losing a limb "at or above the joint." Sometimes, although rarely, losing the use of a limb qualifies. Also included in dismemberment losses is loss of sight in one or both eyes, loss of speech sometimes and more rarely, loss of hearing. AD&D policies pay two ways:

1. Principal Sum. The Principal Sum in an AD&D policy is the amount paid as a death benefit. It is the maximum amount the policy would pay.
2. Capital Sum. The Capital sum in an AD&D policy is the amount specified (scheduled) in the policy that will be paid if there is a loss of limb or eyesight. It is usually expressed as a percentage of the Principal Sum. The loss of one foot or hand might pay 50% of the Principal Sum. The loss of both eyes would pay 100% of the Principal Sum.

D. Hospital Indemnity (Income) Policies

These policies pay a specified dollar amount while the insured is confined to a hospital room. The amount specified can be paid per day, per week or per month. The money is paid directly to the insured without regard to other insurance and without regard to actual medical bills. If a person purchased a Hospital Indemnity (Income) Policy with a \$100 per day benefit and stayed ten days in the hospital, the policy would pay \$1,000 regardless of other insurance or the charges. (Called Hospital Confinement Policies).

E. Surgical Expense Policies

Surgical Expense Policies pay for medically necessary surgery. Benefits may be paid according to a schedule in the policy or payment may be made on "usual and customary" charges. Many policies base their payments on "reasonable" charges.

1. Schedule.

A schedule in the policy lists almost every type of surgery and states a dollar amount the policy will pay for that procedure.

2. Usual and Customary.

Usual and Customary is defined in the policy as either the average charge in a particular geographical area or the average charge of a specific surgeon.

3. Reasonable.

Reasonable is often used either in the place of Usual and Customary or in union with Usual and Customary. Medicare, for example, states that their "Approved" amount is what is "Reasonable." They base Reasonable on a national fee schedule.

F. Hospital Expense Policies

These policies, sometimes referred to as "Hospital Policies," pay benefits when a patient is required to be hospitalized. They usually pay for several types of charges.

1. Room and Board.

Room and Board charges are usually paid, according to the policy, on one of these bases:

a. Indemnity. A specified dollar amount is stated in the policy that is paid each day the patient is hospitalized.

b. Reimbursement. Reimbursement pays the actual charges for a semi-private room.

2. Miscellaneous Hospital Expenses. Miscellaneous charges can be the major part of a hospital bill. These are almost all hospital charges other than the daily room and board expenses.

G. Major Medical Policies

Major Medical Policies provide broad coverage for all types of losses caused by either an accident or an illness. They possess several important elements:

1. Deductibles.

The deductible is chosen by the insured to keep costs down. Although deductibles may be applied several different ways, the main point is that the deductible amount must be paid by the insured before the insurance company is required to pay. A typical deductible would be \$500. Zero deductibles have virtually disappeared with the rising costs of medical care. A corridor deductible is used in a supplemental major medical plan. After the basic plan benefits are exhausted, the corridor deductible must be satisfied before more benefits would be paid from the basic plan.

2. Coinsurance.

Coinsurance is a sharing of expenses between the company and the insured. The sharing starts after the insured has paid the deductible. The sharing is stated as a percentage such as 80/20, meaning the insurer pays 80% and the insured pays 20%.

3. Stop-Loss.

In order to protect the insured from a catastrophic loss, many Major Medical policies will contain a Stop-Loss. After the insured pays an amount stipulated in the policy, the insurer pays 100% of the rest of the charges.

4. Minimum Texas Standards for Major Medical Expense Coverage include an aggregate maximum benefit of not less than \$10,000.

H. State Mandated Benefits

State mandated benefits include well baby care covering prenatal care, care at birth and postnatal care. *Newborn children must be covered immediately following birth. The mother is required to notify the insurer within 31 days following birth so the child can be added to the insurance coverage for premium purposes.* Adopted children cannot be excluded from benefits. Serious mental illnesses must be covered. Cancellation is prohibited for HIV and AIDS.

I. Disability Income Policies

Disability Income Policies are designed to replace a major portion of income that is lost when a person is totally and permanently disabled.

1. Definitions.

Several key terms are critical to the understanding of Disability Income Policies.

a. Occupation.

1) "Any Occupation."

Some policies require that the insured be disabled to the point where they cannot work at any occupation for which they are reasonably prepared by "education, training or experience." This is a very restrictive definition that allows an insurer broad latitude to deny benefits. Many leaders in the insurance industry believe that these policies should not be sold.

2) "Own Occupation."

A less restrictive definition that serves insureds much better is the "Own Occupation" definition. The insured would receive benefits if they were unable to work at their own occupation they have reasonably been prepared to perform by "education, training or experience." A surgeon who loses the use of the hand she uses in operating on patients would be denied payments under the "Any Occupation" definition, but would receive benefits under the "Own Occupation" policy.

b. Total Disability and Residual Disability.

1) Total Disability.

Most policies require the disability to be "total and permanent" before the benefits would be paid.

2) Residual Disability.

This definition is currently used by most insurance companies for their insured's who have a disability less than total and permanent. The policy connects the benefit payments to the proportion of earnings lost without regard to the insured's occupation

c. Presumptive Disability.

When a person is receiving disability income payments, the company will require medical proof every six months that the disability is continuing. This is not required if the disability is Presumptive. A Presumptive disability would be the loss of two legs or total and permanent blindness.

2. Benefit Amounts.

Disability Income Policies pay a stated dollar amount in benefits in monthly income. The amount is usually 60% of their previous income because the individual buying the policy would not have to pay federal income taxes on the disability income. Most disability income policies will provide for an Adjustment of Benefits clause that would adjust the payments in relation to the earnings of the disabled person.

3. Probationary Period.

All Disability Income Policies will have a Probationary Period that begins on the day the policy goes into effect. It is usually thirty (30) days and the policy will not pay for any disability that arises from sickness during that period of time (Accidents are excluded). The Probationary Period has a one time only application - the first thirty (30) days of the policy's life. It protects the insurance company from "buying a claim" where someone is already ill when the policy goes into effect. Probationary Periods are also found in Long-Term Care Policies.

4. Elimination Period (Deductible).

An elimination period specifies a period of time from the onset of a disability when the policy does not pay benefits. It is similar in function to a deductible in a Major Medical Policy. The period chosen can be from thirty (30) days to up to two (2) years, depending upon the applicant's situation. The applicant might have adequate savings to pay expenses for several months following the onset of a disability. The applicant might work where there is a salary continuation benefit in the event of a disability. Elimination Periods, like deductibles, keep premiums low. The longer the Elimination Period, the lower the premium. The shorter the Elimination Period, the higher the premium.

5. Benefit Period.

The Benefit Period is chosen by the applicant and it is the length of time the policy will pay disability benefits.

- a. Short Term Disability (STD). Short Term Disability would provide payments from one to twenty-four (24) months.
- b. Long Term Disability (LTD). Long Term Disability would provide payments for longer than two (2) years. Some policies pay until the insured reaches age 65.

6. Recurrent Disability.

If a person is receiving disability payments during a Benefit Period, they might recover from their disability and go back to work. In such a case, the disability payments would end. If the disability returns, the policy would resume payments. Would the insured be charged with another Elimination Period? Not if the policy contained a Recurrent Benefit, either in the policy or as an added rider. The person is required to suffer the recurrent disability within a specified period of time, usually within the first six (6) months after returning to work. Sue has a Disability Income Policy with a thirty (30) day Elimination Period and Recurrent Benefit and she is disabled for three months, goes back to work for three months, and her disability returns for three months. Her policy would pay her five months of benefits because only one Elimination Period would be charged.

7. Additional Types of Disability Income Policies.

a. Business Continuation Insurance.

This policy pays the salaries of support people in case the principal is disabled and cannot keep the business going for a period of time. A nurse working in a physician's office could have her salary continued if the physician is disabled for a period of time.

b. Business Overhead Expense Policy.

These contracts are special policies in health insurance that are sold to professionals, business partners and small corporations. The policy provides payments for overhead expenses such as utility bills, rent or mortgage payments if the owner is disabled. Some policies pay salaries of employees but a Business Continuation Policy is usually used for this. These policies would not pay to add new stock to the store's inventory. The premiums are deductible as a business expense, but taxes must be paid on any benefits received.

c. Disability Buy-Out Policy.

Disability Buy-Out Policies are used to fund a buy-sell agreement between partners or stockholders when one of the owners is disabled. The premiums are not deductible, but the benefit is received tax free.

d. Key-Person Disability Policy.

The policy compensates the owners of a business if a Key-Person's services are lost to the company because of a disability. The premiums are not deductible and the benefit is paid to the company tax free.

J. Dental Insurance

1. Types of Dental Treatment.

- a. Diagnostic and preventive (prophylaxis treatments).
Many coverages give special emphasis to diagnosis and prevention by waiving deductibles for routine oral examinations. Dental insurance pays for prophylaxis treatments.
- b. Restorative – Tooth implants, etc.
- c. Endodontics - Treatment for diseases of the central cavity (pulp) of a tooth. Examples: root canal and filling a cavity.
- d. Periodontics - Treatment of diseases of the gums.
- e. Prosthodontics - Artificial replacement of teeth, such as dentures, bridges, crowns, etc.
- f. Orthodontics - Straightening of irregular teeth. Braces ("devices" or "appliances") are often used. Dental insurance pays for this because it promotes healthy teeth and gums.

2. Indemnity Plans.

- a. Basic (scheduled) plans. Features first dollar coverage with scheduled limits.
- b. Comprehensive (nonscheduled) plans. This is sometimes called the Major Medical approach and, like Major Medical, there are deductible, coinsurance and policy limits.
 - 1) If the dental coverage is combined with other medical coverage's, there may be an integrated deductible, where the deductible for one area (regular medical) is counted toward the dental deductible. In the same way, money spent on dental bills that meet the deductible would be credited to the medical expense deductible. This can only occur when the same insurance company is covering both medical and dental expenses.
 - 2) Dental expenses may be subject to a separate deductible.
- c. Group Dental Plans.
 - 1) A Probationary Period maybe used.
 - 2) Late enrollees in the plan may have limited benefits.
 - 3) There is usually no conversion privilege.

III. GROUP HEALTH INSURANCE

The majority of Americans who have health insurance are covered under a group plan. Because one Master Policy is issued to the employer, savings result in lower premiums and more liberal underwriting than found in individual health policies. The members of the group receive certificates of insurance rather than a policy. The certificate is proof of insurance.

A. Individual Employer Group

Requires ten (10) persons. If a group starts with ten (10) eligible employees and one person dies, the group is still intact, but ten (10) is required to start. The group must be "natural," meaning they did not come together merely to purchase insurance. In order to be in the group three months employment is usually required and full-time employment status, which is 30 hours of work per week.

1. Plans are either contributory or noncontributory. A contributory plan means that the employee pays part of the premium. (The premium could be for a spouse and children.) All contributory plans require that 75% of all eligible employees participate in order to prevent adverse selection. In all contributory plans the employer is required to pay a minimum of 75% of the premium for the employee. A Noncontributory plan is one where the employer pays 100% of all premiums, requiring 100% participation of the eligible employees.
2. The underwriting of group plans usually evaluates the group as a whole, rather than as individuals.
3. Under the Affordable Care Act all preexisting conditions will be covered from the time of enrollment without any waiting period.
4. Coordination of Benefits. Found only in group health plans, coordination of benefits prevents duplicate payments and over-insurance when a person is covered by more than one group plan. The provision limits the amount of claims from all insurers to no more than the total allowable medical expense. The provision establishes one plan as the primary insurer that will pay first according to the benefits in the policy. Once the primary insurer pays all that it is supposed to pay, the insured may submit the claim for a secondary provider to pay.
5. Conversion privileges. Individuals leaving a group plan must be allowed to convert their group insurance to an individual policy with the same insurer without proof of insurability. The privilege is available to those who are laid off or leave the employment voluntarily and includes spouse and children. Conversions must be applied for within 31 days of separation from the group and individual rates must be paid.
6. COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). Federal law, known as COBRA, requires that workers and family be allowed to remain with the group health coverage after they leave employment or have been terminated for reasons other than gross misconduct. These workers, in any job with twenty (20) or more employees, are allowed to retain their group benefits if they are laid off. If an employer violates the COBRA regulations the employer could lose the

tax deductions for their group premiums. Application must be applied for, with premium, within sixty (60) days following separation from the job.

- a. The worker and family may remain for 18 months.
- b. A divorced spouse and/or dependent children may remain for 36 months.

7. HIPAA is a relatively new federal law governing certain group health insurance plans. It stands for Health Insurance Portability and Accountability Act. Under this Act people who leave one group through a job change and go to another group can be covered immediately with the new group insurance and can not be subjected to a waiting period for preexisting conditions.

B. Small Employer Groups

Small Employer Groups consist of at least two employees but not more than 50. The Small Employer carrier (insurer) must provide health benefits to small employers without regard to claim experience, health status or medical history.

1. Coverage is available if at least 75% of the eligible employees elect to be covered.
2. An Affiliation Period may be established by a small employer carrier not to exceed 90 days for new enrollees and not to exceed 180 days for late enrollees during which time premiums are not collected and the issued coverage is not effective.
3. Case characteristics may include residence, age, gender but may not include claim experience, health status or whether a covered person is or may become pregnant.
4. Dependents include spouse, newborn child, child under the age of 19 years; child who is a full-time student under the age of 23 years and who is financially dependent upon the parent.
5. An eligible employee works on a full-time basis and who usually works at least 30 hours per week.
6. A new employee will be eligible for coverage from the first day of employment without regard to preexisting conditions. (See Affordable Care Act on page 190).
7. Two types of plans may be offered: Basic Plan and Catastrophic Plan. The annual deductible is \$500 for the Basic and \$2,500 for the Catastrophic.

C. Other Types of Groups

1. Multiple Employer Trusts (MET). Several employers form a trust to have enough workers eligible for a standard group. Requires 100 to 200 persons, depending on state laws. All in this group must have the same type of job.
2. Multiple Employer Welfare Arrangement (MEWA). MEWAs are special purpose insurance providers that are exempted under federal law from all state regulations. Labor Union Group. Requires 25 person.
3. Trade Association.
4. Fraternal Organization.

D. Additional Approaches to Funding Health Care

1. Health Savings Accounts (HSAs).

Nearly 18 million people are currently enrolled in Health Savings Accounts. The current law allows a person to choose a plan with a high deductible and put premium savings in an account that they own and control. Deposits to these accounts are made with pre-tax dollars and the account grows tax free. If money is withdrawn for non-medical expenses, a 15% penalty must be paid.

2. Flexible Spending Accounts. (FSAs)

Approximately 30 million people are now using Flexible Spending Accounts. Pre-tax dollars are placed in the fund and they must be spent in the taxable years the funds are deposited. These accounts may be used to pay for medical expenses, dental insurance premiums, long-term care and for children with special medical needs. The funds earn interest tax free but a penalty of 15% is charged for using any of the funds for non-medical purposes.

IV. ADDITIONAL HEALTH INSURANCE PROVIDERS

A. Traditional Insurers

1. Stock insurance companies.
2. Mutual insurance companies.
3. Fraternal Benefit Societies.
4. Blue Cross and Blue Shield (Blue Plans). Blue Cross and Blue Shield are nonprofit, independent organizations providing protection against health costs in a particular geographical region of the country. They are sometimes called "Producer Cooperatives" and their members are called "Subscribers." Blue Cross and Blue Shield pay on a service basis because health benefits are provided directly to the insured instead of monetary reimbursement. Blue Cross pays directly to the hospital and Blue Shield pays directly to the doctor.

B. Preferred Provider Organizations (PPO)

A PPO is formed when hospitals and medical providers agree to offer services at a prearranged discounted cost. For a premium members of the PPO may choose from among the health care providers in the network.

1. Different type of groups organize PPO's. These include insurance companies, Blue Cross and Blue Shield, local groups of hospitals, local groups of doctors, dentists, large employers, trade unions, etc.
2. Providers are paid on a fee-for-service basis, not like HMOs where services are prepaid.
3. PPO's provide a wider range of choices than HMOs and services are usually given in the individual practitioner's office. The PPO itself does not maintain facilities as do most HMOs.

C. TRICARE.

1. Civilian Health and Medical Program of the Uninformed Services.
2. Previously called CHAMPUS.

V. UNIFORM PROVISIONS LAW

The National Association of Insurance Commissioners (NAIC) recommended to the states a model law for individual health policies. The model law, entitled "Uniform Individual Accident and Sickness Policy Provisions Law" has been adopted or authorized in all states. The law contains twenty-three (23) provisions; twelve (12) are required and eleven (11) are optional.

A. Required Provisions

There are twelve (12) required provisions in every individual health policy.

1. Entire Contract and Changes.

The policy, including any endorsements and attached papers, constitute the entire contract of insurance. No change in the policy shall be valid unless approved by an executive officer of the insurance company. Such change must be attached to the policy. An agent does not have the authority to make any change or waive any provision of the policy.

2. Incontestability and Preexisting Conditions.

a. "After two (2) years. . .no misstatements, except fraudulent misstatements. . .shall be used to void the policy or to deny a claim." This is often referred to as a "time limit on certain defenses," meaning the insurance company is limited to two (2) years in contesting certain information in the application.

b. The Affordable Care Act eliminates all preexisting condition requirements. The Affordable Care Act was enacted March 23, 2010.

3. Grace Periods.

A policy enters the grace period when a premium is due but has not been paid. The policy is fully in force during a grace period and benefits would be paid for a loss with the premium due being subtracted from the claim. This provision allows three grace periods, depending on the mode of premium payment.

a. Seven (7) day grace period for weekly collected premiums.

b. Ten (10) day grace period for monthly direct billed premiums.

c. Thirty-one (31) day grace period for all other premium modes.

4. Reinstatement.
 - a. An application for reinstatement must be accompanied with back premiums and proof of insurability. If the agent gives a conditional receipt, the policy is automatically reinstated within forty-five (45) days if the company fails to notify the applicant of approval or disapproval.
 - b. Following reinstatement, there is a waiting period of ten (10) days for any sickness. There is no waiting period for losses caused by an accident.
5. Notice of Claim.
 - a. "Written notice of claim must be given to the insurer within twenty (20) days after occurrence. . .of any loss. . .or as soon. . .as is reasonably possible." Notice of claim given to an agent is the same as notice to the insurance company.
 - b. In cases of disability, the disabled must show proof of continuing disability every six (6) months.
6. Claim Form. The insurer should furnish claim forms within fifteen (15) days of notice of loss. If the company fails to furnish forms, the insured may file their own statement describing their loss. A request to an agent is considered a request to the company and the agent should respond within fifteen (15) days.
7. Proof of Loss. Proof of loss, in written form, should be furnished to the insurer within ninety (90) days of the loss, if possible. In no case, except for absence of legal capacity, later than one year.
8. Time of Payment of Claims. "Indemnities payable. . .will be paid immediately." Periodic payments, as in disability income benefits, would be paid when due.
9. Payment of Claims. Payments are to be made according to the policy.
10. Physical Examination and Autopsy. The insurer, at their expense, can require a physical examination of the insured when and as often as it may reasonably require while a claim is pending. The insurer may also require, at their expense, an autopsy, except where it is forbidden by law.
11. Legal Action. No legal action can be taken, by an insured against the insurance company for sixty (60) days after proof of loss has been submitted in writing. No action can be brought after three (3) years following written proof of loss. The limitations also apply to a beneficiary.
12. Changes of Beneficiary. The insured, as policy-owner, has the right to change the beneficiary at any time, unless an irrevocable beneficiary has been designated.

B. Optional Policy Provisions

There are eleven (11) Optional Policy Provisions in the Uniform Provisions Law. A company may choose to include these in their policy forms or leave them out. Most companies include them.

1. Change of Occupation. If the insured has a claim after changing to a more hazardous occupation, the company will adjust the benefits. The payment will be what the premium would have purchased based on the more hazardous rate. If the insured goes to a less hazardous occupation, the company will lower the premium or, if appropriate, return the excess premium pro rata.
2. Misstatement of Age. If age has been misstated, the company will pay the amount the collected premium would have purchased at the correct age.
3. Other Insurance With the Same Insurer. If the insured has several policies with the same health company, there will be a limit on the payment of benefits and excess premium will be returned. The insured or estate may select which policy would pay benefits and receive a return of premium on the other policy or policies.
4. 4,5. Insurance with other Companies. If the insured has two or more policies with different companies and these companies were not notified that the duplicate coverage's existed, they will only pay a proportionate share of the medical expense claim. The shares each company pays are based on the proportion of the total premiums each company collected.
6. Average Earning Clause. This clause is designed to prevent over-insurance where there is more than one Disability Income Policy. The insurance companies would share in the proportion of lost income based on the proportionate amount of benefits in their policy.
7. Unpaid Premium. When a claim is being paid by a company, any premium due can be deducted from the payment.
8. Canceling a Policy. The insurer may cancel a policy at any time by giving five (5) days notice to the last known address. Any unearned premiums must be returned to the insured, pro rata. Notice of cancellation would not affect any claim that was filed before the cancellation notice.
9. Conformity with State Statutes. Any provision of a policy, on its effective date, automatically conforms to all appropriate state statutes.
10. Illegal Operation. The insurer will not be liable if a claim arises from the insured's commission of a felony or engaged in an illegal occupation. The company would deny any claim and cancel the policy.
11. Narcotics. The insurer is not liable for any loss arising from the insured's use of any narcotic not administered on the advice of a physician. The claim would be denied and the policy would be cancelled.

VI. ADDITIONAL PROVISIONS, CLAUSES AND FEATURES

A. Insuring Clause

The Insuring Clause is one of the most important parts of a health contract. It is on the first page of the policy and contains the insurance company's "promise to pay." The clause identifies the insurer and the insured and gives the circumstances under which the policy will pay the benefits.

B. Consideration Clause

The Consideration Clause of a health policy has two important elements:

1. Premium payment section - States the full, initial minimum premium payment. It may state the effective date and the initial term of the policy.
2. The application is considered part of the Consideration Clause.

C. Benefits Payment Provision

1. Lump sum reimbursements are usually paid under hospital, medical, surgery and major medical policies.
2. Lump sum payments are paid for death or dismemberment policies.
3. Periodic income is paid under disability income policies. The benefits are paid monthly.

D. Workers' Compensation Programs

All states have Workers' Compensation laws that require benefits to be paid for work related injuries, illness or death. Employers are required to provide benefits through self-funding, participating in state programs or buying insurance from private insurance companies. Almost all individual health policies exclude payments if the loss is covered by Workers' Compensation. There are differences among the states, but some of the main uniformities are:

1. Work Related. A worker who is killed in a work related accident will have burial benefits up to a certain amount paid to the family and payments to a surviving spouse and dependents.
2. No Fault. An employee will receive disability compensation for work related impairments regardless of who was at fault. In most cases disability benefits are paid weekly or monthly.
3. Tax Free Benefits. The plan must be financed entirely by the employer and benefits paid to the employee or survivors are received tax free.

E. Renewable Provisions of Individual Health Policies

There are three main types of Renewable Provisions in individual Accident and Health policies.

1. Guaranteed Renewable.

These policies give the insured the right to renew up to a certain age or even for life. However, the company has the right to raise the premiums on the premium due date or on the policy anniversary date. The premiums cannot be raised individually. They can only be raised by classes of insured's.

2. Non-cancelable.

Sometimes called Non-cancelable and Guaranteed Renewable or simply "Noncan." These provisions give the insured the right to renew their policy until they reach a certain age, usually 65. As long as the policy-owner pays the premiums, the company cannot change the policy in any way. The premiums cannot be changed. This provision is usually found in disability income policies.

3. Cancelable Policies.

If a company places Optional Policy Provision number eight from the Uniform Policy Provision Law, the policy is a Cancelable policy. The company has the right to cancel the policy at any time they wish by giving five days notice to the insured's last known address on file with the company. Any unearned premiums would have to be returned pro rata and the cancellation would not prejudice any claims that arose during the policy's effective period.

F. Exclusions: Most individual Accident and Health policies have a number of exclusions and other limitations that are similar to exclusions.

1. Exclusions that provide no benefits if a loss occurs.

- a. Any self-inflicted injury.
- b. Any purely elective medical procedure that was not considered medically necessary, such as elective cosmetic surgery.
- c. Medical procedures that are regarded as "experimental."
- d. Injuries due to war or an act of war.
- e. Injuries suffered while the insured was piloting an aircraft or serving as a crew member.
- f. Using drugs or narcotics not under the care of a physician.
- g. Losses while committing or attempting to commit a felony or involved in any illegal operation.
- h. Foreign travel is sometimes excluded, especially extended overseas stays.
- i. Any losses paid by Workers' Compensation.

2. Limitations That Are Similar to Exclusions.

a. Impairment Rider.

Sometimes an individual Accident and Health policy will be issued with an Impairment Rider. This specifies that certain named medical problem the applicant has when applying for insurance is being "ridered out." The policy will not pay for any loss caused by this condition, even after the waiting period for preexisting conditions has passed. Now rendered inoperative because of the Affordable Care Act.

c. Probationary Periods.

Probationary Periods protect a company from issuing a policy when the insured is already in the process of becoming ill. A specified time (such as thirty (30) days) from the effective date of the policy is stated as a period when the policy will not pay for an illness. These are standard in disability income policies.

G. Riders

An applicant can request that the company enhance the value of a policy by placing riders on the policy for which the applicant pays an extra premium.

1. Multiple Indemnity Rider. The same as Accidental Death in life policies.
2. Waiver of Premium Rider. This rider is usually found in disability income policies, but may be requested on other health policies. Normally, the disability must last at least ninety (90) days and the rider drops off at age 65.
3. Guaranteed Insurability Rider. The insured is allowed to purchase additional disability income protection regardless of their health condition. The options usually can be exercised every three to five years and ends at a certain age.
4. Cost of Living Rider (COLA). These Riders are usually attached to disability income policies and they allow the dollar amount of the benefit to increase as the Consumer Price Index (CPI) increases.

H. Short-Term Medical Policies

Special health policies that are issued for a temporary period are called Short-Term Medical Policies. They are usually issued for six (6) months and cannot be renewed or can be renewed one time only.

I. Occupational and Non-occupational Policies

Occupational policies are health policies that will pay benefits if the loss arises on the job or off the job. Non-occupational policies are more restrictive and will not pay for any loss arising in the work place, whether caused by an accident or illness. Non-occupational policies are the opposite of Workers Compensation, which pays only if the loss is job related.

J. Tax Treatment of Premiums and Proceeds

1. When an individual buys a disability income policy, the premiums are not deductible from their income tax liability. However, the benefits received while disabled are tax-free.
2. If an employer pays the premiums for their employees disability income policy, the premiums are deductible for the employer and the employee would have to pay income taxes on the benefits.
3. Medical expenses cannot be deducted unless they exceed 7.5% of the taxpayers' adjusted gross income. Medical expenses that are reimbursed by insurance cannot be deducted.
4. Under certain circumstances a self-employed person can deduct up to 40% of their health insurance premiums from their income taxes.

VII. SOCIAL INSURANCE

Many citizens are covered by some form of government sponsored or required health plans. At the state level, all states have some type of Workers' Compensation program. At the federal level, Medicare is a major source of health care. Medicaid is a cooperatively funded plan for some of the nation's poor, funded by federal and state dollars, administered by the states.

A. Medicaid

Medicaid was added to the Social Security program in 1965 and is sometimes referred to as Title XIX of the Social Security Act. It is a *public assistance* (welfare program) to the needy, regardless of age. The individual states set the eligibility requirements and administer the program. Funds are provided by the federal government and the states.

B. Medicare

The federally administered Medicare program went into effect in 1966 as part of President Lyndon Johnson's Great Society agenda. The purpose of Medicare is to provide hospital and medical expense protection for those who have reached the age of 65 or have become disabled or have chronic kidney failure. The program is the largest health care program in America and is administered by the U. S. Health Care Financing Administration.

1. Eligibility Requirements.

As a person works and pays taxes, "credits" are earned for Social Security benefits. A maximum of four (4) credits can be earned each year. Forty (40) credits (ten (10) total years, not necessarily consecutively of work) are required. A person qualifies one of three ways:

- a. Those persons age 65 and older who have accumulated the required credits are automatically enrolled in Medicare, Part A. Since a monthly amount (\$104.90 in 2016) is deducted from their Social Security retirement check to help fund Part B benefits, they are allowed to reject Part B. Then, Medicare will not pay for any Part B benefits.
 - b. Disability. If a person has been entitled to Social Security disability.
 - c. Kidney failure. A person is on kidney dialysis.
2. An overview of Medicare Coverage
- a. Part A – Pays for hospital expenses. Everyone who is eligible receives benefits with no premium charged..
 - b. Part B – Pays for doctor bill, lab fees, X-rays, etc. A premium is deducted each month from the member's Social Security check.
 - c. Part C – Medicare Advantage plans. Similar to HMOs, except there are deductibles, copayments, and coinsurance.
 - d. Part D – Outpatient Prescription Drug Coverage..
3. Medicare Part A, for 2016: (Hospital Insurance)
- a. Hospital care. For the first sixty (60) days of hospitalization, Medicare pays for all services except a deductible (\$1,288). The deductible is a sixty (60) day benefit deductible and must be paid for each sixty (60) day benefit period. From the 61st through the 90th hospital day, Part A pays all but a daily coinsurance (\$322). From the 91st through the 150th day the Medicare patient would pay daily coinsurance of \$644. After the 90th day the patient begins using part of their 60 lifetime reserve days. These days are not replaced. After 150 consecutive days the Medicare patient must pay all hospital costs for each day.
 - b. Post-Hospital Skilled Nursing Care.
When a Medicare patient is receiving Post-Hospital Skilled Nursing care, the patient requires 24 hours of treatment under a doctor's orders and supervised by a registered nurse. The facility must be approved by Medicare. All expenses are paid by Medicare during the first twenty (20) days. From the 21st day through the 100th day, there is a coinsurance (\$161) the patient must pay per day. After 100 days, there is no Medicare benefit; patient pays all charges.
 - c. Medicare pays all of the costs for blood after a three (3) pint deductible. The blood deductible under Part A (inpatient hospital care) paid by the Medicare patient would be credited under both A and B.

d. Hospice care is care for the terminally ill. Medicare pays most of the costs for inpatient Hospice care.

4. Medicare Part B, for 2016: (Medical Insurance)

Medicare Part B helps pay doctor bills, surgeon's fees, outpatient care, diagnostic tests, X-rays, ambulance fees, physical and occupational therapy, durable medical equipment, etc.

a. Annual deductible of \$166. The Medicare beneficiary must pay the first \$166 of approved charges before Medicare payments begin.

b. Medicare pays 80% of approved charges after the patient has paid the annual \$166 deductible. The Medicare member pays the 20% coinsurance.

5. Primary Payor and Secondary Payor.

If a person is enrolled in Medicare and is also covered under an employer health plan, the employer plan is considered the primary (pays first) and Medicare is the secondary (excess) payor. If a person is enrolled in Medicare and purchases an individual Medicare supplement policy (Medigap policy), Medicare is the primary payor and the supplement is the secondary payor.

6. Expenses Medicare Considers Ineligible for Medicare Payments:

a. Long-Term care. Medicare does not pay any for any custodial type care, whether intermediate or Long-Term.

b. Elective cosmetic surgery, such as a "nose job." Medicare will pay or necessary cosmetic surgery following an accident or an illness.

c. Routine dental, eye examination (including lenses and frames), hearing aids, and foot care

d. In general, Medicare will not pay for health care obtained outside the United States and its territories.

7. Preventive medicine, generally, Medicare pays:

a. For a one time "Welcome to Medicare" physical exam but it must be completed within six (6) months of qualifying for Medicare.

b. For a cardiovascular screening every five (5) years.

c. For a mammogram once every twelve (12) months.

d. For a pap test and pelvic exam once every twenty-four (24) months.

e. For a colon cancer screening (colorectal) once a year including a colonoscopy once every two (2) years for high risk types and every four (4) years for low risk types.

8. Medicare Outpatient Prescription Drug Coverage (Medicare, Part D). Starting January 1, 2006, a new Medicare prescription drug coverage became available to everyone.
 - b. The coverage is insurance. Enrollees choose a private insurer.
 - c. Those enrolled in Medicare A or B pay a monthly premium.
 - d. Participation is voluntary, but those who enrolled after May 15, 2006 are charged a penalty for their delay in enrolling.

IV. MEDICARE SUPPLEMENT INSURANCE

There are many gaps in medical coverage provided by Medicare. Because of these gaps, many people elect to continue their group coverage's as long as possible and others purchase an individual Medicare Supplement (Medigap) policy from a private insurer.

A. Ten (10) Standardized Medicare Supplement Policies

Most states, including Texas, have adopted legislation that allows the sale of only ten standardized policies. These policies are called "A" through "J", "A" being the most basic, "core" coverage and "J" being the most comprehensive. The sale of these policies are subject to strict state and federal regulations.

1. Companies may give these policies additional names, but must identify them as "A" or "F," etc.
 2. Premiums may vary from company to company for the same policy.
 3. All companies that sell Medicare Supplement policies must offer "A," the core plan. If they wish they may sell any of the others.
- B. It is illegal for a company or agent to represent their product as having an endorsement, or be required, by the state or federal government.
- C. Access to Medigap insurance is guaranteed. Federal law, effective November 5, 1991, guarantees that for six months after enrolling in Medicare, Part B, persons aged 65 and older cannot be denied Medigap insurance because of health problems. There can be no higher premiums charged because of health problems. If they cancel the policy, any reinstatement or the purchase of another policy will require proof of insurability.
- D. All Medigap policies must be Guaranteed Renewable.
- E. All Medigap policies must pay for preexisting conditions after a six (6) month waiting period. A company can only go back six (6) months to define a preexisting condition. If a new policy is purchased that replaces an older policy, the new policy must give credit for whatever waiting period had already been met under the old policy.

- F. Replacement forms must be filled out when replacing a Medigap policy.
- G. All Medicare Supplement salespersons, when selling a policy, must leave with the applicant a booklet entitled, *Guide to Medicare*, and an *Outline of Coverage* that explains the policy provisions to the buyer.
- H. Loss Ratios are Required - All Medigap plans must have a loss ratio of at least 65% for individual policies and 75% for group policies. This means that an average of 65 cents or 75 cents of each premium dollar goes for benefits.
- I. Free Look Period - All Medicare Supplement policies must have a thirty (30) day Free Look period
- J. Prohibited Marketing Practices - It is unlawful for a company or agent to use high pressure tactics to force or to frighten someone into buying a policy. Fraudulent or misleading comparisons used to get someone to switch from one company to another is prohibited. Deceptive "cold lead" advertising is prohibited.
- K. Other Options For Individuals With Medicare
 1. Medicare Select Policies. Medicare Select is permitted to be sold by insurance companies and HMOs in almost all states, including Texas. Medicare Select is the same as standard Medigap policies in nearly all respects. If you buy a Medicare Select policy, you are buying one of the standard Medigap plans. The only difference between Medicare Select and standard Medigap insurance is that each insurer has specific doctors, and in some cases specific hospitals, that you must use, except in an emergency, in order to be eligible for full benefits. Medicare Select policies generally have lower premiums because of this requirement.
 2. HMOs. Individuals on Medicare may choose to join an HMO rather than buy one of the ten (10) standardized policies or a Medicare Select policy.
 3. Texas 65 Health Insurance Plan. This plan is offered by any two or more insurance companies. They agree to pay claims according to the proportion of the premium they receive. The plan is designed only for those who are 65 years of age or older and their spouses.

NOTE: Effective June 1, 2010, the following changes have been made to the current standardized Medicare Supplement plans:

Plans H, I, and J are eliminated because of the changes in the prescription drug benefit.

Plan E is eliminated, being absorbed into Plan D.

New plans M and N will become effective. Plan M will increase cost sharing (50% of the Part A deductible, no coverage for the Part B deductible). Plan N will have a new co-pay structure with \$20 for physician visits; \$50 co-pay for ER and no coverage for the Part B deductible.

VIII. LONG-TERM CARE INSURANCE

Medicare does not pay for any custodial type care. The Medicare program has a limited benefit for post-hospital skilled nursing facility care in an approved Medicare facility. Medicare pays no benefit for any type of custodial care, loosely called "nursing home care." In order to afford the daily costs of custodial care, where people need assistance with dressing, eating, bathing, etc., many people purchase Long-Term care insurance. These coverage's can be provided in group coverage or in an individual policy. Benefits would be paid if help is needed in any two of four areas of Assisted Daily Living (ADL): Getting dressed, preparing food, personal hygiene (bathing) and taking medication. Long-Term Care insurance does not pay for any hospital or medical expenses. Long-Term Care refers to several levels of care, including skilled care, intermediate care, custodial care, home health care, adult day care, and respite care. Long-Term Care policies are regulated by state and federal standards. These standards include:

- A. Policies must be guaranteed renewable.
- B. Policies must furnish benefits for a minimum of twelve (12) consecutive months.
- C. A hospital or nursing home stay cannot be required before benefits are paid.
- D. Policies cannot duplicate coverage's the applicant already has.
- E. Policies may have a six (6) month waiting period it covers preexisting conditions.
- F. Although policies are allowed to contain the standard exclusions found in individual policies, the policy cannot exclude coverage for Alzheimer's Disease.
- G. Policies may have a Probationary Period where benefits would not be paid if an illness occurs in the first thirty (30) days following the effective date.
- H. An Elimination Period may be selected to keep premiums lower. This works like a deductible where the policy would not pay until the insured had been confined to a custodial facility a designated period of time and the insured had paid for the care during the Elimination Period.
- I. The policy may have a recurrent benefit. If an insured left a facility because of improved health and had to return, no additional Elimination Period would be required. The period of remission would have to be less than three (3) months or six (6) months, depending on the policy.
- J. The policy may include a Restoration of Benefits provision. This provision will restore any used benefits if the insured remains out of a Long Term Care facility for a specified period of time, usually six months or longer. Example: If a person purchased an LTC policy with a ten year benefit, went in a custodial care facility for one year and was able to return home for six months or longer, this provision in the policy would restore the year that had been used. The policy would now contain the original ten years of benefits. The year that was used is now restored.
- K. Replacement forms must be filled out if the agent is selling a new policy to replace an older one and an outline of coverage must be given when sale is made.
- L. Policies are required to offer an inflation protection (COLA or Indexing) feature. The applicant may reject it, but must do so in writing.
- M. Reasonable Loss-Ratio standards may be applied by the state to make certain reasonable benefits is paid out for the premium collected.
- N. Policies must have a minimum thirty (30) day free look.

AFFORDABLE CARE ACT

- A. The Patient Protection and Affordable Care Act (PPACA), referred to more commonly as the Affordable Care Act, was enacted March 23, 2010. It required that all residents of the United States must have basic health insurance, and if they failed to do so, would pay a penalty when filing their annual income taxes
- B. The basic requirement in the Affordable Care Act includes:
1. **Young adult coverage.** Health care plans that cover children must cover children up to age 26. Young adults may join or remain on their parent's even if they are:
 - a. Married (coverage does not include the spouse of the child).
 - b. Not living with a parent.
 - c. Not attending school.
 - d. Not financially dependent upon a parent.
 - e. Eligible to enroll in their employer's plan.
 2. **Medical Loss Ratios (MLR).** Medical loss ratio is a financial measurement that shows how much of the premium dollars collected by an insurer must be paid on health care. The ratio is 80%, meaning an insurer is allowed 20% for profits or administrative costs.
 3. **Essential Health Benefits (EHB).** Ten categories of care are listed and there must be a reasonable balance among the categories.
 4. **Basic Health Care Plans.** The basic health care plans are referred to as the metal plans: Bronze, Silver, Gold, Platinum.
 5. **Catastrophic Plans.** In addition to the metal level plans, insurers can offer catastrophic plans to: Individuals under age 30 and individuals who otherwise do not have an affordable health care option.
 6. **Dollar Limits.** No annual or lifetime limits are allowed on essential health Limits.
 7. **Tobacco Rating Standards.** The following provisions apply.
 - a. Health insurance insurers cannot charge an individual who uses tobacco products more than 1.5 times the non-tobacco user's rate.
 - b. For small employers covered individuals are able to avoid the tobacco surcharge by participating in a wellness program, such as a tobacco cessation program.
 8. **Preexisting Conditions.** No insurer is allowed to deny coverage for any preexisting conditions.
 9. **Cobra Regulations.** If a person leaves coverage under the Cobra provisions they would not be required to prove insurability.
 10. **Cancellation of Policies.** As long as the premiums have been paid no insurer is allowed to cancel a policy or drop coverage.

EXAMINATION

SCORE _____

SCORE SHEET: Circle the correct answer

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

PRACTICE EXAMINATION

Accident and Health Insurance

1. Which one of the following policies is an example of a limited policy?
 1. Hospital Expense.
 2. Blanket.
 3. Major Medical.
 4. Comprehensive Major Medical.

2. The principal sum in an Accidental Death and Dismemberment (AD&D) policy could best be described as
 1. The amount paid in the event of death.
 2. A loss involving at least two limbs.
 3. Loss of eyesight.
 4. Loss of speech or hearing.

3. All of following are legal in insurance advertising EXCEPT:
 1. An outline of coverage is given.
 2. The company or person is in business to sell insurance.
 3. Their policy has been approved for sale in the state where it is sold.
 4. The insurance is endorsed by the federal or state government.

4. Under the Medicare program, who pays the excess charges on a medical bill?
 1. The Medicare program.
 2. The patient.
 3. The hospital or doctor presenting the bill.
 4. The federal government.

5. The Affordable Care Act requires that an insurer pay a Medical Loss Ratio (MLR) of which of the following percentage of the customers' medical expenses?
 1. 60%
 2. 70%
 3. 80%
 4. 90%

6. Individuals in a group health policy receive a Certificate of Insurance. This Certificate provides
 1. Detailed explanations of the coverage provided.
 2. Details of waivers and riders attached to the Master Policy.
 3. Proof of insurance.
 4. A list of approved doctors and hospitals.

7. The minimum number in Texas for a Small Employer Group is:
 1. 10
 2. 5
 3. 2
 4. 20

8. When an individual who is on Medicare is considering some alternative to the purchasing of one of the ten (10) standardized Medicare Supplement insurance policies, which one of the following alternatives would they choose if they wished to have more than one company involved in their coverage?
 1. Medicare Select Policy.
 2. HMO.
 3. Hospital Indemnity Policy.
 4. Texas 65 Health Insurance Plan.

9. Most restrictive definition of occupation in a disability income policy would be the
 1. "Any occupation" definition.
 2. "Own occupation" definition.
 3. Capital loss definition.
 4. Principal loss definition.

10. If a person has a Disability Income policy and a disability prevents them from working more than halftime, a "residual disability" definition would limit benefits to
 1. Six months.
 2. Three months.
 3. Twenty-four months.
 4. Thirty-six months.

11. Under what circumstances would a recipient of disability benefits not be required to pay income taxes on the benefits received?
 1. If the individual paid the premiums.
 2. If the company where the disabled person worked paid the premiums.
 3. If the disability was total and permanent.
 4. If the disability was partial.

12. An individual purchased a disability income policy that paid benefits for five years. The policy had a probationary period of thirty days. The policy went into effect on the first day of August. On August 26th, the insured was diagnosed as disabled due to an illness. The policy would pay benefits for how long?
 1. Until the insured could return to work.
 2. Five years.
 3. No benefits would be paid.
 4. A maximum of six months.

13. In the absence of presumptive disability, a person who receives disability benefits must prove continuing disability
 1. At any time called upon.
 2. Once a year.
 3. Every six months.
 4. Only at the beginning of the disability.

14. The choice of an Elimination Period (Waiting Period) in disability policies is chosen primarily to
 1. Adjust the premium.
 2. Receive benefits faster.
 3. Get a better definition of disability.
 4. Have residual benefits.

15. A person has an individual health insurance policy with a typical Change of Occupation Provision. If they sustain a loss while working at a more hazardous occupation than the one they had when they applied for the coverage, the insurance company will
 1. Increase the waiting period to adjust for the occupational difference.
 2. Deny any claims on the grounds of misrepresentation.
 3. Increase the deductible to make up for the occupational differences.
 4. Adjust the benefits to the amount that the premium provides for the new occupation.

16. Under the Affordable Care Act, health plans that cover children must make coverage available to children up to age 26. All of the following statements are true concerning the child's eligibility to remain on their parent's plan EXCEPT:
1. The child is not living with their parents.
 2. The child is not attending school.
 3. The child must not be eligible to enroll in their employee's plan.
 4. The child is not financially dependent on a parent..
17. Travel Accident, Dental, Prescription Drug Card and Cancer policies are all examples of
1. Hospital Indemnity policies.
 2. Group Blanket policies.
 3. Limited policies.
 4. Major Medical policies.
18. What concept best describes a sharing of the costs of medical bills between an insurance company and the insured?
1. Deductible.
 2. Stop-loss limit.
 3. Catastrophic amounts.
 4. Coinsurance.
19. James has a Major Medical policy with a \$100 deductible and an 80/20 coinsurance. In December he incurred \$50 in expenses. The following March he incurred an additional \$200 in expenses. How much of these amounts would the insurer pay?
1. \$120
 2. \$80
 3. \$100
 4. Nothing
20. In Group Insurance, who is responsible for applying for coverage, securing the information, paying premiums, etc.?
1. Insurer.
 2. Agent.
 3. Individuals in the group.
 4. The master policyholder.

21. The type of insurance policy most likely used to cover a group of high school students attending a summer camp is
1. Group benefit.
 2. Individual accident.
 3. Blanket policy.
 4. Comprehensive Major Medical.
22. Which part of Medicare requires the participant to pay premiums?
1. Part A.
 2. Long term care.
 3. Preventive medicine.
 4. Part B.
23. What is the deductible in a Small Employer Group Basic plan?
1. \$1,000
 2. \$750
 3. \$500
 4. \$250
24. Under Worker's Compensation, which of the following would be a covered loss?
1. A worker is injured in an automobile accident while on the way to work.
 2. A worker's foot is injured while at work on an assembly line.
 3. While on a break, a worker is returning from a trip to the Post Office and is injured on a public sidewalk.
 4. A worker is on vacation and is injured in a recreational accident.
25. When a policy owner signs a portion of the rights to collect on a policy to another party to whom the insured owes money, this is called
1. Collateral Assignment.
 2. Absolute Assignment.
 3. Endorsement.
 4. Transfer Assignment.

26. If an employee is covered under COBRA and employment is terminated, group benefits may be continued for
1. 31 days.
 2. 1 year.
 3. 18 months.
 4. 24 months.
27. Required Provision number three (3) stipulates that there must be a minimum grace period for all policies, other than weekly or monthly direct premium policies, of
1. 7 days.
 2. 10 days.
 3. 30 days.
 4. 31 days.
28. Bill enrolls in Medicare, Part B and decides not to purchase an individual Medigap insurance policy. Four months after having enrolled he changes his mind and decides to buy a Medigap policy. How long would Bill have to purchase a policy and not have his health be taken into account by the insurance company?
1. Six months.
 2. Four months.
 3. Two months.
 4. Health would always be a factor.
29. What is the penalty if an employer fails to comply with the COBRA regulations?
1. Loss of benefits to the employees.
 2. Ten (10) percent.
 3. No penalty.
 4. The employer could lose the tax deduction for the cost of the health plan.
30. If a company paying Disability Income benefits is to comply within the Time of Payment of Claims provision, they must pay no less than
1. Monthly.
 2. Quarterly.
 3. Semiannually.
 4. Annually.

31. Long-Term Care insurance policies provide coverage for
1. Vision and dental treatments.
 2. Prescription drugs.
 3. Hospice care.
 4. Custodial Nursing Home care.
32. A health policy that does not pay for a loss arising from the insured's employment is
1. Non-occupational coverage.
 2. Occupational coverage.
 3. Unemployment coverage.
 4. Worker's Compensation.
33. Health care is provided in many different ways. Which one of the following statements best describes health care that is provided on a service basis.
1. Medical services are provided at the place of employment.
 2. A specified payment (indemnity) is provided in the plan.
 3. Health care benefits are provided directly to the insured instead of monetary reimbursements for health care expenses.
 4. Health care is provided to the enrollee on a prepaid basis where the health care services and health care provider are the same entity.
34. An individual purchased a health policy and paid premiums for several years before the policy lapsed. The policy was reinstated on August 1st. On August 8th, the insured entered the hospital with pneumonia. The policy would pay
1. Full benefits.
 2. Half benefits.
 3. Benefits only until they go back to work.
 4. No benefits.
35. If a Long Term Care policy replaces benefits used by the insured, it is called
1. A Texas 65 Health Plan.
 2. An HMO.
 3. Restoration of Benefits.
 4. Medicare Select.

36. Blue Shield is an example of a producer cooperative. Its members are called subscribers and payments are made directly to
1. Doctors.
 2. Hospitals.
 3. HMO's.
 4. PPO's.
37. A woman purchased a health insurance policy and named an irrevocable beneficiary. Later she decided to change the beneficiary. Who would be authorized to request the change?
1. The owner of the policy.
 2. The insured and the beneficiary.
 3. The insured and the agent.
 4. The beneficiary.
38. Which one of the following health care delivery systems allows the member to choose doctors from a list of providers and the insured is given a discount from the usual rate charged by the doctor chosen?
1. Fraternal Association.
 2. Blue Cross, Blue Shield.
 3. HMO.
 4. PPO.
39. Which of the following individuals are entitled to Medicare benefits under the Social Security Act?
1. All individuals receiving benefits under the Aid to Dependent Children program.
 2. All individuals under the age of 65 who have received Social Security disability benefits for at least two years.
 3. All individuals over the age of 62.
 4. All retired military personnel.
40. Model Long Term Care legislation mandates that in order for a policy to be defined as either a group or an individual Long Term Care policy, coverage must be provided for a minimum of
1. Normal life expectancy.
 2. 12 years.
 3. 6 years.
 4. 12 months.

41. Periodic payments of benefits would likely be found in
1. Major Medical policies.
 2. Cancer policies.
 3. Accident policies.
 4. Disability Income policies.
42. Which one of the following clauses provides for the adjustment of benefits in a disability income policy?
1. Relation of earnings to insurance.
 2. Grace period.
 3. Payment of claim.
 4. Time of payment of claim.
43. A person owns an individual health policy. The company cannot non-renew the policy except for failure to pay the premium. The company can raise the premium but only if they raise every premium in the same class. We would say this policy is a(n)
1. Optional Renewable policy.
 2. Guaranteed Renewable policy.
 3. Non-cancelable policy.
 4. Cancelable policy.
44. All of the following statements are true regarding the Affordable Care Act EXCEPT:
1. Even though everyone is required to have insurance, there are no penalties.
 2. Insurers must spend 80% of premiums they collect on health care.
 3. Insurers are no longer allowed to reject an applicant because of preexisting conditions.
 4. Insurers are no longer allowed to place limits on how many dollars they pay in claims on an annual or lifetime basis.
45. When a company issues a life insurance policy and it contains a provision for a higher face amount to be paid if the nation goes through a period of inflation, the policy would contain which of the following?
1. Endorsement.
 2. Amendment.
 3. Term rider.
 4. COLA.

46. Hospital Expense policies typically exclude
1. Hospital stays extending beyond 30 days.
 2. Hospital laboratory tests.
 3. Maternity care benefits.
 4. Expenses incurred primarily for elective cosmetic surgery.
47. Which one of the following is an example of an Optional Provision in the Uniform Provision law?
1. Entire Contract and changes.
 2. Incontestability and Preexisting Conditions.
 3. Proof of Loss.
 4. Misstatement of age.
48. An Individual Health policy is automatically reinstated when all conditions are met for reinstatement and the company fails to give approval in
1. 45 days.
 2. 20 days.
 3. 30 days.
 4. 60 days.
49. The period of time a company has to challenge misstatements on an application is
1. 2 years.
 2. 1 year.
 3. 5 years.
 4. Unlimited.
50. Grace periods are determined by law according to
1. The amount of coverage.
 2. The renewal provision of the contract.
 3. The mode of premium payment.
 4. The wishes of the insured.

51. Required Policy Provision Number 10 allows a company to require an autopsy at their expense EXCEPT:
1. In accidental deaths.
 2. In obviously natural deaths.
 3. Where forbidden by law.
 4. When a family member objects.
52. Following a loss under a health policy, the insured should furnish the company written notice of claims within
1. 10 days.
 2. 20 days.
 3. 31 days.
 4. 60 days.
53. An insurer or one of their agents should furnish claim forms within how many days following a request?
1. 10 days.
 2. 15 days.
 3. 20 days.
 4. 31 days.
54. Proof of loss under an individual health policy should be furnished within how many days?
1. 20 days.
 2. 30 days.
 3. 60 days.
 4. 90 days.
55. An insured is not allowed to bring legal action against an insurer until how many days following proof of loss?
1. 20 days.
 2. 30 days.
 3. 60 days.
 4. 90 days.

56. If a premium is due when an insurer is paying a claim
1. Claims can be denied.
 2. Benefits can be reduced.
 3. Policy can be cancelled.
 4. Premiums can be deducted from the claim.
57. The purpose of optional clauses three, four, five and six of the Standard Provision of a health policy relating to other insurance in a company and insurance in other companies and average earnings is to
1. Prevent someone from profiting from insurance.
 2. To make certain coverage is adequate.
 3. Provide a period of contestability.
 4. Prevent changes by an agent.
58. Optional Provision 10 of the Standard Health policy relates to illegal occupation and protects a company from paying when
1. There is fraud in the application.
 2. The policy is still contestable.
 3. The agent has misrepresented something.
 4. The insured's loss occurred during the commission of a felony.
59. A public assistance program (welfare) providing medical care for the poor is
1. Medicare.
 2. Medicaid.
 3. Old Age Survivors and Disability Insurance Benefits.
 4. Disability Medicare.
60. Which one of the following medical costs is not paid by Medicare because it is considered ineligible?
1. Cancer surgery.
 2. Elective cosmetic surgery.
 3. Dental reconstruction required following an automobile accident.
 4. Hospitalization costs because of diabetes.

61. If a Medicare enrollee is traveling in Europe and suffers a health loss requiring expensive treatment, what would be their coverage under Medicare A and B?
1. They would be covered under A but not under B.
 2. Medicare provides no coverage for those traveling out of the country.
 3. They would be covered under B but not under C.
 4. They would be covered under A and B.
62. The coinsurance percentage Medicare pays under Part B is what percent of the approved amount?
1. 20%.
 2. 50%.
 3. 75%.
 4. 80%
63. The annual deductible under Medicare, Part B is
1. \$628.
 2. \$147.
 3. \$250.
 4. \$157.
64. An agent must notify an applicant that a credit report may be requested under the Fair Credit Reporting Act. This must be done
1. When a prospect is contacted.
 2. When the application is taken.
 3. When the applicant's credit is checked.
 4. When the agent delivers the policy.
65. A person applied for a health policy and did not complete all of the questions on the application. Before they could finish the application and pay the first premium, they became sick. The company would not pay because the applicant had not met the conditions in which of the following required parts of the policy?
1. Preexisting condition clause.
 2. Consideration clause.
 3. Conversion clause.
 4. Entire contract provision.

66. Which one of the following statements is false regarding sources of underwriting information?
1. The information in an inspection report cannot be disclosed to the applicant.
 2. When benefits are large, a medical exam might be required.
 3. Attending Physician's Statement (APS) might be used.
 4. The application is a primary source for information.
67. The payment of Residual Disability benefits might be true of which of the following?
1. Benefits are reduced when an insured is not under a doctor's care.
 2. Payments could be based on the loss of one's employment.
 3. A principal sum might be paid for the partial loss of an arm.
 4. Benefits could be based on loss of time from work, loss of income or loss of function.
68. If an agent fails to complete any of the 30 hours of continuing education required during their two year renewal period, the Department of Insurance will fine them which of the following amounts per hour missed?
1. \$10
 2. \$100
 3. \$50
 4. \$25.
69. To be eligible for Waiver of Premium, the insured must
1. Take a medical exam every month.
 2. Not be able to leave their home.
 3. Continue premium payments.
 4. Be under the care of a doctor.
70. When an applicant signs the application for health insurance and pays the first premium, the agent can tell them they are insured for any covered loss
1. At that time.
 2. When an exam is completed.
 3. When the company accepts the risk.
 4. When all tests are completed.

71. Which of the following Accident and Health Policies would provide benefits for expenses following the breaking of an arm?
1. Disability Income Policy.
 2. Cancer Policy.
 3. Accidental Death and Dismemberment Policy.
 4. Medical Expense Policy.
72. Which one of the following benefits is taxed by the Internal Revenue Service like a regular wage or salary?
1. Social Security Disability.
 2. Welfare benefits.
 3. Worker's Compensation benefits.
 4. Disability income benefits from a policy purchased by an employer for an employee.
73. Preexisting conditions are found in which of the following required provisions of a health policy?
1. Notice of Claim,
 2. Proof of Loss.
 3. Time Limit on Certain Defenses.
 4. Legal Action.
74. Which one of the following is a health care system benefiting veterans and military retirees?
1. TRICARE.
 2. Railroad Retirement Board
 3. Medicare
 4. Medicaid
75. An insured notified the insurance company of a loss immediately following his hospitalization. When the company failed after 15 days to send claim forms, the insured has the right to
1. Sue immediately.
 2. Refuse to give proof of loss.
 3. Have all of his bills paid immediately.
 4. Give the company a description of the loss in the insured's own words.

76. If an insured holds more than one job, the insurer will classify his occupation for a health policy
1. According to which occupation he has held the longest.
 2. According to the one where most of his time is spent.
 3. According to the lowest premium schedule.
 4. According to which is the most hazardous.
77. In Health Policies, the Consideration Clause refers to
1. Minimum required premium.
 2. Full minimum premium or the application.
 3. Application.
 4. The full minimum premium required and the application.
78. Which of the following best explains why a person would buy a Medicare Select policy?
1. Gives more comprehensive coverage than other Medigap policies.
 2. Provides 24 hour coverage.
 3. Has lower premiums.
 4. All Medicare Select policies contain prescription drug benefits.
79. If an applicant for insurance is asked by the company to give blood for a test that would establish if the applicant had the AIDS virus, what is required?
1. The applicant must sign an "informed consent form."
 2. The applicant must pay for the test.
 3. All privacy rights must be waived by the applicant.
 4. Pay an extra premium.
80. From where do most of the funds for Medicare Part A come?
1. Social Security Payroll Taxes.
 2. General tax revenues.
 3. Private contributors.
 4. Premiums charged for Part A benefits.

81. The right to continue group health benefits after leaving the group or after termination is found in
1. Standard Provisions Law.
 2. Disability Benefit Law.
 3. McCarran-Ferguson Act.
 4. The COBRA Law.
82. Some short-term disability income policies have an optional payment of a lump sum for named injuries. This optional benefit is known as
1. Recurrent disability benefit.
 2. Supplemental income benefit.
 3. Elective indemnity benefit.
 4. Hospital income benefit.
83. A person applied for a Major Medical policy and requested that, if the company approves the application, coverage would begin on the date of application. The agent left them with a document called
1. A binding receipt.
 2. A Representation.
 3. A Warranty.
 4. A Conditional receipt.
84. When health policies pay amounts based upon what the average payment is for a certain geographical area, it is called
1. Indemnity.
 2. Cost averaging.
 3. Usual and customary.
 4. Scheduled benefits.
85. Federal law that allows a person to change group insurance coverage's because of a job change without having to go through a waiting period for preexisting conditions would be
1. COBRA
 2. HIPAA
 3. OASDI
 4. RRB.

- When does Medicare pay for a mammogram under their Part B formula?
- 86.
1. As often as the Medicare patient requests.
 2. Once every two (2) years.
 3. Once every twelve (12) months.
 4. Medicare does not pay for a mammogram because it is considered preventive medicine.
87. How is a provider in a PPO paid?
1. A set monthly amount.
 2. A fee for service as given.
 3. The individual provider is not paid.
 4. Prepaid premium emphasizing preventive medicine.
88. A person who is a resident of Texas and is uninsurable might get benefits from which of the following?
1. Texas Health Insurance Risk Pool
 2. Fee-for-service insurance
 3. Hospital Confinement insurance
 4. Workers Compensation fund.
89. When an agent is marketing a Long-Term Care policy, which one of the following benefits must be offered?
1. An inflation benefit.
 2. A surgical benefit.
 3. Lifetime coverage.
 4. Payments for accidents.
90. A Multiple Employer Trust would contain which one of the following elements?
1. All businesses belonging to the Trust must be different types of businesses.
 2. All of the businesses in the Trust must be of a similar type business.
 3. One employer is over all of the employees.
 4. No requirements for the types of businesses who join.

91. A mechanical device or appliance has been placed in a young man's mouth whose family is covered with dental insurance. The insurance would pay under which of the following?
1. Prosthodontics.
 2. Periodontics.
 3. Endodontics.
 4. Orthodontics.
92. When an agent is selling a Medicare Supplement policy, which one of the following must be left with the applicant?
1. An inflation benefit.
 2. An Outline of Coverage.
 3. A supplementary income rider.
 4. A binding receipt.
93. Which one of the following would be the most restrictive in allowing their members to choose their own physicians?
1. Traditional indemnity type of insurance..
 2. PPOs.
 3. HMOs.
 4. Blue Cross-Blue Shield.
94. In a disability buy-out policy, if the policy pays out more than the cost basis, the excess would be taxed in which of the following ways?
1. Capital gains.
 2. Ordinary income.
 3. A ten (10) percent penalty.
 4. It would not be subject to taxes.
95. Premiums paid for personal individual health insurance coverage are deductible as un-reimbursed medical expenses only to the extent that all other un-reimbursed medical expenses exceed what percent of the taxpayer's adjusted gross income?
1. 40%
 2. 33%.
 3. 10%
 4. 7.5%

96. If a physician is concerned that they would lose vital staff members if the physician was disabled for a period of time, which one of the following policies would the physician buy to protect the medical practice?
1. Business Overhead Expense policy.
 2. Business Continuation insurance.
 3. Key Person insurance.
 4. Disability Income policy.
97. Which one of the following statements best describes the Elimination Period in a Disability Income policy?
1. A period of time from the beginning of disability when the insurer is not required to make payments.
 2. A period of time from the effective date of the policy during which the insurer would not pay any benefits.
 3. An explanation of the percentage of payments that would be made in the event of a residual disability.
 4. The period following the Benefit Period when payments end because the insured has returned to work.
98. In group health insurance, which of the following statements is the most accurate regarding the tax liability of the employee when the employer paid all of the premiums?
1. Any amount paid by the insured that exceeds the actual medical bills incurred by the employee would be taxable income to the employee.
 2. Any amount paid by the insurer to the employee is taxable income.
 3. No tax would be due on benefits received.
 4. The employee must pay taxes on any amount received that exceeds the premium paid by the employer.
99. John jumped off of a bus and broke his ankle. Which accident policy would not pay?
1. Major medical policy.
 2. A stipulated premium policy.
 3. Accidental bodily injury.
 4. Accidental means.
100. If an individual purchased a Disability Income policy and later suffered a loss of total and permanent blindness, the policy would regard this as
1. A Presumptive disability.
 2. A Partial disability.
 3. A Residual disability.
 4. A non-covered loss.

ACCIDENT AND HEALTH INSURANCE

Key

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

HEALTH MAINTENANCE ORGANIZATION (HMO) BASICS

I. DEFINING AN HMO

HMOs were developed for a number of reasons. They make health care more affordable for the consumer, both in out of pocket expenses when care is received and also in monthly premium costs. The key elements include:

A. Prepaid Care

A person or organization that arranges for or provides health care services on a prepaid basis is operating an HMO. Prepayment distinguishes HMOs from the traditional fee for service insurance plans which has a separate charge for each service performed. Enrollees in an HMO prepay a monthly premium and this covers all health care expenses except a small co-payment. (Some HMOs may use coinsurance.)

1. HMOs provide services required to maintain good health, including, as a minimum:
 - a. Emergency care, both in and outside of the service area.
 - b. Preventive care.
 - c. Inpatient hospital care.
 - d. Outpatient medical services. (Ambulatory care).
2. A Single Health Care Service Plan provides health care to its enrollees for a particular health need such as vision or dental care.

B. Managed Care

1. The use of a Primary Care Physician (PCP) to control access, determine what medical treatment is required and the best way to provide the needed care and also be cost effective. The PCP is called the gatekeeper.
2. Pre-certification and review. (Utilization Review)
 - a. Pre-certification includes allowing the PCP to direct the care that is given. Many traditional health care insurers are accomplishing the same goals by requiring second opinions before surgery, prior authorization to enter the hospital (except in emergencies), etc.
 - b. Review. During the treatment, the PCP monitors the care to make certain cost controls are in place. This is concurrent review. After the care is completed, audits are used to evaluate the care and costs. This is retrospective review.

C. Contracting Providers

Unlike traditional insurers, HMOs limit the choice of provider to those who are in the network or a part of the HMO provider panel. Claims from non-contracting providers for services, other than emergency care, may be denied unless the enrollee has a Point of Service Option.

D. Negotiated Rates

Under the traditional fee for service insurance, the insurer pays a percentage of the provider's charges and the patient is billed for the balance. HMO providers are paid based on a contracted rate that is normally substantially lower than the provider's usual charges. The provider must accept the HMO reimbursement as full payment and is not allowed to bill the patient except for a prearranged co-payment or a contracted coinsurance amount.

E. Preventive Care

The HMO philosophy is strongly geared to prevention. Both the HMO and providers can realize greater profits if their members remain well. The emphasis on preventive care or wellness care is the heart of cost effectiveness.

F. Sharing the Risk (Capitation)

Indemnity insurance holds no risk for the provider of a service because the financial risk is shared by the patient and the insurance company. In an HMO the financial risk is shared between the HMO and its contracted providers through a process called capitation. Capitation is a prepayment that is based on a flat rate per person paid on a regular basis. The provider receives the same amount whether or not the patient is treated. The provider has an incentive to see that the patient remains healthy.

G. Additional HMO Terms

1. Certified Facility - A health care provider that has been certified by the federal government for providing care to Medicare patients.
2. Dual or Triple Choice - When a person enrolls in an HMO, either two or three health care options will be offered.
3. Inpatient Medical Care - Care received while in a hospital.
4. Outpatient Hospital Care - Services received in clinics, private offices, hospital based outpatient departments, etc. Sometimes called ambulatory care or surgical centers (surgi-centers).

5. Medical Emergency - Bona fide emergency services given after the sudden onset of medical conditions manifesting itself by acute symptoms, including severe pain that would result, without treatment, in jeopardizing the patient's health.
6. Point of Service (POS) Option - When an enrollee in an HMO is allowed to seek care from non-HMO physicians. A premium must be paid for the option and the HMO pays far less for the care when this option is used.
7. Primary Hospital - A general hospital equipped and staffed to handle the medical needs of HMO enrollees.
8. Referral Hospital - A primary hospital also equipped and staffed to handle intensive and specialized medical and surgical care.
9. Referral Specialist - Providers who have specialized their training and education in a specific health field. When necessary, PCPs refer patients to these specialists.
10. Service Area - The geographic area designated by the HMO where enrollees either live or work. The HMO must clearly define the area, furnishing a map to the enrollee. If the enrollee is outside the service area, the HMO will only pay for emergency care.
11. Swing-Bed Hospital - Another name for a Post-Hospital Skilled Nursing facility. This facility provides care just under the level of a regular hospital and must be in a facility separate from the hospital. A registered nurse is required to be available 24 hours a day.
12. A legal process that allows an insurance company to seek payment from a third party that has caused a loss. It more commonly occurs in property and casualty insurance.

V. THREE TYPES OF HMOs

There are three basic types of HMOs:

A. Group Model

Group model HMOs contract with independent medical groups, who provide coordinated care for large numbers of HMO patients for a fixed, per-member fee. These medical groups will often care for the members of several HMOs.

1. The Staff Model is the type where the physicians work directly for the HMO and are employees of the HMO. This model is sometimes called "bricks and mortar" plan because everything is owned by the HMO. This model is not allowed in Texas.
2. Medical Group Model is the model where the physicians work for the Medical Group and are "rented" to the HMO network. Examples of Group Practice HMOs in Texas include Kaiser Permanente and PruCare. These are called "Closed Panel" HMOs because the doctors see only HMO patients.

B. Independent Practice Association Model (IPA)

As the name indicates, the physicians who see HMO patients also have their own separate private practice. Physicians are allowed to represent several HMO networks if they wish to do so. Travelers are an example of an IPA model in Texas. These are "Open Panel" HMOs because the doctors see HMO patients and also non-HMO patients.

C. Mixed Model HMOs

The mixed model HMO is a network based on a variety of contracted relationships linking together a variety of providers, including physicians in group practices and solo practices. This model often offers a wider selection of service sites than either the group or IPA models. Examples of the Mixed Model HMO in Texas include Metlife and NYLCare (New York Life).

EXAMINATION SCORE _____
SCORE SHEET: Circle the correct answer

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

HMO PRACTICE EXAMINATION

1. If a person was enrolled in a Single, Vision, HMO they could expect the HMO to pay for all of the following EXCEPT:
 1. Examination.
 2. Lenses.
 3. Surgery.
 4. Frames.

2. HMOs are required to provide four major types of health care benefits. All of the following are among those four EXCEPT:
 1. Outpatient prescription drug program.
 2. Emergency care.
 3. Inpatient hospital care.
 4. Preventive care.

3. How is the HMO organized when the enrollee has the following features available? They are encouraged to select a primary care physician; they can change if they are dissatisfied; the primary care physician may be in private practice also, or could be under contract with other HMOs; the enrollee checks with the primary care physician first, in all situations, except for out of the area emergency care.
 1. Network.
 2. Independent Practice Association (IPA).
 3. Group Model.
 4. Staff Model.

4. Which of the following is a method of paying a physician a set fee per month for the care and treatment needed by an enrolled person?
 1. Co-payment.
 2. Capitation.
 3. Reinsurance.
 4. Primary care physician.

5. A swing-bed hospital would be a facility that is used in which of the following situations?
 1. Hospice care.
 2. Inpatient care.
 3. Post-hospital skilled nursing.
 4. Custodial nursing care.

6. When an HMO provides pharmacy services in a group contract a committee is appointed to check certain practices. All of the following will be subject to review EXCEPT:
1. Drug utilization review.
 2. Substitution of name brand drugs for generic drugs.
 3. Checking to see if there is a drug profile on the enrolled population.
 4. Patient education on the correct use of medications.
7. Which one of the following is the best definition of an HMO?
1. Any provision of health care provided by a basic health care plan or a single health care service plan to enrollees on a prepaid basis.
 2. Any type of health care system that provides benefits on an indemnity basis.
 3. When a person buys a major medical insurance policy.
 4. When an organization agrees to give the member a discount if the member will use only those physicians in the network.
8. If, as an agent, you were marketing a Point of Service Plan (or Option), what would be one of the reasons it would be difficult to market?
1. The plan makes it hard to control costs.
 2. The Option is so expensive that buyers are hesitant to choose the plan.
 3. The plan would give fewer choices of physicians than an HMO without the Option.
 4. The Point of Service Option has not been well received by the public.
9. All of the following factors can be used in underwriting group health plans EXCEPT:
1. The male/female ratio of employees.
 2. The average age of the employees.
 3. The percentage of minority employee in the census.
 4. The number of former employees and/or dependents on COBRA..
10. Which one of the following statements best describes a referral hospital?
1. The same as a primary hospital.
 2. A hospital that handles only emergency care.
 3. A primary hospital also equipped and staffed to provide intensive medical and surgical care.
 4. A licensed institution that refers seriously ill patients to specialty hospitals.

11. In order to hold down rising medical costs, HMOs have adopted a system of precertification or prior authorization. Which one of the following is an example of this?
 1. Reviewing procedures after a patient has been discharged.
 2. Auditing a hospital bill for possible errors.
 3. Requiring a second opinion before surgery.
 4. Receiving a discount because a certain physician was consulted.

12. An HMO may provide benefits to the grandchild of an enrollee under which of the following circumstances?
 1. The grandchild has been adopted.
 2. The grandchild is under 18 years of age.
 3. The grandchild is a dependent on their income tax filings under age 21.
 4. The grandchild has been a dependent for minimum of five years.

13. If an organization retains the right to sue a third party who caused a loss, it is called the right of:
 1. Adhesion.
 2. Subrogation.
 3. Litigation.
 4. Estoppel.

14. If a mother is covered under a group health plan, how soon after birth would the child be covered?
 1. After 14 days and the company is notified in writing.
 2. After 21 days.
 3. After three months.
 4. Immediately upon birth.

15. In which of the following circumstances would an HMO pay for medical services outside of the defined service area?
 1. In an emergency care situation.
 2. In any situation where medical services are sought..
 3. In any non-emergency situation.
 4. In any situation where the enrollee receives prior approval.

16. If an enrollee leaves an HMO he or she must be given the right to continue their benefits under an individual policy with no proof of insurability required if they apply within 31 days of their leaving the group plan. This is one of the mandatory provisions in HMOs and is called
1. Coordination of benefits.
 2. COBRA benefits.
 3. Right of subrogation.
 4. Conversion.
17. What is another name for a Primary Care Physician (PCP).
1. Provider.
 2. Referral physician.
 3. Gatekeeper.
 4. Referral specialist
18. All of the following could be considered an advantage HMOs would have over the Traditional fee-for-service arrangements EXCEPT:
1. Wide ranging choice of physicians.
 2. Preventive care.
 3. Quality control.
 4. Managed care.
19. A certified facility would best be described as
1. A health care provider that has been approved by a state government to provide care for Medicare patients.
 2. Any organization approved by the American Medical Association.
 3. A facility approved by an municipal or county government.
 4. A health care provider that has been approved by the federal government to provide care for Medicare patients.
20. Ambulatory care is defined by which of the following?
1. Outpatient care.
 2. Care in a hospital after being conveyed in an ambulance.
 3. Any hospital stay.
 4. Post-hospital skilled nursing care.
 4. Patient education on the correct use of medications.

HMO

Key

- | | |
|-----|----|
| 1. | 3. |
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| 3. | 2. |
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| 15. | 1. |
| 16. | 4. |
| 17. | 3. |
| 18. | 1. |
| 19. | 4. |
| 20. | 1. |

NUMBERS THAT MAY APPEAR ON THE EXAMINATION

There are many numbers that might appear on the examination. If you master the numbers and the glossary, you will have laid a solid foundation for success on the exam.

1

- A. An agent can hold only 1 license of the same type.
- B. When an agent holds a temporary license, they can only sell with the 1 company that appointed them.
- C. If an agent's license is revoked, they may apply for another license after 1 year. The license may not be issued.
- D. If a policy states a grace period by month, it can only be for 1 month.
- E. Proof of loss on individual health policies cannot be given after 1 year, except for absence of legal capacity.

2

- A. An insurance license is good for 2 years.
- B. A person who sells insurance without a license is barred from applying for a license for 2 years.
- C. Life and health policies can be contested by the insurance company during the first 2 years after the effective date. After 2 years, incontestable except for fraud or misstatement of age.
- D. A life insurance policy does not have to pay for suicide if the insured commits suicide within the first 2 years. After 2 years, the policy must pay for suicide.
- E. State laws require that a company settle a death claim within 2 months after receiving proof of death.
- F. A person eligible for Social Security may go on Medicare before age 65 if they are disabled for 2 years.
- G. A permanent life insurance policy is required to begin the accumulation of cash values after the end of 2 years.
- H. The minimum number in a Small Employer Group is 2.

3

- A. To apply for a Counselor's license the applicant must have held a General Lines: Life, Accident, Health and HMO license for 3 years.
- B. A tertiary beneficiary is the 3rd person in line to receive the death benefits of a life insurance policy if the primary and contingent (secondary) beneficiaries have already predeceased the insured.
- C. There are 3 Non-forfeiture Options in a permanent (whole life) life insurance policy.
- D. A life insurance policy may be reinstated within 3 years after it has lapsed.
- E. Medicare has a 3 pint deductible for blood under A or B.
- F. Insurance companies are examined by the Department of Insurance once every 3 years after they have been in business for 3 years; once a year in the first 3 years.
- G. There are 3 separate entities than can receive an insurance license: Individuals, Limited Corporations and Limited Partnerships.
- H. No legal action can be taken against a company for failing to pay a claim after 3 years.
- I. A permanent life insurance policy's cash values must be made available for a policy loan after 3 annual premiums have been paid.
- J. An HMO must maintain a file on advertising and complaints for 3 years.
- K. An HMO is required to provide treatment for chemical dependency but they can limit benefits to 3 separate series of payments.

4

- A. All agents must maintain records of continuing education for 4 years.

5

- A. A Jumping Juvenile Policy will "jump" 5 times the original face amount when the juvenile reaches age 21.
- B. There is a 5 month waiting period before an eligible person can begin receiving Social Security disability benefits.
- C. The minimum notice a company gives to cancel individual health policy is 5 days.
- D. An applicant for an insurance license must give his employment history for 5 years prior to the date of the application.
- E. Before an HMO must pay for *in vitro fertilization* a woman must have attempted pregnancy with her spouse for 5 consecutive years.

6

- A. Life insurance policies may be backdated for up to 6 months in order to save age.
- B. A Medicare Supplement Policy and Long-Term Care Policy can only have a 6 month waiting period before preexisting conditions are covered. In both types of policies the insurer may only go back 6 months to define a preexisting condition.
- C. If a person is receiving disability income benefits, they must meet health requirements every 6 months unless the disability is considered "*presumptive*".
- D. A request for a policy loan or cash surrender can be delayed by the insurance company for up to 6 months.

7

- A. An Industrial Policy may have a grace period of 7 days.
- B. The IRS uses the first 7 years of a contract's life to determine if it is a Modified Endowment Contract.

10

- A. The standard Free Look Period for life and health policies is 10 days.
- B. A policy with a monthly direct billed premium mode may have a 10 day grace period.
- C. The penalty imposed by the IRS on qualified funds withdrawn before age 59Y2 is 10 percent.
- D. To form an individual employee group for group insurance requires 10 eligible people.
- E. After an individual health policy has been reinstated, there is a 10 day waiting period for sickness.
- F. An HMO policy or certificate must have a minimum type size of at least 10 points in height.

12

- A. Long-Term Care Policies must provide benefits for at least 12 consecutive months.

14

- A. A newborn child can be added to a family policy under the children's rider after they are 14 days old and the insurance company has been notified. No health questions are asked.

15

- A. Juvenile insurance is insurance on an individual who is 15 years of age or younger.
- B. Claim forms must be furnished by an insurance company (or an agent) within 15 days following the request.

18

- A. A person who has converted group health insurance to an individual policy must be carried by the insurer for at least 18 months. (COBRA)
- B. A person must be at least 18 years of age to apply for an insurance license in Texas.

20

- A. If an agent's license is revoked or suspended, they may appeal to a District Court within 20 days following the revocation or suspension.
- B. In an individual health policy written notice of claim must be given to the insurer within 20 days after any loss.
- C. Medicare pays all costs for Post-Hospital Skilled Nursing for the first 20 days.

21

- A. Jumping Juvenile policies usually make their "jump" in face amount coverage when the insured reaches age 21.
- B. Payor Rider benefits drop from the policy when the juvenile reaches age 21.
- C. Guaranteed Insurability rider options do not begin until the insured reaches age 21.

25

- A. A Labor Union Group requires 25 people.

30

- A. The Continuing Education requirement is 30 hours every two years. (15 each renewal year).
- B. The free look period for Medicare Supplement Policies and Long-Term Care Policies is 30 days.
- C. If the Texas Department of Insurance decides to revoke an insurance company's Certificate of Authority, it is revoked 30 days after the Department notifies them by registered letter.
- D. Disability Income Policies and Long-Term Care Policies may have a probationary period, usually 30 days.
- E. The minimum grace period for HMO enrollees is 30 days.
- F. An employee must work 30 hours per week to be considered a full-time employee and thus eligible for enrollment in group insurance plans.

31

- A. A person leaving group coverage may convert the insurance by paying the required premium within 31 days of leaving the group.
- B. Policies that are paid for annually, semi-annually, quarterly or monthly bank draft will have a 31 day grace period.

36

- A. COBRA allows group health coverage to continue for a divorced spouse and dependents for up to 36 months.

40

- A. Before receiving a temporary license, an agent must have 40 hours of training.
- B. To qualify for Social Security benefits, contributions must be made for 40 quarters.
- C. The last option available under a Guaranteed Insurability rider is at age 40.
- D. Under certain circumstances a self-employed person can deduct up to 40% of their health insurance premiums from their income taxes.

45

- A. An individual health policy is considered reinstated 45 days after the agent has given a conditional receipt unless the insured has been notified otherwise.

50

- A. If an agent renews their license within 90 days following the renewal date, a penalty of 50 percent of the original license fee must be paid.
- B. The penalty for not withdrawing qualified retirement funds after age 70½ is 50 percent of the required withdrawal that was not taken out.
- C. The maximum number of eligible employees allowed for a Small Employer Group plan is 50.
- D. A Single Service HMO is required to deposit \$50,000 with the state.

60

- A. No legal action can be taken for 60 days after proof of loss has been given.
- B. Medicare, Part A, has a 60 day hospital benefit period when a deductible must be paid.
- C. Most Waivers of Premium riders on life insurance policies will not apply if a disability arises after the insured reaches age 60.
- D. According to the IRS rules, a rollover of funds from one insurer to another must be completed within 60 days.
- E. According to COBRA regulations a person has 60 days following severance from group health coverage to apply, with premium, for continuation of group benefits.
- F. All Medicare enrollees receive 60 lifetime reserve hospital days. Once a reserve day is used, it is not renewed.

62

- A. Social Security allows retirement benefits to begin at age 62. The monthly amount received will be lower than it would be if the retiree had waited until age 65 to begin benefits.

65

- A. The maximum monthly retirement benefits paid under Social Security are paid to those who go on the program at age 65.
- B. Most people who qualify for Medicare go on the program when they reach age 65.
- C. A person who is 65 years of age at the time an indebtedness is incurred is ineligible for credit life insurance.

75

- A. A contributory group requires the participation of at least 75 percent of the eligibles in order for the insurer to avoid adverse selection.

80

- A. Medicare, under Part B, pays 80 percent coinsurance on the approved part of the bill.

90

- A. A temporary license is good for 90 days.
- B. An agent may renew their license within 90 days following the renewal date.
- C. An agent applying for a nonresident license must file an original letter of clearance dated within 90 days of the application for the nonresident license.
- D. An Accidental Death Benefit (ADB) will pay if death is caused by an accident and death occurs within 90 days following the accident.
- E. Proof of loss in individual health policies should be given within 90 days, if possible.
- F. An Affiliation Period in a Small Employer Group plan cannot exceed 90 days for new enrollees.
- G. In the unlikely event a Medicare enrollee is in the hospital for more than 90 days in a benefit period, "lifetime reserve days" can be used to pay the bill
- H. Agents may renew licenses on-line if they are within 90 days of the renewal date.

100

- A. Mortality tables assume everyone is statistically dead at age 100 and permanent insurance policies endow.
- B. Medicare, Part B, has a \$135 annual deductible.
- C. Noncontributory groups require 100 percent participation of those eligible for insurance coverage.

MISCELLANEOUS

- A. An individual may tax deduct \$5,000 a year in an Individual Retirement Account (IRA). Actually, it is a deferral of tax, because the tax will be paid at withdrawal.
- B. A Spousal IRA allows \$5,000 a year to be tax deducted (deferred).
- C. Tax deferred funds cannot be withdrawn early without incurring a 10% penalty. The cut-off age is 59½. Funds withdrawn before that age will incur the penalty.
- D. Tax deferred funds must be taken out, starting by age 70½ to avoid penalties. A minimal proportioned amount, based on life expectancy, must be withdrawn annually.
- E. The deductible for a Small Employer Group Basic plan is \$500.
- F. The deductible for a Small Employer Group Catastrophic plan is \$2,500.
- G. A Full Service HMO, when applying for a license to operate in Texas, must deposit with the state Treasurer a sum of \$100,000.
- H. A \$100,000 fidelity (performance) bond must be posted by an HMO for every officer and employee of the HMO.
- I. A fee of up to \$500 is charged an HMO for their annual report.
- J. An HMO must pay \$15,000 to the state when applying for a Certificate of Authority.

GLOSSARY

A

| | |
|---|--|
| A&H A&S | Accident and Health or Accident and Sickness. Once commonly used, now covered under the term, Health Insurance. |
| ABSOLUTE ASSIGNMENT | When the policy owner gives all control and rights to a third party. |
| ACCELERATION OF LIFE INSURANCE BENEFITS | A special benefit under an individual life policy which prepays all or a portion of the death benefit prior to death, based on disabling or life-threatening conditions. May be in the original policy or may be added as a rider. |
| ACCIDENT | A fortuitous event that is unforeseen and unintended. |
| ACCIDENT INSURANCE | A type of health insurance providing benefits for accidental bodily injury. |
| ACCIDENTAL BODILY INJURY | A traumatic damage to the body, originating externally, unexpected and unforeseen by the injured. |
| ACCIDENTAL DEATH AND DISMEMBEREMENT (AD&D) | A type of accident insurance that pays a specified amount for death caused by an accident and also pays on a scheduled basis for the loss of an arm, leg, hand, etc. May be purchased as a separate policy or as a rider to a life or health policy. |
| ACCIDENTAL DEATH BENEFIT (ADB) | Pays an amount stated in the policy if an accident is the cause of death. The benefit may be sold as an Accident Policy, as a rider in a life policy that doubles, triples or quadruples the face amount or as part of a health policy. |
| ACCIDENTAL MEANS | A definition of accident that is more limiting than "accidental bodily injury." The trauma must be accidental; the insured must not have contributed to or caused the mishap. |

ACCUMULATE AT INTEREST

A dividend option where the company retains the interest dividend and invests it for growth.

ACTUARY

A person who specializes in the mathematics of insurance, calculating mortality rates, premiums, reserves, etc.

AD&D

See Accidental Death and Dismemberment.

ADB

See Accidental Death Benefit.

ADHESION

The contract principle of Life and Health Insurance that means the insurer writes the contract, making it a one-sided contract. The insured must accept the contract totally or reject totally. For the insured, the contract is a "take it or leave it" choice. Because the insurer wrote all of the contract, in the event of a legal dispute over the meaning of words, the courts will favor the insured.

ADJUSTABLE LIFE INSURANCE

A type of life insurance contract that combines term insurance and whole life in one policy. The insured may increase or decrease the premiums and the face amount within certain limits.

ADMITTED COMPANY

An insurance company authorized to do business in a state.

ADVERSE SELECTION

When insuring selections are made against the company in that more poor risks are selected than good risks.

AFFORDABLE CARE ACT

A U. S. statute enacted March 23, 2010 that requires virtually all Americans to have comprehensive health insurance. The act required that all preexisting conditions be covered, and eliminated maximum payments on policies.

AFFILIATION PERIOD

A period of time established by a small employer carrier not to exceed 90 days for new enrollees and not to exceed 180 days for late enrollees during which premiums are not collected and the issued coverage is not effective.

AGE CHANGE

The point when a person is considered a year older. Many life insurance companies consider this at 6 months after a birthday. Most health companies use the last birthday for age.

AGENT

An individual who represents an insurance company. They sell and service insurance policies either as Independent Agents or Direct Writers (Captive Agents). Independent agents write for two or more companies and, in theory, search for the most cost effective policy. Direct writers (Captive Agents) represent only one company and sell only their policies. Many states have dropped the word agent in favor of the word producer.

AGENT AUTHORITY

Agency is created by the principal in the relationship with the agent. Agency law classifies all agents according to the type of authority granted by the principal. See Actual or Expressed Authority, Implied Authority and Apparent or Perceived Authority.

AGENCY SYSTEM

A marketing system where insurance companies market their products through agents. The company may be an agency building company or it might work directly with individual agents, through Managing General Agents or through a brokerage system.

ALEATORY

Equal value is not given by both parties to a contract allowing, in some cases, a small premium paid to result in large benefits.

ALIEN COMPANY

An insurance company formed outside of the United States. (In Texas, all companies found outside of Texas are called "foreign/alien" companies.)

AMBUALTORY

Outpatient care as in an Outpatient Clinic like a Surgical Center.

AMERICAN COLLEGE

The accrediting body for the awarding of the CLU (Chartered Life Underwriters) and the ChFC (Chartered Financial Consultant). Located in Bryn Mawr, Pennsylvania, and formerly called the American College of Life Underwriters.

AMORTIZATION

The systematic liquidation of a debt. Payments are arranged so the debt will reach zero at the end of a specific time. A Decreasing Term life insurance can be purchased to amortize at the same rate as a debt.

**ANNUALLY RENEWABLE
TERM (ART)**

A term life insurance policy that provides coverage for TERM (ART) one year and can be renewed without proof of insurability. Sometimes called Yearly Renewable Term (YRT).

ANNUITANT

A person who receives an annuity payment.

ANNUITY

A contract that pays a series of payments to an annuitant during their lifetime and/or to their beneficiaries.

**APPARENT (PERCEIVED)
AUTHORITY**

An agent has Apparent Authority when a third party (client) believes that the agent has such because of the circumstances in which the principal (company) has placed the agent. Example: If a principal gives an agent receipt books, applications, sales manuals, etc., the third party would assume that an agency relationship exists between the company and the agent.

APPLICANT

A person applying for insurance.

APPLICATION

The form the applicant uses to provide information (representations) to an insurance company to help the company to evaluate the risk.

APS

See Attending Physician Statements.

**ASSESSMENT MUTUAL
COMPANY**

A mutual company that is allowed to charge (assess) losses back to policy-owners.

ASSIGNMENT

To transfer rights of a policy to a third party.

ATTAINED AGE

The age of a person at the present or current date.

**ATTENDING PHYSICIAN
STATEMENTS**

The Attending Physician Statements (APS) is information supplied by a physician about the health of an applicant for insurance. Many consider the APS the most important single source of underwriting information.

AUTHORIZED COMPANY

A company admitted to do business in a state.

A

**AUTOMATIC PREMIUM
LOAN**

The insured gives permission to the company to borrow from the cash value of a policy to pay premiums when the insured accidentally fails to pay.

**AVERAGE INDEXED
MONTHLY EARNINGS
(AIME)**

The formula for figuring the Primary Insurance Amount (PIA) for Social Security Benefits.

AVIATION EXCLUSION

One of the historical exclusions in life policies where the company would not pay for death by aviation accident. Such an exclusion usually would not extend to fare paying air travel.

B

BENEFICIARY

A person who receives the benefits from an insurance policy other than the insured.

BEST, A.M.

One of the most widely used services that rates most insurance companies.

BLACKOUT PERIOD

The period of time when Social Security provides no income for a widow. It begins when a widow's youngest child becomes age 16 and continues until, at the earliest, the widow reaches age 60.

BLANKET POLICY

A limited health insurance policy that covers a group of persons who are not individually named, like a sports team.

**BLUE CROSS AND
BLUE SHIELD**

Service organizations whose members are called "subscribers." Benefits are paid directly to the providers, not to the subscribers; Blue Cross to the hospital and Blue Shield to doctors.

BROKER

Represents the client to the company selected for the client. There is no Brokers license in Texas and Agents may call themselves Brokers.

**BUSINESS CONTINUATION
INSURANCE**

Insurance that will pay the salaries of support personnel in the event the owner of the business is disabled. Would pay the salary of a nurse if the medical doctor for whom they work is disabled.

BUSINESS INSURANCE

Life or Health Insurance written to protect business situations such as key person, sole proprietorships, partnerships and corporations.

**BUSINESS OVERHEAD
EXPENSE INSURANCE
(BOE)**

Insurance that pays for continuing overhead (rent, utilities, etc.) while a key person or owner is disabled. Premiums are deductible, benefits are taxed.

BUY-SELL AGREEMENT

A contract that allows a deceased partner's business interest to be purchased by the surviving partner(s). A purchase price is agreed upon in the contract and is often financed by life insurance. All of the partners purchase life insurance policies on all of the other partners' lives.

C

CANCELABLE

An insurance policy that can be ended by the insurer at any time. Most policies are cancelable except life insurance and some health policies that are "guaranteed renewable" or "non-cancelable and guaranteed renewable."

CAPITAL SUM

The maximum amount paid in one sum for losses in accidental dismemberment.

CAPITATION

When a Primary Care Physician is paid by the HMO per enrollee assigned to the PCP whether they see them or not.

CASH DIVIDEND OPTION

A dividend option in a life insurance policy where the company pays the dividend in cash.

**CASH SURRENDER VALUE
OPTION**

A non-forfeiture option in a whole life insurance policy which allows the policy-owner to surrender the policy to the company and receive the cash value amount.

CERTIFICATE OF AUTHORITY

A written statement made by an insurance company explaining the powers they have vested in an agent. Also, in Texas, the document issued to an insurance company from the State Board of Insurance authorizing the company to do business in Texas.

CERTIFICATE OF INSURANCE

A statement received by a member of group insurance in the place of a policy that states the coverage's, benefits, etc. It is proof of insurance.

CHAMPUS

See TRICARE.

CHARTERED FINANCIAL CONSULTANT (ChFC)

A designation awarded by the American College. Recipient must have passed national examinations over life insurance, financial planning, taxation, etc.

CHARTERED LIFE UNDERWRITER (CLU)

A professional designation awarded by The American College in Bryn Mawr, PA. Holders of the CLU must have passed national examinations over insurance, investments, taxation, estate planning, etc.

C

CHECK-O-MATIC

Another name for Monthly Bank Draft.

ChFC

See Chartered Financial Consultant.

CLAIM

The demand of an insured or their representative for benefits due from an insurance policy.

CLU

See Chartered Life Underwriter.

COBRA

See Consolidated Omnibus Budget Reconciliation Act of 1985.

COINSURANCE

An agreement in Health Insurance where costs are shared between the insurer and the insured. Usually stated as a percentage as 80-20.

COLLATERAL ASSIGNMENTS

When the values of a life insurance policy are assigned to someone as collateral for a loan. The creditor would receive up to the value of the loan.

COMBINATION AGENT

An agent who sells both Ordinary Life Insurance and Industrial Life.

COMMINGLING OF FUNDS

When an agent mixes money owed to an insurance company with their own funds. Action is a violation of Unfair Trade Practices in Texas and subjects the agent to disciplinary actions by the Texas Department of Insurance. Also referred to as conversion.

COMMISSIONER

In most states, including Texas, the title of the Chief Executive Officer of the State Insurance Department. In Texas, the Commissioner is the Chief Executive Officer over the Texas Department of Insurance and is appointed by the Governor with the advice and consent of the State Senate. The Commissioner has a two (2) year term of office that expires on February one of odd-numbered years.

**COMMISSIONERS
STANDARD ORDINARY
MORTALITY TABLE**

The table approved by the National Association of Insurance Commissioners. The table forms the basis for calculating minimum values in policies and depicts the number of people dying each year, not as individuals, but in age groups.

COMMON CARRIER

Companies licensed by government units to transport fare paying passengers, like bus companies, air lines, taxis, etc. Usually, when triple and quadruple accidental death benefits are included they are limited to accidents involving a common carrier.

**COMMON DISASTER
PROVISION**

A provision that can be included in a life insurance policy that is designed to protect contingent beneficiaries. It provides that in the event the insured and primary beneficiary are killed in a shared accident, the primary beneficiary must outlive the insured by a minimum number of days to receive benefits. (Usually 10, 15 or 30 days.)

COMPETENCY

The ability to sign a contract. Usually based on age or mental condition.

CONCEALMENT

The failure by an applicant to reveal some information that materially affects the company's ability to evaluate the risk.

CONDITIONAL RECEIPT

If the premium is paid, the company may issue a receipt stating that coverage begins when premium was paid if the company would have issued the policy based on the information available to them.

CONSIDERATION

The premium.

CONSIDERATION CLAUSE

The clause stating what the premium is and when it is to be paid.

C

**CONSOLIDATED OMNIBUS
BUDGET RECONCILIATION
ACT OF 1985 (COBRA)**

Extended group health coverage to terminated employees and their families for up to 18 or 36 months.

CONTINGENT BENEFICIARY

Receives the money if the Primary Beneficiary has predeceased the insured.

CONTRIBUTORY

A plan of insurance (usually group) where the insured pays a part of the premium. Requires 75% participation of all eligible employees.

CONTROLLED BUSINESS

Insurance an agent writes on their own life and on family or business associates. An agent must not limit their business to controlled business.

CONVERSION PRIVILEGE

The right of group policyholders to change to an individual policy, regardless of health, should their group coverage end.

CONVERTIBLE INSURANCE

Right to change to different type of policy with the same company regardless of health.

**COORDINATION OF
BENEFITS**

The formula to determine which company pays as the primary company when a working couple or their dependents have a claim covered by more than one group insurance policy.

COPAYMENT

Under Medicare, the amount the insured must pay, after the deductible, before Medicare pays. Same as coinsurance. Also used in HMOs to designate a small payment made when visiting a physician or getting prescription drugs.

**COST OF LIVING
ADJUSTMENT (COLA)
RIDER**

A Rider that provides for benefits to rise or fall with changes in the cost of living.

CREDIT LIFE INSURANCE

Insurance on a debtor that would pay the lender the amount owed if the debtor dies or is disabled. (In Texas the amount of Credit Life may not at any time exceed the indebtedness.)

C

CSO

See Commissioners Standard Ordinary Mortality Table.

**CURRENT ASSUMPTION
WHOLE LIFE (CAWL)**

A policy that allows the cash values to be higher than the guaranteed levels. This policy is sometimes called "Interest Sensitive Whole Life."

D

DATE OF ISSUE

The date an insurance company issues a policy. This date may differ from the date the policy becomes effective.

DEATH BENEFIT

The proceeds paid to the beneficiary in an insurance policy.

**DECLARATION PAGE
("DEC PAGE")**

The page of a policy giving the information about who is insured, address, etc.

DECREASING TERM

Life insurance where the beginning amount reduces out to zero over the life of the policy.

DEDUCTIBLE

The first dollars in a policy that the insured is required to pay before the company begins payment.

DEFERRED ANNUITY

An annuity contract where payments to the annuitant are delayed until some time in the future.

| | |
|------------------------------------|---|
| DEFINED SERVICE AREA | The geographical area mapped out by an HMO to their enrollees where basic, non-emergency care is provided by the HMO. Outside of this area the HMO will only pay for emergency care. |
| DIRECT RESPONSE SYSTEM | Refers to a marketing system where the insurance company contacts prospective customers directly, without using salespersons. |
| DISABILITY INCOME INSURANCE | A type of health insurance that replaces loss of income if the insured becomes disabled. |
| DISMEMBERMENT | When a part of the body is lost or the use of it is lost through accidental bodily injury. Often blindness and loss of speech are included. Sometimes deafness is included. |
| DIVIDEND | A return of part of the premium paid on a participating policy. |
| DIVIDEND OPTION | The way a dividend is paid to the policy-owner. |
| DOMESTIC COMPANY | An insurance company incorporated in a state where the insurance is sold. |
| D | |
| DOUBLE INDEMNITY | A provision that, under certain conditions, the insurance company will pay a beneficiary twice the face amount of the policy. |
| DREAD DISEASE POLICY | A limited health policy providing benefits only for some named diseases such as polio, encephalitis, cancer, etc. |
| DUPLICATION OF BENEFITS | Coverage in health insurance by two or more policies for the same loss. Each policy will pay its proportionate share of the loss, or one policy will become primary and the other secondary. See Coordination of Benefits. P. 131 In the sale of Medicare Supplement (Medigap) policies it is illegal for an agent to sell a policy designed to duplicate a policy already in place. |

E

E & O

See Errors and Omissions Liability Insurance.

| | |
|-----------------------------|--|
| EFFECTIVE DATE | The time a policy contract is in effect and coverage is furnished. |
| ELIMINATION PERIOD | The period of time between the beginning of a disability and the beginning of benefit payments. (Sometimes called Waiting Period.) |
| ENDORSEMENT | Specifically a change made directly on the policy by writing, printing, stamping or typing that changes some benefit. |
| ENDOWMENT POLICY | A life insurance policy written for a limited number of years. If the insured lives to the end of the contract time, they receive the face amount. If the insured dies during the contract time, the beneficiary receives the face amount. |
| ENTIRE CONTRACT | When an insurance company places a copy of the application inside the policy, these two (policy plus copy of application) are called "Entire Contract." |
| ERRORS AND OMISSIONS | A professional liability policy that protects an agent from an inadvertent lapse of a professional responsibility. |
| ESTOPPEL | A contract principle that states an insurer is obligated to live up to the terms of a contract. |
| ESTATE PLANNING | A procedure for accumulating and conserving wealth. Specifically, estate planning seeks to conserve as much wealth as possible to transfer to heirs. Many different professionals may be involved in estate planning, including attorneys, bankers, financial planners and insurance agents. |
| EXCLUSION | Exceptions stated in a policy that limits the company's obligations to pay. |
| E | |
| EXECUTION CLAUSE | States when a contract goes into effect. |
| EXPRESSED AUTHORITY | Authority granted by the principal (as an insurance company) to the agent (salesperson) in specifically stated language. The grant of authority in the language may be broad or very narrow. |

| | |
|--|---|
| EXTENDED TERM OPTION | One of the three non-forfeiture options of a permanent life insurance policy-owner. The cash value is used to buy a single premium term policy for the same face amount as the previous policy being terminated. The term coverage extends as long as the cash values are able to purchase and then ceases. |
| FACE AMOUNT | The amount stated on the face (first page) of a life insurance policy that the company will pay at death or when the policy matures. |
| FAIR CREDIT REPORTING | Federal law requiring that a person authorize the collecting of credit information about themselves and contains general consumer safeguards. Also called "Privacy Act." |
| FAMILY POLICY | A combination life insurance policy with whole life coverage on the provider and convertible term available for spouse and/or children. |
| FIDUCIARY | A person who is entrusted with funds from others. Example: An insurance agent has fiduciary responsibilities when entrusted with premium receipts. |
| FINRA | The Financial Industry Regulatory Authority. Has now taken the place of the National Association of Securities Dealers. |
| FIXED AMOUNT OPTION | A settlement option on a life insurance contract where the beneficiary receives a set amount for an unspecified time period. Payments would continue until the principal and interest are paid out. |
| FIXED PERIOD OPTION | A settlement option where the beneficiary is paid a regular income for a definite period. |
| FLEXIBLE PREMIUM ANNUITY | An annuity contract that allows the purchaser to make contributions when they wish and for various amounts. |
| FLEXIBLE SPENDING ACCOUNTS (FSAs) | Accounts of pre-tax dollars that can be used to pay medical bills. |

FOREIGN INSURANCE COMPANY

A company incorporated in some other state than where the insurance is written.

FRATERNAL BENEFIT SOCIETIES

Social, religious or ethnic groups which sometimes act as insurers for their members. They are nonprofit, democratic, lodge type organizations with rituals. Sometimes referred to simply as "Fraternals."

FRAUD

An intentional misrepresentation made to secure an advantage and results in a loss to another party.

FREE LOOK PROVISION

A provision that allows a policy-owner to examine a policy a certain number of days and return it for a full refund. The requirement in Texas is ten (10) minimum days for life and health policies except Medicare Supplement Policies and Long Term Care Policies, which are both thirty (30) minimum days. Also called Free Examination or Right of Refusal.

401(k) PLAN

See SECTION 401(k) PLAN

403(b)

See SECTION 403(b).

457

See SECTION 457.

G

GA

See General Agent.

GATEKEEPER SYSTEM

In a Health Maintenance Organization (HMO) where members are required to select a Primary Care Physician (PCP) who provides or authorizes care for the members.

GENERAL AGENT

A person (often called GA) appointed by an insurance company to head a general agency and employ agents. GA's are similar to independent contractors.

GRACE PERIOD

A time period when a premium is due but the insurance is still in force. Periods are commonly seven (7), ten (10) and thirty-one (31) days and are determined by the mode of premium payment.

GROSS PREMIUM

Mortality factors, with interest assumptions calculated, plus loading. This is the premium in the company's rate book.

GROUP INSURANCE

A contract of insurance with an employer or other authority that covers a group of people identified individually by their relationship to the employer. The contract may be for life insurance, health insurance or an annuity. Requires at least ten (10) eligible persons.

**LIFE, ACCIDENT, HEALTH
AND HMO LICENSE
(FORMERLY GROUP I)**

License issued by the Texas Department of Insurance. Considered a broad license authorizing the agent to represent legal reserve insurance companies in the sale of "Life and Health Insurance." The complete title of the license is "General Lines: Life, Accident, Health and HMO License." An exam is required and the license is referred to as "permanent" because it can be renewed every two years.

**GUARANTEED
INSURABILITY**

An option in life and health insurance that allows the insured to purchase specified amounts of additional insurance at specified later times regardless of insurability.

G

GUARANTEED RENEWABLE

A contract that gives the insured the right to renew regardless of health. Premiums may be raised but only by class, not individually.

GUARANTY FUND

The fund in Texas entitled "Life, Accident, Health and Hospital Service Guaranty Fund." Most companies admitted in Texas must contribute to the fund designed to protect insured, their beneficiaries and families when a company suffers financial failure. Some companies are excluded and there are limits to the amount of protection.

H

HAZARD

A specific situation that increases the probability of loss arising from an accident or illness. The hazard might contribute to the occurrence of loss or may contribute to the extent of a loss or both.

HEALTH INSURANCE

A broad term encompassing many forms of insurance against loss by sickness or accident. Also includes disability income insurance.

**HEALTH INSURANCE
PORTABILITY AND
ACCOUNTABILITY ACT**

A federal law giving members of certain groups insurance coverage immediately when changing employment without having a waiting period for preexisting conditions.

**HEALTH MAINTENANCE
ORGANIZATION (HMO)**

An organization of health providers where members prepay for care and are generally limited to the care provided by the organization. HMOs usually operate their own facilities and emphasize preventive medicine.

HEALTH SAVINGS ACCOUNTS

Money can be deposited in these accounts to help pay for small costs as the participant purchases a medical policy to pay for catastrophic losses. The interest in these accounts, called MSAs, grows income tax free.

HIPAA

See Health Insurance Portability and Accountability Act.

**HOLD HARMLESS
AGREEMENT**

An agreement where one party accepts all responsibility, freeing the second party from any risk taking.

HOSPICE

A facility that provides support services and relief from pain for the terminally ill.

**HOSPITAL EXPENSE
POLICY**

A policy that pays the daily hospital room and board charge, miscellaneous charges and sometimes surgical benefits.

**HOSPITAL INCOME OR
INDEMNITY POLICY**

Pays a stated amount of money while the insured is hospitalized without regard to actual medical expenses.

HUMAN LIFE VALUE

The potential earning power of a human being. Often used to calculate life insurance needs. The concept was proposed and promoted by the late Solomon S. Huebner of the American College in Bryn Mawr, PA

IMMEDIATE ANNUITY

When a annuity contract begins paying almost immediately after purchase - the next payment time selected by the annuitant.

IMPAIRMENT RIDER

In health insurance, a rider stating that a precise condition will not be covered.

IMPLIED AUTHORITY

Authority that can reasonably be inferred from Actual (Expressed) Authority. Example: Authority to sell an insurance policy implies the authority to collect premiums.

INCONTESTABLE CLAUSE

A clause stating that after the insurance has been in force a certain time (two years in Texas) the company cannot challenge the accuracy of statements in the application (except for fraud) nor deny benefits. Sometimes called "Time Limit on Certain Defenses."

INDEMNIFY

To restore a loss in whole or part by payment, repair or replacement, but not for more than the actual loss.

INDETERMINATE PREMIUM

A policy that provides for periodic adjustments of premiums. The maximum must be stated in the policy as well as the frequency of redetermination dates.

INDEXED WHOLE LIFE

A policy where the face amount increases as the Cost Price Index (CPI) increases. The buyer may pay a higher premium and thereafter receive increases in the face amount with no additional premium or they may pay for the increases in the face amount as they occur. In all cases, no evidence of insurability is required.

INDUSTRIAL INSURANCE

Industrial Policies, sold in Texas, have the following characteristics: A face amount of \$1,000 or less; Premium is collected weekly; the words "Industrial Policy" must appear on the face of the policy. Sometimes called "Debit" insurance. Many Debit Agents now sell ordinary life making them "Combination Agents."

INSPECTION REPORT

An independent check on information about an applicant usually by a professional inspection agency such as Equifax.

INSURABILITY

The sum total of factors about an applicant that would lead an insurance company to assume the risk.

INSURABLE INTEREST

In life and health insurance, the loss of the insured's life or health should have a negative economic or emotional impact on the beneficiary. This connection should be shown at the time insurance is applied for and can be "blood, business or bucks."

INSURANCE

A device for transferring risk of loss from individuals to an insurer. The insurer agrees for a valuable consideration (premium) to indemnify or pay a certain amount for losses incurred by the insured. The insurer is able to accomplish this by spreading risks among large numbers of insured's.

INSURANCE POLICY

The entire written contract of insurance.

INSURED

The party to a contract that the insurer promises to indemnify in case of loss.

INSURER

The Insurance Company.

INSURING CLAUSE

The clause describing what the company promises to do.

INTEREST

The money the Insurance Company gains on their investment of premium dollars.

INTEREST ADJUSTED COST

When determining the cost of life insurance, the interest that might have been earned on premiums, is taken into account.

**IRREVOCABLE
BENEFICIARY**

When ownership is shared with the beneficiary. New changes that would adversely affect the policy benefits cannot be made without the beneficiary's consent, including change of beneficiary.

J

JOINT LIFE POLICY

Two or more persons are covered under one policy.

JOINT LIFE ANNUITY

Pays to both annuitants only as long as both live. When one dies, payments stop to the survivor.

JUMPING JUVENILE

A children's policy which jumps (usually 5 times) in face amount when the child reaches 21 with no increase in premium and no health requirements.

JUVENILE INSURANCE

Insurance on children, in most states, 15 years and under. In Texas, children 14 years old, though still "minors," may sign an application of insurance.

K

KEY PERSON INSURANCE

Life, Health or Disability Insurance on a key employee whose absence would cause the firm a financial loss. Premiums are not deductible and the benefits are received by the employer tax free.

L

LAPSE

When a policy is terminated because of failure to pay premiums.

LAW OF LARGE NUMBERS

The theory of probability that is the basis for the modern sales of insurance. The larger the number of risks or exposures, the more closely the results will follow that expected from an infinite number of exposures.

LEGAL RESERVE

The amount required by law that a company must have in reserve to pay possible losses.

LEVEL PREMIUM

A premium that remains constant throughout the policy period.

LEVEL TERM POLICY

The face amount remains level throughout the term of coverage.

LIFE ANNUITY

A life annuity provides an income as long as annuitant lives. Whether any money is paid to the beneficiary depends upon the type of life annuity chosen.

LIFE ANNUITY WITH PERIOD CERTAIN

An annuitant is to receive income during a certain number of years. If they die before the period is up, a beneficiary is paid the rest of the period. If they outlive this period certain, they continue to receive payments until the end of their life.

**LIFE, ACCIDENT, HEALTH
AND HMO LICENSE
(FORMERLY GROUP I)**

License issued by the Texas Department of Insurance. Considered a broad license authorizing the agent to represent legal reserve insurance companies in the sale of "Life and Health Insurance." The complete title of the license is "General Lines: Life, Accident, Health and HMO License." An exam is required and the license is referred to as "permanent" because it can be renewed every two years.

LIFE INCOME OPTION

A Settlement Option that provides payments to a beneficiary rather than a lump sum settlement.

LIFE INSURANCE

Insurance that pays a specific sum to a beneficiary when the insured dies.

LIMITED PAY LIFE POLICY

A permanent insurance policy that allows the owner to pay premiums for a specified number of years rather than lifetime. Coverage continues for all of their life after the premium paying period ends.

LIMITED POLICY

A policy that narrowly defines coverage's. In health insurance, it would limit liability to very specific situations like accidents. Examples: Travel, dread disease, dental, etc.

LLOYD'S ASSOCIATION

An organization following the format of Lloyd's of London. It is an insurance facility composed of many different syndicates, each specializing in a particular risk. They handle very large risks and are well known for unusual types of coverage.

LOADING

The amount added to the costs of pure insurance coverage that includes the insurance company's operational costs.

LOAN VALUE

The amount of cash value in a permanent life insurance policy that the owner can borrow.

**LONG TERM CARE (LTC)
POLICY**

In health insurance, a policy providing some payment for intermediate and long term custodial care. For a policy to qualify as an individual or group long term care policy, benefits must be provided for a minimum of twelve (12) consecutive months.

LONG TERM DISABILITY

A type of disability insurance that provides income for two years or longer.

LUMP SUM

When the proceeds of a policy are paid in one single payment.

M

MAJOR MEDICAL INSURANCE

A type of health policy that provides benefits for most types of medical expenses. Usually characterized by deductibles, high limits and coinsurance.

MANAGED HEALTH CARE

Usually refers to ways HMOs and PPOs try to keep medical costs under control. Example: Second opinions before surgery. May also be called Utilization Review.

MASTER POLICY

The policy issued to the employer in a group insurance plan.

MCCARRAN-FERGUSON

A basic law passed by Congress in 1945 that defined individual states as primary regulators.

MEC

See Modified Endowment Contract.

MEDICAL EXPENSE INSURANCE

A broad category of health insurance that provides coverage for medical expenses but not loss of income.

MEDICAL INFORMATION BUREAU (MIB)

An organization located in Boston, Massachusetts, owned by insurance companies to collect and share information on the health history of individuals who have applied for insurance. The information comes from applications for insurance and is usually provided to member companies by code.

MEDICARE

A U.S. government sponsored health care plan intended mainly for person 65 years of age and older who have qualified for Social Security.

MEDICARE PART D

PRESCRIPTION DRUG BENEFIT Beginning in January, 2006 Medicare began paying for Outpatient prescription drugs under Medicare, Part D.

**MEDICARE SUPPLEMENT
POLICIES**

A type of insurance designed to supplement what Medicare pays. Sometimes called a Medicare Wraparound Policy or Medigap Policy. Most states, including Texas, have adopted the Ten (10) Standard Medicare Supplement Benefit Plans. They are called A through J. A is the most basic, core benefit plan and the others offer a variety of benefits. All companies choosing to sell Medicare Supplement Policies are required to offer policy A.

MET

See Multiple Employer Trusts.

MEWA

See Multiple Employer Welfare Arrangement.

MIB

See Medical Information Bureau.

**MISCELLANEOUS
EXPENSES**

In health insurance, usually refers to hospital charges other than room and board.

MISREPRESENTATION

When an insurance company or their agent falsely presents any benefits, terms or coverage's of the policy or the strengths of the company. Also, when an applicant gives false information on an application for insurance.

**MISSTATEMENT OF AGE
CLAUSE**

If a misstatement of age is discovered, the company adjusts benefits to the amount the premiums collected would have purchased at the correct age.

**MODIFIED ENDOWMENT
CONTRACT (MEC)**

A life insurance policy in which the amount of premiums, in the early years, exceed the net level premiums required to provide paid-up benefits in seven years. Policies should avoid this 7-pay test in order to escape tax penalties.

**MULTIPLE EMPLOYER
TRUST (MET)**

Several employers form a trust for health or pension benefits. Two or more financially unrelated companies form METs in order to receive the economic advantages of group insurance.

**MULTIPLE EMPLOYER
WELFARE ARRANGEMENT
(MEWA)**

A type of multiple employer plan where more than one employer participates. These plans may be fully insured (MEWA) or self-funded, wholly or partially. If fully insured, they are often called Multiple Employer Trust (METs).

MUTUAL COMPANY

Insurance company owned by the policy-owners. Sells Participation Insurance where the policy-owners share in the profits via dividends.

N

**NATIONAL ASSOCIATION
OF INSURANCE
COMMISSIONERS (NAIC)**

An association of State Insurance Commissioners. They collect and share information and work to standardize insurance regulations.

NET PREMIUM

That part of the premium based on mortality rates minus assumed interest. (Excludes loading).

NONADMITTED INSURER

A company not admitted to do business in a given state.

NONCANCELLABLE

In health policies a non-cancelable policy means the company cannot raise premiums.

NONCONTRIBUTORY

Group insurance where the employer pays the entire premium. Requires 100% participation of all eligible employees.

NONFORFEITURE OPTIONS

Choices a policy-owner may make with their cash values in a permanent life insurance policy. There are three: Cash Surrender, Reduced Paid Up Insurance and Extended Term Insurance.

**NONOCCUPATIONAL
POLICY**

A health policy that pays for accidents or sickness only if they occur off-the-job.

**NONPARTICIPATING
POLICY (Nonpar)**

A policy that does not pay dividends. Describes most stock company policies, but not all.

**OCCUPATIONAL
ACCIDENT, DISEASE OR
RISK**

An accident, disease or risk arising from, or found in a person's employment.

OFFER AND ACCEPTANCE

Agreement to a contract is shown when an offer is made and is accepted. The applicant makes an offer by submitting an application with premium. The insurance company accepts or declines.

**ONE YEAR TERM
DIVIDEND OPTION**

When dividends are used to buy a one year term life insurance policy.

OPTIONALLY RENEWABLE

A health policy where the company reserves the right not to renew at the anniversary date or at a premium due date.

ORDINARY AGENT

Sells ordinary life insurance rather than industrial.

**ORDINARY LIFE
INSURANCE**

Life insurance other than group life or industrial.

**OTHER INSURANCE
CLAUSE**

A provision health policies providing how claims are paid where more than one policy covers one claim.

PAIDUP ADDITION

A dividend option where the policy owner uses the dividend to make a single premium purchase of permanent life insurance.

PARTICIPATING POLICY

A policy where the policy-owner receives dividends. (Also called Par Policy.)

PAYOR RIDER

A rider on a juvenile policy providing for waiver of premiums if the premium payor is disabled or dies before the juvenile reaches age 21.

PER CAPITA

When a group of persons are named beneficiaries, the proceeds are divided equally among the group, or the surviving member(s) of the group.

| | |
|--|--|
| PERSONAL PRODUCING GENERAL AGENT | A person (PPGA) who contracts directly with the insurance company but is not expected to employ agents. In order to get a strong volume of business from personal producers, companies sometimes insure PPGA contracts with a higher commission than individual agent contracts. |
| PER STIRPES | In beneficiary designation, the proceeds are divided in equal shares to the originally named members or to their nearest kin if any members are deceased. |
| PERMANENT AND TOTAL DISABILITY | Total disability from which the person does not recover. Permanent is assumed after a specified period of time. |
| PERMANENT INSURANCE | Has cash value accumulations. The insurance remains in force as long as the insured lives. |
| PIA | See Primary Insurance Amount. |
| POLICY | The contract of insurance including all riders, amendments and endorsements. |
| POLICYOWNER | The person who controls the policy as to changes such as beneficiaries, settlement options, etc. |
| PPGA | See Personal Producing General Agent |
| P | |
| PREEXISTING CONDITION | A health problem that existed before a policy was issued. Now banned by the Affordable Care Act. |
| PREFERRED PROVIDER ORGANIZATION (PPO) | A selected group of hospitals and doctors and other medical providers who are contracted to perform services at a discount. |
| PREMIUM | The "valuable consideration" for insurance. |
| PRESUMPTIVE DISABILITY | A disability that presumes that a person is disabled regardless of their actual ability. Blindness is an example. This does not require "proving" disability every six months to an insurance company. |
| PRIMARY BENEFICIARY | The first one named to receive death benefits if they are living when the insured dies. |

**PRIMARY CARE PHYSICIAN
(PCP)**

In a Health Maintenance Organization using a Gate-keeper System, every member is assigned to a PCP to provide or authorize health care.

**PRIMARY INSURANCE
AMOUNT (PIA)**

The amount equal to a worker's full retirement benefit under Social Security at age 65. Benefits would be reduced if early retirement (age 62) is taken. PIA also applies to a disabled worker.

PRINCIPAL SUM

The amount paid for death in Accident and Dismemberment Policies.

PROBATE

The process of filing, validating and executing a will by a court. The costs are part of postmortem expenses.

PROBATIONARY PERIOD

The period of time from the effective date of a health policy (usually disability) and the time coverage begins. It occurs only once in a policy's lifetime.

PROOF OF LOSS

The statement and supporting evidence of loss made by the insured to the company. Must be submitted if possible within 90 days following a loss.

P

PURE RISK

When the insured has no hope of gain; only a loss or no loss. Since insurance is not designed for a gain, only restoration of what has been lost.

Q

QUOTATION (QUOTE)

A reference to the premium calculation made by the agent to a prospect.

R

RATED POLICY

When an extra premium is charged because the person to be insured is in substandard health.

REBATE

Offering anything of value, not in the contract of insurance, as an inducement to buy insurance. Illegal in Texas and most states.

| | |
|--|--|
| RECURRENT DISABILITY | A previous disability that has been in remission and returns. The disability contract would define any new waiting periods required, etc. |
| REDUCED PAIDUP INSURANCE | A non-forfeiture option where the insured used the cash value to buy a single premium life policy with a reduced face amount. |
| REDUCED PREMIUM DIVIDEND OPTION | The dividend is applied to the premium. |
| REFUND LIFE ANNUITY | Provides annuity payments for the annuitant's lifetime with a guarantee that a certain amount will be paid. If the amount is not paid during the annuitant's lifetime, a beneficiary receives the balance. |
| REINSTATEMENT | Placing a lapsed policy back in force. |
| REINSURANCE | An agreement between insurance companies where one accepts the risks of another. |
| RENEWABLE TERM | A Term Insurance Policy that can be renewed regardless of the health of the insured. |
| REPLACEMENT | When an insured, which has purchased a policy from Company A, terminates the insurance in order to purchase a policy from Company B. Laws and regulations strictly regulate the replacement of certain types of insurance policies. Not to be confused with reinstatement. |
| REPRESENTATIONS | Information given by the applicant in a application for insurance. The information is presented as true and accurate to the best of the applicant's belief or knowledge. |
| RESIDUAL DISABILITY | R A formula used to replace Partial Disability. Requires that the insured's earnings have dropped a certain percentage from previous disability levels. |
| RETIREMENT ANNUITY | A deferred annuity into which payments are made by the annuitant until retirement. |
| RIDER | An amendment attached to a policy that changes benefits. |

RISK AVOIDANCE

Avoiding a potential loss by eliminating the problem. Example: The sale of a car eliminates the need to insure the car.

RISK MANAGEMENT

Identifying, measuring and treating exposures to potential losses.

RISK REDUCTION

Reducing the possibility of loss. Example: An exercise program for employees reduces the risk of heart attacks.

RISK RETENTION

Retaining part or all of the consequences of a loss. Example: Choosing an elimination period of six months on a disability income policy retains the risk of any loss of income from a disability six months or less in length.

RISK SHARING

When risks are shared. Example: When a sole proprietor takes a partner.

RISK TRANSFER

Transferring a risk from an individual to an insurance company. Example: Purchasing a major medical health policy transfers the risk of medical expenses to the insurance company.

S

SCHEDULE

A health policy that lists the exact amounts the company will pay for a specific operation, procedure or loss. P. 119

SEC

See Securities and Exchange Commission.

SECTION 401(k) PLAN

An employer sponsored retirement savings named after the section in the IRS Code. Employees may invest pre-tax dollars that are sometimes matched in some proportion by the employer. A penalty and taxes must be paid if the money is withdrawn early.

SECTION 403(b) PLAN

A retirement plan offered by public employers and tax-exempt organizations. Under Section 403(b) of the Internal Revenue Code public organizations and tax-exempt groups can contribute funds into a retirement annuity account and tax-shelter (tax defer) the money until it is withdrawn at retirement. Certain restrictions apply.

SECTION 457

The section of the Internal Revenue Code that allows employers to set up a plan of deferred compensation for their employees. It is owned by the employer.

**SECURITIES AND
EXCHANGE COMMISSION
(SEC)**

Federal Agency that regulates the sale of securities. The independent five-member commission was created under the Securities Exchange Act of 1934.

SELF-INFLICTED INJURY

An intentional injury a person causes to himself. Generally, any self-inflicted injury would not be covered by an Accident Policy because the loss was intentional and not caused by an accident. This applies also to Worker's Compensation insurance.

SELF INSURANCE

When money is set aside by an individual or organization to pay possible losses without buying insurance. Usually found in large organizations with the resources to self fund.

SEP

See Simplified Employee Pension.

SERVICE AREA

The geographic area designed by the HMO where the enrollee either lives or works. Outside of this area the HMO only pays for emergency care.

SERVICE ORGANIZATION

Refers to health providers like Blue Cross/Blue Shield. Payment is made to the provider rather than to the insured. Called paying on a "service basis."

SETTLEMENT OPTION

Payment of benefits in life insurance other than lump sum.

SEUA

See South-Eastern Underwriters Association Case.

**SIMPLIFIED EMPLOYEE
PENSION (SEP)**

(Also called SEP-IRA.) Employee individual retirement account funded by an employer or a self-employed person. Plan differs from other pension arrangements because the employee is immediately vested and controls the investment.

SOCIAL SECURITY

The popular name for Old Age and Survivor's Disability and Health Insurance (OASDHI).

**SOUTH-EASTERN
UNDERWRITERS
ASSOCIATION CASE (SEUA)**

An important 1944 U.S. Supreme Court case deciding that insurance transactions constituted interstate commerce and, therefore, were subject to regulation under the Sherman Antitrust Act. In response to this case, the U.S. Congress passed the McCarran-Ferguson Act (Public Law 15) in 1945. This act effectively overturns the SEUA case. The law states that the regulation of insurance is the responsibility of states, not the federal government. The law exempted insurance from Federal antitrust laws if it was covered by state regulation.

SPENDTHRIFT CLAUSE

Protects all benefits being paid to a beneficiary from legal seizure for the debts of the beneficiary or the insured.

STANDARD RISK

A risk that meets the health conditions as the tabular risk on which the rate is based without requiring an additional premium.

STEP-RATE PREMIUM

A policy where the premium increases every year as in Yearly Renewable Term (YRT).

STOCK COMPANY

An insurance company owned by the stockholders.

STOP-LOSS LIMIT

In health policies, a provision that expenses beyond a stated amount for any one accident or illness will be paid by the insurer.

SUBROGATION

A legal process that allows an insurance company to seek payment from a third party that has caused a loss. It is more commonly found in property and casualty insurance.

SUBSTANDARD RISK

A risk that may be charged as extra premiums because the health does not qualify as standard.

SUICIDE CLAUSE

If an insured commits suicide the first two years a life policy is in force, the company is only obligated to pay (refund) the premiums to the beneficiary.

SWING-BED HOSPITAL

Another name for a Post-Hospital Skilled Nursing facility.

T**TAX SHELTERED ANNUITY
(TSA)**

A retirement arrangement permitted under Section 403(b) of the Internal Revenue Code. Funds placed in the plan are not taxable until received at retirement. Restrictions apply.

TERM INSURANCE

Life Insurance that does not have cash value. It is issued for a specific period of time and will terminate if not renewed.

TERTIARY BENEFICIARY

A beneficiary who is third in line behind the Primary and Contingent beneficiaries.

TWISTING

Persuading someone to cancel an existing policy and buy another one when it is against their interests. Referred to as "churning" in the sale of securities. Such actions are illegal and subject the agent to disciplinary measures.

TRICARE

Civilian Health and Medical Program of the Uniformed Services. Previously called CHAMPUS.

U**UNAUTHORIZED INSURER**

A company not admitted to do business in a state.

UNDERWRITER

A professional working in the home office of an insurance company who evaluates the risk and determines if a policy will be issued, under what conditions, and the proper rates to be charged.

**UNIFORM POLICY
PROVISIONS**

In individual health policies, the National Association of Insurance Commissioners adopted 23 provisions. 12 are required and 11 are optional. Most states have adopted these provisions.

**UNIFORM SIMULTANEOUS
DEATH ACT**

Protects contingent beneficiaries. Provides that, in the event the insured and the primary beneficiary die in a common accident and it is not clear who died first, the company will conclude that the primary beneficiary died first.

UNILATERAL

A contract principle in life and health insurance that only the insurance company can be legally required to abide by the contract.

UNIVERSAL LIFE

Flexible premium two-part contract consisting of renewable term and a separate cash value account like a fixed annuity that usually earns more interest than traditional insurance policies. In Texas an agent can sell Universal Life policies with a Life and Health license. No additional training is required because the buyer has no investment options.

USUAL AND CUSTOMARY

In health policies, pays according to the average charges in the geographical area for a particular procedure.

V

VARIABLE ANNUITY

An annuity gives the contract holder the option of having the insurance company invest his or her funds differently from that of a fixed annuity. A variable annuity has two separate accounts: a general (guaranteed) account and a separate (variable) account. The general account provides a guaranteed return; the variable or separate account is invested in mutual fund options, which offer the potential for higher returns but no guarantees. The variable account growth is determined by the stock market.

VARIABLE LIFE INSURANCE

A whole life policy with a separate investment account like a variable annuity. It provides a guaranteed minimum death benefit. The separate investment account may cause the death benefit to be higher. This separate account is a securities investment and, therefore, the account is at risk. Because the agent gives security investment advice, agents are required to be registered with the National Association of Securities Dealers (NASD). Premiums are fixed.

VARIABLE UNIVERSAL LIFE

Combines characteristics of Variable Life policies and Universal Life policies. Premiums are flexible, not fixed, as in Variable. Investment options are broad based. The cash value account may fluctuate according to investment choices made by the insured.

VIATICAL SETTLEMENT

A Viatical Settlement is made when an insured sells his or her life insurance policy to a third party (A Viatical Company) for cash when the insured is terminally ill. They are presently being called "Life Settlements".

WAIVER

A rider that excludes liability for a certain loss. Also, the giving up of a right or privilege. Also, agreeing to give up premium payments during a disability.

WAIVER OF PREMIUM

Usually added as a rider to a policy that provides for the insurance company to waive collecting premiums while the insured is totally and permanently disabled.

WARRANTY

Statements made by an insurance company to an applicant are warranted to be true in all respects.

WHOLE LIFE

Permanent life insurance. The insured will have insurance coverage as long as he or she lives. The insured will have several choices as to premium payments.

WORKERS COMPENSATION

A schedule of benefits paid to a worker if injured while on the job. In case of a job-related death, benefits are paid to a spouse and/or dependents. Benefits are not taxable.

X

X-RAY

Medicare Supplement Policies sold in Texas are required to pay for a mammogram every year on the same basis they pay for other radiological (X-Ray) exams. Medicare only pays (according to their formula) for a mammogram every other year.

Y-Z

YEARLY RENEWABLE TERM

Same as Annually Renewable Term (ART).

YRT

See Yearly Renewable Term.

ZERO DEDUCTIBLE

Zero deductibles were once common in health insurance but have virtually disappeared due to rising costs.

