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Continuing Education

For Illinois Insurance Professionals

CONCERNS IN TODAY'S INSURANCE MARKET

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CHAPTER 1: INSURANCE REGULATION

Introduction

"Regulation" has become a loaded word, especially among financial professionals. Get just a few insurance executives, producers and policyholders in a room, and you could probably get them to argue for hours about government involvement in the industry. Are insurers regulated too much? Too little? And assuming they can all agree that at least some regulation is necessary, should the power to regulate insurance belong to the federal government, each state or a combination of national and local authorities?

Despite our personal opinions regarding the specifics or degree of regulation in our business, we should never forget that the core goal of laws, rules and other restrictions is to protect the public. In insurance, the public includes not only the people who purchase insurance but also the people who sell it. The public might need protection from the following dangers:

- Deceptive sales practices that take advantage of uninformed consumers.
- Unethical marketing techniques that unfairly restrict competition among producers and carriers.
- Unreasonably high prices that prevent insurance from being purchased by buyers who really need it.
- Unreasonably low prices that jeopardize an insurer's claims-paying ability and the economy at large.

To better understand the current state of insurance regulation, consider these statistics from the National Association of Insurance Commissioners and the Federal Insurance Office:

- Insurance companies collected $1.1 trillion in premiums in 2012.
- Roughly 11,600 people had jobs as insurance regulators in 2010.
- There were approximately 7,800 licensed insurers in 2010 (with roughly 350 insurers having their license revoked or suspended that year).
- There were more than 2 million insurance producers in 2010 (with roughly 5,000 of them having their license revoked or suspended that year).
- State insurance departments received more than 300,000 formal complaints from consumers in 2010.
- States collected $18.6 billion as a result of regulatory actions in 2010. Approximately 7 percent of those dollars was earmarked for future regulation, while the rest generally went to other state funds.

With so many jobs and so much money tied to our field, the debate regarding the best way to regulate insurance should be on all of our minds. This course material will help you engage in that important debate by explaining where we are today in terms of regulation, how we got there and where we might be headed.

Federal vs. State Regulation

From as far back as the 19th century, the question of whether insurance should be regulated at the national level or the state level (or perhaps both) has prompted strong responses from a variety of interested parties.

People who support federal regulation of insurance (as opposed to state regulation) typically make the following arguments:

- Federal regulation would allow for a uniform set of rules for insurers and producers, which might simplify compliance for licensees who conduct business in multiple states.
- Federal regulation would provide a baseline of protection for consumers, regardless of where they live, and wouldn't create an incentive for insurers to operate only in states where regulation is relatively modest.

Supporters of state regulation (as opposed to federal regulation) tend to emphasize at least a few of the following points:

- State regulation helps lawmakers and businesses focus on the needs of local communities, which might have different insurance-related concerns than the rest of the country.
- State regulation allows lawmakers and regulators to make experimental changes to the insurance market without impacting markets in other states. Presumably, experiments that work well in one state will be copied by other states, and experiments that fail can be discontinued and ignored by the rest of the country.

Traditionally, the insurance community and local regulators have favored state regulation instead of federal regulation. In fact, it is not uncommon for state regulators and trade groups to reform their rules and requirements in order to preserve the state-based system. Following federal investigations of alleged misconduct in insurance, a collection of state insurance directors (known as the National Association of Insurance Commissioners) often creates model laws or rules that each state is encouraged to adopt. Meanwhile, producer groups will often revise their codes of ethics and insist that members comply with consumer protections that go beyond the requirements of state laws. These steps commonly quiet the debate over federal regulation, but the break in the argument rarely lasts long.

The traditional preference for state regulation has undergone at least a modest shift in recent years. Particularly in regard to licensing, carriers and producers who do business in multiple states have expressed support for a streamlined and more uniform set of requirements from either the federal government or a non-governmental national organization. You'll read more about national licensing later in this course.

Before exploring some of the modern issues related to insurance regulation, let's step back into the past and review some of the regulatory history behind our business.

Early Insurance Regulation

According to the Federal Insurance Office, U.S. insurers have been regulated by state laws from as far back as the late 1700s. New Hampshire, in particular, noted the expansion of the insurance industry within its borders and, in 1851, appointed the first insurance commissioner in the country. Within another 20 years, all states had their own insurance department with their own insurance commissioner at the helm. Arguably the most famous of these commissioners was Massachusetts' Elizur Wright, who instituted solvency requirements for life insurance companies and developed actuarial tables that influenced the life underwriting practices of today.

Paul v. Virginia

One of the first major court cases involving insurance is a good example of how much views on regulation have evolved. The 1869 case Paul v. Virginia centered on the ability of an insurance company to sell its products in multiple states. Virginia law, at the time, required all insurance companies selling insurance to Virginia residents to be licensed with the state and for all agents of out-of-state insurers to have a Virginia license. A Virginia man (Paul) was appointed to transact business in the state on behalf of a New York insurance company, which hadn't satisfied the

state's financial requirements for licensure. Despite living in Virginia and meeting the licensing requirements for individuals, Paul was denied a license on the basis of the New York insurer's lack of compliance. Paul sold insurance in Virginia for the company anyway and was fined $50 by the state.

Contrary to insurers' general belief today, Paul and his supporters argued that the individual states couldn't fine him because his selling of insurance was a form of interstate commerce and, therefore, an activity that should only be regulated by the federal government. Regardless of the specific facts of the Paul case, many of the era's insurers supported federal regulation of insurance because they believed it would exempt them from having to pay various state-level taxes.

The case went all the way up to the U.S. Supreme Court, where a majority of the justices disagreed with Paul's argument. To them, the selling of insurance was essentially a contractual transaction rather than commerce and was, therefore, subject to state laws. Virginia's fine was ruled constitutional, and the case set a precedent for the next several decades. However, although the court determined that state regulation was permissible under some circumstances, it did not specify which aspects of insurance could and could not be regulated at the national level.

The Armstrong Commission

By the early 20th century, problems at U.S. life insurance companies had earned national attention. Several carriers had gone out of business since the Paul case, and those that remained were accused of financial irresponsibility by the popular press. The rivaling newspaper empires of Joseph Pulitzer and William Randolph Hearst targeted companies that had failed to increase policyholder dividends in spite of increased profits. Readers were made to believe that much of a life insurance company's earnings were going to playboy executives and crooked politicians instead of to "widows and orphans."

Those concerns and others led President Theodore Roosevelt to endorse greater federal regulation of insurance as part of his 1904 State of the Union speech. According to the Federal Insurance Office, Roosevelt's ideas were incorporated into a failed Congressional bill that would have created a federal Bureau of Insurance, including a presidentially appointed Comptroller of Insurance.

The pushes for more regulation culminated in the three-month investigation conducted by New York's Armstrong Commission. Following 57 high-profile hearings on life insurance practices, the state implemented several new restrictions on life insurance companies. Under the new laws and rules, insurers were prohibited from engaging in certain kinds of high-risk business, making certain political contributions and selling certain products (including those that provided unfair dividends to policyholders and beneficiaries). Within a few years, the rebating of premiums and the twisting of life insurance policies were prohibited, too. The state also began mandating regular audits of insurers' finances.

The Armstrong Commission's efforts brought changes beyond the New York market. Since companies that were licensed to sell insurance in New York were required to abide by the state's standards when doing business in other parts of the country, many of the state's reforms become the norm in the industry. Meanwhile, the commission's main prosecutor against the insurance companies, Charles Evans Hughes, became a revered public figure, eventually obtaining the position of Chief Justice of the Supreme Court and launching a failed presidential bid as the Republican Party's candidate against Woodrow Wilson in 1916.

United States v. South-Eastern Underwriters Association

The issue of state vs. federal regulation, originally addressed in the Paul case, was revisited in the Supreme Court's 1944 ruling in United States v. South-Eastern Underwriters Association.

In the years leading up to the case, some states had allowed insurance companies to share loss-related data and set property insurance rates together. This collaborative work generally helped strengthen smaller and newer carriers that lacked enough of a history to predict their future liabilities, but it wasn't permitted in all parts of the country and, even where permissible, sometimes had legal limits.

By 1944, a rating bureau known as the "South-Eastern Underwriters Association" had roughly 200 member insurers, which, in total, comprised approximately 90 percent of the property insurance market within a six-state territory. Carriers that didn't join the bureau and set their prices in accordance with its standards were allegedly prohibited from receiving industry-wide loss data and were subjected to boycotts by reinsurance companies. (Reinsurance, in essence, is insurance for insurance companies.) When bribes were allegedly made by the bureau to state regulators in order to maintain existing rates, the U.S. government stepped in and accused the association of violating federal antitrust laws.

South-Eastern didn't strongly deny the accusations regarding monopolies, price fixing and boycotts. Instead, it leaned on the aforementioned Paul v. Virginia ruling and claimed that, regardless of the conduct in question, insurance transactions across state lines weren't commerce and, therefore, weren't required to follow federal interstate commerce laws (including antitrust laws).

The Supreme Court's ruling in United States v. South-Eastern Underwriters Association effectively reversed the earlier precedent set by Paul v. Virginia by concluding that insurance sales across state lines weren't merely contractual arrangements. Instead, they were a form of interstate commerce and, as a result, had to comply with federal antitrust laws.

Despite a dissenting opinion by Justice Harlan Stone, the Court also clarified its stance on the separate regulatory powers of states and the federal government. In general, the mere fact that something is deemed interstate commerce wouldn't automatically make it an entirely federal issue, and the mere fact that something wasn't deemed interstate commerce didn't automatically make it a state issues. Furthermore, subjecting insurers to federal antitrust laws didn't impose on the states' regulatory authority since none of the states explicitly permitted monopolies, price-fixing and other activities prohibited by federal laws. Instead of federal regulation being a contradictory substitute for state regulation and vice versa, the two regulatory systems were intended, in the court's view, to complement each other.

The McCarran-Ferguson Act

In response to the insurance community's negative reaction to the South-Eastern ruling, Congress quickly passed the McCarran-Ferguson Act. Through this 1945 law, the federal government emphasized the public benefit of having insurance regulated primarily by each state rather than by national authorities.

The McCarran-Ferguson Act specifically exempted insurance companies from federal antitrust laws. However, in order for this federal exemption to apply, states must proactively regulate the activities addressed in the federal Sherman Act, Clayton Act and

Federal Trade Commission Act. In general, this means each state must enact its own measures that prohibit boycotts, coercion or intimidation in the insurance market. If a state fails to create these barriers to fair markets, the federal antitrust laws mentioned earlier in this paragraph can be applied to insurance companies. By setting such standards on their own, the individual states have limited the federal government's ability to stop insurers from sharing loss-related data and using industry-wide standard policy forms, such as those property and casualty forms written by the third-party, non-governmental entity known as the "Insurance Services Office" (ISO).

Besides providing antitrust exemptions, McCarran-Ferguson clarified the extent to which other federal laws would be applied to the business of insurance. Specifically, according to the act, "No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance (…) unless such act specifically relates to the business of insurance."

The McCarran-Ferguson Act pushed most aspects of insurance regulation away from the federal government and toward the individual states. However, consumer discontent with the industry tends to rekindle conversations about whether the law should remain in place. After Hurricane Katrina, for example, some prominent federal legislators openly questioned whether the antitrust exemption was being abused and resulting in widespread price fixing and unfair claims practices.

One criticism of McCarran-Ferguson has been its alleged inability to create strong competition in all states. Insurers generally claim that their federal antitrust exemption facilitates the sharing of important loss-related data, which is supposed to help new or smaller carriers make responsible underwriting decisions. Yet detractors point out that some insurance markets are dominated by only a small handful of carriers and aren't inviting to small insurers in the first place.

The occasional movement to amend McCarran-Ferguson is typically also accompanied by some admittedly confusing arguments about the effectiveness of repeal. Some proponents of ending the law focus on the antitrust exemption and believe that repeal would prevent misdeeds such as price fixing. But as supporters of the law point out, the federal antitrust exemption only applies if the states already prohibit this kind of conduct. Since states have already made it illegal for insurers to engage in price fixing, coercion, intimidation and other kinds of market conduct, the real question to ask isn't "Should insurers need to comply with antitrust laws?" Instead, observers who are considering the effectiveness of McCarran-Ferguson must ask themselves, "Are the states enforcing their own antitrust laws effectively without extra enforcement from the federal government?"

This course material won't take a stand on either side regarding the usefulness of McCarran-Ferguson. But since this law has been so instrumental in shaping today's regulatory environment, it is important for you to understand the core pieces of the debate.

The Gramm-Leach-Bliley Act

For centuries, legislation in the United States kept banks out of what were believed to be risky businesses so that depositors' funds were not put in danger. In effect, this meant there were relatively few chances for banks to become involved in the underwriting of insurance or securities.

All the way back in 1864, for example, banks were given the power to carry out tasks directly necessary and incidental to their business. At the time, however, selling insurance was not considered an incidental activity and was therefore prohibited within banking circles. Later, in an attempt to boost faith in banks after the stock market crash of 1929, Congress passed the Glass-Steagall Act, which prevented commercial banks (generally those that take deposits and make loans) from affiliating with any entity that was principally engaged in the sale of securities.

Yet at other important moments, the walls separating the various sections of the financial world crumbled bit by bit. By 1916, state banks in some parts of the country were being allowed to sell insurance. Meanwhile, the Office of the Comptroller of the Currency (OCC) had determined that too many national banks were failing in small towns and decided that federal depository institutions needed to become more competitive. With these economic conditions in mind, the federal government ruled that a national bank could enter into the insurance business if it was located in a town with 5,000 residents or less.

Restrictions have lessened at a swifter pace over the past 30 years. In 1986, the OCC started letting national banks sell insurance products in larger towns and cities if the transaction was conducted through a subsidiary in a town of under 5,000 people. A decade later, the U.S. Supreme Court's ruling in NationsBank of North Carolina v. Variable Annuity Life Insurance Co. upheld the right of commercial banks to sell annuities. All the while, local laws were sometimes allowing state banks into the insurance game, and loopholes in federal laws were often big enough for the occasional bank-sponsored insurance product to slip its way through the market. The insurance industry challenged many of these developments in court, but the challenges were ultimately ineffective.

During the 1980s and early 1990s, Congress debated the deregulation of financial industries on a number of occasions. These legislative attempts at regulating the entry of banks into the investment and insurance businesses generally did not amount to any real change, but two significant events near the end of the 20th century helped force the government's hand.

The first of the two events was the Supreme Court's ruling in Barnett v. Nelson, a Florida case centering on conflicts between federal insurance laws and state insurance laws. In 1974, Florida had enacted a statute that made it illegal for agents to sell insurance in any part of the state if they were affiliated with a "bank holding company," which can be defined as an entity with a controlling interest in one or more banks. Some 20 years later, plaintiffs argued the state statute was unlawfully ignoring the provisions of the 1916 federal statute regarding permissible insurance activities in small towns.

The state responded with a two-part argument that touched on the federal statute as well the McCarran-Ferguson Act, which generally says that a state insurance statute can be pre-empted by a federal law only if the federal law relates specifically to insurance.

In Florida's eyes, the 1916 statute related specifically to banks but not to insurance. The Supreme Court interpreted the matter differently, reasoning that the federal statute related specifically to insurance and that the intent of the 1916 Congress had been for the statute to reign over conflicting state laws. In short, the McCarran-Ferguson Act, which had kept federal regulators out of insurers' hair for years, proved to be more penetrable than expected.

The second significant event occurred on April 6, 1998, when the world was alerted to a merger between Citicorp (a bank holding

company) and Travelers Group (a multifaceted entity that, among other things, was engaged in the underwriting of insurance). Although this merger that gave us Citigroup was technically in violation of the Glass-Steagall Act, provisions in the Bank Holding Act of 1956 gave the newly formed financial organization at least two years to divest itself of its insurance business and avoid criminal charges.

Rather than pushing Citigroup to make a few extra deals and comply with federal law, the two-year grace period was treated as a chance to rally lawmakers behind the idea of making major changes to federal financial regulations. On November 12, 1999, President Bill Clinton signed the Financial Services Modernization Act of 1999 into law, effectively repealing the restrictions within Glass-Steagall and allowing entities like Citigroup to exist concurrently as a bank, insurance company and securities broker. In time, Citigroup spun off its insurance wing into another company, but it was able to do so on its own terms.

Purposes and Expectations Regarding the GLBA

For all the attention it received in the business press and elsewhere, the Financial Services Modernization Act of 1999 (more commonly known as the Gramm-Leach-Bliley Act, in honor of its Congressional sponsors) wasn't exactly shocking or revolutionary in scope. As stated earlier, financial institutions that really wanted to dip their toes simultaneously into commercial banking, investment banking and insurance could often find a way to do it by relying carefully on technicalities in federal and state laws. So it wasn't as if, at long last, a law had finally come along and made the impossible possible.

But what Gramm-Leach-Bliley did do was give banks, insurers and investment firms a clearer path toward unification. If a bank had always wanted to purchase or partner up with an insurer but had not done so for fear of being in noncompliance with U.S. regulations, that bank could finally turn to the GLBA, follow its specifics and feel reasonably confident that it was obeying federal law.

The GLBA and Privacy

By allowing banks, insurers and securities firms to become more tightly intertwined, the GLBA also made it more likely that people's personal information would be shared among businesses. To protect against the possibility that these businesses would infringe upon individual privacy rights, the GLBA includes provisions to protect consumers' personal financial information.

There are three principal parts to the privacy requirements:

- The Financial Privacy Rule.
- The Safeguards Rule.
- The pretexting provisions.

The Financial Privacy Rule governs the collection and disclosure of customers' personal financial information by financial institutions. It also applies to companies that are not financial institutions but still receive such information.

The Safeguards Rule requires all financial institutions to design, implement and maintain safeguards to protect customer information.

The pretexting provisions of the GLBA protect consumers from individuals and companies that obtain personal financial information under false pretenses, a practice known as "pretexting." An example of pretexting would be a phone survey that claims to be gathering information to help insurance companies create new products but, in truth, will be using the acquired information to either sell insurance to the consumer or steal the person's identity.

In response to the GLBA's privacy-related provisions, the individual states updated their rules for insurance companies' handling of consumer information. Although we won't go any further into the specific requirements of the GLBA, you should be aware of the privacy and safeguard requirements in your state. These state-level requirements can be (and often are) more extensive than the Privacy Rule, Safeguards Rule and pre-texting provisions mentioned earlier in this section.

Insurance Regulators and Other Rule-Setting Entities

Now that you have a grasp of insurance's past, let's go into detail about our current regulatory system. In the next several sections, you'll read about where requirements for insurance come from and the various organizations that set the minimum standards for your business.

Laws, Rules and Rulings

In order to comply with the insurance requirements in your state, you have at least three sources that must be considered:

- Laws.
- Rules.
- Rulings.

Laws

Insurance laws are passed by legislators, such as state senators and members of the state's house of representatives. Although it is likely that at least a few legislators in your state have an insurance background, experience in the industry is not a pre-requisite for voting on these laws. Since they usually lack this practical experience, legislators may intentionally (or intentionally) write laws by using broad or non-specific language that might be open to different interpretation. For example, a law might require that insurance producers complete 24 hours of continuing education, but it might not state exactly what qualifies as an "hour" (60 minutes of live instruction? 50 minutes with a break? 10 pages of reading?).

For the purpose of organization, the contents of most insurance laws will appear within a state's "insurance code." However, important laws that impact insurance professionals are also likely to appear elsewhere within a state's long list of statutes.

Rules

Many laws include language that requires the executive branch to establish rules about how a given law should be enforced. This is particularly common when a law is very complex or relates to a specialized field (such as insurance).

Unlike the laws that they help to implement, rules from a state's executive branch are supposed to be formulated and approved by people who have some expertise in the subject matter. Expertise is important at this stage because the rules are intended to clarify the non-specific language or other generalities found in the law. Without clear and careful rules, individuals won't necessarily know how to comply with the requirements, and law enforcement officials might have a hard time prosecuting people for alleged violations.

The rules for implementing insurance laws are usually drafted and approved by the state's department of insurance. States without an insurance department might give rulemaking authority to a department of financial institutions or some similar government agency.

Rulings

Individuals or business entities that believe they have been unfairly harmed by a law or rule may have the opportunity to pursue legal action through the court system. Lawsuits against legislators and regulators typically ask a court to answer at least one of the following questions:

- Did legislators have the constitutional right to pass the law in the first place?
- Do the rules written by the executive branch appropriately reflect the intent of the law?
- Did the executive branch follow its set of rules when penalizing the individual or business entity?

As an alternative to filing a lawsuit, parties who are disciplined as a result of alleged rule violations might have the right to a disciplinary hearing, in which the particulars of the situation can be presented to various members of the insurance department.

Insurance Departments and Insurance Commissioners

State insurance departments are generally intended to protect the public by monitoring market conduct and enforcing the state's various insurance requirements. More specifically, the insurance department is likely to concern itself with the following issues:

- Solvency of local insurance companies.
- Licensing of insurance producers and insurance companies.
- Consumer education regarding insurance topics.
- Fair sales and claims practices in the local insurance market.

The insurance department in most states is headed by an "insurance commissioner." In some parts of the country, this person might instead have the title of "director" or "superintendent." The commissioner is responsible for managing the insurance department, setting its priorities and enforcing the state's insurance rules and laws. He or she might also have the power to hold hearings and either approve or reject insurance rates and insurance products.

Depending on the state, the insurance commissioner will either be appointed by the state's governor or voted into office by the general public for a fixed number of years. Industry observers who prefer the concept of appointment tend to believe that an appointed commissioner will be more inclined to focus on the overall long-term health of the insurance market and less likely to make decisions based on short-term political motives. On the other hand, an elected commissioner might be very sensitive to consumer complaints and would risk being removed from office if his or her agenda isn't perceivably beneficial to a majority of local citizens. Commissioners who are elected to office often have a legislative background, whereas appointed commissioners usually already have some experience as an insurance regulator.

The National Association of Insurance Commissioners

The state insurance commissioners, as well as their counterparts in Washington D.C. and the various U.S. territories, are members of a non-governmental non-profit organization called the "National Association of Insurance Commissioners" (NAIC). The NAIC does not have the power to regulate any aspect of insurance. But because it is comprised of individuals who each have that power, its activities can have a widespread impact on insurance laws and rules in each state.

The original and continued purpose of the NAIC is to promote uniformity in insurance regulation without sacrificing the states' regulatory authority to the federal government. In fact, according to a U.S. Treasury report, a participant at the group's first meeting in 1871 claimed that attendees were "fully prepared to go before their various legislative committees with recommendations for a system of insurance law which shall be the same in all states—not reciprocal, but identical; not retaliatory, but uniform."

In order to achieve its goal of greater uniformity, the NAIC periodically drafts and updates model laws and model rules. The models are written and amended by one of the group's many committees and then presented to the entire membership. If a model is supported by at least two-thirds of the commissioners, it is officially approved and released to the states.

The NAIC models provide a guide to legislators and commissioners who would like to address a particular insurance issue in their state. However, each state legislature (and each state insurance commissioner) retains its own authority and is not required to change its laws or rules in response to the NAIC's recommendations. Depending on the issue at hand, a state might choose to adopt an NAIC model law or model rule in its entirety, only to a certain extent or not at all. Most states, for example, have adopted the portion of NAIC model licensing laws that call for 24 hours of continuing education every two years for producers. But some states continue to require fewer or more hours, and even those that have adopted the NAIC's number of hours have almost always established their own licensing requirements that aren't found in NAIC model documents.

The NAIC holds considerable power in national legislative circles. When Congress or other federal officials threaten to take away some regulatory authority from the states, it is very common for the NAIC to revise its models and push its members to adopt them. In the past, this approach either stalled or defeated efforts to establish a federal producer licensing system, significant oversight of insurance by the Federal Trade Commission and other threats to state powers.

National Council of Insurance Legislators

The National Council of Insurance Legislators (NCOIL) receives less recognition than the NAIC but serves a similar purpose. Like the NAIC, the NCOIL creates model laws with the intent of having them adopted by the individual states. The main difference between the two organizations relates to its membership. Whereas the NAIC is a group for state insurance commissioners, the NCOIL is a group for state senators and state house members.

The Securities and Exchange Commission

The Securities and Exchange Commission (SEC) is a federal agency that regulates many kinds of variable products. In general, a variable product is a financial product that does not guarantee a return of the amount investors put into it. Common types of variable insurance products include variable life insurance and variable annuities.

On occasion, the SEC has claimed that it should have regulatory authority over sales of indexed annuities as well. Indexed annuities generally guarantee a return of the owner's principal investment plus interest, but the amount of interest is based in large part on the performance of the financial markets. Even though most of these products have escaped SEC regulation and continue to be considered insurance products, many financial professionals who sell them have obtained securities licenses just to be safe. Common securities licenses include Series 6 (for mutual funds and variable products) and Series 7 (for stocks).

FINRA

An individual who sells variable products on behalf of an independent broker-dealer (essentially a brokerage firm) is generally known as a "registered rep." Independent broker-dealers and their representatives must comply with state securities and insurance rules as well as requirements mandated by the Financial Industry Regulatory Authority (FINRA).

Formerly known as the National Association of Securities Dealers (NASD), FINRA is a private, non-profit self-regulator for the securities industry. It is heavily involved in securities licensing and enforcement actions. It also enforces continuing education requirements for individuals who sell variable products.

According to its website, FINRA brought more than 1,500 disciplinary actions against individuals and brokerage firms and levied fines of more than $65 million in 2013. During the same year, FINRA referred more than 600 suspected instances of fraud and insider trading to the SEC and other law enforcement agencies.

Producers who sell any kind of variable product should be very careful to research their obligations under state law, SEC regulations and FINRA rules. The combinations of requirements for a particular financial professional might differ depending on the specific kinds of products being sold, the kind of entity employing the producer and whether the producer or employing firm claims it is offering financial advice or not.

The Federal Insurance Office

The massive Dodd-Frank Wall Street Reform and Consumer Protection Act did many things that have impacted various aspects of the financial industry. We will focus here on the law's creation of a new segment within the U.S. Department of the Treasury known as the "Federal Insurance Office" (FIO).

Contrary to popular belief, the Federal Insurance Office is not a regulator. Nor does it have anything to do with the implementation of the Affordable Care Act or the Medicare program. Perhaps most importantly, the FIO was not created in order to shift insurance regulatory power away from the individual states. Instead, the FIO is charged with the following tasks, among others:

- Representing the United States at international insurance forums.
- Administering the federal government's terrorism-risk insurance program.
- Monitoring access to insurance in underserved communities.
- Identifying insurance entities that might merit additional regulation.
- Making recommendations to Congress and other branches of the federal government in order to modernize insurance markets.

Recommendations from the FIO come from the Federal Advisory Committee on Insurance, an appointed group that is supposed to include consumer advocates, academics, insurance professionals and insurance regulators.

The following is an abbreviated list of recommendations from the FIO's first major report to Congress (The full report is available from the U.S. Treasury):

- *For material solvency oversight decisions of a discretionary nature, states should develop and implement a process that obligates the appropriate state regulator to first obtain the consent of regulators from other states in which the subject insurer operates.*
- *States should develop a uniform and transparent solvency oversight regime for the transfer of risk to reinsurance captives.*
- *State-based solvency oversight and capital adequacy regimes should converge toward best practices and uniform standards.*
- *States should move forward cautiously with the implementation of principles-based reserving and condition it upon: (1) the establishment of consistent, binding guidelines to govern regulatory practices that determine whether a domestic insurer complies with accounting and solvency requirements; and (2) attracting and retaining supervisory resources and developing uniform guidelines to monitor supervisory review of principles-based reserving.*
- *States should develop corporate governance principles that impose character and fitness expectations on directors and officers appropriate to the size and complexity of the insurer.*
- *In the absence of direct federal authority over an insurance group holding company, states should continue to develop approaches to group supervision and address the shortcomings of solo entity supervision.*
- *State regulators should build toward effective group supervision by continued attention to supervisory colleges.*
- *States should adopt and implement uniform policyholder recovery rules so that policyholders, irrespective of where they reside, receive the same maximum benefits from guaranty funds.*
- *States should assess whether or in what manner marital status is an appropriate underwriting or rating consideration.*
- *State regulators should pursue the development of nationally standardized forms and terms, or an interstate compact, to further streamline and improve the regulation of commercial lines.*
- *In order to fairly protect consumers in all parts of the United States, every state should adopt and enforce the National Association of Insurance Commissioners Suitability in Annuities Transactions Model Regulation.*
- *States should reform market conduct examination and oversight practices and: (1) require state regulators to perform market conduct examinations consistent with the National Association of Insurance Commissioners Market Regulation Handbook; (2) seek information from other regulators before issuing a request to an insurer;(3) develop standards and protocols for contract market conduct examiners; and (4) develop a list of approved contract examiners based on objective qualification standards.*
- *States should monitor the impact of different rate regulation regimes on various markets in order to identify rate-related regulatory practices that best foster competitive markets for personal lines insurance consumers.*
- *States should develop standards for the appropriate use of data for the pricing of personal lines insurance.*
- *States should extend regulatory oversight to vendors that provide insurance score products to insurers.*
- *States should identify, adopt, and implement best practices to mitigate losses from natural catastrophes.*

- *Federal standards and oversight for mortgage insurers should be developed and implemented.*
- *To afford nationally uniform treatment of reinsurers, FIO recommends that Treasury and the United States Trade Representative pursue a covered agreement for reinsurance collateral requirements based on the National Association of Insurance Commissioners Credit for Reinsurance Model Law and Regulation.*
- *FIO should engage in supervisory colleges to monitor financial stability and identify issues or gaps in the regulation of large national and internationally active insurers.*
- *The National Association of Registered Agents and Brokers Reform Act of 2013 should be adopted and its implementation monitored by FIO.*
- *FIO will convene and work with federal agencies, state regulators, and other interested parties to develop personal auto insurance policies for U.S. military personnel enforceable across state lines.*
- *FIO will work with state regulators to establish pilot programs for rate regulation that seek to maximize the number of insurers offering personal lines products.*
- *FIO will study and report on the manner in which personal information is used for insurance pricing and coverage purposes.*
- *FIO will consult with Tribal leaders to identify alternatives to improve the accessibility and affordability of insurance on sovereign Native American and Tribal lands.*
- *FIO will continue to monitor state progress on implementation of Subtitle B of Title V of the Dodd-Frank Act, which requires states to simplify the collection of surplus lines taxes, and determine whether federal action may be warranted in the near term.*

The International Association of Insurance Supervisors

The International Association of Insurance Supervisors (IAIS) is a Switzerland-based organization of insurance representatives from over 140 countries. The IAIS tends to have little direct impact on the average producer because it doesn't concern itself with issues like licensing or market conduct. However, it does play a major role in establishing global financial standards that are important to the overall health of the world's insurance community.

Assorted Federal Offices and Departments

In the relatively rare instances in which a federal law relates directly to the business of insurance, regulation can be the responsibility of a U.S. Cabinet department or some subsidiary agency. The department or agency with regulatory authority will generally depend on the kind of insurance addressed in the law. Federal health insurance laws are usually enforced by the Department of Health and Human Services. The National Flood Insurance Program is administered by a segment of the Department of Homeland Security. And as was alluded to in our explanation of the FIO, the federal terrorism-risk insurance program is overseen by the U.S. Treasury.

Common Regulatory Issues and Responsibilities

Now that we know who our regulators are, let's turn our focus toward what these various departments and other entities actually do.

Above all else, the purpose of insurance regulation is to protect the public. The next several sections explain some of the most common tasks that are meant to fulfill this important purpose.

Solvency Regulation

When an insurer's assets are enough to honor its liabilities, the company is considered to be "solvent." Solvency is an immeasurably important issue because financially mismanaged carriers might not have enough assets to make good on their promises to pay legitimate claims. An insolvent insurer harms consumers, of course, who might not receive fair compensation for insured losses, but it also has a negative impact on the other insurers in the market. When one carrier fails, other companies might be required to contribute to a state fund in order to pay for the insolvent insurer's liabilities or, at least, might be required to absorb some of the insolvent insurer's customers.

Insurers aim to prove their solvency by submitting annual reports to state regulators. Additional audits might be conducted by the state insurance department every few years for each company or might be done on a more frequent basis if a particular carrier seems financially unhealthy.

In general, states want to know that an insurer has enough "admitted assets" in order to withstand mistakes in underwriting and potential economic downturns. Common admitted assets include the values of stocks, bonds, cash and real estate. But depending on the state and the type of insurance, a carrier might be prohibited from using too much of a particular type of asset in order to prove solvency. For example, most life insurance companies aren't allowed to own significant amounts of stock, although this limit tends to be less stringent for property and casualty companies. An insurer's personal property (such as office furniture and supplies) generally won't qualify as an "admitted asset."

Guaranty Funds

State guaranty funds are used to compensate claimants whose insurance is from an insolvent company. These funds might be financed through periodic fees paid by all insurers in the state, or they might require financial contributions from all carriers once an insolvency actually occurs.

Regardless of how they are structured, guaranty funds are not ideal for consumers or insurers. They often limit a harmed consumer's compensation to a certain amount (such as $100,000) and involve long waiting periods (usually including a liquidation process) before any benefits become available. They also risk penalizing responsible insurers by making them pay for the mistakes of irresponsible carriers. For these reasons and more, regulators and insurance professionals should take solvency requirements very seriously.

Approval of Forms and Rates

Before they can market an insurance policy to the public, insurers generally must have the policy's language (or "form") approved by the state insurance department. The approval of forms is meant to ensure that the products in the market contain the consumer protections required by law (or by rule).

Though not necessarily a roadblock to a form being approved, the policy's readability will sometimes be evaluated, too. Regulators have long believed that insurance policy language is too complex for the average purchaser and have encouraged carriers to revise their forms in ways that increase comprehension. The Insurance Services Office, in particular, has revised its many property and casualty forms over the past several decades in an attempt to make them more understandable. (Many property and casualty carriers utilize these ISO forms as a model for their own forms.)

Rate regulation has multiple goals and, therefore, can be a tricky balancing act. On one hand, regulating the amount insurers can charge for coverage can be a valuable tool that makes insurance more affordable for those who need it. But because of fears about insolvency and other kinds of market disruption, state regulators need to avoid making rates so low that an insurer's ability to cover its liabilities is jeopardized.

There are many types of rate regulation in the United States. The type utilized will depend in large part on the state doing the regulating and the type of insurance in question. States have been active in the regulation of health insurance, property insurance and auto liability insurance but have often been more flexible when dealing with life insurance rates or the price of annuities.

Some of the most common rate-filing methods are summarized below:

- **Open rating:** Rates are generally assumed to be appropriate and will not be reversed by the insurance department unless there is an extreme case.
- **State-made or mandatory bureau rating:** Rates are established by the insurance department or a state-approved panel of experts but not by insurers.
- **File and use rating:** The insurance department receives an insurer's proposed rates but only has a limited amount of time to reject them. If the department does nothing, the rates remain in effect.
- **Prior approval rating:** Rates cannot be used by an insurer until they have been officially approved by the insurance department.
- **Flex rating:** Rates generally don't need to be pre-approved unless they are beyond a particular threshold (such as a rate increase of 15 percent or more).

Assorted Market Regulation

States typically prohibit a number of activities in order to keep the insurance market fair and transparent. When done properly, this helps consumers (who might otherwise be taken advantage of by slick sales gimmicks) and the good-hearted insurance professionals who would otherwise lose business to unethical competitors.

Commonly prohibited activities include (but are not limited to) the following actions:

- "Twisting," in which consumers are encouraged to change insurers for no good reason.
- "Churning," in which consumers are encouraged to change their policies for no good reason.
- "Commingling of funds," in which collected premiums are held in the same account as an agency's general operating funds.
- "Conversion," in which collected premiums are stolen.
- "Baiting and switching," in which false advertising is used to lure new customers into the door, after which they are encouraged to purchase a completely different product.
- "Fraud," in which material facts are misrepresented in order to steal money from the insurance company.
- "Unfair discrimination," in which people pay more for insurance (or aren't offered insurance) for reasons other than their data-supported risk profile.
- "Unfair claims practices," in which insurers wrongfully refuse to give insurance claimants the contractual amount owed to them.
- "Libel," in which false and defamatory statements about competitors or other people are made in writing.
- "Slander," in which false and defamatory statements about competitors or other people are said out loud.

Company Licensing

Insurance companies that want to do business in a particular state generally must have the appropriate license. Among other things, the licensing process might involve auditing the company's finances and investigating the financial and personal histories of its top-level personnel. Unless the insurance department becomes aware of misconduct and initiates more frequent investigations, licensed carriers can generally expect to be subjected to a thorough state audit every three to five years.

Specific licensing requirements might depend on whether the company is a "domestic insurer," "foreign insurer" or "alien insurer." These terms relate to where an insurer has its home office, but their definitions aren't as simple as they might seem.

In regard to licensing, a licensed insurance company is considered a domestic insurer in its home state but is a foreign insurer in any other state where it also has a license. An alien insurer is an insurance company from another country. Since they are all licensed entities, domestic, foreign and alien insurers are collectively known as "admitted carriers."

When insurance cannot be easily obtained in a given state, a consumer might be able to purchase coverage from a "non-admitted carrier." Although they might be licensed elsewhere, non-admitted carriers are not licensed to sell insurance in the buyer's state. In order to provide some consumer protections against an unlicensed carrier, insurance from a non-admitted carrier can only be purchased with the help of specially licensed professionals and only under special circumstances. In general, the producer selling the insurance must be licensed as a "surplus-lines broker" in the buyer's state and must be able to show that adequate coverage from an admitted carrier was not reasonably available.

Producer Licensing

Insurance producers, including agents and brokers, must be licensed in order to sell insurance. However, many states allow someone with an expired license to receive a commission when a consumer renews a policy, as long as the initial sale occurred while the license was in effect. Despite a push for greater uniformity and reciprocity in the licensing process, each state is responsible for enforcing its own licensing requirements.

According to the Federal Insurance Office, more than 2.3 million individuals are licensed to sell insurance. Those 2.3 million people hold over 6 million licenses. The difference in those numbers is the result of many individuals having licenses in multiple states. A license from a producer's home state is the person's "resident license," and any licenses from other states are known as "non-resident licenses."

In order to become licensed as a producer, a person must complete pre-licensing education, pass a state exam, pay various fees and undergo some kind of background check. A few states also require a licensee to already be affiliated with a particular insurance company. This relationship is sometimes called an "appointment." Even if an appointment isn't a mandatory part of the licensing process, each insurance company might have its own requirements and procedures before a licensee can sell the company's products.

Individuals who are interested in obtaining a producer license must choose one or more "lines of authority." The line of authority is the kind of insurance that a license allows someone to sell. At the very least, a state will have a life/health line of authority and a property/casualty line of authority. Many states don't combine life and health or property and casualty and also have additional lines of authority (such as personal lines and limited lines automobile). The chosen line of authority will dictate the kinds of coursework that must be completed and the type of state exam that must be passed.

Upon the conclusion of a license term, a producer can usually renew his or her license by submitting documentation to the department of insurance, paying required fees and completing continuing education. Many states have followed the NAIC's continuing education standard, which requires a producer to complete at least 24 hours of continuing education (including three hours of ethics training) every two years. Individuals selling annuities or long-term care insurance are likely to have additional continuing education requirements. And of course, as in most things related to insurance regulation, each state is likely to have its own rules regarding hours, course content and course delivery.

Multi-State Regulation

Despite their generally strong belief that insurance should be regulated at the state level, many producers and carriers have softened their stance in recent years due to the challenges of multi-state requirements. If an insurer wants to offer the same product across the country, it might have 50 different approval processes to complete (one for each state), including the payment of fees and the tedious completion of paperwork. Similarly, if an insurer or a producer wants to become licensed in more than one state, obtaining the additional licenses might be a long, strenuous process with different requirements across different jurisdictions.

At least in regard to licensing, the federal government and the NAIC have supported greater reciprocity among the states so that producers doing business in different places don't need to jump through so many bureaucratic hoops. In fact, the aforementioned Gramm-Leach-Bliley Act addressed this very issue by suggesting the creation of a national licensing entity.

The National Association of Agents and Brokers

In response to complaints from groups whose members wanted to become licensed in multiple states, Congress inserted producer licensing language into the Gramm-Leach-Bliley Act. Under the law, the states were given an ultimatum: Either enact reciprocity laws that would allow out-of-state producers to easily obtain a non-resident license, or risk the formation of the National Association of Agents and Brokers (NARAB).

NARAB was initially viewed not only as a clearinghouse where producers could easily apply for licenses from multiple states but also as a threat to each state's licensing powers. Fears over federal oversight prompted nearly every state to adopt reciprocity agreements among themselves, as well as many standard licensing rules proposed by the NAIC. For example, the NARAB threat contained in the Gramm-Leach-Bliley Act was at least partially responsible for the implementation by many states of a three-hour ethics training requirement as part of a producer's continuing education.

The response to the original version of NARAB resulted in greater licensing reciprocity across the United States, but producers have since realized the difference between reciprocity and uniformity. While reciprocity allows a licensee in one state to become licensed in another state without having to complete all of the same steps as an unlicensed person, the steps that can be skipped often still differ across state lines. Furthermore, even if producer is only required to complete a few forms and submit fees in order to obtain a non-resident license, someone applying in multiple states hasn't been able to send all the forms and all the fees to one central location. So, a non-resident's application in one state might be approved quickly, while the same person's application in another state might remain unapproved until certain items are delivered or other requirements are satisfied.

The drive for more uniformity was strong enough for NARAB to be reconsidered and supported by both houses of Congress in 2014. This new version of NARAB (sometimes referred to as "NARAB II") would create a licensing clearinghouse and an online portal through which producers would be able to submit all non-resident licensing applications and fees at the same time. Membership would be contingent on having met various requirements established by a board of directors (such as completion of continuing education and a background check) and would be entirely voluntary. A producer who is only licensed in one state or in only a few states might opt against joining NARAB, but producers who want to sell in several states might choose to join.

Since NARAB II does not call for states to lose any of their regulatory authority (and is meant to be more of a facilitator in the licensing process than anything else), the NAIC and several producer organizations supported its creation. However, even though the basics of NARAB II were signed into law in 2015, this attempt at greater licensing reciprocity had not yet been implemented at the time this course was written.

Conclusion

By now, it should be obvious to you that insurance regulation is both an important and dynamic issue. Theories about how to best protect consumers can change just as often as the products being offered to the masses. But no matter what changes ultimately occur, insurance professionals must always be aware of the many regulators who set rules for conduct.

CHAPTER 2: INSURANCE DISCRIMINATION - THEN AND NOW

Introduction

For most people in our increasingly diverse society, the word "discrimination" tends to bring uncomfortably negative images to mind. Some of those images—protesters clashing with local authorities during the Civil Rights movement, or signs for racially segregated public accommodations in the Jim-Crow-era South—are familiar to us from the historical record. Others—such as that of the veteran female receptionist who is curiously passed over for promotions by male bosses—aren't as graphic and tend to come to our attention through the anecdotes of friends and family or from our own personal experiences. In part to avoid seeing those unpleasant pictures, we might try to convince ourselves that discrimination is either a thing of the past or at least something that would never be tolerated in our business.

However, discrimination can be a fascinatingly complicated subject for insurance professionals. This is particularly possible if we detach the social connotations from the word and focus purely on its basic definition. Discrimination, at its most elementary level, occurs whenever two or more people are evaluated individually and treated in different ways on the basis of that evaluation. If we keep this emotionally neutral definition in mind,

we may notice that discrimination is not only common but central to the operation of our industry.

To demonstrate this point, think of the line of insurance in which you have the greatest amount of expertise. Is this insurance made available to some applicants but not others? Is this insurance offered at the same price to everyone? Even if the insurance is offered as part of a guaranteed-issue group plan in which all participants contribute the same amount of premiums, are there differences in pricing from group to group? Unless the insurance is offered to all interested applicants at exactly the same price, some form of discrimination is technically taking place.

Often, arguments that are seemingly about whether discrimination exists are really about whether a particular kind of discrimination is ethical and fair. At least in regard to insurance practices, state regulators have already participated in those arguments and arrived at some clear conclusions for us. For example, insurance commissioners across the United States have generally determined that discriminating against consumers on the direct basis of race, religion or national origin is inappropriate and have made this discrimination illegal. (This is a contrast with many other countries—even developed areas like Western Europe—where insurers sometimes apply different rates to foreigners and non-foreigners.)

While some of the prohibitions against insurance discrimination might seem obvious, perceptions of fairness continue to evolve. Traditionally, insurers and their customers have agreed that discrimination is justified when it is based entirely on a person's risk potential and is backed up by sound actuarial data. But as the underwriting process has become more complex, even insurers with data on their side have had a harder time making their case. Consider the U.S. auto insurance market, where credit history—and not driving history—might have the biggest impact on a driver's auto insurance premiums. Even as the numbers consistently link the likelihood of auto insurance claims to a person's bill-paying activities, many motorists believe, for various reasons, that credit-based insurance decisions are unfairly discriminatory.

At times, the arguments concerning discrimination are about whether a person's risk profile should matter at all. The passage of the Affordable Care Act provoked heated debate regarding the best way to cover the uninsured. But while verbal battles were waged about mandates and the law's rollout, more Americans seemed to come away with the belief that all people—even the very sick—should have access to affordable, high-quality health insurance.

Although this course material will lay out the many arguments for and against certain insurance practices, it shouldn't be interpreted as a political document or as a piece of advocacy. Where matters of anti-discrimination law are addressed, the intent is to promote compliance with federal and state requirements. In cases where the labeling of a particular insurance practice as "fair" or "unfair" is still a matter of major debate, readers will be given enough context to understand both sides of the issue. If you have a firm understanding of what each side believes, you might be able to play a role—small as it may be—in building a consensus.

Racial Issues in Insurance

Race-related issues in insurance date all the way back to the pre-Civil War era, when insurers viewed slaves as property and insured them as such for their white owners. After the war but prior to the Civil Rights movement, insurance companies commonly relied on loss-related data to charge different amounts depending on whether a consumer was white or black.

Race-based pricing was especially common in life insurance and was practiced with regulators' blessings due to the significant disparities in life expectancies between minorities and non-minorities. As reported by the Wall Street Journal, for example, white Americans were on pace to live roughly seven years longer than black Americans in 1955. Statistics like that were at least partially responsible for African Americans being charged sometimes as much as one-third more than other customers.

The significant differences in price didn't always mean that life insurers weren't interested in marketing themselves to black communities. However, when those communities were targeted, companies and their agents tended to emphasize non-traditional products. Instead of stressing usual forms of life insurance with significant death benefits, insurance salespersons went door to door and peddled small burial policies that covered final expenses in exchange for weekly or monthly payments of a few dollars. Even in these instances of targeted sales, race-based mortality tables were used to price the products.

In some cases, the risk-related data that was used decades ago by insurers hasn't changed much. Racial disparities still exist in regard to the quality of health care received by minorities vs. non-minorities, and according to 2008 figures from the Centers for Disease Control, white Americans continue to have longer life expectancies than African Americans. But regulators and the general public have been reinterpreting those numbers ever since the days of the Civil Rights movement. To many observers, those numbers should be ignored because they are more likely the result of economic factors (such as higher poverty rates among minorities) rather than being directly related to race. Even among those who don't fully accept this poverty-linked hypothesis, the use of race-related data to offer or price insurance seems contrary to their morals. For these reasons and more, direct forms of racial discrimination in insurance have been made illegal by state or federal laws in practically all cases.

For sellers of burial insurance, the changes in laws and in societal views put an end to race-based pricing in the issuance of new policies. But many policyholders who had purchased coverage prior to the ban continued to pay the same monthly or weekly installments for decades. According to a report by the state of Florida, 29 U.S. life insurers had not corrected race-based pricing models for pre-existing policyholders by the year 2000. Several class-action suits have been settled in the years since the report.

Despite the ban on direct racial discrimination, some sociologists and civil rights activists are convinced that racial minorities are still not always treated fairly by insurers. As evidence, they often cite the results of "matched-pair" studies. In a matched-pair study, individuals inquire about insurance (usually from property and casualty agents) and take note of their treatment. Individuals who are part of the study will have the same risk profile but will be members of different racial groups.

Multiple matched-pair studies have at least hinted at the presence of racial discrimination at some property and casualty insurance businesses. When leaving messages at these businesses, white callers have sometimes been more likely to have their calls returned. Similarly, individuals posing as insurance applicants have sometimes noted differences in their ability to obtain an insurance quote depending on their race.

On the other hand, critics of those studies have noted the usually small sample sizes of the data and have occasionally posed

questions about the potential for political bias among the groups that conduct the research.

Redlining

Several decades ago, it wasn't uncommon for maps at real estate and lending offices to be marked with red lines, indicating where business was not to be done. Very often, the marked areas were low-income communities where large amounts of racial minorities lived. By marking those areas and refusing to do business in them, companies were ultimately accused of sidestepping the requirements of various civil rights laws that prohibited discrimination on the basis of race. This practice is known as "redlining."

Alleged redlining has often been a problem in communities where rioting has occurred. After race-related riots in the late 1960s prompted an exodus by insurers out of some urban areas, the federal government made reinsurance available to carriers in any state that instituted plans for covering property in seemingly high-risk areas. Though this kind of financial protection for insurance companies is now offered primarily by reinsurers in the private market, the original mechanism for serving high-risk applicants —known as a FAIR plan—still can be found in practically all states.

Decades later, following riots that resulted after alleged police brutality against African-American man Rodney King, businesses in the South Central portion of Los Angeles struggled to reopen due, at least in part, to the unavailability of affordable property and casualty insurance.

Defining Redlining

Discussions about the prevalence of redlining can be stressful because there are many opinions regarding what the term actually means. The debate about terminology relates both to the intent of insurers' actions in certain communities and to the impact—regardless of intent—that those actions have on residents.

To some, redlining only occurs when an insurer flatly refuses to insure properties (or provide other kinds of coverage) in a particular geographic area. To others, it can also include cases where insurance is technically available in all areas but is viewed as prohibitively expensive in certain neighborhoods.

In either of those cases, some people have an even stricter definition and argue that redlining only occurs when the reason why an insurer won't offer affordable coverage in a neighborhood is based on the types of people living there. Conversely, others argue that redlining can occur even if the insurer claims to only be basing its business decisions on environmental risk factors and not specifically on the race, ethnicity or other personal characteristics of the typical resident.

Location and Risk

From many insurers' perspectives, several risk-related reasons exist for pricing and offering property and casualty insurance differently in certain areas. When questioned about business practices that treat urban areas (particularly the dense inner city) less favorably than other communities, insurers tend to cite the following rationales:

- Some urban areas tend to have higher crime rates, including for theft and arson.
- Some urban areas have a disproportionate amount of vacant buildings, which could lead to vandalism or other kinds of damage.
- Some urban areas have an especially high amount of older buildings, which might be in disrepair or have lower market values.
- Urban areas have many properties that are close to one another, which can multiply the impact of a fire, tornado or natural catastrophe.
- For auto insurers, urban areas have more traffic, which could result in more accidents.

Of course, rural areas present their own set of risks. For example, rural homes are likely to be far away from emergency services, and local roads might make it more difficult for police or fire departments to reach the site of an accident.

Redlining and State Regulation

In general, states have frowned on insurers that have attempted to completely avoid doing business in certain communities. This has been the case even when racial or ethnic factors have been absent from the conversation. For an example, consider property insurers that have been spooked by natural disasters in coastal areas, such as parts of Florida. Many of those insurers have learned that if they don't want to provide coverage at all for properties in certain high-risk neighborhoods, they must take the same position toward the rest of the state and will be required to exit the entire market.

Less uniformity exists nationwide regarding the pricing (as opposed to availability) of insurance based on geographic location. Whereas most states allow for some form of territorial rating that makes insurance cost different amounts based on an applicant's location (usually by ZIP code), some put significant limits on those practices. For example, voters in California approved a measure that requires auto insurance rates to be based primarily on a person's driving history and minimizes the impact of a vehicle's usual location.

Where territorial rating practices are permitted, civil rights organizations sometimes raise concerns about how the differences in pricing are impacting minority communities. Depending on the circumstances, they might pose the following questions to insurers, courts or regulators:

- Does territorial rating give insurance companies an opportunity to discriminate intentionally against minorities?
- If territorial rating ends up having a disproportionate but unintentional impact on minorities, should it be allowed?
- Does territorial rating allow insurers to make overly broad judgments about applicants rather than forcing them to look at each applicant's individual risk profile?

Redlining Disclosure Requirements

Groups and individuals who are especially concerned about redlining are typically in favor of laws that would require insurers to report various pieces of data to insurance regulators. The data might include information about an insurer's market share in various communities as well as the race or ethnicity of each applicant and how the applicant's request for insurance was handled.

This kind of requirement already exists at the federal level for mortgage professionals. Under the Home Mortgage Disclosure Act (HMDA), lenders must send specific kinds of information (including the race and ethnicity of loan applicants and whether a loan was approved or denied) to federal agencies, but the law does not extend to the insurance community. Similar insurance-related laws have been proposed at the federal level for decades but have failed to gain much traction.

States have taken different approaches to the issue. Some require race and ZIP-code level reporting to their insurance department. Some require that this data be gathered but only sent to regulators upon request. In other parts of the country, no such reporting is required at all.

Rather than believing that HMDA-like reporting would help prove a lack of discrimination in their business practices, insurance companies have generally opposed these types of requirements. Commonly stated reasons for their opposition appear below:

- Insurers that are shown to be less prominent in minority neighborhoods might be sued even if they had no intention of discriminating against minority groups.
- Applicants who are asked about their race or ethnicity for the purpose of data collection might object and worry about how the information will be used.
- Requiring agents to obtain information about race or ethnicity increases the chances of unethical agents being influenced by the information.
- If information about an insurer's market share in certain neighborhoods is reported and becomes public, competitors might benefit unfairly from the disclosure.
- Insurance regulation has generally been left to the individual states. Federally mandated reporting would conflict with this tradition.

Insurers that don't want greater regulation but are still concerned about risks in certain neighborhoods might want to consider proactive ways in which they can protect their bottom line while still serving all communities. For example, some commentators have suggested education campaigns that are meant to make property owners more aware of how they can reduce their insurance premiums with the help of burglar alarms, smoke detectors and other loss-prevention tools. Similarly, rather than evaluating applicants on a broad ZIP-code level or by the age of a dwelling, underwriting departments might consider ways in which properties can be evaluated on more of a case-by-case basis. For instance, property insurers might consider being open to the idea of offering cheaper insurance to the owners of an otherwise old building that has been either retrofitted to withstand disasters or rewired to reduce fires.

Disabilities and Pre-Existing Conditions

The high cost of health care in the United States helps explain why people's health history has been such an important factor in offering and pricing many kinds of insurance. At the same time, the universality of health-related concerns has made medical underwriting a topic of heated debate. Since we will all inevitably become sick or suffer some kind of physical injury in our life, it's not difficult for us to sympathize with fellow human beings who experience negative insurance-related consequences on account of a pre-existing medical condition. As a society, we seem to be moving much closer to believing that health-related discrimination should be avoided in most cases unless a person's physical problems are tied to smoking and other unwise lifestyle choices.

A consumer's health can have an impact on the cost or availability of many insurance products. It is a major factor in life insurance underwriting and disability insurance due to carriers' concerns about mortality and morbidity, respectively. It can even have an indirect impact on some kinds of property and casualty coverage, too. Businesses with a history of injured workers will pay more for workers compensation insurance, and, according to a survey discussed in the trade publication American Agent and Broker, disabled drivers often pay more for personal auto coverage, due perhaps to the special equipment that some nontraditional drivers require.

But of course, no other kind of insurance is affected by health more than health insurance. State and federal laws over the past few decades have tightened restrictions on various kinds of medical underwriting and have even eliminated the practice in some markets. Many of those legislatively imposed restrictions will be covered in the next several sections. However, as you read about laws like the Affordable Care Act and others, you might find it interesting to note the ways in which the attempts to eliminate one form of discrimination—in these cases, health discrimination—have perhaps heightened the existence of other forms of alleged discrimination (such as discrimination based on age). Rightly or wrongly, anti-discrimination requirements in insurance are not a full guarantee that all consumers will receive the same insurance at the same price.

The Health Insurance Portability and Accountability Act

Not unlike the lawmakers who debated major health reforms in 2009 and 2010, elected officials in the early-to-mid-1990s fought fierce battles over what role the government ought to play in the U.S. health care system. Although opponents of greater federal involvement successfully beat back the Clinton administration's attempt at achieving universal insurance coverage, people on both sides of the argument agreed that a problem known as "job lock" needed to be addressed.

At a time when technological innovations were sparking many people's desire to open new businesses, some workers still clung nervously to their same old jobs. As much as they may have wanted to pursue opportunities at different companies, workers with pre-existing health problems had no guarantee that they would be eligible for coverage through a new employer's insurance plan. Likewise, even if a healthy employee could count on getting self-only coverage through a new job, he or she couldn't bet that the person's cancer-surviving spouse or diabetic child would be eligible too. Rather than risk losing essential health benefits for themselves and their families, these workers would often play it safe and stay in unfulfilling careers.

The Health Insurance Portability and Accountability Act (HIPAA) attacked the problem of job lock by making it illegal for a group health plan to discriminate against someone (including dependents) on the basis of health. As simple as that prohibition may seem, we won't be able to fully grasp its importance unless we know what is meant by words like "discrimination" and "health."

At least as far as HIPAA is concerned, a group health plan would be discriminating against someone in all of the following cases:

- The person is denied membership into the group plan.
- The person is required to pay higher premiums than other group members.
- The person is provided fewer insurance benefits than other group members.
- The person is required to make higher co-payments than other group members.
- The person is required to pay higher deductibles than other group members.
- The person is required to wait longer for coverage to begin than other group members.

Though there are some factors that could cause someone to be discriminated against in a group plan, health can't be one of them. Therefore, an individual can't be treated differently because of:

- A physical or mental condition he or she currently has.
- A physical or mental condition he or she previously had.
- A person's history of making health insurance claims.
- Genetic information that suggests a person is susceptible to medical problems.
- Behavioral, lifestyle or environmental factors that suggest a person might file health insurance claims (such as playing extreme sports, being in a physically abusive relationship or having made a suicide attempt).

One thing you'll realize quickly about HIPAA, though, is that there are plenty of exceptions to its rules and plenty of particulars to keep in mind.

Does Everyone Get Covered?

Although HIPAA prohibits discrimination on the basis of health, it doesn't force employers to offer coverage to all their employees. It only prevents them from denying participation in a group plan for medical reasons.

So, for example, the law doesn't force an employer to have a health plan, and it doesn't stop the health plan from discriminating against people for non-health reasons. A plan that covers full-time employees but excludes part-time workers isn't violating HIPAA. (The requirement to have a group health plan at companies with 50 or more full-time employees was instituted several years later under the Affordable Care Act.)

HIPAA Exemptions

Group plans that aren't health plans are generally exempt from HIPAA's requirements. This is true even when benefits are triggered by a person's medical problems. For example, the rules generally don't apply to:

- Workers compensation.
- Group disability insurance.
- Group life insurance.
- Group accidental death and dismemberment insurance.
- Group auto insurance.

Dental, vision and long-term care insurance offered through a group aren't subject to HIPAA's nondiscrimination rules if either of the following is true:

- They're offered under a different contract, certificate or policy than other health insurance.
- They're provided to employees for an additional cost, and employees can choose not to take them.

Can You Reward Healthy People?

Many group health plans reward people who have healthy lifestyles. For example, it's not uncommon for employees to pay less for their insurance if they maintain a good weight or don't smoke.

There are obvious benefits to having a healthy workforce, but employers and group plans need to understand that a person's weight and smoking habits are considered health factors. Therefore, giving preferential treatment to non-smokers or thinner people can amount to a HIPAA violation if special rules aren't followed.

Plans that reward healthier people are allowed if they give unhealthy people an alternative way of qualifying for the same reward. For instance, a plan rewarding non-smokers might also opt to reward smokers who enroll in a smoking cessation program. A plan rewarding physically fit employees might also opt to reward overweight employees who agree to follow an exercise regimen.

Let's go over more of the rules for these kinds of plans. Be aware, however, that, like all the law-related information in this course, the information is intended for general purposes. Due to the complexity of legal issues, you should seek out an expert if you have specific questions about how the law impacts you.

Rules for Wellness Programs

Programs that promote health to group members are known as "wellness plans" or "wellness programs." Companies have found that the best way to increase participation in a wellness program is to offer direct financial incentives to their employees. These incentives might include cheaper health insurance, a waiver of certain deductibles or the chance to receive gifts.

If a company is planning on offering employees incentives as part of a wellness plan, the incentives can't be given on a discriminatory basis. Rewarding employees for simply participating in a wellness program isn't discriminatory. But tying those incentives to an employee's personal health can be against the law.

To be compliant with HIPAA, a wellness plan that rewards anyone for their health must adhere to several rules. Let's go over them one by one.

Design of the Plan

The wellness plan must be designed to promote health in a reasonable way. It is illegal to design something with the intent of discriminating against someone and then try to pass it off as a wellness plan.

Chances to Qualify

Employees must be given the chance to qualify for the wellness plan at least once a year.

Size of Rewards

No matter the kind of reward a wellness plan offers, the value of the reward can't be greater than 30 percent of the cost of covering the individual. The cost of coverage includes the portion paid by the employee and the portion paid by the employer. It can also include the cost of insuring the employee's dependents if they are eligible to participate in the wellness plan. (The 30 percent limit on rewards is an increase that was prompted in 2014 by language in the Affordable Care Act.)

Reasonable Alternatives

If a wellness plan is going to reward people for being in good health, there needs to be a reasonable alternative way for unhealthy people to qualify for the same reward. The alternative is reserved for cases in which adhering to the plan's regular standards would be unreasonable for a particular employee or would put the employee's health at risk.

For a few examples, let's think back to plans that reward people for not being overweight or not smoking. Since it would not be reasonable or medically advisable for a grossly overweight employee to slim down dramatically over a very brief period of time, the employee might have the alternative option of enrolling in an exercise program. Since it would be unreasonable to expect a lifelong smoker to suddenly quit the habit, an employee might be given the alternative option of enrolling in a smoking cessation program.

Reasonable alternatives for wellness plans can't force employees to achieve a particular health-related outcome. For

the employee enrolled in the exercise program, this means the plan can't require that the person slim down to a certain weight or body-mass index. For the employee in the smoking cessation program, it means the person still can't be forced to quit. In both examples, simply participating in the program would need to be enough for the employee to be rewarded.

Though plans need an alternative for their wellness programs, they have some leeway in deciding what the alternative should be. As long as it is reasonable for all employees, a single alternative can be used for everyone in the group. On the other hand, a plan has the option of tailoring the alternative to an employee's individual needs. So if a disability prevents an employee from enrolling in an exercise program, the plan can work with the person to come up with another way of qualifying for the reward.

If a reasonable alternative can't be found for a particular employee, the plan might simply waive eligibility requirements for that person. In any case, the plan can require a doctor's note in order for someone to be eligible for a reasonable alternative.

Notice of Alternatives

All materials that describe a wellness plan to employees must mention the existence of a reasonable alternative. They do not need to mention what the alternative is. That can be worked out between the plan and the employee.

The U.S. Department of Labor has suggested using the following language in a wellness plan's materials:

- *If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, call us at (insert plan's telephone number) and we will work with you to develop another way to qualify for the reward.*

The Affordable Care Act

The Affordable Care Act (sometimes known as "Obamacare") is a massive, complex law that prompted several major changes to our country's health care system. However, many of the changes were intended to serve the same purpose: making it simpler for unhealthy people to find and keep affordable health insurance coverage.

Prior to the law's implementation in 2014, health insurance could be tough to find if you had already been treated for a major medical problem. If you were applying for coverage and were treated for a serious issue within the last few years, a plan in the individual market (as opposed to the group market) might have refused to cover you at all. If you had been sick within the past six months and applied for group coverage, the group plan could have subjected you to a waiting period before paying for any treatment related to that ailment. For some group members, the waiting period for treatment of pre-existing health problems lasted up to 18 months.

Applicants for health insurance can no longer be denied insurance because of a pre-existing health condition. Once they're accepted by a plan, there can't be any waiting period for benefits because of a pre-existing condition. Unhealthy individuals will be eligible for practically any kind of health insurance on the market as long as they purchase it during an annual open enrollment period.

Restrictions on Premium Rates

Shoppers in the health insurance market will discover that the Affordable Care Act's anti-discrimination provisions don't just pertain to access to insurance. They relate to pricing as well.

As a result of the law, insurers in the individual and small-group markets are generally prohibited from charging people more because of personal health. Gender-based pricing is now illegal in these markets, too. In fact, when two people (or two small groups) purchase exactly the same kind of health insurance, only the following factors can be used to charge them different rates:

- Age (with the cost for one age group equaling no more than three times the cost for any other age group).
- Tobacco use (with the cost for smokers equaling no more than 1.5 times the cost for nonsmokers).
- Geographic rating area (as determined by each state).
- Whether the insurance is for an individual or a family.

In essence, the rating reforms mean people in the individual market will be charged as if they were part of a large group. Although the cumulative health status of their geographic rating area might impact the cost of insurance, their own health status won't have much of an effect on what they pay.

People in the small-group market were already part of a pool for the purpose of pricing, but the new rules make the size of that pool much bigger. For better or worse, the risk of insuring unhealthy people will be spread out and shared among a broader population.

The rules about rating generally don't apply to "grandfathered plans." At a basic level, grandfathered plans are individual and group health plans that already existed on March 23, 2010 (when the law was passed), and haven't undergone significant changes since then.

As you can see, the requirements of the Affordable Care Act eliminate some forms of discrimination but still don't treat all applicants in a completely equal fashion. For example, the law allows insurers (and group plans) to charge people more based on their age, and although health factors are generally no longer a part of underwriting in the individual market, shoppers might still pay more if they smoke.

In spite of the summaries provided here, be aware that the Affordable Care Act is a complicated law that is still in the process of being implemented. If you are in charge of compliance at your business, you should consider contacting an expert or researching this law more closely through the U.S. Department of Health and Human Services.

Mental Health Parity

As mental health has become less of a stigmatized topic, the insurance-related rights for individuals with mental health problems have grown. In 1996, Congress passed the Mental Health Parity Act, which required lifetime and annual dollar limits for mental health care to be equal to the dollar limits for physical health care. The law didn't require coverage for mental health care, and those insurers providing such coverage could still have different limits for mental health if they weren't based on annual or lifetime dollar limits. For example, a plan could still have different copayments or coinsurance fees for mental health and could put different limits on the number of covered visits. The law applies to group plans with more than 50 members.

The Mental Health Parity and Addiction Equity Act of 2008 expanded upon the requirements of the earlier law. Under the act from 2008, plans covering mental health care must have

substantially the same limits for mental health care and physical health care in regard to most aspects of coverage, including deductibles, coinsurance fees, copayments and number of visits. As with the earlier law, it doesn't force plans to cover mental health care in the first place. It applies to group plans for more than 50 people and, as a result of the Affordable Care Act, also is applicable to policies sold in the individual market.

Many states require coverage of mental health care in some plans. For example, Illinois requires group plans for more than 50 employees to cover "serious mental illnesses." Insurers offering plans to smaller groups in the state must offer mental health coverage to the employer, but the employer can decline it. At the federal level, the Affordable Care Act required most non-grandfathered health insurance plans in the group and individual market to cover mental health services and prohibited lifetime and annual caps on those benefits. However, the specifics of what kinds of mental health care needed to be covered were left up to the individual states.

Genetic Information

Thanks to the wonders of modern science, medical tests have the potential to dissect our DNA and determine whether our genetic material makes us especially susceptible to certain diseases. Although genetic tests generally won't guarantee that we will develop a given medical condition, their results can help interested people manage certain risks. If a man and a woman both test positive for a particular genetic condition, they might take the results into consideration before having children together. If a young adult tests positive for a gene linked to cancer or Alzheimer's disease, the person might allow this information to influence his or her lifestyle choices and financial plans.

In spite of the advances in genetic detection, not all patients believe that genetic tests make sense for them. To some, the testing can amount to knowing too much about one's future and can lead to serious distress if test results suggest the likelihood of a debilitating condition. To others, a genetic test lacks much value unless it can conclusively prove that a medical condition will, in fact, manifest itself. In other words, although they might not have a problem with testing to see if they conclusively have breast cancer, they see little point in a test that only proves that they are at a higher risk for the disease.

Even among people who believe genetic testing has its benefits, there continues to be widespread trepidation regarding how genetic information might be used by third parties. If the results of a test become known to an employer, might a worker suffer workplace discrimination so that the business can save money on its various insurance plans? If results of a test become known to an insurer, might the information cause the person to be disqualified or charged more for life, disability, health or long-term care insurance? Might an insurer require a genetic test in some cases even if the patient doesn't want to know the results? And if a test reveals that a person's genetic code makes him or her a higher risk for contracting a specific disease, will an insurer treat it as a pre-existing condition and refuse to cover any eventual treatment for that disease?

Based on those concerns, it's likely that many patients who would otherwise be interested in genetic testing have declined to learn more about their hereditary medical risks. Some doctors have counseled against having the tests because of discrimination and privacy issues, and many patients who get these tests will pay in cash so that their insurer is less likely to know about them.

Although cases of genetic discrimination by employers and insurers are relatively rare, the public's fears surrounding this form of discrimination are real. According to a poll referenced in 2009 by the New York Times, 63 percent of people would refuse to take a genetic test if either an employer or an insurer were likely to learn the results. Such concern, according to the scientific community, makes it harder for researchers to conduct genetic studies that could lead to life-changing discoveries. The National Institutes of Health has said that 30 percent of people who are approached to be part of genetic research projects decline because they are worried about possible discrimination.

Despite the public's many concerns, some insurance companies don't see a problem in using genetic information to offer or price their products. Insurance, after all, has historically been offered in connection with an applicant's risk profile, and a person's genetics are, indeed, an indicator (if not an absolute predictor) of medical risks. To some inside the industry, genetic information seems like the perfect tool for evaluating someone for various forms of accident and health insurance.

Insurers also note the possibility for unfairness if applicants are allowed to receive genetic testing results without having to disclose the information on an insurance application. If, for example, a consumer knows that he or she is at greater risk of contracting Alzheimer's disease, it seems more likely that the person will be interested in long-term care insurance. But if that applicant (and people in similar situations) aren't required to disclose their increased risk, there is a chance that the market for long-term care insurance will become overcrowded by people with this increased risk. This problem, known as "adverse selection," could destabilize the market and result in either higher prices or even insolvency among insurance carriers.

The Genetic Information Non-Discrimination Act

By 2008, nearly every state had passed laws that protected the public's genetic information. However, requirements weren't consistent across the country, and self-insured businesses that operated their own health plans under the Employee Retirement Income Security Act were generally exempt from state-level anti-discrimination rules.

Greater uniformity was achieved through nearly unanimous Congressional support of the Genetic Information Non-Discrimination Act (commonly known as "GINA"). This federal law went into effect in 2009 and prohibits discrimination by health plans and health insurers on the basis of genetic information (including the medical history of family members). In practical terms, this means a health insurance company or health plan cannot take any of the following actions:

- Deny eligibility for insurance because of someone's genetic information.
- Charge people more because of their genetic information.
- Use genetic information to categorize an ailment as a pre-existing condition.
- Require individuals to take genetic tests as part of the enrollment or application process.

Although some genetic protections already existed under HIPAA, those protections generally didn't help people outside of group health plans, and they didn't stop a group from being penalized as a whole because of the cumulative genetics of its members.

In spite of these protections, GINA doesn't stop insurers or group plans from taking any of the following actions:

- Discriminating against people on the basis of a medical condition that has actually materialized and been diagnosed. (For example, a person whose genes make

him or her a high risk for cancer but hasn't been diagnosed with cancer would be protected by GINA. However, someone who already has a genetic form of cancer would need to rely on protections under other laws, such as HIPAA and/or the Affordable Care Act.)
- Refusing to cover the cost of genetic tests.
- Limiting certain kinds of covered care to people who have certain kinds of genetics. (For example, some kinds of preventive care might only be covered by insurance if a person's genetics make him or her a high risk for a particular condition.)
- Discriminating on the basis of genetic information in the life insurance, disability insurance or long-term care insurance markets. (However, this form of discrimination might be prohibited by state laws.)

Gender Discrimination

When an insurance company prices its products without any gender-based differences, it is engaging in "unisex rating." The arguments in support of unisex rating are somewhat similar to those against race-based rating practices. Like a person's race, gender is not something that is chosen by the individual at birth. Due to this lack of choice, many people believe insurance companies should not price their policies in different ways across gender lines. They make this case even as insurers point toward risk-related data that seem to separate the sexes.

Unisex rating, while not practiced by all U.S. insurers, is becoming more common among carriers in other parts of the world. When males in Europe complained that charging them more for life insurance was discriminatory, the European Court of Justice—the highest court in the European Union—agreed with them. The ruling struck down discriminatory practices in more than 25 countries. The court's decision, though, had no impact on companies in the United States.

Americans are generally protected from gender-based insurance discrimination when they obtain coverage through an employer's group plan. Laws like the Civil Rights Act of 1964, the Equal Pay Act and HIPAA collectively prevent employee benefits (including group insurance) from being offered to men but not to women and vice versa and stop a group health insurance plan from requiring different premium contributions from males and females.

Outside of the workplace, the rules regarding gender-based discrimination in insurance are a bit of a hodgepodge that depend on both the state in question and the kind of insurance being sought. A few states prohibit practically any form of gender-based differences in the offering of insurance and even prohibit the common practice of charging different gender-based amounts for life insurance. Other parts of the country prohibit gender discrimination in the offering of some forms of insurance (such as health insurance) but not others. A third faction of states puts percentage-based limits on gender-based pricing but doesn't outlaw the practice entirely. Before the Affordable Care Act put an end to gender discrimination in the pricing of health insurance in the individual market in every state, more than half of the individual states didn't limit gender-based pricing for individuals.

Insurance Discrimination Against Men

As a society, we've come to view gender discrimination as an issue that mainly has a detrimental impact on women. However, some major forms of alleged insurance discrimination have resulted in men paying more than their female counterparts. In most states, it is still widely accepted that men will pay more for life insurance because of their shorter life expectancy and the shorter amount of time that an insurer will be able to profit from their premiums.

Similarly, in areas where auto insurers are allowed to make gender-based decisions, men tend to pay more because of their greater accident history. The difference in pricing is especially pronounced among young drivers, with insurers apparently assuming that young males will be more reckless behind the wheel than young females.

Insurance Discrimination Against Women

Historically, insurance discrimination against women has mainly been an issue in the health insurance market. When gender-based pricing has been allowed, females have generally paid more for health insurance than males.

To people with only basic knowledge of health insurance, the increased cost for covering women might seem like a byproduct of pregnancy and various maternity-type expenses. Indeed, childbirth and prenatal care are expensive. But since those kinds of care have traditionally been excluded from individual health insurance policies (as opposed to group plans) or only covered through the addition of an expensive rider, they don't explain why health insurers in the individual market have usually given women higher rates.

Regardless of their child-bearing capacity, women have traditionally been charged more for individual health insurance products because they utilize medical services on a more frequent basis than males. Particularly through age 55, women are more likely to visit their doctors, receive preventive services and use prescription medications. As men and women approach senior citizenship, costs become more leveled across gender lines, with older men eventually using more care than older women.

Women who have obtained their health insurance through a group employer have been protected for decades from having to pay more for coverage than their male colleagues. With the implementation of the Affordable Care Act, it became illegal for health insurers to charge women more even if they were purchasing their own medical insurance and weren't part of a group plan. At the time this course was being written, federal law didn't prevent women from being charged more for other forms of accident and health insurance (such as long-term care insurance), although some states were considering outlawing the practice or had already done so.

Maternity Care

The high cost of childbirth has been a problem for many women, including some who already have insurance. Historically, policies purchased in the individual market didn't need to cover maternity care, and those offering some coverage would limit it to certain circumstances. Women who delivered via a non-elective caesarian section might have had some insurance protection, but those who had normal vaginal births often had to pay thousands of dollars completely out of pocket. In either case, there frequently were no benefits pertaining to prenatal tests and treatments unless special financial arrangements were made.

Coverage for maternity care has been much more widely available to women in group health insurance plans. In 1978, Congress enacted the Pregnancy Discrimination Act, which clarified that discrimination against pregnant women was an illegal form of gender discrimination under the Civil Rights Act of 1964. As a result, health insurance plans for businesses with more 15 employees had to cover maternity care and had to do so on a level equal to other medical services. The requirement

provided pregnancy coverage to enrolled employees and to their enrolled spouses.

The passage of the Pregnancy Discrimination Act has often left employers wondering whether the law requires them to cover some controversial kinds of care. Abortion coverage must be provided, but only to the extent that the procedure is necessary to preserve the life of the mother. Regulators and courts have gone back and forth regarding whether the law requires plans to cover contraception. In 2000, the Equal Employment Opportunity Commission—which enforces several labor-related laws on the federal government's behalf—ruled a plan covering other preventive services (such as screenings, immunizations and physicals) must also cover medically prescribed contraception. Similarly, some courts have argued that excluding prescribed contraception is discriminatory because it is used entirely by women and because the health-related effects of contraception disproportionately impact females. More recently, some judges have ruled otherwise, arguing that as long as a plan doesn't cover male-targeted contraception, it doesn't need to cover female-targeted contraception.

The Affordable Care Act addresses pregnancy issues in several ways. In 2014, the requirement to include coverage of maternity care was extended to smaller group plans and to policies in the individual market. Federal regulations also now require non-"grandfathered" health plans (including group plans and policies in the individual market) to cover certain kinds of preventive care without applying copayments, deductibles or coinsurance fees to them. (Grandfathered plans, in general, are individual and group health plans that already existed on March 23, 2010, and that haven't undergone significant changes since then.) FDA-approved contraceptive services for women are considered a form of covered preventive care under the regulations. A limited exemption allows some religious organizations to avoid paying for contraception coverage, but their impacted employees must still be offered the coverage at no cost by their insurance company. (At the time this course was being written, some employers and religious groups were challenging the law's contraception requirements at various levels of federal court.)

Plans and policies offering maternity-related benefits must also comply with the Newborns' and Mothers' Health Protection Act of 1996. This federal law was enacted to eliminate "drive-through deliveries," in which new mothers and their infants were discharged prematurely from hospitals for insurance reasons. The law applies to practically all kinds of health insurance, including group plans from an insurance company, self-insured plans created by employers, and policies offered to applicants in the individual market.

Under the Newborns' and Mothers' Health Protection Act insurers covering vaginal births must pay for at least two days of hospitalization for the mother and child. For caesarian births, the requirement is three days. An insurer can still impose deductibles, copayments and coinsurance fees, but cost-sharing can't differ from day to day. For example, if a policy requires a 20 percent coinsurance fee for the first day of hospitalization for a vaginal birth, the fee can't increase for the second day. Mothers are entitled to the coverage regardless of whether they've had their hospital stay certified or approved in advance by their insurer. However, the insurer is allowed to impose higher cost-sharing requirements if certification or approval is not obtained.

By the time the Newborns' and Mothers' Health Protection Act went into effect, most states had already passed similar legislation. Depending on where they live, mothers and their babies might be entitled to additional insurance-related rights.

Domestic Abuse

Some insurance shoppers have complained that they have had problems with insurance companies because of domestic abuse. To some companies selling life, health, disability and property insurance, victims of domestic abuse have been viewed as higher risks. In the life, health and disability markets, the victims might be viewed in a negative light because their relationship history suggests the potential for physical harm. In a broader sense, some companies have believed that victims who stay in abusive relationships lack a certain level of personal responsibility, which could hint at the way they take care of themselves and their property.

Domestic abuse has also created some claims-related issues that have pitted insurers' ethics against their contractual obligations. Suppose a married couple purchases a house and obtains a homeowners policy for the dwelling and its contents. A year later, they experience serious marital problems, with one spouse moving out of the home but remaining a co-insured party on the homeowners insurance policy. In an attempt to harass the spouse who still lives in the home, the other spouse commits vandalism at the property. Since the vandalism was committed intentionally by someone who is covered by the policy, the insurer might be legally capable of denying the victimized spouse's vandalism claim. (Rules vary by state.) But would this be the ethical thing to do?

In another scenario, imagine a case in which a fearful victim with children is weighing the possibility of reporting an abusive spouse to authorities. Since the victim is already undergoing financial strain, he or she is concerned that an insurer who learns about the domestic abuse will use it as an excuse to raise the victim's premiums. Might this concern about insurance sway the victim's decision and serve as a reason to remain in the harmful relationship?

Alleged discrimination against abuse victims received greater attention in the 1990s, when, according to news reports from McClatchy Tribune Business News, the U.S. House Judiciary Committee found that half of the country's top 16 health insurers took domestic violence into account as part of their underwriting processes. Since then, most states have enacted laws and rules that restrict this practice in some form.

Marriage Discrimination

Society has tended to view marriage as a symbol of stability, and insurance companies have tended to agree. Where laws have permitted them to do so, insurers have sometimes provided cheaper insurance to applicants who have a spouse. At times, the assumption is that married couples are more family-oriented than single people, which supposedly makes them more responsible in certain aspects of their life. Unnamed sources have gone a step further and proposed that married couples deserve to pay less because they seem less likely to engage in insurance fraud. But for whatever the reasons, insurers in some states have been known to charge married couples less for auto insurance.

Spousal issues regarding the offering of health insurance tend to involve employee benefits. Many businesses with health plans will offer enrollment to employees' spouses, although company contributions for spousal coverage are often either less than the amount paid for employees or non-existent. In recent years, many companies have instituted spousal exclusions in their health plans and have either prevented spouses from joining at all or have put certain conditions on spousal enrollment. For example, as detailed in benefit trade publications like HR

Magazine, a group plan might exclude spouses who are eligible for health insurance at their own jobs or might require an additional premium contribution from a spouse who doesn't want insurance through his or her own employer but wants to enroll in a spouse's plan.

Sexual Orientation

As acceptance of gay and lesbian families has increased, employers and health insurance professionals have often responded by choice or by law. Even before same-sex marriage started expanding to several states, a majority of Fortune 500 companies were offering insurance benefits to their employees' same-sex partners.

At first, businesses catered to their gay or lesbian workers by offering group health insurance enrollment to domestic partners. Eligibility and enforcement tended to vary in this regard. In communities where domestic partnerships already existed as a matter of local civil law, companies could verify a partner's eligibility through government documents. In other cases, partners would be eligible for enrollment by affirming that they'd lived together for several years and were sharing their money in a manner similar to a married couple.

At the time, the general reasoning was that domestic-partnership benefits were a way to help gay and lesbian employees who lacked the legal ability to obtain spousal coverage. Ironically, this attempt to address perceived discrimination against one group of workers occasionally caused employers to ponder if their solution actually amounted to discrimination against a second group. Whereas some companies continued to reserve domestic-partner benefits for gay and lesbian partners, others decided to give unmarried heterosexual couples the same chance to enroll in group plans. In cases where domestic-partner benefits were made available regardless of sexual orientation, opposite-sex couples often accounted for the majority of enrollments.

With the passage of civil unions and the introduction of same-sex marriages in many states, health insurance benefits for gay and lesbian partners became less of a voluntary issue and more a matter of law. In general, couples in a civil union or same-sex marriage are entitled to the same state-level insurance benefits as married opposite-sex couples. However, the federal Defense of Marriage Act (DOMA) initially prevented same-sex spouses from receiving insurance benefits that exist under federal law. This prohibition meant, for example, that civil unions and same-sex marriages didn't make gay and lesbian partners eligible for spousal benefits available through Medicare, HIPAA, the Veterans Administration or a self-insured group health plan. (A self-insured group health plan is a plan in which the employer pays most claims on its own rather than simply purchasing a plan through a health insurance company. Self-insured group plans are often exempt from state insurance laws but often must abide by federal insurance laws.)

At the time this course material was being prepared, federal and state agencies were in the process of implementing various changes that resulted from a 2013 U.S. Supreme Court ruling that found a major portion of DOMA to be unconstitutional. As a result of the ruling, same-sex marriages that are valid in the states must be recognized by the federal government, and married same-sex couples are expected to receive the same benefits under federal law (including insurance benefits) as married opposite-sex couples. Furthermore, in 2015, another Supreme Court case deemed that same-sex marriage was a constitutional right that must be recognized in every state.

Due to the timeliness and complexity of this evolving legal issue, interested students should consult an expert if they must make insurance decisions that relate to same-sex couples.

HIV/AIDS

By the time AIDS became a matter of public knowledge, thousands of Americans had already been infected with the disease. While scientists and medical professionals struggled to understand how the AIDS virus impacted the body, people who were diagnosed as being HIV-positive were essentially being given a death sentence. Even with the best treatments that were available at the time, a newly diagnosed patient could reasonably expect to live no more than a few more years.

The spread of AIDS created an opportunity for insurance professionals who viewed life insurance as a potentially versatile asset. A new segment of the industry started offering "viatical settlements," in which AIDS patients were offered lump sums in exchange for selling their life insurance to investors. When the patient died, the investors collected the death benefit.

Advances in AIDS treatments have since made it possible for HIV-positive people to live relatively healthy lives for several decades and have made viatical settlements less common. Meanwhile, some AIDS activists have pressured life insurance companies to examine recent AIDS-related data and rethink their approach to HIV-positive applicants. If an applicant is HIV-positive but does not have any of the manifested symptoms of AIDS, should the person automatically be denied life insurance? If an applicant is not HIV-positive but engages in protected sexual activity with an HIV-positive spouse, should the HIV-negative person be issued a policy? Research conducted during the development of this course unearthed these kinds of questions from news reports but didn't uncover any clear answers.

Credit Scoring

Since the 1990s, companies specializing in personal lines property and casualty insurance have been criticized for basing rates and underwriting decisions on consumers' credit histories.

Practically all insurers who take credit history into account, according to the Federal Trade Commission (FTC), do it for new potential customers who are applying for a policy. Some, but not all, of these companies will evaluate a policyholder's credit again (and make pricing adjustments) when coverage is up for renewal.

According to a comprehensive report from the FTC, the first major system for evaluating insurance customers on the basis of credit was introduced in 1993 by Fair Isaac and Company (FICO), which had already developed similar systems for mortgage lenders and other creditors. Eventually, other companies started offering similar services, and some insurers have since created their own systems.

Although credit history is generally a reflection of someone's tendency to pay bills, insurers don't use this data to judge whether a consumer will pay premiums on time. Instead, they use it to get a broad picture of a person's risk potential and the likelihood of the person actually making insurance claims. Even among critics of this practice, the data, so far, has been very clear that there is a strong correlation between negative credit history and high claim frequency. According to a 2004 study from the Texas Department of Insurance, people with low credit scores file three times as many auto and homeowners insurance claims as people with high scores. The state also found that credit history was an even better predictor of future auto insurance claims than a person's driving history. In a report commissioned by the Iowa Department of Insurance, researchers from St. Ambrose

University said, "[T]he current evidence for the predictive power of insurance credit scoring is overwhelming."

Insurers have stressed the correlation between credit scores and claims, but they haven't been consistent in explaining why the correlation exists. In fact, when a State Farm insurance spokesperson was asked by the Daytona Beach News Journal why credit scores are such a good predictor of insured losses, the answer was a succinct, "We don't know why." When pressed for an explanation (either on the record or privately), other insurance professionals have posed the following hypotheses:

- People with bad credit have less disposable income and are less likely to self-insure for relatively small losses, which means they will make more insurance claims.
- People with bad credit have less disposable income and, therefore, are less likely to maintain their vehicles and homes in ways that might prevent certain losses.
- People with bad credit lack personal responsibility and are more likely to put themselves in risky situations.
- People with bad credit may be experiencing financial difficulties and, therefore, might be tempted to commit insurance fraud.

While the first two items on that list might seem logical, the last two are viewed as offensive to many people and might explain why consumers have resisted the use of their credit information in insurance. Some critics point out that bad credit isn't necessarily a sign of carelessness, especially in cases where financial problems are caused by medical issues or widespread unemployment. Others don't care what the statistics say and simply have a problem believing that personal finances should have any impact on how an insurer perceives their driving ability. Insurers have already decided that certain data (such as the different life expectancies across racial groups) should be disregarded as a matter of principle. So, should the link between credit and claims (no matter its strength) be treated in a similarly dismissive way?

To a somewhat lesser extent, insurers' use of credit information to set rates has raised concerns regarding discrimination against minority groups, especially black and Hispanic consumers. The aforementioned report from the Texas Department of Insurance found that those two minority groups had lower credit scores on average and that they "tend to be over-represented in the worse credit score categories and under-represented in the better credit score categories." The report from the FTC reached similar conclusions, but neither report recommended an end to credit-based insurance decisions. Insurers claim that accusations of discrimination are illogical in regard to credit scoring because credit reports do not contain information about race, ethnicity or even income.

Despite the public's misgivings about the use of credit information in insurance, insurers say that most consumers benefit from this practice and receive lower premiums as a result of it. According to a 2004 report from the Florida Insurance Council, eliminating credit from insurers' underwriting and rate-setting criteria would have increased family premiums for auto and homeowners insurance by more than $200. A report cited in the state's Daily Record newspaper found that complaints to the Maryland Department of Insurance increased after the state prohibited the use of credit information.

Practically all states have implemented restrictions on the use of credit information in insurance, but those restrictions aren't identical across the country. Whereas some states prohibit the practice mainly in auto insurance transactions, others extend it to property insurance as well (or vice versa). Some allow credit information to be considered for new customers but not existing ones. A few states, such as California, ban the use of credit information in practically all cases. Others, such as Illinois, allow its use but prohibit insurers from using it as the sole factor for taking adverse action (such as a rate increase) against a consumer. In states where use of credit information is allowed, insurers might still need to consider special cases of financial difficulty, such as when bad credit is caused by medical hardship or job loss.

Age

Age is an accepted, significant factor in the offering and pricing of life insurance. After all, the older a person is, the greater the chance of death. But as people grow older, they might also have different experiences paying for health or casualty insurance.

The Affordable Care Act aimed to level the cost of insurance for people regardless of their individual health status. At the same time, though, lawmakers understood that the utilization of health care increases as patients grow older. So while individual health status can generally no longer be used to discriminate against someone who is purchasing major medical insurance, insurance companies are still permitted to charge older people more than younger people. The disparity between rates for young people and older people might be limited to a specific ratio by either federal or state law.

In casualty insurance, age-related discrimination has been alleged by younger drivers (who tend to get into the most accidents) and elderly drivers (who tend to be involved in more fatal crashes). Some auto insurance companies will decrease the cost of insurance for older drivers who complete special refresher courses.

Treating employees differently based on age within a group insurance plan may be possible in some cases. But a thorough review of state and federal employment laws should be considered prior to the implementation of any age-based requirements.

Occupation

Auto insurers in some states have been known to offer discounts to drivers who are engaged in certain professions or who have achieved a certain education level. In general, these discounts have been provided to white-collar professionals who have at least completed four years of college. The discounts were scrutinized heavily in Florida, where the state's insurance commissioner claimed in 2007 that one company would've charged a mechanic 300 percent more than it would've charged an engineer who lived in the same area and had the same driving record. After multiple insurers testified that they did not consider how the discounts based on occupation and education level might impact various racial and ethnic minority groups, a department spokesperson accused them of "willful blindness." In response, according to McClatchy Tribune Business News, one company representative claimed it would be ludicrous for his company to discriminate against blue-collar workers since most of the company's customers had blue-collar jobs.

Dog Breed

Along with covering the contents and structure of people's dwellings, homeowners insurance provides financial protection to property owners who are held liable for various accidents. According to 2008 figures from the Insurance Information Institute, approximately one-third of homeowner liability insurance claims resulted from dog bites, and, as reported by the

Palm Beach Post newspaper, the average amount of those dog-related claims was a massive $25,000.

In order to guard against the risk of dog-bite insurance claims, some carriers have implemented internal policies that make it more difficult for owners of certain breeds to obtain affordable homeowners insurance. Those policies have been known to be particularly strict in regard to their treatment of pit bulls, a breed which, some say, might be predisposed to aggressive behavior because of its links to illegal dog fighting. A 2000 study from the Centers for Disease Control and Prevention (CDC) counted 238 cases of fatal dog bites, the majority of which were from pit bulls and Rottweilers.

For owners of pit bulls, the breed-related restrictions can prompt some tough choices. Some owners have reported being denied insurance from traditional insurance companies because of their dog and have needed to secure coverage through their state's typically more-expensive FAIR plan. Others admit to lying about their dog's breed in order to keep their family pet without experiencing financial penalties. Insurance worries have even had an impact on animal shelters and rescue services. In Minnesota, one pet adoption organization told the local Star Tribune newspaper that roughly one-sixth of adoption applications are withdrawn by potential dog owners in anticipation of insurance problems.

The alleged discrimination against certain breeds has been criticized, particularly in cases where consumers are denied insurance or charged more even though their pet has no history of violence. Even the aforementioned CDC, which noted the disproportionate number of deaths caused by pit bulls, hasn't endorsed insurance practices that are based only on an animal's breed. A few states have banned the practice, and several others have debated the issue over the past decade or so.

Travel Plans

U.S. consumers who apply for life insurance have sometimes experienced underwriting problems when they've revealed plans to travel to certain countries. When these problems arise, they often involve areas of the Middle East, such as Israel and Palestine, or third-world countries that are locked in a civil war. Many states, including Illinois, have enacted rules that either prohibit or limit travel plans from being used to deny insurance or to increase someone's premiums.

Conclusion

Opinions about insurance-related discrimination have evolved over time and have sometimes challenged our understanding of what is fair or unfair. In order to remain solvent and protect themselves from major losses, insurance companies must analyze risk very carefully. But in order to maintain positive relationships with customers, they must be aware of how the public views their methods of offering and pricing certain products.

Above all else, even when insurance professionals believe that a particular person or a particular group should be treated differently in regard to pricing or availability of coverage, they must be mindful of anti-discrimination rules from federal and state governments. Ethical concerns about discrimination can be handled by examining various facts and applying them to our unique value systems. Questions of law should be referred to appropriate experts to ensure full compliance.

CHAPTER 3: ANTI-TERRORISM EFFORTS IN INSURANCE

Introduction

Whether they want to or not, today's insurance professionals need to consider how the threat of domestic or international terrorism might impact their business. The potential damage brought on by suicide bombers and other violent extremists can produce significant losses in practically all lines of insurance. Meanwhile, some members of the insurance community are required to be especially vigilant and help the federal government uncover suspicious financial activities.

The first main section of this material will provide a historical perspective on the industry's reaction to the September 11, 2001, terrorist attacks. Later, you will read about some of the compliance-related measures that were implemented in response to those awful events.

Terrorism and the Insurance Industry: Pre-9/11

Prior to September 11, 2001, few Americans outside of the airline industry concerned themselves with obtaining terrorism risk insurance. If average citizens worried about the issue at all, they usually confined their thoughts to the effects of terrorism on overseas vacations. A pricey trip to London, for example, could have become even more costly for the traveler if unrest regarding Northern Ireland prompted someone to set off bombs in the city, forced the cancellation of commercial flights and indefinitely stranded the tourist a long way from home.

The cautious American could have guarded against such hypothetical disasters by purchasing a policy like the one Access America introduced in 1986, according to the Boston Globe, which covered losses sustained as a result of foreign terrorism at a cost of $3 to $7 for each travel day.

In retrospect, however, even that rare example of a pre-September 11 terrorism insurance policy hints at the era's treatment of terror as a largely implausible threat to U.S. citizens. The terrorism aspect of the policy snared some modest media attention for its parent company, but, in reality, the coverage represented only one element of a multi-faceted product that also insured against emergency hospitalization (terrorism-related or otherwise), lost luggage and other potential hassles for globetrotters.

Until 9/11, even major domestic insurance companies didn't seem to be giving a significant amount of thought to the level of terrorism risk in the United States. Standard policies from property insurers shielded carriers from having to cover most losses caused by war, but the language of these war exclusions generally wasn't specific enough to be enforceable after an attack from someone other than a foreign government.

This relatively soft approach to terrorism-related insurance issues continued even as the United States found itself in violent situations during the last quarter of the twentieth century. When suspected Libyan bombings in West Berlin prompted U.S. retaliation in 1986, Libyan leader Muammar al-Qaddafi vowed revenge. Although Qaddafi's threats provoked an increase in the cost of terrorism insurance for the airline industry, insurers did not alter their treatment of coverage for commercial properties on American soil.

When four men set off a car bomb underneath the World Trade Center seven years later, killing six people and injuring 100, neither insurers nor lawmakers put forth a resolute effort in the name of change. In 1995, domestic terrorists bombed a federal

building in Oklahoma City, killing more than 100 people and injuring more than 400. At that time, some insurers wondered out loud about their business's approach to terrorism, but the industry never progressed beyond the talking stage to the point of implementing widespread exclusions of such risks.

Those worries about terrorism on the home front had faded, for the most part, by early September 2001, with insurers experiencing a modestly decent period in their business cycle following years of soft markets but generally adequate profits. According to the U.S. Treasury's June 30, 2005, report on terrorism risk insurance, property and casualty insurers had earned either increased or steady levels of surplus between 1994 and 2000.

The terrorist attacks on the World Trade Center and the Pentagon changed all of that by offering indisputable proof of America's vulnerability to acts of mass destruction. At their most human level, the events of September 11 altered Americans' perception of their place in an often dangerous world. The country proved strong enough to withstand horrific threats on its livelihood, but a logical observer could no longer argue that the United States was somehow protected from outside enemies by an invisible shield of military strength and international influence. America learned the hard way that the risks involved with terrorism required greater vigilance and preparation than had previously been expected. The time had come for the country to consider scary scenarios that were once unthinkable.

The Attacks and the Initial Response

The September 11 attacks on the United States killed approximately 3,000 people, injured several thousands more and resulted in damage that was initially estimated to be anywhere from $25 billion to $70 billion. Despite the fact that national security reigned over the minds of most Americans during the days that followed, the nation's business community forced itself to ponder who would shoulder the financial burden of the costliest disaster in U.S. history up to that point. Although the shocking, catastrophic nature of the situation showed exactly why a person or business should purchase insurance, even policyholders with extensive coverage had a reason to nervously hold their breath in anticipation of an industry-wide response.

Traditionally, insurance companies can exempt themselves from having to pay certain insurance claims following acts of war. A massive conflict on domestic soil, after all, could potentially bankrupt the issuer. Although many life insurance providers omitted these exemptions from their policies after the Vietnam War, many property and casualty insurers still contain the exemption.

The violent, politically motivated attacks of September 11 certainly seemed like an instigator of battle. In speech after speech, President George W. Bush and members of his administration used the phrase "act of war" to describe al-Qaeda's hijacking and subsequent crashing of four U.S. planes. Legal definitions of "acts of war," though, usually contained references to nations. Regardless of the United States' eventual invasion of Afghanistan in response to the Taliban regime's support of al-Qaeda, the September 11 attacks were technically carried out by an independent, internationally organized terrorist group and not by a specific government.

These factors presented the insurance industry with a few choices. It could have ignored the act of war exemptions and made huge payments to policyholders, or it could have invoked the war exemptions and risked being overruled by the government and disdained by the public.

The only good news for insurers was that they had incorrectly counted on experiencing heavy seasons of earthquakes and hurricanes in the several months preceding the attacks. Mother Nature spared the United States somewhat from natural disasters during that time, spoiling insurers' expectations but leaving them with enough money to handle some other form of trouble.

Within days of the terrorist acts, the industry announced its intention to pay all legitimate insurance claims that were caused by al-Qaeda's assaults.

Insurers Feel Fiscal Pain

Of all the disasters ever experienced in the United States up to that time, the events of September 11 affected the broadest range of insurers. The financial repercussions of the attacks bruised even the era's most fiscally strong carriers, while exposing the mismanagement and instability of weaker companies.

At the time of the attacks on the World Trade Center and the Pentagon, General Re Corp. was the fourth-largest reinsurer in the world, helping major insurance companies manage their own risks. Under the guidance of investor Warren Buffett, General Re's parent company, Berkshire Hathaway, had increased its net worth for 37 consecutive years. September 11 cost Berkshire Hathaway roughly $2.28 billion, with most of that total resulting from the insurance end of the conglomerate.

Assessing his company's preparedness in regard to terrorism, Buffett claimed General Re could perhaps withstand another attack similar to those on the World Trade Center and the Pentagon but that anything larger or more sophisticated in its weaponry could seriously disable his business. Buffett frighteningly envisioned a future in which terrorists would move beyond the use of airplanes and bombs and toward nuclear, chemical and biological weapons that could destroy enormous amounts of properties and human lives.

With those concerns on his mind, Buffett said General Re could not cover losses from chemical or biological warfare and that coverage for nuclear-related losses would be an expensive rarity for his reinsurance customers. The company also began paying greater attention to the potential risk of highly concentrated properties by putting stricter limits on the number of structures it insured within the same geographic area. Buffett addressed his industry's old-school approach to terrorism, pointed a finger at himself and said failing to charge consumers an extra amount for coverage of terrorism losses was a huge mistake.

But General Re still stood firmly on its two legs after September 11 and could look forward to a profit-making phase brought on by price increases and people's general cravings for insurance following a catastrophic event. Other companies were not so lucky.

By September 2002, two insurance companies had reached a state of insolvency and ceased writing new policies as a result of al-Qaeda's suicide missions. The demise of Copenhagen Re was a relatively straightforward case of policy risks coming to life and proving too costly for the carrier to handle. Many of the reinsurer's best and brightest employees had left the organization years earlier, and its premiums and reserves seemed uncomfortably low compared to industry norms during the pre-September 11 business cycle.

North Carolina-based Fortress Re's tale, however, as reported by Mark Maremont in a series of articles for the Wall Street Journal, detailed a multi-faceted mess of questionable

accounting and ethics. Employed as a U.S. agent for Sompo Japan Insurance Corp., Fortress became a visible force in aviation reinsurance. The company sold policies that covered anywhere between the first $50 million to $400 million of damages from a crash. Those risky plans made Sompo liable if nearly any of its insured planes went down. In order to reduce its risk, Sompo instructed Fortress to purchase reinsurance that would reduce the parent organization's liability. Fortress received one-third of any profits, minus the cost of the reinsurance.

Following the four hijackings on September 11, all of which occurred on planes that were insured by Sompo, Fortress finally surrendered its well-guarded books to its overseas bosses. In fact, Fortress had not purchased traditional reinsurance that allowed Sompo to share risks with other parties. Instead, the agent had opted for cheap finite reinsurance. Via that arrangement, Sompo received immediate financial assistance from its reinsurers when paying claims, but the Japanese company was required to pay the money back with interest over a number of years. By purchasing less-expensive finite insurance instead of traditional reinsurance and by allegedly failing to alert its superiors to the financial commitments involved with the policies, Fortress Re, according to an eventual lawsuit, falsified its profits and thus allegedly received higher commissions from Sompo than it deserved.

In the end, the combination of Fortress's alleged actions and the September 11 attacks caused Taisei Fire, one part of the Sompo empire, to become the second Japanese casualty insurance company to file for bankruptcy protection since World War II, and Sompo reported a loss of $1.4 billion as a result of September 11.

A Coverage Crisis Begins

These examples of major losses help explain why, in late September 2001, spokespeople for the insurance industry announced to the U.S. House Financial Services Committee that carriers planned to exclude terrorism coverage from standard property and casualty policies beginning in January of 2002. Reinsurers (which essentially provide insurance for insurance companies) did not want to share in the risks, and insurers did not want to keep the risks for themselves.

Many state regulators sat on the exclusion issue and waited for the federal government to address the problem. When that did not happen by December 31, 2001, (when 70 percent of U.S. property and casualty policies were due to expire), the terrorism coverage exclusions went into effect in 45 states. New York, California, Georgia, Florida and Texas were the only states that denied insurers' requests to exclude terrorism risks.

The exclusions added in 2002 did not wipe out all terrorism coverage, but they gave insurers flexibility. Some small insurers still offered free coverage, but those instances were relegated to low-risk policyholders. A shoe store in Beaufort, South Carolina, for example, might have been eligible for terrorism insurance at no additional cost, but an office building in the heart of Boston almost certainly had to pay for it.

Metropolitan businesses watched their premiums soar thanks to insurers' new attitude toward terrorism. Chicago's chief financial officer Walter Knorr reported that the city spent $125,000 in 2001 for $750 million in coverage for its airports. After September 11, the same insurer charged $7 million for $150 million of protection.

Businesses Ponder Life Without Coverage

Had the events of September 11 not occurred, exclusions of terrorism in insurance policies might not have produced much major concern among various sectors of the business world. But with al-Qaeda's attacks fresh in everyone's minds, many people—whether they were buyers and sellers of real estate, mortgage lenders or investors—became extremely reluctant to make major financial commitments to projects that were not fully insurable.

As the December 31, 2001, date for renewals of most commercial property and casualty policies approached, the business community faced an undesirable future without affordable terrorism protection. Most lenders required all-risk insurance for loans above $50 million, and if a property owner lacked insurance against terrorism, lenders could claim that the borrower was in violation of the terms of mortgage agreements and could call for repayment of existing loans.

Without the insurance, businesses worried that new loans would be denied and that developers would be forced to stop building trophy properties that might seem like obvious targets for terrorists. Widespread downturns in the real estate industry would inevitably affect the national economy. According to a late 2001 report by the Mortgage Bankers Association, the real estate trade produced 12 percent of the year's gross domestic product and employed 8.5 million people. Those figures included not only brokers and salespersons in real estate but also workers in the construction industry, who would lose jobs if there was nothing to build.

Some in the real estate and mortgage fields predicted that a company's inability to obtain terrorism risk insurance on a particular property would force the business to relocate. Although that possibility might have helped less densely populated areas of the country by bringing jobs and economic growth to different communities, people generally agreed that high concentrations of businesses in major cities created greater levels of efficiency and competition.

Documented Effects of Exclusions and Decreased Availability

In some cases, the fears surrounding the unavailability of terrorism insurance were proven valid by real problems that surfaced in 2002. In other cases, what actually occurred in the business world did not support the worries of the uninsured and the underinsured. Under the circumstances, many insureds got creative with their coverage and did their best to adjust to a rapidly hardening market.

A number of property owners dealt with high prices by insuring their entire real estate portfolio at a low level. Owners calculated that, in this way, they could survive an attack financially if each of their buildings was at least partially covered. Some companies opted to spread out and open smaller offices instead of containing every aspect of their business within a single skyscraper. However, lack of coverage did not force a massive exodus by businesses away from cities like New York and Chicago to areas of the country where the risk of terrorism seemed lower.

Some banks did not pull back loans from uninsured borrowers, but they asked for higher rates of return on their loans. Other lenders exempted small businesses from all-risk requirements unless a business was situated near a high-risk property. Assorted lenders financed initially uninsured projects but insisted that property owners eventually seek out affordable terrorism coverage.

The relatively small amount of specific, reported horror stories related to terrorism insurance probably made some people

wonder if real estate agents and lenders were blowing the issue out of proportion, but on a broader scope, some numbers supported claims of a crisis. GMAC announced in June 2002 that it had rejected $1 billion in loan requests because applicants did not possess adequate terrorism coverage. A 2002 survey conducted by the Real Estate Round Table found that deals of $15.5 billion in 17 states had been postponed or revoked due to the missing insurance.

Terrorism and Workers Compensation

Businesses that managed to avoid problems related to real estate still had to address terrorism coverage through their workers compensation plans. With some exceptions for certain industries and small businesses, employers in almost every state must monetarily compensate employees who are physically or mentally harmed while performing job-related activities. The September 11 terrorist attacks resulted in $3 billion to $5 billion in workers compensation claims. These collective claims involved deaths and physical injuries, as well as many cases of serious stress disorders.

Regulators in 45 states generally allowed insurers to exclude terrorism coverage from property and casualty policies, but most did not allow carriers to extend that exclusion to workers compensation. Reinsurers, on the other hand, had the power to exclude coverage and left the insurance companies with an undesirable choice between raising prices for commercial policyholders and not doing business with certain employers at all.

Terrorism risk insurance for workers compensation was not as difficult to find as similar coverage for commercial property. In an act of last resort, employers could obtain coverage through state high-risk pools. But businesses hoping to get good deals for workers compensation could not avoid high prices in either the traditional or nontraditional markets.

Fearing attacks similar to September 11, insurers that offered workers compensation coverage began collecting more extensive information about their current and potential clients. They started to care less about the nature of a company's business and more about that company's office space and number of employees. Organizations that occupied several floors in skyscrapers and employed hundreds of workers at the same location sometimes struggled to obtain terrorism risk coverage. In some cases, businesses requested insurance from 30 carriers and received only one quote in response.

Protecting Insurers Through TRIA

In an effort to keep the economy moving and ensure that terrorism risk insurance was available, Congress passed the Terrorism Risk Insurance Act of 2002 (TRIA). Among other things, this law created a federal backstop for insurers that could be utilized if insured losses from a terrorist attack were to ever exceed certain dollar amounts. In return for this federal reinsurance, commercial property and casualty insurers were generally required to make terrorism coverage available to all of their policyholders. Businesses often had to pay extra for this offered coverage, but they could refuse it by signing the appropriate forms.

Even before TRIA was introduced in Congress, the federal government's role in stabilizing the market for terrorism coverage was a matter of fierce debate. Supporters of the law generally believed that the potential for economic uncertainty was too great for the government to do nothing. They also often claimed that the government had a responsibility to help insurers manage terrorism risks because terrorist activities are often committed in response to a government's foreign policy decisions. On the other hand, critics of a federal backstop have been concerned about the government potentially taking on too much financial liability and interfering with the free market.

Those points of view were still competing with each other while this course material was being written. After being extended multiple times, the provisions of TRIA actually expired at the end of 2014. However, as they had in the past, insurance trade associations successfully convinced lawmakers to reinstate and extend the law through 2020.

Protecting the Public Through Anti-Money Laundering Programs

Considering all the human and financial losses caused by the events of 9/11, it makes sense for insurance professionals to support all reasonable precautions that could thwart similar attacks. As a first step in terrorism prevention, concerned individuals should take time to understand how terrorist organizations are financed. This learning process should emphasize not only the common sources of funding but also how that money moves undetected throughout the global financial system.

Many details regarding al-Qaeda's financial history are provided in the federal government's 9/11 Commission Report. Figures in the document are intriguingly contradictory, painting a portrait of an organization that spent relatively little money on specific plots but still required significant resources to survive. According to the report, the entire undertaking of the 9/11 attacks cost al-Qaeda only roughly $400,000, but total annual expenses for the group in the years leading up to 2001 were estimated at $30 million.

Initially, al-Qaeda was assumed to be funded mainly through the personal fortune of its leader and founder, Osama bin Ladin. Between inheritance of his family's successful construction company and an assortment of ownership interests in other profitable companies, bin Ladin was believed to have a fortune near $300 million. Indeed, later projections confirmed that he was a wealthy man. But those early estimates still greatly overestimated his net worth, and, by the start of the 21st century, many of his personal assets had been either frozen or forfeited amid disputes with multiple Middle Eastern governments.

In reality, most of al-Qaeda's operations were funded through a system of charities. While some donors made major contributions with apparent knowledge of where their money was going, others merely gave money to their local places of worship in accordance with their religious duties and weren't aware of its ultimate destination.

Judgment and detection of terrorism-linked charities was complicated, to a certain degree, by the fact that the groups usually weren't merely a front for violent activities and actually did engage in some legitimate humanitarian work. Meanwhile, when the United States or other vigilant nations unearthed clear connections between terrorists and charities, attempts to halt the flow of money were sometimes hindered by noncooperation from certain foreign governments. These factors (along with several others) combined to create opportunities for al-Qaeda to launder money across the globe.

What Is Money Laundering?

According to some reports, the term "money laundering" dates back to the Prohibition era, when organized crime boss Al Capone used laundry service establishments as fronts for alcohol-related business ventures. Historians have questioned

the accuracy of those origins, but Capone's use of a cleaning service as a front for illegal activities was ironically appropriate, particularly if we consider a money launderer's ultimate goal.

Criminals engage in money laundering in order to hide financial assets that are either obtained through or used in illegal activities. In essence, a launderer attempts to wash away any trace of illegal behavior to the point where neither a financial institution nor a law enforcement agency can tell the difference between the dirty money belonging to a criminal organization and the clean money earned through legitimate business practices.

Money laundering has been committed seemingly throughout history and was originally a way for indebted borrowers to hide money from their creditors. Authorities in the United States started taking the crime more seriously in the 1970s in the hope that seizing laundered funds would starve various drug cartels. After 9/11, the federal government began hoping that similar anti-money laundering activities could destabilize terrorist organizations.

For the cartels and other sects of organized crime, money laundering is often a way to withdraw profits after illegal activity has already occurred. In the case of terrorist groups, however, the opposite is often true. Instead of using laundering techniques to obtain funds after committing illegal activity, terrorists are likely to use those techniques in order to facilitate illegal activity in the first place. Due to the differences between money laundering by terrorist groups and money laundering by other criminals, money laundering by terrorists is sometimes known as "reverse money laundering" or "money laundering in reverse."

In total, the International Monetary Fund, has estimated that between $600 billion and $1.5 trillion is laundered throughout the world every year. Those figures amount to roughly 2 percent to 5 percent of global domestic product.

How Criminals Commit Money Laundering

Some money laundering schemes are relatively simple, and others are complex enough to keep skilled law enforcement authorities scratching their heads for years. In most cases, though, the operation goes through three stages, which we will call: "placement," "layering," and "integration."

Placement

When a criminal is in the "placement" stage, he or she is trying to introduce dirty money into the regular economy in a manner that arouses minimal suspicion. This is done through various techniques. For instance, a launderer might make bulk cash deposits that include money linked to criminality and money linked to a cash-heavy front business, such as a car wash, dry cleaning service, convenience store, restaurant or liquor store. Particularly in regard to terrorist groups, placement might begin at a completely bogus or semi-legitimate charitable organization. Within an insurance context, placement might occur by purchasing a cash-value insurance policy or annuity with a large sum of cash.

Concerns about the placement stage of money laundering are at least partially responsible for rules requiring many U.S. financial institutions to report cash transactions of $10,000 or more to the federal government. Criminals might work around this requirement by simply breaking down a large cash deposit into smaller amounts that don't reach the $10,000 threshold.

Layering

In the "layering" stage of money laundering, launderers and their associates attempt to create a financial maze for regulators by wiring money from one account to another or allowing money to pass through several types of financial institutions. The laundered funds might be moved back and forth between foreign or domestic financial companies regardless of any penalties for early withdrawals. For example, a launderer might use an insurance company to layer money by quickly replacing one fixed annuity with another for no legitimate reason. Any surrender charge resulting from the transfer might be dismissed by the launderer as part of the cost of doing business.

To help ensure their layering does not receive much attention, some launderers have gone so far as to bribe financial workers. Some have even bought their own banks here or abroad in order to facilitate schemes. Although inappropriate activity by financial insiders is certainly possible at large institutions, launders might be particularly attracted to smaller entities, where irregular account activity is less likely to be flagged by internal safeguards.

Integration

The final stage in the money laundering process is "integration." At this point, the money is presumed to be untraceable, "cleaned up" and ready to be spent for personal items or to pay for future criminal activity. This stage is sometimes also referred to as the "receiving" stage.

Cooperating With Foreign Entities

Though a criminal could certainly launder money solely on American soil, many of the money laundering cases that attract federal attention involve foreign banks, individual foreign clients and foreign businesses.

Offshore banks in places such as Panama and Switzerland have attracted an international clientele eager to avoid various tax penalties in their own countries. One concern regarding these parts of the world is the anonymity with which a foreign person or business can create offshore accounts. Unlike in the United States, some countries' banking systems do not maintain customer identification records and often pride themselves on the privacy protections available to their native and foreign customers.

Offshore financing of illegal activity can exist on a number of levels. In its simplest form, it might be done by creating a "correspondent account" used by or set up for a legitimate foreign person or business. In a more complicated plan, people might respond to an advertisement in a foreign publication that highlights attorney services for offshore clients. As documented in the publication Insight, a U.S.-based launderer could rely on one of these attorneys to form a front business in the foreign country with only the lawyer's name on all the paperwork. Dirty money could then be transferred to the offshore front, and, sooner or later, the U.S. entity could ask the foreign front for a loan, which would be granted and paid back with interest, thereby making the illegal funds clean.

The U.S. government continues to pass stricter laws related to bank and wire transfers to and from correspondent accounts and shell companies. In some cases, international pressure has resulted in banking reforms that have reduced some of the potential for money laundering at foreign financial institutions. However, even when the United States pressures or successfully convinces a government to change its financial privacy laws, it appears as if another country comes along and meets the small but powerful demand for anonymous transactions and tax havens.

Without the full support of law enforcement agencies in other countries, efforts to minimize money laundering's impact on U.S.

citizens require greater vigilance among domestic entities. In fact, as a result of 9/11, rules have been put in place to help prevent money laundering at many of the nation's insurance companies.

Money Laundering in Insurance

Despite the federal government's concern regarding the links between money laundering and terrorist groups, most of the documented cases of money laundering in insurance have been perpetrated by drug dealers. In one case, according to the Financial Action Task Force and cited in the Journal of Money Laundering Control, a trafficker converted $80,000 of drug money into a cashiers check and used it to purchase a single-premium, cash-value life insurance policy, only to surrender the policy for its cash value a mere three months later. Perhaps the most striking aspect of the case, according to reports, was that the salesperson who sold the policy had full knowledge of the money's origins. Instead of reporting the applicant to supervisors or police, the producer demanded and received a higher sales commission in exchange for facilitating the transaction.

A similar but more elaborate case of insurance-related money laundering is detailed in multiple issues of the Federal Register and earned the code name "Operation Capstone" from the U.S. Customs Service. According to court documents and interviews cited by the federal government, Columbian cartels took money earned from drug deals in Mexico and the United States and used it to purchase hundreds of life insurance policies in Europe. Policies worth as much as $1.9 million were surrendered after roughly a year in spite of early withdrawal fees that sometimes exceeded 25 percent of the cash value. But, as stated by the government, "The penalties … merely represented a 'business cost' of using the insurance products to launder the illicit narcotics proceeds." While Operation Capstone was still winding down, the government also noted similar plots involving variable annuity products.

The USA Patriot Act

The insurance industry's greater involvement in anti-money laundering activities stemmed from the passage of the USA Patriot Act. The law, which sailed through Congress just six weeks after the 9/11 attacks, resulted in many changes regarding national security that are beyond the scope of this course. However, both the relevant and irrelevant portions of the law paint a picture of a country that was revaluating its understanding of risks and taking quick action in response to a national crisis.

Through the law and the rules that followed it, the federal government signaled that any piece of information about potential terrorist activity—no matter how small—had value. And even though the documented examples of money laundering in insurance weren't connected to terrorist groups, regulators weren't interested in waiting for a test case. If there were ways to exploit the financial system in order to hide significant amounts of money, criminals would presumably find them. One of the best ways to prevent another attack, lawmakers believed, was to fill the holes in the system before they could be exploited.

Title III of the USA Patriot Act contains the International Money Laundering Abatement and Financial Anti-Terrorism Act. This major section of the law, according to the U.S. Department of the Treasury, made the following important changes in regard to money laundering, among other things:

- Encouraged law enforcement, regulators and financial institutions to share more information with one another about suspected terrorism and money laundering.
- Strengthened the ability of the Departments of Justice and Treasury to seize the funds of individuals and businesses in foreign countries.
- Created new rules for verifying the identity of new customers at financial institutions.
- Gave legal protection to businesses and individuals who report suspicious financial activities to the government.
- Prohibited businesses from telling customers about certain government investigations involving suspicious financial activity.
- Required financial institutions (including some insurance companies) to establish anti-money laundering programs.

We will address that last important point in greater detail later in these course materials. However, in order to understand both the requirements and the reasons for them, it may be helpful to have a bit more background information at our disposal.

The Bank Secrecy Act

The money laundering sections of the Patriot Act were technically amendments to a 1970 law known as the "Bank Secrecy Act" (BSA). The earlier law called on financial institutions to assist law enforcement by keeping detailed account records and by reporting large currency transactions (generally, those exceeding $10,000) to the U.S. Treasury.

Particularly since 9/11, BSA compliance has been a major issue for a wide variety of businesses. A partial list of entities that must follow certain portions of the law appears below:

- Banks.
- Credit unions.
- Thrifts (savings and loan organizations).
- Currency exchanges.
- Broker-dealers selling securities.
- Investment companies.
- Mortgage lenders.
- Casinos.
- Insurance companies.

Although insurance companies had long been included in the Bank Secrecy Act, practical requirements for those companies were relatively minor. According to the Federal Register, the only BSA requirement for insurers throughout most of the law's history was a section calling for financial institutions to report cash transactions of $10,000 or more to the government. Whereas some other business entities had to follow specific rules that were designed to implement the law, those initial rules didn't address insurers.

The BSA amendments in the Patriot Act prompted regulators to finally clarify an insurance company's obligations in regard to the decades-old law. And along with other financial institutions, insurers discovered that many of those obligations related to the careful creation of internal anti-money laundering programs.

BSA Rules for Insurance Companies

Following the passage of major legislation, the government often issues regulations that are intended to explain how the law should be followed in more practical terms. Anti-money laundering regulations that are specific to the insurance industry went into effect at the federal level in May 2006. We will address some of the details of those regulations shortly, but here's a quick summary of them in advance:

- Some insurance companies must implement procedures to detect possible money laundering.

- Some insurance companies must take special measures to verify the identity of their customers.
- Some insurance companies must appoint compliance officers who are charged with overseeing anti-money laundering procedures.
- Some insurance companies must train their employees to detect potential money laundering.
- Some insurance companies must file special reports with the federal government when money laundering is suspected.

The federal BSA rules for insurers have filled in some of the gaps in parts of the country that lacked their own anti-money laundering rules. When the regulations were originally proposed, according to the National Association of Insurance Commissioners, 12 states didn't have any anti-money laundering requirements for insurers, 29 didn't require documentation of large cash transactions, and all but one didn't specifically require insurers to report possible money laundering to authorities.

In the event that you are legally responsible for anti-money laundering compliance at an insurance company, please be aware that these course materials won't mention the specifics of any state-level laws or state-level rules. Similarly, if BSA compliance is part of your job, you should consult with an expert who is familiar with your situation or at least review the current rules on your own. The explanations of BSA rules that are provided here are intended for general purposes and are not meant to be used as legal advice or as a comprehensive set of an insurer's obligations under various anti-money laundering laws.

Role of FinCen

Anti-money laundering enforcement in the United States is overseen by a section of the U.S. Department of the Treasury called the "Financial Crimes Enforcement Network" (FinCEN). FinCEN was created in 1990 in order to fulfill the following purposes:

- Advise the federal government on issues of financial intelligence and financial crimes.
- Maintain databases related to financial intelligence and financial crimes.
- Analyze data in an effort to decipher criminal activity.
- Promote better communication and sharing of relevant financial information among law enforcement entities.
- Coordinate anti-money laundering procedures with the United States and foreign governments.

Although audits of an insurer's anti-money laundering program (and the imposition of any fines) might be handled by other parts of the Treasury department, FinCEN plays an advisory role in the determination of BSA-related penalties. According to experts quoted in the trade publication Rough Notes, FinCEN might base its disciplinary recommendations on the following factors, among others:

- The amount of money successfully laundered through the company.
- The company's history of compliance (or non-compliance) with BSA requirements.
- The amount of anti-money laundering training conducted by the company for its employees.

Covered Insurance Products

In general, the BSA rules for insurance companies are only applicable to transactions involving "covered products." In choosing which kinds of products would be deemed "covered products," regulators examined the money laundering process and tried to determine the kinds of policy-related features that might attract criminals. Insurance products that can be cancelled in exchange for their cash value are the most likely candidate and are especially vulnerable to laundering when they have free-look periods or modest surrender charges. In short, any insurance product that can easily be converted to real money might be a problem.

Based on those conclusions, the federal government chose to classify the following forms of insurance as "covered products:"

- Permanent life insurance.
- Annuities.
- Any other insurance product with cash value or investment features.

There are many different kinds of permanent life insurance, including whole life, universal life and variable life. The BSA rules define "permanent life insurance" to mean "an agreement that contains a cash value or investment element and that obligates the insurer to indemnify or to confer a benefit upon the insured or beneficiary to the agreement contingent upon the death of the insured."

Many forms of annuities exist, too, including fixed annuities (which offer death benefits along with guarantees of principal and interest) and variable annuities (which might offer some guarantees but are partially dependent on the rise and fall of the stock market). The BSA rules have been applied to both kinds of annuities, with the federal government defining an annuity as "an agreement between the insurer and the contract owner whereby the insurer promises to pay out a fixed or variable income stream for a period of time."

The third group of covered products—essentially anything with cash value or investment features (other than permanent life insurance or an annuity)—was included as a safeguard to ensure that unforeseeable products of the future would still be part of the rules. For example, although FinCEN was unaware of any major property and casualty insurance products that could be exchanged for cash value, it wanted to protect itself in case that hypothetical product ever became a reality.

In commentary from the November 3, 2005, Federal Register, the federal government stressed that there wasn't a minimum dollar amount that would turn a cash-value insurance policy into a non-covered product. However, regulators expect the amount of the cash value to influence an insurer's specific response to a possible suspicious situation. A transaction involving a policy worth $1 million, for instance, might be scrutinized differently than one involving a policy worth only $1,000.

Non-Covered Products

Insurance products without cash values are generally considered to be poor vehicles for money laundering. A scheme in which dirty money is used to purchase real estate (or property insurance) and then laundered by committing property insurance fraud is technically possible but would presumably be much more difficult to complete than the simple purchase and surrender of permanent life insurance.

At the time this course material was being written, several kinds of insurance products were exempt from the majority of BSA requirements, including the rules about anti-money laundering programs. Some of those exempted products are listed below:

- Group life insurance.
- Group annuities.

- Term life insurance.
- Property insurance.
- Casualty insurance.
- Accident and health insurance.
- Reinsurance (essentially, insurance for insurance companies).
- Annuities that are part of a structured workers compensation settlement.
- Credit life insurance.

Insurance companies that do not sell any "covered products" are exempt from the majority of the BSA and its rules. Insurance companies that sell a combination of covered products and non-covered products must abide by the BSA anti-money laundering rules when selling covered products but not necessarily when selling non-covered products.

Be aware that a single product might have characteristics of both a covered product and a non-covered product and that the government has reserved the right to broaden its list of covered products. If your company has questions about whether a particular product must comply with BSA rules, FinCEN can provide a determination for you upon request.

Anti-Money Laundering Programs

An insurance company selling covered products must have an anti-money laundering program that has been reasonably designed to prevent the laundering of money or the funding of terrorism through the organization. The program must be explained in writing and approved by senior management, and a copy of the program must be made available to federal auditors upon request.

In some respects, anti-money laundering programs may be structured in ways that are similar to an insurer's other anti-fraud programs. However, there is usually a difference in the main purpose behind these two types of prevention programs. Whereas anti-fraud programs are generally intended to prevent an insurer from losing money, anti-money laundering programs are meant to serve society as a whole and might help identify illegal activities that don't have a direct impact on an insurer's finances. An early surrender of an annuity, for example, is unlikely to harm the insurance carrier and therefore might not trigger an investigation under the insurer's anti-fraud program. But an anti-money laundering program might flag that scenario as a potentially suspicious activity.

The rules about anti-money laundering programs were intended to be flexible so that they could be implemented at a wide variety of financial institutions. In choosing the particulars of their program, insurance companies are expected to conduct a thorough risk assessment that analyzes their relationship with covered products. Since no two insurance companies are likely to sell exactly the same amount of covered products in exactly the same way, it's possible that no two anti-money laundering programs will be exactly alike.

The federal government requires insurance companies to consider all relevant information as part of creating an anti-money laundering program. According to the Federal Register, factors that should be considered include (but are not limited to) the following:

- Whether the company accepts cash payments for its products.
- Whether the company sells policies in exchange for a single premium or lump sum.
- Whether the company's products allow policyholders to borrow money against their cash value.
- Whether the company accepts business from countries that either sponsor terrorist activities or don't cooperate with U.S. anti-money laundering efforts.

Technically, insurance companies, and not their agents, are required to implement an anti-money laundering program. However, as a condition of their business relationship with a carrier, agents can be ordered to comply with an insurance company's anti-money laundering rules.

Knowing Your Customer

In general, BSA rules require financial institutions to develop a "customer identification program." This type of program typically involves confirming the identity of new customers and collecting birthdates, tax identification numbers, names, addresses and more.

Based on the research conducted for this course, experts don't seem to be in total agreement regarding the extent to which insurance companies must implement customer identification programs. However, the federal government has made it clear that insurers must at least collect enough personal information to run an effective anti-money laundering program. Personal information might also need to be collected in order to comply with other federal anti-terrorism laws.

Red Flags

An insurer's anti-money laundering program will be ineffective (and likely non-compliant with BSA rules) unless the individuals behind it are aware of the "red flags" (or warning signs) of laundering activity. These red flags can relate to the personal responses and behaviors exhibited by individual clients in a question-and-answer session, the products sought by customers, the transactions made by clients and much more.

Although the red flags might be a bit different for each insurer, here are several to be aware of:

- A cash-value product is surrendered at great expense to the owner.
- An owner borrows the maximum amount possible from a cash-value product with policy-loan features.
- An applicant insists on paying large premiums with cash.
- A business has no physical U.S. address (for example, only a P.O. box) and is incorporated in a country that has been known to take a soft approach to anti-money laundering enforcement. (The Financial Action Task Force maintains an up-to-date list of "red flag" countries.)
- Deposits or payments are made in pieces rather than in typical lump sums.
- The owner surrendering a cash-value product has no reasonable explanation for the surrender.
- An applicant displays an unconventionally high amount of interest in policy loans.
- Large purchases are made by people who seem unlikely to afford them (for example, a student buying large amounts of cash-value life insurance).
- Currency used to purchase a product has a strange odor or odd markings.
- The type of product purchased by someone is in conflict with a needs-based analysis conducted by an agent or broker.

- Owners, annuitants or beneficiaries of cash-value products seem unconnected to one another and lack an insurable interest in one another's lives.
- A consumer asks whether certain transactions must be reported to the Internal Revenue Service.
- Information provided on an insurance application turns out to be false.
- An individual wants to purchase insurance but is very reluctant to provide necessary personal information.
- An applicant wants to purchase an interest-sensitive product but expresses no concern about the product's performance.
- An expensive insurance product is purchased by someone who has only been in the United States for a very short time and has no reasonable explanation for the transaction.
- An applicant is very interested in "free-look" periods that allow for a return of premiums after a policy cancellation but expresses little concern about other aspects of the product.
- Personal identification cards have suspicious pictures or suspicious dates on them.
- Policy ownership is transferred without a reasonable explanation.
- A consumer is engaging in an irregularly high number of insurance transactions.

Despite all these potential warning signs of money laundering, it is important to remember that an individual red flag has a chance of being nothing more than a false alarm. When evaluating red flags in accordance with a company's anti-money laundering program, professionals shouldn't be afraid to use common sense or to seek advice from management.

Also, companies and individuals may find that anti-money laundering techniques sometimes clash with a consumer's expectation of privacy. This is especially true if an insurance professional decides to question an applicant whose interest in a particular product lacks a logical explanation. Companies may want to evaluate their anti-money laundering programs carefully so that their crime-prevention efforts don't violate professional ethics or a person's legal rights.

Checking Government Lists

The previous section mentioned the Financial Action Task Force and its list of countries that have been known to take money laundering less seriously than others. This list can be helpful in running an effective anti-money laundering program in compliance with BSA rules.

Note, however, that checking certain lists is not only an important task for companies that need an anti-money laundering program. According to legal experts cited in multiple trade publications (such as Business Insurance and National Underwriter), even an insurance company that doesn't need to comply with the Bank Secrecy Act might still need to crosscheck its customers against lists of suspected or designated terrorists from the Office of Foreign Asset Control. According to those sources, this requirement might even apply to property and casualty insurers, health insurers and other insurance-related entities that aren't considered to be a target for money laundering.

Role of Compliance Officers

An insurance company's anti-money laundering program must be overseen by a compliance officer. The officer can be one person or a group of people but must be someone with the authority to implement the program across all departments and who has strong knowledge of how the insurance company operates.

The amount of hours spent on anti-money laundering activities will depend on the intricacy of the program, the size of the organization and the company's level of risk. But regardless of the size of the job, the compliance officer is expected to have the following responsibilities:

- Implementing a program that reflects the insurer's level of risk.
- Making updates to the program as necessary.
- Remaining up-to-date on FinCEN requirements.
- Coordinating anti-money laundering training programs for employees and agents.
- Answering questions from employees, agents and others about the program.

Program Audits

An insurer's anti-money laundering program must continue to reflect the company's level of risk and be in compliance with the latest FinCEN requirements. In order to ensure that the program remains effective and up to date, the program must be audited by an unbiased person. The insurer can hire a third party to conduct the audit or have the audit performed by its employees. However, anyone who is serving as the program's compliance officer cannot also serve as its auditor.

Audits should be done whenever a company's level of risk related to money laundering is likely to change. For example, an audit might be in order if the company starts offering new kinds of products or starts targeting a new type of customer. There is no specific timeframe or deadline (such as every year or every six months) for conducting mandatory audits.

When an auditor notes potential problems with an insurer's anti-money laundering program, the auditor's findings and recommendations should be put in writing. Copies of the written audit should be provided to the compliance officer and senior management.

Compliance for Variable Products

Broker-dealers and other organizations that offer variable life insurance or variable annuities are likely to have additional anti-money laundering requirements because they sell securities. In addition to federal laws and the various BSA rules, regulations from FINRA (the main non-governmental regulatory body for the securities industry) should be reviewed by these entities. If a company sells insurance and securities, it may need different anti-money laundering procedures depending on the type of product being sold.

Mandatory Training

Insurance companies with an anti-money laundering program must ensure that the people working for them are properly trained to detect possible money laundering and to follow proper procedures. The specifics and scope of the training should reflect a person's role within the organization and his or her potential exposure to money laundering schemes. For some people at the insurance company, the training might be relatively intensive. For others, the training might be very basic.

Mandatory training can be handled internally by the insurance company or outsourced to a competent third party. Examples of a possibly competent third party include another insurance company, a bank, a broker-dealer or any other company that is required to have its own anti-money laundering program. At the time this material was being written, there was no required format

for the training. For example, training might be done in person at a company meeting, in person in a formal classroom setting, in a hard-copy written format or over the internet. Training programs are not approved by FinCEN and do not need to be approved for continuing education credit by a state's insurance department. However, an insurance company's compliance officer must review the content of the training and believe it is satisfactory. A more thorough evaluation might be required if the training provider does not have its own anti-money laundering program.

Insurance agents and brokers do not need their own anti-money laundering programs and do not need to complete anti-money laundering training in order to maintain their insurance license. The responsibilities of establishing a program and ensuring adequate training of individuals have been reserved for insurance carriers (not individual licensees) because carriers are more likely to have the resources to establish a program and are likely to already have similar training programs in regard to fraud prevention.

Still, it is very likely that an insurer's anti-money laundering program will involve participation from agents and brokers and have internal training requirements for those licensed salespersons. Agents and brokers are in the front lines in the battle against fraud and money laundering and are often the best sources of information about applicants and policyholders. Since they tend to know their customers, they are likely to have an important perspective regarding red flags and whether a particular person might be engaging in illegal behavior.

Agents and brokers must comply with an insurance carrier's anti-laundering program. In the event that an agent or broker doesn't follow proper procedures, the company's designated compliance officer is expected to take corrective action. In serious cases, the insurer might decide to sever its relationship with the agent or broker.

Suspicious Activity Reports

A key component of an anti-money laundering program is the proper filing of "Suspicious Activity Reports" (SARs) with FinCEN. These special reports involve the use of specific government forms and must be filed with FinCEN when an insurer notices suspicious activity involving at least $5,000 in assets. For example, a transaction involving that amount (in cash or otherwise) would need to be filed under any of the following circumstances:

- The funds used in the transaction seem to be derived from illegal activity.
- The transaction seems designed to hide illegal funds.
- The transaction seems designed to facilitate illegal activity.
- The transaction is unusual and is done without any reasonable explanation.
- The transaction involves less than $5,000 but seems designed to avoid the filing of a report.

In spite of these general requirements, there are many cases in which a suspicious transaction might not require the filing of a report. For example, SARs do not need to be filed in connection with transactions that do not involve covered products. (Again, covered products are generally limited to cash-value life insurance and annuities.) Similarly, a report does not necessarily need to be filed when possibly illegal activity doesn't involve money laundering or terrorism. For example, according to federal guidance, a report would not necessarily need to be filed in the case of an applicant who has lied about medical issues in order to obtain life insurance.

Individual insurance producers are not expected to file a report on their own. However, they are important to the reporting process because they are likely to provide important information that a carrier will need to complete a report. Agents and brokers who do not follow a carrier's anti-money laundering program will prevent insurers from satisfying the company's reporting requirement.

SAR Deadlines

SARs must be filed within 30 days after an insurer notices suspicious activity and can identify who is doing it. If the person behind the suspicious activity is unknown, the insurer can take an additional 30 days to investigate. However, in an emergency situation, such as a clear link to terrorism, the insurer is expected to contact law enforcement immediately. The SAR deadlines don't release the insurer from having to respond right away in an emergency.

Completing SARs

SARs fail to serve their purpose when they are filed incorrectly. With this in mind, FinCEN has stressed the importance of providing sufficient details about a suspicious transaction in a report's main "narrative" section. This section should answer five basic questions concerning the suspicious transaction: who, what, where, when and why?

Answers to the first four of those questions should provide the facts of the suspicious transaction. Once those facts have been provided, the insurance company should explain why the facts of the transaction are considered suspicious.

All relevant information should be provided on the FinCEN SAR form. At the time this course material was being written, the government was not accepting attachments to these forms.

Individual documentation about the suspicious transaction should be maintained by the insurer for at least five years. If FinCEN requires additional information, it will contact the insurer via the contact items provided on the SAR form.

SAR Confidentiality

Financial institutions are obligated to keep the existence of SARs confidential. An insurer is forbidden from informing customers that a report has been filed about them. If information related to a report is subpoenaed, the insurer should contact FinCEN for instructions.

In general, the only parties who can be told about SARs are law enforcement entities, other financial institutions (in limited circumstances) and the insurer's management team.

Reporting Large Transactions

Insurance companies are required to fill out a special report when they receive $10,000 or more in cash in one transaction or in related transactions. This requirement preceded the other BSA rules mentioned in these materials and must be made separately from a Suspicious Activity Report. This currency report is made regardless of whether the transaction seems suspicious.

Conclusion

Terrorism prevention should be a priority for practically everyone in the United States, and insurance professionals are no exception By being observant and following some basic federal guidelines, insurance licensees can play a small yet very important role in keeping our country safe.

CHAPTER 4: THE VIATICAL AND LIFE SETTLEMENT MARKET

Introduction

It may be easy to view the secondary market for life insurance as a purely American creation; just one extreme example of what a modern market economy can produce. Yet the practice of selling one's life insurance to strangers has its origins across the ocean in England, where economically poor individuals who suffered from serious illnesses could auction off their life insurance policies to the highest bidder at least as early as the 19th century. U.S. authorities who knew about these auctions and considered them despicable aimed to keep them out of our country by promoting non-forfeiture laws on a state level beginning in the 1860s.

Between that time and the 1980s, Americans with life insurance to their name were left in an odd position. As policy owners, they technically had the right to renounce policy benefits and put them in another person's hands. But beyond offering their policy as collateral to a creditor or surrendering it to the insurance company, they lacked formal ways of selling their policy for necessary cash.

When they look back on the state of life insurance as it was 30 years ago, multiple industry experts note that a person who wanted to sell an in-force yet unwanted policy usually had to deal with a "monopsony;" an environment in which people who market their goods and services can only do business with one buyer. That lone potential purchaser in those days was effectively the same company that issued the policy, and the "take it or leave it" offer from that buyer was never greater than the policy's cash surrender value.

Although the option of canceling a policy for its cash surrender value was certainly better than having no options at all, it was often far from a financial life saver for someone with a need to create immediate income from a policy. Then, as now, the cash surrender value often amounted to a very small amount if the owner had not yet paid significant premiums on the policy. At that time, insurance companies made no changes to surrender values for clients who had developed life-threatening illnesses.

Of course, the needy policyholder with a permanent life insurance policy also had the ability to receive a speedy delivery of dollars from the insurer by requesting a loan against the contract's cash value. But the amount available to the individual via a loan was sometimes very small compared to the policy's death benefit.

Meanwhile, critically ill people with term coverage could neither apply for a policy loan nor surrender their policies for cash. They received nothing positive from their insurance, other than the guarantee that a named beneficiary would receive some money when they passed away.

None of this boded well for people who were dying of AIDS during the late 1980s. As the disease attacked their immune system and made them too sick to remain in the workforce, many AIDS patients lost their income and employer-sponsored health insurance and struggled to pay for medical treatment that could have prolonged their lives. Those who were fortunate enough to hang onto their health coverage often found that their medical plans would not pay for the latest experimental drugs and therapies that scientists were developing to combat the new health crisis. Rather than being able to concentrate on enjoying their last days as much as possible, the terminally ill often spent their time worrying about how they were going to pay for medical attention and still have enough money for such essentials as housing, food and utilities.

Typical AIDS patients—young and unmarried men—sometimes owned inexpensive term life insurance policies that had been made available years earlier through an employer. But with death catching up to them and no dependent spouses or children to think about, they began to question the practical value of such coverage and had no way of receiving any personal benefits from what, in some cases, was the largest item in their estate.

The AIDS community's financial dilemmas caught the attention of a few insurance veterans, financial planners and entrepreneurs who had watched well-insured close friends or family members die of AIDS or cancer with little or no money left in their pockets. Searching for ways to turn life insurance into a greater financial asset for the terminally ill, these businesspersons developed a secondary market for life insurance in the United States by promoting what have become known as "viatical settlements."

The word "viatical" comes from the Latin term "viaticum," which was used first to describe a bundle of provisions given to Roman officers as they headed out on long, dangerous missions and was later associated with the religious sacrament of last rights administered to dying Catholics. In theory, viatical settlements and the companies that provide them take that old terminology and apply it to modern circumstances.

In exchange for receiving the eventual death benefits created through a terminally ill person's life insurance policy, a viatical organization pays a major portion of the policy's face value to the dying individual, thereby giving the terminally ill policyholder money to help with medical bills or other needs.

For the purpose of a hypothetical example, suppose a person with a $100,000 life insurance policy has been diagnosed with terminal cancer and is expected to die in roughly one year. By selling the policy to a viatical company—effectively making the company the beneficiary of death benefits—, the person might receive a lump-sum payment of $80,000 from the organization.

During his or her remaining lifetime, the terminally ill person would be able to spend the $80,000 as he or she sees fit. After the insured dies, the viatical organization would file a claim with the life insurance company for the full $100,000 death benefit and would expect to earn a $20,000 profit from its investment.

The first major viatical company in this country was started in Albuquerque, New Mexico, in 1988. After spreading to portions of the South and Midwest, the young industry made its way to such metropolitan areas as New York City and San Francisco, where a high prevalence of AIDS cases suggested there might be a favorable market for viatical settlements.

By the 1990s, the viatical business was growing and trying to find a place within mainstream America. Despite still being linked to the AIDS epidemic, viaticals were increasingly targeted at people with other serious illnesses, and funding for the settlements was coming from individual and institutional investors in big cities and small towns.

At least for a brief period, some advocates for the terminally ill praised viatical companies for creating financial opportunities for the sick. Meanwhile, many investors were won over by marketers who claimed that giving money to a viatical company was practically a charitable act; a good deed that would help the less fortunate among us enjoy their last days and pass away with an enhanced sense of dignity.

The promised yields on investments probably didn't hurt either. Many companies sold the idea of these transactions as an allegedly safe way for people to make at least 15 percent on their principal investment. That advertised yield greatly outpaced interest rates on certificates of deposit, and the basically nonexistent relationship between viaticals and the economy appealed to risk-averse investors who were fearful of market fluctuations.

In time, demand for viatical settlements and similar services helped transform the secondary life insurance market from a million-dollar industry in the early 1990s into a billion-dollar industry near the beginning of the new millennium.

How Do Viatical Settlements Work?

If you consider that viatical settlements involve such delicate matters as dollars and death, you will hardly be surprised to learn that these transactions are extremely complex and often packed with safeguards that protect the original policy owner, the ill person's loved ones and the viatical investor.

The viatical process involves a front end (in which ownership of a policy is transferred from the original policyholder to a viatical company) and a back end (in which the viatical company usually resells all or a portion of the purchased policy to a third-party investor).

At this point in our course, we will study the viatical transaction in a roughly chronological fashion, beginning with front-end activity.

The Front-End Viatical Process

A policy owner who seeks out a viatical settlement is known as a "viator." In most cases, the viator and the person covered by the life insurance contract are the same person. However, as long as proper permission is obtained from the insured individual, a policy owner can "viaticate" (or sell) an insurance contract that covers someone else's life. Such leniency makes it possible for trusts and corporations to qualify as potential viators.

A viator can sell nearly any kind of individual or group life insurance policy, including but not limited to a whole life, universal life, variable life or term life contract. Even federal employees with group life insurance have been known to viaticate their coverage.

Still, some life insurance products are easier to viaticate than others. Among the more challenging types are term life insurance and group life insurance.

Term Life Insurance

Term life insurance is probably the simplest kind of life insurance. This classic product is sometimes called "pure insurance" because, unlike other life insurance policies, it lacks investment options and has no cash value. Instead, term life customers pay premiums only so that beneficiaries can potentially receive the policy's "face value."

The face value is clear to the insurer and the policyholder when the policy is issued, and it generally does not change as long as premiums are paid. The face value is not dependent on the economy or the insurer's financial performance. If a person who is insured through a $100,000 term life policy dies, the insurance company pays $100,000 to beneficiaries, barring any unusual circumstances.

As their name suggests, term life policies remain in effect for a contractually agreed-upon time and then expire. People who opt for a term life policy instead of a permanent life policy tend to have short-term needs and view beneficiaries' welfare as their top life insurance concern. A father, for example, might purchase a term life policy in order to ensure that his young children will have some financial support if he were to die before they reach adulthood.

When a policy's term concludes, the insured individual can reapply for another term insurance policy. However, premiums for the new term policy are likely to be higher than premiums under the old policy. This is because the person's susceptibility to mortality risks will have increased with age.

If policyholders have no interest in renewing a term life policy, they can sometimes exchange it for one of the several kinds of permanent life insurance policies.

Term life insurance creates problems in a viatical transaction because the coverage is temporary and could run its course before the terminally ill person dies. Suppose a viatical company purchases a term life policy from a terminally ill man who is expected to die within two years and has five years of coverage left on his contract. If the man dies within the remaining five years of the policy, the viatical company will still be able to collect a death benefit from the insurer. But if the company's estimate of the man's life expectancy is wrong and the man lives for another six years, the company might never receive any death benefits from the insurance company.

Viatical companies will usually only purchase term life policies if the policies can be converted to permanent coverage. In general, insurance companies will allow their term life customers to convert to a whole life or universal life policy at least until insured persons turn 65.

Group Life Insurance

Group life insurance is most commonly used to insure several people who work for the same employer. Premiums for group coverage usually depend on the collective age of the group participants and help pay for limited death benefits in the neighborhood of one or two times an insured person's annual salary.

Group life insurance involves very little underwriting and, therefore, can allow an ill or older individual to obtain some coverage at a low price. Some employers even offer limited group life benefits at no cost to their workers. The typical employer-funded group plan will pay at least enough death benefits to offset funeral and burial expenses and perhaps some debts.

When the policy that is up for sale involves group coverage, the viatical company will want a guarantee that the group's administrator will not cancel the coverage for any reason. As protection against this risk, the viatical company might force the viator to leave the group plan and convert the coverage to an individual policy.

Along with these cancellation concerns, viatical companies will be interested in the group insurer's attitude toward beneficiaries. In order for any settlement to be feasible, the viatical company must have the ability to become the insured's irrevocable beneficiary. Yet some group contracts do not grant irrevocable beneficiary status to any party, do not allow for transfer of ownership and do not even permit a corporation to be listed as a revocable beneficiary.

It is worth noting, however, that these obstacles are not necessarily insurmountable. Human resource professionals have noted that group life insurers are occasionally sympathetic and flexible when they learn that an insured wishes to sell his or her coverage to a viatical company.

Brokerage Companies and Settlement Companies

Before potential viators start actively shopping their life insurance policies around the secondary market, they must understand the differences between "viatical brokerage companies" and "viatical settlement companies." These two kinds of organizations perform separate duties and ultimately serve separate audiences.

A viatical brokerage company should operate with the viator's best interests in mind. Brokerage employees usually help viators fill out applications for settlements, collect and deliver paperwork, solicit bids for viators' life insurance policies from settlement companies and analyze the pros and cons of any offers that are received.

A viatical settlement company, to a certain degree, operates with its own or its investors' best interests in mind. Settlement companies evaluate the life insurance policies that are up for sale in the secondary market, use underwriting techniques to estimate insured persons' remaining life expectancies, make settlement offers to desirable clients and either gather or directly provide the money that is used to purchase a viator's policy. (Please note that, in Illinois' Viatical Settlements Act, settlement companies are referred to as "viatical settlement providers.")

Viatical Brokers

Viators have the option of either using a broker to handle a viatical transaction or contacting settlement companies on their own. Many viators choose to utilize brokerage services, not only to avoid the work of negotiating with settlement companies but also because an experienced broker will at least have a general idea of which settlement companies might be most likely to show an interest in purchasing a particular policy.

In Illinois, the term "viatical settlement broker" is defined as follows:

"Viatical settlement broker" means a licensed insurance producer who has been issued a license pursuant to Section 500-35(a)(1) or 500-35(a)(2) of the Insurance Code who, working exclusively on behalf of a viator and for a fee, commission, or other valuable consideration, offers, solicits, promotes, or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers or one or more viatical settlement brokers. "Viatical settlement broker" does not include an attorney, certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

A broker is entitled to a commission when a viatical settlement has been finalized. This commission can reduce the amount of money the viator would otherwise receive from a settlement company. Commissions for viatical brokers are paid by settlement companies and typically run as high as 6 percent of the sold policy's death benefit. In rarer instances, the broker may receive a commission equal to a portion of the settlement amount, usually no more than 30 percent of the total given to the viator.

Doctors, lawyers and financial advisers have been known to occasionally receive finders' fees from brokerage and settlement organizations when they refer people to viatical companies, but public concerns over conflicts of interest have caused some states to prohibit these fees.

Verifying Information and Obtaining Consent

Whether the viator utilizes a broker or opts to handle the sale of a policy alone, he or she must grant and obtain various types of consent and provide various bits of personal information to settlement companies in order for the bidding process to begin.

To protect themselves from litigation, viatical companies will not purchase a life insurance policy in the secondary market unless the policy owner agrees to a settlement. This means, for example, that a terminally ill individual who has transferred policy ownership to a trust cannot enter into a viatical settlement without the trustee's signed permission.

A viatical company will also usually refuse to buy a policy if the person covered by the insurance contract fails to give written consent. Therefore, a business that owns a life insurance policy on a terminally ill employee generally cannot viaticate the ill person's coverage without obtaining permission from the sick individual.

This consent requirement serves legal, ethical and practical purposes. It ensures that insured persons will not unknowingly end up in a situation in which a complete stranger has a financial interest in their death. It also helps settlement companies obtain the kind of private medical information that is essential to proper underwriting in the viatical industry.

In some states, including Illinois, terminally ill persons cannot enter into a viatical agreement unless they acknowledge they are doing so through their own free will and unless an attending physician concludes that they are in a sound state of mind.

Because viatical settlement companies ultimately become irrevocable beneficiaries on the policies they purchase, any pre-existing irrevocable beneficiaries must actively renounce their policy rights in order for a settlement to be valid.

Though not legally required to do so, many companies will also refuse to bid on policies unless revocable beneficiaries consent to a potential sale. This practice exists as a deterrent to possible legal action that might otherwise be brought by an insured's angry family members or other interested parties. To date, this legalistic safeguard seems to have worked well enough. Research conducted during the development of this course found no major lawsuits filed by pre-existing beneficiaries against viatical companies.

As obvious as it may sound, a settlement company must be able to verify that a policy being shopped in the secondary market actually exists and is configured as advertised by a broker or viator. When applying for a viatical settlement, the viator will likely need to disclose the policy's face value, list the policy number and provide copies of the insurance contract and the policy application form.

The viatical company will need permission to contact the insurer that issued the policy so that it can confirm this information and investigate any possible barriers to a smooth transfer of ownership. Although the insurance company might charge a fee for verifying this information, the National Association of Insurance Commissioners (NAIC) has proposed standard legislation that would forbid insurance companies from charging higher verification fees to viatical companies than to other inquirers.

When someone from a viatical company contacts an Illinois insurer to verify coverage and other details, the insurer has 30 days to respond. The insurer can use those 30 days to examine

the sick person's medical records and other documents in an attempt to detect possible fraud.

A basic questionnaire submitted by the viatical company to the insurer will likely address the following issues:

- The policy's face value.
- The identity of all current policy owners.
- The identity of any revocable or irrevocable beneficiaries.
- The existence of any outstanding loans on the policy.
- The existence of any liens a creditor might have on a policy.
- The applicability of any contestability periods or suicide clauses.
- The amount of premiums required to keep the coverage in force.

The importance of life expectancy to proper viatical underwriting makes medical analysis an essential part of the transaction process. No matter a life insurance policy's face amount, the viator or other covered individual will usually not need to submit to a medical examination in order to qualify for a viatical settlement. But applicants are not exempt from having to fill out health-related questionnaires and will usually need to give settlement companies access to their medical history over the past two years.

The forms used by viatical companies to access an applicant's medical records are similar to those given to life insurance applicants and should comply with standards set forth in the Health Insurance Portability and Accountability Act (HIPAA).

Upon becoming authorized to view an applicant's medical records, the settlement company will put its own underwriting team to work in order to come up with a settlement offer. Alternatively, it may outsource the job to experts who specialize in underwriting for viaticals.

Determining the Size of Settlements

Once the settlement company receives and analyzes the insured's medical records and verifies coverage with the insurance company, the viator may receive a settlement offer for the life insurance policy. Competition in the viatical industry and differing investment objectives among settlement companies make it unlikely that a viator will receive exactly the same offer from multiple viatical organizations. But there are several variables that nearly all viatical companies take into account before they make any offer to a viator.

Life Expectancies

The main consideration among these variables is the insured person's remaining life expectancy. As morbid as it may seem, neither settlement companies nor their investors are keen on working with applicants who have several years left to live. Long life expectancies diminish investment returns for settlement companies and their investors because the people who fund the viatical settlement need to pay a longer stream of premiums to the insurer to keep the policy active. Overly healthy applicants might also tie up investors' money for an unacceptably long time, since no one in the viatical business gets a return on an investment until insured people die.

As a general rule, viatical settlements are made available to terminally ill individuals who have a remaining life expectancy of two years or less. All else being equal, applicants with longer life expectancies can anticipate receiving a smaller percentage of their policy's death benefit than applicants with shorter life expectancies. Someone with an estimated two years left to live might only be offered 50 percent or less of a policy's death benefit from a settlement company. Someone who is expected to live for just a few months might be able to sell a life insurance policy for as much as 90 percent of the death benefit.

The responsibility for careful underwriting for life expectancies rests with the settlement company and its underwriters. The viator will suffer no penalty if the insured lives longer than expected.

Policy Premiums

As a previous paragraph briefly pointed out, policy premiums influence the size of a viatical settlement. Applicants who own inexpensive policies (relative to the death benefit) or who have a waiver of premium clause in their policies can expect to receive higher settlement offers than the average viator.

When the viatical industry began, some settlement companies required the viator to pay premiums on a viaticated life insurance policy for at least one year after the settlement date. However, it is now standard industry practice for settlement companies and their investors to handle payment of all premiums until the insured person dies.

Health of the Insurer

Like any savvy insurance customer, a viatical settlement company wants to ensure that the life insurer that issued a policy will be financially strong enough to honor eventual claims. Devastating occurrences, such as natural disasters and terrorist attacks (not to mention poor business planning), have been known to place some insurers into insolvency, thereby preventing policyholders from receiving benefits in full and in a timely manner. State guaranty funds may help a failed insurer's clients receive some policy benefits, but these funds usually cap the amount available to policy owners at $100,000 or so.

Many settlement companies are hesitant to buy policies issued by life insurance companies that have not received decent marks from insurance rating organizations, such as Standard & Poor's, A.M. Best and Weiss Ratings. If an applicant wants to viaticate a policy that was purchased from a lowly rated insurer, the settlement company may make a lower offer to the viator. Drafts of the NAIC's Viatical Settlement Model Regulation have suggested that settlement companies be allowed to reduce a viator's payout if the viaticated policy comes from a company that has not received one of the four highest ratings from A.M. Best or a similarly high grade from another rating organization.

Age of the Policy

At times, the age of the life insurance policy can mean the difference between receiving a high offer from a settlement company, a low offer from a settlement company, or no offer at all. Life insurance policies typically contain suicide clauses and contestability clauses that allow the issuing company to void coverage within two years of the purchase date if the insured takes his or her own life or if the insurer discovers that an applicant obtained insurance through fraudulent means. Successful cancellation by the insurer would leave the settlement company and its investors empty-handed at claim time, and even unsuccessful attempts by the insurer to cancel a viaticated policy could cost the settlement company thousands of dollars in legal fees.

Most companies in the secondary market will not purchase a policy that is less than two years old or that is still subject to any

type of contestability period. Among the companies that do not boycott these young policies, settlement offers for contestable coverage are usually very tiny. It is not uncommon for a viator with a contestable policy to receive less than 10 percent of the contract's death benefit.

Policy Loans

Potential viators should not forget about any outstanding loans they have on their life insurance policy.

Several reasons exist for people to take advantage of a life insurance policy's loan provisions. For example, prospective borrowers are unlikely to be turned down by their insurance company as long as their policies serve as adequate collateral for a loan. Along with this privilege come fewer questions on a loan application and greater overall privacy than a person would receive from a traditional lending institution, such as a bank.

Though the federal government has tightened tax laws pertaining to life insurance loans over the past several decades, borrowing from a life insurance policy is still likely to incorporate fewer tax issues than borrowing from a person's 401(k) or other retirement account. Also, unlike other credit situations, a loan from a life insurance company usually comes with a low-pressure obligation to pay off the debt. If a person dies or cancels a policy without paying off a loan, the company can simply take money out of the policy's cash value or death benefit.

Policy loan provisions are an important and attractive feature of permanent life insurance, but the insurer's ability to subtract the amount of outstanding loans from the death benefit makes them an undesirable element in a viatical transaction.

Because interest on policy loans can further decrease the death benefit if the loan is left unpaid, a settlement company will want to satisfy the terms of any existing lending agreement between the insurer and the insured immediately after buying someone's coverage. When bidding for a policy with an unpaid loan attached to it, the company might look at all other underwriting factors first, come up with a specific settlement amount, deduct the unpaid balance on the loan from that settlement amount, and offer the result to the viator.

Economic Influences

Despite their distance from major market risks, viatical settlements can be influenced by the national economy in subtle ways. This is demonstrated, in some cases, by the bids settlement companies make on people's policies. If a settlement company wants to purchase a policy in the secondary market and needs to borrow money to fund the settlement, current interest rates will factor into the amount of money that will be offered to the viator.

The Settlement Contract

If a viator wants to accept a settlement company's bid, he or she must sign the settlement contract. The settlement contract is a legal document that spells out the rights of the viator and the settlement company. If a settlement company does not live up to the terms and conditions of the contract, it risks losing its license.

The settlement contract will contain the following pieces of important information:

- The exact amount of money the viator is due to receive from the settlement company.
- When and how the money will be delivered to the viator.
- How the settlement company may remain in contact with the insured individual.
- Under what conditions the viator may terminate the settlement agreement.

The cover page to any viatical settlement contract in Illinois must be a document titled "Important Consumer Notices." According to state law, the document must contain the following language:

"By entering into a viatical settlement contract:

(1) You are making a complex financial decision that may or may not be in your or your family's financial best interest. Seek independent advice from financial planning experts and responsible government agencies.

(2) You may not be able to purchase another life insurance policy.

(3) You could lose Medicaid and other valuable government benefits.

(4) You will receive proceeds that may be subject to federal and state taxes and to the claims of creditors.

(5) You have sold your life insurance policy to strangers who have a financial interest in the life and death of the person whose life is insured by the policy.

(6) You or your residence may be contacted on a regular basis to determine if you have died or if your health status has deteriorated."

Before the contract becomes a binding agreement, the viatical settlement company and the viatical broker must typically make several important disclosures to the viator and remind the seller of various important facts. Many of the disclosures that must be made by either the settlement company or the broker are listed below:

- A reminder that beneficiaries will lose their right to death benefits in the event of a settlement.
- Disclosure of the fact that the settlement might jeopardize the viator's ability to qualify for another life insurance policy.
- Disclosure of the fact that the viatical broker represents the viator and does not represent the insurance company.
- Disclosure of the fact that the viator can cancel the transaction and retain ownership of the insurance policy within 30 days after a contract has been finalized or 15 days after money has been transferred to the viator, whichever date is earlier.
- Disclosure of the fact that the viator will be entitled to receive the agreed-upon settlement amount within three days after the settlement company obtains ownership of the insurance policy.
- Disclosure of the fact that viaticating the policy could cause a viator to lose important policy rights and privileges, including conversion rights or any waiver of premium.
- Disclosure of the fact that the settlement company can periodically contact the viator after the settlement in order to confirm relevant information, such as the insured's health status.
- Disclosure of the fact that the settlement will result in someone having a financial interest in the insured's death.

- A reminder that a viator with a group life insurance policy should contact the insurer to see if there are any conditions related to viaticating the coverage.
- Disclosure of the fact that a settlement could have a negative effect on the viator's eligibility for Medicaid and other need-based government programs. (With a few exceptions, a person cannot receive full Medicaid benefits if their personal assets are worth more than a few thousand dollars.)
- Disclosure of the fact that settlement proceeds may be accessible to a viator's creditors.
- A reminder that there are other opportunities for financial relief (including but not limited to accelerated death benefits from a life insurance company) besides viatical settlements.
- Disclosure of the fact that, under some circumstances, settlement proceeds may be taxed by federal and state governments.
- Disclosure of the fact that sharing of the insured's personal, medical and financial information is possible. (The document containing this disclosure must state, "A viatical settlement provider or viatical settlement broker may ask the insured for medical, financial, and personal information. All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of the insured's family members, the insured's spouse or the insured's significant other, may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every 2 years.")

Under Illinois law, some disclosures are required specifically from a viatical broker. Many of these disclosures, which must be made no later than when the settlement contract is signed by all parties, appear below:

- The broker's name, business address and phone number.
- A detailed description of all offers and counteroffers that were received during the bidding process.
- Any business or personal connections between the broker and any party making a settlement offer. (If there is a financial relationship between the two, the document containing this disclosure must state, ""The financial relationship between your viatical settlement broker and the provider of the viatical settlement creates a potential conflict of interest between your financial interests and the financial interests of the viatical settlement broker and viatical settlement provider. The individual brokering this viatical transaction owes you a fiduciary duty or a duty of loyalty. Your viatical settlement broker must advise you based exclusively upon your best interests, not the best interests of the viatical settlement broker or the viatical settlement provider.")
- The manner in which the broker will be compensated.
- The size of the broker's compensation.
- If the broker's compensation is based on the final settlement amount, then the amount of the final settlement and the percentage the broker will receive from that settlement.
- The party or parties who, as a result of a settlement, will become policy owners and policy beneficiaries.
- Whether or not the policy will be resold once a settlement is completed.

Other disclosures are required to be made specifically by settlement companies. No later than when all parties sign the settlement contract, a settlement company must disclose the following facts:

- Any relationship that exists between the settlement company and the insurer.
- The company's name, address and phone number.
- Any arrangements that have been made or any relationships that exist between the settlement company and another party who will eventually be purchasing the policy.
- If the policy being viaticated covers more than one person, then the fact that viaticating it could jeopardize the other person's coverage and a reminder that the viator should discuss this matter with the insurer.
- The amount of money the settlement company will ultimately be able to receive as a result of the transaction.
- The amount, if known, of any benefits other than the regular death benefit (such as accidental death and dismemberment coverage) and what will happen to those benefits as a result of the transaction.
- The name and contact information of the escrow agent who will be involved in the transaction.
- The fact that the viator has the right to receive and inspect escrow-related documents.

In Illinois, settlement contracts are not enforceable unless a licensed physician verifies in writing that the insured individual is in a sound state of mind and is not being pressured to viaticate a policy. With a witness present, prospective viators must also attest to the following in writing:

- That they understand how the viatical settlement process works.
- That they are aware of the benefits available through their life insurance.
- That they are not being pressured to sell their life insurance.
- That any terminal or chronic health condition that might make their life insurance attractive to investors began after they purchased their policy.

Transfer-of-Ownership Forms and Escrow Agreements

Along with the settlement contract, the viator often receives important supplementary documents, including transfer-of-ownership forms and a copy of an escrow agreement.

Transfer-of-ownership forms and change-of-beneficiary forms must be completed by the viator and submitted to an escrow agent. Though viatical companies generally prefer to become owners of the policies they buy, insurable interest laws in some states may prohibit a transfer of ownership between an individual and a viatical organization. When faced with this potential legal hurdle, the viatical company might still be able to gain the right to a policy's full death benefit as an irrevocable beneficiary.

The escrow agent is responsible for sending the viator's completed forms to the settlement company. The settlement

company usually picks the escrow agent, but it must limit its choice to a properly licensed entity that has nothing to gain from the sale of the viator's policy.

When the transfer-of-ownership forms are returned by the viator to the escrow agent, the settlement company has three days to move all money intended for the viator into an escrow account. This account should be insured by the Federal Deposit Insurance Corporation.

Assuming the insurer approves the transfer of ownership from the viator to the settlement company, the escrow agent releases the settlement amount to the viator through a wire transfer or check.

Receiving Payments

Money for a viator must be deposited into an escrow account no later than three days after the escrow agent has received the completed policy ownership forms. If the money arrives at a later date, the settlement may be considered null and void, and regulators might take legal action against the settlement company.

Some viators have the option of receiving settlement proceeds in a few periodic installments or in long-term pieces, as if the settlement were a modified kind of annuity. But many people who have monitored the viatical industry since its inception have warned potential viators that agreeing to anything other than a lump-sum settlement could lead to problems if a settlement company ever closes its doors. Some states' insurance and securities laws require that all viatical settlements in the area involve lump-sum payments to sellers.

Though the viator's federal tax obligations may depend on the manner in which the settlement proceeds are spent, viators are not required to use their settlement money to fund any medical care.

Rescission Clauses

If viators develop strong second thoughts about having sold their life insurance policy to a viatical company, they may be able to cancel the transaction in accordance with the settlement contract's "regret provision" or "rescission clause." A regret provision or rescission clause is similar to the free-look provision found in life insurance policies and allows the viator to void the settlement agreement and retain policy ownership for any reason.

A common rescission period lets a viator cancel a viatical settlement within 30 days of signing a settlement contract or within 15 days of receiving settlement proceeds, whichever date is earlier. In unregulated parts of the country, the length of the rescission period will differ among settlement companies.

If the viator has already received money from the viatical company as part of a settlement, the amount must be paid back in full for the agreement to be canceled. Likewise, a viator who wants to utilize a regret provision must reimburse the settlement company for any money it used to eradicate outstanding loans on the policy.

If the viator dies during the settlement's rescission period, the viatical company relinquishes its ownership rights, and the insurance company pays death benefits to the insured's chosen beneficiaries as if the transaction had never occurred. However, in order for benefits to shift back to the original beneficiaries, the insured's estate must give the settlement company its money back within 60 days after the death.

If the settlement is rescinded due to death or any other reason, a viatical broker who has already been compensated by the settlement company must return the compensation within five days after being asked.

Contact With Viators

The relationship between the viator and the settlement company will continue, in some way, for as long as the insured individual remains alive. While finalizing the details of a viatical settlement, the viator must give his or her contact information to the settlement company.

After the settlement has been legally completed, the company uses this contact information to periodically check up on the insured individual. In an arguably gruesome yet true reality of the viatical business, these regularly scheduled peeks into the insured's life essentially involve the settlement company asking if the person is either dead or at least close to death.

In the early days of viatical settlements, insureds complained of being harassed by antsy settlement investors who could barely wait to gain access to a policy's death benefits. In response to insureds' concerns about potential invasions of privacy, the NAIC has proposed (and many states have implemented) limits on the amount of contact a settlement company can have with a viator.

In Illinois, viatical companies can contact viators no more than once every three months when the insured's remaining life expectancy is greater than one year. Companies are not allowed to contact viators more often than once every month when the insured's remaining life expectancy is one year or less.

For reasons of privacy or convenience, a viator can decline to serve as the main point of contact for the settlement company during this stage of the viatical process. Instead, the viator can bestow this role upon another person, such as a physician, family member or friend, who is at least 18 years old.

The responsibility for keeping an eye on the insured belongs to the settlement company rather than to a settlement company's investors. The settlement company can employ its own staff to conduct these checkups, or it can hire an independent third party.

The company or the third party may conduct these periodic inquiries through the mail, over the telephone or over the internet. In addition to or in place of these inquiries, many established companies use Social Security databases to confirm an insured person's death.

Upon being able to verify that the insured has died, the settlement company is responsible for filing a timely death claim with the insurance company and distributing proper shares of the resulting death benefits to investors.

The Back-End Process

Much of what occurs on the back end of a viatical transaction is probably more relevant to financial planners and investment strategists than to insurance producers. But we cannot adequately understand the successes, failures and controversies within the secondary market for life insurance unless we know at least some general information about how settlement companies deal with investors.

A few settlement companies have significant financial backing and purchase unwanted life insurance policies in the secondary market for their own portfolios. However, most settlement companies repackage viaticated insurance policies in some way and market them to third-party investors. In Illinois, if a settlement company goes a step further by either reselling a policy or

changing the policy's beneficiary, it must notify the viator no later than 20 days after the change.

The young viatical market featured a lot of individual investors who funded all or part of a single viator's settlement. A retiree from Florida, for example, might have chosen to give $100,000 to a viatical company in order to fund a settlement designed for an unnamed male across the country with AIDS and a remaining life expectancy of nine months.

Over time, many of these individual investors lost money in the secondary insurance market, either because a viatical company had engaged in unethical business practices or because the people insured by the viaticated contracts were simply living much longer than expected. Meanwhile, critics of viatical companies continued pointing out that giving individual investors a stake in another person's life insurance policy could create some uncomfortable—let alone dangerous—situations for the sick.

That occasionally perilous investment environment evolved for the better into the secondary market we have today, in which reputable foreign and domestic institutional investors (such as banks and insurance companies) purchase interests in a diverse collection of viaticated policies in order to minimize their investment risk. Each settlement company might have a small group of institutional investors, all of whom have their own idea of what kind of policies the company ought to buy.

Viatical investors, be they individuals or financial institutions, need to collectively contribute more than the settlement amount offered to a viator. They must help the settlement company pay the remaining life insurance premiums, fund commissions for brokers and cover general operating expenses.

More often than not, these investors technically do not become the owners of a viaticated policy, but they do earn themselves a piece of the policy's death benefit when the insured person passes away. Barring some grossly inadequate underwriting by the settlement company, they receive a return of principal plus interest.

It is important to note here that, unlike many traditional investment vehicles, viatical investments offer simple, total interest rather than compounded, annual interest. It should also be noted that this simple, total interest is almost never guaranteed. Returns on viatical investments will depend almost entirely on the insured's date of death, with yields getting smaller and smaller the longer the person lives.

Are Viaticals Ethical?

Since arriving in the United States a few decades ago, viatical settlements have continued to be one of the most divisive issues in the insurance and financial worlds. Regardless of the potentially positive monetary opportunities for investors in the secondary market, many critics have always viewed the term "viatical settlement" as a euphemism for something that threatens and sometimes takes advantage of sick people during a time when they are arguably at their most vulnerable. A quick inquiry on a popular search engine at the time of this writing revealed there were more than 800 items on the Web that linked viaticals to the word "ghoulish."

Insurable Interest Concerns

People's occasionally queasy feelings toward the viatical industry are understandable, if not entirely warranted. After all, viatical companies and investors do not make any money until an insured person dies, and they make more money if the person dies sooner than expected. Investors might indeed hope that viators experience some dignity and some relief from financial stress as a result of a settlement, but one has to wonder how those investors would react if medical professionals developed a cure for a terminal disease. Would their humanity cause them to be happy for affected viators and rejoice over the fact that the viators, their friends and their family would be spared from the grief that is associated with death? Or would their first instinct lead them to worry primarily about the substantial sum of money they will end up losing as a result of the cure? With many investors having locked their retirement savings in viaticals, some critics believe the latter is the more likely response and that the industry is merely a corporate-built arena in which investors can gather and root for people's deaths.

For some observers, their objection to viaticals relates as much to safety as to ethical principles. Back when viatical investment opportunities were being marketed to individuals rather than to financial institutions, naysayers were worried that a viaticated policy would wind up in the wrong hands and that the terminally ill would answer their doors someday and be greeted by an assassin who might take matters into his own hands if he believed the insured was living too long.

These worries were probably not reduced when it was revealed that a viatical businessman in Texas had served prison time for hiring a hit man to kill people for insurance money. It was perhaps just a matter of time before the seedy potential in viaticals captured the attention of fiction writers, including author Richard Dooling, who incorporated viatical settlements into the fraud-focused plot of his 2002 novel "Bet Your Life."

The ethical issues involved with viatical settlements tend to relate to the way these transactions treat a highly valued concept known as "insurable interest." In order for applicants to secure any kind of insurance policy, they must demonstrate that they have an insurable interest in the person or thing that is to be covered by the contract. This means the owner of the policy must have an economic or emotional reason for wanting the insured individual or item to remain unharmed.

Life insurers have consistently recognized that an individual most likely wants to remain unharmed and have therefore allowed a person to own a life insurance policy on his or her own life. Insurers have also recognized that a person's spouse, parents, employers and business partners often have financial and emotional reasons for wanting him or her to remain unharmed. Therefore, the parties in a familial or business relationship are often permitted to own insurance policies on one another's lives.

Viatical settlements involve a viator and at least one party who lacks an insurable interest in the person covered by a life insurance policy. Yet viatical settlements are permissible in spite of an absence of insurable interest because many insurers' internal operating policies, as well as many states' laws, only require that insurable interest exist at the time the policy is issued. (Settlements that involve someone with an insurable interest are exempt from the requirements in Illinois' Viatical Settlements Act.)

Requirements pertaining to insurable interest often do not apply to transfers of policy ownership because the person insured by the policy either is the one actively pursuing the transfer or has the right to reject a transfer of ownership between the original owner and a third party. In other words, viatical settlements are permitted because the settlements usually require the insured's consent.

In a few cases from the viatical settlement's early days, the worries over seemingly elastic definitions of insurable interest involved more than the relationship between insureds and investors. Finders' fees, now illegal in various forms in some states, caused some people to be additionally concerned when they contemplated the consequences of these settlements.

Of particular concern were those fees payable to legal professionals, financial consultants and physicians. A few consumer advocates feared that the terminally ill, in a desperate search for advice, would pursue any plan proposed by their trusted advisers, even if that plan involved venturing out into the relatively fresh and untested waters of viatical settlements, and even if those trusted advisers had a financial interest in seeing sick people rush to a particular viatical company.

Even more disturbing to some were cases in which doctors received money for referring their patients to viatical companies and instances in which AIDS clinics were paid to advertise the services of specific settlement providers. Though the AIDS clinics in particular claimed that introducing their patients to the idea of viatical settlements was merely yet another opportunity to help the sick, some people seemed to imply that any individual or organization that was in the business of providing medical treatment and counseling to the terminally ill should have had no links to an industry that made its money from death benefits.

Legislation proposed by the NAIC would make it illegal for viatical companies to knowingly pursue funding for a settlement from anyone who is in any way responsible for the insured's health.

Privacy Concerns

Beyond the issues of insurable interest and the potential for foul play, a few people who claim to be looking out for the interests of viators have suggested that the viatical industry might jeopardize its clients' privacy, particularly in regard to health.

When viatical companies first arrived in the United States, AIDS was considered a problem of potentially epidemic-level proportions and was still a disease that had several social stigmas attached to it. Out of fear of professional or social backlash, several patients felt it necessary to keep their condition hidden, even from family and close friends.

Of course, those social stigmas still exist today to a degree, but the ethical issue of privacy in the secondary market has arguably become less specific as settlement companies have broadened their target market to include people other than AIDS patients. Rather than being concerned about insureds being identified as people with specific terminal illnesses, privacy advocates seem to have shifted their efforts to a general argument that basically says, "No matter if you are dying of cancer, feeling pain in your lower back or experiencing absolutely no ill health at all, your medical history should only be shared with people on a need-to-know basis."

Like a life insurance company, settlement companies must have access to pertinent medical records in order to underwrite an applicant properly. But the line between necessary and unnecessary sharing of personal information sometimes gets blurry when a company engages in back-end activity. Any sale of the policy from one viatical company to another increases the number of people who have knowledge of the insured's condition.

Settlement companies that sell interests in policies to investors have sometimes divulged more information to prospective financial clients than viators may have expected. One of the industry's pioneering companies was criticized in the early 1990s for allowing investors to pick their own viator and for making investors aware of the viator's initials, the viator's life expectancy, the viaticated policy's cash value and the insurer's rating.

As much as this assortment of information may have helped investors make sound financial decisions, it was feared that a little detective work could have pulled the curtain away from viators and made their identities visible to the very people whose financial prosperity was dependent upon their deaths.

Illinois law prohibits the sharing of an insured's personal, financial or medical information in many cases. For example, it is illegal for the insured person's identity to be disclosed to anyone at a settlement company who is responsible for marketing viaticated policies to investors.

The sharing of the insured's personal, financial or medical information is allowed under limited circumstances. For instance, sharing would be allowed in the following situations:

- The sharing is necessary in order for the viator to obtain a settlement, and the viator or the insured agrees to the sharing.
- The sharing is necessary in order for the viatical company to secure adequate funding for the settlement, and both the viator and the insured agree to the sharing.
- The sharing is necessary in order for a settlement company to transfer a viaticated policy to another settlement company.
- The sharing is necessary in order for the viatical company to confirm the insured's health.
- The sharing is necessary in order for the viatical company to comply with orders from the government.

The limits on information sharing do not exempt Illinois licensees from maintaining proper records of their transactions. Many important documents must be kept for a minimum of five years in order to help regulators investigate wrongdoing. These documents need to be legible and complete, and they can be stored electronically, on paper or in some other form. A list of records that must be retained can be found in the Viatical Settlements Act:

Licensees shall for 5 years retain copies of:

(1) all proposed, offered, or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of the contract or purchase agreement, whichever is later;

(2) all checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the transaction;

(3) all other records and documents in any format related to the requirements of this Act, including a record of complaints received against the licensee and agents representing the licensee and a list of all life expectancy providers that have provider services to the licensee.

A settlement company must also file an annual report by March 1 that details the company's business transactions from the previous calendar year. The contents of this annual report are explained in the Viatical Settlements Act:

The approved annual statement for a viatical settlement provider shall include all of the following information:

(1) A list of each life insurance policy, including policy number, date of issue, unique internal identifier maintained by the viatical settlement provider and available upon examination, insurance company issuing the policy, date the viatical settlement contract

is signed by the viator, viatical settlement broker receiving compensation, and any premium finance companies, if known.

(2) Addresses and contact information for those persons listed in item (1).

(3) A list of all life expectancy providers who have directly or indirectly provided life expectancies to the viatical settlement provider for use in connection with a viatical settlement contract.

(4) Any other information required by the Director. (In the Viatical Settlements Act, "Director" means the director of the Illinois Department of Insurance.)

Payment Concerns

Another criticism of viaticals involves the size of settlements. Some people wonder if, in spite of their professed mission to help insureds get fair market value for their unwanted policies, viatical companies might try to exploit the terminally ill by betting that a sick person will accept any offer from a settlement company, no matter how small the amount might be. Early media reports on the viatical industry suggested that a few companies were threatening to take settlement offers off the table if the viator did not agree to terms within a few days.

Standard pricing for viatical settlements was one of the first issues tackled by the NAIC when it began crafting its Viatical Settlements Model Act in the 1990s. Mirroring industry practice, the association's recommendations linked the size of a fair viatical settlement to the insured's life expectancy, with sicker people set to receive more money than healthier applicants.

A 2007 version of the model law called for viators to receive no less than the following portions of a life insurance policy's death benefit, unless a low-rated insurer or policy loans factor into the settlement:

- If the insured's remaining life expectancy is less than six months, the viator should receive a settlement equal to no less than 80 percent of the policy's death benefit.
- If the insured's remaining life expectancy is at least six months but less than one year, the viator should receive a settlement equal to no less than 70 percent of the policy's death benefit.
- If the insured's remaining life expectancy is at least one year but less than 18 months, the viator should receive a settlement equal to no less than 65 percent of the policy's death benefit.
- If the insured's remaining life expectancy is at least 18 months but less than 25 months, the viator should receive a settlement equal to no less than 60 percent of the policy's death benefit.
- If the insured's remaining life expectancy is greater than or equal to 25 months, the viator should receive a settlement that is at least the greater of the policy's cash surrender value and any applicable accelerated death benefits that would be available from the insurance company.

It should be stressed that the contents of the NAIC's model regulation and model law, as summarized in parts of this material, are merely guidelines that lay the basic framework for the viatical laws in the individual states. Each state is free to adopt all or none of the NAIC's models.

Local governments have been especially hesitant to include the NAIC's minimum settlement amounts in their insurance codes. The Viatical Settlements Act does not force companies in Illinois to follow the NAIC's rules regarding the size of settlements.

Broker Compensation Concerns

In recent years, the secondary market has faced some tough questions about the manner in which viatical brokers receive their share of settlements. With many brokers' commissions coming out of the viaticated policy's death benefit rather than out of the settlement amount, some people wonder if there is a big enough incentive for brokers to shop policies aggressively and bring back the highest possible offers to their clients. In 2006, New York's attorney general accused some companies in the secondary market of paying "co-brokering" fees to brokers in an attempt to keep competitors' bids hidden from viators.

Brokers in Illinois should understand that they have a legally imposed fiduciary duty to viators, meaning that they are required to pursue bids that are in the viator's best interest. They should also be aware that they may need to disclose the size and source of their commissions to their clients.

Defending Viatical Settlements

At this point, it is perhaps worth stressing that, in spite of the somewhat negative tone the reader might have detected in the previous paragraphs, many people who have criticized the viatical industry have not been viators themselves. Documented feedback from the terminally ill has often been positive, with viators telling reporters how a settlement helped them pay off debts, fund a dream vacation, treat their loved ones to extravagant gifts or spend their last days in a state of reduced stress.

When the U.S. House of Representatives Committee on Financial Services conducted a day-long hearing on alleged fraud in the viatical industry, hardly any of the attention was focused on the plights of wronged viators. Rep. Sue Kelly even said, "The industry began, in large measure, as a noble means of allowing AIDS patients to pay their steep medical bills before death," and Ohio Director of Insurance Lee Covington said, "While the nature of viatical transactions is dependent on the death of the viator, the social benefit of viaticals are extremely valuable for some terminally ill persons and some senior citizens."

Before turning his attention to frauds committed against investors, Rep. Michael Oxley conceded that, "A properly conducted viatical settlement can benefit all parties involved."

Only Rep. Luis Gutierrez talked at length about the alleged mistreatment of viators, saying, "(Viators) are so desperate for this cash that they act quickly—without information, without guidance … As a result, viators often settle for unreasonably low offers."

Tax Breaks, Fraud and Life Settlements

The Health Insurance Portability and Accountability Act

The viatical industry appeared ready to break out into the mainstream in 1996 when Congress passed the Health Insurance Portability and Accountability Act (HIPAA). Until that point, a viatical settlement's tax treatment was extremely uncertain, with some alleged experts insisting that the Internal Revenue Service viewed settlement proceeds as taxable income, others claiming the transactions were subject to capital gains taxes, and a third group professing that one portion of a settlement was taxable income and another portion was a capital gain.

A few viatical companies did nothing to ease all this confusion. Some of them made it a point to tell prospective viators that settlement proceeds would not need to be reported on a specific

tax form, such as a 1099, and perhaps led their clients to believe that they could get away with paying no taxes on their settlements at all.

HIPAA made it possible for many viatical settlements (excluding those involving a business relationship between the viator and the insured) to be treated like the tax-free death benefit paid to a life insurance beneficiary. However, in order for the viator to receive settlement proceeds without needing to pay capital gains or income tax on the money, several conditions must be met.

In order for any of its viators to receive the federal tax breaks made possible through HIPAA, the settlement company must be properly licensed in the state where the viator resides. If the settlement is executed in a state with no licensing requirements for viatical companies, the tax breaks are available to the viator only if the company adheres to various sections of the NAIC's Viatical Settlement Model Act and the Viatical Settlement Model Regulation.

Assuming the company offering the settlement meets those requirements, viators can receive a tax-free viatical settlement if the person insured by the viaticated policy is a "terminally ill individual." For tax purposes, the federal government defines "terminally ill individual" as "an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification." As clarification, the government defines the term "physician" as "a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action."

HIPAA does not provide full tax breaks to viators when the person insured by a viaticated life insurance policy is expected to live longer than two years, but the legislation does not completely ignore those people either. A limited tax break is available to viators if the insured qualifies as a "chronically ill individual." According to Title 26 of the U.S. Code, a "chronically ill individual" is defined as follows:

The term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as—

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

Within the above excerpt, you probably noticed the term "activities of daily living." These activities come from the long-term care (LTC) insurance industry. An insured's inability to perform multiple activities of daily living is a standard benefit trigger for LTC policies.

Most LTC insurers in the United States incorporate at least the following six activities of daily living into their benefit triggers:

- **Bathing:** Including the ability to move in or out of a shower or tub, clean oneself and dry oneself.
- **Dressing:** Including putting on clothing and any medical accessories, such as leg braces.
- **Eating:** Including chewing, swallowing and using utensils.
- **Transferring:** Including moving in and out of beds, cars and chairs.
- **Toileting:** Including being able to get to a restroom facility and perform related, basic personal hygiene.
- **Continence:** Including controlling the bladder and bowels and performing related, basic personal hygiene.

When the insured person in a viatical settlement is deemed a chronically ill individual, the viator only avoids tax obligations on the portions of the proceeds that are considered a return of premium and on the portions of the proceeds that are used to pay for "qualified long-term care services." The U.S. Code defines these services in the following manner:

The term "qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

(A) are required by a chronically ill individual, and

(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Factors such as the policy's cash surrender value and the amount of premiums paid will determine whether the rest of a settlement for a non-terminally ill person will be taxed as income or as a capital gain. If the cash surrender value is less than the premiums paid, the remainder of the settlement will be taxed as a capital gain. If the cash surrender value is greater than the premiums paid, the IRS treats the difference between the cash surrender value and the premiums paid as taxable income. Then, the difference between the settlement amount and the cash surrender value would be taxed as a capital gain.

Taxation of a settlement can be difficult to understand, and, of course, tax laws can change over time or be interpreted differently by the IRS depending on a viator's situation. For these reasons, brokers should consult with an expert before providing specific tax-related information to clients

Problems for the Viatical Industry

To many viatical companies and legislators, the federal tax breaks available as a result of HIPAA seemed destined to breed positive results for businesses and government. In an ideal world, formerly hesitant policyholders were expected to hear about HIPAA's effect on viaticals, determine that this new and somewhat mysterious industry was legitimate and sell their unwanted insurance contracts for the kind of cash that would significantly reduce people's dependence on such cash-strapped social programs as Medicaid. But several developments combined to dash those high hopes.

A few factors were perhaps beyond most of the industry's control and revealed some of the weaknesses in the general concept of viaticals. Others were attributable to a few discouraging companies that were less than truthful with their investors.

Throughout the first few years of the viatical business, settlement companies and their financial associates had little reason to be concerned about their decision to target AIDS patients as potential viators. In the absence of a small medical miracle, people who had progressed from being HIV-positive to having

AIDS were expected to live no longer than a few more years. Even when viatical companies underestimated an AIDS patient's remaining life expectancy, the miscalculation was not likely to cause tremendous liquidity problems for investors or cause the settlement company to pay too many unforeseen premiums.

That changed when, in 1995, the Food and Drug Administration started approving the use of "protease inhibitors," drugs that have proven to be effective in slowing or preventing the spread of the AIDS virus in the body. Though hardly a cure for the disease, protease inhibitors, along with other medicines, have made it possible for someone who contracts the AIDS virus today to live an additional 20 years or more. In a relatively quick fashion, these drugs managed to turn a terminal condition into a potentially chronic one.

This was all good news for the AIDS community, of course, but was hardly a welcome medical advancement from the perspective of investors who had spent thousands of dollars on viaticated policies. Within a few years, the media were busy telling stories of people who were waiting twice as long for a return on their viatical investments. Handfuls of investors became incredulous when they received notices from viatical companies, informing them that the amount of money that had been set aside to pay premiums was running out and that, if they wanted to maintain their claim to any portion of eventual death benefits, they would need to reach into their wallets and pull out some additional cash. A few retirees wondered out loud if the ill people in whom they had invested their nest egg might actually outlive them.

It wasn't just the productive work of scientists and drug companies that was spoiling investors' chances of netting big yields from viaticals. In a somewhat ironic twist, some of the same safeguards that the industry had instituted in order to protect the privacy of viators ended up making it easier for unethical companies to abuse and defraud innocent investors. Without access to insureds' medical records, investors had no way of knowing how well the settlement companies were underwriting policies and estimating life expectancies. Without the insured's personal information, an investor could not even verify that an insured individual actually existed.

In numerous lawsuits, state regulators, the Securities and Exchange Commission (SEC) and individual investors accused viatical companies of various frauds. In some cases, money received from fresh investors was allegedly being used to pay off old investors, and no new policies were ever purchased. Sometimes, according to prosecutors, settlement companies did in fact purchase viaticated policies, but they employed doctors who would purposely downgrade an insured's projected life expectancy in order to make the person's policy more attractive to investors.

In a practice known as "clean-sheeting," some viatical companies encouraged terminal patients to apply for several small life insurance policies from multiple providers, lie about their health and viaticate the policies in exchange for a small settlement. This brand of fraud either hurt insurers, who had to pay death benefits when the fraud went undetected, or hurt investors, who lost their principal when an insurer spotted a fraud and canceled a dishonestly obtained policy.

On occasion, individuals were duped by misleading advertisements that appeared in the pages of obscure trade magazines and major financial newspapers. Marketers sometimes stressed the alleged safety of investing in viaticals, saying viatical investments were on par with certificates of deposit but not bothering to mention that, unlike CDs, viatical investments have no firm maturity date and are not insured by the Federal Deposit Insurance Corporation. A few ads took people's public comments out of context and made it seem as though nationally recognized financial advisers and even members of the Supreme Court were endorsing viatical investment strategies.

This collection of dishonest deeds and outright frauds resulted in a lot of bad press for the industry and caused regulators in some states to warn residents about the risks involved with viatical settlements. State efforts were particularly strong in Florida, where, according to the SEC, one company had misrepresented or misjudged the life expectancy of 90 percent of its viators and where, in the summer of 1999, five of the state's eight licensed viatical settlement companies were being investigated by the local insurance department. In 2000, a Florida grand jury estimated that roughly half of viatical investments were linked to insurance fraud.

By 2002, the North American Securities Administrators Association had listed viaticals near the middle of the pack on its annual list of the top-ten investment scams in the continent, and multiple trade groups had removed the word "viatical" from their names, perhaps as a way of distancing themselves from the embarrassing scandals.

Legislative Responses to Fraud and Other Deceptive Practices

Due in large part to these problems, states are requiring much more of viatical companies than they did during the industry's earlier days. For example, in 2009, Illinois passed legislation that requires all settlement companies to establish an internal antifraud plan. At a minimum, the plan must address the following issues:

- How to detect fraud.
- How to resolve possible detection of fraud.
- How suspected frauds will be reported.
- How underwriters and other employees will be trained to prevent fraud.
- How the insured's life expectancy will be calculated.
- What to do when information on an insurance application does not match the information in a person's medical records.
- Who will be in charge of the antifraud plan.

The antifraud plan mentioned above is just one of many requirements in Illinois law that are designed to prevent devious behavior by viators, brokers and settlement companies. Other fraud-related rules that must be followed are listed below:

- It is illegal to knowingly allow someone who has been convicted of a felony involving dishonesty or breach of trust to participate in viatical-related business.
- All viatical contracts and applications must state, ""Any person who knowingly presents false information in an application for insurance or a viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison."
- A licensee who suspects fraud must report it to the Illinois Department of Insurance.
- Licensees who report fraud to regulators and provide evidence to them are generally exempt from civil liability that might otherwise arise from sharing information. This assumes, of course, that the reporting is done in good faith.

- If whistleblowers incur legal fees on account of reporting possible fraud, the state can reimburse them for their expenses.

Since viatical licensees are required to report fraud, it is important for them to understand what "fraud" actually means under Illinois law. The Viatical Settlements Act clarifies the meaning of fraud as follows:

A person commits the offense of viatical settlement fraud when:

(1) For the purpose of depriving another of property or for pecuniary gain any person knowingly:

(A) presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, life expectancy provider, viatical settlement purchaser, financing entity, insurer, insurance producer, or any other person, false material information, or conceals material information, as part of, in support of or concerning a fact material to one or more of the following:

(i) an application for the issuance of a viatical settlement contract or insurance policy;

(ii) the underwriting of a viatical settlement contract or insurance policy;

(iii) a claim for payment or benefit pursuant to a viatical settlement contract or insurance policy;

(iv) premiums paid on an insurance policy;

(v) payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or insurance policy;

(vi) the reinstatement or conversion of an insurance policy;

(vii) in the solicitation, offer, effectuation, or sale of a viatical settlement contract or insurance policy;

(viii) the issuance of written evidence of a viatical settlement contract or insurance; or

(ix) a financing transaction; or

(B) employs any plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies; or

(C) enters into any act, practice, or arrangement which involves stranger-originated life insurance.

(2) In furtherance of a scheme to defraud, to further a fraud, or to prevent or hinder the detection of a scheme to defraud any person knowingly does or permits his employees or agents to do any of the following:

(A) remove, conceal, alter, destroy, or sequester from the Director the assets or records of a licensee or other person engaged in the business of viatical settlements;

(B) misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(C) transact the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

(D) file with the Director or the equivalent chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceals information about a material fact from the Director;

(3) Any person knowingly steals, misappropriates, or converts monies, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or any other person engaged in the business of viatical settlements or insurance;

(4) Any person recklessly enters into, negotiates, brokers, or otherwise deals in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the person or the persons intended to defraud the policy's issuer, the viatical settlement provider or the viator; or

(5) Any person facilitates the change of state of ownership of a policy or the state of residency of a viator to a state or jurisdiction that does not have a law similar to this Act for the express purposes of evading or avoiding the provisions of this Act.

Viatical companies in Illinois must also abide by the following rules when advertising their services:

- Advertisements should not include any false or misleading language. (Offering a person a free-look period or a chance to examine a settlement contract before signing it does not exempt a company from this rule.)
- Statistics used in advertising should be attributed to their source and should not be outdated.
- Advertisements should not lead people to believe that a company and its products are affiliated with the government.
- References to specific insurance companies should not be made without those companies' consent.
- Settlement companies cannot falsely advertise that insurance involved in a viatical transaction will be free.
- Companies must maintain copies of their marketing material in case the Department of Insurance needs them at a later date.
- Advertisements cannot disparage alternatives to viatical settlements, such as policy loans or accelerated death benefits.
- If an advertisement contains a testimonial by someone who will benefit when people engage in viatical transactions, this conflict of interest must be disclosed.
- Advertisements cannot disparage insurance companies or other members of the viatical industry.
- Advertisements must clearly identify the entity that is behind them.
- Advertisements that emphasize the speed of the settlement process must disclose the average time that passes between filling out an application and receiving a settlement offer and between agreeing to an offer and receiving settlement funds.
- Advertisements that emphasize the amount of money that viators can receive must disclose the average percentage of a policy's face value that other viators received over the preceding six months.
- Required disclosures in advertisements cannot be intentionally hidden or disguised in ways that are meant to make them confusing or misleading.
- Advertisements cannot imply that a competitor in the secondary market is unlicensed.

One common complaint about the regulation of viatical companies in this country has been that the laws enacted in various states, while giving adequate protection to viators, do not shield individual investors well enough from unethical opportunists. Drafts of NAIC model laws and regulations say investors should be made aware of the following things before their money can be used to fund a settlement:

- Returns will not be accessible until the insured person dies.
- Rates of return are not guaranteed and will depend on how long the insured person lives.
- Investors may lose money if the insurance company that is associated with the viaticated policy becomes insolvent.
- Premiums paid to keep the life insurance policy in force will have an effect on the rate of return.
- The investors may lose some or all of their money if the insurance company contests the validity of the insurance policy.

Not every state has adopted these various rules in their entirety or even at all. In 2007, more than 10 years after the NAIC approved its first edition of the Viatical Settlements Model Act, the trade publication Best's Review said some 12 states hadn't passed viatical-specific laws. In fact, a debate has raged for at least a decade as to whether viatical companies should be regulated by the individual states or the federal government.

Regulation of Viatical Settlements

Because few investors had enough money to fully fund a viatical settlement on their own, early members of the viatical community began letting people buy "fractional interests" in viaticated policies. With a fractional interest, an investor funds only a portion of a settlement and shares any death benefits with other investors. A person might have a fractional interest in a single life insurance policy or in several policies.

Upon hearing about the buying and selling of fractional interests, the federal government claimed settlement companies had ventured into the marketing of securities and should therefore be subjected to federal regulation by the SEC. For the most part, the viatical industry disagreed, saying the sale of life insurance policies in the secondary market—no matter the method—was comparable to selling a piece of real estate or other kind of personal property. The industry was not against all forms of regulation, but it generally believed designating viatical transactions as securities would overcomplicate matters for buyers, sellers and middlemen.

On an admittedly basic level, securities involve investment contracts, must be registered with federal authorities, may not be sold unless accompanied by prospectuses and may not be sold by anyone who lacks an appropriate securities license. Some viatical companies claimed the cost of satisfying many of those requirements would be too much for some brokerage and settlement companies to handle and that the licensing requirements would prevent a significant portion of front-end and back-end workers from conducting business.

The regulatory issue was confronted in court when the SEC charged Living Benefits, Inc. with marketing unregistered securities. A U.S. district court ruled in the government's favor, but an appeals court eventually overturned a portion of the ruling and concluded that the company was selling neither securities nor insurance contracts.

That court ruling against the SEC has made it important for viatical professionals to be aware of the unique laws and regulations in their respective states. The majority of states that regulate viatical companies have taken it upon themselves to classify interests in viaticated policies as securities, but this does not necessarily mean state securities departments have the final say in all viatical matters.

A state may give its insurance department full authority to regulate viatical transactions. Alternatively, it may divide regulatory responsibilities by letting the insurance department handle all issues related to dealings between viators and viatical companies and letting the securities department handle all issues related to dealings between viatical companies and investors.

At the time of this writing, a few states had still not chosen to enact specific regulations for local viatical companies. The Life Insurance Settlement Association maintains a database of the applicable viatical laws and regulations in each state on its Web site, http://www.lisassociation.org.

The Viatical Settlements Act

In 2009, Illinois passed its Viatical Settlements Act, which went into effect on July 1 of the following year. Adapted in part from NAIC model legislation, the law sets many consumer-conscious limits on the relationship between viators and settlement companies and requires settlement companies and brokers to become licensed with the state's insurance department.

In order to become a licensed viatical broker, a person must obtain an insurance producer license and pass a pre-licensing education course. Before working as a broker, the person must hold the insurance producer license for one year and pay a $500 registration fee. Individuals who work for a registered viatical brokerage company with its own insurance license may also be able to work as viatical brokers.

Settlement companies must pay a $3,000 fee in order to get a license for the first time and a $1,500 annual fee to renew a license. In order to qualify for a license, a settlement company must satisfy the requirements listed below:

- The company has provided a detailed plan of operation to the Illinois Department of Insurance.
- The company is viewed as competent and trustworthy and is likely to act in good faith in dealings with the public.
- The company has the education and experience that would be appropriate for a licensee.
- The company has demonstrated financial responsibility by either obtaining a surety bond or making a deposit worth at least $125,000.
- The company can provide a certificate of good standing from the state where it is permanently located.
- The company has created an acceptable antifraud plan.

A settlement company's license can be revoked in Illinois for any of the following reasons:

- The licensee misrepresented important facts when applying for licensure.
- The licensee has acted dishonestly or in a manner that is not financially responsible.
- The company's payments to viators are unreasonable.
- The company has violated an insurance law.
- The company has used an unacceptable settlement contract.

- The company has violated the terms and conditions of a settlement contract.
- The company has failed to meet the standards required for all new licensees.
- The company has assigned or transferred a policy to an inappropriate party.
- The company has violated the Viatical Settlements Act.

Anyone who solicits, sells or negotiates viatical settlement contracts must complete a one-time four-hour training course, as well as four hours of viatical-specific continuing education every two years. Individuals who are also licensed as insurance producers might be able to apply the four-hour continuing education requirement toward their insurance education requirement. The following topics should be covered in the four-hour courses:

- State and federal laws regarding viatical settlement transactions.
- Potential tax implications for participants in viatical settlement transactions.
- The impact that participation in a viatical settlement transaction can have on a person's eligibility for public assistance.
- Alternatives to viatical settlements.
- Suitability standards for consumers.

Many important parts of the Viatical Settlements Act (including information about disclosures, advertising and contact with viators) have been summarized in other sections of this course. A viatical licensee who disobeys the rules set forth in the act can be fined up to $50,000 for each violation.

Life Settlements

Faced with a souring public reputation and advances in AIDS treatment, the viatical companies of the late 1990s and early 21st century had to find a new way to survive. At first, a few companies merely stopped buying policies from AIDS patients and shifted their focus toward people with terminal cancer or other life-ending illnesses. But this strategy equated to a temporary patch for the industry's problems instead of a permanent fix. A groundbreaking cancer drug would have sent the industry back to the drawing board.

Gradually, the industry took note of the growing number of senior citizens in this country and recognized that, like terminally ill policyholders, many older Americans had purchased life insurance that no longer served much of a purpose for them. Many seniors who had originally bought life insurance for their children's sake no longer needed to worry about their grown son or daughter's financial stability. Many who purchased a policy years ago in order to provide for a spouse had gotten divorced or had been widowed. Businesses that had bought key-person policies on the lives of valued employees were watching those workers retire and wondered if it was economically prudent to keep paying premiums for the coverage. Other individuals had initially bought life insurance as part of a tax-sensitive estate plan but had later learned that changes in the tax code had granted their estate a tax exemption.

Assuming that many of these seniors would be intrigued by the chance to get more from their unwanted life insurance policies than their cash surrender values, the secondary life insurance market left most of its viatical business behind and began fiercely promoting a similar kind of financial arrangement known as a "life settlement."

Life settlements work like viatical settlements with a few important exceptions. The biggest difference between the two is that life settlements do not involve viators who are terminally ill. Instead, the typical viator in a life settlement is 65 or older with a remaining life expectancy of 15 years or less. To qualify for this kind of settlement, the insured must have experienced some moderately significant health problems since applying for the coverage.

Unlike viatical settlements, which may apply to policies big and small, most life settlements must involve an unwanted policy with a minimum face amount, usually somewhere near $100,000 or $250,000.

For various reasons (including life expectancy and the generally higher cost of insuring the elderly), a viator in a life settlement transaction receives a much smaller settlement than a viator in a viatical transaction. Life settlement amounts can range from 10 percent to 40 percent or more of the death benefit. Some settlement companies advertise that their average viator receives at least the viaticated policy's cash surrender value multiplied by three.

As with a viatical settlement, money received as part of a life settlement may be used by the viator as he or she pleases. Portions of life settlements that are considered a return of premium are tax-free to the viator. Portions that are not considered a return of premium but are not greater than the policy's cash surrender value are taxed as income. All additional proceeds are taxed as capital gains.

The back end of the life settlement process is also very similar to a traditional viatical setup, with settlement companies either holding onto viaticated policies for their own portfolios or, more commonly, selling interests in several policies to groups of investors.

The young industry's reliance on institutional investors, rather than on individual investors, might be a major reason why some of the ethical concerns and instances of fraud that were prevalent in the viatical market have not been as problematic in the life settlement industry. At least on a privacy level, viators seem more comfortable with banks, insurance companies and other impersonal business entities having an interest in their life insurance policies than with unknown individuals having that same sort of interest.

Unlike most professionals in the secondary market, Illinois law does not use the term "life settlements" to describe these transactions. Instead, the state continues to view a life settlement as one kind of viatical settlement. Therefore, businesses and individuals who are involved with life settlements must follow the rules contained in the Viatical Settlements Act.

Insurers' Reaction to the Secondary Market

You might be more than a little bit curious about how insurance companies have been affected by viatical and life settlement businesses and about how people working in the competing primary and secondary life insurance markets view one another.

At alternating points in time, the relationship between life insurance companies and viatical companies has been helpful or hostile on both sides. Viatical companies initially promoted themselves by criticizing life insurance companies for forcing unhappy policyholders to either hang onto their coverage or accept allegedly unfair settlements in the form of cash surrender values. Yet viatical companies have also admitted that life insurance agents are the average person's most likely source for

information about potential opportunities in the secondary market.

For years, settlement companies have complained about insurers that refuse to employ people who have held jobs with viatical organizations and that allegedly do not let their agents discuss viatical-related options with clients. Some viatical companies have even claimed that insurance agents expose themselves to potential lawsuits when they know a client is interested in canceling a policy but do not mention the option of viaticating the coverage.

When pressed about this issue, insurance professionals sometimes say they lack enough personal expertise to advise clients in regard to the secondary market, or that they have legal or ethical reasons of their own for avoiding the subject. With viaticated contracts often occupying a gray area between insurance policies and securities, some agents and their employers have worried about mentioning viaticals and finding themselves in a licensing dispute with regulators. Other insurance workers have heard about the instances of fraud in the secondary market and claim they want to protect their clients from possible abuse.

In spite of insurers' stated reasons for avoiding mentions of viatical settlements in conversations with their clients, one can easily make the case that the main conflict between insurers and settlement companies boils down to dollars and cents. Once viaticals became an option for millions of Americans, industry observers predicted insurance companies would lose money as a result of falling "lapse rates."

Lapse rates represent the number of people who discontinue their coverage before their life insurance policy matures. These rates are significant indicators of expected profits for a life insurance company. When a policy lapses, an insurance company is no longer obligated to pay a death benefit to beneficiaries and often makes money on the policy as a result.

A healthy amount of lapses can reduce the insurer's reinsurance costs because the corresponding reinsurance company will need to back up fewer death claims. This reduction in cost might be passed down to new policyholders in the form of lower premiums. Conversely, when few policies lapse, the insurer makes less money, the reinsurance company tends to charge more for its services, and premiums are likely to rise.

Prior to the debut of viaticals and life settlement companies, it seemed nearly certain that a large percentage of terminally ill people and senior citizens would eventually let their policies lapse. But once settlement companies and their investors started stockpiling these policies with no intention of ever letting them lapse, insurance companies had to accept that more of their policies would end up reaching the claims stage.

The prospect of having to pay out more death benefits than originally planned did not sit well with insurers during the viatical era, and the secondary market's shift toward life settlements has done little to alter the displeasure.

It also should go without saying that the insurance community could not have been pleased by the instances of clean-sheeting in the viatical market. In some cases, as we have already noted, insurance companies spotted these frauds promptly and saved themselves from losing thousands of dollars in death benefits. In other cases, insurers recognized the scams too late and were forced to honor fraudulent claims.

Stranger-Originated Life Insurance (STOLI)

Insurers have also frowned upon the life settlement industry's involvement with "wet paper," "wet ink" or "stranger-originated life insurance" (STOLI) policies.

Similar to clean-sheeting, STOLI is life insurance that is bought by an individual at the suggestion of a life settlement company in exchange for money or gifts. When a policy becomes incontestable, the insured transfers ownership rights to the settlement company in accordance with a secret, pre-existing agreement. The Viatical Settlements Act defines stranger-originated life insurance in the following manner:

"Stranger-originated life insurance" or "STOLI" means an act, practice, or arrangement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person or entity who, at the time of policy inception, could not lawfully initiate the policy himself or itself and where, at the time of policy inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy or policy benefits to a third party. Trusts created to give the appearance of an insurable interest and used to initiate policies for investors violate insurance interest laws and the prohibition against wagering on life.

To some insurers, STOLI presents a problem of principle by ignoring the insured's true need for life insurance and by turning a product designed for risk management into a clear investment vehicle. Even many settlement companies share this distaste for STOLI and sometimes worry that companies that promote it will give the federal government a good reason to eliminate the positive tax treatment of some viatical and life settlements.

STOLI was a major issue for members of the NAIC when they gathered to create updated versions of their viatical settlement model laws and regulations in 2006 and 2007. While insurers wanted to institute a waiting period between the time a policy is issued and the time a policy can be sold to a life settlement company, the secondary market cautioned that a rigidly enforced waiting period would penalize people who experience a major life change soon after acquiring their coverage.

The Viatical Settlements Act addresses the issue of STOLI by requiring that insurance companies be notified when a policy involved in a viatical settlement is less than two years old. A policy of that age cannot be viaticated in Illinois, other than in the following situations:

- The life insurance policy was converted from another group or individual life insurance policy, and the combined time that the policies were in force is at least two years.
- The viator or the insured has become terminally or chronically ill within the past two years.
- The viator has gotten a divorce within the past two years.
- The viator has retired within the past two years.
- The viator's spouse has died within the past two years.
- The viator has become disabled to the point of not being able to work within the past two years.
- The viator has filed for bankruptcy within the past two years.

- A family member who was the policy's sole beneficiary has died within the past two years.

All the public disharmony between insurers and their rivals in the secondary market tends to overshadow the fact that there is a considerable degree of peaceful and even mutually beneficial overlap within the two industries. Life insurance entities such as CNA Financial Group and BMI Financial Group have scooped up viatical and life settlement companies for themselves or have developed their own settlement businesses from scratch. After years of mystery, it was revealed that the insurance giant American International Group was the main financial force behind life settlement leader Coventry. In a clear and public sign that insurance professionals and viatical veterans can coexist in business, former Illinois Director of Insurance Nat Shapo became Coventry's chief compliance officer in 2005.

Accelerated Death Benefits

Competition from the early viatical companies helped push the insurance industry into offering "accelerated death benefits." These benefits entitle insureds to a portion of a policy's face value if they come down with a particular disease, are deemed terminally ill or require long-term care.

Accelerated death benefits work like a combination of traditional life insurance benefits and viatical settlements. When a person is diagnosed with a chronic illness that requires assistance with multiple activities of daily living or has less than a year to live, a policy with accelerated death benefits typically nets the individual up to 50 percent of the policy's face value. These benefits are treated like viatical settlements in the tax code, meaning that people with less than two years to live receive them tax-free, and that people who are chronically ill do not need to count the benefits as income when the money is used to pay for qualified long-term care services.

The portion of the policy's face value that is not given out to the client in the form of accelerated death benefits is earmarked for the policyholder's beneficiaries. Unlike a transaction in the secondary market, accelerated benefits have no effect on policy ownership or beneficiary status. Meanwhile, the policyholder remains responsible for paying premiums in full and on time.

The cost of accelerated death benefits and the manner in which an insurer charges for them vary among companies. A few companies charge the policyholder for these benefits for as long as the policy is in force. Others include these benefits in policies from the very beginning but only start charging for them when the insured becomes ill or needs care. These days, a consumer might even be able to secure a policy that includes these benefits at no additional cost.

There has been much debate regarding which financial option—a settlement in the secondary market or an accelerated death benefit from an insurer—is more valuable to unhealthy consumers. Where people stand on this issue will depend on what they want most out of their life insurance policy when they become seriously ill.

In most cases, ill policyholders receive a larger percentage of their policy's death benefit when they opt for viatical settlements over accelerated death benefits. Whereas an insurer's accelerated benefits might offer a client no more than 50 percent of a policy's death benefit for personal use, a viatical settlement company might be willing to buy the same policy for 80 percent of the death benefit or more.

Still, if we compare the amount of death benefits that ultimately go to policyholders and beneficiaries against the amount of money that goes to third parties in these two options, accelerated death benefits might be deemed the better deal. When a viator sells a policy for 80 percent of its face value, the remaining 20 percent of the policy's value becomes the property of a settlement company and its investors. But when a policyholder utilizes a 50 percent accelerated death benefit provision, almost all of the policy's remaining half will eventually belong to the person's chosen beneficiaries.

In many states, including Illinois, a viatical or life settlement company cannot purchase an unwanted life insurance policy unless the viator understands that accelerated death benefits may be available through the person's insurance company.

Conclusion

The story of viatical and life settlements is probably far from over. At the time this material was being written, the settlement industry was still influencing the way some insurance companies conducted business, and entrepreneurs were still experimenting with ways to make life settlements increasingly attractive to insureds and investors.

Whether we love, hate or have complicated feelings about viatical and life settlements, it is difficult to deny that the secondary market forces us to think seriously about what a life insurance policy ought to provide for its owner. Whereas life insurance can ensure that survivors are taken care of, these settlements keep the attention on policyholders and have the potential to provide another kind of peace.

Below is the Final Examination for this course. Turn to page 118 to enroll and submit your exam(s). You may also enroll and complete this course online:

www.InstituteOnline.com

Your certificate will be issued upon successful completion of the course.

FINAL EXAM

1. Traditionally, the insurance community and local regulators have favored _____.
   A. state regulation
   B. federal regulation
   C. county regulation
   D. heavy regulation

2. The McCarran-Ferguson Act specifically exempted insurance companies from _____.
   A. state and federal taxation
   B. federal antitrust laws
   C. state and federal privacy requirements
   D. telemarketing rules

3. The Safeguards Rule requires all financial institutions to design, implement and maintain safeguards to protect _____.
   A. consumer information
   B. government employees
   C. policy dividends
   D. minority policyholders

4. Insurance laws are passed by _____.
   A. judges
   B. attorneys
   C. legislators
   D. business groups

5. The rules for implementing insurance laws are usually drafted and approved by ____.
   A. the President
   B. consumer organizations
   C. the state's department of insurance
   D. the Securities and Exchange Commission

6. The insurance department in most states is headed by a(n) _____.
   A. insurance commissioner
   B. elected state senator
   C. licensed consumer advocate
   D. FINRA-registered representative

7. In order to achieve its goal of greater uniformity, the NAIC periodically drafts and updates _____.
   A. codes of ethics
   B. model laws and model rules
   C. mandatory marketing materials
   D. recommendations to the National Association of Securities Dealers

EXAM CONTINUES ON NEXT PAGE

8. The Securities and Exchange Commission (SEC) is a federal agency that regulates many kinds of _____.
   A. commercial property insurance
   B. fixed annuities
   C. variable products
   D. lapse rates

9. When an insurer's assets are enough to honor its liabilities, the company is considered to be _____.
   A. solvent
   B. insolvent
   C. ratable
   D. stock-owned

10. State guaranty funds are used to compensate claimants whose insurance is from a(n) _____.
   A. solvent carrier
   B. insolvent company
   C. fraternal organization
   D. multi-licensed insurer

11. Insurance companies that want to do business in a particular state generally must have the appropriate _____.
   A. code of ethics
   B. pre-existing customer base
   C. regulatory letters of recommendation
   D. license

12. In regard to licensing, a licensed insurance company is considered a domestic insurer in _____.
   A. its home state
   B. every state
   C. foreign countries
   D. the Western hemisphere

13. When insurance cannot be easily obtained in a given state, a consumer might be able to purchase coverage from a(n) _____.
   A. admitted carrier
   B. non-admitted carrier
   C. independent adjuster
   D. unlicensed agent

14. Insurance producers, including agents and brokers, must be licensed in order to _____.
   A. take state exams
   B. sell insurance
   C. file formal insurance complaints
   D. provide coverage to their employees

15. In order to become licensed as a producer, a person must complete pre-licensing education, pass a state exam, pay various fees and _____.
   A. have a college degree or equivalent diploma
   B. serve an apprenticeship under another licensee
   C. specify whether compensation will be paid as commissions or fees
   D. undergo some kind of background check

16. Upon the conclusion of a license term, a producer can usually renew his or her license by submitting documentation to the department of insurance, paying required fees and _____.
   A. obtaining sponsorship from a supervisor
   B. completing continuing education
   C. writing to the state insurance commissioner
   D. attending a disciplinary hearing

EXAM CONTINUES ON NEXT PAGE

17. Race-related issues in insurance date all the way back to the pre-Civil War era, when insurers viewed slaves as _____.
    A. potential customers
    B. common beneficiaries
    C. uninsurable perils
    D. property

18. Alleged redlining has often been a problem in communities where _____ has occurred.
    A. rioting
    B. political redistricting
    C. health epidemics
    D. economic uncertainty

19. The Health Insurance Portability and Accountability Act attacked the problem of "job lock" by making it illegal for a group health plan to discriminate against someone on the basis of _____.
    A. employment status
    B. gender
    C. health
    D. educational background

20. Many group health plans reward people who have _____.
    A. healthy lifestyles
    B. low life expectancies
    C. no children
    D. insurance backgrounds

21. Programs that promote health to group members are known as "_____."
    A. self-insured programs
    B. health-care operations
    C. HIPAA-eligible groups
    D. wellness plans

22. Applicants for health insurance can no longer be denied insurance because of a _____.
    A. history of insurance fraud
    B. pre-existing health condition
    C. failure to pay premiums
    D. service-area limitation

23. By 2008, nearly every state had passed laws that protected the public's _____.
    A. genetic information
    B. right to receive life insurance
    C. entire investment in variable annuities
    D. ability to obtain free terrorism-risk insurance

24. When an insurance company prices its products without any gender-based differences, it is engaging in _____.
    A. unlawful discrimination
    B. unisex rating
    C. adverse selection
    D. post-claims underwriting

25. Americans are generally protected from gender-based insurance discrimination when they obtain coverage through _____.
    A. life insurance companies
    B. any U.S. auto insurer
    C. an employer's group plan
    D. an alien insurance company

EXAM CONTINUES ON NEXT PAGE

26. Since the 1990s, companies specializing in personal lines property and casualty insurance have been criticized for basing rates and underwriting decisions on consumers' _____.
    A. health
    B. life expectancy
    C. credit histories
    D. birthplace

27. Age is an accepted, significant factor in the offering and pricing of _____.
    A. commercial property insurance
    B. life insurance
    C. workers compensation insurance
    D. reinsurance programs

28. In order to guard against the risk of dog-bite insurance claims, some carriers have implemented internal policies that make it more difficult for owners of certain breeds to obtain affordable _____.
    A. life insurance
    B. disability insurance
    C. homeowners insurance
    D. professional liability insurance

29. Prior to September 11, 2001, few Americans outside of the airline industry concerned themselves with obtaining _____.
    A. terrorism risk insurance
    B. auto insurance
    C. life insurance
    D. long-term care insurance

30. Traditionally, insurance companies can exempt themselves from having to pay certain insurance claims following _____.
    A. stock market booms
    B. acts of war
    C. significant dry seasons
    D. regular state audits

31. Many details regarding al-Qaeda's financial history are provided in the federal government's _____.
    A. 9/11 Commission Report
    B. Dodd-Frank hearings
    C. Armstrong Commission summary
    D. McCarran Ferguson review

32. Criminals engage in money laundering in order to hide financial assets that are either obtained through or used in _____.
    A. real estate transactions
    B. illegal activities
    C. Ponzi schemes
    D. legitimate charitable efforts

33. Money laundering has been committed seemingly throughout history and was originally a way for indebted borrowers to _____.
    A. avoid penalties from the Internal Revenue Service
    B. engage in the sale of illegal drugs
    C. hide money from their creditors
    D. commit acts of terror

EXAM CONTINUES ON NEXT PAGE

34. The insurance industry's greater involvement in anti-money laundering activities stemmed from the passage of the _____.
    A. Health Insurance Portability and Accountability Act
    B. USA Patriot Act
    C. Fair Lending Act
    D. Producer Licensing Model Act

35. Following the passage of major legislation, the government often issues regulations that are intended to _____.
    A. correct the law's inaccuracies
    B. explain how the law should be followed
    C. reveal who lobbied for and against the law
    D. preserve federal power over the states

36. Anti-money laundering enforcement in the United States is overseen by a section of the U.S. Department of the Treasury called the _____.
    A. International Criminal Court
    B. Office of Management and Budget
    C. Financial Crimes Enforcement Network
    D. Federal Insurance Office

37. There are many different kinds of permanent life insurance, including whole life, universal life and _____.
    A. term life
    B. credit life
    C. variable life
    D. group life

38. Insurance products without cash values are generally considered to be poor vehicles for _____.
    A. risk management
    B. money laundering
    C. financial planning
    D. policy exchanges

39. An insurance company's anti-money laundering program must be overseen by a(n) _____.
    A. independent attorney
    B. compliance officer
    C. licensed insurance agent
    D. retired law enforcement official

40. Broker-dealers and other organizations that offer variable life insurance or variable annuities are likely to have additional anti-money laundering requirements because they sell _____.
    A. term life insurance
    B. property insurance
    C. performance bonds
    D. securities

41. A key component of an anti-money laundering program is the proper filing of _____.
    A. business associate agreements
    B. death certificates
    C. Suspicious Activity Reports
    D. security breach notifications

42. In exchange for receiving the eventual death benefits created through a terminally ill person's life insurance policy, a viatical organization pays a major portion of the policy's face value to the _____.
    A. revocable beneficiary
    B. dying individual
    C. state insurance commissioner
    D. insured's preferred charity

EXAM CONTINUES ON NEXT PAGE

43. As their name suggests, term life policies remain in effect for a contractually agreed-upon time and then _____.
    A. are surrendered for money
    B. expire
    C. increase in value
    D. become property of the beneficiary

44. If policyholders have no interest in renewing a term life policy, they can sometimes exchange it for one of the several kinds of _____.
    A. modified endowment contracts
    B. permanent life insurance policies
    C. commercial property insurance forms
    D. excess and surplus insurance products

45. Viatical companies will usually only purchase term life policies if the policies can be converted to _____.
    A. permanent coverage
    B. an annuity
    C. LTC insurance
    D. accelerated death benefits

46. Group life insurance is most commonly used to insure several people who _____.
    A. have the same skills
    B. work for the same employer
    C. have the same ethnic background
    D. already have individual life insurance

47. To protect themselves from litigation, viatical companies will not purchase a life insurance policy in the secondary market unless the policy owner _____.
    A. is in good health
    B. has agreed to a settlement
    C. is in the insurer's service area
    D. is also the beneficiary

48. In some states, including Illinois, terminally ill persons cannot enter into a viatical agreement unless they acknowledge they are doing so through _____.
    A. a doctor's recommendation
    B. their own free will
    C. no consultation with an attorney
    D. a family member's advice

49. As a general rule, viatical settlements are made available to terminally ill individuals who have a remaining life expectancy of _____.
    A. 15 years or less
    B. 10 years or more
    C. 2 years or less
    D. half the standard expectancy

50. Policy loan provisions are an important and attractive feature of _____.
    A. homeowners insurance
    B. term life insurance
    C. permanent life insurance
    D. errors and omissions insurance

END OF EXAM

Turn to page 118 to enroll and submit your exam(s)

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CHAPTER 1: INSURANCE FOR LIFE

Introduction

Life insurance is not only one of the most popular kinds of insurance in society but also one of the oldest. The practice of providing financial assistance to dependents after someone's death dates at least as far back as ancient Mesopotamia, where the Code of Hammurabi required the state to provide compensation to families when a robbery resulted in a victim's death. Over time, life insurance concepts also found their way into guilds and religious societies. When a fellow tradesman or worshiper passed away, members of these organizations would pool their money together and help pay for funerals and other final expenses.

Early life insurance arrangements were relatively informal and would often only involve short-term contracts between two people. An individual who was scheduled to undergo a dangerous task or a risky journey would sometimes pay a single sum to a wealthy person in exchange for an agreement to provide death benefits to surviving family members. But if the person paying the sum to the wealthier person survived the particular ordeal, the wealthier person (known as the "underwriter") could keep the money and wouldn't need to pay anything to the family.

The creation of life insurance companies was the byproduct of consumer demand and actuarial principles. The world was becoming more industrialized, and fewer heads of households could adequately prepare for death by leaving valuable farmland to their heirs. Meanwhile, underwriters realized that they could reduce their financial risks by insuring several lives instead of just one. The need for life insurance became more broadly recognizable regardless of social class, and the businesses that were interested in offering this important product became bigger and bigger.

Today's life insurance companies have collectively underwritten trillions of dollars in coverage on millions of lives. And even among the relatively few adults with absolutely no life insurance, the idea of protecting their loved ones in the event of an untimely death has almost certainly crossed their mind. Many of them are just waiting for someone to explain how this insurance actually works.

Purposes of Life Insurance

Most life insurance purchases are made to help survivors deal with the financial consequences of a loved one's death. Long-term consequences typically include the loss of the deceased's income, which would have otherwise been used to maintain a family's standard of living and help achieve such future goals as repayment of a mortgage loan or funding of a child's college education. Short-term consequences might include the unexpected costs pertaining to funerals, burials and unpaid medical bills.

Unlike other major assets that might be passed down from the deceased to heirs, life insurance proceeds are typically exempt from the sometimes drawn-out probate process. As a result, beneficiaries usually don't need to wait too long after a death before receiving the money they might desperately need.

Over the past 50 years or so, life insurance has successfully served other purposes, too. These additional uses of life insurance might not be applicable or suitable for the average purchaser, but they can certainly help a buyer under the right circumstances. For example, a life insurance policy might play an important role in the financial plans of the following hypothetical consumers:

- Bill is a wealthy retiree who wants to leave as much of his estate as possible to family, friends and charities instead of losing a significant chunk of it to federal estate taxes after his death. With the right kind of life insurance policy, he might be able to help his family pay off the sizable estate tax bill or even avoid it altogether.
- Jan has just made the last mortgage payment on her home and is in the last few years of her career. She has two adult and financially independent children and is reasonably confident that her savings and Social Security will be enough to fund a modest retirement. However, she would like a third layer of income in case her projections end up being slightly inaccurate. With the right kind of life insurance policy, she might be able to earn some extra interest on her money or even exchange part of the policy's death benefit for emergency cash withdrawals.
- Mike has a high-risk, high-reward philosophy when it comes to investing, and it's served him and his family well. However, he knows he should park at least some of his money in a low-risk investment in case the market experiences a major depression. With the right kind of life insurance policy, he might be able to create some balance in his portfolio.
- Melinda and Brian are successful business partners who aren't sure what would happen if one of them were to die in an accident. They both have spouses, but it's not clear whether either spouse would want to take over part of the business. With the right kind of life insurance, Melinda and Brian can ensure that the surviving partner can purchase the deceased partner's portion of the business and that the surviving spouse is fairly compensated.

Over the next several pages, we will explore these big, small and medium-sized needs in greater detail and explain how life insurance might cater to them. To a lesser (but still important) degree, we will also be sure to acknowledge that as flexible as life insurance can often be, it isn't the best solution to every problem.

Determining Life Insurance Needs

Despite the versatility and popularity of life insurance, the amount of coverage that is appropriate for a purchaser will be different from person to person. In fact, what's considered an appropriate amount at the time of purchase is likely to be different from the amount that is truly needed by the same person several years later.

Even when applicants recognize the importance of life insurance, they often misjudge the size of death benefits that they really need in order to accomplish their goals. In order to guide people to the right amount, life insurance producers must become familiar with each prospect's financial situation and continue to encourage an open dialogue in the years following a sale.

For several decades, the life insurance industry attempted to determine an applicant's needed amount of coverage by calculating the individual's "human life value." This calculation relied heavily on the insured person's income and unfortunately led to such broad recommendations as, "Everyone should purchase life insurance equal to at least five times their annual salary."

The focus on income was both understandable and a good start, but it didn't allow for variables in family structures (such as single-income families vs. two-income families) or for long-term goals

that weren't necessarily tied to salary (such as a desire, regardless of current income, to fund a surviving child's education).

Rather than rely on basic calculations of human-life value, most of today's life insurance professionals estimate the suitable amount of coverage by conducting some kind of "needs analysis." Income is generally an important factor in a needs analysis, but it is far from the only variable that is considered. A common, thorough needs analysis explores the specifics of a person's financial goals and is likely to involve getting answers to the following questions, among others:

- How much money will dependents need in order to maintain their current standard of living and keep up with inflation?
- How much money will dependent children need for school tuition and basic necessities?
- How long is a person likely to remain a dependent and rely on money from a policy's death benefit?
- How much money should beneficiaries receive—regardless of need—as a gift from the deceased?
- If the insured is in training for a potentially lucrative career, how much money should dependents receive in order to offset the loss of expected high earnings?
- How much money should beneficiaries receive in order to offset debts (such as a mortgage loan) that the insured person would normally pay for?
- How much money should beneficiaries receive in order to pay estate taxes?
- How much money should beneficiaries receive in order to pay funeral costs, burial costs and other expenses directly related to the insured person's death?
- How much money should be reserved for a favorite charity or some other non-traditional beneficiary?
- What other sources of income (such as savings, Social Security benefits, other insurance and survivors' employment income) are likely to be in place in order to accomplish the buyer's goals?

One potential drawback to a needs analysis is that it is subject to change in the years after a policy has been in force. Mortgage loans are paid off. New children are born, and older ones (we hope) become financially independent. Marriages begin and sometimes end. These occurrences are practically a part of life and are likely to have an impact on how much life insurance is really necessary for a given individual.

Producers should, therefore, feel obligated to make contact with their existing customers at least every few years and suggest conducting a revised needs analysis. If the revised analysis points toward a smaller need, the insured is likely to save a bit of money. And if the revised analysis shows a larger need, obtaining the larger death benefit can help keep the owner's goals on track.

Is Life Insurance for Everyone?

If insurance professionals are going to trust the results of a needs analysis, they must be willing to acknowledge those relatively rare cases in which the need for coverage is very small or even nonexistent. If an individual has no dependents, life insurance might not truly be necessary. If someone's sole concern is having enough money for burial, funeral and other end-of-life expenses and the person is already covered under a modest group life insurance plan, the purchase of a separate policy might not be a legitimate priority.

Although it may be acceptable to emphasize some of the other positive features of life insurance (such as tax issues and the potential to receive dividends or low-interest loans from the insurance company), producers should never forget that the most important promise contained in a life insurance policy is the insurer's promise to pay a death benefit. If the size of the death benefit is not one of the buyer's major concerns, life insurance might not be the best solution to the person's problem. Or at the very least, the purchase of life insurance for this type of person should probably be considered within the context of the buyer's overall financial plan. Such cases might require knowledge beyond the typical insurance producer's realm of expertise and might need to include consultation with the person's attorney, accountant or other trusted adviser.

Understanding Life Insurance Companies

Most life insurance in the United States is issued by large insurance companies. Policies might also be obtainable through fraternal organizations, banks and (to a considerably lesser degree) credit card companies. The same companies that sell life insurance are also likely to sell annuities and some forms of accident and health insurance.

Insurance companies can generally be categorized as either "stock companies" or "mutual companies." A stock company is owned by investors who might or might not have purchased insurance from that particular company. A mutual company, on the other hand, is owned by the same individuals who have purchased insurance from it. In other words, the company's stockholders and its policyholders are the same people. As stockholders, people who purchase life insurance from a mutual company might receive sums of money called "dividends," which can be given as cash or used to reduce future insurance premiums.

Life insurance policies that have the potential for payments of dividends are called "participating policies." Life insurance policies that do not include the potential payment of dividends to policyholders are called "non-participating policies" and are primarily sold by stock companies. Some mutual companies might also offer non-participating policies to the public. In exchange for the lack of possible dividends, non-participating policies tend to have lower initial premiums.

Regardless of whether they're organized as stock or mutual companies, life insurers rely on actuarial data called "mortality tables" to help them price their products and decide how many lives to insure. Mortality tables are statistically–based representations of each age group's susceptibility to death each year. These tables usually break mortality rates down for insurers by giving them the annual, estimated deaths per 1,000 people in each age group. Although they can't necessarily predict how long a particular person will live, they help insurers make relatively accurate predictions about how many of an insurer's policyholders will die over a given time period and, as a result, how much money will need to be paid to beneficiaries.

Insurer Solvency

Regulators require that life insurance companies keep a significant amount of money in reserve in order to pay death benefits and provide refunds to consumers who are entitled to them. However, an unstable company still might struggle to honor its contractual obligations during a bad economy or at any point when a significant number of policyholders suddenly decide to cancel their coverage. States generally have guaranty funds that can compensate beneficiaries if a life insurance company is unable to make good on a legitimate claim, but there are limits to

the amounts that these funds will pay, and the wait can be long and inconvenient.

For these reasons and more, consumers and producers should focus not only on the price of life insurance but also on the financial stability of the company that is behind the given policy. Ratings organizations such as A.M. Best and Weiss Ratings can provide an evaluation of an insurer's financial health and can help producers determine which companies are more likely than others to become insolvent or are at least more likely to raise prices.

Life Insurance Agents

A person who wants to sell life insurance to others must be licensed. The type of required license will depend on the type of life insurance to be sold.

The basic life insurance license issued by a state's insurance department can be used to sell most kinds of life insurance. However, some kinds of life insurance are actually a combination of insurance and a securities product. These types of insurance are collectively known as "variable life insurance" and have a cash value that can increase or decrease in conjunction with the stock market or other economic factors. In order to sell variable life insurance, the seller must have a life insurance license issued by his or her state and must pass the appropriate federal exam pertaining to securities. (These exams are typically known by a series number, such as "Series 6," "Series 7" or "Series 63.")

In addition to being regulated by the state insurance department, an insurance agent who sells variable life insurance is also regulated by a national regulatory body called the "Financial Industry Regulatory Authority" (FINRA). Both FINRA and a state's insurance department require that life insurance professionals complete continuing education courses in order to renew their license.

Duties of Life Insurance Agents

Along with explaining products and evaluating consumers' needs, life insurance agents often act as "field underwriters" for the insurance company. As a field underwriter, the life insurance agent is expected to consider a potential buyer's risk profile and determine whether the person is likely to be a good customer.

Although insurance companies employ other underwriters who do not also work in sales, good field underwriting can reduce an insurer's administrative costs and help an applicant maintain reasonable expectations about whether affordable coverage will ultimately be obtainable. As a result, producers should develop strong knowledge regarding an insurance company's underwriting guidelines and understand which types of applicants are probably too risky to insure.

When members of the public purchase life insurance, they typically refer to the person who sold it to them as "their agent." Technically, however, someone who is a life insurance agent represents the insurance company in the sales transaction. This is yet another reason why life insurance agents must be careful not to overburden an insurer with knowingly risky applicants.

If an applicant has a medical condition, hobby or lifestyle that he or she does not want to disclose to the insurer, the agent must disclose the information anyway. Despite being strongly associated with sales, an observant agent is also the life insurance company's first line of defense against insurance fraud. Agents have an obligation to only bring applicants and insurers together in good faith.

Upon receiving all necessary information (often including medical reports) from life insurance applicants, agents will collect an initial insurance premium and be responsible for sending these funds to the insurance company. When the applicant pays the first premium, the agent will also typically issue some kind of a receipt, which may be conditional or fully binding.

If the agent issues a fully binding receipt, the applicant will have immediate coverage under the life insurance policy and can't have the coverage rescinded by the insurer unless fraud is detected.

In most cases, the receipt issued by the agent is conditional upon all of the application information being reviewed and approved by the insurance company's underwriting department. If an applicant with a conditional receipt would have been approved by the underwriting department but dies before the approval takes place, the policy will be in force, and death benefits will be awarded to the deceased's beneficiaries. If an applicant with a conditional receipt wouldn't have been approved and dies before the underwriting department has completed its review of the application, the policy will not be in force, and no death benefits will be paid.

Before engaging in a life insurance transaction on behalf of an insurance company, agents should have a clear understanding of the types of receipts they may issue. They should also provide as much clarity to applicants as possible and not allow consumers to believe coverage is in place when it is still subject to an underwriter's approval.

The Life Insurance Application

Life insurance applications are intended to give underwriters the facts they need to either accept or reject a potential policyholder. In practically every case, the application is considered part of the contract (along with the insurance policy) between the insurer and the buyer. If the insurer later discovers that an application wasn't completed honestly, the policy might be cancelled (in a process known as "rescission"), or the owner might be forced to pay higher premiums.

While each insurer is likely to include different items on its applications, a modern life insurance application is still likely to ask the applicant to provide information about the following topics:

- Name.
- Age.
- Health.
- Amount of requested coverage.
- Gender.
- Address.
- Occupation.
- Hobbies.
- The applicant's relationship to the insured individual.
- The applicant's relationship to the policy's beneficiary.
- Other life insurance products that the person already owns.
- Other life insurance products that the person applied for but did not receive.

The applicant must sign the application and attest that the information on it is accurate to the best of his or her knowledge. A separate portion of the application also requires the agent's signature and provides space for the agent to leave any additional comments that might be helpful to the insurance company's underwriting department. Upon receipt, the underwriting department will review the application, evaluate the

applicant's risk profile and request additional information as necessary.

Evaluating the Application and Pricing the Policy

Prices for life insurance—and the factors that influence them—will differ from company to company. Though practically all life insurance carriers will care about risk-related issues such as age, health and tobacco use, the line between an insurable person and an uninsurable person isn't identical across the industry. Similarly, depending on the specific policy and the insurer's underwriting criteria, the same person might be eligible for relatively cheap coverage from one company but only qualify for relatively expensive coverage from another.

Still, we can make some basic generalizations about how life insurers categorize applicants and how they view certain types of applicant-related information. For the purposes of this course material, we will say that life insurance companies categorize insurance applicants into three broad groups:

- **Preferred risks:** These are applicants with an above-average life expectancy for their age. They will generally pay the smallest amount for life insurance.
- **Standard risks:** These are applicants with an average life expectancy for their age. They will generally pay a moderate amount for life insurance.
- **Substandard risks:** These are applicants with a below-average life expectancy for their age. They will either pay the largest amount for life insurance or will not be issued a policy at all.

In practice, the various categories of applicants tend to be greater in number and more complex. For example, some companies have a category for "super-preferred" risks, which is essentially for applicants whose life expectancy is extremely high for their age rather than just above average. Several sub-categories might also exist based on whether an applicant is a smoker or a non-smoker.

Life Insurance and Medical Information

Information about an applicant's health is central to life insurance underwriting. The more information an underwriter has at his or her disposal, the quicker and fairer the underwriting process can be.

As we will see in the pages that follow, life insurance producers and their clients must have an open dialogue about family histories, medical diagnoses and drug treatments, even as each party does its best to remain respectful toward the subject matter and preserve as much privacy as possible.

In order to evaluate an applicant's risk profile, life insurance agents must do more than simply ask if the person is in "good health." Many insurance veterans will tell you that most of their prospects claim to be healthy, even if their cholesterol and blood pressure levels are dangerously high and their medical files are abnormally thick. Unless they are suffering from a diagnosed and terminal medical problem, many potential buyers might assume that most of their health issues are minor and, therefore, don't really need to be disclosed.

For clarity's sake, a life insurance producer should ask the applicant to disclose any ailment or injury that required either hospitalization or prescription medication. The insurance company will ultimately want to know the reasons behind any past or imminent surgeries, learn why applicants visited any medical specialists and find out the identities of people's current physicians.

In addition to inquiring about one's personal medical status, a life insurance company will probably ask about family history. For risk management purposes, the insurer will ask if an applicant's blood relatives—usually limited to parents and siblings—died young or were diagnosed with cancer, heart disease or other serious ailments. Note, however, that some states prohibit discrimination on the basis of genetics as long as the applicant has not been officially diagnosed with a genetic condition.

Life insurers use industry databases and attending physicians' statements to verify applicants' medical histories. But files obtained through the Medical Information Bureau, which we will study later, are not substantial enough to give an underwriter a guaranteed understanding of an individual's health situation, and the files sometimes contain errors or misleading facts. Meanwhile, attending physicians' statements might be too vague in some respects and overly detailed in other areas.

For these reasons and more, life insurance applicants are typically given space on an application to elaborate on their conditions as needed. They can explain, for example, that their cancer was diagnosed 10 years ago and has not been detected in recent checkups, or that a drug usually given to patients with liver problems was, in fact, prescribed for a completely different and less serious condition.

The Medical Information Bureau

One controversial—and some would say misunderstood—source of applicants' medical information is the Medical Information Bureau (MIB). Founded in 1902, the Massachusetts-based organization claims to have saved the buying public millions of dollars by detecting consumer fraud in the life and health insurance markets. This nonprofit entity is funded by over 600 life and health insurers that pay dues to the MIB based on the number of times they access the organization's database and the number of policies they have on file with the bureau.

When a person applies for an individual life, health or disability policy, an insurance company that maintains membership with the MIB may choose to report medical information to the bureau. The bureau does not accept any information directly from hospitals or doctors. All information must come from member insurers, and the insurers' information must have come either from the applicant or from a physician who received the applicant's consent. The applicant's consent usually comes from an item on the insurance application called an "MIB Pre-Notice," which explains the kinds of information an MIB member might report and the reasons why insurers access MIB files.

MIB records consist of codes, with each code representing one of 230 specific risk factors. The MIB does not intend for its codes to disqualify someone automatically for life or health insurance. Instead, it expects its members to view these codes as red flags and encourages insurance companies to investigate an applicant's specific health status independently. The meaning behind each code is not disclosed to the public or to unauthorized employees.

The MIB maintains files for seven years and also keeps an "Insurance Activity Index," which keeps track of the MIB members who access a consumer's file within two years. Access to the files is granted only to MIB members who either have a pending application or a pending insurance claim.

The MIB's low profile might explain why there has been confusion over the years regarding consumer's access to their MIB records. In fact, the bureau operates in a fashion similar to the major credit bureaus in the United States. Consumers are entitled to view

their MIB file once each year by calling the organization and providing it with their name, address, birthday and other identifying information. Consumers can also receive a free view within 30 days of a negative action taken against them by an insurance company. Additional copies of one's MIB file require a processing fee and a 30-day waiting period.

When people make a valid request for their information, the MIB will tell them what appears in their file, who reported all the information and the names of members who accessed their file. If consumers believe there is an error in their file, the MIB requires the insurer that reported the disputed data to reinvestigate the matter. When people are not satisfied with the results of a reinvestigation, they have an opportunity to add a note to their file that explains the dispute from their point of view.

Paramedical Exams

Sometimes a life insurance applicant can be issued or denied a policy based on the information found in an application and an attending physician's statement. However, many companies require each applicant or certain applicants to go through a paramedical examination before a policy may be issued.

Examined applicants can expect to have their blood pressure taken, their height and weight measured and, perhaps, some of their blood analyzed. If an applicant is not required to submit to a paramedical examination, he or she has probably bought a somewhat pricy policy or opted for a relatively small death benefit.

Life Insurance and Gender

Initially, societal views about gender and the idea of men being the financial providers for families meant that very few women purchased life insurance. As females took a greater liking to the product, they found that child-bearing risks created an unfavorable situation for them. According to a historical overview printed by Best's Review, if a woman was of child-bearing age, she was often denied life insurance or only offered it at a high price. Costs were even steeper if she applied during the first three months of pregnancy, and a one-year waiting period was common if she was any closer to giving birth.

As childbirth became safer, women began living longer on average than men. For instance, according to the Centers for Disease Control and Prevention, a woman's life expectancy in 2003 was 80 years, and a man's life expectancy was 74.7 years.

The difference in life expectancy between the sexes explains why gender-based prices continue to be allowed for life insurance. In general, if a man and a woman of the same age both apply for the same policy with the same death benefit, the man will be required to pay a bit more.

The opposite is true when a life insurance company issues an annuity. In that case, if a man and a woman of the same age both request to receive regular payments from the insurance company through an annuity, the woman will receive smaller regular payments than the man.

The different treatment of men and women in insurance has become increasingly unique to the life insurance side of the industry. Federal and state governments have moved to ban gender discrimination in health, property and casualty insurance in various ways.

Underwriting and Smoking

America's relationship with smoking has changed quite a bit since the days when doctors puffed away in front of their patients and celebrities hawked cigarettes on television. According to the U.S. Department of Health and Human Services, in 2002, only about 25 percent of men smoked, compared to 20 percent of women. Life insurance companies have changed with the times and have given discounts to non-smokers at least far back as the 1960s.

For a long time, most life insurance companies granted coverage at a discount if the applicant had avoided cigarettes for at least a year. Over time, some companies have flirted with different rating classes for smokers and charged people a little less if they smoked cigars or pipes rather than cigarettes. People have also been grouped based on the number of cigarettes they smoke in a day.

Tests for nicotine are a common part of the application and underwriting process. If the insurer discovers that an alleged non-smoker actually uses tobacco products, the person can usually still obtain life insurance by paying a higher premium.

Underwriting and Hobbies

What people do during their free time can say a lot about their chances of living a long life. In an era when extreme sports have their own televised events, life insurers have become increasingly careful when confronted with applicants who race cars, climb mountains, fly small planes or have other dangerous hobbies.

An extreme hobbyist's insurability will depend on the details of the activity. If a man climbs mountains, does he intend to find his way to one of the world's tallest structures? If a woman enjoys scuba diving, how deep does she plan on swimming? If the applicant is a pilot or race car driver, is his or her vehicle in excellent condition? Will the applicant be engaging in the hobby alone or in a group setting where help is more likely to arrive in an emergency?

Experience can also be a key underwriting factor in these cases. If someone has gone through some kind of licensing or certification process, the underwriter might view the applicant as someone who learned proper procedures and who is expected to adhere to a safety-first code of conduct.

When a dangerous hobby is likely to have a significant impact on an applicant's eligibility for life insurance, it might be possible to obtain affordable coverage by excluding the hobby as a covered cause of death or by paying a higher premium.

How Life Insurance Policies Work

At this point, we will review the common parts of a life insurance policy and their importance to consumers. The policy is considered part of a contract between the person buying the insurance and the company issuing it. Therefore, it is very important that applicants, policyholders, agents and insurers all have a firm understanding of what a policy actually says.

Unlike many kinds of personal lines property and casualty insurance carriers, the life insurance industry does not use the same standard policy forms across all states and all companies. In other words, a policy from Company A in one state isn't guaranteed to be written the same way or contain exactly the same features as a policy from Company B in another state. However, regulatory trade organizations such as the National Association of Insurance Commissioners (NAIC) have drafted life insurance rules and laws that many states have implemented with minimal or no changes.

Even where guidelines from groups like the NAIC have not been followed, state rules often dictate the wording of certain policy

sections as well as their placement and font size. Such rules aim to create at least some level of uniformity and consumer protection regardless of which company is actually selling a life insurance product.

Ownership Rights

Besides the insurance company, there are at least three parties who are connected by a life insurance policy:

- The owner.
- The insured.
- The beneficiary.

The "owner" is the person who has "ownership rights" over the policy and is the only party, besides the insurance company, who decides how the policy is set up. In most cases, the owner is the same person who is responsible for paying the life insurance premiums. This person will sometimes be referred to as the "policyholder."

The "insured" is the individual whose life expectancy is analyzed during the application/underwriting process and is the person whose death will result in payments to the policy's beneficiary. The insured and the owner are usually the same person, but it is also possible for one person to be the owner of a life insurance policy on another person's life. For instance, a husband and wife might have a life insurance policy that lists the husband as the owner and the wife as the insured or vice versa. You'll read more about possible arrangements between the owner and the insured in the section called "Insurable Interest."

The "beneficiary" is the person or entity who will receive death benefits when the insured passes away. Although there is tremendous flexibility regarding who can be a life insurance beneficiary, the owner is typically the only person who can make that choice. In fact, an owner even has the ability to change his or her mind and replace one beneficiary with another after the policy has been issued. You'll read more about how this works in the section called "Beneficiaries."

Other rights that belong to the owner (and not to the insured or the beneficiary) are listed below:

- The right to use the life insurance policy as collateral for a loan from the insurer or another lender.
- The right to withdraw money from the policy's cash value (if the policy has cash value).
- The right to terminate the life insurance policy or make changes to it (pending the insurance company's approval).
- The right to receive dividends from the insurance company (if the policy is a participating policy purchased from a mutual insurance company).
- The right to decide whether the beneficiary will receive death benefits in a lump sum or in multiple installments.
- The ability to transfer all or a portion of the ownership rights to someone else.

Assignment

The ability to transfer a life insurance policy's ownership rights to someone else is known as "assignment." There are multiple types of assignment. In an "absolute assignment," the policy's original owner transfers all ownership rights. More commonly, though, an owner will only assign certain rights to other people and maintain control over other aspects of the coverage.

One of the most common types of assignment is a "collateral assignment." In this arrangement, the owner gives a creditor the right to name itself as the policy's beneficiary in exchange for a loan. If the owner pays the creditor back before the insured dies, the creditor's limited ownership rights end and are returned to the previous owner. If the owner's debt has not been paid off at the time of the insured's death, the creditor will be repaid from the death benefit, and any remaining death benefits will be paid to the owner's chosen beneficiary.

Regardless of the type of assignment or the reason behind it, the insurance company must be notified and approve of the assignment before it can go into effect. If the owner fails to alert the insurer to an assignment and a death occurs, the insurance company might not need to honor the transfer of ownership and might only need to abide by the version of the policy that it has on file.

Insurable Interest

Before someone can purchase insurance, the insurance company must believe that the policy's owner will want the insured item or insured individual to remain unharmed. This desire to keep insured items or insured people out of danger is called "insurable interest."

Since most people would prefer to stay alive for a reasonably long time, they are considered to have an insurable interest in their own lives and are therefore allowed to purchase life insurance on themselves. The rare exception to this rule about insuring yourself might arise if you attempt to purchase a policy with an unreasonably high death benefit.

Insurable interest can also exist between two or more people. For example, it is generally assumed that family members and business partners have an insurable interest in one another. However, in the event that someone is purchasing life insurance on another person, both the intended owner and the intended insured will usually need to sign the application. One exception to this rule might involve a parent purchasing life insurance on a newborn.

For the purpose of life insurance, insurable interest only needs to exist at the point when the insurer receives the application. If circumstances change between then and the time of the insured's death, the owner has the option (but is not obligated) to assign the policy to a more appropriate party. As an example, consider a scenario in which a married couple purchased insurance on each other's lives but ultimately got divorced. Even if neither person is dependent on the other for palimony, alimony or child support, the divorce (and the possible loss of insurable interest) typically won't invalidate the old coverage.

It is important to note that insurable interest is only needed between the owner and the insured. A life insurance policy's beneficiary is likely to have an insurable interest in the insured person's life but is not technically required to have one. The owner can typically name any person or any organization as a beneficiary.

Paying Premiums

Another decision left up to the owner is the schedule for paying the premiums. Policyholders can usually opt among making monthly, quarterly or annual payments. Paying annual premiums is a common recommendation because it reduces the insurer's administrative costs and can actually make coverage a little cheaper. Single-premium policies are also available but are rarely sold because few people have the disposable income to make such a large purchase in just one installment. Regardless of the payment schedule, premiums can typically be paid via check, a pre-authorized debit or bank account or (in the case of group life insurance) a payroll deduction.

Life insurance premiums are usually "level," meaning they remain the same for either the entire duration of the policy or for at least an extended period of time. If the policyholder has insurance that is intended to remain in force for the rest of someone's lifetime, level premiums tend to be the default option. If the insurance is only temporary but has the potential to be renewed for another period of time, the policyholder will typically pay level premiums equal to one amount until the renewal option is exercised. Then, level premiums equal to a different amount will be paid until the policy is either cancelled or renewed again. This temporary coverage (usually with renewal options) is called "term life insurance" and will be explained in greater detail later in these course materials.

Paid-Up/Limited-Pay Policies

Believe it or not, some life insurance products are designed to let the owner stop paying premiums at a certain point and still keep the coverage intact. These "limited-pay" or "paid-up" policies tend to cost more than other forms of life insurance during the first several years after they're purchased, but they can be beneficial for consumers who want permanent life insurance protection without having to worry about premiums during retirement.

When an insurer sells a limited-pay life insurance policy, it is making assumptions about the policy's future "cash value." The cash value is essentially a combination of the premiums that have already been paid, plus interest earned on those premiums, plus (in the case of a participating policy) dividends from the insurance company. We will explore this concept in more detail later in this course.

With a limited-pay policy, premiums will stop being paid once the cash value reaches a certain amount determined by the insurance company. At that point, the insurer will expect the policy's cash value to be large enough to offset the need for the premiums.

A true limited-pay or paid-up life insurance policy will contain a contractual guarantee that the owner will, indeed, never need to pay premiums after a certain point. With this type of policy, it makes no difference whether economic factors end up being less favorable than the insurance company's projections.

Unfortunately, some consumers have been confused by insurance company projections and have purchased similar kinds of policies that didn't contain these guarantees. Instead, they relied on an agent's verbal assurances or based their buying decisions on confusing charts from the insurance company. Assuming that their premiums would permanently "vanish," many of these confused or misled buyers eventually learned that they needed to pay premiums again in order to keep their coverage in force. For this reason and others, it is imperative that insurance agents communicate clearly regarding what a life insurance actually guarantees and what pieces of data are merely based on assumptions.

Grace Periods

In the event that a consumer either forgets or chooses not to pay premiums on time, the life insurance policy usually will remain in effect for at least one month after the due date. (Some states allow even more time if the owner is a senior citizen.) This is the policy's "grace period." If the insured dies during the grace period, the insurance company will pay death benefits to the beneficiary minus the amount of unpaid premiums.

Automatic Premium Loans

Life insurance policies that are designed to insure someone for the rest of his or her life (as opposed to insuring the person for only a pre-determined number of years) have a cash value that can be utilized in case premiums still haven't been paid by the end of a grace period. Usually at no cost, insurance companies will include an amendment or "rider" to these policies that allows for an "automatic premium loan." When this type of feature is included in a policy, the insurance company will use part of the policy's cash value in order to compensate itself for unpaid premiums after a grace period. As long as the cash value is sufficient to pay the premiums and a bit of interest on the loan, the policy will remain in force, and the insured will remain covered.

Note, however, that many insurance policies sold today are "term insurance" policies and do not have any cash value. The automatic premium loan option is one of several differences between term coverage and permanent coverage. We will explore the other important distinctions between these two broad types of life insurance later in these materials.

Waiver of Premium

Many life insurance policies include a "wavier of premium" provision, which excuses the owner from paying premiums while he or she is significantly disabled. The ability to exercise this provision might be limited to owners of a certain age, such as those younger than 65. When it is exercised, it continues to waive the owner's premium as long as the disability can be verified.

Waivers of premium can seem like a neat addition to a life insurance policy, but they might not make the most financial sense if the owner needs to pay something extra in order to get it. Presumably, the same people who would struggle to pay life insurance premiums while disabled would also struggle to pay rent, mortgage debts, utility bills and other essentials, none of which would be helped by life insurance. For this reason, someone who is interested in a waiver of premium should probably take a step back and consider all the ways disabilities might impact one's financial health. Assuming the cost isn't overly prohibitive, this type of person should probably consider speaking with an agent about a separate disability insurance policy. Remember, for most people, life insurance should be about the death benefit.

Reinstatement Clauses

"Reinstatement clauses" give people who cancelled their life insurance a chance to regain it under special conditions. The chance to reinstate a cancelled or "lapsed" policy generally lasts three to five years depending on the insurer.

The good news about opting for reinstatement is that the policyholder might be able to regain the previously cancelled policy's cash value. Plus, when the policy is reinstated, the owner will often be charged the same premiums that were in place at the time of cancellation instead of a higher premium based on the person's age.

The bad news for people who want to reinstate a cancelled policy is that the owner will need to pay all premiums that would've been due between the point of cancellation and the point of reinstatement. Also, the insured might need to medically qualify for coverage again and might run into problems if he or she has experienced serious medical issues in the interim. As a result, many people only pursue reinstatement if they are likely to earn back a significant amount of a policy's cash value. Insurable

people who cancel one policy and later want life insurance again might simply consider applying for a brand-new policy instead.

Death Benefits

The size of a life insurance death benefit is generally decided at the time of application by the policy's intended owner. Of course, there are some minor exceptions to this rule. For example, an insurer might be hesitant to issue a multi-million-dollar policy on a middle-income stay-at-home parent because the death benefit would seem significantly out of line with the person's needs and might be a red flag of insurance fraud. Similarly, applicants who only want a tiny bit of coverage might be required to purchase a bit more in order to cover the insurer's administrative costs.

The size of the death benefit that will be payable to beneficiaries is sometimes known as the policy's "face amount" or "face value." So a term life insurance policy with a $100,000 death benefit might be said to have a "$100,000 face." In order to properly calculate the appropriate death benefit for an insurance applicant, please review the section "Determining Life Insurance Needs" found earlier in these materials.

Settlement Options

The ways in which death benefits can be paid to beneficiaries after the insured's death are called "settlement options." A settlement option can be chosen by the owner in advance of the insured's death or, if the owner decides not to pick one, left up to the beneficiary.

Most beneficiaries would probably prefer to choose the settlement option on their own after the insured has died, but there are cases in which having the owner pre-select the manner of payment is advisable. If the policy's beneficiary is a child or even an adult who is not particularly responsible with money, the owner can choose a settlement option that restricts access to death benefits but still provides necessary money to the underage or untrustworthy individual.

The most common settlement option gives the death benefit to the beneficiary in a single lump sum. In fact, if neither the owner nor the beneficiary voices a preference for a particular settlement option, this will likely be the insurance company's default way of paying policy proceeds. Other common settlement options are listed below:

- Leave the death benefit with the insurer and allow it to earn interest until a particular time or event.
- Leave the death benefit with the insurer but allow the beneficiary to receive periodic payments of dividends and/or interest.
- Break the death benefit into chunks of money that are given to the beneficiary at regular intervals until a certain date has passed.
- Break the death benefit into chunks of money that are given to the beneficiary at regular intervals until the money runs out.
- Convert the death benefit into an annuity that pays the beneficiary a set amount for the rest of his or her life.

No matter the chosen option, the insurance company will usually need to receive a valid death certificate before it will give death benefits to the beneficiary. Copies are usually available from funeral homes, cremation service providers and local government offices.

Beneficiaries

The beneficiary on a life insurance policy can be a person, business, charity, trust or estate. It is usually chosen by the owner, who even has the right to name himself or herself as the beneficiary.

While it is sometimes possible for the owner and the beneficiary to be the same person, the beneficiary cannot also be the insured. This makes sense when we consider that the beneficiary receives money after the insured dies. In the event that the insured is listed as the beneficiary, the death benefits will technically be passed along to the deceased's estate, which can create probate and tax issues that will be explained later.

Most beneficiaries are "revocable beneficiaries" and can lose their right to death benefits if the owner completes the appropriate paperwork with the insurance company. Other beneficiaries are "irrevocable beneficiaries" and cannot lose their beneficiary status unless they first provide consent to the insurer. As much as the owner might want to replace this kind of beneficiary with someone else, the owner lacks the power to make this type of change. Common scenarios in which an irrevocable beneficiary might be used include those in which a lender is named as a beneficiary until a debt is repaid and those in which former spouses are required to keep their former husband or wife (or their children) as beneficiaries as part of a divorce settlement.

Other distinctions can be made between "primary beneficiaries" and "contingent beneficiaries." A primary beneficiary is the first person in line to receive death benefits when the insured passes away. As long as the primary beneficiary is alive at that time, the contingent beneficiary receives no money from the insurance company. On the other hand, if the primary beneficiary passes away before the insured's death, the contingent beneficiary will receive the policy's face amount. Having a contingent beneficiary can be particularly helpful if the insured and the primary beneficiary die in the same accident.

Even if the person who is supposed to benefit from the life insurance policy is very obvious to the applicant, care must be taken to ensure that the designation of a beneficiary is absolutely clear. For example, generic phrases such as "my spouse" or "my children" should be replaced with the actual names of those intended beneficiaries. If the purchase of a policy is followed by divorce and remarriage to a different person, it may be unclear as to which spouse is entitled to the death benefits. Similarly, if the beneficiary simply contains phrases like "my children," there might eventually be a dispute as to whether each child should receive the same percentage of the death benefit or perhaps an argument over whether children from previous marriages should receive money, too.

Including a child as a beneficiary can cause problems if the insured dies before the child becomes an adult. Since this can cause the death benefits to be tied up for an unreasonable time in the court system, many life insurance professionals recommend that parents create a trust to receive and hold the money until the child turns 18 or 21. Similar recommendations are often made for adult sons or daughters who are intended to be beneficiaries but are significantly disabled. When these recommendations are followed, the death benefit for sons or daughters might be reduced in order to cover the cost of establishing and maintaining the trust.

Entire Contract Clause

The "entire contract clause" is a seemingly minor portion of a life insurance policy that actually provides some important mutual protection to insurers and their customers. It essentially states that the entire contract between the insurer and the applicant

consists of the policy itself, the application and any medical report obtained during the underwriting process.

For the insurer, this means that any exclusions or restrictions relating to the policy must be disclosed in these documents and can't be added at a later date without the owner's consent. For the applicant, this means that even if the person attempts to hide certain medical issues by being vague on the application, the insurer can utilize information in the medical report to make a final decision about pricing and eligibility.

Incontestability Clause

Many years ago, insurance companies began inserting "incontestability clauses" into their policies in order to strengthen the level of trust between the public and the life insurance community. The purpose of the clause is to assure policyholders that the insurer won't take unreasonable measures in order to deny death benefits to beneficiaries.

Under the most common type of incontestability clause, the insurance company has only two years from the policy's effective date to investigate potentially false information on the original application and rescind the policy. If the insurance company detects potential fraud on the application after this two-year period has expired, the insurance company usually must still keep the policy in force and pay the death benefit when the insured dies.

Exceptions to the two-year limit—though relatively few in number—are still important to know. They include, but are not necessarily limited to, the following circumstances:

- The insurance company determines that the beneficiary is planning to murder or has murdered the insured.
- The insurance company determines that an impostor was involved in completing the insured's medical exam.

If the insurance company determines that an applicant did not honestly disclose his or her age or gender, a different portion of the policy (and not the incontestability clause) will determine what happens next. This type of situation is explained in the next section.

Misstatement of Age or Gender

Under a "misstatement of age or gender clause," the insurance company is allowed to adjust the policy's face amount (effectively, the death benefit) if the applicant's stated age or gender turns out to be incorrect. This clause is separate from the incontestability clause and doesn't allow the insurer to rescind an entire policy. It can also be exercised regardless of whether the error in age or gender is discovered later than two years after the policy's issue date.

Believe it or not, many cases of incorrect ages and genders are honest mistakes committed by applicants and insurance producers. For example, an applicant who is asked for his or her age might be confused by the fact that some insurers care about the person's exact age at the time of application while others actually round up to the next age if the applicant's birthday is within the next few months. Meanwhile, a producer who is helping to insure a child might learn the child's name from parents and incorrectly assume that the name is only used by one of the two sexes.

These problems can be minimized by asking very clear questions on the application and during any fact-finding interviews. Instead of asking for ages, some insurers are clearer and ask for birthdates. Instead of asking for names of children and allowing themselves to make assumptions about gender, agents can simply ask the parents to identify the child's gender. It might seem like a silly request in some cases, but it can prevent inconveniences and surprises in later years.

Suicide Clause

Similar to the incontestability clause, the "suicide clause" allows the insurance company to deny death benefits to beneficiaries if the insured commits suicide within two years of the policy's issue date. This clause is intended to prevent a problem called "adverse selection," in which insurance is primarily purchased by high-risk consumers who are certain that they will be using it.

By putting a two-year exclusion on suicides, insurers believe that they are protecting themselves adequately against buyers who intend on killing themselves soon after an insurance purchase. However, once the two-year period has ended, cases of suicide will generally result in death benefits going to the beneficiary.

If the suicide clause is to be exercised after the insured's death, the burden of proof regarding the suicide belongs to the insurer. In other words, the death is considered to not have been a suicide unless the insurer can prove otherwise. Instead of the death benefit, beneficiaries who are impacted by the suicide clause will often receive a return of all premiums paid by the policyholder to the insurer.

Exclusions

Although life insurance policies tend to have fewer specific exclusions than property and casualty insurance policies, a few causes of death that aren't covered deserve to be mentioned here.

Aviation

Earlier in these materials, you read about dangerous hobbies and how they can sometimes be excluded as a cause of death if an applicant's eligibility for affordable coverage is in jeopardy. Depending on the policy, aviation might be considered one of those dangerous hobbies or might have its own exclusion regardless of whether the applicant engages in it.

When aviation exclusions are included in a life insurance policy, they typically exclude deaths that occur while flying or riding in a non-commercial plane. Deaths of passengers on commercial flights are usually not exempt from coverage.

War

War exclusions tend to be included or excluded from life insurance policy's depending on whether the country is experiencing a time of peace or unrest. When they are included, the exclusions might be reserved for cases in which the insured is within the allowed age range for joining the military.

Dividends

Policyholders whose coverage was issued by a mutual insurance company are eligible for "dividends." Within the context of life insurance, dividends are a refund of premiums paid back by the insurer to the consumer. These refunds are possible when an insurer underestimates its mortality risks, has a better-than-anticipated return on its investments or figures out a way to reduce its administrative expenses.

The policyholder (not the beneficiary) is the person who receives dividends and gets to decide how to use them. Common uses for policy dividends are as follows:

- They can be paid directly to the policyholder.
- They can be kept with the insurer and used to reduce or eliminate future premiums.

- They can be kept with the insurer and used to increase the policy's death benefit.
- They can be kept with the insurer and used to increase the policy's cash value (if the policy has cash value in the first place).

Since dividends are commonly used to offset future premiums and as a factor in long-term financial planning, it is very important to note that they are never guaranteed. Most mutual insurance companies do their best to provide dividends to policyholders each year, but the size of an annual dividend can rise one year and drop the next. It's even possible for participating policyholders to go a year or more without receiving any dividends.

Another important point to remember about life insurance dividends is that they are generally tax-free. This can be a confusing point because of the ways in which the term "dividends" are more commonly used by stockbrokers, financial planners and other investment professionals.

It can be simpler to understand if you remember that life insurance dividends are considered a refund of paid premiums. In most cases, people will pay for life insurance premiums with money that has already been subjected to income taxes. So if dividends are considered to be a return of those already-taxed dollars, the money won't be taxed again.

One relative exception to this rule about taxes involves cases in which dividends are allowed to accumulate with the insurance company and earn interest. When those dividends are paid out in the form of cash or as part of the death benefit, the dividends themselves will be free from income taxes, but the interest earned on them will usually be taxable.

Free-Look Periods

A policy provision called a "free-look period" gives new policyholders a short period of time to possibly reconsider their purchase, cancel the policy and receive a refund of that first premium with no questions asked. In order to receive a full return of the first premium, the owner must return the policy to the home office or to the producer before the free-look period expires.

The free-look period begins on the day the policy's owner receives the newly issued life insurance policy from the insurer. The deadline for a complete return of premium and other related fees will depend on state laws and policy language. Some insurers limit the free-look period to 10 days. Others allow for a 20-day period. In some states, people over the age of 60 have received a 30-day free-look period for life insurance policies and annuity contracts.

Policy Riders

Now that we've gone through the basics of how life insurance policies work, let's focus on common add-ons to those policies. In the insurance community, these add-ons are referred to as "riders." Though they can technically be any amendment to an insurer's basic insurance policy (including an amendment that removes a consumer-friendly feature within the insurance contract), we'll focus on those beneficial riders that can give the buyer better coverage or, at least, greater flexibility.

Some riders might be offered for free by the insurer, but most are likely to be added to a life insurance policy only when the owner is willing to pay extra premiums. The extra cost for each individual rider probably won't seem high, but costs can add up when viewed as an entire package. Just as they would with any aspect of an insurance product, consumers should weigh the cost of a rider's benefits against their needs. An experienced and honest life insurance producer can play an important advisory role during this process.

Guaranteed Purchase Option

A rider allowing for a "guaranteed purchase option" gives the owner the opportunity to purchase additional life insurance at various points without needing to medically qualify for it. This rider typically can be exercised at specific intervals (such as every five years or every 10 years) or upon certain major life events (such as marriage or the birth of a child). The ability to exercise a guaranteed purchase option is usually restricted by age and is likely to disappear once the insured turns 65. (The exact cutoff for using the option will depend on the product and the insurer.)

The guaranteed purchase option is probably best suited for individuals who predict they will need more life insurance but are concerned about developing a major health problem before they have a chance to buy it. If, however, the buyer is interested in this rider simply because of the risk of being older and having to pay higher premiums because of age, the guaranteed purchase option won't alleviate the concern. When the guaranteed purchase option is exercised, any additional insurance purchased at that point will be priced on the basis of the insured's current age (known as "attained age") and not on how old the person was when originally applying for the policy (known as "issue age.") In other words, this rider prevents the insurer from charging the person more for new coverage because of health, but it doesn't stop the insurer from charging the person more for new coverage because of age.

Accelerated Death Benefits

Life insurance that is designed to cover someone until they are very old typically has a cash value that can be used to borrow money against in case of an emergency. However, millions of life insurance customers have a product called "term insurance," which isn't meant for older people and doesn't have the flexibility of cash value. Furthermore, even among people with cash-value life insurance, there are scenarios in which the amount of money available to borrow or withdraw is insufficient to meet the owner's pressing financial needs.

The desire to access a significant amount of money from a life insurance policy became particularly intense during the era of the AIDS crisis in the 1980s and 1990s. Many AIDS patients struggled to maintain their standard of living while paying for necessary medical care and often didn't have assets besides life insurance to help with those major costs.

Transactions called "viatical settlements" allowed terminally ill individuals to sell their in-force life insurance policies to investors in exchange for several thousands of dollars. In return for paying the insured significant amounts of money and agreeing to pay any remaining premiums, the investors were entitled to the death benefits when the ill person eventually passed away. Over time, viatical settlements evolved into "life settlements," in which the person selling his or her life insurance to an investor is a senior citizen rather than a terminally ill individual.

Viatical and life settlements allowed term life insurance customers to receive necessary dollars in connection with their policies and allowed those with cash-value life insurance to get significantly more from investors than they could receive from their insurance company. Although the life insurance industry generally frowned on these transactions, it eventually decided to adapt by offering "accelerated death benefits."

Someone with an accelerated death benefit rider has the opportunity to receive a portion of the policy's death benefit (not just the policy's cash value) when the insured is diagnosed with a terminal illness. In general, a terminal illness is defined as any illness that is likely to result in the person having less than two years to live. Similar riders are also available for cases in which money from the death benefit might be needed to fund long-term care services.

The recipient of accelerated death benefits can use the money to pay for whatever goods or services he or she deems necessary and doesn't need to spend it on medical care. When the insured dies, any portion of the death benefit that was not already provided as an accelerated death benefit will be passed along to the policy's beneficiary.

Double Indemnity

A "double indemnity" rider is a popular add-on to life insurance policies that doubles the death benefit if the insured dies in an accident. The rider is often paired with "dismemberment" coverage, which pays a certain amount if the insured loses a limb or an eye but is still alive.

In order for the double indemnity rider to be exercised, the insured must die within a certain period (often 90 days) following the accident. Also, the death typically needs to occur before the insured reaches a certain age, such as 65.

The possibility of a doubled death benefit is very attractive to consumers, but that attraction tends to ignore statistics and the important concept of a needs analysis. Most deaths result from illnesses or natural causes, so the double indemnity rider usually doesn't pay off. Furthermore, consumers rarely consider the fact that the manner in which the insured dies is unlikely to have an impact on the beneficiary's needs. A family with one income, two children and a mortgaged house isn't likely to be in worse shape if the insured dies in a car accident instead of from a heart attack.

If a double indemnity clause is included in a life insurance policy at no cost, most insurance professionals won't object to it. But if it can only be added in exchange for a higher premium, the money used to purchase the rider might be better used by purchasing a higher overall death benefit. By spending the money in this fashion, the owner gains extra protection regardless of whether death is caused by an accident or by something completely different.

Cost of Living Adjustments

Whether it's intended to benefit a spouse into senior citizenship or a young child who will eventually need money for college, the appropriateness of a death benefit can change as a result of inflation, deflation and other effects on the money supply. Rather than completing a new needs analysis every few years, some life insurance buyers might choose to address their concerns about inflation by purchasing a "cost-of-living adjustment" (COLA) rider. This type of rider can increase the death benefit in connection with an economic index (such as the Consumer Price Index) or can be formulated to add a specific dollar amount of coverage on a regular schedule.

Return of Premium

A "return of premium" rider might be added to a term life insurance product if the owner believes the insured is likely to outlive the term of the policy. If the insured dies while the policy is in effect, the beneficiary receives the death benefit. If the insured is still alive when the policy expires, the beneficiary receives the sum of premiums paid by the owner to the insurance company.

This rider ensures that the owner doesn't lose much (if anything) if the policy never pays a death benefit, but it also can make term life insurance (generally considered the cheapest type of coverage) significantly more expensive.

Types of Life Insurance

We've gone through the basic need for life insurance, the most common policy provisions and some of the most popular riders to life insurance products. But there are still many specific types of life insurance that deserve to be explained here, all of which function in their own way and serve different purposes.

The next several pages will be devoted to a review of these various types of insurance products, beginning with a discussion of the differences between term life insurance and the many types of permanent life insurance.

Term Life Insurance

"Term life insurance" is life insurance that is scheduled to remain in force for a set period of time and then expire. It is the least complicated form of life insurance and—if only kept for a relatively short period of time—the cheapest.

Term life insurance is a good fit for people whose need for coverage is temporary. It's also a potentially appropriate product for someone who may technically have a permanent need for coverage but is unwilling to pay higher premiums.

Common examples in which term life insurance might be a wise choice include:

- A spouse wants to provide death benefits for the other spouse in case death occurs prior to the survivor being eligible for Social Security.
- A parent wants to provide death benefits that will mainly be used to fund the cost of raising a child until the age of 18 or 21.
- An adult child wants to provide death benefits for aging parents in case the adult child dies before the parents.
- A homeowner wants to provide death benefits to a creditor in order to pay off the remaining balance of a mortgage loan or other debt.
- Business partners want to insure one another in case one of them dies but are unsure how long the partnership will last.

Term life insurance policies generally can cover people for anywhere from one to 20 years. During each specified term (number of years), both the death benefit and the premiums will usually remain unchanged. Then, at the end of a term, the policyholder usually has the ability to renew the policy for another term regardless of the insured's health. However, coverage under the new term will usually be based on the insured's age at the time of renewal.

The ability to renew for another term (in exchange for a higher age-based premium) will often continue to be an option for the policyholder until the insured turns 65 or some other age established by the insurer. If the policyholder intends on keeping life insurance in force longer than that, permanent life insurance (and not term life insurance) might be the better choice.

Unlike the various types of permanent life insurance, term life insurance has no cash value. In practical terms, this means the policyholder is paying purely for the death benefit and not for the ability to utilize the policy in other ways. Since it lacks cash value,

term life insurance can't be used as collateral for a loan, can't be used to accumulate and withdraw interest, and can't be surrendered in exchange for a lump sum or series of payments from the insurance company. If the insured dies during the policy term, the beneficiary gets the face amount. If the insured dies after the policy term, or if the policy is cancelled, the beneficiary typically gets nothing.

Without cash value, term life insurance is generally less expensive and less complicated than permanent life insurance. This price differential is particularly likely when the policyholder does not intend to renew a term policy beyond middle age. Still, the consumer who saves money by purchasing term life insurance loses the flexibility that is provided by permanent life insurance. Producers owe it to their clients to make sure that this tradeoff is appropriate.

Conversion Options

Even if consumers opt for term life insurance, they often have the option to convert their insurance policy to permanent coverage at a later date. This can be helpful for unhealthy policyholders because the conversion is not contingent on re-taking (and essentially passing) another medical exam.

Upon conversion from term to permanent life insurance, the difference in premiums will depend on the product and the insurance company. While it is common for companies to base premiums for converted coverage on the insured's age at the point of conversion, some insurers will keep the premiums the same unless the owner also wants to make changes to the death benefit. When the conversion doesn't change the policyholder's premiums, it is likely that the insurance company charged the owner in advance for the conversion option. When the conversion results in an increase in premiums based on the insured's attained age, it is more likely that the conversion option was part of the policy all along and didn't force the owner to pay extra for it in advance.

Decreasing Term and Credit Life Insurance

Most types of term life insurance are "level-term" products. A level-term life insurance policy has a death benefit that remains constant throughout the term of the contract. In rarer cases, though, consumers will purchase "decreasing term" insurance.

Decreasing term life insurance has a death benefit that shrinks over time. The death benefit might be designed to drop on a specific schedule, such as upon a certain date, or might be tied to a specific event. Even as the size of the death benefit goes down, the premiums remain the same.

"Credit life insurance," which is purchased in case a borrower dies before paying off a loan, is arguably the most popular form of decreasing term insurance. This type of insurance is actually a form of group insurance that is often offered by banks and other financial institutions. There generally aren't many decisions for individual consumers to make in regard to how the product will work, and it is not commonly sold by insurance professionals unless they work directly for those financial institutions.

Permanent/Whole Life Insurance

In contrast to term insurance, permanent life insurance is meant to insure someone for the rest of his or her life. There are many variations on permanent life insurance, a few of which will be covered in the next few sections.

Permanent life insurance is intended for individuals whose need for life insurance is unlikely to ever end. This kind of life insurance typically has premiums that don't change (unless the owner makes special arrangements with the insurer) and is capable of remaining in force until the insured reaches the age of 100. In the event that the insured turns 100, the policy's face amount will be paid to the beneficiary. This payment to the beneficiary is sometimes referred to as an "endowment" and releases the insurer from having to pay a death benefit when the insured eventually passes away.

Besides being capable of remaining in force until the insured reaches 100, permanent life insurance differs from term life insurance in the following respects:

- In addition to paying for the death benefit, policyholders with permanent life insurance are also paying premiums that give their life insurance a "cash value."
- Policyholders with permanent life insurance can borrow money from the insurer in an amount close to their policy's cash value.
- Policyholders with permanent life insurance might be able to withdraw a portion of their cash value and still keep their insurance in force. (This is especially common if the owner has "universal life insurance" or "variable life insurance." We will explore these two types of permanent coverage later.)
- Policyholders with permanent life insurance might be entitled to interest that is credited to their cash value at certain points. (Note that this is different from the dividends received by policyholders at mutual insurance companies. A permanent life insurance policy purchased from a stock insurance company won't be credited with dividends but can still qualify for this other kind of interest.)
- Policyholders who cancel a permanent life insurance policy are entitled to "non-forfeiture benefits," which might include a refund of the policy's cash value or a temporary amount of free insurance.

Since life insurance death benefits are generally exempt from the probate process and can be structured to escape federal estate taxation, permanent life insurance is a common tool for relatively wealthy people who are concerned about estate planning. It's also a common financial vehicle for well-established businesses that are interested in creating long-term succession plans in case an owner dies. Some financial advisers even recommend it as a cushion for investors who keep most of their portfolio in the stock market and other riskier corners of the economy.

A Warning on Terminology

It's important to note that some of the terminology used by the media and financial professionals to describe permanent life insurance can be confusing or inconsistent. For example, many people use the terms "permanent life insurance" and "whole life insurance" interchangeably. Others reserve the term "whole life insurance" for permanent life insurance policies that are essentially as plain as possible. Using the latter definition of "whole life insurance" can be beneficial in cases where the speaker or writer wants to emphasize the difference between a basic permanent life insurance policy and some of the more complex permanent life insurance products (such as universal life insurance and variable life insurance).

Arguments Over Permanent Life Insurance

Despite the positive features of permanent life insurance, it is very common for insurance producers and other financial professionals to engage in fierce debates regarding whether permanent coverage is appropriate for the average person.

Proponents of permanent life insurance tend to point out that the need or desire to leave a death benefit to family members or charities doesn't always go away and that buying a permanent policy ensures that this need or desire can be fulfilled no matter how old or unhealthy the insured eventually becomes. They also often point to the flexibility involved with cash values and the ways in which the cash-value portion of a policy can essentially be used as an interest-bearing savings account for college tuition or some other expensive purchase.

On the other hand, many advisers favor a philosophy known as "buy term and invest the rest." These people believe that the price for permanent life insurance (particularly in the policy's early years) is too expensive for most buyers and that the growth of a policy's cash value is both too slow and too small to justify the cost. The "buy term and invest the rest" strategy recommends that consumers buy term life insurance for the death benefit and put the extra money that they would've spent on permanent life insurance into mutual funds or other interest-bearing opportunities.

The debates about permanent life insurance can get rather heated, particularly since the motives and expertise of people on each side of the argument are often called into question. Those who strongly stress the positives of permanent life insurance are often life insurance producers who claim they know more about these policies than other financial professionals and want to save their clients from the higher risks involved with stocks and mutual funds. Those who favor the "buy term and invest the rest" approach are often financial planners who question whether life insurance agents are recommending permanent coverage in exchange for large sales commissions.

Though the arguments over permanent vs. term insurance can be emotional, reasonable professionals should understand that no product is good or bad for everyone. Each type of insurance, including permanent life and term life, was created in response to a particular need. Since no two people's needs will be exactly the same, it is important to analyze each scenario carefully and admit that every product can be beneficial under the right circumstances.

Cash Value

Permanent life insurance has a cash value, which can be used in a number of ways while the insured is still alive. It can be kept with the insurance company and credited with interest. It can be withdrawn in pieces in order to supplement someone's retirement income. It can even be withdrawn in a lump sum in order to pay for large expenses. When insurance professionals stress the savings component of permanent life insurance, they are referring to the likely growth of the policy's cash value.

Each payment of premiums for permanent life insurance will be split into money meant to cover the cost of the death benefit (known as the "mortality cost"), money meant to cover the insurer's administrative expenses and money meant to be credited toward the policy's cash value.

In general, a policyholder who continues to pay premiums and makes no withdrawals from the cash value will watch the cash value increase over time. However, the degree of increases in the cash value will usually depend on how long the policy has been in force. Since the insurer incurs greater administrative expenses during the early years of a policy, a smaller percentage of the owner's premiums will be earmarked for cash value at that time. Similarly, since it is more expensive to insure older people than younger people, a larger percentage of premiums paid in the later years of a permanent life insurance policy might be devoted to the mortality cost and not to the cash value.

Depending on the type of permanent life insurance being purchased, policyholders may have the ability to access their cash value in a lump sum or in smaller amounts. When they do, the insurance company might have the right to impose a surrender charge that reduces the amount available to the owner. This type of charge is also common in annuity contracts and is designed to prevent insurers from losing money that they would have ordinarily been allowed to invest. The surrender charge might only apply to withdrawals that are beyond a certain percentage of the cash value (such as 10 percent per year) and might only be enforced during the first several years after the policy is issued.

Regardless of any surrender charges, owners might need to wait a few months before their request for a withdrawal is honored. This common practice dates back to the days of the Great Depression and is meant to prevent the insurer from having to surrender a significant amount of assets unexpectedly during a period of economic panic.

This section on cash value is an appropriate place to re-emphasize the important role played by the policy's owner. The right to access or otherwise use the cash value belongs solely to the owner and not to the insured nor to the beneficiary. When a permanent life insurance policy is interrupted by a death, the beneficiary receives the death benefit. The beneficiary does not receive more money if the policy had a cash value and does not receive less money if the cash value is lower than the death benefit. Decisions about what to do with the cash value (including whether to use it to increase the death benefit) are made by the owner.

Policy Loans

Policyholders with permanent life insurance have the option of using their cash value to get a loan from the insurer. Originally, loans to policyholders were offered at a fixed interest rate, generally around 8 percent. In order to protect their solvency, companies have since offered policy loans with variable interest rates that are dependent on an economic index. Still, many borrowers find that loans from their insurance company are still cheaper than loans from a bank or other lender. And since the policy's death benefit can serve as collateral for the loan, policyholders wanting to use their cash value in this way usually won't be subjected to a credit check.

Loans from life insurance companies are relatively cost-effective and simple to obtain, but policyholders should be careful not to ignore their repayment obligations. Outstanding debts to the life insurance company will be subtracted from the death benefit. If the borrowed amount is relatively large and has been subject to a significant amount of interest, the beneficiary might not receive enough money to meet his or her needs.

Policy Illustrations

"Policy illustrations" are charts or graphs that are meant to reflect premiums, cash values or other aspects of a life insurance product that can or will change. They are used to help applicants understand the differences between life insurance products and the ways in which those products might or might not meet people's needs.

Though they can certainly be used in sales presentations for term life insurance, policy illustrations are even more important to sales of permanent life insurance because the product itself is often more difficult to understand. The best illustrations

supplement a life insurance agent's presentation and help producers set clear expectations regarding how much coverage will cost and how cash value will grow. The worst illustrations paint an overly optimistic picture of future costs and cash values and are often responsible for people buying unsuitable products.

In order to avoid dissatisfied customers and possible legal action, insurance professionals must use illustrations that make a clear distinction between the insurer's projections and its guarantees. Good life insurance professionals accept personal responsibility when they use illustrations and make sure that their verbal explanations reflect the content of these supplementary materials.

Instead of relying on consumers to notice any disclaimers on an illustration, agents should explain the information in the disclaimers as part of their conversation. Above all else, prospects should not be allowed to make a life insurance purchase unless they have been told what is guaranteed and what isn't.

Non-Forfeiture Options

Many years ago, life insurers were under attack for poor market conduct. Among other things, companies were accused of tricking people into buying the wrong type of insurance. Even if the consumer had already paid a significant amount of premiums for an inappropriate policy, a buyer who recognized the error and decided to cancel the coverage got nothing in return. The inclusion of "non-forfeiture options" was part of a larger effort to regain the trust of regulators and the public.

Non-forfeiture options allow policyholders to still utilize their insurance's cash value even if they decide to cancel their coverage. Since these options are tied to cash value, they are not available to people who only have term life insurance.

Upon cancelling a permanent life insurance policy, the owner typically can choose any of the following non-forfeiture options:

- Receive the cash value as a payment from the insurance company.
- Use the cash value to purchase "extended term insurance," which will provide temporary life insurance protection with the same death benefit as the cancelled policy. No future premiums will be required.
- Use the cash value to purchase reduced "paid-up" permanent insurance, which will remain in force for the rest of the insured's life but with a lower death benefit than the cancelled policy. No future premiums will be required.

If given a choice, most consumers are likely to opt for the cash value as a payment from the insurance company. Most insurers, on the other hand, prefer to hold onto the cash value as part of their portfolio and will make extended term insurance the default option.

Variations on Permanent Life Insurance

The first wave of permanent life insurance products generally aligned with the features that have already been described in these materials. Over time, the insurance industry began catering to an audience that was either looking for more flexibility with regard to payment of premiums or willing to take more risks with their investments.

New types of permanent life insurance were introduced in the 1970s and 1980s, allowing for a wide range of options for applicants to choose from. Those options are too numerous to mention in detail here, but certain types (such as universal life insurance and variable life insurance) are too important and too popular for us to ignore.

Universal Life Insurance

"Universal life insurance" is a type of permanent life insurance that is mainly intended to provide flexibility in regard to the required premiums and the size of the death benefit. People with universal life insurance generally have the ability to adjust their premiums or their death benefit at various points in order to suit their needs. For example, a family undergoing some temporary financial stress might be able to reduce their premiums in order to have more money for other important expenses. Alternatively, an adult who purchased universal life insurance while single might decide to increase the death benefit upon starting a family.

These changes to a person's life insurance plan can be done in different ways even if the policyholder has something other than universal life insurance, but universal life makes these kinds of changes simpler.

Transparency of Universal Life Insurance

Buyers of universal life insurance gain a greater understanding of how their premiums are actually spent. At least once each year, policyholders receive a statement from the insurer that shows how much of their payments have been applied to each of the following categories:

- Insurer's administrative expenses.
- Cost of the death benefit (also known as "mortality cost").
- Cash value.

This information can help consumers determine if they're paying a fair amount for the death benefit and can also help them make informed decisions about cash value. For example, an owner who is especially interested in growing a policy's cash value can decide to pay higher premiums. An owner who isn't as worried about cash value and is mainly concerned about the death benefit can decide to lower his or her premiums to an amount closer to the policy's mortality cost.

Limits on Universal Life Insurance

Despite its flexibility, universal life insurance does have some limits that policyholders can't ignore. When an owner chooses to reduce the required premiums without making proportionate reductions in the death benefit, the premiums that the owner chooses not to pay will come out of the policy's cash value. If the policy's cash value is insufficient to cover this amount, the beneficiary might receive a reduced death benefit. In some cases where cash value is too low, the policy can even lapse, and coverage will end.

There are also limits for policyholders who actually want to increase their premiums. These increases are typically done in order to increase cash values and to allow more of the owner's money to earn tax-deferred interest.

The IRS is aware of this strategy and will only allow it to be used up to a certain threshold. If the owner increases premiums to an extremely high amount without also making similar increases to the policy's death benefit, the policy can lose its favorable tax status. In fact, when this occurs, the policy isn't even considered to be life insurance anymore. Instead, it will be deemed a "modified endowment contract."

The line between life insurance and modified endowment contracts can depend on complicated math and IRS rules. It is

therefore the insurer's responsibility to enforce maximum limits on premium contributions. The average policyholder isn't expected to keep track of these limits on his or her own.

Variable Life Insurance

Variable life insurance is a form of permanent life insurance that exposes a policy's cash value to market risks in exchange for potentially higher returns. The owner still pays premiums for mortality costs and administrative expenses, and the beneficiary is still guaranteed to receive a death benefit when the insured dies. However, the policyholder (and not the insurance company) has control over how the premiums applied to cash value are invested. This is in contrast to the other forms of insurance we've covered in this course, which generally require that the insurer invest premiums in safe places and guarantee that the cash value won't drop due to economic downturns.

Variable life insurance premiums for mortality cost and administrative expenses become part of the insurance company's general account. Premiums applied to cash value, on the other hand, go into a "separate account" for the policyholder. The separation of this money is meant to ensure that bad investment choices by policyholders don't jeopardize the insurance company's solvency.

Money in the policyholder's separate account will be invested in a manner similar to mutual fund contributions. Most insurers offer a variety of investment options, including the chance to put money into bonds, government securities and domestic or foreign stocks. The owner of a variable life insurance policy can invest in several of these options at the same time and move money from one option to another within certain insurer-imposed limits. Any growth or decline in the cash value as a result of the owner's investments won't be taxable until the money is actually withdrawn and paid to the owner.

Variable life insurance can work well for people who want to pay for a death benefit and are comfortable with the uncertainty of long-term investing. People who are generally not comfortable investing in mutual funds and tend to worry about the short-term performance of their portfolios should probably avoid this product. Although variable life insurance has a guaranteed minimum death benefit that won't decline in a bad economy, the insurer will make no guarantees regarding the cash value unless the owner is willing to amend the policy with a potentially expensive rider.

Since variable life insurance transfers risk to the policyholder, it is considered a securities product by state and federal regulators. As a securities product, it cannot be sold unless the applicant first receives a document called a "prospectus." The prospectus is intended to explain the non-guaranteed aspects of the policy and how the product has performed over short and long stretches of time. Variable life insurance products must also be approved for purchase by the federal Securities and Exchange Commission (SEC).

Life insurance producers who want to sell variable life insurance must also be licensed to sell securities. This includes not only the basic type of variable life insurance described here but also hybrid types of variable life products (such as variable universal life insurance). For more about licensing and regulation pertaining to securities, see the earlier section called "Life Insurance Agents."

Life Insurance Options for Spouses

Special kinds of life insurance exist for married couples who want coverage for both spouses. Though not exactly cheap, these products are generally less expensive than separate policies for each spouse.

"Joint life insurance" pays a death benefit to the surviving spouse when the other spouse dies. It is generally used to help the surviving spouse deal with the financial impact of losing a life partner.

"Survivorship life insurance" only pays a death benefit after both spouses have died. It is generally used as an estate planning tool that can reduce the impact of federal estate taxes.

Industrial Life and Burial Insurance

Decades ago, it was common to find insurance agents going door to door and selling "industrial life insurance." This type of insurance is essentially a small amount of life insurance that is intended to cover small funerals and burial expenses. Premiums for industrial life insurance would be collected on a weekly or monthly basis at the policyholder's home by salespersons known as "debit agents."

Industrial and similar types of very small life insurance policies tended to be marketed heavily in low-income communities because each premium installment was usually no more than a few dollars. But as the years went by, these types of products developed bad reputations among regulators and consumer advocates. While each premium payment may have seemed relatively small, the total amount paid for these policies was widely considered to be deceptively high. Unethical salespeople worsened industrial life's reputation by encouraging people to purchase multiple policies instead of helping them obtain coverage under a single contract.

These days, industrial life insurance is rarely sold. Although similar types of insurance might still be available through the mail, most insurance professionals believe these products are only suitable for elderly or unhealthy applicants who can't obtain life insurance in any other way.

Life Insurance for Children

Some insurance agents advise parents to purchase life insurance on their children. Reasons given for this type of purchase usually include the following rationales:

- Cash-value life insurance on a child can later be used to fund the child's college education.
- Buying life insurance on a child ensures that the child will have coverage as an adult even if he or she eventually develops a serious health condition.

A common life insurance product for children is a "jumping juvenile policy." This product has a relatively small face amount in the beginning but allows the death benefit to increase substantially when the child reaches adulthood.

Some life insurance professionals are skeptical of child-centered life insurance products. Most life insurance purchases are conducted in order to help dependents recover financially from someone's death. Since very few people are dependent on a child for money, it's not always easy to justify a policy on a son or daughter.

At the very least, parents who are considering life insurance on their children may want to first evaluate whether they have enough life insurance on themselves. After all, the financial

impact of a parent's death is usually more detrimental to families than the financial impact of a child's death.

Corporate Life Insurance

So far, most of our focus has been on the ways in which life insurance can help individuals and families. There are also cases in which life insurance can be beneficial for a business. Depending on the circumstances, a business might be wise to purchase life insurance on an employee or on an owner.

Key-Person and Corporate Split-Dollar Insurance

A business can suffer major losses when an important employee passes away. Even if the deceased's position is later filled by someone else, the new person might need a significant amount of time to become as skilled and experienced as his or her predecessor. Waiting for the new person to catch up can cost the company a significant amount of money.

"Key-person life insurance" is meant for businesses that are worried about the financial impact of an important employee's death. The business is the owner of the key-person policy and usually lists itself as the beneficiary. Though the employee does not benefit from the policy, the insurance can't be issued without the employee's consent.

A corporate split-dollar life insurance policy has potential benefits from both the employee's and business's points of view. With this type of permanent life insurance product, the employee pays the portion of the premiums intended to cover mortality costs. Meanwhile, the business contributes a portion of premiums to fund the policy's cash value. If the employee passes away, the company will receive a death benefit equal to the policy's cash value. Any remaining death benefit will go to a beneficiary designated by the employee.

Buy-and-Sell Plans

"Buy-and-sell plans" aren't a type of life insurance, but they usually require a life insurance component in order to function properly. These plans are made among business partners and are an attempt to eliminate ownership problems when a partner dies.

Life insurance on each partner is often included in these plans as a way for surviving partners to purchase the deceased person's part of the business from the person's heir. Instead of needing to sell assets in order to purchase the deceased partner's share, the surviving partners can buy out the previous owner's heirs with money from the death benefit.

Life Insurance Replacements and Exchanges

Replacing one insurance policy with another must be done with care. When done thoughtlessly, it can cause sick people to lose their coverage and put long-term tax benefits in jeopardy.

Still, the fact that someone already has life insurance doesn't mean there isn't a better, more suitable product out there. Policyholders should be encouraged to review their life insurance needs at least every few years to ensure that they have appropriate coverage.

In general, the IRS allows policyholders to replace one life insurance policy with another without having to pay taxes on the replaced policy's cash value. However, these swaps (known as "1035 exchanges") should only be done upon careful review of relevant tax rules and perhaps with the help of a qualified tax expert.

Even in cases where 1035 exchanges are done correctly, some insurers will impose a surrender charge on permanent life insurance policies. For example, a company might be allowed to keep 10 percent of a policy's cash value if a policy is cancelled within the first year of purchase. Since these charges are set by insurance companies and not by the government, they can vary from company to company or policy to policy. Documentation concerning these charges should be reviewed carefully prior to any exchange.

Practically every state has rules pertaining to life insurance replacement transactions. While these rules have the potential to differ across the country, they usually require that agents provide special disclosure forms and receive signed statements from policyholders.

Life Insurance Tax Issues

In addition to providing potentially significant death benefits to survivors, life insurance is sometimes championed because of its positive tax features. Tax issues related to life insurance will be explained in the next few sections.

Be aware that the information provided here is meant solely as a summary of a much more complicated topic. For more specific details about life insurance and tax rules, you should conduct further research, preferably with help from a qualified tax professional.

Income Taxes

Life insurance death benefits are generally tax-free to the beneficiary. One exception to this rule would be a case in which all or a portion of the death benefit is left with the insurance company and allowed to earn interest. When those death benefits are eventually paid out the beneficiary, the beneficiary will owe income taxes on the interest.

Dividends received from mutual insurance companies are generally tax-free to the policyholder. This is because these types of dividends are actually considered a return of the owner's premium. Again, there is an exception if the dividends remain with the insurance company and are allowed to earn interest. When the dividends are received by the owner, income tax will be owed on the interest.

Cash values that are accessed by policyholders (in installments or a lump sum) are likely to require some payment of income taxes. The amount of tax owed will depend on the difference between the cash value and the amount of premiums or dividends that the owner gave to the insurer. The difference between those numbers will be considered income and will be subject to federal income tax. However, cash value will grow on a tax-deferred basis until the owner receives it as payment from the insurance company.

Estate Taxes

The federal estate tax can significantly reduce the amount of assets that can be passed along from the deceased to heirs or beneficiaries. This tax is generally due within nine months after someone dies, although it doesn't apply to all people or all kinds of property.

Life insurance policyholders who want death benefits to escape the estate tax must make sure that their policy is set up properly. Life insurance death benefits might be reduced by federal estate taxes if any of the following statements are true:

- The deceased owned the policy at the time of death.

- The deceased didn't own the policy at the time of death but transferred his or her ownership rights to someone else within the past three years.
- The deceased's estate is listed as the beneficiary.

Despite the effect of estate taxes and its link to life insurance, two important disclaimers should be made here.

First, the federal estate tax is primarily an issue for individuals who have a relatively large amount of assets. In 2015, the estates of people who died with assets less than $5.43 million were not taxed by the federal government. (Be aware that the dollar amount for exemptions from estate taxes tends to change from year to year.) So while estate taxes can be a major concern for many people, the issue is not likely to have a practical effect on the average life insurance applicant.

Finally, if estate taxes are a legitimate worry, the applicant or policyholder is likely to need more financial advice than a typical life insurance agent is qualified to offer. Insurance producers can play an important role in estate planning, but a concerned consumer is likely to also need the services of an experienced attorney or tax professional.

Conclusion

By now, you should be able to comprehend the versatility of life insurance products. There are different kinds of life insurance for a wide range of scenarios. With the help of a trained and dedicated insurance professional, buyers are likely find a policy that grants them great peace of mind.

CHAPTER 2: PROTECTING PEOPLE'S HOMES

Introduction

More than just a place to store people's stuff, a house is often a source of pride for its owner. No matter if it's a brand-new dwelling or a well-worn fixer-upper, it is likely to symbolize many years' worth of hard work and disciplined saving. When we step out onto the sidewalk and view our homes from the outside, our eyes will tell us we are looking at nothing but a sturdy combination of walls, windows and doors. Yet our hearts and minds inform us that we are also looking at comfort and privacy for our families, as well as at what is probably the biggest financial asset most of us will ever possess.

With so much wealth and so warm feelings invested into every inch of a dwelling, it's no wonder nearly every homeowner in the United States has insured his or her property against several common perils. Even after their mortgage loans have been paid off in full and the choice between being covered or uninsured is left up entirely to them, these people rarely tempt fate by cancelling their policies altogether. Their gut and experience tell them that anything from a fire to a burst pipe can take away some of that dwelling-related pride at any moment, and they have no intention of paying entirely out of pocket in order to get it all back.

This means that the mission for insurance producers who sell homeowners insurance is a relatively refined one. Unlike their peers who sell life insurance or disability insurance, homeowners insurance agents don't need to spend much time explaining the basic need for coverage. That need, as evidenced by the roughly 95 percent of homeowners who have the insurance, is already understood by the general public.

However, understanding the basic need for the insurance and understanding how coverage is applied are, of course, two very different things. While a homeowner might feel very smart and responsible upon finalizing coverage for a prized piece of real estate, it is very likely that the policy itself will go unread and get stuffed into a dresser drawer until a loss occurs.

Because many homeowners believe they are too busy to read a long and legalistic policy form, they often have an inaccurate understanding of what they are paying for. They might not know whether their dwelling is covered by too little insurance or too much insurance. They might not comprehend the essential differences between actual cash value coverage and replacement cost coverage. They might not be aware that, in addition to covering a home and its contents, homeowners insurance can cover damages and defense costs when the insured is liable in an accident.

Admittedly, even the most considerate and knowledgeable producer cannot guarantee that the insured will be satisfied by an insurer's response to a claim. Try as they might, producers cannot force the insured to read his or her policy. Nor can they assume that those who *do* read it will understand every important provision or exclusion.

Producers can, however, think back to the days before they started working in the industry and recall all the important things they did not know then about homeowners insurance but do know now. By putting themselves back in the buyer's shoes, they might be able to determine the kinds of coverage issues that ought to be thoroughly addressed before a sale and at renewal times.

This material was created within that frame of mind. Although it is a comprehensive review of the various coverage forms in existence today, it is also an attempt to break those forms down and explain how they apply to common kinds of losses. While some of the specifics mentioned here might conflict with the language of a particular policy being sold by a particular insurance company, the reader will be reintroduced to topics that are relevant to all coverage forms, no matter where a proud homeowner actually resides.

It Begins With a Mortgage…

Even if a prospective homeowner remains unsold on the benefits of having insurance, the person's mortgage lender will require coverage. If the person refuses to abide by the lender's terms, the loan will be cancelled, and the potential real estate transaction will be quashed.

By requiring insurance, the lender is not just looking out for the borrower's best interests. Rather, it is doing what it can to protect its own financial stake in the property. Should a fire ever reduce a home to nothing but ash, the mortgage company or bank wants to be certain that it will still be able to recover the loan balance.

Traditionally, lenders have forced borrowers to purchase insurance that is equal in value to their mortgage loan. This amount is often relatively close to the home's replacement value at the time of purchase, but it may be higher or lower than that. When the level of insurance mandated by the lender is not equal to the home's replacement value, the owner is in the undesirable position of being either underinsured or over-insured.

The risk of underinsurance rises with each passing year of home ownership. This is because increases in construction costs often outpace any inflation guards that may or may not have been incorporated into the insurance contract. The jump in prices for materials and labor isn't bad news for the lender, whose investment will be protected regardless of what builders charge. But for the homeowner, it can be a major problem that inhibits the rebuilding process.

On the other hand, the lender's requirements might make the borrower overly insured, since the mortgage loan includes the cost of land. Because the land itself will still be around even if the dwelling is destroyed, it seems illogical to insure it. Based on this complaint, some states do not allow lenders to require insurance above the home's replacement cost.

Remedies and additional concerns related to underinsured property and over-insured property appear in later portions of this text.

Who Is the Insured?

In addition to listing other important details, the declarations page of a homeowners insurance policy will contain the name of the "insured." In most cases, the insured is the policyholder who is responsible for paying premiums to the insurance company and is eligible for compensation after an insured loss. Though the typical insured is both the owner and occupant of the entire dwelling, an insured can also be someone who owns or occupies just a portion of a dwelling or who owns a building under construction. Even a tenant can be an insured if he or she takes some initiative and purchases the appropriate policy.

Coverage of liability and personal property is often broad enough to apply to individuals other than the named insured. Such protection extends to any relatives who live with the insured, as well as to a non-relative who is under 21, lives at the insured premises and is being cared for by the insured or the insured's family. This means everyone from the insured's spouse to the insured's foster child or parent can be covered by homeowners insurance, assuming they all reside with the named insured.

At the turn of the century, most insurers clarified coverage for sons, daughters and other young people who may be attending college away from home. Full-time students remain covered for property losses and liability until they turn 24, as long as they are related to the insured and lived with the insured immediately prior to attending school. Although there are exceptions to this rule (particularly in regard to personal property), we will hold off on discussing them for now.

Under limited circumstances, the liability section of a homeowners insurance policy may extend to non-relatives and third parties who live in their own homes. For example, if an insured leaves his dog with a friend while he is on vacation, the friend will be covered by the dog owner's policy for liability if the dog bites the friend's mail carrier.

It would be unwise, however, to assume that homeowners insurance is a big tent that covers everyone who is remotely affiliated with the named insured. Contrary to popular belief, tenants who are not related to the insured are not protected by their landlord's policy. And even an insured's relatives might lack coverage if they are merely guests in the insured's home instead of permanent residents.

While an insured's spouse gets coverage if he or she lives on the same premises, former spouses are likely to need their own insurance immediately after a divorce. Similarly, insurance executives say domestic partners might be covered if their names are added to the deed to the property, but those who lack a legally recognized financial interest in the residence are likely to need their own renters policy.

If the person named on the declarations page dies, the policy is assigned, in part, to the deceased's legal representative. This transfer of coverage is applicable only in regard to liability at the deceased's residence and to damage to the deceased's property. It does not cover the legal representative's belongings and does not cover liability stemming from an offsite accident. So, while there might be coverage when someone slips on ice at the deceased's property, there would probably not be any coverage if the deceased's legal representative were to accidentally hit someone with a golf ball at an offsite driving range.

Six Policies for the Price of One

Several decades ago, property owners insured their homes through a "dwelling policy." This kind of insurance only addressed the most basic of perils, including fire, and did not contain personal liability protection. In order to cover themselves comprehensively, families had to purchase separate polices or add riders to their dwelling contracts. (Dwelling policies are still used today as a way of covering rental properties that are not owner-occupied.)

Since purchasing separate policies took up too much time and cost too much money, many carriers left dwelling forms behind in the 1950s and encouraged homeowners to buy a multi-part product that had been designed specifically for their insurance needs. That product, known as "homeowners insurance," built upon the basic dwelling policy and features six important kinds of coverage all rolled into one.

Each of the six kinds of coverage has its own letter. "Coverage A" covers a person's dwelling, while "Coverage B" takes care of detached structures, such as garages and sheds. "Coverage C" reimburses people for the loss of their personal property, and "Coverage D" gives them money when their dwelling is uninhabitable. Since coverages A through D all relate, in some way, to the insured's property, they are mentioned one after another in Section I of most policy forms.

Personal liability is covered under Coverage E, and Coverage F pays for other people's medical costs after an accident regardless of who is at fault. Since coverages E and F both relate to damage to third parties or their property, they follow each other in Section II of most policy forms.

Each kind of coverage has its own dollar limit, but these limits are generally dependent upon one another. An insurer's limit of liability for Coverage B, for instance, is often equal to 10 percent of its limit for Coverage A. Although each insurer may require its customers to purchase a minimum amount of coverage, people are allowed to increase any of the six limits of liability by paying more in premiums.

To better understand the strengths and weaknesses of the standard homeowners insurance policy, let's go through these six kinds of coverage one at a time.

Coverage A

As mentioned previously, Coverage A insures a person's dwelling. In simplest terms, the "dwelling" is the structure a person lives in. Most often, the dwelling is a one-family building used by the insured and the insured's relatives. However, a multi-unit building might be considered a covered dwelling if it is designed for two, three or even four families and is occupied in part by the policyholder. (Companies using older coverage forms might still limit the number of units to two.) In most homeowners policies, the dwelling and all the land and other structures surrounding it are collectively known as the "residence premises."

In addition to covering the dwelling, Coverage A is used to insure other structures that are both on the residence premises and attached to the home. An attached garage would be insured

through Coverage A, as might a deck. Garages and other structures not attached to the dwelling are covered by another part of the policy.

The Confines of Coverage A

Coverage A is probably the most important and most commonly utilized component of a homeowners insurance policy, but it has some limitations. The coverage generally applies to a single residence premises and not to any other residential or rental properties the person owns. It might not insure a vacation home, for example, unless the address of the vacation home is specifically added to the policy and listed on the declarations page. Coverage A also excludes losses related strictly to land, including the land beneath and around a dwelling. This exclusion applies to physical damage as well as to any decrease in the land's value.

Coverage B

Coverage B is property insurance for a homeowner's detached structures. A "detached structure" may be defined as a structure that is separate from a dwelling but still situated on the residence premises. According to policy language adopted by the Insurance Services Office (ISO), the detached structure may be separated from the dwelling by way of open space, a fence or a utility line. Common examples of these structures are listed below:

- Detached garages.
- Barns.
- Sheds.
- Pools.
- Mailboxes.
- Driveways.
- Sidewalks.
- Satellite dishes.

A little bit of Coverage B is included in most homeowners insurance policies, even in cases where the insured doesn't have any detached structures at the property. By default, this insurance is usually equal in value to 10 percent of the homeowner's dwelling coverage. So if a dwelling is insured for $100,000 through Coverage A, detached structures on the same residence premises will be insured for $10,000. These structures can be covered for as much as their replacement cost if the insured pays the appropriate premium.

Coverage B and Business Property

Homeowners insurance policies contain a few exclusions that pertain specifically to Coverage B. Most notably, a detached structure is not insured against property damage if any part of it is used to conduct business. This exclusion would be invoked if a homeowner were to use a garage as an office or as a place to store an employer's business property. It would also apply if a homeowner were to rent out a detached structure to someone who does not reside in the insured dwelling.

There are some exceptions to the business exclusion. For instance, a detached structure remains covered if the owner rents it out to a third party who only uses it as a private garage. Coverage also remains intact when the business property stored in a detached structure belongs to no one but the insured or one of the insured's tenants. Depending on the policy, employees may be allowed to store a company car in their garages and not lose coverage.

It is worth noting that Coverage B only insures a homeowner's detached structures. It does not insure any personal or business property that is kept inside those structures. Personal property and business property are addressed elsewhere in the policy.

Coverage C

The business property and personal property mentioned above might be insured through Coverage C, which is more commonly referred to as "contents coverage." In general, contents coverage is for all the belongings the insured owns or uses. Although the insurance for these items is part of a homeowners policy, the insured's contents remain covered outside the home, too. In fact, Coverage C is meant to insure people's personal property all over the world.

At the insured's request, Coverage C can be extended to include personal property that is owned by a guest or domestic employee. When this option is exercised, it is limited to property at the insured's residence. Liability protection pertaining to other people's property can be found elsewhere in the standard policy.

Like the dollar limit for Coverage B, the dollar limit for Coverage C is expressed as a percentage of Coverage A. Most policies provide the insured with contents coverage equal to at least 50 percent of the person's dwelling coverage. So if a dwelling is insured for $100,000, the insured will be entitled to no more than $50,000 to repair or replace all damaged or stolen items.

Since tenants and condo owners receive minimal benefits under Coverage A, these individuals are allowed to insure their belongings for a dollar amount of their own choosing. Special polices for these kinds of consumers are mentioned in greater detail elsewhere in this chapter.

Fair Warnings About Contents Coverage

There are a few negative aspects of Coverage C that the consumer should know about. First and foremost, the insured needs to understand that the standard homeowners form will only reimburse people for their personal property's "actual cash value." An item's actual cash value is its replacement cost minus depreciation.

As an example, suppose someone purchases a new television set for $800, uses it for five years and loses it in a fire when its estimated value has dropped to $300. In this case, the insurance company would only need to reimburse the person for a $300 loss. It would not necessarily need to pay for a new TV.

Insurance that does not take depreciation into account is known as "replacement cost coverage" and can be purchased at an additional price.

An insured should consider upgrading or downgrading his or her contents coverage as living situations at the residence premises evolve. If a spouse or an elderly parent moves in with the insured, additional coverage may be necessary in order to fully cover everyone's belongings. If an adult child or a former spouse has moved out of the dwelling, it may be possible to get by with less insurance.

Of course, the amount of appropriate coverage will depend on the kinds of valuables a person possesses. Families with nothing more than basic belongings (such as clothes, furniture and the most common types of appliances) are likely to need less contents coverage than a family known for having all the latest gadgets.

Limits on Location

Coverage C insures the policyholder's personal property on a worldwide basis. But in spite of this flexibility, the standard policy allows the insurer to limit coverage depending on where the lost

or damaged property was normally stored. If an item was normally kept at a residence premises that is occupied by the insured but not listed on the policy's declarations page, reimbursement will amount to no more than 10 percent of the person's Coverage C limit or $1,000, whichever amount is greater.

As an example, pretend a homeowner has insured the contents of a country house for $50,000. Let's further suppose the homeowner also keeps an apartment in the city and does not have a renters policy for it. If a fire were to break out in the apartment and destroy $50,000 worth of contents, the homeowner would still be able to make a claim on his policy. But he would be reimbursed for no more than $5,000.

Policy language allows for at least two exceptions to this rule. In general, the rule does not apply when property has been moved from an insured residence so that repairs can be made to the dwelling. So in our previous example, the policyholder would remain fully covered if damage to the country house made it necessary to move his belongings to the apartment. The 10 percent limit is also ignored during the first 30 days after personal property has been moved from the insured dwelling to a new principal residence.

Limits on Special Items

Insurance companies generally have no problem covering basic belongings that are common to the average household. But in an effort to mitigate risk and keep premiums down, they set coverage limits on some highly valued items. These limits are enforced on a per-claim basis and are sometimes known as "special limits of liability." In most policies, these limits apply to the following kinds of personal property:

- **Jewelry:** Though not defined in most policies, "jewelry" can mean any item that adorns a person's body for a decorative purpose, including all kinds of rings, necklaces, earrings or watches. Homeowners insurance will provide no more than $1,500 to replace these items when they are stolen. While there is no special limit of liability when a jewelry claim involves a covered peril besides theft, the insured should keep in mind that most policies only cover personal property against perils that are named specifically in the insurance contract. Mysterious losses—including those that occur when a stone comes off its setting or when a ring falls down a drain—are typically not covered by homeowners insurance.
- **Furs:** If a fur is stolen, the insured will receive no more than $1,500 as compensation for the loss. If an insured files claims for stolen jewelry and furs at the same time, the insurer will pay up to $1,500 combined for both kinds of items. It will not apply $1,500 toward the jewelry and another $1,500 toward the furs.
- **Silverware and similar items:** Coverage of silverware, gold-ware, platinum-ware and pewter-ware is limited to $2,500 in the event of theft. There is no specific limit when these items are affected by other covered perils.
- **Money:** Coverage of lost or damaged cash, bank notes, bullion, debit cards and some metals is limited to $200.
- **Valuable documents:** Insurers put a $1,500 limit on manuscripts, passports, stamps, tickets, letters of credit, deeds, securities and other important kinds of documentation. It makes no difference whether these documents are printed on paper or stored electronically.
- **Guns:** Firearms and ammunition are only covered for up to $2,500. This limit applies only to instances of theft.
- **Boats**: All watercrafts and all their related parts and accessories are covered for up to $1,500. Liability coverage for boaters is dependent on several factors and is addressed elsewhere in this course.
- **Trailers:** Trailers and semi-trailers are insured for up to $1,500.
- **Electronic items and accessories:** Some electronic devices receive limited coverage when they are kept on or inside a motor vehicle. For a $1,500 coverage limit to apply, a device must be versatile enough to be used with and without the help of the vehicle's electrical system. Presumably, a cell phone or a portable music player would fall under this category. According to the ISO, accessories impacted by the $1,500 limit include audio tapes, CDs, wires and antennas.
- **Tombstones:** Believe it or not, homeowners insurance makes special mention of grave markers and mausoleums. These items are covered for up to $5,000 per occurrence.

Scheduling Valuables

There are plenty of carriers who will let their clients "schedule" special items and cover them for their full replacement cost. In addition to increasing the insurer's limit of liability on a particular item, scheduling gives the owner extremely broad coverage on an all-risk basis. The lost piece of jewelry that we mentioned earlier, for example, would be covered if its owner were to schedule it.

Illegal Items and Substances

It probably goes without saying, but Coverage C cannot be used to insure illegal items. This exclusion applies to unlawful substances, such as non-prescribed narcotics, as well as to any item that has been stolen. At the time of this writing, it was unclear as to whether medical marijuana was a covered prescription medication or an excluded illegal substance.

Other kinds of limits or exclusions, including those related to animals, business property and other perfectly legal items, will be mentioned at another point in our study.

Coverage D

Having insurance to help replace or repair a dwelling or personal property can be a blessing. But what are homeowners and their families supposed to do between the time a loss occurs and the time they are allowed to move back into a permanent residence? How are they supposed to handle all the expenses that arise from being displaced?

Those questions are answered by Coverage D, which is commonly known as "loss of use coverage." Loss of use coverage is exactly what it sounds like. It pays money to the insured when the residence premises is made uninhabitable by a covered peril.

When thinking of examples in which loss of use coverage would come into play, it's easy to envision a disaster that causes a total loss. However, loss of use coverage might also be utilized in cases in which only a portion of a dwelling has been severely damaged. For example, if a tornado makes the only bathroom in a dwelling unusable, the insured might be able to receive some benefits through Coverage D.

Depending on their situation, homeowners are entitled to one of two kinds of benefits while their residence premises is effectively out of service. The most common kind comes in the form of "ALE benefits," which pay for "additional living expenses." Additional

living expenses are those expenses the homeowner encounters as a direct result of not being able to use his or her home. Among other possibilities, these expenses may include the cost of meals and temporary lodging.

A lesser-known benefit is available to landlords when a rented portion of the residence premises becomes unusable. This benefit reimburses the insured for the fair rental value of a dwelling until necessary repairs are completed.

Some insurers limit benefits under Coverage D to a set percentage of Coverage A. When a dollar limit is used, it is often equal to 20 percent of the dwelling's insured value. So if a house is insured for $100,000, the owner will have $20,000 of coverage for loss of use. Renters and condo owners are typically entitled to loss of use coverage that is equal to 20 percent or 40 percent of their contents coverage.

Homeowners need to be aware of any time limit that the insurer imposes on loss of use benefits. Although some insurers will honor loss of use claims until the insured has either moved into a permanent residence or until benefits have exceeded a particular dollar amount, some carriers will also start denying those claims after a year or two. This can be particularly problematic for homeowners who are intent on rebuilding after a total loss. If a contractor is hard to find or falls terribly behind schedule, the insured might need temporary housing beyond Coverage D's time limit.

On the positive side though, the benefits made possible through Coverage D do not end simply because the policy's term has expired. Homeowners are entitled to receive these benefits after the policy's expiration date, as long as the damage to the residence premises occurred while the insurance was in force.

Before moving on to other portions of the standard policy, let's examine ALE benefits in greater detail.

Additional Living Expenses

Barring other specific limits, additional living expenses will be covered for the reasonable amount of time it would take to either repair the damaged dwelling or move permanently to a new one. During this time, homeowners are reimbursed only for the difference between their pre-loss and post-loss expenses. So if a family spent $400 each month on food prior to losing their home and has spent $600 each month since then, the carrier will reimburse the family for the extra $200. The other $400 will not be considered an additional living expense.

ALE benefits may also be reduced by the amount of expenses that are eliminated by a loss of use. If an insured is spending an extra $800 dollars on temporary housing but is no longer spending $100 on utilities, the carrier might knock the reimbursable portion of the housing costs down to $700.

ALE benefits are designed to help homeowners and their families maintain their standard of living. This is a particularly important point when a displaced individual is looking for a temporary place to live. A family of four, for example, will not be forced by the carrier to move from a two-bedroom house into a studio apartment. Likewise, the carrier will probably not cover the cost of moving from a three-room unit to a multi-story house.

Beyond housing, ALE benefits can help pay for food, utilities and storage costs. They might even reimburse people for transportation expenses if they need to travel farther than usual to get to work. But even though the ALE section of most policies does not contain any specific exclusions, that hardly means all goods and services will be covered. In a 2005 look at crime risks, for example, the trade publication Best's Review examined ALE benefits and said an insured would probably not have coverage for emotional counseling or temporary housing after a burglary.

Acts of Civil Authority

Pretend you and your family are driving back home after a vacation. You're ready to turn down your street when you notice police officers and barricades blocking your way. After getting out of your car, you're told that there was a serious fire in the neighborhood. Your home, you learn, was not seriously damaged, but you are forbidden from accessing the residence until local authorities have completed an investigation.

Situations like this are said to involve "acts of civil authority." An act of civil authority, just like major damage to a dwelling, can produce additional living expenses, such as the cost of food and lodging. Luckily for affected policyholders, these expenses are covered by homeowners insurance.

The standard policy pays additional living expenses for up to two weeks when the insured's dwelling becomes inaccessible because of damage to a nearby structure. The damage must be caused by a peril that is covered by the insurance policy. If the damage makes the rented portion of a dwelling inaccessible, the homeowner may be entitled to the property's fair rental value on a prorated level for up to two weeks.

Coverage E

Coverage E is an important yet often overlooked component of a homeowners insurance policy. It provides personal liability insurance to the homeowner and other insureds in the amount of $100,000 or more.

This insurance applies when a third party accuses the insured of being negligent and causing accidental harm to the person or the person's property. As simple as that may sound, properly understanding the applicability of Coverage E requires us to address several factors.

The first factor we need to cover is "negligence." In general, a person who acts negligently does not take reasonable steps to ensure the safety of other people or their property. Depending on the circumstances, a homeowner might be considered negligent if he or she allows ice to form on the residence premises and a visitor slips on it. Similarly, the insured might be termed negligent if the insured's dog is allowed to roam free and attacks a stranger.

The insured's alleged negligence needs to have resulted in loss or damage to property or in bodily injury to the third party. In the case of property damage, the third party's property needs to have been broken, devalued or made unusable in some way. According to policy language used by the ISO, bodily injury must involve "bodily harm, sickness or disease, including required care, loss of services and death."

The personal liability insurance made possible through Coverage E can pertain to an insured's alleged negligence anywhere in the world, with a few exceptions. The worldwide reach of the coverage seems to be applicable when the alleged damage is tied to the insured's actions. So if an insured accidentally breaks someone's nose by hitting the person with an errant baseball, he or she should be covered for the damages no matter if the incident occurs in the insured's backyard or at a park across the country.

Geography does matter when damages aren't caused directly by the insured but are related to conditions at a particular location. Suppose a person owns a house and a condo and has only insured the house. If the person throws a party at the condo and

a guest has a serious fall there and sues, the owner might not be covered by homeowners insurance. In this situation, coverage might only be possible if insurance for the house was purchased before the owner bought the condo.

Benefits remain available to an insured when the damage arises out of a location that the insured is renting temporarily for non-business purposes. Under the right conditions, for example, the policy could be used to cover injuries in an insured's hotel room or at a banquet hall that the insured has rented.

Damage to Other People's Property

Major claims for benefits under Coverage E often involve cases in which bodily harm has been done to another person. However, a homeowner can also file claims under Coverage E when he or she has damaged another person's property.

The standard homeowners insurance policy provides up to $1,000 (sometimes $500) to cover the replacement cost of another person's damaged property even if there hasn't been any negligence. This provision allows benefits to be paid to the owner of the damaged property regardless of whether the insured is technically at fault. The insurance can even be used to pay damages caused by the intentional acts of an insured who is younger than 13. So if a homeowner's young son intentionally hurls a ball at a neighbor's garage or window and damages the neighbor's property, the parent's insurance company will pay to repair the damage.

Beyond those $1,000 or so, damage caused by an insured to another person's property might not be covered unless the insured has been negligent.

Personal Liability Exclusions

The Coverage E portion of a homeowners insurance policy contains several significant exclusions. To prevent conflicts at claim time, insurance producers might want to discuss these exclusions with buyers before a policy is ever issued.

Homeowners should remember that Coverage E only gives them personal liability insurance. It does not help them manage professional liability risks or business liability risks. If homeowners injure another person or damage another person's property during the course of conducting business or rendering professional services, they are unlikely to be protected by their homeowners insurance in any way. In order to address those kinds of risks, they will need to purchase other insurance products.

Coverage E also does not help the insured deal with liability claims not related to bodily injury or property damage. Therefore, if a person is fearful of being sued for libel, slander or invasion of privacy, homeowners insurance is not the solution to the problem.

In some cases, the personal liability insurance will be worthless, depending on how the insured caused bodily injury or property damage. A homeowner is not insured for personal liability when the injury or damage is linked to sexual, physical or mental abuse of another person. Also, as a result of AIDS-related lawsuits in the 1980s and '90s, homeowners insurance no longer pays claims for bodily harm when an insured is liable for the spread of a communicable disease. Claims related to the use, creation, possession, delivery or sale of controlled substances will also be denied, including those linked to marijuana, cocaine and LSD.

Sometimes, even the identity of the wronged party in a liability dispute is important to the insurance company. Although Coverage E can be used to cover losses sustained by a guest at a residence premises, it does not cover losses sustained by another insured.

Underwriting for Personal Liability

Because most major kinds of personal liability disputes tend to involve an auto accident or a workplace situation (neither of which would be covered by homeowners insurance), Coverage E is usually not something that makes homeowners insurance unaffordable or hard to obtain. Still, some insurers tightened their underwriting guidelines in recent years and have been hesitant to offer inexpensive homeowners insurance to certain kinds of property owners.

Homeowners insurance is occasionally hard to find for people who own property that could create a safety hazard for nearby residents. Specifically, insurers have been known to underwrite with extra care when a current or prospective policyholder has a pool or trampoline.

Depending on the insurer, a person's eligibility for affordable coverage might be enhanced if the homeowner complies with reasonable safety guidelines. For example, if a homeowner insists on owning a pool, the insurer might demand that the pool not feature a diving board. If a homeowner wants to keep a trampoline in his backyard, the insurer might want the person to keep unattended children off of the premises by erecting a high fence.

Personal Umbrella Policies

If a homeowner feels especially vulnerable to a major liability claim, a "personal umbrella policy" might give the person some comfort. A personal umbrella policy is excess liability insurance that kicks in when a person's primary insurance policies have reached their limits. It also fills in some of the circumstantial coverage gaps that exist in many homeowners insurance policies. It usually insures the policyholder against $1 million in damages or more.

Umbrella policies provide relatively inexpensive insurance protection, but coverage is conditional in some respects. For the umbrella policy to pick up where the primary policy left off, the insured needs to remain covered by a company-mandated amount of primary liability insurance. If the insured allows the required amount of primary coverage to lapse, the insured's out-of-pocket expenses from a lawsuit are likely to be very high.

Defense Costs

With the price of defending oneself in court so high these days, it is important for an insured to know that defense costs are included in nearly all homeowners insurance policies. The insurer has a duty to defend the inured in court, no matter if the suit against the person is legitimate or frivolous. The money to pay for this defense comes out of the insurance company's pocket and generally will not run out until the insurer has paid settlement costs or damages in an amount equal to Coverage E's limit of liability.

Unlike some other kinds of insurance contracts, homeowners insurance policies allow the insurance company to select the legal team that will handle the insured's defense. They also give the insurer the power to settle a liability dispute at a time of its own choosing and conduct its own investigation of the situation. When an insured participates in the investigation or in the defense process, the insurance company will reimburse the person for lost income up to $250 per day.

The insurer's obligation to pay defense costs is usually greater than its obligation to pay damages or settlement costs. To

demonstrate this point, let's imagine a situation in which a homeowner has been sued because of someone else's death. If a court were to rule that the death resulted from the homeowner's intentional acts, the insurance company would probably be within its rights to deny any claims for damages or settlement costs. However, until it is clear that the homeowner's acts were indeed intentional, the carrier would likely be responsible for handling defense costs.

Some courts have allowed insurers to deny coverage of defense costs in situations like the one mentioned above, but many of those rulings have been reversed on appeal. At the very least, insurance professionals should realize that denying defense coverage to homeowners is not an easy thing to do.

Coverage F

The sixth major type of coverage found in homeowners insurance policies is "Coverage F." Coverage F provides up to $1,000 for medical expenses when a third party is injured by the insured or on the insured's property. It covers these expenses regardless of whether the insured is at fault.

The $1,000 of coverage made available through Coverage F can be applied to medical expenses that an injured third party incurs within three years after an accident. The $1,000 can be used to pay for any of the following:

- Private nursing.
- Hospitalization.
- Ambulance services.
- X-rays.
- Dental work.
- Physician services.
- Surgery.
- Prosthetic devices.
- Funeral expenses.

Coverage F is only intended to pay for expenses that are indisputably medical in nature. It is not designed to reimburse an injured third party for non-medical losses, such as any loss of income while a victim recovers from an injury.

In order for an insurer to authorize benefits under Coverage F, at least one of the following circumstances must apply:

- The person was injured while on the insured's property and was not guilty of trespassing.
- The person was injured directly by the insured or the insured's activities.
- The person was injured by the insured's household employee while the employee was fulfilling his or her job duties.
- The person was injured by an insured's pet.
- The person was injured near the insured's property because of the condition of the insured's property. (In this case, think of a tree with hazardous branches that extend into a neighbor's yard.)

Coverage F cannot be used as medical insurance for anyone who is considered an insured by the insurance company. So if a husband is mopping his kitchen floor and his wife slips and injures herself, the wife's medical expenses will not be covered by homeowners insurance. Injuries sustained by an insured's domestic employees might represent exceptions to this exclusion, but the insurer will still refuse to pay any expenses when an alternative form of reimbursement is available through disability laws or workers compensation laws.

Common Coverage Forms

Up until now, we have studied homeowners insurance policies and their corresponding terms and conditions in a very general sense. However, consumers need to realize there are several distinct variations on the typical homeowners insurance policy.

Most property insurance companies in the United States use homeowners insurance policies with language written by the Insurance Services Offices (ISO). The ISO's standard policies have names that feature the letters "HO" followed by a number. In theory, a person could purchase an HO-1, HO-2, HO-3, HO-4, HO-5, HO-6, HO-7 or HO-8 policy.

Some property insurance companies do not base their policies on ISO language. Alternatively, they might use terms and conditions authored by the American Association of Insurance Services (AAIS). In Texas, the names of homeowners insurance policies contain the letters "HO" followed by another letter of the alphabet.

Because the ISO's policy forms are much more common than AAIS forms, the information in this course was derived from common interpretations of ISO language. Before heading deeper into specific contractual language, let's summarize the most commonly recognized homeowners forms from the ISO.

HO-1

The HO-1 policy form is sometimes referred to as the "basic form." Rarely sold these days, it insures the homeowner's property against fewer perils than the typical homeowners policy, and it contains very broad exclusions by comparison.

An insurance policy modeled after the ISO's HO-1 form insures the homeowner against property losses caused by the following perils:

- Fire.
- Lightning.
- Wind.
- Hail.
- Explosion.
- Riot and civil commotion.
- Aircraft.
- Vehicles.
- Smoke.
- Vandalism and malicious mischief.
- Theft.
- Volcanic eruptions.

As mentioned earlier, the dwelling's insured value represents the dollar limit for Coverage A, and many of the policy's other dollar limits are based on this number. With an HO-1 policy in force, detached structures are covered for 10 percent of Coverage A. Coverage of contents is equal to 50 percent of Coverage A. Loss of use coverage is equal to 10 percent of Coverage A.

HO-2

The HO-2 policy form is sometimes referred to as the "broad form." This policy is fairly popular and insures the homeowner against property losses caused by many common perils. In addition to covering losses brought on by all the perils mentioned in the HO-1 form, the HO-2 form reimburses the insured for losses related to the following:

- Falling objects.
- Weight of ice, snow or sleet.
- Accidental discharge of water or steam.
- Accidental overflow of water or steam.

- Freezing.
- Sudden and accidental tearing, cracking, burning or bulging of heating, air conditioning, water or steam systems.
- Sudden and accidental discharge from artificially generated electrical current.

With an HO-2 policy in force, detached structures are covered for 10 percent of Coverage A. Coverage of contents is equal to 50 percent of Coverage A. Loss of use coverage is equal to 20 percent of Coverage A.

HO-3

The HO-3 policy form is sometimes referred to as the "special form." It is generally considered the standard version of modern homeowners insurance. When phrases such as "the typical policy" and "the standard policy" are used in this chapter, the reader should infer that we are talking about the HO-3 policy form.

Unlike previously mentioned homeowners forms, the HO-3 form covers the insured dwelling and detached structures on an "all-risk" basis. This means a loss will be covered by the policy unless the insurance contract specifically excludes it. Simply put, an all-risk policy is as comprehensive as insurance tends to get.

When explaining the positive features within HO-3 policies, insurance producers sometimes forget to mention that the all-risk coverage applies only to the dwelling and detached structures. By default, HO-3 policies cover personal property on a "named-peril" basis just like HO-1 policies and HO-2 policies. This means a loss pertaining to personal property will only be covered if it has been caused by a peril specifically mentioned as a covered peril in the insurance contract. With respect to personal property, the covered perils in an HO-3 policy are basically the same as those in an HO-2 policy.

With an HO-3 policy in force, detached structures are covered for 10 percent of Coverage A. Coverage of contents is equal to 50 percent of Coverage A. Loss of use coverage is equal to 20 percent of Coverage A.

HO-4

The majority of residential tenants do not have renters insurance. However, this insurance can be an important element of proper risk management for millions of consumers.

Contrary to popular belief, a renter's personal property is generally not covered by the landlord's insurance policy. This is true no matter if damage to the property is caused by the property's owner or by another tenant in the same building.

From a liability standpoint, tenants without renters insurance might have to pay out of pocket for legal services and court-awarded damages if they are ever sued by a third party. While a landlord might still be held liable for slip-and-fall injuries on the property's steps, adjoining sidewalks or common areas, a renter can be held liable for similar injuries suffered inside his or her portion of the residence premises. The renter might also be liable for hazards—such as a fire—that start in his or her portion of the premises and spread far enough to damage another tenant's property.

All these potential problems may be managed through the HO-4 policy form, which is used to insure renters and their belongings. The HO-4 policy form insures personal property against the same perils named in the HO-2 form. But the typical renters insurance policy is different from other homeowners policies in several respects.

The most significant difference between HO-4 policies and the other forms we've previously discussed is that the HO-4 policy's emphasis is on contents coverage rather than on dwelling coverage. This makes sense because the responsibility of maintaining the building and fixing structural problems usually belongs to the landlord. Instead of expressing the dollar limit for contents coverage as a percentage of Coverage A, a renters policy is meant to provide as much contents coverage as the tenant wants. It also often provides personal liability protection.

Despite its emphasis on contents coverage, a renters policy may contain a very limited amount of dwelling insurance. This coverage can be used to reimburse tenants when they have made improvements or additions to their rented dwelling and suffer damage to those improvements or additions. This insurance can only be utilized if the tenant paid for the improvements or additions and has not been reimbursed by the landlord.

If a person shares a rented dwelling with a roommate who is a non-relative, his or her renters policy probably does not cover the roommate's belongings or the roommate's liability. Policies that jointly cover non-related residents of the same dwelling can be obtained from some insurance companies upon request.

The HO-4 policy form is for renters and not for landlords. But that doesn't mean landlords will receive no insurance benefits when a loss occurs entirely within the privately rented portion of their building. Many homeowners insurance policies cover a landlord's furnishings in rented rooms, rented homes or rented apartments for up to $2,500. Covered furnishings may include appliances and carpeting. This insurance does not apply when a landlord's furnishings have been stolen.

With an HO-4 policy in force, the tenant's improvements or additions to the rented portion of the dwelling are covered for 10 percent of Coverage C. Loss of use coverage is equal to 20 percent of Coverage C.

HO-5

The HO-5 policy form gives the insured all-risk coverage for both the dwelling and personal property. As good as that may sound, HO-5 policies can be very expensive.

If a person prefers all-risk coverage for both the dwelling and its contents, the insurer will probably not even bother selling the person an HO-5 policy. Instead, the all-risk coverage for personal property will simply be added onto an HO-3 policy for an additional cost.

HO-6

Condominiums and townhouses are covered by a "master policy," which is purchased by an elected association on behalf of all residents at the complex. The master policy will cover damages to a building's exterior, as well as common areas such as basements and hallways. The extent to which the master policy insures each individual unit is left up to the association.

The portions of each unit that are not insured by the master policy will be disclosed in the association's bylaws or in similar documents. At the very least, the policy ought to cover the unit's walls, ceiling and floors.

Those parts of the unit that aren't covered by the master policy are the individual owner's responsibility. Of course, each individual owner is also responsible for obtaining his or her own insurance for personal property and personal liability.

To address the concerns of condo dwellers and townhouse owners, insurance companies sell policies based on the HO-6 form, also known as the "unit-owners" form. The unit-owners form features named-peril coverage for the insured's personal property and a little bit of named-peril coverage for the unit itself. The named perils in an HO-6 policy are the same as those in an HO-2 policy.

With an HO-6 policy in force, the unit and detached structures are often covered by default for $1,000. Loss of use coverage is equal to 40 percent of Coverage C.

HO-7

HO-7 policies are meant to insure mobile homes, which can also be covered by adding endorsements to other homeowners forms. Because HO-7 policies are rarely mentioned in the same breath as other homeowners forms, they will not be addressed at any other point in this chapter.

HO-8

The HO-8 policy form is sometimes known as the "modified" form. It is not used in all states and is typically used to cover older homes in urban areas when the dwelling's market value is considerably lower than its replacement cost.

In many ways, the coverage available through an HO-8 policy is identical to the coverage in an HO-1 policy. However, in a very important difference, HO-8 policies cover the dwelling only up to its actual cash value. Unlike the HO-2, HO-3 and HO-5 forms, they do not insure the dwelling up to its replacement cost.

In general, actual cash value is the property's replacement cost minus depreciation. A few states have multiple definitions of "actual cash value" with regard to dwellings. In California, for example, actual cash value generally means replacement cost minus depreciation. But if a dwelling in that state is covered for actual cash value and is completely destroyed, the owner might receive the dwelling's fair market value or the policy's dollar limit, whichever is less.

Unlike all other common kinds of homeowners policy forms, the HO-8 form limits coverage of theft to $1,000 per occurrence, and it generally does not cover instances of theft in a place other than the residence premises.

With an HO-8 policy in force, detached structures are covered for 10 percent of Coverage A. Coverage of contents is equal to 50 percent of Coverage A. Loss of use coverage is equal to 10 percent of Coverage A.

Replacement Cost v. Actual Cash Value

Most homeowners insurance policies cover buildings up to their "replacement cost" and cover contents up to their "actual cash value." The dwelling's replacement cost is the amount it would take to rebuild a new dwelling of like kind and quality in the same general area as the existing dwelling. Though the new dwelling and the old dwelling do not need to be identical in every little way, the essential features must be the same.

An item's "actual cash value" is its replacement cost minus depreciation. The actual cash value may be determined by taking the replacement cost and multiplying it by the amount of time the item would otherwise be expected to last. Pretend a new stereo costs $800 and is expected to last 10 years. If the insured has owned a similar stereo for five years (50 percent of 10 years) and loses it in a fire, the insurer might calculate the item's replacement cost as $400 (50 percent of $800).

In the event of a partial loss (such as damage to only one part of a dwelling), actual cash value would be calculated by subtracting depreciation from the replacement cost of only the affected parts of the property. Pretend a storm has only damaged a dwelling's five-year-old roof. If a new roof costs $10,000 and is expected to last 10 years, the roof's actual cash value immediately prior to the storm would have been approximately $5,000.

A few states have multiple definitions of "actual cash value" with regard to homeowners insurance. However, if a dwelling in that state is covered for actual cash value and is completely destroyed, the owner will receive the dwelling's fair market value or the policy's dollar limit, whichever is less.

Although most dwellings are insured with replacement cost coverage rather than with actual cash value coverage, understanding the actual cash value can still be important because it is the amount that most insurers will provide until damage has been fixed. After repairs at the home have been completed, the policyholder will receive the difference between the replacement cost and the actual cash value.

Replacing the Dwelling

Until roughly a decade ago, homeowners had the ability to insure their dwelling at "guaranteed replacement cost." This meant that the insurer would pay to replace the entire dwelling even if the cost was higher than the policy's Coverage A limit. If the price of building materials created a situation in which it cost $120,000 to replace a home that was insured for $100,000, the extra $20,000 would be picked up by the insurance company.

An assortment of catastrophes in the 1990s made it tougher to obtain guaranteed replacement coverage. Instead, insurers offered "extended replacement coverage," This insurance will still provide some extra coverage when the cost of replacing the dwelling is larger than the policy's Coverage A limit. However, extended replacement benefits are capped, often at 120 percent or 125 percent of the Coverage A limit. If a person has insured a home for $100,000 and has extended replacement coverage that caps benefits at 125 percent, the insurer will pay up to $125,000 to replace the dwelling. Any costs beyond $125,000 will be the owner's responsibility.

The disappearance of guaranteed replacement coverage has made it increasingly important for homeowners to be mindful of their dwelling's replacement cost. Although the insurer should be able to determine the proper replacement cost when the policy is first issued, it is up to the buyer to seek additional coverage when the home's replacement value rises.

One basic way to estimate a dwelling's replacement cost is to find out the average cost to build one square foot of property and then apply that figure to the building's size. Producers should keep in mind, though, that rebuilding costs can vary significantly by ZIP Code and that the square-footage method might not provide an accurate result when the dwelling is an antique-style home that differs from other structures in the area. To better calculate replacement costs, many insurers now engage in "total component estimating," which tries to address the uniqueness of each dwelling.

If a homeowner is concerned about the continued accuracy of the dwelling's replacement cost, helpful endorsements can be added to the policy. To guard against increases in local building costs, the insured can opt for "inflation protection." This feature will recalculate the dwelling's insured value on a regular basis and may increase the policy's Coverage A limit by a few percentage points. It's also possible to obtain a "demand surge

endorsement," which can go into effect when construction prices rise after a catastrophic event.

Even with some form of replacement cost coverage in place, the insured will need to repair or replace the damaged property in order to receive a check for the full replacement cost. Until the dwelling has been repaired or replaced, the insurer will only provide compensation up to the property's actual cash value. Insurers make an exception to this rule when the cost of repairs or replacements is less than 5 percent of the dwelling's insured value and less than $2,500.

Replacing Contents

Though contents are usually covered up to their actual cash value, replacement cost coverage may be available for the right price. Due to their uniqueness, paintings and antiques might not be eligible for replacement cost coverage.

Many years ago, insurance companies that covered personal property on a replacement-cost basis would actually secure a replacement item for the insured. These days, some insurers will still offer to replace certain items, such as jewelry, by purchasing them at a wholesale price. But most U.S. carriers just write checks to cover personal property losses.

An insured can cash a carrier's check for an item's actual cash value and use that money in any way. Still, if the person expects to receive a second check for the difference between the actual cash value and the replacement cost, proof of replacement will be necessary.

Coinsurance Clauses

When consumers decide how much replacement cost coverage to purchase for their dwelling, they need to think about more than just the possibility of a total loss. Smaller losses will not be covered in full if the amount of replacement cost insurance is less than the amount listed in the policy's "coinsurance clause." In order to differentiate it from the slightly different coinsurance requirements in commercial policies, a coinsurance clause in a homeowners insurance policy is often called an "insurance to value provision."

The coinsurance clause in a homeowners policy gives people an extra incentive to adequately insure their dwellings. The clause is basically the insurance industry's way of acknowledging that small claims are more common than large claims and that people should buy more insurance in order to make small claims less burdensome for everyone.

The typical homeowners insurance policy has a coinsurance clause that requires the insured to cover a dwelling for at least 80 percent of its replacement cost. In this context, the replacement cost would be the cost of rebuilding a similar structure on the same spot at the time of the claim. This is an important point because a person who insures a home at only 80 percent of its replacement cost at the time of purchase will not satisfy the policy's coinsurance requirement if construction costs increase over time. If the person were to suffer a loss, he or she would probably be looking at some steep out-of-pocket expenses.

If a homeowner does not insure the dwelling for at least 80 percent of its replacement cost and suffers a partial loss, the insurer will not reimburse the insured for the entire loss. Instead, the insured will be entitled to the actual cash value of the damaged portion of the property or an amount that is prorated based on how close the person is to meeting the coinsurance requirement. The larger of these two figures will be paid by the insurance company. The rest of the loss will not be covered.

Some Coinsurance Examples

Even for insurance veterans, coinsurance clauses can be confusing. Let's look at a few examples of how this kind of clause might affect a homeowner.

Sally purchased replacement cost coverage for her home in the amount of $80,000. After a fire, it was determined that the cost to replace the home would have been $100,000. Since Sally's amount of replacement cost coverage ($80,000) was equal to 80 percent of the home's replacement cost ($100,000 × 80% = $80,000), she met her coinsurance requirement and had her claim paid in full, up to her Coverage A limit.

Jim purchased replacement cost coverage for his home in the amount of $175,000. After a windstorm damaged the dwelling's roof, it was determined that the cost to replace the home would have been $200,000. Since Jim's amount of replacement cost coverage ($175,000) was greater than 80 percent of the home's replacement cost ($200,000 × 80% = $160,000), he met his coinsurance requirement and had his claim paid in full, up to his Coverage A limit.

Mark purchased replacement cost coverage for his home in the amount of $300,000. After a major hailstorm, it was determined that the cost to replace the home would have been $500,000. Since Mark's amount of replacement cost coverage ($300,000) was less than 80 percent of the home's replacement cost ($500,000 × 80% = $400,000), he did not meet his coinsurance requirement and was only covered for a portion of his losses.

Pro-Rated Settlements

When a settlement is pro-rated because of a failure to satisfy coinsurance requirements, an insurance professional can look at the coinsurance clause, plug in the appropriate numbers and determine the amount, in dollars, the insurance company will pay to the policyholder.

To determine the covered portion of a loss, we must first determine the size, in dollars, of the coinsurance requirement. This is accomplished by multiplying the 80 percent coinsurance requirement by the home's replacement cost at claim time. So, for our friend Mark, we would multiply 80 percent by $500,000 and get a result of $400,000.

In the next step, we need to divide the amount of purchased replacement cost coverage by the size of the coinsurance requirement in dollars. For Mark, we would divide $300,000 by $400,000 and get a result of 0.75. This means Mark would be covered for no more than 75 percent of any losses to the dwelling except after a total loss.

Now all we have to do is multiply our answer from the previous step by the actual loss. Suppose the hailstorm caused $40,000 of damage to Mark's building. His insurance company would multiply $40,000 by 75 percent and get a result of $30,000.

Unless the actual cash value of the damaged portion of the property is greater than $30,000, this is the amount Mark will receive from his insurance company. The remaining $10,000 would be considered an uninsured loss.

The preceding steps can be summarized in the form of the following equation:

- Pro-rated settlement = [Coverage A limit ÷ (80 percent × replacement cost at claim time)] × actual loss

As important as the coinsurance clause sometimes is, it is often only a factor when there is partial damage to a building. It is often not applicable when a building is completely destroyed, and it

does not impact coverage of contents, additional living expenses or personal liability claims. The clause does not exist in H0-4, HO-6 or HO-8 policy forms.

Peril-Specific Information

Now that we've reviewed the basics of the most common homeowners forms, let's get a little more specific and look at how these forms address specific perils.

Water Damage

Coverage of water damage is probably the least understood aspect of homeowners insurance. Even after all the legal back and forth between homeowners and insurers following Hurricane Katrina, roughly one-third of households still believe incorrectly that they are covered for flood losses by way of their homeowners insurance.

Let's briefly mention those kinds of water-related losses that are generally excluded from the standard policy. They include losses caused by the following:

- Flood.
- Surface water.
- Water backup from sewers, drains or sump pumps.
- Foundation seepage.
- Hydrostatic pressure.
- Ignored wear and tear.

Though small leaks that go unaddressed and cause property damage are considered a form of wear and tear and are not covered by homeowners insurance, policyholders are insured against damage from sudden leaks and overflows. Homeowners can be reimbursed for their losses when there is sudden accidental discharge or overflow of water from a plumbing system, air conditioning system, heating system, sprinkler system or an appliance. Damage stemming from a burst pipe or overflowing toilet, for example, should be covered under many circumstances.

It may also be possible for the homeowner to be reimbursed for the cost of tearing out a portion of the dwelling in order to repair the cause of water damage. Depending on the policy, the insured might not be compensated for costs that do not relate to tearing up a part of the dwelling and relate only to fixing the faulty system or appliance.

Sudden kinds of water damage are excluded from coverage if the homeowner has not taken reasonable steps to prevent a major loss. Depending on the policy and the nature of the damage, these reasonable steps can pertain to the temperature in the dwelling at the time of the loss. For instance, damage caused by frozen pipes is generally not covered if the homeowner has not taken reasonable measures to keep the dwelling heated.

Many policies contain a "vacancy clause," which sometimes denies coverage of water damage and other losses (including freezing) when the dwelling has been vacant or unoccupied for anywhere from 30 to 60 days. This clause can sometimes be disregarded if the owner turned off the water in anticipation of the vacancy or left the home's heating system on during the vacancy. Due to a lack of uniformity even among the various ISO policy forms, the insured should examine the exact policy language related to this clause before making a claim.

Water Damage Caused by Weather

Most of the aforementioned water-damage exclusions involve man-made problems, wear and tear and mechanical failure. But what about water damage caused by major storms?

In most cases, a homeowners insurance policy covers damage that is caused by the weight of water or ice. The policy does not cover this kind of damage when it is done to pools, patios, sidewalks, driveways, retaining walls, fences or foundations.

When personal property is damaged by direct contact with rain, snow, sleet, sand or dust, losses are only covered if the contact was caused by an opening in the dwelling that did not exist prior to a windstorm or hailstorm. A homeowner would not be covered, for example, if rainwater were to enter his home through preexisting openings in his already run-down roof.

When a storm creates an opening in a dwelling, the insured must take reasonable steps toward minimizing the damage. These steps might include placing a tarp over a roof or moving personal property to another part of the dwelling where it is less likely to be harmed.

Mold

The existence of mold is neither new nor something that is entirely avoidable. Some amount of fungus, whether seen or unseen, is bound to eventually form when an enclosed area is subjected to moisture on a regular basis. For property insurers, though, mold has been especially bothersome in the 21st century.

To some degree, mold has become a bigger issue in recent years because of changes in building codes and construction methods. In an effort to improve insulation and reduce energy costs, builders have been tightening up the space between a home's structural elements and have made it easier for moisture to become locked inside.

Meanwhile, from a medical perspective, mold has sometimes been viewed as the new asbestos, supposedly capable of causing otherwise healthy people to become ill from continued exposure. What's worse, there are many different molds out there, and the scientific community is still not entirely sure which molds cause health problems.

As a result, some homeowners have become concerned about their personal liability in regard to mold. A few have even asked insurers to help them replace personal property that was in close proximity to the fungus. For all these reasons and more, many property insurers have either put extra limits on mold coverage or have at least toyed with the idea.

While some carriers have introduced sub-limits that apply to mold removal, many others have left their old policy language intact. In general, these companies don't cover all varieties of mold damage, but they will cover the removal of hidden mold that was caused by a covered kind of water damage. So while the insured might not be covered for mold removal after a flood, the person might be covered for mold removal after a sudden discharge of water from a plumbing system.

Water Damage and Other Perils

When losses are caused by water damage and another peril, homeowners might be surprised by what the insurer will and will not cover. Although wind is not an excluded peril in a homeowners insurance policy, many victims of Hurricane Katrina learned that their losses were not covered because damage to their homes was caused partially by floods.

On the positive side, however, a homeowner is still likely to be covered for theft if someone were to break into the dwelling after a flood. It's even possible for a policy to cover water damage that is caused by someone who is trying to extinguish a fire.

Because insurance companies tend to deal with these sorts of situations in different ways, producers are encouraged to study their policy forms carefully before discussing multi-peril losses with consumers.

Theft

All commonly used homeowners forms list theft as a covered peril. For insurance purposes, "theft" can be defined as an instance in which someone else takes possession of personal property without the owner's consent.

To the insured's benefit, theft does not need to be proven in order for the loss to be covered. It only needs to be the most logical explanation as to why property has disappeared. For instance, although an insurer could argue that something small like a diamond ring has been merely misplaced rather than stolen, the insurer would consider a missing grand piano to be stolen even if there were no other signs of forced entry at the residence premises.

In spite of that flexibility, there are several limits to theft coverage that the consumer should be aware of. For one, the fate of a theft claim might depend on the likely crook's identity. The standard policy does not cover the loss when an insured's property is stolen by another insured.

The insurer will also want to know where the theft took place. In general, losses are not covered if theft occurred at any of the following locations:

- A portion of the residence premises that is rented to a non-insured.
- The site of the residence premises if the residence premises is still under construction.
- Another residence that is owned, rented or used by the insured but is not currently being lived in by the insured.

That last exclusion may create some serious coverage gaps for people who own more than one home, but it usually includes some leeway for students. When a student lives away from home during the school year, theft at the school-year residence is covered by homeowners insurance as long as the student occupied the school-year residence within 45 or 60 days prior to the theft. Producers should study their company's policy forms in order to fully understand these residency requirements.

Depending on the policy form and the exact items that have been stolen, coverage of theft might be limited to a specific dollar amount. Types of personal property that may not be entirely covered against theft include jewelry, furs and firearms. Theft of campers, trailers and watercrafts is not covered at all if it occurs off the residence premises.

Purchasers of HO-8 policies should be made aware of the fact that their policy only covers theft for up to $1,000 per occurrence. An HO-8 policy might also exclude coverage of theft that occurs beyond the residence premises.

Recovered Items

As unlikely as it may seem, there really are times when stolen property is recovered by law enforcement or some other party. When this happens, the insurer and the recipient of insurance benefits are usually obligated to contact each other. The insured can then choose one of two options: Either the insured can return the insurance money and retain ownership of the recovered property, or the insured can keep the money and pass ownership of the property along to the insurance company. These options are usually spelled out in the policy's "recovered property" clause.

Vandalism and Malicious Mischief

Vandalism and malicious mischief are said to have occurred when someone has done intentional damage to another person's building or belongings. The standard homeowners policy insures the policyholder against vandalism to the dwelling and to contents.

The insurer can void vandalism coverage for the dwelling when the dwelling has been vacant for an extended period of time (usually a month or two). However, a building is not "vacant" just because it is unoccupied. In general, the dwelling is considered vacant only when no one lives there and only when it no longer stores people's personal property. The policy also makes it clear that a dwelling is not vacant if it is still under construction.

Fire and Smoke

Homeowners policies do not define the word "fire," but insurance professionals and legal experts generally agree that coverage only applies to fires that have the following characteristics:

- The fire involves a visible flame.
- The fire was either unintentional or was at least unintentionally allowed to spread beyond the confines of safety. (Since a fire in a fireplace is within its proper confines, the insured might not be covered if personal property were to accidentally fall into the flames.)

As for smoke, consumers who own fireplaces and opt for basic coverage should read their policy. Though other policy forms usually provide coverage of smoke damage stemming from the use of a fireplace, HO-1 policies exclude this kind of loss.

Windstorms

In order to reduce their exposure to risk after Hurricane Andrew, many insurers in coastal states added windstorm deductibles to their homeowners insurance policies. The amounts and triggers of these deductibles may vary significantly from one policy to the next. Whereas one insurer's wind deductible might apply to any kind of windstorm, another carrier might only enforce the deductible after a hurricane. A report on the subject by National Underwriter showed some deductibles were triggered when winds reached a specific speed, when a windstorm lasted for a particular length of time or when winds of a particular speed were detected within a specific distance from an insured's property.

Windstorm deductibles are typically listed as a set percentage of a dwelling's insured value. If a homeowner has insured a home for $100,000 and has a windstorm deductible of 5 percent, he or she will end up paying out of pocket for any portion of wind-related losses that does not exceed $5,000.

The Insurance Information Institute has said insurance consumers may be eligible for flat, dollar-based wind deductibles if they pay an additional premium. Some companies might even agree to drop the windstorm deductible altogether if the owner retrofits a home in a manner that satisfies various structural requirements.

Windstorm Coverage From the States

With windstorm disasters being so costly over the past 20 years, it's no wonder many private carriers have been hesitant to cover homes in high-risk areas. At one time or another, homeowners in many states have found that insurance companies will either refuse to sell property insurance to them or only provide policies that do not list wind as a covered peril.

For residents of these communities, these shortages have created some obvious problems. Affected property owners aren't

just unprotected against significant losses; they also may be in violation of their mortgage lending agreement.

In response to such predicaments, many states have established insurers of last resort for high-risk homeowners. These state-initiated entities may provide comprehensive homeowners insurance coverage to area residents, or they might simply cover the windstorm risks that have been refused by private insurance carriers.

Regardless of which specific perils they cover, these insurers of last resort usually charge consumers higher premiums than private insurers. The higher premiums reflect not only the insured property's high risk potential, but also these entities' general desire to avoid competing with private carriers. Wind-prone states with a government-initiated insurer of last resort include Florida, Texas and Mississippi.

Collapse

In most cases, policy language defines "collapse" to mean an instance in which all or part of a building falls down or caves in and becomes uninhabitable. The term generally does not apply when visible bulging, shrinking or cracking has merely made collapse a possibility. It also is not used to mean a situation in which a building has been broken into separate pieces but is still standing.

Homeowners insurance covers losses that are caused by collapse if the collapse is due to a peril listed in the personal property section of the policy. Such losses are also covered when they are brought on by hidden decay, hidden damage caused by insects or vermin, the weight of animals, people or property or the weight of rain on a roof. Collapse caused by improper construction may be covered if the collapse occurs during the construction stage.

For the victim of a hurricane or tornado, these assorted provisions and exclusions mean that a dwelling's collapse will be covered if it is caused by the force of wind or by the weight of debris that has been blown onto the building. Collapse after a hurricane is not covered when it has been aided by the force of flood waters. To insure against that kind of loss, a homeowner will need to purchase flood insurance.

Aircrafts

The creators of homeowners insurance were kind to people who don't own airplanes and unsympathetic to the people who do. A person's dwelling and personal property are insured if they are damaged in any way by an aircraft. However, aircrafts and their parts (whether they are attached to a craft or not) are not covered under any section of the various policy forms. The only crafts that escape this exclusion are hobby or model crafts that do not carry people or things.

In similar fashion, coverages E and F specifically exclude nearly all liability claims that pertain to aircrafts. Coverage is only possible when the liability claim relates to an injured residence employee who was performing his or her job duties at the time of the loss.

Falling Objects

The dwelling is covered if it is damaged by a falling object, be it a tree, a spacecraft or some other item. Personal property that is damaged by these objects will only be covered if the dwelling's roof or exterior walls were also affected by the fall. So, while a homeowner might be covered if a tree were to fall through his roof and damage some of his belongings, he might not be covered if he were to accidentally drop an air conditioner on his antique coffee table.

Power Outages and Electrical Surges

Losses brought on by power failures are not covered by homeowners insurance unless an outage is caused by a covered peril that has struck the residence premises. For example, it's possible that coverage would apply if the failure was caused by a lightning bolt that hit near the dwelling. But the homeowner would not receive any compensation if the failure was caused by a problem at the local utility company.

Although homeowners insurance usually lists artificially generated electrical current as a covered peril, the practical benefits of this coverage can be very narrow. The standard policy does not cover electrical damage to tubes, transistors or circuits within computers or appliances.

We will not go into detail about them here, but riders can be purchased in order to expand coverage of power failures and electrical surges. When consumers buy these products, they often do so with intent to insure their personal computers or perishable items.

Earth Movement and Volcanic Eruptions

"Earth movement" is a broad term that can be used to describe earthquakes, mudslides, landslides and the formation of sinkholes. Damage caused directly by earth movement and nothing else is excluded from coverage in all the standard ISO policy forms. Still, homeowners receive some compensation when earth movement is followed by any of the following:

- Fire.
- Theft.
- Explosion.
- Breakage of glass.

Though damage is covered when it is caused by a volcanic eruption, covered property usually must be exposed to a harmful amount of ash or lava. Losses from any tremors or quakes that precede, accompany or follow a volcanic eruption are not covered. For the purpose of determining a deductible, the insurance company will consider all eruptions that occur within 72 hours of one other to be a single occurrence.

War

Homeowners insurance policies contain a war exclusion that prevents the insured from receiving compensation for war damages. The clause pertains to declared war, as well as to undeclared war, civil war, insurrections and any discharge of a nuclear weapon. Losses caused by riots and civil commotion are addressed elsewhere in these policies and are not excluded from coverage.

Because the standard war clause was written prior to the events of 9/11, homeowners insurance does not specifically mention damage from non-nuclear acts of terrorism. Though insurers did not invoke war exclusions after the attacks on the Pentagon and World Trade Center, many carriers included terrorism exclusions in the years and months that followed. The Terrorism Risk Insurance Act of 2002 (commonly known as "TRIA") requires that insurance companies offer terrorism coverage in various commercial lines of business, but the law does not apply to homeowners insurance.

On one hand, a homeowner's claim for terrorism damage might be denied on the basis of the war exclusion. Or perhaps the claim would be covered if the attack were to involve a covered peril,

such as fire or explosion. Obviously, one hopes homeowners will never again be put in a position where terrorism losses are a pressing issue.

Nuclear Reactions

Homeowners insurance provides practically no property or liability coverage when losses are caused by a nuclear hazard. A rare exception might be possible if a dwelling sustains fire damage due to the hazard. Damage caused by nuclear attacks, whether the attacks are intentional or unintentional, is considered war damage and is not covered.

Special Coverage Issues

The next several sections of this material address how homeowners insurance caters to people who may have relatively specific coverage concerns. These people include those who have children, those who operate a home-based business and those who have pets.

Information about these and other topics tends to be scattered throughout most policy forms. For the sake of optimum comprehension and convenience, we have gathered up those assorted pieces of information and attempted to categorize them in an appropriate manner.

Children of the Insured

A person's child is considered an insured under a standard homeowners policy. In essence, the child's property is treated as if it were the parents' property, and any losses that the child causes are treated as if they were caused by the child's mother, father or guardian.

Property insurers' treatment of a child's property and personal liability probably seems simple enough while the child is young, living entirely at home and not earning any money. But the child's insurance status might appear less clear when he or she heads off to college or works part time. Let's review how insurers deal with children who are working toward a degree and/or earning their own money.

Children and Personal Property

College is an opportunity for many young people to move away from Mom and Dad and start fending for themselves. Depending on finances, the person's school and personal choice, a college student might spend the academic year living in a dorm room, fraternity house, sorority house or privately rented apartment with or without roommates. Along with all the other changes that the student will encounter, there is likely to be a difference in the way his or her property is covered by homeowners insurance.

The standard policy will continue to cover a college-aged child who is away at school if the child is a full-time student and is 23 or younger, a relative of the homeowner and a resident of the residence premises prior to the move. A full-time student who is not related to the named insured will be covered at school if the student is 20 or younger and was under the care of an insured at the residence premises prior to the move. The meaning of "full-time student" is based on the school's definition of that term.

If the college student's belongings are covered at all away from home, the coverage will still be equal to only a portion of Coverage C's dollar limit. If a covered student's personal property is lost or damaged, the carrier will provide compensation that is no more than $1,000 or 10 percent of the Coverage C limit, whichever is greater.

Let's assume that a mother's home is insured for $100,000. With Coverage C equal to 50 percent of Coverage A, her personal property is covered for $50,000. Therefore, if her son suffers a loss while living at school, the policy will reimburse her for her son's belongings up to $5,000.

The student's belongings are covered against the same perils as the parent's belongings, but there may be special conditions that apply in cases of theft. For theft at the school-year residence to be covered at all, the student needs to have lived there within a specific timeframe prior to the loss. This timeframe is often equal to 45 days or 60 days and is probably a non-issue when theft occurs during the typical spring or winter break. However, students who leave their belongings at the school-year residence over longer periods (such as over summer vacation) could potentially lose their theft insurance.

Adult children who live at home and are not full-time students might not be covered by their parents' insurance anymore. The existence of coverage will depend on the carrier and the family's circumstances. Producers should examine their policy forms before giving definitive answers to these consumers and their relatives.

Children and Liability

Children who are covered for property losses under their parents' policy are also covered for personal liability. But liability issues can surface much earlier than during the child's college years. This is especially possible if the child does chores for neighbors in exchange for money.

Pretend that a homeowner's 14-year-old daughter spends part of her summer mowing lawns and babysitting other people's children. How would an insurer respond if she were to do major damage to a neighbor's yard or accidentally injure a young child?

Though homeowners insurance does not cover an individual who causes property damage or physical harm while conducting business, the standard policy makes an important exception for many minors. An individual who is under 21 remains covered for personal liability in a business situation if the individual is self-employed, has no employees and only conducts business on a part-time or occasional basis.

Pets of the Insured

As millions of people already know, animals can have important roles in a household. Companionship and security are only two of the advantages of having pets. Yet homeowners are sometimes unaware of various exclusions that go into effect when an animal causes property damage or bodily injury.

Covering Pets

The standard homeowners policy does not reimburse people for the loss of their birds, animals or fish. If the family dog becomes injured, dies or runs away, the insurance company will provide no financial assistance to the owner. However, strangely enough, the policy does not specifically exclude coverage of amphibians or reptiles. It might therefore be possible (if not probable) for a turtle or frog to be covered against the perils that are listed under Coverage C.

Pets and Property Damage

Homeowners insurance does not cover damage to the dwelling when it is caused by the insured's pet or an animal that is otherwise in the insured's care. Still, the typical policy does cover damage to the dwelling when it is caused by stray creatures.

Suppose, for example, that a deer runs through a homeowner's glass door. Since the deer does not belong to the homeowner, the insurance company will pay for the damage. Unless the

homeowner has all-risk insurance for contents, any damage that the deer does to personal property would not be covered.

Damage to the dwelling that is caused by a stray creature is not covered when the creature is a bird, insect, rodent or vermin. Rodents include mice, beavers, rats and squirrels. Examples of vermin include coyotes.

Pets and Personal Liability

An insured is covered anywhere in the world for personal liability when his or her pet harms another person or damages another person's property. If a homeowner is walking his dog and the dog bites a stranger, it is likely that the insurance company will pay to defend the insured in court and pick up the cost of a settlement or legal judgment. This coverage is broad enough to also cover a third party who agrees to look after the pet on a temporary basis without charging a fee.

Third parties are not covered for liability when they care for a person's pet as part of their business or when they care for the pet without the owner's permission. A kennel, for example, would need its own liability insurance. There is also no liability protection when the property damage or bodily injury is suffered by another person who is covered by the same policy.

Dog Bites

Though dogs are considered by many to be man's best friend, they can also be serious biters. According to the Centers for Disease Control and Prevention, half of all children are bitten by a dog by the time they turn 12.

Of course, dogs have always bitten people. But the amount of medical and liability claims related to these attacks seem to have grown in recent years. According to the Insurance Information Institute, insurers lost $356 million because of dog bites in 2007, and approximately 5 percent of all homeowners' losses from 2006 were linked to such events.

Fearing significant losses, some carriers have cracked down considerably on property owners who house perceivably aggressive pets. When evaluating a dog owner's eligibility for liability protection, many insurers have been known to focus on the animal's breed, regardless of whether or not the dog has any history of violent behavior. These companies are interested not just in the frequency of biting among certain breeds but also the likely degree of injury that can be caused by a single attack.

Though each insurer may have its own position on dogs, affordable homeowners insurance has sometimes been hard to find for owners of the following breeds:

- Pit bulls.
- Rottweilers.
- Dobermans.
- German shepherds.
- Chow-chows.
- Great Danes.
- Wolf hybrids.

Some insurers don't pay much attention to breeds but will still take adverse action against homeowners when a pet has harmed another person. If a dog has already seriously injured someone, the owner might be denied insurance altogether or might only be allowed to renew an existing policy at a higher price. To maintain affordable coverage, the owner might have to prove that the animal has been euthanized or agree to exempt the insurer from all future kinds of dog-bite liability.

Home Offices and Business Property

Whether they are paid by an employer or work for themselves, an increasing number of Americans are working from home these days. Working from the comforts of one's own dwelling certainly has its advantages. It may eliminate the stress that comes with a long rush-hour commute, and it may even enhance the efficiency of workers who know how to manage their time well.

But doing business beyond the confines of a traditional workplace has its risks, particularly in regard to property losses and personal liability. According to a study conducted by International Communications Research in 2004, 60 percent of home businesses are not covered by any kind of insurance other than a homeowners policy. To better serve that potentially underinsured majority, we ought to review how the standard policy treats various business losses.

What's a Business?

Before we look specifically at property and liability risks, we need to know what the word "business" means to most property insurers. It's certainly not surprising that activities related to one's occupation or trade are usually considered business activities. But what about money-making activities that are more casual and sporadic in nature, such as babysitting, tutoring or holding a yard sale? Depending on the circumstances and the policy language, people who engage in these activities might be conducting "business," at least as far as the insurer is concerned. Then again, they might not.

According to common policy language, a "business" can be operated on a full-time, part-time or occasional basis. An insured is conducting business whenever he or she receives compensation (monetary or otherwise) for performing tasks or providing services. However, an insured is not engaged in business in any of the following situations:

- The insured is working as a volunteer and is only compensated for the expenses that he or she incurs while performing volunteer duties.
- The insured is providing home day-care services to a relative.
- The insured is providing home day-care services to a non-relative but is only receiving home day-care services in return.
- The insured is performing an activity for compensation but did not receive more than $2,000 in compensation for this activity during the 12 months prior to the policy's inception.

Business Property Losses

When a homeowner suffers a loss that relates to business property, reimbursement might depend on where the damaged or lost property was stored. The Coverage A section of the standard policy does not contain a business exclusion. So if a person conducts business in a home office that is part of the dwelling and a covered peril causes structural damage to the office, the insurer is likely to pay for repairs. However, if this portion of the dwelling becomes uninhabitable, the insured cannot collect any lost business income through Coverage D.

As we noted earlier in this material, there are business exclusions that apply specifically to Coverage B. In general, the insurer will not pay to repair or replace a detached structure if any part of it is used to conduct business. To review exceptions to the Coverage B exclusions, please refer to the section of the course titled "Coverage B and Business Property."

Coverage C insures business property but only up to a certain point. When the business property is lost or damaged while on the residence premises, reimbursement will not exceed $2,500. When business property is lost or damaged while off the residence premises, reimbursement will often not exceed $250 or $500. This coverage does not include the loss of business data.

The insured can increase coverage of business property with the help of riders, but many insurance professionals believe alternative products, such as a business owners policy, are a better solution for many home-based bosses.

Business and Liability

In general, homeowners insurance does not cover individuals who harm other people or other people's property while conducting business. This exclusion represents a major coverage gap, particularly for those home-based businesspeople who deal with customers and clients face-to-face. Possible liability scenarios that would probably not be covered by homeowners insurance include the following:

- A customer trips over a rug at someone's home office and breaks a toe.
- While conducting business outside the office, the homeowner accidentally damages another person's property.
- While renovating a home office, a contractor slips on the homeowner's wet floor and breaks an ankle.

According to some insurance producers, home-based workers should purchase additional liability insurance even if they only communicate with customers, colleagues or bosses over the phone or the computer. To support their argument, they often point to a hypothetical situation in which a worker has a business package shipped to his or her home and the delivery person slips on ice at the residence premises.

Despite that possibility, there are some insurers who would cover this kind of loss if the injury was caused by poor home maintenance and not by the insured's business activities. It's also possible that this kind of injury (not to mention the one suffered by the contractor in our previous example) would be covered by some other form of insurance, such as workers compensation, health insurance or disability insurance.

Still, no matter what other kinds of coverage might be applicable to another person's injury, homeowners should understand that legal outcomes can be unpredictable and that the standard policy does not force an insurer to defend a business in a liability dispute.

As the reader might recall, homeowners insurance provides some liability protection for minors who engage in business activities. For coverage to apply, all of the following must be true:

- The insured is under 21.
- The insured is self-employed.
- The insured's business activities are not part of a full-time job.
- The insured has no employees.

Residence Employees

The standard homeowners insurance policy contains several references to "residence employees." A residence employee is an individual who works for the insured by performing household tasks or other activities that have nothing to do with the insured's business. Though there may be exceptions depending on whether the person is paid directly by the homeowner or through an agency, maids and gardeners are two common examples of residence employees.

The standard policy allows a residence employee to be considered an insured under limited circumstances. Under Coverage C, residence employees can be an insured and receive insurance benefits when their personal property is lost or damaged while being stored in a residence where the homeowner is residing. Under Coverage F, third parties can receive reimbursement for medical care when they are injured by a residence employee. For Coverage F benefits to apply to those third parties who are not on the residence premises, the injury must have occurred while the residence employee was performing his or her job duties.

The applicability of coverages E and F can become complicated when the person who suffers bodily injury is a residence employee. In general, the insurance company will not pay defense costs, settlement costs or medical expenses when the injured employee should be covered by workers compensation, non-occupational disability laws or occupational disease laws. If the homeowner was required to purchase workers compensation coverage and did not do so, neither the homeowner's personal liability nor the employee's medical expenses will be covered by the insurance company.

Of course, these exclusions in no way prevent the insured from being sued by a residence employee. They merely make the homeowner responsible for any defense or settlement costs that are associated with a legal dispute.

Removing Trees and Debris

Even if a covered peril does not make direct contact with a dwelling, the home can still be damaged by debris and trees that get flung about by strong winds or other forces of nature. The cost of removing debris and fallen trees can sometimes amount to thousands of dollars. Fortunately for the homeowner, this expense may be covered by insurance.

The standard homeowners insurance policy covers removal of debris. When the cost of removing the debris and repairing or replacing damaged property is greater than the insurer's limit of liability, the homeowner may receive an additional 5 percent of coverage that can be applied specifically to debris removal.

When a tree falls on the residence premises, a homeowner may be reimbursed for its removal. This free additional insurance has a cumulative limit of $1,000 per occurrence, and no more than $500 may be applied to the removal of a single tree. For removal to be covered, the tree needs to have either done damage to the homeowner's property or blocked access to a driveway or a ramp for handicapped persons.

Following a windstorm, policyholders often wonder who is responsible for removing a neighbor's tree from their property. Regardless of where a fallen tree once stood, the party who suffers the property damage should file a claim with his or her insurance company. The neighbor would be liable for the loss only if the tree was obviously dying or was not being maintained properly by its owner.

Motorized Vehicles and Watercrafts

The next few sections contain many details about how motor vehicles and boats are addressed in the typical homeowners policy. Yet because the provisions and exclusions mentioned here can be so complex, students should not discuss these coverage issues with the public without reviewing the appropriate policy forms.

Damage of Vehicles and Watercrafts

Just in case the exclusion isn't obvious, we will begin by reminding ourselves that damage to automobiles is not covered by homeowners insurance. Auto losses are meant to be covered by auto insurance policies.

Despite that general exclusion, Coverage C can be used to repair or replace motor vehicles that do not need to be registered under local law, assuming one of the following statements is true:

- The vehicle is only used to maintain the residence premises.
- The vehicle was made for the benefit of a disabled person.

With those conditions in mind, we can suppose that a woman's pickup truck would not be covered by homeowners insurance but that her riding lawnmower and her live-in mother's wheelchair might be.

As for auto parts and accessories, these items are not covered if they are already installed. Electronic devices that are only meant to function with the help of the auto's power supply are also excluded from coverage. Conversely, electronic equipment that is in a car but can still be operated via another power source is covered for up to $1,500. Another $1,500 limit applies to all trailers and semi-trailers.

Watercrafts are covered by homeowners insurance but probably not for their true value. Insurance for these crafts and all their parts and accessories is worth no more than $1,500. Also, a craft or a trailer might not be covered at all if it is stolen from a location beyond the residence premises.

Damage From Vehicles

Damage done by a vehicle is a covered peril in most homeowners insurance policies. There's also additional insurance that may be utilized when someone else's vehicle damages trees, shrubs or plants on the residence premises. This additional coverage can equal as much as 5 percent of the homeowner's Coverage A limit, but the insurance company will not pay any more than $500 to replace a single tree, shrub or plant.

Some homeowners are not covered when a vehicle that is owned or driven by an insured does damage to exterior property, such as a fence or a sidewalk. Concerned buyers should examine policy language in order to figure out if this exclusion is a part of their insurance contract.

Vehicle and Watercraft Liability

The liability section of most homeowners insurance policies doesn't provide much coverage for the homeowner when an insured's vehicle is linked to bodily injury or property damage. Based on common ISO language, personal liability protection is only possible if one of the following is true:

- The property damage or bodily injury occurs while the vehicle is in storage at the insured location.
- The vehicle is only being used to help maintain the residence premises.
- The vehicle was made to assist a disabled person and is being used for that purpose.
- The vehicle does not belong to the insured and is not meant to be driven onto public roadways.
- The vehicle belongs to the insured, is not meant to be driven onto public roadways and causes property damage or bodily injury on the residence premises.
- The vehicle is a golf cart that holds less than four people, goes less than 25 mph and is being operated appropriately at or near a golf course.
- The vehicle is a golf cart that holds less than four people, goes less than 25 mph and is being operated in a private community where the insured lives and where golf carts are permitted.

As if those conditions weren't enough, the typical policy with ISO language will not provide liability protection to the insured if any one of the following statements is true:

- The vehicle is registered with a local authority or is required to be registered.
- The vehicle is being used in a contest of some kind, such as a race.
- Property damage or bodily injury occurs while someone was renting the vehicle from the insured.
- The insured is using the vehicle to transport people or property and is requiring people to pay a fee for the transportation.
- The vehicle (other than a golf cart) is being used by the insured during a business activity.

Similar conditions and exclusions pertain to watercraft liability, but they also tend to take technical factors, such as a craft's horsepower, into account. Insurance professionals who want to help consumers cover watercrafts should refer back to their policy forms.

Credit Cards

A little-known provision in homeowners insurance policies covers people for as much as $500 when their credit cards or bank cards are used without their permission. Those same $500 can be used when an insured is the victim of check forgery or unknowingly accepts counterfeit money. The $500 is considered extra insurance and can be utilized by the policyholder without having to pay a deductible.

For purposes of the $500 limit, the insurer will consider all instances of unauthorized use by the same person to be one loss. So if a thief uses a credit card to make a $500 purchase and then uses it again to make a $200 purchase, the most the victim will receive is $500.

The $500 for unauthorized use of credit cards and bank cards is not accessible to an insured if the unauthorized use was committed by another person who lives on the residence premises. The insured's claim will also be denied if the credit or bank card was given to the user with the insured's consent.

Identity Theft

Identity theft can make an innocent person responsible for a criminal's debts. According to the Federal Bureau of Investigation, it is one of the fastest growing crimes in the United States.

Insurance companies have responded to the threat of identity theft by either including some identity theft coverage in their homeowners policies or providing optional riders to interested customers. But no matter how the coverage is sold, the insurance usually does not reimburse the victim for losses that are caused by the thief. Rather, it pays expenses that an insured incurs while trying to clear his or her name. These expenses might include the cost of legal fees, replacement documents and long-distance phone calls. There's also coverage for any income that the insured loses while trying to resolve the situation.

Vacant Land

In addition to covering a residence premises, a homeowners insurance policy covers property damage and liability claims that relate to vacant land. Additional dwellings that are under construction are also covered if they are being built to hold no more than four families and if the named insured plans on living there. The standard policy does not cover vacant land that is intended for farming purposes.

Loss Assessment Fees

When a homeowners association or condo association suffers an uninsured loss or has to pay a high deductible, the cost is often shared evenly by all members. Each member's portion of this cost is known as a "loss assessment fee."

Homeowners insurance covers loss assessment fees up to $1,000 per policy period, and a policy rider can help make the coverage worth even more. In order for the assessment fee to be paid by the insurance company, the loss needs to have been caused by a peril that is not excluded in other parts of the policy.

In other words, if the loss would not have been covered if it had been suffered by the homeowner, the insurer will not be responsible for any part of the assessment fee. For example, because homeowners insurance does not cover flood damage, loss assessment fees that are the result of a flood will not be the insurer's responsibility.

Loss assessment fees can be covered by homeowners insurance even when they are the result of a liability claim. The liability claim can relate to property damage or bodily injury for which the association is liable, or it can relate to an act by an association's director, officer or trustee.

If the fee is the result of a liability claim that relates to a director, officer or trustee, the insurer will only pay it under certain conditions. First, the director, officer or trustee needs to have been elected to his or her position. Second, the director, officer or trustee needs to have received no money for serving in the position.

Whether they relate to property damage or liability, loss assessment fees are not covered by homeowners insurance when a government entity is the one doing the assessments.

Building Ordinances

When homeowners estimate their dwelling's replacement cost, they often forget to factor in possible changes to local building ordinances.

Local codes are often altered in order to make homes safer and more energy-efficient, but existing homes are often exempt from the new requirements. When a home that had been exempt from the new requirements is destroyed, any replacement home must be built in full compliance with the law.

When homes are destroyed relatively soon after they have been built, owners are not likely to be burdened by the changes in building ordinances. Any changes that might have been made to local codes since the original home's construction are likely to be few in number, and the cost to construct a new home will probably not be far away from the destroyed home's insured value. But if the destroyed home was several years old, the owner might need to comply with many changes to the codes and could be significantly underinsured.

Depending on the policy and the differences between the old and new ordinances, homeowners insurance might not pay to make a replacement dwelling entirely compliant with local laws. If the value of Coverage A is not enough to rebuild the dwelling and make mandatory upgrades, some policies will force the owner to pay all the additional costs. Other policies give additional insurance to the owner that can be used specifically to pay for mandatory upgrades during the rebuilding process. When offered, this insurance is usually equal to 10 percent of Coverage A. People who do not have this insurance or are frustrated by its limits can guard against risk by adding a rider to their policy.

Intentional Acts

The "intentional acts exclusion" in a homeowners insurance policy prohibits any kind of coverage when damage or bodily injury was done on purpose by an insured. This exclusion acts as a fraud deterrent and would prevent an arsonist, for example, from collecting insurance money after a fire. The exclusion is irrelevant when damage to another person's property is caused intentionally by an insured who is 12 or younger.

The intentional acts exclusion has been known to create some controversy, particularly when it is applied to a personal liability claim for bodily injury. To demonstrate the kinds of problems that can arise, imagine that you get into an argument, lose your temper and punch a man in the mouth. In addition to knocking out one of his teeth, your punch causes the man to fall and bang his head on the corner of a table. The knock on the head causes brain damage, and the man's family takes you to court.

Alternatively, let's pretend a mother's child is attempting to shoot a classmate with a BB gun and accidentally nails an innocent bystander in the eye. The bystander suffers permanent loss of vision and sues the mother for damages.

In both examples, there was certainly intent to harm another person, but the extent of the actual harm was accidental. While you might have meant to knock the man's teeth out, you certainly didn't intend for him to become brain-damaged by the blow. While the child did intend on hitting someone with a pellet from his gun, he didn't mean to hit the person who ended up being the victim. So how would an insurance company respond to these situations?

It's very possible that there would be no coverage in both cases. Many policies make it clear that intentional injury is not covered even if the severity of the actual injury is different from the severity of the intended injury. Those same policies might also state that injuries that were intended for one person but inflicted upon a different person are still uncovered intentional acts. When tested in legal cases, these exclusions have been upheld by some courts and rejected by others. A court's opinion is likely to be based on the specifics of the situation.

The need to challenge an intentional acts exclusion might be less likely if the insured caused bodily injury in an act of self-defense. Liability claims are generally covered when intentional harm was committed in order to shield people or property from danger.

Liberalization Clause

Often buried near the end of an insurance contract, the policy's "liberalization clause" could make the insured eligible for free additional coverage at a later date. The clause states that if the carrier decides to modify the policy in a way that gives additional insurance to new customers at no cost, existing policyholders must also receive these free benefits.

So if the insurer decides to omit the aforementioned intentional acts exclusion from a policy in order to attract new homeowners, the exclusion must also be omitted for everyone who has already purchased that policy.

Duties After a Loss

After a loss has occurred, the insured's first responsibility is to keep the damage from getting worse. If a storm has damaged a roof, for example, the homeowner needs to take all reasonable steps to keep the home's contents from being harmed by the elements. Personal property might need to be moved away from the residence premises, and a tarp might be necessary in order to keep precipitation out of the home. Failure to take these reasonable kinds of steps might result in uninsured losses.

When the insured does what is reasonable to keep additional losses at a minimum, the insurance company will usually pay any related expenses. The tarp we mentioned in the previous paragraph, for instance, might ultimately be paid for by the insurer. Homeowners should keep track of the work they do to mitigate their loss and should hang onto any receipts.

The insured should also know who to contact after a loss. If the insured has reason to believe that a claim will be filed for property damage or personal liability, he or she should either get in touch with the agent who serviced the policy or try to reach the insurance company directly. In the event of theft, contact with the insurance company should not be made until after the victim has alerted proper authorities and cancelled any stolen credit cards.

Meeting With Adjusters

If a claim is made for property damage, the insurer might set up a time for the homeowner to meet with a claims adjuster. It is the adjuster's job not only to evaluate the extent of the loss, but also to determine if damaged property can be repaired rather than replaced. When a household has suffered a seemingly total loss, the adjuster might able to meet with the insured fairly quickly. If the dwelling has sustained some damage but is still inhabitable, the adjuster might meet with the homeowner within a few days or weeks of the loss.

Taking an Inventory

While waiting for an adjuster to arrive, homeowners should be thinking about and gathering their inventory of belongings. This inventory should document all personal property that may be lost or damaged.

In the heat of a crisis, it will be easy for a person to forget what he or she owns. So it is extremely important for the owner to think ahead and take this inventory before a loss ever occurs. This inventory can be in the form of documents or photos and should be kept at an offsite location where it is unlikely to be damaged, such as in a safe deposit at a bank.

Proof of Loss and Additional Documentation

To set a settlement into motion, the insured will have to complete a "proof of loss form" and submit it to the insurance company within a few months of a request. The proof of loss form will ask the insured for a variety of information, including the following:

- An inventory of lost or damaged personal property.
- A description of damage to the dwelling and other structures.
- An account of when and how the loss occurred.
- Proof of any additional living expenses.
- Confirmation of who owns the property and who was living at the residence premises at the time of the loss.
- A list of other insurance policies that might reimburse the insured for the loss.

A claim under coverages E or F might require some additional documents, as well as additional participation from the insured. If a person files a claim for personal liability, the carrier should expect to receive all relevant documents pertaining to the situation, including any demands for money from a third party. At the company's request, the insured may need to participate in the settlement process by gathering evidence, contacting witnesses or attending legal proceedings. If a person files a claim for medical payments, the carrier can demand copies of the person's medical records and require that the person be examined by a doctor of the insurer's choosing.

Loss Settlements and Appeals

In general, the insured can expect to have a valid claim paid within a few months after the homeowner and the insurer have agreed on the scope of the loss. If the company estimates the loss at one amount and the homeowner disagrees with that amount, independent appraisers will attempt to settle the issue. If a claim is denied because the insured failed to make a payment or submit a proof of loss form, the homeowner's mortgage lender may make a claim on its own behalf.

Cancellations and Non-Renewals

Because the loss of their insurance can put people in financial danger, consumers need to know how to prevent policy cancellations and what their rights are when an insurer wants to suspend coverage. In general, an insurance company can rescind a policy for any reason within a few months of issuing it. After that, cancellations and non-renewals are usually only permissible under one of the following circumstances:

- The insured has failed to pay premiums in a timely manner.
- The insured seriously misrepresented his or her susceptibility to losses.
- The amount of risk that is posed by the insured has changed since the policy's issue date.

Insurance professionals should note that this information about cancellations and non-renewals is intentionally basic. Each state has its own insurance laws that explain when adverse action may be taken against an insured. These laws often mention grace periods for late-paying policyholders, as well as the amount of notice that the insurer must provide to homeowners. To ensure your compliance with these specific laws, please consult with a dependable legal source in your area.

Money-Saving Tips for Homeowners

The cost of homeowners insurance varies from state to state and tends to reflect the likelihood of a natural catastrophe in a given area. Residents of disaster-prone states like Texas, California and Mississippi, for example, tend to pay more for coverage than people in relatively safer states like Illinois and North Dakota. But regardless of where they live, policyholders can take steps to lower their insurance premiums.

Probably the simplest way to bring premiums down is to increase the policy's "deductible." The deductible is the dollar amount that the homeowner must pay out of pocket before a loss can be covered by the insurance policy. Usually found on the policy's declarations page, the deductible can often be as low as $250 and as high as the insured wants it to be. An increasing number of carriers are offering deductibles that amount to a certain percentage (such as 1 percent) of a dwelling's insured value. Generally, the higher the deductible, the lower the premiums.

Other possible methods of reducing premiums might only be acceptable to certain insurance companies. In the past, some

(but not all) companies have been known to give discounts to the following kinds of homeowners:

- Senior citizens who spend most of their time at home.
- People who install deadbolt locks and other security-friendly devices.
- People whose dwellings are located near fire stations.
- People who retrofit their homes in order to withstand threats of nature.
- People who purchase homeowners insurance and auto insurance from the same company.
- People who have a favorable credit history.

Conclusion

As the reader can see, homeowners insurance does much more than protect people's homes. Its unique offerings of dwelling coverage, contents coverage, liability coverage and other benefits make it more than just one of the most important kinds of insurance. It is also an indisputably versatile product that addresses many common risks. Its broad appeal can help a knowledgeable insurance producer become a great success.

CHAPTER 3: ANTICIPATING ACCIDENTS

Introduction

Though long-term studies have shown an increase in life expectancies and a decrease in deaths from such serious medical problems as cancer and heart trouble, improvements in mortality have magnified some serious risks for the working public. Many injuries and illnesses that would have quickly killed people three decades ago are now more likely to leave people incapacitated for several months or years. Meanwhile, the demands of a fast-paced business environment are affecting mental health and could be factoring into innumerable debilitating accidents.

No matter its true cause, disability can strike anyone at any time and is probably much more common than we would like to admit. According to the National Safety Council, a disabling incident occurs every second, and the Social Security Administration believes at least 30 percent of today's 20-year-olds will suffer a disability at some point in their life. At nearly every age, the likelihood of disability is greater than the likelihood of death.

Taking precautions to combat the financial consequences of disability is rarely thought of as a priority for the average adult. Because their idea of disability is based mainly on stereotypes involving wheelchairs and around-the-clock nursing care, people tend to disregard the aforementioned statistics and develop a misguided sense of invincibility. Since they don't know many people who fit into those stereotypes, they often doubt that a disabling incident will happen to them,

A few people might realize that a disability can mean anything from a bout with a respiratory disease to a nagging back injury, but they too will avoid the topic because it can be so scary. Whereas death has the potential to be quick and painless, a disability is nearly guaranteed to produce significant discomfort and make us dependent on others for an extended period of time. Putting off this form of risk management might not be the smart thing to do, but it certainly seems to be in tune with our human tendency to ignore what frightens us.

Even if they are brave enough to consider the physical side of life with a disability, people often misjudge the impact that an illness or injury can have on their finances. When a disability occurs, the harmed individual is often robbed of his or her biggest asset: the ability to earn a living. If a 40-year-old making $50,000 a year were to become disabled and permanently unable to work, lost income through age 65 could total $1.25 million, not counting adjustments for inflation. In all likelihood, that number would be considerably higher than the combined value of the person's home and savings.

Admittedly, most disabilities are not permanent and will not create a million-dollar loss of take-home pay. But that hardly guarantees they can be overcome by the typical family without some careful planning. Disabilities lasting several months or longer are one of the leading causes of foreclosure in the United States, causing even more homelessness than the death of a family member. If a parent's disability continues for too long, important goals such as funding a child's education might need to be postponed or abandoned, and a family's hard-earned standard of living might never be the same again.

Disability insurance replaces a portion of people's income when they are too sick or too hurt to do their job. It isn't exactly health insurance, yet it can ensure that there is enough money for life's essentials during a health crisis. It isn't exactly life insurance, yet it can serve a similar purpose by providing financial assistance to dependents when the head of a household becomes incapable of paying bills.

Injury or Illness

For insurance purposes, having a disability usually means a person is suffering from an accidental injury or illness. The injury or illness can involve many sorts of circumstances and do not need to have occurred in conjunction with performing one's job duties. The injury must have occurred during the policy period, and an illness must have started during that same period.

If symptoms of an illness were noticed prior to the policy period and were strong enough to cause a reasonable person to seek medical attention, the illness will be viewed as a pre-existing condition. Disabilities linked to pre-existing conditions might not be covered at all or might only be covered after a long waiting period.

A few disability products are accident-only policies and do not cover losses brought on by sickness. This coverage is often impractical because the majority of disability claims are linked to cancer and other diseases. Like life insurance policies that only cover people who die of a specific illness or from a specific kind of accident, an accident-only policy is probably only suitable for workers who cannot qualify for or afford other coverage.

Loss of Ability

To trigger disability insurance benefits, an injury or illness must be severe enough to have had a negative impact on the insured's professional life. More specifically, a policy will probably state that the injury or illness must be preventing the person from performing essential job duties. Depending on the insurance contract, the worker might need to be unable to perform one essential task, all essential tasks or a certain portion of tasks, such as 20 percent.

These requirements can be modified to emphasize a time element rather than a task element. As an example, consider someone who can still perform all individual job duties but must work fewer hours because of pain or fatigue. In this case, the worker might be eligible for benefits if lost time is equal to a certain percentage of a regular workweek. Like a situation involving someone who can perform some duties but not others, this is an example of a partial or "residual" disability. More information about partial and residual disabilities (which are not

covered under some disability insurance contracts) appears elsewhere in this course material.

When coverage is contingent on the inability to perform job-related tasks, those tasks are usually related, for a limited time, to a person's specific occupation. Suppose Jim, a writer, and Jane, a mover, are both injured to the extent that they are unable to engage in heavy lifting. Since heavy lifting is not considered a normal aspect of a writer's job, Jim will probably not qualify for disability benefits. Jane, on the other hand, has a job that requires heavy lifting. Therefore, she might receive some insurance payments.

Coverage based on the person's own job duties is known as "own-occupation" coverage and is usually only available for a few months or a few years. Eventually, a person might only be eligible for continued benefits if the individual is incapable of having any job that is in line with his or her education level and experience. You'll read more about own-occupation insurance shortly.

Loss of Income

Some disability policies base coverage strictly on a person's inability to perform tasks, but many contracts in today's market also require a loss of income at some point. A number of insurers will not provide money to a person with a partial disability unless an injury or illness has reduced the insured's income by at least 20 percent.

Loss of income must have been caused clearly by a disability rather than by other factors. For example, a burn victim who could still do some work if her office hadn't been destroyed by fire will probably not be eligible for benefits during the rebuilding process.

Under a Doctor's Care

The insured cannot just call the insurer, claim to be disabled and expect to receive compensation. In order for the disability to be considered valid, the person usually must be under a doctor's care.

At the very least, the doctor caring for the insured typically must have enough experience to properly treat and evaluate the disability. Being under a dermatologist's care, for instance, would not suffice for someone who is supposedly disabled by a back injury. Being under a chiropractor's care would not be enough for someone who is disabled by skin cancer.

Sometimes a person claiming a disability will be required to see a physician who has been selected by the insurance company. Despite this limited control over the person's care, the insurer usually cannot force a disabled person to undergo specific kinds of treatment or surgeries. Some policies require that the insured be hospitalized before disability benefits can begin, but these contracts are very rare or might be prohibited in some states.

After a person has been diagnosed with a long-term disability, the insured and the qualified physician will need to file forms with the insurance company on a periodic basis. These filings are used as a way of verifying the disability's continued existence. The reporting requirements might be relaxed if the disability is serious, obvious and permanent.

Own Occupation vs. Any Occupation

The best (and often most expensive) kinds of disability insurance base their definition of "disability" on the insured's own occupation. People with own-occupation coverage will receive compensation when they cannot perform their basic job duties. Their ability to do a different job is irrelevant.

To demonstrate the positives of own-occupation coverage, let's use the classic example of a disabled doctor. Suppose a hand injury prevents the doctor from treating patients. If the doctor lacks own-occupation coverage, the insurer might deny his claim and argue that he could earn a living as a lecturer at a medical school. But if he has own-occupation coverage, the insurer cannot make that case, and the doctor might be eligible for full disability benefits until he can practice medicine again.

Own-occupation coverage is particularly popular among high-income professionals, such as doctors and lawyers. This is because they are the ones who would probably experience the steepest drop in income if they were to change careers. The many years of schooling and all the student loans that were required to achieve their professional goals also tend to make own-occupation insurance attractive to these people.

In the past, high-income professionals could even receive own-occupation coverage that catered to their exact specialty. If a heart surgeon could no longer perform heart surgery but remained capable of working as another kind of physician, she would still receive full benefits. Today, this form of insurance is either unavailable or only offered at a very high price.

Other varieties of own-occupation insurance that have been available over the years are explained below:

- If people are unable to perform the duties of their own occupation, they can get a job in another field and still receive their full benefits.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, their benefits will end.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, they will receive a portion of the difference between their pre-disability income and their new income.
- If people are unable to perform the duties of their own occupation, they can receive their full benefits until they choose to do some other kind of work. After that, they will receive limited payments until their new income equals a particular portion of their pre-disability income.
- If people are unable to perform the duties of their own occupation, they can receive full disability benefits for a limited period of time, such as two years or five years. After that, they can only continue to receive benefits if they meet stricter requirements. (This is the most common kind of own-occupation coverage.)

If a disability policy does not include own-occupation coverage (or if own-occupation coverage has expired while the person is still disabled), the insured probably has what can be called "any-occupation" coverage. In general, this kind of disability insurance pays full benefits when people cannot perform the duties required by their own occupation and also cannot handle any job that would be suitable for them, based on their education, experience and training. An injured doctor, for example, would not receive disability payments if he was still capable of working at a medical school.

The essential duties of the person's occupation probably should be determined before the applicant purchases a disability policy. If both sides are not clear about these duties, the policyholder and the insurance company could find themselves arguing over some odd questions at claim time. For example, if a teacher loses her voice but is still capable of grading papers, is she disabled?

If an injured doctor cannot treat patients but can perform clerical tasks at his office, will he receive disability payments? As strange as these kinds of questions might seem, it is not uncommon for them to be the central issue in a lawsuit.

Long-Term Disability vs. Short-Term Disability

A working person can be covered by "short-term disability insurance" or by "long-term disability insurance." Short-term policies allow disabled people to collect benefits for a brief period of time, usually no longer than six months in most parts of the country. Long-term policies let people receive money for a few years, until they retire or, in rarer cases, until they die.

Workers in a few states are entitled to a portion of their regular income when they suffer a short-term, non-occupational disability. Benefit periods range from six months in some areas to one year in states such as California. Sources of funding differ too, with some states (including California) requiring employee contributions from workers, and others mandating self-insurance by employers.

Most people who work (but not necessarily reside) in the following states or territories are covered for short-term disabilities by law:

- California.
- New York.
- New Jersey.
- Rhode Island.
- Hawaii.
- Puerto Rico.

Someone with a short-term disability policy will probably receive benefits sooner than someone with a long-term policy. Short-term disability benefits from private companies usually go into effect immediately after an injury and no more than a week after the beginning of an illness.

Long-term disability insurance often provides no benefits to the insured unless an injury or illness has lasted for several months. This waiting period is known as the policy's "elimination period" and will be explained in greater detail in the next section.

In most states, short-term disability insurance is purchased by employers as part of a group plan and is rarely marketed to individuals. Long-term disability insurance can be either provided through an employer-sponsored group plan or purchased outside of the workplace by one person.

Elimination Periods

The benefits made possible by disability insurance are usually not approved immediately after an injury or illness. Most likely, the insured will receive no financial assistance from the insurer until after the passage of a time-based deductible known as the "elimination period." Any losses that occur during this period are not the insurer's responsibility.

The elimination period begins on the first day the insured is unable to work. It can last anywhere from a few days to a few years. Short-term policies in many states often have no elimination period for injuries and a week-long elimination period for illnesses. Long-term policies tend to have 30-day, 60-day or 90-day elimination periods and do not have separate waiting periods for injuries and illnesses.

A person's preference for a longer or shorter elimination period might be based on finances and health. All else being equal, a longer elimination period will reduce the insurance premium. A longer elimination period might also make it easier for an unhealthy applicant to qualify for a policy in the first place.

Before choosing an elimination period, applicants should determine how long they would be able to support their financial needs without any income. If a three-month stretch without any income would plunge a family into bankruptcy, there would be little point in purchasing a policy with a long elimination period.

Recurrent Disabilities and Exceptions to the Elimination Period

Most policies have a "recurrent disability clause," which explains how the elimination period is applied when disabilities go away for a while and then reoccur.

Suppose, for example, that someone with a 90-day elimination period was disabled for a year, came back to work for a week and has realized that more recovery time is needed. Does the person have to wait another 90 days before benefits can begin again?

The insured is usually not subjected to a new elimination period if the same disability reoccurs within six months of the person's initial recovery. Some policies in some states extend this timeframe to a full year if the person is covered for a disability for life or through age 65.

If a recurrent disability does not trigger a new elimination period, any benefits that have already been paid to the insured for the disability will still apply to the policy's benefit limit. In other words, if a policy calls for up to a year's worth of benefits, a person who was disabled for nine months, went back to work for a week and became unable to work for the same reason for another six months would only be covered for 12 of those combined 15 months of disability. However, if the second case of disability were to trigger a new elimination period, the benefit limit would be reset, and the person might be covered for those additional months.

As long as the period of disability is not interrupted by a return to work, multiple disabilities can satisfy a single elimination period. For example, consider someone with a 60-day elimination period. If a broken ankle keeps the person out of work for 30 days and a bout with pneumonia keeps the person out of work for more than another 30 days, the two disabilities can be combined to satisfy the 60-day waiting period.

There are also some cases in which even a long-term disability policy will not require an elimination period. The elimination period is often waived when a person suffers a loss of both eyes, both ears or multiple limbs.

Benefit Periods

When a disability insurance policy's elimination period ends, the policy's "benefit period" begins. The benefit period is the maximum amount of time the insurer will pay benefits to the policyholder for a disability. The insured will receive payments from the insurer until he or she is no longer disabled or until the end of the benefit period, whichever comes first.

Like the elimination period, the benefit period can have a major impact on a policy's price and its availability. Usually, the longer the benefit period, the higher the premiums will be. Unhealthy individuals who would otherwise not qualify for disability insurance might be able to purchase a policy with a short benefit period.

Not surprisingly, there are different benefit periods for short-term and long-term disability insurance. Short-term policies typically have benefit periods no longer than three or six months. A benefit

period for long-term disability insurance might last two years, five years, until normal retirement age or until death.

A lifelong benefit period is rare these days, but an insurance professional might encounter one while working with a client who purchased a policy a long time ago. Though contracts with this benefit period can pay full benefits for life when a disability is caused by an injury, they often call for a reduction in benefits over time when a disability is caused by an illness that occurred late in life. The size of the reduction usually depends on when the disability began.

Suppose a man becomes disabled by multiple sclerosis at age 55 and will remain disabled for the rest of his life. In this case, a lifelong benefit period might entitle him to full benefits until he turns 65 and 80 percent of his regular benefits during additional years. If the same man were to become disabled by disease at 64, he would receive an even smaller portion of his regular benefits after turning 65. However, if he were to become disabled by disease at a relatively young age (maybe in his 40s or earlier), he might not have his benefits reduced at all.

Don't let all this talk about lifetime benefits trick you into thinking a disability can occur at any age and still be covered. Even if a policy makes it possible to receive benefits for life, the disability that triggers those benefits must begin prior to the policy's expiration date. Most people have the option of renewing their insurance beyond the expiration date, but renewal is rarely allowed after age 65. If an elderly person is collecting disability insurance benefits, it is probably because the person became disabled at a young age and had comprehensive coverage.

Benefit Amounts

By now, you should understand how disability benefits are triggered and how long they can last. But just knowing that insurance money is available will not be enough to ease a person's fears. Developing a financial contingency plan that responds to a disability will be very difficult unless you know what the exact benefit amount will be.

Since disability insurance is meant to replace income, it should not be at all surprising to learn that the benefit amount will be based on a worker's salary or wages. The income used to calculate the benefit amount will be the insured's taxable income during the 12 months prior to the disability, or perhaps the average income earned over the previous few years.

Like workers compensation, disability insurance will not replace the insured's entire paycheck. For most people, the benefit amount will be 60 to 70 percent of their pre-disability income. Insurers and state regulators enforce this percentage-based limit in order to encourage people to return to work and discourage them from committing fraud.

High-income workers might receive benefits below 60 to 70 percent of their pre-disability income. This is possible because the benefit period often has a dollar limit in addition to a percentage limit. For example, an insurer might agree to pay 60 percent of a person's salary but cap monthly benefits at $5,000 per month. Based on those figures, workers making $50,000 would have 60 percent of their income replaced by insurance, but workers making $150,000 would have their monthly benefits capped at $5,000 and would therefore receive only 40 percent of their regular income. Dollar limits are especially common in group disability plans, which might explain why many doctors, lawyers and business executives prefer individual coverage.

Believe it or not, there are some situations in which a person might be interested in lowering the benefit amount. Like reductions in the benefit period, smaller benefit amounts can help high-risk applicants receive coverage. For people who are considered lower risks, a lower benefit amount can mean lower insurance costs.

Excluded or Subtracted Income

Workers in sales should realize that disability insurance often does not compensate people for lost bonuses or commissions. Unearned income, such as money derived from investments, is also excluded from the benefit amount, and too much of it can even reduce the amount of money the insurer will provide. This might be done in cases where the level of unearned income would significantly reduce the person's desire to return to work.

Other compensation that a disabled person receives, such as workers compensation, Social Security benefits and payments from other disability insurers, can also lessen the benefit amount.

How to Find Disability Insurance

People interested in obtaining disability insurance can start their search in one of two ways: They can inquire about coverage that might be available at their workplace or through a trade association. Or they can contact an insurer independently and look into buying an individual policy.

Each of these options has positives and negatives pertaining to affordability, availability and more. As we go over them here, try to think about the kinds of people who might be best suited for each kind of coverage.

Group Disability Plans

Other than in states with a government-run program, most workers who have disability insurance obtained it through an employer's group plan. Businesses start group plans because they help attract qualified job applicants and because they can solve the ethical and financial issue of whether to keep paying a valued employee while the person can't work. Employees like them because they are often open to anyone regardless of health status and usually cost less than individual insurance.

Funding for group disability plans can be structured in many ways. Premiums might be paid entirely by the employer, entirely by the employee or split between the two. Plans that shift the cost of coverage to the worker are becoming more common, but participation in them must be voluntary. An employer cannot force an employee to contribute to a group plan in order to keep the plan's premiums down or to keep the group's insurance from being cancelled.

Strong participation is vital to group plans because it diversifies the group's risk and makes it possible for coverage to be available to members who have a higher chance of disability. To avoid situations in which only the disability-prone members of a group opt for insurance, a carrier might only approve guaranteed-issue coverage when both of the following conditions are met:

- The group plan will cover at least 10 to 15 participants.
- A significant portion of eligible participants join the plan.

Businesses that do not satisfy those requirements may still be eligible for insurance at a group rate. However, each prospective member of the group might have to be medically underwritten on an individual basis.

The usual absence of major medical underwriting in group disability plans does not mean every group will be eligible for decent and affordable insurance. Underwriters in the disability market are likely to evaluate a group by looking at the following factors:

- The group's size.
- The group's median income.
- The group's average or median age.
- The percentage of men and women in the group.

Many group plans are configured so that the employer pays for a very basic policy and the employee has the option of purchasing additional coverage at a group rate. Exercising that option might require some medical underwriting, but it can help the person get around some of the problems associated with traditional group plans.

Negative aspects of some group disability plans are as follows:

- Group plans usually provide no more than two years of own-occupation coverage.
- Group coverage is often not portable when a person changes jobs.
- Benefit amounts for group plans are often capped at a lower amount than individual policies.
- Benefits from employer-funded group plans are taxed as income to the employee.
- Group coverage can be cancelled by the insurer or the employer without the employee's permission.
- When the insurer denies a group member's claim, federal law makes it difficult for group participants to sue for pain and suffering, exemplary damages or reimbursement of legal fees.

No matter its positives and negatives, group disability insurance remains a non-issue for millions of employees in most parts of the country. Many smaller businesses don't offer it at all, and companies that do are not always required to make it available to their entire staff.

Though employers are not allowed to deny group participation to a particular employee for health or personal reasons, some states may let them restrict coverage to entire classes of employees. It is not uncommon for employers to base employee eligibility on the following factors:

- The employee's income.
- The employee's responsibilities.
- The number of years the employee has worked for the company.
- The number of hours the employee currently works for the company.

Individual Disability Policies

If group disability insurance is unavailable or insufficient, a worker can apply for an individual disability policy. Individual policies, which cover one person, are only purchased by a very small portion of the population, but they are popular among high-income professionals. These policies are superior to group coverage in the following ways:

- Individual policies can pay a disabled person a larger portion of income.
- Individual policies are more likely to compensate a disabled person for the loss of bonuses and other kinds of performance-based income.
- Individual policies are portable when the insured changes jobs.
- Benefits from individual policies are usually tax-free.
- Federal law does not prevent the insured from suing the insurer and collecting more than the dollar amount of a disputed claim.
- Individual policies are owned by the worker and cannot be cancelled by anyone else other than the insurance company.

Potential drawbacks to individual coverage include less availability and higher premiums. Lower costs and reduced medical underwriting might be possible if the individual policy is bought from the same insurer that handles the person's employer-sponsored group coverage.

Association Policies

If neither group coverage nor an individual policy appeals to a worker, disability insurance might be obtainable through an association or group that the person belongs to. If the person pays dues to a professional organization, for example, it might be a source of affordable coverage.

Disability insurance for association members is like employer-sponsored group coverage in some respects and individual coverage in others. Some people purchase it because it can be cheaper than an individual policy and doesn't expire when you change jobs. Still, some medical underwriting might be required, and the association can cancel it without members' permission. Coverage will also terminate if the person leaves the group.

Underwriting Factors

Applicants are often more likely to be denied disability insurance than life insurance. Stricter underwriting standards exist in the disability market because the insurer is concerned with "morbidity" (the risk of illness or injury) instead of "mortality" (the risk of death). Death is certainly final and, therefore, a more dramatic event than an illness or injury. But insurers realize there are a lot more things that can disable you than can kill you.

In the next several sections, we'll look at some of the issues that influence disability underwriting. When you finish reading, you should have a basic idea of who is most likely to qualify for a better policy at a good price.

The Applicant's Age

Like traditional health insurance and long-term care coverage, disability insurance is cheaper for younger people. Older applicants typically pay more for coverage than young ones due to the expected deterioration of the body and reduced resiliency. Whereas a young person might become sick or injured and be able to return to work before the end of a policy's elimination period, an older person with the same ailment is likely to need a longer recovery time.

Concerns about the duration and frequency of claims from older clients have pushed insurers to avoid covering people at a certain age. An applicant for a new individual policy might be turned down if he or she is 60 or older, and policies bought in younger years are usually not renewable beyond 65 or 67. Some carriers might relax their age restrictions if an older person continues to work at a full-time job.

On occasion, the insurer will notice that a person's age was misstated on an application form. Depending on the severity of the misstatement and when it is noticed, the insured will either lose coverage entirely or have the policy's benefits adjusted accordingly.

The Applicant's Occupation

Even though most occupational injuries will be covered primarily by workers compensation, an applicant's job will still be important to a disability underwriter. The physical and mental stress that people experience through their work can wear the body down

and make them more susceptible to disabilities in their private lives.

Disability insurers tend to sort all occupations into one of four or five groups, with each group representing a different degree of risk. The price and availability of coverage will depend on which group the applicant's job belongs to. If the person is approved for insurance and then switches occupations, the premiums and the benefits can change to reflect the altered risk.

The degree of risk associated with an occupation can, of course, be measured by looking at the worker's physical responsibilities. Construction workers and factory workers will probably pay more for coverage and be eligible for fewer benefits than clerical employees and software engineers because the difference in manual labor is so great. Jobs that frequently take people overseas for extended periods are also considered to be risky, maybe because of exposure to regional diseases.

A rise in mental health claims has also made the emotional demands of work important. Insurance will probably still be available for stock brokers and employees at high-volume call centers, but the level of anxiety and depression in these professions is catching the industry's attention.

The Applicant's Gender

In states where gender rating is allowed, women get lower rates than men when it comes to life insurance. But the reverse is often true in the disability market. Since women are more likely to become disabled, they pay more for their individual coverage. The reasons for the gender-based difference in claim frequency aren't entirely clear, but pregnancy, breast cancer and longer life expectancies are probably all contributing factors.

Group disability coverage is often provided at a unisex rate, and women may be able to get a better price on an individual policy if they buy one through their employer's insurance company.

The Applicant's Health

A person's medical history, which is deemphasized in group underwriting, takes on greater importance in the market for individual disability policies. Since there is no clear way to diversify the risk of covering one person, the insurance company will be very interested in an applicant's physical condition.

An applicant's medical history may be derived from information provided on a medical questionnaire or from data on file with the Medical Information Bureau. If these sources aren't enough for the insurer to form a clear picture of the person's risk potential, the applicant might need to undergo a physical examination, which can be completed at the carrier's expense.

There are obviously numerous physical ailments and lifestyle choices that can create problems for disability insurance applicants. Some of the more general warning signs for disability underwriters are as follows:

- The applicant has a history of back problems.
- The applicant is a smoker.
- The applicant has high blood pressure.
- The applicant is taking prescribed medications for a chronic condition.

While certainly unhelpful, habits and conditions like the ones mentioned above won't necessarily make an applicant ineligible for disability insurance. Instead, they might disqualify the person from receiving certain protections, such as own-occupation coverage or coverage of partial disabilities. Alternatively, or in conjunction with these kinds of limits, the perceivably unhealthy consumer might need to accept higher premiums, longer elimination periods, shorter benefit periods or lower benefit amounts.

If the insurer discovers that an applicant for disability insurance has a relatively significant illness or injury, the illness or injury will be viewed as a "pre-existing condition." In general, a pre-existing condition is something that has caused the applicant to pursue medical advice or treatment within the last three to six months, or something that would have caused a reasonably prudent person to do so. Policies sold in some states might have a broader definition of pre-existing conditions that includes any medical problems encountered within the past two years. Pre-existing conditions might not be covered at all or might only be covered after a long waiting period.

The Applicant's Income

Because disability insurance benefits are based on the insured's income, an applicant will have to prove his or her earnings before a policy can be issued. This can be done by supplying the insurer with copies of recent tax forms.

Benefit amounts usually depend on a person's current income, but there are some occasional exceptions. Young professionals and others whose income is likely to rise significantly in the not-too-distant future can sometimes obtain coverage that is meant to reflect their projected long-term earnings. High-profile college athletes, for example, have been known to buy multi-million-dollar coverage that protects them if they suffer a career-ending injury before joining the professional ranks.

Insurance can be reduced or denied if an applicant's income or net worth is extremely high or extremely low. At either end of the spectrum, the insurer will not provide insurance if the applicant's economic status would discourage a disabled person from returning to work as quickly as possible.

Issues to Consider

Once a person grasps the basics of disability insurance, there is an assortment of relatively specific secondary concerns that ought to be addressed. These issues can be very important to people who want the most comprehensive policy available or who have special insurance needs. Many of these topics are summarized in the next several sections.

Residual/Partial Disabilities

Because recovery can be a gradual process, people who are interested in disability insurance deserve to know how a policy treats partial or "residual" disabilities. A residual disability is a disability that either prevents people from doing some but not all of their job duties or forces them to work fewer hours.

Some kinds of disability insurance only protect the insured from "total disability," an illness or injury that prevents a person from doing any work. However, coverage of residual disabilities is often included as a policy rider.

To receive compensation for a residual disability, there usually must be at least a 20 percent to 25 percent negative difference between the insured's pre-disability income and post-disability income. That percentage is multiplied by the benefit amount for a total disability, and the result is provided to the harmed individual.

As an example, let's assume a woman normally makes $50,000 per year and has a disability policy that would pay her 65 percent of her income in the event of a total disability. Therefore, her monthly benefit amount for a total disability would be roughly

$2,708. But if the woman becomes partially disabled and suffers a 50 percent loss of income, she would be entitled to approximately $1,354 (or 50 percent of $2,708).

When a person qualifies for residual benefits, the insurance company is often required to provide at least 50 percent of the regular benefit amount for the next six months of disability. Residual benefits end either when the person's new income is no longer satisfactorily lower than the person's pre-disability income or when the policy's benefit period expires, whichever comes first.

Sometimes the insured can do part-time work and still qualify for full disability benefits. If the difference between pre-disability income and post-disability income is very large, such as 75 to 80 percent, the insurer will treat the residual disability like a total disability. Certain injuries, such as loss of both eyes, both ears or multiple limbs, are considered total disabilities no matter what the person can actually do or how much money the person is actually making.

Some insurance policies provide no residual benefits unless the residual disability occurs immediately after a total disability. Conversely, "zero-day residual coverage" offers benefits regardless of a total disability as soon as the policy's elimination period has passed.

Non-Cancelable vs. Guaranteed Renewable

Individual disability insurance policies can be either "guaranteed renewable" or "non-cancelable." These two terms explain how long a policy can remain in force and how long premiums will remain the same.

A guaranteed renewable policy can be renewed by the policyholder until the insured reaches age 65. The insurance company is not allowed to cancel the policy because of the insured's personal health status or raise premiums for that same reason. If the insurer wants to increase the cost of a guaranteed renewable policy, it must do so for all covered people in a particular class, such as all policyholders in a certain group of professions or age group. When the insured turns 65, the policy might be renewable if the person pays premiums and works a full-time job.

These days, there are more guaranteed renewable policies than non-cancelable policies. A non-cancelable policy can be renewed by the policyholder until the insured reaches age 65. The insurance company is not allowed to cancel the policy unless the purchaser either made a grave misstatement when applying for it or stops paying premiums. The insurer is not allowed to increase the price of the policy even if a proposed increase would apply to all people in a particular class.

Group plans can be cancelled by the insurer or the party paying for the insurance and are not portable when a participant changes jobs or leaves an association. Premiums for group insurance can rise over time.

Pre-Existing Conditions

For obvious reasons, disability insurance companies have little interest in selling coverage to people who are already ill or hurt. This explains why many insurers refuse to honor disability claims that are linked to "pre-existing conditions."

In general, a pre-existing condition is any health problem that caused a person to seek out medical advice or treatment within three to six months prior to the policy's issue date. It can also mean any condition from that period that would have made a reasonable person seek advice or treatment. In some states, a pre-existing condition might be any medical problem that the insured experienced within the past two years.

Pre-existing conditions are typically not covered by group disability insurance until the person has been insured for an extended length of time, such as 12 months or 24 months. Individual policies set similar limitations on pre-existing conditions, but the restrictions might apply only to ailments that were not disclosed to the insurance company prior to the issue date.

Mental Health Benefits

Disabilities involving emotional problems make insurers uncomfortable because they often cannot be detected through medical testing and are not always responsive to medication or cognitive therapy. The potential for large and drawn-out losses remains high enough for many insurers to deny disability coverage to applicants who are taking prescribed psychiatric drugs.

People who make it through the underwriting process and are approved for insurance are likely to have their benefit period shortened to two years when they become disabled by mental illness. This cutoff in compensation will probably be waived if the mental illness puts the insured in a hospital or is clearly caused by an organic disease, such as Alzheimer's disease.

Similar two-year limits are commonly enforced for other kinds of self-reported disabilities that are not easily confirmable. Claims related to chronic fatigue syndrome, an increasingly common issue for insurers, are usually impacted by these restrictions.

It is worth noting, however, that special limitations for mental illness and other self-reported disabilities have angered consumers to the point of legal action. Critics argue that the two-year limits are unfairly discriminatory toward classes of disabled people, and the caps on benefits might not be allowed in a particular state.

Pregnancy

Disabilities stemming from pregnancy can be covered by disability insurance, but it depends on when a woman purchases her policy. If the woman is already pregnant when she applies for insurance, her application can be denied outright or her pregnancy can be treated as a pre-existing condition. If she purchases her insurance before becoming pregnant, she might be eligible for benefits if there are complications. Pregnancy exclusions that are enforced when the policy is purchased can often be eliminated in time to cover the women during subsequent pregnancies.

Though certainly an issue for many women, pregnancy coverage is not utilized after most births. To receive compensation, a woman must experience complications that are enough to disable her beyond the elimination period. Depending on the policy, the elimination period for pregnancy coverage might be longer than the elimination period for other injuries and illnesses.

Rehabilitation Benefits

Some disability policies provide rehabilitation benefits, which can assist people financially as they attempt to reenter the workforce. Benefits can go toward a vocational training program that has been pre-approved by the insurance company. Participants in occupational rehab programs can still receive their regular disability benefits as long as they remain disabled.

Tax Concerns

The taxation of disability benefits is often an important factor when workers can't decide between enrolling in a group plan and purchasing an individual policy. Although group plans are usually less expensive than individual policies, they can produce negative tax consequences during some inconvenient times.

When disability insurance premiums are either paid by an employer or paid by a group member with pre-tax dollars, benefits received by the insured will be taxed as income. From the government's perspective, treating benefits as income makes up for the premiums that the employer deducted for itself as business expenses and for regular compensation that was not reported as income on a healthy employee's tax returns.

Having to pay taxes on disability benefits can be burdensome for people who are unable to work, especially since disability insurance never makes up for 100 percent of someone's income. After taxes, a benefit amount that is supposed to replace 65 percent of one's income might be closer to 40 percent of that income. The 40 percent is certainly better than nothing, but it might not be enough to uphold a family's standard of living for long.

Disability benefits are tax-free when premiums were paid with after-tax dollars. In practical terms, this means that benefits from most individual policies do not need to be shared with the Internal Revenue Service. Group plans funded entirely with participants' after-tax dollars are also treated this way.

When premiums come from the employer as well as from an employee's after-tax dollars, only a fraction of disability benefits will be taxed as income. In general, the fraction of benefits that is tax-free will be equal to the fraction of premiums that was paid with after-tax dollars.

Please note that the information in this section applies to federal tax laws. Each state might have its own way of dealing with disability benefits for tax purposes.

Policy Cancellations

Even a policy that is advertised as "guaranteed renewable" or "non-cancelable" can be rescinded by the insurance company in limited circumstances. If an applicant misstates a major fact or tells a lie that influences an underwriting decision, the insurer often has two years from the policy's issue date to investigate the matter and cancel coverage. (Some lies or misstatements might not result in cancellation but will reduce a person's benefits.) This two-year window is known as the policy's "contestability period."

Grace Periods and Policy Reinstatements

Some disability insurers allow for a "grace period", which lets the policyholder miss payment of a premium without immediately losing coverage. Similarly, if a person misses payments and loses the insurance, it may be possible to have the policy reinstated when those late payments are made. When this is allowed, the insurer is not responsible for covering any disability that began while the person was temporarily uninsured.

Common Exclusions

There are some kinds of disabilities that will not be covered, no matter how severe they might be or how long they might last. These exclusions are important to know, but they aren't difficult to understand. In fact, you might find that many of them are rooted in common sense.

Intentional Injuries

Since insurance premiums are based on risk rather than a person's intentions, disability insurance will not cover someone who purposely becomes ill or injured. The insured will receive no compensation for the aftereffects of a failed suicide and is not supposed to get any benefits when an injury was staged in order to obtain disability checks.

Some older policies have even stricter exclusions and provide no benefits when a person becomes unintentionally injured while intentionally doing something dangerous. Contracts with this language might not cover people who have an accident while engaged in a particularly risky hobby, such as skydiving or bungee jumping.

A few disabilities arguably come close to being intentional but are still covered by most disability insurers. Injuries that result from organ donation or plastic surgery, for instance, can sometimes be covered if they extend beyond the elimination period.

Disabilities caused by alcoholism or drug abuse are often self-inflicted yet not exactly intentional. Some insurance companies treat substance abuse problems in a manner similar to mental illness, limiting the benefit period to a year or two.

Illegal Activity

Insurance companies expect their policyholders to abide by the law and will not compensate someone who becomes disabled while committing a crime. Some policies also specifically state that the insured will receive no benefits while in prison.

Of course, fraudulent disability claims are illegal and will be denied. To shield itself from fraud, an insurance company might ask applicants to disclose any criminal history.

War Disabilities

Disability insurance policies do not compensate people who are hurt while fighting a war or while engaged in other military activities. Instead, benefits are typically provided by the federal government.

Important Riders and Policy Features

Having spent a lot of time going over restrictions and exclusions, let's move in the opposite direction and examine some of the consumer-friendly portions of a disability insurance policy. A few of these attractive features can be found in basic disability contracts. However, most of them are popularly added as riders, often at an additional cost.

Cost-of-Living Adjustment

A benefit amount that seems large enough today might be insufficient in 10 years when the cost of goods and services has increased. Disability policyholders can work around this risk by purchasing a "cost-of-living adjustment" rider.

A cost-of-living adjustment can increase disability payments when the insured has been unable to work for at least one year. On an annual basis, the benefit amount will be recalculated to reflect the 12-month change in a specified economic index.

Though deflation can cause the benefit amount to drop at some point, money owed to the insured will not be lower than the benefit amount that was in effect before the first cost-of-living adjustment. The insurer may impose caps on the cost-of-living adjustment to protect itself from overly expensive claims.

Future Purchase Option

Major changes in people's lives can cause them to reevaluate their insurance situation. When a person gets married, buys a home or becomes a parent, buying more disability insurance often seems like a good idea. At times like these, a "future purchase option" can come in handy.

A future purchase option gives the insured the chance to buy more insurance later in life without having to medically qualify for it. For example, if a healthy man buys disability insurance at 25, becomes diabetic by age 40 and decides to buy more coverage, the insurance company would not be allowed to deny his request for additional coverage or make him pay a higher price because of his diabetes.

A future purchase option can be very helpful, but it cannot be exercised at any time and in any amount. Policyholders may only take advantage of the future purchase option during certain windows of opportunity, often near renewal periods every few years. Some insurers provide additional purchase opportunities when the insured experiences a major life event like the ones mentioned in the first paragraph of this section.

No matter when or how often a future purchase option is used, the additional insurance cannot push the benefit amount above 100 percent of the insured's income. As usual, the insurer will not want the future purchase option to be used as an incentive for people to avoid employment.

People who are interested in a future purchase option should recognize that it can help them when they become unhealthy but not when they are merely getting older. Though health cannot be considered when additional insurance is bought through a future purchase option, insurers are allowed to base the cost of the additional insurance on the insured's age at the time of sale. Also, the amount of coverage that can be bought via the future purchase option can decline as the insured grows older.

Waiver of Premium

Someone who becomes disabled will have plenty of financial worries besides how to keep paying for insurance. If applicants want to keep their coverage intact while they are disabled without having to concern themselves with premiums, they can purchase a "waiver of premium" rider. A waiver of premium excuses the policyholder from paying premiums after the insured has been disabled for 90 days or after the elimination period has passed, whichever comes first.

Return of Premium

One of the barriers to any insurance sale is a person's belief that money will go toward a policy that will never actually be used. A reluctant insurance applicant can minimize this concern by purchasing a "return of premium" rider.

A return of premium provision lets the policyholder receive a refund of premiums that have not been paid back to the insured in the form of benefits. The insurer might add up the amount of premiums that the person has paid, subtract the amount of benefits that the insured has received and multiply that result by a particular percentage. The return of premium might occur at age 65 or at scheduled intervals after several years.

Retirement Protection Riders

When insurance companies cut back on selling disability policies with lifetime benefits, the outlook for retired claimants became awfully bleak. With benefits now commonly ending at age 65, people who remain ill or injured beyond that point must rely on government assistance and their own savings to pay their living expenses. But because they have been disabled and unable to earn an income for so long, these people have missed out on the chance to make adequate contributions to retirement accounts and make extra money through employer matches.

To help their customers deal with this problem, disability insurers offer retirement protection riders. When the insured becomes disabled, the insurer provides an amount equal to the employee's and employer's regular retirement contribution and puts it in an insurer-managed trust. Contributions are made until the insured recovers or turns 65, whichever happens first.

Catastrophic Disability Rider

As if being unable to work isn't bad enough, many disabled people are too hurt or too ill to perform basic personal tasks like bathing or eating. In order to ensure that their needs are met, they might have to rely on around-the-clock assistance from family members or professional caregivers.

Such extreme cases of disability can greatly increase a person's expenses, but the cost might be manageable with the help of a "catastrophic disability rider." A catastrophic disability rider increases a disability policy's benefit amount when the insured is cognitively impaired or is unable to perform two or more "activities of daily living" (ADLs).

Insurance professionals who specialize in long-term care policies are already familiar with ADLs. The most common ADLs are as follows:

- **Bathing:** Including the ability to move in and out of a shower or tub, clean oneself and dry oneself.
- **Dressing:** Including the ability to put on clothing and any medical accessories, such as leg braces.
- **Eating:** Including the ability to chew and swallow food and use utensils.
- **Transferring:** Including the ability to move in and out of beds, cars and chairs.
- **Toileting:** Including the ability to get to a restroom and perform related personal hygiene.
- **Continence:** Including the ability to control the bladder and bowel muscles and perform related personal hygiene.

Principal Sum Benefit

The principal sum benefit (also known as the "capital sum benefit") is basically extra dismemberment insurance. It provides an additional amount of money (often equal to a year's worth of total disability payments) when the insured loses an eye or limb. Even if the insured suffers dismemberment on several occasions, the benefit will be available no more than twice during the person's lifetime.

Hospital Confinement Benefits

Hospital confinement benefits can help the insured receive insurance money without having to go through an elimination period. This policy feature makes the insurer responsible for paying full disability benefits for each day that a sick or injured person is hospitalized. Days spent out of the hospital will not be covered until the end of the elimination period.

Unconventional Kinds of Disability Insurance

There's more to find in the disability insurance market than just individual policies and group plans for workers. High-quality coverage also exists for business owners and can even be included as a rider to more popular insurance products like life

insurance policies. These kinds of disability insurance aren't as popular as those we've already mentioned, but no study of the disability market would be complete without them.

Business Overhead Expense Policies

Few small businesses would be capable of surviving without the labor, expertise and networking skills of their owners. Even if a company is resilient enough to continue during an owner's absence, managers and staff would probably have to work extra hours and tighten the business's budget to remain profitable.

Companies can manage the risk of an owner's disability by purchasing "business overhead expense insurance." If an owner becomes too ill or injured to work, this insurance covers continuing business costs such as employee salaries, rent and utilities. With the appropriate rider attached to it, it can also pay the price of hiring an owner's replacement.

Like disability insurance for individuals, business overhead expense policies have an elimination period and a benefit period. Still, they differ from traditional kinds of disability insurance in a few important ways.

One major difference is the length of the benefit period. Whereas disability policies for individuals can be made to last until age 65 or later, policies that cover business expenses often provide money for no more than two years. It is assumed that if the owner has not returned to work by then, he or she will have at least sold the business or transferred authority in an appropriate manner.

Another difference between business overhead expense insurance and regular disability insurance relates to how the benefit amount is calculated. Regular disability policies provide only a fraction of a person's income, but business overhead policies can cover all of a company's ongoing expenses. The appropriate benefit amount will be determined during the application stage when the applicant shows the insurer proof of regular business expenses. Based on those figures, the insurer will pay for all incurred expenses during a disability up to a specific monthly limit. If a business goes a month without reaching that limit, unused benefits can be carried over and applied to expenses in another month.

A business overhead expense policy does not cover a disabled owner's lost income. In order to receive help with personal expenses, the owner must purchase an individual disability insurance policy or enroll in a group plan.

Disability Buyouts

Businesses with multiple shareholders often draft buy-and-sell agreements, which explain what should happen to a shareholder's stake in a company when the person leaves the organization. When companies purchase insurance to help them comply with these agreements, they are usually trying to make it easier for living owners to eventually purchase a deceased owner's shares. However, insurance can also be used in situations where a shareholder is dealing with a long-term disability.

"Disability buyout insurance" provides money to healthy shareholders so that they can purchase a disabled shareholder's portion of the business. Each policy will probably be designed to help the healthy owners meet the requirements of the company's buy-and-sell agreement. For example, depending on what is stated in the buy-sell agreement, the policy might allow beneficiaries to receive a large lump sum, or it might compensate people through regular installments.

Because there will probably be no need to buy out a shareholder who only has a short-term disability, these policies typically do not pay any benefits until the disability has lasted for a year, two years or more.

Key-Person Disability Insurance

Some employees are so valuable to a business that a company would lose a significant amount of money if any of those workers were to become disabled. A replacement might eventually be hired, but the new employee is unlikely to be as proficient as the disabled employee right away.

Businesses can purchase "key-person disability insurance" to protect themselves from losses when an important employee is too ill or injured to work. Coverage is similar to the kind found in individual policies and group plans, but the benefits are meant to compensate the employer, not the employee. Many sports teams, for example, purchase key-person insurance to reimburse themselves in case a star player with a guaranteed contract becomes seriously injured and can no longer compete.

Disability Riders

If workers would rather not purchase a full-blown disability policy, they might still have the option of getting some coverage as a rider to their life insurance policy. In fact, that's how disability insurance was originally offered to the public.

Disability riders are very similar to regular disability policies, but they offer fewer benefits for a shorter length of time. Instead of receiving benefits that are based mainly on income, the insured might get a few dollars of disability coverage for every $1,000 of life insurance. These benefits usually do not continue for more than a few years.

Other methods that disabled people can use to get money from their insurer include taking advantage of loan provisions in a life insurance policy and making an early withdrawal from an annuity. However, these options are not always preferable or even possible. Policy loans can only be done if the person has permanent life insurance (rather than term insurance), and withdrawals from annuities can create disadvantageous tax situations.

Credit Disability and Dread Disease Insurance

When someone wants insurance but cannot obtain a disability policy or a disability rider, they might try shopping for "credit disability insurance" or "dread disease insurance." These kinds of insurance can be easy to purchase and tend to have small premiums. However, they spark debate in the industry because they only provide benefits under very limited circumstances.

Credit disability insurance makes the insurer responsible for the insured's debt while the person cannot work. Living expenses are not covered by this insurance.

Dread disease insurance gives people money when they are diagnosed with a specific illness. For example, a policy might pay benefits to the insured only in the event of a cancer diagnosis. Money received through this insurance is designed to go toward medical expenses, but policyholders are often allowed to use it as they please.

Conclusion

Disability policies aren't always easy to understand, but gaining an understanding of them and passing this knowledge along to the public can be worth the effort. People who are unaware of disability insurance might end up relying on workers compensation or Social Security and discover all too late that

those sources of protection are sometimes unavailable or inadequate.

Of course, no insurance can prevent all bad things from happening. But comprehensive disability insurance can allow people to focus on recovering from physical problems without having to worry too much about financial ones.

CHAPTER 4: INSURING YOUR HOBBY

Introduction

Since we've spent so much time studying scary, worst-case scenarios, it's probably a good idea to take a relatively light-hearted break and turn our attention to subjects that can be a bit more fun. Let's go over how to insure art, musical instruments, stamp collections and other hobby-related items.

Over the past dozen years or so, flea-market fanatics and consumers of all things collectible have had reason to smile. Thanks to online auction sites such as eBay, accumulating interesting and rare valuables has never been simpler. If you've already run out of antique stores to scour in your town or simply don't have the time to shop for new finds in person, you're no longer out of luck. Nearly anything a buyer might want, be it an antique copy of a great book or an original oil painting from the 16th century, can be purchased from the comforts of home with a few mouse clicks, a little luck and enough money.

Meanwhile, millions of Americans have lounged in their living rooms each week and watched "The Antiques Roadshow," the highest-rated program on public television. The show and others like it can lead viewers to believe that the people who spend their weekends going from garage sale to garage sale might be onto something. The program, which blends history lessons with the big-money thrills of a game show, teaches us that sometimes what looks like junk is not junk at all.

An elderly woman's wallet-sized painting of a baby? Turns out it's worth roughly $15,000, one hundred times what she paid for it in 1950. That 1920s Art Deco jewelry that came from a Hawaiian man's great-aunt? It could fetch nearly $200,000 on the market, according to an expert appraiser.

Recent history has also seen an increase in the number of millionaires around the globe. According to Merrill Lynch and Cap Gemini's 2007 World Wealth Report, there were a record 9.5 million millionaires in the world in 2006. That translates to a jump in the number of people who can splurge on Picassos, diamonds and the best bottles of wine money can buy.

Many new members of the wealthy class have purchased art, antiques, gems and other valuables as a way of satisfying a long-held affection for these supposedly finer things. Others admit they can't tell a Manet from Monet or a real diamond from a fake, but they have gotten into the art and jewelry markets anyway for investment purposes. In fact, the appeal of fine arts has been monetarily enticing enough for some financial service organizations to employ art investment consultants and people who can assist jewelry owners with tax issues.

When examined together, all the aforementioned developments in modern society point to the same conclusion: Consumers have never been more conscious of the fact that a piece of personal property can appreciate in value and either be passed lovingly onto heirs or be sold at a significant profit.

The Insurer's Role in Protecting Valuables

As was hoped by the Chubb Insurance Group when it first agreed to sponsor the "Roadshow" program, the public's attention to art, antiques and other appreciating valuables has created opportunities for dedicated insurance producers. If clients believe an item is worth a small fortune, they are likely to be interested in the ways to properly insure that item against damage, loss or theft.

Would a standard homeowners insurance policy be enough to cover an expensive stamp collection that gets destroyed in a fire? Would special insurance be needed to cover a lost engagement ring? And what about jewelers and gallery owners who handle valuables on a daily basis? How can insurance companies help them protect their inventory?

Believe it or not, there are many insurance professionals who become genuinely excited when given the chance to answer those questions. A lot of the people who help clients insure art were artists themselves at one point or got wrapped up in art history while attending college. For them, an art insurance rider or stand-alone fine arts policy is a link between their private passions and their professional callings.

Other producers lack a personal history with the kinds of property that they insure, but they still find great pleasure in helping consumers protect some very intriguing items. Countless insurers can claim to have helped people insure modest homes and typical household belongings. But how many can say they've helped cover a mummy, a copy of "The Gettysburg Address" or a ridiculously large collection of Coca-Cola memorabilia?

Readers should rest assured that they do not need to become experts in art, antiques, jewelry or wine in order to help insure those things. Being able to tell the difference between an abstract Jackson Pollack painting and a child's wild scribbles is the responsibility of an appraiser and the person who wants to insure the art. It is not the job of the insurance producer.

Still, when given the probable value of a piece of property, the professional producer ought to understand how to cover the item sufficiently. He or she should also be able to tell a client what to expect from the insurer if the item or one like it is ever damaged, lost or stolen. As an added bonus, the insurance professional can explain the risks that are associated with certain kinds of property, so that consumers can better protect their valuables and manage their insurance costs.

This chapter contains special sections on insurance for art, antiques, jewelry, musical instruments and more. Upon reading it, students will have a general understanding of how insurance companies treat each of these items. They are also likely to note commonalities among each section and determine that, no matter the item and no matter its value, there is almost always a way to insure someone's treasure.

Personal Property and Homeowners Insurance

The most basic way to cover art, antiques, jewelry and the like is to rely on the benefits that are made available through either a homeowners insurance policy or a renters insurance policy. Both of those products feature "contents coverage," which is essentially insurance for all the personal property stored in people's homes and elsewhere.

In a homeowners insurance contract, maximum contents benefits are equal to a specified fraction of the corresponding building's insured value. Often, that fraction is equal to one-half or three-fourths of the dwelling coverage. So, if a home is insured for $100,000 with 50 percent contents coverage and is subjected to fire or some other covered peril, the owner will receive no more than $50,000 in contents benefits. Renters insurance involves

practically no dwelling coverage, so the consumer is allowed to choose the amount of contents coverage.

Many people believe that their homeowners insurance is good enough to cover their valuables and collectibles. And contrary to what some aggressive salespersons might say, these customers are not necessarily wrong. Basic benefits may be enough to indemnify a homeowner who loses one or two paintings in a fire. Larger amounts of collectibles may be adequately covered, too, assuming that the contents of the collection are worth a few thousand dollars or less. But people who own pricier pieces deserve to know that there are several limits to what homeowners insurance will cover.

Cumulative Limit

Basic contents coverage under an unaltered homeowners insurance policy applies to unscheduled items. This means that a customer does not declare ownership of any specific items when applying for the policy. In practical terms, it also means the policy's benefit limit is intended to cover all items in a home, other than those that have been excluded specifically from the policy.

The unscheduled approach to coverage can produce positive or negative consequences for a claimant. On the one hand, it frees the person from having to phone the insurer whenever he or she buys something new and wants the item covered. It also allows the insured to get the benefit of the doubt at claim time, helping him or her receive benefits despite a lack of receipts.

On the negative side, the total replacement cost of a person's belongings can be greater than the cumulative benefit limit for unscheduled items. This undesirable situation is particularly possible when damage is done to something of significant value, such as an old painting or a priceless piece of jewelry.

Imagine that a fire has totally destroyed a person's home and that she has a $50,000 limit on contents coverage. Keep in mind that she will need to replace everything she owns with that money. She'll need new clothes, new appliances, new furniture, new kitchenware, and those are just the basics. The $50,000 might turn out to be enough to handle most of her replacement purchases if her extravagances were few. But what happens if she had started an art collection prior to the fire and had lost a $40,000 painting in the blaze?

As an unscheduled item under her policy, the painting would be lumped in with all her other belongings, and she would still receive no more than $50,000 to replace the totality of her property.

Covered Perils

Homeowners insurance contracts can be "named-peril" policies or "all-risk" policies.

Named-peril policies only provide financial protection against those dangers that are specifically mentioned in the insurance contract. Perils that are commonly covered by this insurance include the following:

- Fire or lightning.
- Windstorm or hail.
- Explosion.
- Riot or civil commotion.
- Aircraft.
- Vehicles.
- Vandalism or malicious mischief.
- Theft.
- Falling objects.
- Freezing.

An all-risk policy provides financial protection against every peril, other than those that are specifically listed as exclusions. Some of the commonly excluded perils within all-risk policies are listed below:

- Flood.
- Earth movement, including earthquakes.
- Wear and tear.
- Mold.
- Rot.
- Acts of war.
- Nuclear reactions.

The most popular form of homeowners insurance is the HO-3 form, which many insurance people market as an all-risk policy. Yet the "all-risk" tag is often only partially appropriate in that case.

While H0-3 policies are all-risk in regard to dwelling coverage, their contents coverage may be offered by default on a named-peril basis. This still entitles policyholders to benefits when common perils like fire and theft leave them without a valuable work of art or piece of jewelry. But it keeps the door open for countless kinds of uninsured losses. Hypothetical claims that would almost certainly be denied under this kind of policy include the following:

- A claim for a ring that fell down a drain.
- A claim for an antique vase that was knocked over by a housecat.
- A claim for a stamp collection that was ruined by a spilled drink.
- A claim for a painting that was damaged when a careless party guest leaned his elbow into it.

Sub-Limits

Not even all-risk contents coverage can ensure that a homeowner will be reimbursed for the true value of a lost, stolen or destroyed item. In addition to the cumulative benefit limit that applies to all unscheduled items, insurance companies put sub-limits on the amount of money that people can receive in connection with certain kinds of property. Among other possibilities, a homeowners insurance policy typically sets a low ceiling on coverage for jewelry, stamp collections, coin collections, furs and firearms.

Depending on the policy and the item, the insured is likely to receive no more than a few hundred dollars or a few thousand dollars when he or she files a claim for these belongings. The sub-limits are in effect no matter how much an item or collection is worth, and they will often be enforced even if the policyholder has purchased replacement-cost coverage for personal property.

Sub-limits for the aforementioned items exist because these valuables present special levels of risk to insurance companies. Jewelry, for example, is expensive to replace, easy to lose and often the target of thieves. That's a triple whammy that many careful underwriters are likely to shun.

At the same time, though, the sub-limits can be viewed as being beneficial to many insurance customers. The limited protection for jewelry, stamps, furs and firearms helps keep premiums down for people who do not own these items and encourages those who do own them to take greater care of their collections.

If there is a problem with the sub-limits in homeowners insurance, it is that most policyholders do not know they exist. In a survey conducted by the Chubb Insurance Group in 2002, more than 80 percent of participants proved to be unaware of the fact that

coverage for jewelry and other valuables can max out at a few thousand dollars or less.

When appropriate, these underemphasized sub-limits can be turned into non-issues through the purchase of either a special stand-alone policy or an add-on to a homeowners insurance policy.

Covering Valuables Through Add-Ons and Separate Policies

Insurance customers who want special coverage for valuables and collectibles have several options to choose from. They can purchase a rider or endorsement that is attached to their homeowners insurance contract, or they can leave their homeowners policy as it is and buy a separate policy that has been crafted specifically for jewelry, fine arts, musical instruments and other specific types of personal property. Separate policies sometimes give property owners the broadest coverage, but add-ons to homeowners policies can work just fine for many buyers.

Insured Values

One major reason to buy an add-on or a separate policy for valuables is that these products give owners greater control over their items' insured values. An item that would otherwise be subjected to a sub-limit under a homeowners insurance policy can be insured for an amount that at least approaches its true worth.

The special items that are mentioned in this chapter are typically insured for either their "replacement cost" or their "fair market value." An item's replacement cost is whatever amount it would take to purchase a substitute item of like kind and quality. An item's fair market value is basically the amount of money that owners would receive if they were to sell the item in its current condition.

To arrive at either of these figures, insurance companies often require applicants to have a formal appraisal done on their valuables. Pictures, receipts and general descriptions may suffice if an item is being insured for a few thousand dollars or less.

Broader Coverage

Other differences between these special insurance products and homeowners policies relate to the completeness of coverage. In general, these add-ons and separate policies provide all-risk insurance. As a result, the dropped ring, the knocked-over antique, the soggy stamps and the elbowed painting are all likely to be covered if their owner has bought the proper add-on or separate policy. Assorted accidents will only be considered uncovered perils if they are specifically listed as exclusions within the insurance contract.

What About the Deductible?

Add-ons and special policies for valuables often do not have a deductible. This further differentiates these products from homeowners insurance, which typically makes the owner responsible for $250 or more of otherwise insurable losses.

What's Excluded?

Though covered perils under either an add-on or a special policy for valuables tend to be greater in number than covered perils under a homeowners policy, some exclusions will still be enforced. A few of them may be removed for an additional premium. Others may be non-factors if a consumer chooses a separate policy over an add-on.

Commonly excluded perils are as follows:

- Flood.
- Earth movement.
- Accidental breakage (often an optional covered peril).
- Acts of war.
- Wear and tear.
- Damage caused by insects or vermin.
- Damage that occurs during retouching or restoration.
- Loss of property when it is seized by police or other authorities.

Where to Find Coverage

To obtain special coverage for items like jewelry, paintings and collectibles, property owners can turn first to the insurer that issued their homeowners policy. However, many property insurance companies lack experience insuring certain valuables and will not be willing to insure something if they do not adequately understand the relevant risks. Also, even if a property insurance company is willing to insure a few valuables for a customer, it may draw the line when the person's collection is worth a large sum of money.

If the property insurance company isn't comfortable enough adding coverage to its own homeowners contract, the person will have to peruse the market for a separate policy.

When shopping for a separate policy for valuables, a person is likely to work with a specialty broker and come into contact with a specialty insurer. The market for this coverage will be much smaller than the homeowners insurance market, but consumers are likely to find at least one or two companies or agencies that are not scared off by the items in question.

There are insurers that specialize in fine arts, jewelry, musical instruments and oddball collectibles. Some even extend their services to gallery owners, professional jewelers and other businesspeople who handle valuables on a daily basis.

Scheduling and Blanket Coverage

People can specially insure their valuables by "scheduling" them. Scheduling involves itemizing a person's valuables and insuring each item for a specific amount. A person with two paintings, for example, might schedule one of them for $50,000 and the other for $100,000.

Scheduling may minimize disputes at claim time because it often forces the owner to prove ownership of an item before insurance can be issued. It's also a relatively simple solution if a person wants to insure only a few items of special value. Scheduling is less beneficial for people who want to insure large collections, since each item must be appraised and added to the policy individually.

"Blanket coverage" is an alternative to scheduling. Rather than covering different items at different amounts, it provides uniform benefits that apply to every piece in a collection.

Blanket insurance for valuables is likely to feature a cumulative benefit limit as well as a per-item benefit limit. Suppose, for example, that a book collector has insured her manuscripts with blanket coverage that has a $100,000 cumulative limit and a $1,000 per-item limit. If a fire breaks out and destroys all of the collector's books, she may be in line for a full $100,000 settlement. But if the fire only damages two books, the insurer might simply multiply the two books by $1,000 and pay the collector a $2,000 settlement.

Because each item covered by a blanket policy does not require its own appraisal, the per-item limit could work in the collector's favor or against her. If the two books were the gems of her collection and were worth more than $2,000, she won't be fully covered for her loss. Yet if the two books were relatively insignificant and were actually worth less than $2,000, she'll have more than enough insurance to cover the items.

Property Insurance Appraisals

An "appraisal" is a formal, expert opinion that pertains to an item's authenticity, condition and value. It may entail taking pictures of an item, measuring it and conducting historical and market research.

There are many different kinds of appraisals and many reasons for property owners to have one done. For our purposes though, appraisals are mainly important because they help owners decide how much property insurance to buy. They also help underwriters realize how much risk they may be absorbing when they issue a policy.

Appraisals for valuables are usually not required when the items are being insured through a typical homeowners insurance policy. However, appraisals are often mandatory when a person wants to schedule an item for a large sum of money or obtain significant blanket coverage for a collection.

When performed properly and regularly, appraisals can assist owners in understanding the value of their property and can give them a good reason to modify their insurance portfolios. Besides having an initial appraisal completed in order to set coverage in motion, businesses and individuals can pay for additional appraisals that will determine whether an item's value has gone up or down since coverage began.

By and large, things like paintings tend to appreciate in value over time, whereas items like computers and other electronics depreciate in value with each passing year. To avoid being underinsured or over-insured, it is sometimes recommended that policyholders have their valuables appraised every three to five years.

Each appraiser might have his or her own way of assessing fees to consumers. Some might charge a flat amount, while others will charge an hourly rate or a daily rate for their services.

Consumer advocates and insurance professionals generally agree that people should avoid doing business with appraisers who ask for a percentage of an item's appraised value. This sort of fee structure is even forbidden by many appraisal organizations because it creates the appearance of ethical misconduct, leaving people to wonder if an appraiser has inflated an item's value for the purpose of personal gain. Some insurance professionals also caution that an appraisal that is given to a buyer by a seller might be inaccurate, since sellers want their customers to feel as though they have gotten a good deal on an item.

Insurance consumers will want to feel as though an appraiser has the necessary expertise to come up with a well-reasoned assessment of their property's value. An appraiser who specializes in real estate valuations, for example, is probably not the best person to appraise someone's jewelry. Likewise, someone who specializes in appraising business assets is probably not the perfect candidate to evaluate a personal coin collection.

A generalist in the field, called an "estate appraiser," might be the easiest choice for property owners if they have a variety of different items to insure and are looking for a one-stop shop. Otherwise, they will probably be served best by someone whose expertise is focused almost entirely on a specific market.

Due in part to a general lack of licensing requirements for personal property appraisers, there are no guarantees that a person has proper expertise. The absence of regulation in this area contrasts significantly with the state-level licensing requirements that apply to real estate appraisers. Still, many personal property appraisers belong to trade organizations, such as the American Society of Appraisers. These organizations routinely require members to pass exams and adhere to codes of ethics.

Covering Art and Antiques

A homeowners insurance policy does not exclude art or antiques from coverage. Nor does it subject these items of beauty and craftsmanship to any sub-limits. Yet there are several reasons why a person might opt to insure art and antiques through a fine arts add-on or a separate fine arts policy.

With nothing covering it other than homeowners insurance, a painting, sculpture or even a centuries-old piece of furniture is treated like just another piece of personal property. In the event of a covered loss, insurance benefits for these items will come out of a person's general contents coverage and will eat away at the policy's benefit limit. Since contents coverage is often equal to just 50 percent of a dwelling's insured value, this insurance, by itself, might not be enough to cover an expensive collection.

Another problem with basic art and antique benefits in homeowners insurance policies relates to the named-peril nature of regular contents coverage. Something as valuable and fragile as an antique vase can lose a significant portion of its value if it becomes scratched or chipped. However, significant perils like accidental breakage are typically excluded from a homeowners policy. Other excluded perils that an art lover or antique collector might care about include overexposure to sunlight and damage to pieces while they are in transit.

Fine Arts Policies and Add-Ons

Many of these significant risks, among many others, can be managed appropriately when people insure their art and antiques through a fine arts rider or a separate fine arts policy. Overall, these special products are very similar to all the other property-specific riders and policies that are mentioned in this chapter, but they also address some of the risk management concerns that are especially important in the art world. For instance, a fine arts policy or rider is more likely than just about any other policy or rider to be a "valued contract," with an item insured for its market value.

Someone who has a valued contract generally knows how big an insurance cash settlement will be after a loss. If a painting is scheduled for $500,000 and is damaged beyond repair, the owner can expect to receive $500,000 from the insurance company.

Insurers use valued contracts to insure arts and antiques because of the uniqueness of these belongings. If the Louvre were to ever lose Leonardo da Vinci's "Mona Lisa" in a fire, it isn't as if the museum's insurer could get in touch with a wholesaler or even a private dealer and purchase a replacement at a reduced cost. Even if the insurer could get its hands on another work by da Vinci (hardly an easy task to begin with), the replacement would not be a real replacement at all. Rather, the alternate painting would have its own past and its own special

status in the art world, all of which would make it worth something different than nearly every other painting in existence.

As long as an owner can prove ownership of the artwork or antique and as long as the item is stolen or damaged beyond repair, an insurance company is not likely to get involved in a heated debate over art history and replacement paintings. Instead, the company is likely to rely on insurance appraisals that were done on the item and cover the item for its insured value.

The relative predictability of a fine arts settlement does not mean, however, that policyholders can avoid taking responsibility for properly covering their art and antiques. A fine arts policy does not increase in value the minute an insured item becomes more valuable on the market. The owner must evaluate coverage periodically and perhaps make changes to it in order to remain adequately insured.

Suppose a collector of modern art bought a painting 20 years ago and has insured it ever since for $10,000. If the artist has died since that time, resulting in a current market value of $50,000 for the painting, the collector would not be entitled to a $50,000 settlement after a loss. Instead, the claimant would receive no more than $10,000, the original and unchanged value of the insurance policy.

Insuring Fine Art From Place to Place

Insurers who specialize in fine art also understand that valuables such as paintings and antiques are not just things that individuals hang on their living room walls or put atop their mantles. These items travel frequently and are often loaned out to museums and galleries.

Owners may agree to these temporary loans for a multitude of reasons. For instance, putting a piece on display at a venerable museum might increase its value and do wonders for an owner's investment. Risk management is often a deciding factor, too. If a work of art or an antique is on loan to a gallery, that means it is out of the owner's home and that protecting it from theft or damage is the borrower's short-term responsibility.

In spite of these benefits for their owners, paintings and similar items can make an insurer nervous while they travel the globe. Valuables can be crushed on their way to a destination, dropped by movers or stolen from trucks. In fact, according to an item in the trade publication American Artist, most fine arts claims for damage and theft are filed while an insured item is being transported from place to place.

In an effort to manage these unwelcome risks, owners, borrowers and insurers often take several important precautions. When an item is to be transferred temporarily from one party to another, a formal loan agreement is often drawn up. Among other information, the agreement is likely to list the current condition of the item, the party that will be responsible for insuring the item and the party that will be responsible for handling shipments. In most cases, the party that borrows the item (usually a gallery or museum) is the one who insures it.

After arrangements have been made with each party's insurance company, the item will be ready to become covered by the borrower's policy from the time it leaves the owner's hands until it comes back to that person. Coverage has typically been exclusive to transit within the United States and Canada, though worldwide benefits have long been available for an additional premium. Global coverage may also be available through the federal government's Arts and Artifacts Indemnity Program, which will be explained at a later point in this text.

Before an insurer agrees to cover art and antiques in transit, it may insist that shipping guidelines be followed by experienced personnel. An owner cannot just stuff a fragile item in a cardboard box, take it to the post office and expect it to be covered for damage while en route to a borrower's address.

Most paintings should be shipped in wooden, temperature-controlled crates. Antiques require just the right amount of foam so that they are properly cushioned without being crushed by too much packing material. If an owner is not sure who to hire to handle packing and shipping, the insurance company might be able to recommend a reliable specialist.

New Purchase Protection

When people pay big money for art or an antique, there is always a chance that their new prized possession could get damaged or stolen before insurance coverage can be formally obtained. Luckily for avid collectors, many fine arts policies feature "new purchase protection." Thanks to this feature, a person can buy something valuable and have it covered immediately for a limited time, even if there isn't an insurance agent in sight to schedule it.

Though new purchase protection varies among providers, it usually covers new purchases for 30 or 90 days and is equal to either a set dollar amount or a set percentage of all similar items that have already been insured through the add-on or fine arts policy. As an example, a freshly bought painting might be covered for $10,000 or 25 percent of the cumulative insured value of all paintings that have already been scheduled by the owner.

New purchase protection is not applicable when the owner makes a purchase and has not insured similar items with an add-on or separate policy. In other words, people who have only scheduled their paintings would probably not receive new purchase protection for their first rare stamp.

Pair and Set Coverage

Let us assume that a person has found a full set of antique figurines and wants to insure all the pieces with an add-on or a separate fine arts policy. Though each individual figurine is worth something on the open market, the fact that the set is complete gives it a value that is higher than the sum of its parts.

Insurers that offer fine arts policies often take this into account and make "pair and set coverage" available to their customers. This coverage is also sold by many companies that insure sets of jewelry, including earrings.

Pair and set coverage in a fine arts policy gives an owner the option of receiving the full insured value of a set when a lost or damaged piece causes the rest of the set to depreciate in value. However, in order to receive the full value of a set, the owner must surrender the remaining pieces to the insurer. As an alternative, the insurance contract may permit the owner to keep the rest of the set and receive a cash settlement that covers the depreciation.

Restorations

If a painting or antique is damaged in some way, the insurer might not automatically consider it a total loss. Instead, the insurer may retain the services of an expert who will examine the item and determine if it is possible to restore the item to its full value.

If restoration is possible, the insurer will gladly pay for repairs as an alternative to replacing the item or settling for its insured value. Types of damage that are sometimes reversible through careful restoration include those caused by oxidation, soot or smoke.

Considering a Fine Arts Appraisal?

Whether an owner had an item appraised years ago or is considering having a valuation done on a newly acquired possession, there are a few art-specific concerns that owners should keep in mind. Above all else, art owners should understand that paintings, sculptures and similar items are, in some ways, similar to stocks. Some depreciate over time. Others go up in value over a relatively brief period. Everything depends on attitudes and behaviors within the art market. If owners do not have the desire or the finances to do a regularly scheduled appraisal of their art, they should at least keep tabs on this market and consider contacting an appraiser when supply and demand for their valuables shifts significantly in one direction or the other.

As a way of diving deeper into this point, let's compare the value of a Michelangelo to that of modern art. Even an inexperienced art collector knows that paintings by Michelangelo have been worth a lot of money for a long time, will probably continue to be worth a lot of money for many years and almost certainly should merit some special insurance coverage. On the other hand, many forms of modern art were worth a relatively small amount up until the last few years. But thanks to a flood of new millionaires who flooded the art market toward the end of the last century, modern art increasingly became a tasteful addition to people's collections. People who had long ago insured their modern art for a small figure saw the value of their property rise to significant heights. As a consequence, insurance companies that underwrote fine arts risks encouraged collectors to have frequent appraisals done on their modern art as a way of maintaining sufficient coverage.

Some fine arts policies anticipate the financial appreciation of paintings and other items by offering a kind of inflation protection. For instance, an insurance contract might call for the policyholder to receive as much as 150 percent of a painting's insured value, depending on how much appreciation has occurred between the policy's starting date and the date of a claim. This kind of policy does not penalize the owner when a claim has been made on a depreciated item. If the item is worth less than its insured value and a loss occurs, the owner is still likely to receive a settlement equal to 100 percent of the insured value.

Preventing Damage to Art and Antiques

Since a claim on a fine arts policy can amount to thousands of dollars or more, it is no wonder that insurers stress the importance of risk mitigation to their customers. This stress is communicated not only through marketing campaigns but also through the premiums different people pay to cover their valuables. In general, applicants who have a passion for fine arts and demonstrate knowledge of how to keep their valuables safe will be rewarded with good coverage at an affordable price. Conversely, applicants who demonstrate carelessness with their belongings may face higher premiums.

Contrary to what many fictional capers depicted in books and movies tend to suggest, theft is not the biggest risk to a work of art. Instead, art collectors and their insurers should mostly be concerned about various kinds of damage that can be sustained by an expensive item. Since we have already touched on damage that can be done to art and antiques in transit, we ought to set those risks aside and focus chiefly on damage that can occur in private homes.

Picking the right room in which to store art and antiques could help minimize the need for future restorations and insurance claims. In this way, expensive art is not comparable to personal keepsakes that can be stashed in a typical basement or attic. It sometimes requires just the right climate in order to remain in good condition.

Since moisture can be destructive, paintings should not be placed in a spot where a leak is possible. For fear of water seepage, some people even claim it is a bad idea to hang a painting on a wall if the wall's other side is on the home's exterior. Still, a total lack of moisture in the air can cause wood to warp. As a precaution, the art collector may want to put a humidifier wherever paintings are stored.

Minimized exposure to light and to controlled fires is essential to preserving artwork. Too much sunlight will cause colors to fade, and placement above a fireplace might put an item in unwelcome contact with smoke.

Art Theft

Now and then, details of an art heist will add some excitement to the evening news. Of note, there was the $200 million theft of 12 paintings, including a Degas, a Rembrandt and a Manet, from a Boston museum in 1990. There were the criminals who went into an Oslo museum in 2004 and came out in broad daylight with Edvard Munch's "The Scream". There were even cases involving the Irish Republican Army in which people's stolen art was being ransomed back to them in a proposed exchange of paintings for prisoners. On the whole though, theft of the world's most priceless paintings probably occurs more often in crime novels than in the real world.

Theft of well-known paintings from museums is rare, and when these cases do occur, there is still a decent chance that the art will eventually be recovered. The reasons why are simple. If a painting like da Vinci's "Mona Lisa" were to disappear, the news would reach most corners of the world and be heard by art experts and non-experts alike. Since practically everyone would know about the theft, the painting would become extremely difficult to sell. Probably the only realistic option available to the thief or reseller would be to find a buyer in a foreign country where laws regarding stolen property are not as strict.

The Art Loss Register

In 1991, the art and insurance communities banded together to fight art theft and created the Art Loss Register (ALR). Through offices around the world, the ALR maintains a database of roughly 170,000 paintings, antiques, collectibles and other items and uses that database to help rightful owners recover stolen property. Individuals can register a lost or stolen item, or they can register a new purchase in order to prove that it does not belong to someone else.

On a broader level, the ALR's database is available to national and international law enforcement entities, including the FBI and Interpol, and assists those entities in finding and redistributing works of art. Among other endeavors, the ALR attempted to hasten the return of items that were looted from museums in Baghdad during the recent Iraq war and has provided free recovery assistance to families who lost valuables during the Holocaust.

The ALR's database is not just for art and is not just for well-known pieces. Though the database generally lists items that are worth at least $2,000, registration is open to virtually any item, as long as the owner pays a fee and can properly identify the item for recovery purposes.

Along with contributions from individuals, the ALR receives money from insurance companies that subscribe to its services.

When a lost or stolen item is recovered thanks to the ALR, the organization receives a commission based on the item's value.

Buyback Rights

After a claim for a lost or stolen work of art has been paid, the item becomes the insurance company's property. This means that if the item is ever found, it will not automatically go back to the owner. However, some insurers provide "buyback rights" to policyholders.

In general, buyback rights give a person the ability to purchase a recovered item from an insurance company for the lesser of the claim amount or the insured item's market value. If the insurance company has spent any money in an attempt to recover the item, relevant expenses may be added to the buyback amount. For example, the person who repurchases an antique might have to reimburse the insurer for any reward that was given to an informant.

Title Insurance for Art

As German soldiers stomped their way through various countries during World War II, looting stripped many overrun Europeans of their art. Adolf Hitler and those who were in charge of raids were on the lookout for examples of modern art, impressionism, surrealism or any picture that was at all thought to be "un-German" in its color or style.

Some of the captured pieces were either destroyed or sold to other countries. Other pieces were kept intact by the Nazis and marked for inclusion in a nationalistic art museum that Hitler (himself a failed artist) planned to establish. In total, it is estimated that this long and thorough pillage involved at least one-fifth of all the art in Europe at the time.

During the 70-plus years that have followed the war, successive generations have attempted to return plundered paintings and other works of art to their rightful owners. Of course, this has been good news to victimized survivors and their families, but it has put some modern collectors in a tight spot. If a person has spent thousands of dollars on a painting that turns out to have been stolen in a Nazi raid, what happens to the person's investment when a court gives ownership rights back to the original owner? That question has prompted a recent interest in title insurance for art.

The companies that offer this insurance reimburse collectors when a court orders that ownership of art be transferred to another party. They also cover the defense costs that are related to the case. Premiums can be paid in a lump sum, or they may be payable in yearly installments. Coverage may remain in place as long as the owner does not sell the art or gift it to another party. When the policyholder dies, coverage for the art can extend to the person's heirs.

Before issuing title insurance for art, the insurance company is likely to conduct its own investigation into the item's "provenance" or ownership history. If this investigation gives the insurer reason to believe that the item was stolen, the company will refuse to do business with the applicant. According to the ARIS Corporation, which offers title insurance to U.S. art collectors, the results of this underwriting investigation are considered confidential.

Insurance for Museums

An individual's art collection is often small enough in size and value for the owner to insure each piece fully and separately. Museums, on the other hand, usually lack the resources to follow this risk management strategy. The contents of their collections are often too numerous for scheduling to seem like a practical option, and their collections' value, sometimes in the billions of dollars, often makes full coverage unaffordable.

Rather than insure each work of art for its independent value, many museums prefer to purchase blanket coverage that can apply to every piece in their possession. Under this kind of policy, there is a cumulative benefit limit and usually a per-item benefit limit. For example, a policy might insure an entire collection for a cumulative total of $1 million and limit coverage of each individual item to $100,000.

Museums and galleries have ways of cutting their insurance costs besides adjusting benefit limits. Out of all the paintings and other works that are likely to be in its care, a museum may opt to only insure those pieces that are on display. Or the museum might decide not to insure its most famous pieces against theft, figuring that a criminal would have too difficult a time reselling those items for a theft to be worth all the trouble.

Underinsured museums are probably more common than outsiders believe. The Boston museum that lost 12 paintings in what is believed to have been the costliest case of art theft in U.S. history had no insurance to cover the lifted pieces.

Museums' tendency to leave insurance gaps in place speaks not only to the low frequency of theft in these artistic environments but also to the high level of non-insurance risk management that is typically practiced there. Money and time that could go toward securing scheduled coverage for paintings is often spent alternatively on security systems and fire prevention strategies.

The Arts and Artifacts Indemnity Program

After eight million people in seven cities came to marvel at the wonders of King Tut's tomb between 1976 and 1979, traveling exhibitions featuring paintings, antiques and artifacts started passing through the United States on an increasingly regular basis. But with so much that could go wrong while irreplaceable items are transported around the globe, these tours are understandably difficult to insure through traditional channels.

In an effort to promote the lending of historically significant items from other countries to the United States, the federal government (through the National Endowment for the Arts) introduced the Arts and Artifacts Indemnity Program in 1975. The program provides exhibit-specific insurance to importers and exporters of eligible items when the importer or exporter is a U.S. museum or an American non-profit organization. According to the program's Web site, eligible items can include art, artifacts, historical documents, photos, video tapes and seemingly anything else that is certified by a government designee as being "in the national interest."

Federal insurance can cover an eligible exhibit for up to $1.2 billion and cover multiple exhibits for up to $10 billion at a time. Recipients of the coverage are responsible for a deductible, which can range from $15,000 to $500,000 depending on the exhibit's insured value. As is the case with most commercially available kinds of insurance policies, higher benefit limits require higher deductibles.

Payouts from the Arts and Artifacts Indemnity Program, which are subject to Congressional approval, have proven to be very rare. By the early 21st century, the program had insured more than 700 exhibits and paid only two claims for a total of just over $100,000.

Perhaps that thin claims history stems from strict underwriting guidelines. To be eligible for federal coverage, an applicant must already have some experience at coordinating an international

exhibit. Applicants must also agree to ship eligible items properly and display them in a secure environment. Fragile items, including glassware, some oil paintings and pieces made of parchment, may be considered too delicate for federal coverage.

If a museum is denied coverage by the federal program, it will need to examine its options with commercial insurers.

Covering Jewelry

An unaltered homeowners insurance policy contains a sub-limit that applies collectively to jewelry and furs. Often this sub-limit is no bigger than $1,000 or $2,000 for both kinds of items, though some companies will increase this amount to $10,000 for an additional premium. Unlike other common sub-limits which are enforced when claims relate to damage or theft, the limit on jewelry and furs is only enforced when covered items are stolen.

Even in high society, furs are not bought as commonly as they used to be. Jewelry, though, continues to be treasured by the general public. Therefore, we will set the subject of furs aside at this point and concentrate on the ways in which insurers cover diamond rings, necklaces and all the shiny, showy decorative pieces in between.

"Jewelry" is a broad term, often undefined in insurance contracts, that can be used to describe seemingly any item that adorns a person's body for a decorative purpose. Belongings that fall into the basic jewelry definition are often made of precious or semiprecious stones or metals, but less-valuable items may be thought of as jewelry, too. Though a fake fur is treated like regular contents in a homeowners policy and is therefore not subject to the aforementioned sub-limit, an imitation piece of jewelry (such as a cubic zirconia) is still jewelry from an insurance perspective and will be subjected to a sub-limit if it is ever stolen.

The good news for many insurance customers is that their jewelry's value is often no higher than their policy's sub-limit, particularly when coverage has been increased to $10,000. The bad news is that the limited number of covered perils in their homeowners policy still leaves them with a major insurance gap.

Because jewelry is usually small, it lends itself well to several kinds of accidents around the house, most of which would not be covered by the typical homeowners insurance policy. A piece that falls on the floor and is sucked up by a vacuum cleaner wouldn't be covered, nor would one that is chewed up or swallowed by a mischievous pet. A woman who loses her cherished engagement ring while washing dishes, only to realize that it has gone down the drain, wouldn't be covered either.

Jewelry Policies and Add-Ons

Add-ons and special policies that insure people's jewelry are similar to those that insure art and antiques. They can insure jewelry for its appraised value, or they can cover a collection and contain a per-item benefit limit. There is often no deductible to worry about, and benefits are available on an all-risk basis.

Besides providing financial protection against countless other perils, the all-risk feature allows the policyholder to file valid claims for "mysterious disappearance." This peril (which might not be covered by the most basic kinds of homeowners policies) is not as narrow as it sounds. A mysterious disappearance can indeed involve a loss that has perplexed the jewelry's owner, but it can also involve a disappearance that an owner can easily attribute to a specific accident. For example, when an owner knowingly but unintentionally drops an insured ring down a drain, the loss is covered as a mysterious disappearance.

One major difference between insurance for jewelry and insurance for art relates to how benefits are calculated at claim time. A work of art is usually considered unique and therefore irreplaceable by an insurance company. So a claim for a total loss under a fine arts policy is likely to result in a settlement that is equal to an item's insured value. However, from an insurer's point of view, jewelry can be replaced by other jewelry of like kind and quality.

The insurance community's attitude toward replacement jewelry permits an insurance company to avoid paying the benefit limit of a jewelry policy, even after a total loss. In this case, the claimant is still entitled to a replacement item of like kind and quality, but the insurer can possibly purchase the replacement at a wholesale price.

Considering a Jewelry Appraisal?

Like all other valuables, pieces of jewelry can only be insured properly if the owner has a good sense of their true value. There are at least a few things to keep in mind if a non-expert is thinking about having jewelry appraised.

Above all else, the owner should have confidence in the jewelry appraiser's expertise and trust that the appraiser's verdict will not be influenced by a conflict of interest. A jewelry store that has sold an item to a customer may be willing to include an appraisal with the item, but the buyer and the insurance company might prefer an appraisal from another source. After all, it is possible, if not probable, that the seller will inflate the appraised value in an effort to make the buyer feel like a savvy and satisfied shopper.

People who possess jewelry made out of gold and silver ought to remember that those metals are common investment vehicles. Their value can rise one day and drop the next. Fluctuations in their value might make expensive appraisals of gold and silver jewelry impractical, but they also give insurance customers a reason to evaluate the size of their coverage on a regular basis.

Product Warranty

Insurance for jewelry can be a great relief when an item is lost or stolen, but damage to a piece does not need to result in an insurance claim on every occasion. Before they contact their insurers, owners of damaged jewelry should recognize that some jewelers offer a limited lifetime warranty for their products. Most likely, this warranty extends to cases in which a stone has become unattached from the rest of the item. In order to keep the warranty in place, the owner might need to bring the jewelry back to the jeweler for regular inspections.

Jewelry Theft and Premiums

Jewelry theft is more common than art theft. This is reflected, to some degree, in the cost for jewelry coverage and in the discounts that are available to extra-careful insurance customers.

While annual premiums for fine arts coverage are likely to amount to a few cents for every $100 of insurance, annual jewelry premiums can amount to a few dollars for every $100 of insurance. For some applicants, the size of the premium will depend on where they live. People who reside in rural areas may be offered lower premiums than clients in urban areas, where theft is considered a higher risk.

People in any community can probably reduce their premiums by agreeing to store their jewelry in a safe deposit box for extended periods. When owners agree to this arrangement, they will need to contact their insurer when the jewelry is removed from the box and contact their insurer again when the jewelry has been put

back in its safe place. The premium will be pro-rated to reflect the amount of time that the jewelry was not locked up.

Jewelers Block Insurance

Since the 1880s, insurance companies have tried to address the needs of professional jewelers by selling a product known as "jewelers block insurance."

Jewelers block insurance covers the inventory of jewelry shop owners and wholesalers. Annual premiums may equal a few percentage points of the inventory's insured value, but coverage and cost can be adjusted so that they are in step with a policyholder's business cycle. For instance, a shop owner may decide to have one level of coverage for 11 months of the year and an increased level of coverage in December, when approximately one-third of all diamond sales take place.

Before issuing coverage, underwriters who deal with commercial jewelry are likely to evaluate an applicant's premises and daily procedures. Security systems and the manner in which inventory is displayed to the general public will be especially important.

To be eligible for coverage, a jewelry store may need to have at least two employees on site while the store is being opened or closed. Showcases will need to be equipped with locks, and items may need to go into a safe if the store is going to be unoccupied at any time. While showing pieces to customers, an employee might be permitted to unlock only one case at a time, and the store itself might limit the number of individual items that can be taken out of an unlocked case for a customer's perusal.

If jewelers block policyholders misrepresent their commitment to security, or if they do not follow an insurer's security requirements, their theft claim can be denied.

Covering Stamps, Coins and Other Collectibles

There are many reasons why Americans collect things. A stamp collection might be a cherished item that represents a bond between the parent who started it and the son or daughter who kept it growing. A baseball card collection may be something that has nostalgic value for people who miss the summers of their youth. Or at a basic level, a box of movie memorabilia might just be something that helps introduce like-minded strangers to one another and nurtures some lasting friendships.

Unfortunately, an insurance company cannot reimburse owners for all the love and time that went into a lost, stolen or damaged collection. But it can offer policies that cover the monetary value of people's favorite things.

All collectibles can be insured up to a point through a typical homeowners insurance policy. However, some of the most traditional kinds of collections may not be covered for all that they're worth. Stamps and other fragile items made out of paper will only be covered up to a certain dollar amount if they are damaged or stolen. Depending on the policy, this sub-limit can range from a few hundred dollars to a few thousand dollars. Similarly, a homeowners insurance policy will have a sub-limit of a few hundred dollars for collectible paper money and coins.

Additional coverage for stamps and coins might not be important to people with small collections, but big-time collectors might have an interest in it. Deals on special policies for these items are sometimes available to members of hobby associations, such as the American Philatelic Society (which is for stamp collectors) and the American Numismatic Association (which is for coin collectors).

Insurance for other collectible items (stuffed animals, toys, memorabilia, etc.) usually does not involve any sub-limits. Still, owners sometimes buy add-ons and special policies for these things in order to obtain all-risk coverage.

Shopping around for special insurance for collectibles has its plusses and minuses. On one hand, an insurer might have reason to view some collectibles as low risks for theft. After all, a common thief probably doesn't have his or her pulse on the market for mint-condition action figures and, therefore, probably wouldn't waste valuable time sifting through a victim's toys. On the other hand, the claims history for various collectibles is relatively thin, making the magnitude of other risks unclear to many underwriters.

If an insurer does not specialize in covering collectibles, the cost of insuring unconventional items with that company may be relatively high.

Covering Musical Instruments

In some cases, an instrument can be just as valuable as a work of art. A violin, in particular, can be worth a large amount of money depending on who made it and how many similar pieces are thought to exist.

Unlike a work of art, an instrument often cannot maintain its market value if it is kept in storage or put on display in a glass case. Optimum sound may only be achievable if the instrument is played regularly. Of course, playing an instrument on a regular basis opens the door for accidental breakage, a risk that is not covered by a basic homeowners insurance policy.

Professional musicians have it even tougher since their instruments are considered business property, which receives only minimal coverage under a homeowners insurance policy. A property insurer may have an income-based cutoff point that separates professionals from non-professionals. If so, a musician may be able to play occasionally for money and still have some losses covered by homeowners insurance.

Musicians of all skill levels can buy an add-on or a separate policy to eliminate these coverage gaps. An insurance contract that specifically caters to musicians is likely to cover instruments and musical equipment on a worldwide, all-risk basis.

Beyond that, policy features may be unique to each insurer. Some policies have a deductible for each loss, while others do not. Some policies will cover theft from an unattended vehicle, while others will exclude it.

Covering Fine Wines

A wine collection can be a financial asset as well as a source of rich dinnertime enjoyment. But maintaining a fine assortment of flavors can be a risk-filled challenge if the owner is not careful.

People who collect expensive wine need to keep their bottles in a controlled environment in order to allow for the natural aging of the grapes. The ideal environment has very little light and an ideal temperature between 55 degrees and 60 degrees. Owners also need to keep everyone's clumsiness in check so that a highly valued vintage is not dropped or knocked over.

Because neither a temperature problem nor accidental breakage is usually covered by homeowners insurance, a collector will sometimes purchase special coverage for wine in the form of an add-on or a separate policy. Wine collectors can schedule each bottle for its own amount of coverage, or they can insure every bottle for the same amount with blanket coverage. If they wish, they can even combine the two methods by scheduling a

particularly valuable bottle and covering everything else with a blanket policy.

Whichever way they choose to cover their collection, owners who drink a bottle of wine or give one away as a gift will want to inform the insurance company of their action. That way, the owner will not continue to pay for coverage that is no longer necessary.

Conclusion

Admittedly, many of the add-ons and special policies that have been the stars of the last several pages can be thought of as niche products. With the possible exception of jewelry, they cover items that the typical American family might not own. They do, however, demonstrate how well insurers have recognized the uniqueness of each possible applicant.

By offering special products that can be adjusted or formulated to cover seemingly all types of personal property, insurance companies are building relationships with people who have intriguing passions. Their commitment to offering these products to all kinds of collectors is likely to help the industry add to its own collection of satisfied customers.

Below is the Final Examination for this course. Turn to page 118 to enroll and submit your exam(s). You may also enroll and complete this course online:

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FINAL EXAM

1. Most life insurance purchases are made to help survivors deal with the financial consequences of _____.
   A. estate taxes
   B. rising education costs
   C. a loved one's death
   D. business continuation issues

2. Rather than rely on basic calculations of human-life value, most of today's life insurance professionals estimate the suitable amount of coverage by _____.
   A. interviewing friends and family
   B. using pre-determined actuarial values
   C. averaging likely income over several years
   D. conducting some kind of needs analysis

3. Most life insurance in the United States is issued by _____.
   A. large insurance companies
   B. fraternal organizations
   C. banks and credit unions
   D. independent investors

4. Insurance companies can generally be categorized as either "stock companies" or "_____."
   A. financial companies
   B. mutual companies
   C. excess and surplus companies
   D. managing general agencies

5. Life insurance policies that have the potential for payments of dividends are called _____.
   A. cash-value products
   B. variable-term products
   C. participating policies
   D. non-participating policies

6. In addition to being regulated by the state insurance department, an insurance agent who sells variable life insurance is also regulated by a national regulatory body called the _____.
   A. Federal Insurance Office (FIO)
   B. Financial Industry Regulatory Authority (FINRA)
   C. Department of Health and Human Services (HHS)
   D. Department of Labor (DOL)

7. Along with explaining products and evaluating consumers' needs, life insurance agents often act as _____.
   A. unlicensed attorneys
   B. policy beneficiaries
   C. field underwriters
   D. independent adjusters

EXAM CONTINUES ON NEXT PAGE

8. Information about an applicant's health is central to _____ insurance underwriting.
   A. property
   B. casualty
   C. life
   D. marine

9. Life insurers use industry databases and attending physicians' statements to verify applicants' _____.
   A. medical histories
   B. insurance needs
   C. criminal record
   D. marital status

10. The ability to transfer a life insurance policy's ownership rights to someone else is known as _____.
   A. rescission
   B. assignment
   C. revocation
   D. post-claims underwriting

11. For the purpose of life insurance, insurable interest only needs to exist at the point when the insurer _____.
   A. receives the application
   B. charges the last premium
   C. pays the death benefit
   D. consolidates with another carrier

12. Many life insurance policies include a "wavier of premium" provision, which excuses the owner from paying premiums while he or she is _____.
   A. out of the country
   B. significantly disabled
   C. participating in a legal proceeding
   D. pursuing a policy replacement

13. The size of the death benefit that will be payable to beneficiaries is sometimes known as the policy's _____.
   A. dividend
   B. maturity amount
   C. face amount
   D. human life value

14. The ways in which death benefits can be paid to beneficiaries after the insured's death are called _____.
   A. dividend options
   B. settlement options
   C. policy riders
   D. insuring agreements

15. Most beneficiaries are _____.
   A. children
   B. trusts
   C. revocable beneficiaries
   D. irrevocable beneficiaries

16. Similar to the incontestability clause, the "suicide clause" allows the insurance company to deny death benefits to beneficiaries if the insured commits suicide within _____ years of the policy's issue date.
   A. two
   B. five
   C. 10
   D. 15

EXAM CONTINUES ON NEXT PAGE

17. The _____ begins on the day the policy's owner receives the newly issued life insurance policy from the insurer.
    A. deductible period
    B. free-look period
    C. coinsurance period
    D. assignment period

18. A rider allowing for a "guaranteed purchase option" gives the owner the opportunity to purchase additional life insurance at various points without needing to _____.
    A. pay extra for it
    B. medically qualify for it
    C. contact the insurance company
    D. provide identifying information

19. A "double indemnity" rider is a popular add-on to life insurance policies that doubles the death benefit if the insured dies ____.
    A. within a month of the sale
    B. in an accident
    C. from a pre-existing illness
    D. of natural causes

20. Term life insurance is a good fit for people whose need for coverage is _____.
    A. permanent
    B. temporary
    C. mandated by law
    D. incalculable by a producer

21. Unlike the various types of permanent life insurance, term life insurance has no _____.
    A. beneficiary
    B. death benefit
    C. cash value
    D. settlement options

22. _____ life insurance is intended for individuals whose need for life insurance is unlikely to ever end.
    A. Group
    B. Industrial
    C. Permanent
    D. Decreasing term

23. Policyholders with permanent life insurance have the option of using their cash value to _____.
    A. get a loan from the insurer
    B. medically qualify for better coverage
    C. convert to a casualty insurance policy
    D. avoid payments of alimony or palimony

24. Variable life insurance is a form of permanent life insurance that exposes a policy's cash value to market risks in exchange for _____.
    A. lower premiums
    B. more guarantees
    C. potentially higher returns
    D. larger death benefits

EXAM CONTINUES ON NEXT PAGE

25. Life insurance producers who want to sell variable life insurance must also be licensed to sell _____.
    A. securities
    B. finite insurance
    C. reinsurance
    D. endowment contracts

26. _____ is meant for businesses that are worried about the financial impact of an important employee's death.
    A. Key-person life insurance
    B. Credit life insurance
    C. Industrial life insurance
    D. Disability income insurance

27. Life insurance death benefits are generally _____.
    A. taxed as income to the beneficiary
    B. taxed as income to the insured
    C. taxed as income to the owner
    D. tax-free to the beneficiary

28. The risk of underinsurance _____ with each passing year of home ownership.
    A. decreases
    B. increases
    C. stays the same
    D. is unavoidable

29. Insurance that does not take depreciation into account is known as _____.
    A. commercial property insurance
    B. buy-back value coverage
    C. replacement-cost coverage
    D. market-value coverage

30. With the price of defending oneself in court so high these days, it is important for an insured to know that defense costs are included in nearly all _____.
    A. commercial property policies
    B. homeowners insurance policies
    C. credit life insurance policies
    D. disability insurance policies

31. The insurer's obligation to pay defense costs is usually _____ its obligation to pay damages or settlement costs.
    A. less than
    B. greater than
    C. equal to
    D. a specific fraction of

32. The HO-1 policy form is sometimes referred to as the _____.
    A. basic form
    B. intermediate form
    C. condominium form
    D. replacement-cost form

33. The majority of residential tenants _____.
    A. are insured for premises liability
    B. do not have renters insurance
    C. are covered by dwelling policies
    D. are liable for poor exterior maintenance

EXAM CONTINUES ON NEXT PAGE

34. _____ and townhouses are covered by a master policy , which is purchased by an elected association on behalf of all residents in the complex.
    A. Apartments
    B. Single-family homes
    C. Condominiums
    D. Boarding houses

35. The coinsurance clause in a homeowners policy gives people an extra incentive to _____.
    A. adequately insure their dwellings
    B. have jewelry and artwork appraised
    C. shop regularly for a new agent
    D. alert the insurer to changes in familial status

36. If a homeowner does not insure the dwelling for at least 80 percent of its replacement cost and suffers a partial loss, the insurer will _____.
    A. pay the owner an amount equal to the property's actual cash value
    B. pay the owner an amount equal to the property's replacement cost
    C. not reimburse the insured for the entire loss
    D. choose the contractor who will do repairs

37. _____ replaces a portion of people's income when they are too sick or too hurt to do their job.
    A. Medical expense insurance
    B. Long-term care insurance
    C. Stop-loss insurance
    D. Disability insurance

38. If symptoms of an illness were noticed prior to the policy period and were strong enough to cause a reasonable person to seek medical attention, the illness will be viewed as a(n) _____.
    A. genetic condition
    B. pre-existing condition
    C. disability
    D. occupational disease

39. A few disability products are accident-only policies and do not cover losses brought on by _____.
    A. gunshot wounds
    B. chronic muscular problems
    C. head injuries
    D. sickness

40. Coverage based on the person's own job duties is known as _____.
    A. own-occupation coverage
    B. any-occupation coverage
    C. workers compensation
    D. employer-sponsored disability insurance

41. A working person can be covered by short-term disability insurance or by _____.
    A. long-term disability insurance
    B. permanent disability insurance
    C. partial disability insurance
    D. interminable disability insurance

42. The insured is usually not subjected to a new elimination period if the same disability reoccurs within _____ of the person's initial recovery.
    A. six months
    B. one year
    C. two years
    D. five years

EXAM CONTINUES ON NEXT PAGE

43. _____ is vital to group plans because it diversifies the group's risk and makes it possible for coverage to be available to members who have a higher chance of disability.
    A. Medical underwriting
    B. Strong participation
    C. Insurance scoring
    D. Fraud prevention

44. Some disability insurers allow for a _____, which lets the policyholder miss payment of a premium without immediately losing coverage.
    A. grace period
    B. elimination period
    C. extended period of indemnity
    D. free-look period

45. _____ policies only provide financial protection against those dangers that are specifically mentioned in the insurance contract.
    A. All-risk
    B. Named-peril
    C. Participating
    D. Non-participating

46. A(n) _____ policy provides financial protection against every peril, other than those that are specifically listed as exclusions.
    A. all-risk
    B. named-peril
    C. participating
    D. non-participating

47. A(n) _____ is a formal, expert opinion that pertains to an item's authenticity, condition and value.
    A. schedule
    B. rider
    C. appraisal
    D. receipt

48. _____ coverage in a fine arts policy gives an owner the option of receiving the full insured value of a set when a lost or damaged piece causes the rest of the set to depreciate in value.
    A. Named-peril
    B. Act of civil authority
    C. Pair and set
    D. Actual cash value

49. After a claim for a lost or stolen work of art has been paid, the item becomes the _____ property.
    A. claimant's
    B. insurance company's
    C. appraiser's
    D. government's

50. Jewelers block insurance covers the inventory of _____.
    A. jewelry shop owners and wholesalers
    B. antique dealers
    C. personal property appraisers
    D. museums

END OF EXAM

Turn to page 118 to enroll and submit your exam(s)

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1. Ⓐ Ⓑ Ⓒ Ⓓ	8. Ⓐ Ⓑ Ⓒ Ⓓ	15. Ⓐ Ⓑ Ⓒ Ⓓ	22. Ⓐ Ⓑ Ⓒ Ⓓ	29. Ⓐ Ⓑ Ⓒ Ⓓ	36. Ⓐ Ⓑ Ⓒ Ⓓ	43. Ⓐ Ⓑ Ⓒ Ⓓ
2. Ⓐ Ⓑ Ⓒ Ⓓ	9. Ⓐ Ⓑ Ⓒ Ⓓ	16. Ⓐ Ⓑ Ⓒ Ⓓ	23. Ⓐ Ⓑ Ⓒ Ⓓ	30. Ⓐ Ⓑ Ⓒ Ⓓ	37. Ⓐ Ⓑ Ⓒ Ⓓ	44. Ⓐ Ⓑ Ⓒ Ⓓ
3. Ⓐ Ⓑ Ⓒ Ⓓ	10. Ⓐ Ⓑ Ⓒ Ⓓ	17. Ⓐ Ⓑ Ⓒ Ⓓ	24. Ⓐ Ⓑ Ⓒ Ⓓ	31. Ⓐ Ⓑ Ⓒ Ⓓ	38. Ⓐ Ⓑ Ⓒ Ⓓ	45. Ⓐ Ⓑ Ⓒ Ⓓ
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3. Ⓐ Ⓑ Ⓒ Ⓓ	10. Ⓐ Ⓑ Ⓒ Ⓓ	17. Ⓐ Ⓑ Ⓒ Ⓓ	24. Ⓐ Ⓑ Ⓒ Ⓓ	31. Ⓐ Ⓑ Ⓒ Ⓓ	38. Ⓐ Ⓑ Ⓒ Ⓓ	45. Ⓐ Ⓑ Ⓒ Ⓓ
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