Chapter 1

Answers to Review Questions

1. For purposes of this book, risk is defined as the possibility of loss. Uncertainty is the state of mind of being unsure. As a consequence, uncertainty can vary significantly from one person to another, even when each is confronted with the same set of facts, the same objective reality, or the same risk.

2. Damage to the printing equipment and paper are examples of direct losses. The loss of income from having to close temporarily and the extra expense of having to rent other premises at a higher cost are examples of indirect loss.

3. Answers:
   a. Risk—the possibility of Sally's children losing her financial support
   b. Peril—Sally's death
   c. Hazard—her high blood pressure, which increases the chance of loss

4. The types of hazards are as follows:
   a. physical hazards
   b. attitudinal hazard (carelessness)
   c. moral hazard

5. Answers:
   a. Although the probability of death for a woman aged 29 is quite small, she is only one person, and knowledge of the probability is no help in measuring the risk (possibility of loss) she alone faces. If she dies, her family will suffer a loss of her future income that would have been available for their support. The financial loss to her family would be severe even though the chance of loss is small. This situation of low probability but high severity is where insurance works most effectively and efficiently.
   b. Life insurance companies measure their probabilities by observing large numbers (mass) of similar (homogeneous) exposures (females aged 29 insured in the past) in the statistical group from which they make their estimate of the probability of a female dying at age 29. They also apply this estimate to a large number (mass) of (homogeneous) exposures (females aged 29 insured at present) in estimating the percentage of the currently insured females aged 29 who will die during the year. However, the insurer cannot determine any better than Janet whether she or any particular individual in the group will or will not die this year.

6. Answers:
   a. Particular risks are loss possibilities that affect only individuals or small groups of individuals at the same time, rather than a large segment of society. Fundamental risks, in contrast, are loss possibilities that can affect large segments of society at the same time.
   b. Dealing with particular risks is generally thought to be the responsibility of the individuals who are exposed to them. However, some social insurance programs also deal with particular risks. Fundamental risks, on the other hand, are not the
fault of any specific individual; dealing with them is generally thought to be the responsibility of society as a whole through government action.

7. Home ownership can give rise to
   a. pure risk by providing a possibility of loss from fire, windstorm, theft, and many other property-related perils as well as from legal liability (for example, the possibility of someone falling down your shaky stairs to the basement)
   b. speculative risk by providing a possibility of a gain or a loss when the home is sold

8. Insurance is concerned mainly with the economic problems created by pure risks where there is only the potential for loss or no loss. The pure risks confronting individuals and businesses are ordinarily divided into three categories: risks involving the person, risks involving loss of or damage to property, and risks involving liability for injury or damage to persons or the property of others.

9. Gambling creates risk, while insurance transfers or reduces a risk that already exists.

10. A risk must substantially meet the following five requirements:
    - The amount of the loss must be important.
    - The loss must be of an accidental nature.
    - Future losses must be calculable.
    - The loss must be definite.
    - The loss cannot be excessively catastrophic.

    Many insurance risks do not meet each of the requirements perfectly, but when considered as a whole, they may meet the requisites adequately.

11. Risk-tolerance levels vary from person to person, situation to situation, and risk to risk. Based on research on the risk tolerance of individuals, we know the following:
    - Most people are more risk averse than they are risk tolerant.
    - Risk taking in physical or social activities does not necessarily correlate with high risk tolerance in financial matters.
    - The way in which questions about a risk are worded or posed to a person can influence the person's attitude toward that risk.
    - Emotions can severely limit a person's ability to make rational decisions about a risk.
    - People tend to overestimate low-probability risks and underestimate higher-probability risks.
    - People are more likely to be risk averse if the major impact of a possible loss will fall on them or their loved ones, rather than mainly on strangers.
    - Most people have a greater fear of risks with which they are inexperienced than of risks with which they are familiar.

12. Because pure risks generally produce either losses or no losses, they represent a cost to society with little or no offsetting benefit. Losses could cripple a business or cause an individual or family great financial hardship. Direct physical loss, such as fire damage, results in several billion dollars of property loss each year in the United States. Indirect loss, such as lost profits following a direct loss, is also considerable. Billions of dollars are lost, too, because of the loss of human life values due to such perils as death and disability. Even if no losses ever occur as anticipated, at least three factors add to the costs of risks: (1) fear and worry, (2) inadequate preparation, and (3) expenses of managing risks.

13. Insurance can be defined from the following viewpoints:
a. economic—insurance reduces risk by transferring risks to an insurer, who combines policyowners’ potential losses
b. legal—insurance transfers risk by the terms of a contract
c. business—insurance is a financial institution specializing in the treatment of risk
d. social—insurance pools losses by using group members’ contributions to pay losses suffered by some group members
e. actuarial—insurance predicts and distributes losses using actuarial estimates based on principles of probability

14. Risk transfer and risk spreading are key elements in most definitions of insurance. Other common elements include indemnification, the ability to make reasonable estimates of future losses, the ability to express losses in definite monetary amounts, and the possibility of adverse, random events occurring outside the insured’s control.

15. Benefits include the following: Insurance pays for losses, provides a basis for credit, encourages peace of mind, stimulates saving, offers the advantages of specialization, and fosters loss prevention. Costs of insurance include operating costs, insurer profits, opportunity costs, possible increased losses, and adverse selection.

16. Social insurance programs tend to have the following characteristics: compulsory employment-related coverage, partial or total employer financing, benefits prescribed by law but not uniform for everyone, benefits as a matter of right, and emphasis on social adequacy rather than individual equity.

17. Individual insurance is usually owned by the person or entity that is insured or who owns the property. Group insurance is issued as a single contract to someone other than the person insured and provides coverage to a number of persons.

Coverage under individual insurance normally begins with the inception of the contract and ceases with its termination. Under group insurance, individual members may become eligible for coverage long after the inception of the contract or lose their eligibility status long before the contract terminates.

Individual insurance underwriting typically requires the individual to show evidence of insurability. Under group insurance, underwriting is focused on the characteristics of the group, and individual members are usually not required to show evidence of insurability when initially eligible for coverage.

Individual insurance rates are based on characteristics of the insured person, entity, or property; under group insurance, the group as a whole may be experience rated.
Chapter 2

Answers to Review Questions

1. The four steps in the risk management process are identification, measurement, choice and use of methods to treat each identified risk, and administration.

2. Many risk managers might say that the objective is to "preserve the assets and income of an organization or household by providing protection against the possibility of accidental loss." More specific risk management goals might include (1) survival, (2) peace of mind, (3) lower costs (or higher net income), (4) stable earnings, (5) minimal interruption of business operations or personal life, (6) continued growth, and (7) satisfaction of social responsibility with a good public image.

3. The risk manager's responsibilities and authority in a large organization are quite broad and cut across many of the organization's activities. The risk manager of a larger firm has, in a majority of cases, full responsibility in the property and liability area for (1) identifying and evaluating risks, (2) selecting insurers, (3) approving insurance renewals and amounts, (4) negotiating insurance rates, (5) seeking competitive insurance bids, (6) keeping insurance records, (7) choosing deductibles, and (8) handling insurance claims. The risk manager usually shares authority for (1) deciding whether or not to insure or retain (including self-insuring) financial risks, (2) selecting insurance agents and brokers, (3) instituting safety programs, and (4) reviewing contracts other than insurance. In some organizations, the risk manager also has some responsibility for life and health insurance programs, while in others, these programs fall within the scope of the human resources or personnel department.

Sometimes, particularly in small- and medium-sized firms, an insurance agent, broker, or consultant serves as the risk manager, because the organization has no one person assigned to these responsibilities. Larger agencies and brokerages, especially, offer to serve in this capacity. Care must be taken to see (1) that the services are much broader than mere insurance coverages and include loss prevention and other risk treatment alternatives, and (2) that the insurance agency or brokerage representative or consultant knows the firm's special individual needs.

4. Risk control methods attempt to minimize the frequency or severity of losses, focusing on losses that might occur to assets and income. Risk financing methods facilitate paying for losses that do occur.

5. Although some unusual risks with a high chance of loss can be avoided, realistically, risk avoidance is an alternative for only a limited number of risks. Some risks may be impossible to avoid; others may not be economically desirable to avoid because of the high costs of doing so or because avoiding one risk will create another.

6. Unplanned risk retention is the result of lack of planning, or lack of knowledge concerning the exposure. Unplanned risk retention can also result from unintentional or irrational actions or from passive behavior due to lack of thought, laziness, or lack of interest in discovering possibilities of loss.

7. Deductibles lower insurance premiums by eliminating the relatively high claims costs associated with small losses. From the insurer's perspective, deductibles also minimize attitudinal hazards by making an insured responsible for a portion of any loss.

8. Retention through the use of deductibles generally provides a more cost-effective method of handling high-frequency, low-severity losses than the purchase of first-dollar insurance for those losses. With insurance, Sam's premium would contain a charge for expected losses (close or equal to actual losses in the case of high-frequency, low-severity losses). By using a deductible and keeping the freed-up premium dollars invested, Sam can
reduce the cost of his insurance, and he also can earn a return on his money until it is needed to pay the high-frequency, low-severity losses.

9. Family or business retained risks are commonly financed by (1) absorption in current operating expenses or family budgets, and (2) emergency funding and reserves. Businesses also employ (3) self-insurance through a formal program of risk retention, and (4) captive insurers, which are separate subsidiary insurance companies established to write the parent company's insurance.

10. Answers:
   
a. The insurance equation shows that an insurer's sources of income equal the uses of income. An insurer receives income from (1) premiums (or insurance payments from policyowners), (2) investment earnings, and (3) other income. The uses of income are (1) covered losses, (2) the cost of doing business, or expenses, and (3) profits, which may be used to pay dividends or held as retained earnings.

b. Probability measures the chance of occurrence of a particular event. In the field of insurance, the theory of probability has proved to be of great importance in measuring (predicting) losses. The probability of loss is expressed algebraically in a fraction whose numerator is the number of unfavorable outcomes and whose denominator is the total number of all possible outcomes. The insurer can reduce the total of all the uncertainties to within a reasonable degree of certainty. Within calculable limits, the insurer can foresee the normal losses and estimate losses from catastrophes to compute the premium necessary to pay all losses, as well as to cover expenses and profits.

c. As the number of independent events increases, the likelihood increases that the actual results will be close to the expected results. Insurance is concerned with the number of times an event, or loss, can be expected to happen over a series of occasions. Certain events occur with surprising regularity when a large number of instances is observed. The regularity of the events increases as the observed instances become more numerous.

d. Use of the mathematical laws of probability and large numbers requires adequate statistical data. Unless accurate statistical information is available, predictions in the form of probabilities will be defective. In each of the lines of insurance, carefully compiled statistics are assembled to accumulate experience as a basis for rate making.

11. Four methods of risk identification are as follows:

   • **survey forms.** Although most often used in business situations, survey forms are also appropriate for nonprofit organizations, as well as for individuals and families. In the business sector, small- and medium-sized businesses need good risk and insurance surveys as much as larger firms do. The smaller businesses, in fact, are particularly vulnerable to financial ruin as the result of a mistake or omission regarding insurance protection. Risk and insurance survey forms focus on risk detection, identification, and classification. Sometimes they also include estimates of the possible loss values, which are part of risk measurement.

   • **financial statement analysis.** In financial statement analysis, each account in the balance sheet, the profit and loss statement, and other financial statements is listed separately and analyzed to determine the potential perils that might cause losses. A comprehensive analysis of a firm's financial statements thus becomes a very useful method for identifying both direct and indirect losses. Similarly, for a family, financial records can reveal many of the risks confronting a household.
• Personal inspections. Personal inspections of a business or a household by insurance consultants or agents are a significant source of information about possible losses.

• Contract analysis. Hold-harmless agreements can mean liability exposures are transferred to or by the client. Other relevant contracts involve short-term auto rental agreements, auto lease agreements, apartment rental agreements, agreements for the purchase or sale of a house, and the master deed or declarations of a condominium complex.

12. At the level of the household or small business organization, the choice of the best technique or combination of techniques is likely to be determined by such hard-to-quantify factors as the following:

• maximum probable loss associated with a particular risk in comparison with the household's or firm's financial and other capacities for bearing risk
• legal restrictions that may force or preclude the use of one or more of the available techniques
• extent to which the household or firm is able to exert control over the loss frequency or severity associated with the risk
• loading fees (expense charges) associated with the available risk management techniques
• value of ancillary services that may be provided as part of the risk treatment technique, especially the insurance technique
• time value of investable funds that may be gained or lost by using certain of the available techniques
• federal income tax treatment of losses under the various techniques
• possible unavailability of certain techniques for dealing with some pure risks
• ethical considerations

13. A review of insurance priorities first assumes that, for each of the pure risks that have been identified and measured in the risk management process, insurance will be used if it is available. The most suitable policy and its cost are listed for each risk as a benchmark against which to evaluate other possible techniques. Listing insurance policies also clarifies which risks must be treated by means other than insurance—that is, the risks for which no insurance policy is available.

Next, insurance coverages are grouped into priority categories, such as

• essential (for example, insurance required by law or losses of possibly disastrous results for the household or business)
• desirable (for example, losses that would seriously impair but not totally wipe out the financial position of the household or business)
• available (all other types of insurance coverage)

Finally, each insurance coverage is compared with the other available techniques for treating the particular risk.

A different approach to selecting the most appropriate technique is to group the most logical techniques based on the probable frequency and severity of the losses associated with each pure risk confronting the family or organization.

14. The three building blocks in an insurance program are

• Social insurance. The first building block is several social insurance programs, each of which is designed to provide a floor of protection against certain perils. For example, Social Security (OASDI) covers the perils of old age, death, and disability.
• employer-sponsored insurance. The second building block is various insurance programs made available at work. Group insurance programs can provide specified types of coverage, such as group life insurance, group medical expense insurance, and a pension plan.
• individual insurance. The third building block—individual insurance—should fill in coverage gaps left by social insurance and employer-sponsored insurance and increase total coverage amounts to the necessary levels.

15. Norma and Sidney's approach to risk management should follow a four-step process:
   a. Norma and Sidney should begin with risk identification, using a combination of tools, such as survey forms, checklists, and questionnaires; financial statement analysis; personal inspection of their premises; and analysis of any contracts, especially the master deed or declarations on their condominium and the lease agreement on their car.
   b. Norma and Sidney should attempt to measure the risks associated with the various loss exposures they identify, taking into account both loss frequency and loss severity. Among other factors, they should consider both the maximum possible loss and the maximum probable loss associated with their various exposures. For example, the maximum possible loss resulting from fire or hurricane damage to their condominium is likely to be limited to the value of the condominium unit, its contents, and any additional living expenses that result from the damage; they can set insurance limits accordingly. On the other hand, potential liability losses can be very high; to preserve the assets on which their retirement depends, they must be sure to have high limits of liability insurance.
   c. The third step in the risk management process is to evaluate both the suitability and the cost of various methods of treating their pure risks. Property insurance and liability insurance were briefly mentioned in connection with risk measurement, but insurance is not the only option for dealing with risks. Safe driving and periodic physical exams are among many risk control measures Norma and Sidney should consider. In deciding which risks to insure and which to retain, Norma and Sidney can determine whether insurance is essential, desirable, or available, and they can group their various exposures by their frequency and severity characteristics.
   d. Last but not least, Norma and Sidney need to put their risk management plan into action by purchasing insurance, scheduling physical exams with their doctors, and taking other measures to administer their risk management program. They should also engage in a periodic review to address any changes that might be necessary.
Chapter 3

Answers to Review Questions

1. Both stock and mutual insurance companies are corporations. A stock company is owned by stockholders who elect the board of directors and who typically receive any dividends. A mutual company is owned by policyowners who elect the board of directors and who typically receive any dividends.

2. Answers:
   a. Probably the most important reason for demutualization is to enable the insurer to raise capital quickly. A second and often related reason is to enable the insurance company to diversify its activities by acquiring other insurers or other types of financial institutions through the issuance or exchange of stock. A third reason for demutualization is to facilitate payment of certain types of noncash compensation to the insurance company's key executives and board members.
   b. One disadvantage of demutualization is that the time, cost, and complexity may be enormous due to the difficult regulatory, tax, legal, and accounting problems that must be overcome. Of particular importance is the regulatory requirement that the policyowners of the company that seeks to demutualize be compensated adequately for loss of their ownership rights. A second disadvantage of demutualization is that, as a stock company, the insurer might become vulnerable to a hostile takeover. Third, as a stock insurer, the company would have to meet SEC and state rules relating to its equity securities. Fourth, demutualization represents a major change in corporate philosophy by introducing an explicit profit motive, a change that may be difficult for senior executives and other long-standing employees of the former mutual company to accept.

3. Reciprocal exchanges are not mutual insurers in the legal sense because the individual subscribers assume liability as individuals, not as a group as a whole. Another basic difference from mutual insurers is that reciprocal exchanges are not incorporated but are formed under separate laws as associations under the direction of an attorney-in-fact.

4. Lloyd's itself does not directly issue insurance policies; rather, insurance is written by underwriting members who sign "each for himself and not for another." The insurer, then, is not Lloyd's but the underwriters at Lloyd's. A policyowner insures at Lloyd's but not with Lloyd's.

5. Both stock and mutual insurance companies attempt to operate in a very competitive marketplace, and profits or contributions to surplus account for only a small component of the insurance premium. Factors other than the insurer's organizational structure have a greater bearing on the ultimate cost of insurance to the consumer.

6. First, financial planners must understand insurance marketing because they are, in many cases, active participants in the marketing process, deriving some of their compensation from being participants. Second, working with consumers of insurance, financial planners need to understand the choices among insurers and agents that clients must make in buying insurance. Finally, the methods companies use to sell and service insurance contracts are significant in determining their costs and usefulness.

7. The agent's powers are defined by his or her agency contract with the insurer. The agency contract spells out the agent's express authority. The agent also has implied or incidental authority to carry out those acts needed to exercise his or her express authority. An agent's acts may bind the principal even if those acts are outside the scope of the agent's express or implied authority, or if the acts are within the agent's apparent authority. This type of authority arises when the agent, without contrary action by the
principal, performs an act that appears to a reasonable person to be within the agent's express or implied authority.

Among the legal duties an agent owes to his or her principal are the duty to be loyal to the principal, not to be negligent, and to obey instructions given by the principal. Duties the principal owes to the agent include the duty to give the agent an opportunity to work, to compensate the agent, to keep accounts of amounts owed to the agent, and to reimburse the agent for authorized payments the agent makes and liabilities he or she incurs while working for the principal.

8. Answers:
   a. The life insurance agent's authority is limited in the ability to accept business or bind the coverage. The life insurer issues the contract after receiving the written, signed application and, often, a medical examination report. The agent may not cover the policyowner immediately, nor may contract modifications be made later without the insurance company's approval.
   b. Agents appointed to represent property and liability insurers are granted the authority set forth in the agency agreement. These agents may bind their companies for a client's coverage in certain cases. This is done by an oral or written binder, which is temporary evidence of coverage until the full insurance policy is issued by the insurance company.

9. Answers:
   a. Tom would be covered immediately by XYZ Insurance Company under the homeowners policy. Property-liability agents typically have express authority to bind their companies for most cases involving a homeowners policy. However, even if the agent didn't have express authority to bind the company in this case, the company would be bound by the agent's apparent authority exercised when the agent told Tom he was covered.
   b. Tom would not be covered immediately by ABC Life. A life insurance agent does not have the authority to cover the applicant immediately.

10. Answers:
    a. An agent (often referred to as a producer) is a representative of the insurance company (called the principal in agency law). A broker acts on behalf of the applicant for insurance or the policyowner after the insurance goes into effect.
    b. An insurance agent is acting under specific and delegated authority from the insurer and is sometimes authorized to bind coverage within specific limits. A broker, on the other hand, has no such authority. In fact, because the broker represents the applicant or policyowner, the applicant or policyowner is bound by the broker's acts.

11. Answers:
    a. Historically, a general agent was an individual entrepreneur granted a franchise by an insurer to market the insurer's products in a specified geographic area. The general agent represented only that one insurer, and he or she was responsible for hiring, training, motivating, and supervising agents. The general agent was compensated solely by commissions on business the agency produced and was fully responsible for all expenses of operating the agency. In more recent times, however, insurance companies have typically given some form of financial assistance to the general agent, perhaps paying some of the costs involved in hiring and training new agents and/or providing an allowance to cover some of the operating agency's expenses.
b. In the branch office or managerial system, the insurer establishes branch offices in the areas where it writes business, with each branch headed by a manager who is a salaried employee of the insurance company. Again, the manager is responsible for hiring, training, motivating, and supervising agents for the company, but the insurer bears all costs of operating the branch. The branch manager may also receive a bonus as part of his or her compensation, depending on the quantity and quality of business the branch writes. Payment of bonuses to branch managers, together with coverage of some general agency operating expenses, has tended to blur somewhat the historical distinctions between the two agency systems.

c. A variation of the general agency system that has become significant in some life insurance companies is the personal producing general agent (PPGA) system. In this system, the insurer hires an experienced agent with a proven record of sales success as its general agent in a given territory. Unlike a traditional general agent, however, the PPGA's main responsibility is to sell the insurer's products, rather than to build an agency force for the company. The PPGA often receives higher commissions than other agents to help cover his or her own operating expenses. The PPGA may be expected to meet certain sales quotas for the company, but he or she may also be allowed to represent other insurers.

12. Answers:

a. Under the independent agency system, an agency represents several companies or groups of companies, while under the exclusive agency system, only one company is represented.

b. Under the independent system, the agency is an independent business organization and pays its own operating expenses; under the exclusive system, the insurer may cover the agent's operating expenses, particularly for new agents.

c. In the independent agency system, commission rates are generally the same for renewing property and liability policies as for the sale of new policies, while in the exclusive agency system, lower commission rates are paid for renewals than for new business.

d. The independent agent generally has ownership, use, and control of policy and expiration data; under the exclusive system, the insurer has these rights.

e. The independent agent generally collects premiums and settles small claims (although the trend is toward the insurer performing these functions). Under the exclusive system, the insurer generally performs these duties, although the agent may collect initial premiums and settle some small claims.

13. Neither type is inherently better. An independent agency can "shop" among the coverages available from more than one insurance company, but an exclusive agency might be able to provide sound and competitively priced coverage from the single company he or she represents. It is more important for the client to consider the coverage, the price, and the character of the agent than to consider the type of marketing system involved behind the scenes.

14. Answers:

a. The insurance company headquartered in their state is referred to as a domestic insurance company; the insurance company based in another state is technically known as a foreign insurance company. Assuming both companies are licensed to do business in their state, the difference should have no effect on the Olsons.

The mutual insurance company that provides their life insurance is a company owned by its policyowners. As part-owners of the company, the Olsons can vote
to elect the company's board of directors, and they may receive dividends in the form of a check or a premium discount.

The stock insurance company that provides their homeowners insurance is owned by corporate stockholders who have purchased shares of stock. The stockholders elect the company's board of directors. Stockholders may receive dividends.

The reciprocal exchange that provides their auto insurance is an unincorporated association through which each policyowner insures other policyowners. The reciprocal exchange is managed by an attorney-in-fact rather than a board of directors.

Blue Cross and Blue Shield, which provide the Olsons' group medical expense protection, traditionally operated by providing physician and hospital services rather than reimbursing for such services. Today, most such plans operate much like insurance companies, but they may benefit from favorable state taxation, and their underwriting and rating flexibility might be limited.

The differences in these different organizations' corporate structures have little, if any, practical effect on the Olsons.

b. The insurance salesperson who represented many different insurance companies apparently worked for an independent agency—an independent business that has a contract with the various insurance companies it represents. The salesperson representing only one insurer was probably an exclusive agent, contractually bound to sell insurance for one insurance company or group of related companies.
Chapter 4

Answers to Review Questions

1. Answers:
   a. With adverse selection, the insurer's actual losses and expenses on insurance written would far exceed the expected losses and expenses built into its premium rates, and its underwriting losses would tend to be substantial. Through underwriting selection, insurers attempt to choose applicants for insurance so that the insurer's actual losses and expenses on insurance written would approximate the expected losses and expenses built into its premium rates. This would leave an acceptable margin for profit (or at least a small enough loss so that it could be offset by investment income).
   b. Applicants who are not rejected in the selection phase of underwriting are assigned to the class that best fits their hazards and are charged the rate for that class. Therefore, an applicant with greater hazards is likely to be assigned to a class with a higher rate than an applicant who brings fewer hazards to the insurance company.

2. The applicant for an insurance contract often makes both written and oral statements. Signed written statements are normal procedures in life and health insurance, and the application becomes a part of the contract. Auto and business insurance applicants also frequently prepare written statements as a means of giving the insurance company basic underwriting details. Agents in many kinds of insurance give their companies reports, opinions, and recommendations that are valuable aids to the insurers in selecting or rejecting applications. Many insurers maintain separate inspection departments to provide the underwriters with physical inspection and engineering reports on applicants' properties. The insurer's claims department, too, can be a source of important underwriting data for renewal decisions.

   Insurers also combine efforts to maintain bureau or association lists of insurance applicants—for example, MIB offers a centralized source of information about applicants for life insurance. In many kinds of insurance, companies use outside agencies to supplement the information gathered from the applicants, agents, and other insurer representatives. Sources include physicians, financial rating services, credit investigators, motor vehicle reports, court orders, and inspection agencies.

3. The primary purpose of reinsurance is to enable the insurer to spread or diversify losses. Reinsurance also reduces the ceding company's reserve requirements, which drain surplus and restrict growth. In addition, reinsurers offer many technical advisory services to new insurers or those expanding to new types of insurance or territories.

4. Facultative reinsurance is optional for both the insurer and the reinsurer. Each facultative reinsurance contract is written on its own merits and is a matter of individual bargaining between the primary insurer and the reinsurer. In treaty, or automatic, reinsurance, the primary insurer agrees in advance to transfer some types of loss exposures, and the reinsurer agrees to accept them.

5. The objective of insurers and claims departments is to pay covered claims in an amount that reflects a fair and equitable measure of the loss, subject to policy terms.

6. With property insurance, some agents have their companies' authority to settle a simple claim with the policyowner immediately. The authority can extend to actually issuing checks in the name of the company. In life insurance, the agent is often involved in loss payment as an intermediary but not as an adjuster. The life insurance agent usually forwards the death notice and certificate to the insurer, and the check is issued by the
company, often for delivery by the agent to the policyowner's beneficiary. For larger policies, the agent may need to explain various installment payment options in place of a lump-sum cash payment.

7. The four steps in the claims adjustment process are as follows:

   - The insurer must be notified as spelled out in the policy. Often, the time frame is specified as "immediately," "promptly," or "as soon as practicable," and a few types of policies may be more specific. This step must occur with all types of insurance.
   - The claim is investigated to determine whether a loss occurred and, if so, whether it is covered by the policy. In life insurance, this process is usually quite simple, but complicating factors occasionally arise.
   - The third step in the process of adjusting a claim is filing a proof of loss. In life insurance, proof of loss may be in the form of a death certificate. In other lines, a written and sworn statement that details all the specifics of the loss may be required.
   - Finally, the amount to be paid must be determined in one of three ways: denial of the claim, payment of the claim in full, or payment of a lesser amount than the claimant seeks. Life insurance claims are usually simpler because there are no partial losses. There can, however, be some complicating factors that affect the amount to be paid, including an accidental death benefit provision, a misstatement-of-age-or-gender clause, or a settlement option selected by the policyowner or by the beneficiary.

In other lines of insurance, the amount to be paid, if any, can be more difficult to determine. Numerous policy provisions may deal with other insurance covering the same loss, provide for a deductible, specify that recovery will be affected by the amount of insurance carried relative to the value of the covered property, give the insurer the choice of two or three methods to calculate the amount of the loss, stipulate the use of appraisers to establish the amount of the loss, and impose a specific limit on the insurer's liability for certain types of losses.

8. Answers:

   a. The insurance rate is the unit cost for the coverage; the insurance premium is the price charged for the total coverage provided by the policy. The insurance premium is determined by multiplying the rate by the number of exposure units (number of units of coverage).
   b. An insurance rate is typically developed using the pure premium method, which first requires an estimate for the future loss costs per unit of coverage during the policy period. This portion of the rate is called the pure or net rate and entails a statistical analysis of past loss data with a projection of that experience into the future policy period. Added to the pure rate is a loading factor, which covers the insurer's anticipated expenses and provides a margin for profit and contingencies. The sum of the pure rate and the loading is called the gross rate, which is the rate applied to an insured.

9. Answers:

   a. Most of the capital insurers hold comes from premiums paid by policyowners. Funds that are not immediately needed to pay operating expenses are invested, and the return on these investments provides an additional source of capital.
   b. The insurer's funds are used primarily to pay claims. Funds not needed immediately are invested, and earnings on these invested funds help to lower the cost of insurance and to provide a profit for the insurer.
Chapter 5

Answers to Review Questions

1. The general purpose of insurance regulation is to protect the public against insolvency or unfair treatment by insurers. From the state’s viewpoint, regulation is also important as a revenue producer through state taxes on insurance premiums. The insurance business is among the types of private enterprise subject to considerable government regulation because it is generally classed as a business that is “affected with a public interest.” Although competition is an effective regulator for some businesses, uncontrolled competition in insurance could work a hardship on the buyers of insurance, most of whom do not understand insurance contracts.

2. Insurers engage in self-regulation through a variety of collaborative activities. Two examples are the American Council of Life Insurers (ACLI), which promotes better public relations and legislation, and The American College, which strives to improve insurance education and set standards for professional courses and designations.

3. Three basic methods of providing insurance regulation that the government uses are (1) legislative action, (2) administrative action, and (3) court action. Legislation is the foundation of insurance regulation because it creates the insurance laws. The insurance laws of each state are often combined in an insurance code. Administrative action refers to the application and enforcement of insurance laws, which is the responsibility of the insurance commissioner in each state. Court action provides detailed interpretations of troublesome parts of the law.

4. The regulation of insurers falls into the following three categories:

   • formation and licensing of insurers. Insurance companies must meet specific standards of organization that are often higher than those set for general business organizations. Standards are necessary to ensure the solvency, competence, and integrity of the insuring organization. The first step is incorporation, which is an introductory process in which the state recognizes and approves the existence of a new legal identity. The next step, licensing, is a check on the insurer’s financial condition to ascertain that it has the required initial capital and surplus for the kinds of insurance permitted in the license. The objective of licensing is to provide a preliminary method of lessening the chance of the insurer’s financial insolvency, particularly during the difficult formative years.

   • supervision of insurer operations. The states exercise some control over many phases of the operations of insurers. Most obligations of insurers extend years into the future, so the state provides supervision to see that the promises in the contracts are fulfilled. The ways in which insurer operations are supervised are strikingly different among the states and among the various kinds of insurance. Most states provide some regulation of the following: contracts and forms, rates, reserves, asset and surplus values, investments, product licensing, unfair trade practices, unfair claims practices, and taxation.

   • rehabilitation and liquidation of insurers. The insurance commissioner of a state presides over the insurance company’s liquidation. Some liquidations occur due to financial insolvency; others are voluntary in order to effect a corporate reorganization or merger. All outstanding liabilities and contracts may be reinsured so that no loss results to policyowners.

5. Answers:

   a. contracts and forms. Because insurance policies are complex legal documents that are often not fully understood by consumers, they could be used to mislead or
unfairly treat policyowners. Consequently, in many lines of insurance, policy forms must be approved by, or at least filed with, the insurance commissioner.

Life and health insurance contracts are not standard contracts in the sense that similar forms or benefits are required. Most states do, however, provide some uniformity by requiring a number of standard provisions in life and health contracts pertaining to such items as the grace period, loan and surrender values, and the like. Examples of little regulation over contracts are found in the transportation insurance field. Except for a few required provisions, these contracts are among the most nonuniform of insurance contracts and should be carefully studied by policyowners to determine what benefits, conditions, and exclusions they contain.

b. rates. The price of insurance contracts is controlled to a varying degree in the different lines of insurance. In some lines of insurance, such as aviation insurance, practically no regulation exists in the states. In life insurance, regulation involves maintaining minimum reserves, rather than setting the prices that must be charged. Most other major kinds of insurance are subject to some direct rate regulation.

The statutory standards are set forth in an insurance rating law. Basic standards recognized by rating laws usually require that (1) rates be reasonable and adequate for the class of business to which they apply, (2) no rate be unfairly discriminatory, and (3) consideration be given to the past and prospective loss experience and a reasonable underwriting profit. Rates are considered reasonable (not too high) and adequate (not too low) when, along with investment income, they can be expected to produce sufficient revenue to pay all losses and expenses of doing business, and to produce a reasonable profit.

Instead of direct regulation of insurance prices by required rate approval, some state laws supervise the cost of life insurance by limiting the portion of the premium that can be used for expenses other than claims.

c. reserves. The states require insurers to maintain (as a liability) a minimum reserve considered adequate to meet policy obligations as policies mature. In life insurance, the legal reserve is an amount that, augmented by premium payments under outstanding contracts and interest earnings, is sufficient to enable the life insurer to meet its assumed policy obligations. Minimum reserve requirements are also thought to indirectly regulate life insurance rates, at least by reducing the likelihood of inadequate rates.

In property and liability insurance, the unearned premium reserve must at all times be adequate to pay a return premium to policyowners in the event of cancellation of a policy before it expires.

A second type of reserve required of property and liability insurers is the loss reserve. Because many claims do not involve immediate payment of all losses that have occurred, a reserve must be set up to ensure their payment.

d. asset and surplus values. The value of assets reported in the Annual Statements of insurers must be correct and conservative in order that liabilities, reserves, and residual surplus items have true meaning. Securities held by insurers are valued according to practices adopted by a committee of the NAIC. Stocks are usually given year-end market values, while most bonds are carried at amortized values. Some assets of insurance companies are not allowed to be reported in Annual Statements as assets. These nonadmitted assets are thought to be of marginal quality or of little liquidity for policyowners if their insurers should get into financial difficulty.

e. investments. To protect the solvency of insurers, most states have laws governing the types of securities that may be purchased for investment. The strictest
regulations apply to life insurers, which are subject to vigorous supervision of their investment portfolios. Bonds and common stocks are the prime investments in the portfolios of life insurers, although most states grant some limited permission for certain other investments, such as stocks as a percentage of assets or of surplus. Real estate holdings, especially commercial properties, are also limited to a maximum in various states.

The investment of assets by property and liability insurers is also supervised, although the laws are more lenient and vary greatly among the states. The general practice aims at requiring the safest types of investments for all assets held as reserves (unearned premium and loss reserves) and other liabilities. Cash, bonds of high grade and specified experience, and perhaps preferred stocks of proven quality may be permitted for such assets. The remainder of assets (representing capital and surplus) may be invested in a wider range of securities, including common stocks meeting certain standards. Limitations on real estate holdings, the size of single investments in relation to total assets or surplus, and investments in foreign companies, as well as many other restrictions, are also common.

f. agents’ licensing. An important control of insurer operations is through laws in all states that require licensing for insurance agents and brokers. The insurance departments usually administer these laws; the objective is to permit insurers to use only competent and trustworthy representatives. The standards vary tremendously, from little more than payment of a license fee to a comprehensive written examination following required attendance in insurance courses approved by the department. The examinations are often divided into separate tests for different lines of insurance. The examinations for insurance brokers are usually more difficult and extensive than those given to agents. Some adjusters and consultants also must be licensed in a few states. Almost all states now require continuing education as a condition for license renewal.

g. trade practices. Unfair trade practices in insurance are made illegal in all states under laws similar to the Federal Trade Commission Act. These laws aim at retaining jurisdiction for the states (under the provisions of Public Law 15) in preventing fraudulent and unethical acts of agents and brokers. They provide fines and, more important, suspension or revocation of licenses as penalties for violations.

The insurance commissioner has broad powers to prevent unfair practices and exercises this authority by investigating complaints, as well as by initiating investigations of any questionable acts of insurers or their representatives.

h. claims practices. Most states now have enacted laws patterned after the NAIC’s model acts and regulations pertaining to unfair claim settlement practices. Some of the practices that are regarded as unfair are the following:

• failing to investigate claims promptly
• failing to communicate with or acknowledge communications from clients on a timely basis
• failing to provide a reasonable explanation as to why a claim has been denied
• failing to maintain procedures for complaint handling about claims
• misrepresenting pertinent policy provisions affecting claims
• failing to try to settle a claim once the insurer’s liability has become clear
• attempting to settle a claim for far less than a reasonable person would expect to receive based on the insurer’s advertising material
6. In recent years, all 50 states have adopted insurance guaranty fund plans to at least partially protect consumers against the insolvency of insurers. The plans are administered on a state-by-state basis, but usually they assess solvent insurers in order to pay the unpaid claims of an insolvent company and to return unearned premiums to its policyowners. Insurers each pay a proportional share of the losses, based on their premium volume in the state.

The guaranty funds appear to protect the consumer reasonably well. In some states, several improvements have been adopted concerning (1) giving the guaranty funds immediate access to assets of the insolvent insurer (rather than waiting until liquidation proceedings are completed), (2) giving the guaranty funds priority before general creditors to obtain assets of the insolvent insurer, and (3) permitting a tax offset against premium taxes to solvent insurers for money paid into the guaranty funds. Even with these improvements, however, problems remain in the areas of lengthy delays before consumers receive their money and dollar limits on some types of claims that will be paid.

7. Advocates of state regulation of insurance have pointed out such reasons as (1) the local nature of many insurance transactions, for which any difficulties can best be resolved on a state basis, (2) the reasonable success of state regulation for many years, during which insurance has become an important and sound business, (3) the value of regulation on a state-by-state basis, which permits gradual changes and innovations in regulation without applying them to the entire country all at once, and (4) the help of the NAIC in recommending model legislation to the states to achieve some uniformity in insurance regulation. While recognizing that state regulation is not perfect, its supporters claim that federal regulation would be cumbersome, expensive, less effective, and fragmented among dozens of agencies.

Proponents of federal regulation of insurance have criticized state regulation on many points, emphasizing (1) inconsistencies and lack of uniformity in regulation of insurers, (2) inadequate funding for the important tasks of the insurance commissioners, and the short-term and political aspects of their term of office, (3) the need for greater standardization in insurance contracts to cover many interstate exposures, and (4) the desire for increased competition to ensure availability and lower, fairer prices for insurance. Implicit in these criticisms of the present state of insurance regulation is the idea that federal regulation would be better.

8. Probably the single most important criterion a client should use to select an insurance company is the insurer's financial strength. Selection of an insurer should also be based on its willingness to pay claims.

Another criterion that clients should use to evaluate insurers is service. The insurer's ability to provide proper protection for the applicant is essential. As part of the evaluation of an insurer's service, the applicant is interested in knowing whether or not the insurer is liberal with respect to underwriting. The insurer's facilities for loss-prevention recommendations that may reduce insurance costs are also important to the consumer.

Another important criterion in the evaluation of an insurer, of course, is the cost of the products it offers. Initial costs are only part of the necessary analysis; final costs over a longer period of protection must be considered, including possible rate changes, dividends, assessments, or premium adjustments under some types of rating plans.

9. The criteria to help clients choose an agent or broker include

- **knowledge and ability.** The agent or broker must have the background and experience necessary to identify, analyze, and treat risk properly.
- **willingness.** If qualified, can and will the agent or broker also take the time to apply his or her knowledge conscientiously to fully appraise all the client's needs.
and alternatives? The producer must be able and willing to see that services (including those of the producer’s staff and insurance companies) are performed in the most effective way possible.

• **integrity and character.** Agents or brokers must be able to command the confidence and trust of the policyowner.

• **representation.** Good agents or brokers generally do not deal with weak insurers. They must represent or have contacts with one or many insurers that can provide the required protection and services for the policyowner. All the necessary coverages, including even special or unusual ones, must be available through the agent(s) in a prompt and efficient manner and at a reasonable cost. The insurer or insurers represented should be capable of writing many different kinds of insurance with a progressive attitude toward newer coverages and forms designed to meet the particular needs of individual buyers.
Chapter 6

Answers to Review Questions

1. Unlike most of the physical goods—like a car—that are purchased for immediate use, insurance provides future benefits when loss payments are made. However, the relief from anxiety and freedom from worry about financial losses are immediate and continual benefits throughout the period of protection.

   Insurance has a contingent nature, in that benefits are paid based on particular events. Policyowners buy insurance against many perils, despite feeling that such perils will not really cause losses to them. Insurance can be considered a service contract or a bundle of services, rather than a single physical product.

   Financial risk is a final characteristic that differentiates insurance from other goods and services. The basis of the insurance contract is uncertainty about many perils that may cause accidental loss. Insurance transfers the financial risk of such losses to the insurer, a professional risk bearer. Other service contracts may be future and contingent, but they do not involve payment for the occurrence of such unexpected perils as fire, windstorm, disability, and death.

2. Answers:

   a. offer and acceptance. A legally binding agreement, or contract, requires both an offer by one party and an acceptance by another party. In insurance, the offer is usually made in a request for coverage by the prospect, or applicant.

   Before a contract is effective, acceptance of the offer is necessary. In property and liability insurance, the agent often has authority to bind, or accept, the offer even without receiving any payment from the applicant. In life insurance, a written application with the first premium payment is usually considered the offer to the insurer. Most courts hold that acceptance occurs if the applicant meets the normal underwriting standards of the insurer, and coverage becomes effective as of the time of the application and premium payment. If the premium was not paid with the application, the offer to insure is made by the insurer. The insurance is accepted when the contract is delivered to the applicant while the applicant is in good health, and the premium is paid. If the applicant does not meet the underwriting standards of the insurer, the insurer may make a counteroffer with a different contract, which the prospect may accept or reject upon delivery by the agent.

   b. legal purpose. A legally binding contract must have a legal purpose or object. The courts will not enforce a contract that has an illegal purpose or is contrary to public policy.

   c. competent parties. Valid contracts require that the party making the offer and the one accepting the offer be legally competent to make the agreement. In insurance, the most common problem arises in connection with applicants who are under the age of legal majority. Some insurance contracts are voidable by applicants who are minors, and these applicants will receive a full return of the premiums paid if they later decide to make the contract void. Some states have made exceptions for life, health, and auto insurance contracts by establishing special age limits of 14 or 16; beyond this age, minors are considered to have the legal capacity to insure themselves, and a contract is binding on them.
A similar problem may occur in insurance written for insane or intoxicated persons. They cannot make legal contracts because they fail to understand the agreements.

Insurers, too, must be competent to enter into a legal contract by meeting charter and license requirements of the states. In cases where such legal capacity is lacking, many courts have nevertheless held the contracts binding on the insurer, or on its corporate officers personally, rather than penalizing a good-faith purchaser of the coverage.

d. **Consideration.** The final requirement for a valid contract is some consideration exchanged by both parties to the agreement—a right or something of value given up, or an obligation assumed. In insurance, the applicant typically makes a premium payment, or the contract may become effective on the basis of the applicant's promise to pay and to meet other conditions of the contract. The insurer's consideration is its promise to pay for specified losses or to provide other services to the policyowner.

3. **Answers:**

   a. **Unilateral nature.** The insurance contract is a unilateral one because only one party, the insurer, makes a legally enforceable promise. If the company fails to fulfill the promises it makes, such as to pay the specified benefits at the death of the insured, the insurer may be held legally liable for breach of contract. The insured makes no such promises after the contract comes into force (although, of course, failure to live up to policy conditions like paying the premiums may release the insurer from the contract).

   b. **Personal nature.** The insurance contract is personal and covers the person rather than the property. Insurance provides repayment of a loss arising out of an undesired happening by indemnifying the person who has incurred the loss.

   c. **Conditional nature.** The obligation to perform on the part of one of the parties to an agreement may be conditioned upon the performance of the second party. A clause in an insurance contract requiring such performance is usually referred to as a condition. Failure of one party to perform relieves the other party of his or her obligation.

4. **Answers:**

   a. As a general rule, the benefit of doubt in an insurance contract goes to the insured if the terms are unclear.

   b. Sue is bound by the contract whether she read it or not. A planner should take great care to explain the contract to his or her client because the chances are good that the client will not read and/or understand it.

   c. Under the parol evidence rule, oral evidence cannot be used to modify the contract.

5. As a contract of indemnity, insurance provides compensation for a covered loss but only to the extent of that financial loss. Insurance will not buy a new car. However, it will pay an amount of money that reflects the cost of repairing or replacing the vehicle that was damaged or destroyed, subject to any deductible that might apply.

6. The purposes of requiring an insurable interest in insurance contracts are to prevent gambling, to decrease moral hazard, and to help measure the actual loss. Without an insurable interest, a contract is a wager or gambling contract. It also could be an undesirable incentive for some persons to cause losses or injuries on purpose. When an insurable interest exists, no profit results because policyowners merely receive repayment for the loss they have suffered.
7. Answers:
   a. An insurable interest exists because your client may suffer a financial loss if his
debtor friend dies before repaying the loan.
   b. An insurable interest exists because an auto owner or driver can sustain losses to
his or her car by collision, theft, or other perils.
   c. No insurable interest exists because your client did not own the precious stone at
the time it was destroyed. For property to be insurable, an insurable interest must
exist at the time of the loss.

8. The common-law doctrine of subrogation gives the insurer whatever rights the insured
possessed against responsible third parties. It is basically a process of substitution, with
the other driver's insurer taking over the legal rights of its insured to recover from Cheryl.

   In common law, it is a matter of equity that, on paying the insured the amount of the
loss, the insurer has a right of action against any other person who may have caused
the loss.

   The right of the insurer against other negligent persons usually does not rest on any
contractual relationship, but arises out of the nature of the contract of insurance as one of
indemnity. If the insured is indemnified, it would be inequitable for him or her also to try to
collect from the party responsible for the loss. If the insured were permitted to do this, a
double collection of the loss from both the insurer and the party responsible might result
in a profit to the insured. Subrogation also holds wrongdoers responsible for the results of
their wrongful actions, instead of permitting them not to pay only because an insurance
contract bought by someone else was in force. The overall cost of the insurance to
policyowners is also reduced in this manner.

9. The difference between concealment and misrepresentation is that the applicant conceals
if a silence is maintained when there is an obligation to speak; he or she misrepresents if
a statement is made that is not true.

10. Answers:
   a. Declarations are factual statements that identify the specific person, property, or
activity being insured and the parties to the insurance transactions; they also
provide descriptive information about the insurance being provided.
   b. The definitions section carefully defines terms used in the policy. Because
ambiguities in the contract are likely to be construed against the insurer, this
section of the policy is a substantial help in making the insurer's intentions precise.
   c. The insuring agreements spell out the basic promises of the insurance company.
   d. Every insurance policy has exclusions—situations that the insurer does not cover.
The exclusions usually apply to certain perils, types of losses, types of property, or
types of activities.
   e. The insuring agreement is not an absolute promise by the insurer with "no
strings attached." Instead, the promise is a qualified one, enforceable only if the
policyowner fulfills a number of conditions that are spelled out in the policy.

11. Both noncancelable and guaranteed renewable policies give the policyowner the right
to renew the coverage at each policy anniversary date, although possibly only to some
stated age, such as 65. These policies may not be terminated by the insurer during the
period of coverage. A truly noncancelable policy guarantees future rates for the coverage
in the contract itself. In a guaranteed renewable policy, the insurer does not guarantee
future rates for the coverage. Instead, the insurer retains the right to raise the rates for
broad classes of insureds, but not just for individual insureds with poor claims experience.
12. As a general legal principle, whenever the wording in an endorsement or rider conflicts with the terms of the policy to which it is attached, the endorsement or rider takes precedence. The assumption underlying this principle is that an alteration of the basic agreement between the policyowner and insurer more accurately reflects the true intent of the parties than does the basic agreement itself.
Chapter 7

Answers to Review Questions

1. Part A of Medicare and all the benefits of the Social Security program are financed through a system of payroll and self-employment taxes paid by all persons covered under the programs. In addition, employers of covered persons are also taxed. (These taxes are often referred to as FICA taxes because they are imposed under the Federal Insurance Contributions Act.)

In 2011, an employee and his or her employer pay a tax of 6.2 percent each on the first $106,800 of the employee's wages for Social Security. The employee and employer also pay the Medicare tax rate of 1.45 percent on employee wages. The wage bases are adjusted annually for changes in the national level of wages.

Part B of Medicare is financed by a combination of monthly premiums paid by persons eligible for benefits and contributions from the federal government.

2. Answers:

a. Evelyn does not meet the first test to determine if a person is fully insured under Social Security, as she has not earned 40 credits. However, she does qualify as fully insured under the second test. If Evelyn dies or is disabled this year, 28 credits is more than the number of years elapsing after she reached 21 and the year prior to her death or disability.

b. Evelyn is not currently insured because she would not have earned 6 credits during the last 13 quarters if she were to die today. However, this has no bearing on her survivors benefits because she is fully insured.

c. Although Evelyn is fully insured, she is not disability insured because she does not have the minimum number of credits within a recent time period. She would need 20 credits during the last 40 calendar quarters, and she only has 4.

3. A worker who is fully insured under Social Security is eligible to receive monthly retirement income benefits as early as age 62. However, the election to receive benefits prior to the full retirement age results in a permanently reduced benefit. Beginning in 2003, the age at which full benefits are payable started to increase in gradual steps from age 65 to age 67. Workers born in 1960 or later will wait until age 67 for their full retirement benefits. Additional benefits are also available to certain dependents of the retired worker. These dependents include a spouse aged 62 or older, a spouse caring for a worker's child, and dependent, unmarried children under age 18.

4. If a deceased worker was either fully or currently insured at the time of death, the following categories of persons are eligible for benefits:

- dependent, unmarried children under age 18. This child's benefit will continue until age 19 as long as he or she is a full-time student in elementary or secondary school. In addition, disabled children of any age are eligible for benefits as long as they were disabled before reaching age 22.

- a spouse caring for at least one child of the retired worker who is (1) under age 16 or (2) disabled and entitled to a child's benefit

    If the deceased worker was fully insured, the following categories of persons are also eligible for benefits:

- a widow or widower aged 60 or older. However, benefits are reduced if taken prior to full retirement age. This benefit is also payable to a divorced spouse if the marriage lasted at least 10 years. The widow's or widower's benefit is payable to a disabled spouse at age 50 as long as the disability commenced no more than 7
years after the (1) worker's death or (2) end of the year in which entitlement to
a mother's or father's benefit ceased.
  • a parent aged 62 or over who was a dependent of the deceased worker at the
time of death

5. Answers:
   a. The definition of disability requires a mental or physical impairment that prevents
the worker from engaging in any substantial gainful employment. The disability
must also have lasted (or be expected to last) at least 12 months or be expected
to result in death. A more liberal definition of disability applies to blind workers who
are aged 55 or older. They are considered disabled if they are unable to perform
work that requires skills or abilities comparable to those required by the work they
regularly performed before reaching age 55 or becoming blind, if later.
   b. Certain family members not otherwise eligible for Social Security benefits may be
eligible if they are disabled. Disabled children are subject to the same definition of
disability as workers. Disabled widows or widowers must be unable to engage in
any gainful (rather than substantial gainful) employment.

6. Answers:
   a. The primary insurance amount (PIA) is the amount a worker receives if he or
she retires at full retirement age or becomes disabled; it is the amount on which
benefits for family members are based. If a worker is retired or disabled, benefits
are paid to family members, as follows: The spouse at full retirement age, or a
spouse at any age caring for a disabled child or a child under 16, receives 50
percent of the worker's PIA. Each child under 18 or disabled also receives 50
percent of the worker's PIA. If a worker dies, benefits are paid to family members,
as follows: The spouse at full retirement age receives 100 percent of the worker's
PIA. A spouse at any age caring for a disabled child or a child under 16 receives
75 percent of the worker's PIA. Each child under 18 or disabled also receives
75 percent of the worker's PIA. Additionally, a worker's sole dependent parent
receives 82.5 percent, while two dependent parents receive 75 percent each.
However, the full benefits described above may not be payable because of a
limitation imposed on the total benefits that may be paid to a family.
   b. If the total amount of benefits payable to family members exceeds the family
maximum, the worker's benefit (in the case of retirement and disability) is not
affected, but the benefits of other family members are reduced proportionately.

7. If a worker elects to receive retirement benefits prior to full retirement age, benefits are
permanently reduced by 5/9 of 1 percent for each of the first 36 months that the early
retirement precedes full retirement age and 5/12 of 1 percent for each month in excess
of 36. A worker who delays applying for benefits until after full retirement age is eligible
for an increased benefit for each month of late retirement until age 70. The size of the
increased benefit depends on the worker's date of birth.

8. Beneficiaries under full retirement age are allowed earnings of up to $14,160 in 2011, and
this figure is subject to annual indexing for later years. If a beneficiary earns more than
this amount, then his or her Social Security benefit is reduced by $1 for each $2 of excess
earnings. There is one exception to the test: The reduction is $1 for every $3 of earnings
in excess of $37,680 (in 2011) in the calendar year a worker attains full retirement age, for
earnings in months prior to reaching that age.

9. Social Security benefits are increased automatically each January if there was an
increase in the CPI for the 1-year period ending in the third quarter of the prior year. The
increase is the same as the increase in the CPI since the last cost-of-living adjustment, rounded to the nearest 0.1 percent.

10. Social Security benefits do not begin until an application for benefits is made. Applications can be made by phone, online, or in person. To ensure timely commencement of retirement benefits, an individual should apply at least 3 months before he or she wants benefits to begin. Application for disability and survivor benefits should be made as soon as possible after the onset of disability or the death of a covered worker.

An individual will have to file certain specified information and records to prove eligibility for benefits. These include the following:

- Social Security number
- birth certificate
- W-2 forms or self-employment tax return for the prior year
- military discharge papers if applicant had military service
- spouse’s birth certificate and Social Security number if he or she is applying for benefits
- children’s birth certificates and Social Security numbers, if applying for children’s benefits
- proof of U.S. citizenship or lawful alien status if applicant was not born in the United States
- name of bank and account number so benefits can be directly deposited

Proof of death is required for receipt of survivors benefits, and verification of disability is needed to begin disability benefits.

11. If the applicant wishes to appeal a Social Security decision, he or she can do so in writing within 60 days after receiving a written denial of benefits.

The first level of appeal is called a reconsideration; it is a complete review of the claim by someone who did not take part in the first decision. If an applicant disagrees with the reconsideration decision, the applicant may request a hearing. In most cases, applicants will attend such hearings, either in person or by video conference. They may bring representatives and witnesses, and the government may also have expert witnesses. The administrative law judge may question the applicant and witnesses, and the applicant and his or her representative may also question the government witnesses.

If an applicant disagrees with the hearing decision, he or she may ask for a review by Social Security’s Appeal Council. It may refuse to hear the case, return it to an administrative law judge, or make a decision itself. If the applicant disagrees with the Appeal Council’s decision or the Appeal Council refuses to hear the case, the applicant may file a lawsuit in federal district court.

12. Answers:

a. The types of benefits available under Medicare Part A are as follows:

- hospital benefits. Part A pays for inpatient hospital services for up to 90 days in each benefit period (also referred to as a spell of illness). A benefit period begins the first time a Medicare recipient is hospitalized and ends only after the recipient has been out of a hospital or skilled-nursing facility for 60 consecutive days. A subsequent hospitalization then begins a new benefit period.
- skilled-nursing facility benefits. In many cases, a patient may no longer require continuous hospital care but may not be well enough to go home. Consequently, Part A provides benefits for care in a skilled-nursing facility if a physician certifies that skilled-nursing care or rehabilitative services
are needed for a condition that was treated in a hospital within the last 30
days. In addition, the prior hospitalization must have lasted at least 3
days. Benefits are paid in full for 20 days in each benefit period and for an
additional 80 days with a daily copayment charge.

• **home health care benefits.** If a patient can be treated at home for a
medical condition, Medicare Part A will pay the full cost for an unlimited
number of home visits by a home health agency. To receive these
benefits, a person must be confined at home and be treated under a home
health plan set up by a physician.

• **hospice benefits.** Hospice benefits are available under Part A of Medicare
for beneficiaries who are certified as being terminally ill with a life
expectancy of 6 months or less.

b. The following deductibles and copayment are required:

• **hospital benefits.** In each benefit period, covered hospital expenses are
paid in full for 60 days, subject to an initial deductible ($1,132 in 2011).
This deductible is adjusted annually to reflect increasing hospital costs.
Benefits for an additional 30 days of hospitalization are also provided in
each benefit period, but the patient must pay a daily copayment ($283 in
2011) equal to 25 percent of the initial deductible amount. Each recipient
also has a lifetime reserve of 60 additional days that may be used if
the regular 90 days of benefits have been exhausted. However, once a
reserve day is used, it cannot be restored for use in future benefit periods.
When using reserve days, patients must pay a daily copayment ($566 in
2011) equal to 50 percent of the initial deductible amount.

• **skilled-nursing facility benefits.** Benefits are paid in full for 20 days in
each benefit period and for an additional 80 days with a daily copayment
($141.50 in 2011) that is equal to 12.5 percent of the initial hospital
deductible.

• **home health care benefits.** There is no charge for these benefits other
than a required 20 percent copayment for the cost of such durable medical
equipment as oxygen tanks and hospital beds.

• **hospice benefits.** There are modest copayments for some services.

c. Exclusions under Part A of Medicare include the following:

• services outside the United States and its territories or possessions.
However, there are a few exceptions to this rule for qualified Mexican
and Canadian hospitals. Benefits will be paid if an emergency occurs in
the United States and the closest hospital is in one of these countries.
Persons living closer to a hospital in one of these countries than to a
hospital in the United States may also use the foreign hospital even if
an emergency does not exist. Finally, there is coverage for Canadian
hospitals if a person needs hospitalization while traveling the most direct
route between Alaska and another state in the United States. However,
this latter provision does not apply to persons vacationing in Canada.

• elective luxury services, such as private rooms or televisions

• hospitalization for services not necessary for the treatment of an illness or
injury, such as custodial care or elective cosmetic surgery

In addition to the exclusions, there are times when Medicare will act
as the secondary payer of benefits.
a. Part B of Medicare provides benefits for most medical expenses not covered under Part A. These can include physicians' and surgeons' fees, diagnostic tests, physical therapy, drugs and biologicals that cannot be self-administered, radiation therapy, medical supplies, rental of medical equipment, prosthetic devices, ambulance service, mammograms and Pap smears, diabetes glucose monitoring and education, diabetic screening for persons at risk of diabetes, screening blood test for detection of heart disease, colorectal cancer screening, bone mass measurement, prostate cancer screening, pneumococcal vaccination and flu shots, and home health care services as described for Part A when a person does not have Part A coverage or when Part A benefits are not applicable.

b. With some exceptions, Part B pays 80 percent of the approved charges for covered medical expenses after the satisfaction of a $162 annual deductible (in 2011). A lower level of benefits is paid for mental health care. A few charges are paid in full without any cost sharing. These include (1) home health services, (2) pneumococcal vaccinations and flu shots, (3) certain surgical procedures that are performed on an outpatient basis in lieu of hospitalization, (4) diagnostic preadmission tests performed on an outpatient basis within 7 days prior to hospitalization, (5) mammograms, (6) Pap smears, and (7) an initial physical examination.

c. Exclusions include most drugs and biologicals that can be self-administered, most routine examinations, routine foot care, most immunizations, most cosmetic surgery, most dental care, custodial care, eyeglasses, hearing aids, and orthopedic shoes.

14. Medicare Advantage plans include HMOs, PPOs, PSOs, private fee-for-service plans, Medicare medical savings accounts, and special needs plans. These plans must provide all benefits available under Parts A and B. They may include additional benefits as part of the basic plan or for an additional fee.

15. Answers:

a. Medicare Part D is available to all Medicare beneficiaries entitled to Part A and enrolled in Part B. There is a monthly premium. However, the premium is partially or totally waived for persons with very low incomes.

b. Medicare prescription drug plans are private plans offered by insurance companies, managed care plans, and other organizations. There are two basic types of Medicare prescription drug plans. One type of plan is for persons enrolled in most Medicare Advantage plans. As long as the Medicare Advantage plan has such a prescription drug program, members can obtain their prescription drug coverage only through that program. The other type of plan, referred to as a stand-alone plan, is available to persons enrolled in original Medicare or in Medicare Advantage plans without prescription drug programs. The main differences between these two types of plans are in the process of enrollment and premium payment.

c. After an annual deductible ($310 in 2011) is met, the plan pays 75 percent of the next $2,840 of covered drug costs, then payment ceases until the beneficiary's out-of-pocket costs reach $6,153.75. Subsequently, the plan pays up to 95 percent of covered drug costs. All of these dollar amounts are indexed annually.

d. Medicare prescription drug plans do not have to cover every prescription drug, but they must cover at least two in every prescription category. Each plan has a formulary, which lists the drugs it will cover.

16. There are many variations among Medicare prescription drug plans:
• Most plans have more drugs on their formularies than required by law.
• Many plans have no annual deductible or a deductible lower than that of a standard prescription drug plan.
• A few plans provide benefits in the coverage gap.

17. Answers:
   a. All payroll taxes and other sources of funds for Social Security and Medicare are deposited into four trust funds: an old-age and survivors fund, a disability fund, and two Medicare funds. Benefits and administrative expenses are paid out of the appropriate trust fund from contributions to that fund and any interest earnings on accumulated assets. The trust funds have limited reserves to serve as emergency funds in periods when benefits exceed contributions, such as in times of high unemployment.
   b. The solution to ensuring the adequacy of these funds lies in doing one or both of the following: increasing revenue into the trust funds or decreasing benefit costs. There are numerous ways to do each. These ways include raising the tax rate, increasing the wage base for Social Security, subjecting a greater portion of income benefits to taxation, raising the age for benefits, lowering cost-of-living increases, increasing Medicare deductibles and copayments, and establishing some degree of privatization of Social Security.

18. Benefits received in the form of monthly income under Social Security are partially subject to income taxation for some Social Security recipients. If the modified adjusted gross income is $25,000 or less for a single taxpayer ($32,000 or less for married taxpayers filing jointly), Social Security benefits are not taxable. If the modified adjusted gross income is between $25,001 and $34,000 ($44,000 for married taxpayers filing jointly), up to 50 percent of the Social Security benefit is includible in taxable income. If the modified adjusted gross income exceeds $34,000 ($32,001 to $44,000 for married taxpayers filing jointly), up to 85 percent of the Social Security benefit is includible in taxable income. The exact amount of the taxable Social Security benefit is determined by complex formulas that are beyond the scope of this discussion. Medicare benefits and any lump-sum Social Security benefits are received tax free.

19. Answers:
   a. The objectives of unemployment insurance are to provide periodic cash income to workers during periods of involuntary unemployment and to help the unemployed find jobs.
   b. Unemployment insurance programs are financed primarily by unemployment taxes levied by both the federal and state governments.
   c. The right to benefits depends on the worker’s attachment to the labor force within a prior base period. During this base period, the worker must have earned a minimum amount of wages or worked a minimum period of time, or both. The right to benefits is also contingent on an unemployed worker’s being available for work, and being both physically and mentally capable of working.

20. Temporary disability laws enable employees to collect disability income benefits regardless of whether their disability begins while they are employed or unemployed. These laws are generally patterned after the state unemployment insurance law and provide similar benefits.

21. Answers:
   a. Workers’ compensation laws were enacted to require employers to provide benefits to employees for losses resulting from work-related accidents or diseases.
b. Medical care benefits for medical expenses are usually provided without any limitations on time or amount. Disability income benefits are a function of an employee's average weekly wage over some time period. Death benefits provide burial allowances in a flat amount, varying by state; death benefit cash income payments to survivors are a function of the worker's average wage prior to the injury resulting in death. Rehabilitation benefits are payable for medical rehabilitation and vocational rehabilitation.

22. Unemployment insurance benefits and benefits received under temporary disability laws are included in a recipient's gross income. Workers’ compensation benefits are received free of income taxation.
Chapter 8

Answers to Review Questions

1. When an income producer's family is completely dependent on his or her personal earnings for subsistence and the amenities of life and the income earner dies, the unrealized portion of his or her total earnings potential is lost. Life insurance can enable the family to retain the same economic position that they would have enjoyed had the income earner lived. At this point, term life insurance will provide the most protection at the lowest cost. Marty will probably want term insurance that is renewable, to preserve his insurability, and also convertible, so he can change it to permanent insurance when the Gibsons' financial situation improves.

2. The annual premium under the yearly renewable term plan must (along with interest earned during the year) pay the policy's share of death claims each year for the group (class) to which the insured has been assigned. The death rate rises at an increasing rate as age increases for the class from year to year, so the overall premium also rises at an increasing rate.

Premiums under the level-premium plan are constant throughout the premium-paying period. In the early years, the level premium is larger than the policy's share of the death claims. In the years when the level premiums are more than sufficient to meet the policy's share of the death claims, the excess premiums are accumulated at interest in a reserve to help pay the policy's share of the death claims in later years when (in most cases) the policy's share of the death claims is larger than the policy's level premium. With cash value insurance, the reserve increases over the years and equals the face amount of the policy at the maturity of the policy.

The term plan provides protection for the face amount of the policy; the level-premium plan provides protection for the net amount at risk, equal to the face amount of the policy minus the reserve. The term plan provides no cash value; the level-premium plan builds cash value (except for short-term level-premium term policies, where the reserve is very small).

3. Answers:

a.

(1) Term insurance provides temporary death protection for the policy period. With whole life insurance, there is permanent death protection as long as the policy remains in force.

(2) If the insured lives beyond the end of the policy period with term insurance, no benefit is paid. For a whole life policy, if the insured is still alive at maturity age (usually age 100), the policy matures, and the face amount (for tax purposes, the cash value) is paid.

(3) With yearly renewable term insurance, the full gross premium is used to pay mortality costs, expenses, contingencies, and profit. With level-premium policies, whether term or whole life, the early-year premiums are greater than needed (along with interest) to pay mortality costs, expenses, contingencies, and profit. The excess premium is accumulated at an assumed rate of interest in a reserve.

b. If the client buys a 10-year renewable term policy, he or she may extend it at the end of 10 years without proof of insurability. The client will pay the new higher-level premium that reflects the higher death rates in the next 10 years. If
the client's policy was not renewable term, he or she would have to reapply for insurance and prove insurability again.

c. If the client buys a 10-year *convertible* term policy and then needs a more permanent form of insurance, he or she can switch it to whole life insurance or another form of permanent insurance sold by the insurer in the future without proof of insurability.

d. A decreasing term policy can be used for funding the balance of the client's mortgage when he or she dies.

e.  
   (1) There is no difference in permanence of protection.
   (2) With an ordinary life policy, the premium is paid as long as the insured lives (up to the assumed mortality age 99), and premium outlay will be smaller per year than that for limited-payment whole life policies of the same face amount. With limited-payment whole life policies, the shorter the premium payment period, the larger the amount of premium outlay per year.
   (3) Because limited-payment whole life policies have higher premiums for the same death benefit as ordinary life policies, their reserves and cash values are larger than for ordinary life policies.

4. Participating (par) policies provide for the payment of dividends to the policyowner. These policies anticipate charging a small extra margin in the premium with the intent to return part of the premium as policyowner dividends, depending on the extent to which the insurer has favorable experience from interest, mortality, and/or expenses. Nonparticipating policies do not provide for the payment of policyowner dividends.

5. Answers:
   a. An endowment policy pays the death benefit at the death of the insured or at the end of the policy period, whichever comes first. The endowment policy requires a much higher premium than whole life and has a savings element much larger relative to the protection element for whole life insurance.
   b. A 1984 tax law change eliminated the tax-free buildup of cash values for most newly sold endowment policies, so endowment purchases do not make sense today.

6. Answers:
   a. A variable life insurance policy provides no interest rate guarantee and no minimum cash value.
   b. The SEC requires variable life policies to be registered and all sales to be subject to the requirements applicable to other registered securities. Policy sales may be made only after the prospective purchaser has had a chance to read the policy prospectus. The SEC also requires that the insurance company be registered as an investment company and that all sales agents be registered with the SEC for the specific purpose of variable life insurance policy sales. Agents who sell variable life insurance policies must be licensed as both life insurance agents and securities agents.
   c. Variable life insurance policies give the purchaser several investment options into which the funds can be directed. The policyowner is free to put all of the funds into one of these choices or to distribute the funds among the options in whatever proportions he or she desires. Some insurance companies have more than a dozen funds to choose from in their current product offering.
d. Variable life insurance contracts include mortality charges for the death benefits they provide. Consequently, the return on the invested funds within a variable life insurance contract will never equal that of a separate investment fund that does not provide death benefits but invests in assets of a similar type and quality.

e. There are two basic ways used to link a policy’s death benefit to the associated portfolio’s investment performance—the level-additions method or the constant-ratio method. Regardless of the linkage design, a minimum death benefit is guaranteed while the policy remains in force. The purchaser selects a target level of investment performance as a benchmark against which actual investment performance will be measured. Performance in excess of the target level is used to fund incremental increases in the death benefit; performance below the target amount requires downward adjustments in the death benefits to make up for the deficit.

f. After administrative charges, the balance of the premium payment goes into the cash value account. Cash value accounts are further diminished by mortality charges to support the death benefits. The actual value of the cash component is determined by the net asset value of the separate account funds that make up the policy portfolio. The cash value of a variable life policy fluctuates daily. Each day’s net asset value is based on the closing price for the issues in the portfolio on that trading day. Variable life insurance policies usually limit maximum policy loans to a slightly smaller percentage of the total cash value than is traditionally available in whole life policies.

g. The prospectus must contain a full disclosure of all the contract provisions, including expenses, investment options, benefit provisions, and policyowner rights under the contract. Other information explains the expense charges levied by the insurance company against variable life insurance contracts, surrender charges, and investment portfolio information.

7. Answers:

a. Premiums are flexible after the first year—the only time that a minimum level of payment is required.

b. The higher the amount or proportion of prefunding through premium payments, the more investment earnings will be credited to the policy and utilized to cover mortality and administrative costs. All premium suggestions are based on some assumed level of investment earnings, and the policyowner accepts the possibility that actual investment earnings will be less than necessary to support the suggested premium. Even though investment earnings cannot go below the guaranteed rate, a long-term shortfall may necessitate either an increase in premiums or a reduction in coverage at some future point. The accumulations from prefunding are credited to the policy’s cash value and are quite visible to the policyowner. The earnings rates applied to those accumulations are also clearly visible as they fluctuate with current economic conditions.

c. The policyowner can make partial withdrawals from the policy’s cash value without incurring indebtedness. There is no obligation to repay those funds, nor is there any interest incurred on the amount withdrawn. Withdrawals do affect the policy’s future earnings, because the fund still intact to earn interest for future crediting periods is reduced by the amount of the withdrawal. The effect on the death benefit depends on the type of death benefit in force.

d. The target premium amount is the suggested premium to be paid on a level basis throughout the contract’s duration, or for a shorter period of time if a limited-payment approach was originally intended to fund the policy. The target
The premium amount is a suggestion and carries no liability to the insurer if it is inadequate to maintain the contract.

e. (1) The level death benefit design is much like the traditional whole life design. The death benefit stays constant, the cash value increases over time, and the net amount at risk decreases.

(2) Under the increasing death benefit design, a constant net amount at risk is superimposed over the policy's cash value. As the cash value increases, the total death benefit also increases. A reduction in the cash value will reduce the death benefit. At the insured's death, the policy's stated face amount plus its cash value are paid.

f. Most insurance companies credit current interest rates on the universal life cash value as long as there are no policy loans outstanding. Once the policyowner borrows funds from the cash value, the insurance company usually credits a lower interest rate or earnings rate to the portion of the cash value associated with the policy loan.

g. From each premium dollar paid for universal life insurance, deductions are made for expenses and mortality. In addition, the universal life cash value account is increased at the current crediting rate to reflect investment earnings on that cash value. These dollars help to reduce the policyowner's current and future out-of-pocket premium expenses. The actual rate is credited at the insurer's discretion and tends to fluctuate, reflecting current economic conditions.

8. If just enough premium is paid annually to cover policy expense and mortality charges for the year, the universal life policy will essentially be the equivalent of yearly renewable term insurance, providing pure protection for the year with no cash value (savings). As the amount of premium paid in each year increases (with the policy death benefit unchanged), the universal life policy will provide protection and savings comparable to that available with longer and longer term insurance, then comparable to an ordinary life policy, and finally comparable to limited-payment whole life insurance with a shorter and shorter premium-payment period.

9. Answers:

a. Federal income tax law requires that to meet the tax law definition of life insurance, a specified proportion of the death benefit must be derived from the amount at risk (for tax purposes, that is the death benefit minus the cash value). Whenever the cash value in the contract becomes high enough that the proportion is no longer satisfied, the death benefit of the universal life policy starts to increase, even though the contract has a level death benefit design.

b. With the increasing death benefit design, a constant amount at risk is superimposed over the policy's cash value. Thus, the total death benefit payable equals the policy's stated face amount plus its cash value. If the cash value decreases (for example, because premium payments were skipped), the death benefit will likewise decrease.

10. Answers:

a. Variable universal life insurance is similar to variable life insurance in that it gives policyowners several options for directing the investments. The policyowner can reposition the portfolio at any time. Like variable life, variable universal life has no interest rate or cash value guarantee. Variable universal life, like variable life, is technically classified as a security and is subject to regulation by the SEC. In
addition, sales of both variable universal life and variable life policies require a prospectus.

b. Variable universal life insurance and universal life policies incorporate similar premium flexibility, death benefit design, and partial withdrawal features. Like universal life policies, variable universal life policies have no guarantee that once the cash value is large enough to carry the policy, it will always be able to do so.

c. Variable universal and indexed universal life insurance both reflect changes in the market. However, variable universal life is based on the performance of specific funds selected by the policyowner, while indexed universal life is based on increases or decreases in an external index, such as the Standard and Poor's 500. Agents selling variable universal life insurance and indexed universal life insurance must have a life insurance license; agents selling variable universal life must also have a securities license.

11. A survivorship or second-to-die policy is written on two or more lives and payable on the death of the last insured to die. These policies are used to fund federal estate taxes of wealthy couples whose wills provide for maximum tax deferral at the first death. However, they could also be used to fund a specific need, such as in this situation, where funds are necessary upon the death of the second spouse.

12. Answers:

a. To be eligible for a group insurance plan, an employee must be in a covered classification of workers, work on a full-time basis, and be actively at work. He or she may be required to fulfill a probationary period and, in some cases, to show insurability and meet premium contribution requirements.

b. Most group life coverage is provided without individual evidence of insurability. However, this evidence is required in some cases, such as when an employee decides after the expiration of the eligibility period that he or she wants the coverage after all.

c. The amount of group life insurance on each covered worker is normally set according to a schedule, most commonly based on earnings. In an earnings schedule, the amount of insurance is often equal to some multiple of earnings, such as two times the employee's annual earnings, rounded up to the next $1,000 and subject to a maximum benefit. Benefits may also be a flat amount for all employees or based on position. In a position schedule, differing benefit amounts are provided based on each employee's position within the firm.

d. Any employee whose group life insurance ceases has the right, according to the master contract, to convert to an individual insurance policy. Conversion does not require proof of insurability and must occur within the first 31 days of eligibility to convert. The individual policy may be any type the insurer offers except term insurance, and the face amount may not exceed the amount of group life insurance. The premium for the individual policy is based on the employee's attained age at the time of conversion.

e. Additional amounts of insurance may be made available to some or all classes of employees. Proof of insurability is usually required to obtain the additional amount, except when the amount of coverage is small, and the employer does not usually pay any part of the premium for the additional insurance.

    Dependent life insurance also may be available. Coverage is usually optional, with the employee paying the entire cost. The amount of insurance is usually modest, and the employee typically is not allowed to select which of his or her eligible dependents will be covered but must decide on an all-or-none basis.
Answers to Review Questions

1. The declarations page of most life insurance contracts contains the name of the insurance company; the identities of the insured, the policyowner, and the beneficiary; specific policy details; a general description of the type of insurance provided by the policy contract; a statement about the policy's free-look provision; and the insurer’s promise to pay.

2. State statutes require that life insurance policies include certain provisions that meet minimum standards. Each insurance company may select the actual wording it puts into the contract, but the wording must be approved by the state.

3. Frank should review these policy provisions to answer his questions:
   a. grace period. Life insurance policies include a grace period, during which an overdue premium may be paid without a lapse in coverage. The standard length of the grace period is 30 or 31 days. Frank’s coverage is still in force.
   b. policy loan provision. The policy loan provision gives the policyowner access to the cash value that accumulates inside the policy without terminating the policy. The policyowner requests a loan, and the life insurer lends the funds confidentially. The loan provisions in the policy specify the portion of the cash value that is available for loans and how interest will be determined. In most policies, over 90 percent of the cash value is available for loans.
   c. incontestable clause. The incontestable clause provides that once the policy has been in force for 2 years during Frank’s lifetime, the insurer cannot deny payment to the beneficiary because of concealment or misrepresentation in the application.
   d. dividend options. In addition to a reduction in premiums (and cash), participating whole life policies generally offer
      • accumulation at interest. The insurer retains the dividends in the equivalent of a savings account with a minimum guaranteed rate of interest, although a higher rate may be credited if conditions warrant. The accumulated dividends may be withdrawn at any time. If not withdrawn, they are added to the death proceeds or to the nonforfeiture value if the policy is surrendered.
      • purchase of paid-up additions. Each dividend purchases a small amount of additional fully paid-up whole life insurance on an attained age basis. The purchase premium does not contain expense loading, and no evidence of insurability is required.
      • purchase of term insurance ("fifth dividend"). Some insurers use a portion of the dividend to buy 1-year term insurance equal to the policy’s then cash value, with the remainder used to buy paid-up additions or to accumulate at interest. Alternatively, other insurers use the entire dividend to buy 1-year term insurance. In either case, the term insurance is purchased on the basis of the insured’s attained age.

4. The insurer will adjust the death benefits to the amount that the premium paid would have purchased at the correct age. The premium at age 50 would have been $720 for $500,000 of insurance, or $1.44 per thousand. If the correct rate had been applied, Sara’s annual premium of $480 would purchase $333,333 of insurance. The insurer will pay Sara’s beneficiary $333,333.

5. The policyowner has the option of taking a reduced amount of paid-up whole life insurance, payable upon the same conditions as the original policy. The amount of the paid-up insurance is the amount that can be purchased at the insured’s attained age
by the net cash value (cash value, minus any policy indebtedness, plus any dividend accumulations) applied as a net single premium. The paid-up insurance is purchased at net rates.

The other option provides extended term insurance in an amount equal to the original face amount of the policy, increased by any dividend additions or deposits and decreased by any policy indebtedness. The length of the term is that which can be purchased at the insured's attained age with the net cash value applied as a single premium. If the insured fails to elect an option within a specified period after default of premiums, this option is usually the one that automatically goes into effect.

6. The types of settlement options, in addition to the lump-sum or cash option, most commonly found in life insurance policies are as follows:

   • interest option. Death proceeds are retained temporarily by the insurer, and only the interest is paid to the beneficiary periodically. A minimum interest rate is guaranteed in the policy, although insurers frequently pay a higher rate if investment earnings warrant. Death proceeds are paid at a specified later date at the request of the beneficiary, or on the occurrence of a specified event, such as the death of the beneficiary.

   • fixed-period option. Installment payments consisting of both the death proceeds and interest are made to the beneficiary over a specified period of time. A minimum interest rate is guaranteed. If the insurer pays a higher rate than the guaranteed rate, the amount of the installment payment is increased accordingly.

   • fixed-amount option. Level periodic installments of a specified amount are paid to the beneficiary. The payments consist of a portion of the death proceeds and interest, and they continue for as long as the funds held by the insurer last. Unlike the fixed-period option, excess interest earnings under the fixed-amount option do not increase the size of the periodic payments but instead extend the length of time during which the payments will continue.

   • life income options. Death proceeds are applied as a single premium to purchase an annuity for the beneficiary. Various forms of annuities may be available, most commonly straight life income, a life income with a period certain, a life income with some type of refund feature, and a joint-and-survivor life income.

7. Most states prohibit provisions or practices that would do the following:

   • make the producer an agent of the policyowner for purposes of completing an application
   • cause forfeiture of a policy for failure to pay a policy loan, so long as the cash value of the policy exceeds the total indebtedness
   • promise something in the declarations and take it away in the fine print (spelled out in less value statutes)
   • provide too short a time period for the policyowner to sue the insurer
   • permit backdating a policy by more than 6 months

8. Answers:

   a. The primary beneficiary is the person or organization that is to receive the proceeds if he, she, or it survives the insured. The estate of the insured may be named primary beneficiary, although this is usually unwise because it subjects the proceeds to transfer taxes and costs that can be avoided.

   b. A contingent beneficiary is a person or organization that is to receive the proceeds only if the primary beneficiary predeceases the insured or loses entitlement to any of the proceeds for some other reason. If the primary beneficiary is eligible
to receive the policy proceeds, the rights of the contingent beneficiary to the proceeds are extinguished.

c. If a beneficiary is named revocably, the policyowner can change the designation at any time prior to the insured's death without the beneficiary's consent. If the beneficiary is named irrevocably, the policyowner must obtain the beneficiary's consent before changing the beneficiary. Normally, an irrevocable designation requires the beneficiary's consent to the exercise of various other ownership rights in the policy, such as surrendering for cash or borrowing against the nonforfeiture value.

9. Yes, Bill's beneficiary would receive the death benefit. Although most insurance contracts do not provide coverage for a death by suicide within the first 1 or 2 years after the policy is issued, they do cover suicide after the exclusion period has expired.

10. Some insurers permit the insured to withdraw policy death benefits under certain circumstances. These accelerated benefits provisions state that if the insured develops a medical condition that renders the insured terminally ill, then he or she may withdraw a portion of the policy's death benefit. According to the NAIC Accelerated Benefits Model Regulation, the condition that permits the payment of the accelerated benefits must be a medical condition that drastically limits the insured's normal life span expectation (for example, to 2 years or less). Therefore, Harold may be able to withdraw his policy's death benefits due to his poor prognosis.

11. Double indemnity may give the illusion of double coverage. However, certain conditions must be satisfied in order for the insurer to pay double the face amount. One requirement is that death must occur as a result of an accident.

12. The guaranteed purchase option, also called the guaranteed insurability option, helps policyowners protect themselves against the possibility that the insured might become uninsurable. Under the typical option, the owner may purchase additional insurance in specified amounts at specified times or ages of the insured. Typically, this provision allows additional purchases every 3 years, upon marriage, and after the birth of a child, provided the events occur before the insured reaches a specified maximum age (often age 45). No evidence of insurability is required to exercise the option. Also, the new coverage is normally not subject to a new suicide provision or a new incontestability clause.

13. Susan could use the policy's cash surrender value to purchase an annuity that would provide her with a stream of income, but that does not seem to be what she needs. Rather than using the policy's cash value to fund a trust, Susan should seriously consider the reduced paid-up insurance option or the extended term insurance option. The extended term option would provide $250,000, to be split among the three grandchildren, if Susan dies before the end of the extended term. The reduced paid-up option would provide a smaller payment, but coverage would not expire.

In deciding among these options, Susan should first consider her health. If poor health has reduced her life expectancy, insurance might be a better choice than the cash option—and vice versa. In choosing between paid-up whole life insurance and the extended term option, Susan needs to recognize that college expenses are a temporary need that no longer exists after her grandchildren have completed college (unless they are paying off college loans). She should therefore consider the ages of the children, which, in turn, relate to how soon they will need money for college. Next, she needs to consider the period of extended term insurance that would be available under her policy.

14. The contract is voidable. Robin and Diane can seek a refund of premiums, or they—or a designated beneficiary if they should die—can seek to enforce the policy against the
insurer. Antea may also be fined or penalized by the state for selling a contract that has not been approved.
Chapter 10

Answers to Review Questions

1. Life insurance planning includes a determination of how much insurance is needed and an evaluation of the proper type of insurance. The first of these tasks is usually based on an analysis of the client's needs. The second task begins with a decision between temporary versus permanent coverage and proceeds to the selection of a particular type of policy.

2. The first step in the financial needs analysis is to estimate the family's financial needs in the event of the client's death, both lump-sum needs and ongoing needs. Lump-sum needs encompass, for example, final medical expenses not covered by insurance, repayment of debt, estate taxes, final expenses, probate costs, attorneys' fees, ongoing short-term household operational expenses, and an emergency fund. Information needed to determine the lump-sum needs includes the spending habits of the surviving dependents, as well as the level of liquid or near-liquid assets available at the death of the client.

   Ongoing income needs also must be estimated for four time periods: (1) the readjustment period immediately after the client's death, (2) the period following the readjustment period and continuing until the youngest child becomes self-sufficient, (3) the blackout period between the time that the youngest child becomes self-sufficient and the surviving spouse becomes eligible again for Social Security, and (4) the period after the surviving spouse becomes eligible again for Social Security and for any other pension benefits. Sources of income are identified that can offset the ongoing income needs. Information needed to determine the sources of income includes determining the Social Security retirement benefit, identifying other employer-provided plan benefits, and estimating the surviving spouse's earnings. Then the present value of the income shortfall is calculated and added to the lump-sum needs at death that are not covered by liquid or near-liquid assets.

3. The financial needs analysis approach, which involves the liquidation of principal, calculates the amount of additional life insurance needed by computing the gap between the needs of the client's dependents and the resources available to meet those needs in the event of the client's death. In this case, $50,000 of additional life insurance would be needed to meet the lump-sum needs ($300,000 minus $250,000 from existing insurance and savings). Another $200,000 of life insurance would be needed to meet the children's income support needs after taking into account their Social Security benefits after their mother's death. Thus, Sophie would need an additional $250,000 ($50,000 plus $200,000) of life insurance to meet her family's needs in the event of her death.

4. Unlike the capital liquidation approach in financial needs analysis, which assumes that policy proceeds will provide a life income through orderly consumption of available funds, the capital needs analysis approach assumes that the income benefits can be provided from investment income only. First, family financial needs are determined in the same manner as in the capital liquidation approach. Then the client's personal balance sheet is prepared. All the liabilities, immediate cash needs, and all assets that do not produce income are subtracted from the total assets. The remainder is the client's present income-producing capital. Finally, the additional capital needed to achieve the desired income objective, net of all other income sources, is computed. The amount of additional capital needed to meet the desired objective is calculated by dividing additional income needed by the applicable interest rate that represents the after-tax rate of investment return anticipated on the capital sum.
5. The use of permanent life insurance meets these three key objectives of an investment program:

- **safety of principal.** The life insurance industry has compiled a solvency record over the years that is unmatched by any other type of business organization. It has survived war, depression, and inflation; losses to policyowners have been relatively rare. Even the few companies seized by the regulators in recent years have been able to honor most of their policyowners' contracts.

- **yield.** Life insurance companies unquestionably obtain the highest possible yield commensurate with the standard of safety they have set for themselves and the regulatory constraints within which they operate. It is highly questionable that the typical life insurance policyowner can, over a long period, earn a consistently higher yield than a life insurance company without taking on a greater degree of speculative investment risk. Annual increases in cash values are not subject to federal income taxes as they accrue, while the earnings from a separate investment program are often taxed as ordinary income.

- **liquidity.** The liquidity of a life insurance contract is unsurpassed. The policyowner's cash value can be tapped at any time, sometimes subject to surrender fees. This can be accomplished through surrender for cash, through policy loans, or through partial withdrawals (in many newer life insurance products).

6. Among the distinguishing characteristics that may make one type of permanent life insurance preferable over another for a particular client are the following:

- length of the planned premium-paying period
- emphasis on cash value versus protection. If the client places heavy emphasis on the cash value element, he or she should consider a very short premium-paying period (perhaps even single-premium whole life) or an endowment (though some of the advantage of the tax-deferred buildup of the savings element can be lost).
- time when death benefits are needed. If the principal need for funds is at the death of the main income-earner, a single-life policy is appropriate. However, if the principal need for funds is to provide estate liquidity when the surviving spouse dies, the client should consider a joint or survivorship life (second-to-die) policy.
- desire for inflation protection. Variable life, universal life, variable universal life, or equity-indexed insurance can provide increasing amounts of death benefit protection.
- importance of yield versus safety in the savings component. If the client's risk-tolerance permits, variable, universal, or variable universal life may be appropriate as a way to achieve a higher yield.
- unbundling of cost components. If the client wants to know where his or her premium dollars go, he or she should consider variable, universal, or variable universal life insurance.
- premium-payment flexibility. If this is an important consideration, universal life or variable universal life can be appropriate recommendations.

7. Answers:

a. The surrender cost index indicates the cost of surrendering the policy and withdrawing the cash value at some future point in time, such as 20 years. The result is the average amount of each annual premium—in this case, $7.35 per $1,000 of coverage—that is not returned if the policy is surrendered for its cash value.

To compute the surrender cost index, the usual steps are as follows:
(1) Assume that each annual premium is placed in an account to accumulate at 5 percent interest until the end of a 20-year period.

(2) Assume that each annual dividend is placed in an account to accumulate at 5 percent interest until the end of the 20-year period.

(3) Subtract the 20th-year cash value and the result of step 2 from the result of step 1.

(4) Divide the result of step 3 by the future-value-of-an-annuity-due factor for 20 years and 5 percent. The result represents the estimated level annual cost of the policy.

(5) Divide the result of step 4 by the number of thousands of dollars in the policy's death benefit. The result is the estimated level annual cost per $1,000 of coverage.

b. The net payment cost index is useful when the main concern is the death benefit, rather than the cash value to be paid at some future point in time, such as the end of the 20th year. The procedure for calculating this index is identical to that for the surrender cost index, except that in step 3 there is no subtraction of the 20th-year cash value.

c. The calculations must take into account the time value of money. The future value of all premium payments is compared to the eventual cash value plus the future value of dividends accumulated. The net shortfall, or future value of net costs, is then annuitized across the payment period.

8. The major elements of the NAIC model regulation are as follows:

• The new regulation applies to life insurance policies for more than $10,000 of death benefit.
• Each illustration used in the sale of a life insurance policy covered by the new regulation must be clearly labeled “life insurance illustration” and must include certain specified pieces of information about the company, the agent, the proposed insured, and the policy and its benefit features.
• The NAIC model regulation prohibits insurers and their agents from misrepresenting various specified types of information to the client.
• The illustration must clearly indicate what elements are guaranteed and what elements are nonguaranteed.
• Any amount illustrated as being available upon surrender will be the amount after deduction of surrender charges.
• Each illustration must be accompanied by a narrative summary that describes the policy premiums and features and defines column headings used in the illustration.
• The summary should also state that actual results may be more or less favorable than those shown in the illustration.
• The regulation states that illustrations for universal life policies must comply with the regulation requirements and that the insurance company must issue annual reports to policyowners after the policy is issued, and it specifies the content of those annual reports.
• The regulation further stipulates that policyowners have the right to request an in-force illustration annually without charge.

9. Answers:
a. Due to increased competition and improved mortality experience, a policyowner may be able to substantially improve his or her situation by replacing an existing policy with a new one from either the same or a different company.

b. The Unfair Trade Practices Act contains prohibitions against misrepresentation, including misrepresentations to induce the lapse, forfeiture, exchange, conversion, or surrender of any life insurance policy.

c. The replacing agent must state whether the policy is a replacement at the time of application. For a replacement, the agent must give the applicant a prescribed notice alerting the applicant to the need to compare the existing and the proposed benefits carefully and to seek information from the agent or insurer from whom he or she purchased the original policy.

The replacing insurer must advise the other insurer of the proposed replacement and provide accurate information on the new policy. The replacing insurer must also give the applicant at least a 20-day free look at the new policy, during which time he or she has an unconditional right to a full refund of all premiums paid if he or she decides not to retain the policy.

The existing insurer or agent has 20 days to furnish the policyowner with accurate information on the existing policy, including its premium, cash values, death benefits, and dividends.

10. A group that is rated as substandard by an insurer is expected to produce a higher mortality rate than a group of normal lives. If 1,000 persons, each of whom is engaged in a hazardous occupation, are granted insurance, it is certain that the death rate among them will be greater than the death rate among a group of people the same age who are not engaged in a hazardous occupation. To allow for the higher death rates (called extra mortality) that will certainly occur within the substandard group, the company must collect an extra premium from—or impose special terms on—all who are subject to the extra mortality, because it is not known which of the members of the group will be responsible for it. Every member of the group is not expected to survive for a shorter period than the normal life expectancy. In fact, it is a certainty that this will not be the case; it is known merely that a larger proportion of the people in a standard group will attain normal life expectancy.

11. The methods life insurers use for handling substandard risks include the following:

- **increase in age.** Under this method, the applicant is assumed to be a number of years older than his or her real age, and the policy is written accordingly. This method of dealing with substandard applicants is often used when the extra mortality is markedly increasing and will continue to increase indefinitely.

- **extra percentage tables.** If an applicant presents an increasing hazard, the life insurer may charge premiums that reflect the appropriate increase in mortality. Depending on company practice and state law, surrender values may be based on the special mortality table or may be the same as surrender values under policies issued to standard applicants.

- **flat extra premium.** Under this method, the life insurer increases the standard premium by a specified number of dollars per $1,000 of insurance. The flat extra premium method is normally used when the hazard is thought to be constant (deafness or partial blindness, for example) or decreasing (as with a family history of tuberculosis or the aftermath of a serious illness or surgical operation, in which case the flat extra premium is usually temporary). The flat extra premium is widely used to cover the extra mortality associated with certain occupations and avocations. It is not reflected in policy values and dividends.
• **liens.** When the extra mortality to be expected from an impairment is of a distinctly
decreasing and temporary nature, such as that associated with convalescence
from a serious illness, an insurer might agree to create a lien against the policy
for a number of years; the amount and term of the lien depend on the extent of
the impairment. If such a method is utilized, the policy is issued at standard rates
and is standard in all respects except that, should death occur before the end
of the period specified, the amount of the lien is deducted from the proceeds
otherwise payable.

• **other methods.** When the degree of extra mortality is small, or when its nature
is not well known, the life insurer may make no extra charge but, if the policy
is participating, may place all of the members of the group in a special class
for dividend purposes, adjusting the dividends in accordance with the actual
experience. Another approach is to deal with the impairment by merely limiting
the plan of insurance to one with a high savings component.

12. The major benefit of viaticating a policy is that cash will be available to the policyowner to
fund the insured's final needs. However, the surviving family will no longer be provided for
by the policy. Other pitfalls include potential loss of social benefits based on need and
the lack of regulation regarding privacy. Furthermore, state regulation is not uniform
(and may be nonexistent), information regarding the provider's financial strength may be
unavailable, and fraudulent practices taint the industry.

13. Accelerated benefits, also known as living benefits, are a provision in some life insurance
policies permitting the policyowner to withdraw part of the death benefit under certain
circumstances, typically involving the insured's terminal illness. A terminally ill insured
might alternatively participate in a viatical settlement, in which a policy on his or her life is
sold to a viatical settlement provider for a portion of its face value. The viatical settlement
provider becomes the policy's beneficiary and will continue paying the premium to keep
the policy in force until the insured dies, at which point the viatical settlement provider
expects to receive a substantial return on its investment. Life settlements operate in a
manner similar to viatical settlements except that the insured may be in good health. An
insured who participates in a life settlement typically receives a relatively small portion
of the policy's intrinsic value and might be better off exercising one of the policy's
nonforfeiture options or asking existing beneficiaries to make the premium payments.

14. Answers:

   a. The business can purchase life insurance on Betty, a key employee, to cover the
   possibility of an income loss and/or increase in expenses resulting from her death.
   Term insurance can be purchased if the primary concern is the key employee's
dollar value to the business. Decreasing term might be appropriate because the
key employee loss exposure decreases as the insured approaches retirement.
   Key employee insurance, however, is usually coupled with some other purpose,
such as providing a retirement benefit for the key employee. Permanent life
   insurance is typically purchased to meet this objective.

   b. Suzie can set up a buy-sell agreement with the two minor shareholders so that
   upon Suzie's death, her shares will be sold to the surviving owners of the business.
   The agreement may be funded with life insurance and should indicate how that life
   insurance will be structured and paid for. If an entity arrangement is used, the firm
   itself enters into an agreement with each owner specifying that, on the death of an
   owner, the firm will buy and the deceased's estate will sell the business interest
   of the deceased. The firm carries life insurance on each owner, with the firm as
   beneficiary, to provide the money to fund the agreement. If a cross-purchase
   approach is used, each stockholder is both a seller and a purchaser. On the death
of one owner, the decedent’s estate will sell, and the other owners will buy, the
deceased’s interest. To fund this type of agreement, each owner should carry and
be the beneficiary of insurance on the lives of the other owners.

c. The company can provide group term life insurance to participating employees
under a Sec. 79 benefit plan. This plan allows the employer a tax deduction for
premium payments on behalf of a participant unless the premium amounts cause
the tax code’s reasonable compensation test to be exceeded (an unlikely event).
If the coverage provided by the plan is nondiscriminatory, the first $50,000 of
coverage is provided tax free to all plan participants.

15. A properly designed buy-sell agreement includes provisions that state the purpose of the
agreement, state the commitment of the parties, contain lifetime transfer restrictions,
specify a purchase price for the business or a method for determining the purchase price,
and specify how the purchase price will be funded.

16. Federal tax treatment of life insurance is as follows:

a. Subject to some exceptions, lump-sum proceeds paid under a life insurance
contract by reason of the insured's death are excludible from gross income for
federal income tax purposes. The basic requirement for the income tax exclusion
for life insurance proceeds is that they be paid by reason of the death of the
insured. Current law also extends the exclusion to certain accelerated death
benefits made on behalf of an insured who is terminally ill and expected to die
within 24 months. The most important exception to the general rule of excluding
life insurance death proceeds from federal income taxation is the transfer-for-value
rule, which provides that if a policy is transferred from one owner to another
for valuable consideration, the income tax exclusion is lost. (There are some
exceptions to the transfer-for-value rule.)

b. Death proceeds distributed as a series of payments under a settlement option
generally include an element of interest earned, which is taxable. However, the
portion of a settlement option payment that represents principal (the policy's face
amount) still qualifies for the income tax exclusion.

c. Policy dividends are treated as a nontaxable return of premium and reduce the
policyowner's basis. If total dividends paid exceed total premiums, dividends are
taxable to that extent. If dividends are used to reduce premiums or otherwise paid
back into the policy (for example, to buy paid-up additions), the basis reduction
caused by the payment of the dividend is offset by a corresponding basis increase
when the dividend is reinvested in the policy because it is then treated as an
additional premium payment.

d. The inside buildup (increase in the cash value or investment fund) of a permanent
life insurance policy is not subject to taxation as long as it is left inside the policy.

e. If a policyowner withdraws funds from a policy's cash value, the general rule is that
the withdrawal is first treated as a nontaxable return of basis. The excess, if any,
of the amount of the withdrawal over the policyowner's current basis is taxable in
the year of withdrawal. However, there are important exceptions, including certain
withdrawals from universal life policies and withdrawals from policies classified as
modified endowment contracts (MECs).

One exception typically occurs in a universal life contract. If a cash value
withdrawal results in a reduction in the policy's death benefit during the first 15
years of the policy, the withdrawal may first be taxed as income to the extent of
income earned within the contract. This income-first, or LIFO (last-in, first-out),
method of taxation is the reverse of the general rule of basis-first, or FIFO (first-in,
first-out), taxation that life insurance typically enjoys.
f. Loans from a policy are not taxable unless the policy is a MEC.
g. Any life insurance policy that falls under the definition of a MEC is subject to an income-first tax treatment with respect to loans and most distributions from the policy. A 10 percent penalty tax also generally applies to the taxable portion of any loan or withdrawal from a MEC unless the taxpayer has reached age 59 1/2. With respect to loans (not withdrawals) from a MEC, the policyowner receives an increase in basis in the policy equal to the amount of the loan that is taxable. However, the nontaxable portion of a loan from a MEC will not affect the policyowner's basis. A nontaxable portion of a withdrawal, on the other hand, will reduce basis.
h. The general rule is that premium payments for individual life insurance policies are not deductible for federal income tax purposes. This rule applies regardless of who owns the policy and whether it is used for personal or business purposes. However, in certain situations, life insurance premiums can be deductible because they also fit the definition of some other type of deductible expense, not because they are premium payments—for example, because they are for a policy written for the benefit of a charitable organization or because the premium is a corporate expense or part of an alimony payment.

17. Three aspects of federal gift taxation can be briefly described as follows:

a. The federal gift tax applies only if there has been a completed transfer and acceptance of property and the transfer was for less than full and adequate consideration.

b. Qualifying gifts of $13,000 in 2011 (indexed annually)—the annual exclusion—or less may be made by a donor to any number of donees without gift tax consequences. The annual exclusion amount is indexed to inflation, and it will increase in $1,000 increments. To qualify for an annual exclusion, the gift must provide the donee with a present interest.

c. Two types of gifts are fully deductible from the gift tax base. First, the marital deduction provides that unlimited qualifying transfers made by a donor to his or her spouse are fully deductible from the gift tax base. Second, qualifying gifts to a legitimate charity are deductible.

18. The starting point in the federal estate tax calculation is determining the property in the decedent’s gross estate. This includes all property that passes under the deceased's will or, in the absence of a valid will, under the state intestacy law, as well as property transferable by other means by the decedent at death. Certain items are deductible from the gross estate for estate tax calculation purposes: legitimate debts of the decedent, reasonable funeral and other death costs of the decedent, and the reasonable cost of estate settlement, such as the executor's commission and attorney fees. Qualifying transfers to a surviving spouse and transfers to qualifying charities are also deductible from the estate tax base. Then the unified credit, if it has not been exhausted to shelter lifetime gifts, is applied against transfers made at death. The estate may also take a deduction on the federal estate tax return for state death taxes paid.

19. Answers:

a. Life insurance proceeds payable to or for the benefit of the insured's estate are includible in the estate, regardless of who owned the contract or who paid the premium.
b. When insurance proceeds are paid to a named beneficiary other than the insured's estate, incidents of ownership in the policy at the time of death are the key criteria for determining inclusion. In this case, because the insured held an incident of
ownership at the time of his or her death—the right to change the beneficiary—the policy is included in his gross estate.

c. Although the decedent had transferred all rights to the policy to his wife, the transfer occurred within 3 years of his death. Under the 3-year rule, life insurance transferred to a third party for less than full consideration within 3 years of the insured's death is automatically includible in the insured's gross estate.

20. Life insurance can serve as an estate enhancement in order to provide for the basic needs of the decedent's heirs. This is particularly true for young clients, clients with family members dependent on their income, and/or clients with small- to moderate-sized estates. Also, insurance can provide estate liquidity/wealth replacement for older clients or clients with large estates, providing coverage for probate expenses, death taxes, and estate liquidity needs.
Chapter 11

Answers to Review Questions

1. Answers:

   a. The primary function of life insurance is to create an estate or principal sum; the primary function of an annuity is to liquidate a principal sum, regardless of how it was created.

   b. Life insurance and annuities are based on the same fundamental pooling, mortality, and investment principles. First, both insurance and annuities use the pooling technique. In insurance, all make contributions so that the dependents of those who die prematurely are partially compensated for loss of income. In annuities, those who die prematurely contribute on behalf of those who live beyond their life expectancy and would otherwise outlive their income. Second, both life insurance and annuity costs are based on probabilities of death and survival as reflected in a mortality table. Finally, under both arrangements, premiums are discounted for the compound interest that the insurance company will earn.

2. If the annuitant is willing to pool savings with those of other annuity owners, the administering agency can provide all the participants with an income of a specified amount as long as they live—regardless of longevity. This arrangement implies the willingness of participants to have all or a portion of their unliquidated principal at the time of death used to supplement the principal of those who live beyond their life expectancy. Therefore, each payment under an annuity is composed partly of the annuitant's principal, partly of the unliquidated principal of other annuitants who die early, and partly of investment income on these funds.

3. Annuities can be classified as follows:

   a. The annuity can be distributed on a pure annuity basis, which provides periodic income payments that continue as long as the annuitant lives but terminate at that person's death. A refund annuity is any type that promises to return, in one manner or another, a portion or all of the purchase price of the annuity.

   b. The annuity may be a single-life annuity, or it may cover two or more lives. A joint-life annuity provides that the income ceases at the first death among the lives covered. A joint-and-last-survivor annuity provides that the income ceases only at the last death among the lives covered.

   c. An immediate annuity makes the first benefit payment one payment interval after the date of purchase. Under a deferred annuity, more than one payment interval will elapse after purchase before the first benefit payment is due.

   d. A deferred annuity can be purchased with either a single premium or periodic premiums.

   e. Annuity payments may be fixed, providing a fixed number of dollars for each benefit payment, or they may be variable, providing payments based on the investment performance of the assets underlying the annuity.

4. Immediate and deferred annuities differ as follows:

   a. Although deferred annuities can be purchased with either single premiums or periodic premiums, immediate annuities can be purchased only with single premiums because the first benefit payment is made at the end of one payment period from the purchase date of the annuity.
b. Although all annuities have a liquidation period, deferred annuities also have an accumulation period when funds are accumulated with the insurance company to provide the annuity income benefits during the liquidation period.

5. Jim should purchase a deferred annuity on a periodic premium basis (flexible premiums in case he wants to contribute more or less in some periods). To protect against loss of purchasing power, he should use a variable annuity product. When he reaches retirement, he can choose a joint-and-last-survivor option to guarantee an income to him and his wife as long as either is living. At that time, he can also decide whether he wishes to keep the annuity in a variable mode or switch to fixed payments during the liquidation period. He can also decide at retirement whether he wants any additional guarantees (for example, 10 years certain).

6. The following would occur after Ann’s death:
   a. The annuity payments would cease under a pure annuity.
   b. Annuity payments would continue to Ann’s beneficiary for the remainder of the 20 years—in this case, for 19 years and 10 months—if Ann had purchased a life annuity with 20 years certain.
   c. Under an installment refund annuity, payments would continue to Ann’s beneficiary until the insurer had paid out the purchase price of $300,000.

7. Answers:
   a. A joint-and-two-thirds-annuity is a modification of the joint-and-last-survivor annuity that decreases annuity income to the survivor to two-thirds of the original amount.
   b. Joint-and-two-thirds-annuities are commonly used to provide a life income to married couples under the assumption that a surviving spouse does not require as much income as the two annuitants.
   c. High sales commissions have led sales representatives to overplay the benefits of annuities and downplay the substantial fees and lack of liquidity involved in an annuity. The NAIC model regulation requires that an insurance producer or insurer should have reasonable grounds for believing that a proposed annuity is suitable for the consumer based on facts the consumer provides concerning his or her needs, financial situation, investments, and other insurance products. Before executing an annuity sale, the insurer or producer should also make reasonable efforts to obtain information concerning the consumer’s financial status, tax status, and investment objectives as well as other reasonable information.

8. During the accumulation period of a deferred variable annuity, premium deposits are applied to the purchase of accumulation units. The accumulation unit is assigned an arbitrary value, such as $10, at the inception of the plan, and the initial premiums purchase accumulation units at that price. Thereafter, the units are revalued each month to reflect changes in the market value of the common stock that constitutes the company’s variable annuity portfolio. On any valuation date, the value of each accumulation unit is determined by dividing the market value of the common stock underlying the accumulation units by the aggregate number of units. Dividends are usually allocated periodically and applied to the purchase of additional accumulation units, although they may simply be reinvested without allocation and used to increase the value of each existing accumulation unit. Capital appreciation or depreciation, both realized and unrealized, is always reflected in the value of the accumulation units, rather than in the number of units. A portion of each premium payment is deducted for expenses, and the remainder is invested in accumulation units at their current market value.

At the beginning of the liquidation period, the accumulation units are exchanged for annuity units. The number of annuity units that the annuitant will acquire depends on the
company's assumptions as to mortality, dividend rates, and expenses, and on the market value of the assets underlying the annuity units. In essence, the number of annuity units is determined by dividing the dollar value of the accumulation units by the present value of a life annuity at the participant's attained age in an amount equal to the current value of one annuity unit. The number of annuity units remains constant throughout the liquidation period, but units are revalued each year, reflecting the current market price of the common stock and the mortality, investment, and expense experience for the preceding year. The dollar income payable to the annuitant each month is determined by multiplying the number of annuity units the annuitant owns by the current value of one unit.

9. Key features of equity-indexed annuities include the following:
   - *participation rate formula*. This formula defines the potential return of the annuity, based on increases in the value of a stock index.
   - *term period*. Most contracts anticipate a series of terms of uniform length; however, some contracts reserve the insurer's right to modify the term period available for continuation at the expiration of any existing term.
   - *participation rate*. The participation rate is used in the participation rate formula to determine the amount of the index gain that can be applied (if any) to produce more than the guaranteed yield. Higher participation rates may be available from some insurers if the purchaser accepts a lower guaranteed interest rate.
   - *cap on the crediting rate*. Some contracts cap the crediting rate that is applied to the accumulated value of the contract, preventing full formula participation in times of very rapid index increases.
   - *minimum crediting rate*. Most contracts specify a floor of 0 percent as the minimum extra interest crediting rate applicable to the accumulated value. This prevents the application of a negative percentage in the formula to reflect plunges in the index value, and it ensures that the fixed-interest-rate guarantee is the worst possible outcome.
   - *no SEC regulation*. Equity-indexed annuities currently are regarded as fixed annuities and may be sold by agents who are not licensed to sell variable products.
   - *minimum guarantees*. The minimum guarantees under equity-indexed annuities are lower than those for traditional fixed-interest annuities, and the rates actually guaranteed apply to less than the full amount paid as a premium. The specified interest rate applied each year to the contract value is set forth in the contract and remains fixed unless a negotiated change is later agreed to by both the contract owner and the insurance company.

10. Life insurance companies cope with problems of adjusting annuity prices for anticipated future increases in life expectancy in three ways:
   - computing annuity premiums on the basis of mortality tables that reflect annuitants' lower mortality. This current approach has replaced an earlier technique of using age setbacks.
   - using a low-interest assumption in the premium formula. Intensified competition among insurance companies and between insurance companies and investment media, however, has caused companies to adopt interest assumptions closer to the level of their actual investment earnings.
   - calculating the premiums and/or benefits on a participating basis, which enables the insurance company to use conservative assumptions.
11. Under a charitable gift annuity agreement, Lynn would donate cash or other assets to the institution. In exchange for the gift, the institution would provide Lynn with fixed payments for life.

   Because Lynn's donation is an irrevocable gift, she would be entitled to an immediate income tax deduction based, in part, on the value of the donated asset. A further benefit is that assets used to fund the gift annuity are generally removed from Lynn's taxable estate.

   Besides realizing immediate tax benefits, Lynn would receive a periodic annuity payment. The payment may be annual, monthly, or at some other interval. Only part of these payments is taxable income, because a portion of the payments is deemed to be a tax-free return of the donor's gift during the donor's expected lifetime under federal tax regulations.

   Benefits to the institution are any difference between its earnings and its costs of providing periodic payments. The institution also benefits from the residual value of the donated property, if any, after Lynn's death.

12. The usual structured settlement uses an annuity to provide periodic payments that meet the recipient's financial needs as much as possible. The periodic payments of income are received tax free by the claimant during his or her life and by the claimant's beneficiaries thereafter for the balance of any guarantee period. All timing decisions, as well as the exact amount of money, are predetermined by the defendant and its insurer, who are the legal owners of the annuity. Structured settlements might be more useful than a lump sum in replacing a lost income stream and addressing specific needs, such as the ongoing expense of medical treatments or household help, that require a continual and ongoing source of funding.

13. Advantages of structured settlements include the following:

   • for the injured party—The structured settlement provides financial security for the lifetime of the injured party. The use of periodic payments reduces the possibility of dissipation of funds through mismanagement, imprudent investment, unwise expenditures, misuse, or neglect by claimants and their families or guardians. Payments represent personal bodily injury damages, which are excluded from income tax.

   • for the plaintiff's attorney—Attorneys are assured that the settlement is guaranteed and will not be subject to dissipation as is a lump-sum settlement. Some attorneys believe that recommending a structured settlement insulates them from exposure to legal malpractice because attorneys do not take a sizable portion of the total value of the benefit payable as a lump sum at the time of settlement.

   • for the judge—Guaranteed lifetime periodic payments ensure the plaintiff's financial security, regardless of when he or she dies. Unlike the lump-sum settlement, the judge or jury does not need to determine how much money the plaintiff will need for the rest of his or her life.

   • for the public—The injured party does not become a ward of the state and is assured of a guaranteed income and proper care. The delay of prolonged litigation is avoided, reducing court costs and placing fewer burdens on an overloaded judicial system.

   • for the defendant's liability insurer—The offer of additional, tax-free income may make the settlement more attractive to the claimant, who will receive more money in total than with a lump-some payment.

   Disadvantages of structured settlements can arise from the insurer's insolvency, resulting in delayed and/or reduced benefits. Also, the annuitant must absorb losses in excess of any state guaranty fund limitations. Moreover,
the annuitant cannot accelerate or decelerate future payments, so problems can
coccur if more immediate cash is needed than the stream of payments provides.

14. A client with a reduced life expectancy is likely to qualify for an impaired risk annuity.
Because the applicant's health is considered in the underwriting process, annuity
payments are increased (or the premium lowered) in relation to the shorter life expectancy.
Chapter 12

Answers to Review Questions

1. Premium rates for employer-provided medical expense plans are increasing at a high percentage, and large increases are predicted to continue. A great majority of Americans are satisfied with their own health care plan; dissatisfaction is higher among plans with the greatest degree of managed care. Surveys indicate that Americans are becoming less satisfied with and less confident about the health care system in general, despite satisfaction with their own coverage. Federal legislation continues to change the character of medical expense plans, as witnessed by Medicare drug benefits and favorable tax treatment of HSAs.

2. Answers:

   a. She is covered. Hospital expense benefits are typically payable for a period of from 31 to 365 days.
   b. She is not covered. Cosmetic surgery is generally not covered unless it is needed to correct a condition resulting from an accidental injury.
   c. She is covered. Extended care facility benefits typically are provided to people who have been hospitalized for a period of at least 3 days. Confinement in the extended care facility must usually be for the same or a related condition for which the covered person was hospitalized. An extended care facility typically furnishes room and board and 24-hour-a-day skilled-nursing care under the supervision of a physician or a registered professional nurse.
   d. She is not covered. Home health care benefits are not designed for custodial or rest care. They are designed for those situations when the necessary part-time nursing care ordered by a physician following hospitalization can be provided in the patient's home.
   e. She is probably covered. Major medical plans give broad coverage for necessary expenses incurred for medical services and supplies that a physician has ordered or prescribed, including prescription drugs. However, prescription drugs are often covered under a carve-out plan and subject to copayments. She might be subject to a step-therapy provision and only have coverage if she had already tried a less expensive drug that proved to be ineffective.

3. The exclusion for preexisting conditions in many major medical plans differs from the other exclusions in major medical plans in that it applies only for a limited time, after which the condition is no longer considered preexisting and is covered in full, subject to any other contract limitations or exclusions.

   A preexisting condition is typically defined as any illness or injury for which a covered person received medical care during a 3-month period prior to the person's effective date of coverage. Usually, the condition is no longer considered preexisting after the earlier of (1) a period of 3 consecutive months during which no medical care is received for the condition or (2) 12 months of coverage under the contract by the individual.

   Some insurers provide limited coverage rather than exclude coverage for preexisting conditions.

   Under PPACA (Health care reform), pre-existing conditions are prohibited, except for grandfathered individual health plans, for children under the age of 19. As of January 1, 2014, insurers are prohibited from discriminating against or charging a higher premium rate for any individuals based on pre-existing conditions.

4.
a. The initial deductible is the amount that a covered person must pay for covered expenses before the plan will pay any insurance benefits.

b. The family deductible is a provision that waives future deductibles for all family members once a specified aggregate dollar amount of medical expenses has been incurred or after a specified number of family members have satisfied their individual deductibles.

5. Peggy's out-of-pocket expenses are calculated as follows:

\[
\begin{align*}
\text{\$2,000 of covered medical expenses} \\
\text{– \$250 deductible (out-of-pocket expense)} \\
\text{\$1,750} \\
\text{\times .20 (percentage Peggy is required to pay)} \\
\text{\$350 (out-of-pocket expense)}
\end{align*}
\]

Therefore, Peggy will have to pay \$600 of her medical expenses out of pocket, and the insurance company will pay the remaining \$1,400.

6. A true managed care plan should have five basic characteristics: controlled access to specialists and hospitals, emphasis on case management, encouragement of preventive care and healthy lifestyles, sharing by medical care providers in the financial consequences of medical decisions, and careful selection and monitoring of medical providers.

7. HMOs act like insurance companies and the Blues in that they finance health care. However, unlike insurance companies and the Blues, they also deliver medical services. HMOs offer their subscribers a comprehensive package of health care services, generally including benefits for outpatient services as well as for hospitalization. Subscribers usually get these services at no cost except the periodically required premium and, in some cases, a copayment. HMOs emphasize preventive care and provide such services as routine physicals and immunizations. HMOs provide for the delivery of medical services, which in some cases are performed by salaried physicians and other personnel employed by the HMO. Although this approach is in contrast to the usual fee-for-service delivery system of medical care, some HMOs do contract with providers on a fee-for-service basis. Subscribers are required to obtain their care from providers of medical services who are affiliated with the HMO.

8. PPOs typically differ from HMOs in several respects. First, the preferred providers are generally paid on a fee-for-service basis as their services are used. However, fees are usually subject to a schedule that is the same for all similar providers within the PPO contracts, and providers may have an incentive to control utilization through bonus arrangements. Second, employees and their dependents are not required to use the practitioners or facilities that contract with the PPO; rather, a choice can be made each time medical care is needed, and benefits are also paid for care provided by nonnetwork providers. However, employees are offered incentives to use network providers; these incentives include lower or reduced deductibles and copayments, as well as increased benefits, such as preventive health care. Third, most PPOs do not use a primary care physician as a gatekeeper, so employees do not need referrals to see specialists.

9. A POS plan is a hybrid arrangement that combines aspects of a traditional HMO and a PPO. With a POS plan, participants in the plan elect, at the time medical treatment is needed, whether to receive treatment within the plan's tightly managed network, usually an HMO, or outside the network. Expenses incurred outside the network are reimbursed in the same manner as expenses for nonnetwork services under PPO plans. One type
of POS plan, the open-ended HMO, consists of traditional HMO coverage with an endorsement for nonnetwork coverage. The other type of POS plan, the gatekeeper PPO, requires the PPO participant to elect a primary care physician in the manner of an HMO participant. This physician acts as a gatekeeper to control utilization and refer members to specialists within the PPO network. However, at any time care is needed, a covered person can elect to go outside the network.

10. The first approach to consumer-directed plans is the defined-contribution medical expense plan. Under this approach, the employer generally pays a fixed-dollar amount toward the cost of coverage. This amount is often pegged to a fixed percentage of the cost of the least expensive plan available, usually an HMO. An employee who elects a more expensive plan must make a greater contribution to the cost of his or her coverage.

The second approach is the use of savings accounts. Typically, an employer will provide employees with a high-deductible medical expense plan. The employer often then puts dollars into a savings account from which an employee can make tax-free withdrawals to pay medical expenses that are not covered because of the deductible.

11. Benefit carve-outs can be used to contain costs via managed care techniques. A well-managed specialty provider may also provide a higher quality of care.

12. Three types of benefit carve-outs can be described as follows:

a. **prescription drugs.** The typical prescription drug plan covers the cost of drugs (except those dispensed in a hospital or in an extended care facility) that are required by law to be dispensed by prescription. Drugs for which prescriptions are not required by law are usually not covered even if a physician orders them on a prescription form; a frequent exception is injectable insulin, which is generally covered. Some plans have a copayment, which may vary depending on whether the drug is generic or brand name; other plans have a three-tier or four-tier structure for generic drugs, formulary drugs, and brand-name nonformulary drugs.

b. **vision benefits.** Normally, a benefit schedule is used that specifies the type and amounts of benefits and the frequency with which they will be provided. If the plan is written by a provider of vision services, a discount for costs incurred with the provider that are not covered by the schedule of benefits may be available. Benefits are generally provided for eye examinations by either an optometrist or an ophthalmologist, and larger benefits are sometimes provided if the latter is used.

c. **behavioral health.** Behavioral health programs offer treatment for mental health, alcoholism, and drug addiction. These programs should use case management to design and coordinate treatment plans and to monitor the follow-up needs, have a referral mechanism, have a provider network, and provide patient access to care on a 24-hour basis.

13. Eligible dependents usually include an employee’s spouse who is not legally separated from the employee and children (including stepchildren, adopted children, and children born out of wedlock) under the age of 26. Under health care reform legislation (PPACA), dependent children will be permitted to remain on their parents’ insurance plan until their 26th birthday, including children that no longer live with their parents, are not a dependent on a parent’s tax return, are no longer a student, or are married. In addition, coverage may also continue (and is required to be continued in some states) for children who are incapable of earning their own living because of a physical or mental infirmity. If an employee has dependent coverage, all newly acquired dependents (by birth, marriage, or adoption) are automatically covered.

14. HIPAA’s provisions put limitations on preexisting-conditions exclusions and allow an employee to use evidence of prior insurance coverage to reduce or eliminate the
length of any preexisting-conditions exclusion when the employee moves to another employer-provided medical expense plan.

15. The plan of the stepparent who is the spouse of the parent with custody takes priority over the father’s plan.

16. Unless an employee elects otherwise, the employer’s plan is primary and Medicare is secondary. Except in plans that require large employee contributions, it is doubtful that employees will elect Medicare to be primary because employers are prohibited from offering active employees or their spouses a Medicare carve-out, a Medicare supplement, or some other incentive not to enroll in the employer’s plan.

Medicare is the secondary payer of benefits when persons who are eligible for Medicare benefits receive treatment for end-stage renal disease with dialysis or kidney transplants. Medicare provides these benefits to any insured workers (either active or retired) and to their spouses and dependent children, but the employer’s plan is primary during the first 30 months of treatment only; after that time, Medicare is primary and the employer’s plan is secondary.

Medicare is also the secondary payer of benefits to disabled employees (or the disabled dependents of employees) under age 65 who are eligible for Medicare and who are covered under the medical expense plan of large employers (defined as plans with 100 or more employees). Medicare, however, does not pay anything until a person has been eligible for Social Security disability income benefits for 2 years. The rule applies only if an employer continues medical expense coverage for disabled persons; there is no requirement for such a continuation.

17. Benefits are usually paid on a first-dollar basis, but subject to dollar maximums. Benefits also are subject to annual maximums based on number of visits or days or on a flat dollar limit. Benefits may be paid directly to the insured, or the plan may use a preferred-provider network with the insured typically receiving a discount on charges the plan benefits do not cover. Vision, dental, and prescription drug benefits may be available for an additional premium, or the insured may be provided with a discount card for these services.

18. Answers:

   a. A strong likelihood. One characteristic of dental insurance seldom found in medical expense plans is the inclusion of benefits for routine diagnostic procedures, including X rays.
   b. A strong likelihood. Treatment for diseases of the dental pulp within teeth, such as root canals, is covered under the category of endodontics.
   c. Almost no likelihood. A common exclusion in dental plans is the replacement of lost, missing, or stolen dentures.
   d. Almost no likelihood. A common exclusion in dental plans is services that are purely cosmetic, which includes teeth whitening.
   e. Some likelihood. Some dental plans include benefits for orthodontics, which involves the prevention and correction of dental and oral anomalies through the use of corrective devices, such as braces.

19. Additional medical and dental benefits for executives may include reimbursement for deductibles and coinsurance under the employer’s plan; coverage for annual physicals and the extra cost of private hospital rooms; and extra coverage for mental or emotional treatment, hearing care, vision care, and dental work.

20. A portion of an employee’s contribution for coverage may be tax deductible as a medical expense if that individual itemizes his or her income tax deductions. Under the Internal Revenue Code, individuals are allowed to deduct certain medical care expenses (including dental expenses) for which no reimbursement was received. This deduction is
limited to expenses (including amounts paid for insurance) that exceed 7.5 percent of the person's adjusted gross income.

21. Premium-conversion plans and FSAs are funded with salary reductions that lower an employee's taxable income for federal tax purposes. Therefore, federal taxes (and often state income taxes) are also reduced. In addition, the amount of the salary reduction is not subject to Social Security and Medicare taxes that would otherwise be payable.
Chapter 13

Answers to Review Questions

1. Answers:

a. The term *group health plan* as used by COBRA is broad enough to include medical expense plans, dental plans, vision care plans, and prescription drug plans, regardless of whether benefits are self-funded or provided through other entities, such as insurance companies or HMOs. Long-term care coverage is not subject to COBRA rules.

b. Under COBRA, each of the following is a *qualifying event* if it results in the loss of coverage by a qualified beneficiary:

   • the death of the covered employee
   • the termination of the employee for any reason except gross misconduct
   • a reduction of the employee's hours so that the employee or dependent is ineligible for coverage
   • the divorce or legal separation of the covered employee and his or her spouse
   • for spouses and children, the employee's eligibility for Medicare
   • a child's ceasing to be an eligible dependent under the plan

c. A *qualified beneficiary* is defined as any employee, or the spouse or dependent child of the employee, who on the day before a qualifying event was covered under the employee's group health plan. In addition, the definition includes any child who is born to or placed for adoption with the employee during the period of COBRA coverage.

2. The Health Insurance Portability and Accountability Act (HIPAA) encourages states to adopt mechanisms for helping individuals find alternative coverage. If the state does not have its own plan, the state alternative must provide a choice of health insurance coverage to all eligible individuals, impose no preexisting-conditions restrictions, and include at least one form of coverage that is either comparable to comprehensive health coverage offered in the individual marketplace or comparable to (or a standard option of) coverage available under the group or individual laws of the state.

If a state fails to adopt an alternative to federal regulation, then insurance companies, HMOs, and other health plan providers in the individual marketplace must make coverage available on a guaranteed-issue basis to individuals with 18 or more months of creditable coverage and whose most recent coverage was under a group health plan, although coverage does not have to be provided to an individual who has other health insurance or is eligible for COBRA coverage, Medicare, or Medicaid. No preexisting-conditions exclusions can be imposed.

3. Answers:

a. The basic benefits that must be included in all ten original Medicare supplement policies consist of the following:

   • *hospitalization*. This is the coinsurance or cost sharing of Part A benefits for the 61st through the 90th day of hospitalization and the 60-day lifetime reserve. In addition, coverage is extended for 365 additional days after Medicare benefits end.
   • *medical expenses*. This is the Part B insurance for Medicare-approved charges for physicians' and medical services.
   • *blood*. This is the payment for the first 3 pints of blood each year.
b. Persons aged 65 or older may buy any available Medicare supplement policy, regardless of health status, at any time during the 6-month period after initial enrollment for Medicare Part B benefits. If a person initially elects a Medicare Advantage plan in lieu of original Medicare, the person will be eligible to purchase a Medicare supplement policy, without evidence of insurability, if he or she leaves the Medicare Advantage plan during the first 12 months of coverage and returns to original Medicare. Similarly, a person who drops Medicare supplement coverage and elects a Medicare Advantage plan can regain Medicare supplement coverage if he or she decides to drop the Medicare Advantage plan during the first 12 months of coverage. Also, a person can obtain a medigap policy on a guaranteed-issue basis because an employer-provided plan that supplements Medicare terminates, because a Medicare Advantage plan no longer provides coverage, or because the person loses eligibility by moving out of the plan’s service area.

4. Answers:

a. *Temporary medical insurance* provides coverage for periods between 30 days and 1 year to under-age-65 individuals and their dependents who are between permanent medical plans. The plans are similar to individual major medical policies; applicants usually have a choice of deductibles and coinsurance percentages.

b. *International travel medical insurance* provides coverage ranging from a minimum of 15 days to a maximum of 1 year, with optional renewal of some policies for up to 5 years. Benefits cover the expenses of inpatient and outpatient hospitalizations, as well as medical and related services. Deductibles are selected, and coinsurance levels are frequently available at 80 percent up to a specific dollar amount; 100 percent is payable thereafter to the policy maximum. Coverage typically ceases when a person returns to his or her home country.

c. *Hospital confinement indemnity insurance* provides the insured with a fixed daily cash benefit during a covered hospitalization. A spouse or dependent child is usually eligible for coverage, although benefits may be reduced. The policy provides daily benefits in the event of hospital confinement in a specified dollar amount for a defined period, and additional benefits are available as a standard feature or as a rider.

d. *Specified disease insurance* provides benefits to insured individuals and covered family members upon the diagnosis of or medical events related to the treatment of a disease named in the policy. Benefits vary, and provisions may utilize a combination of three payment structures: per-day or per-service, expense-incurred, or a lump-sum payment. Benefits are contingent on a diagnosis of the specified disease, but payments will cover the first day of care or confinement even though the diagnosis is made at some later date.

e. *Critical illness insurance* provides a substantial one-time lump-sum cash benefit for listed critical illnesses. Some of these conditions result from injury, as well as disease, and include specified major surgeries. The policyowner selects a maximum benefit amount, which can range from $10,000 to several hundred thousand dollars. The maximum benefit is payable only once—upon the first diagnosis of a condition or specified surgical treatment that is covered.

5. Federal legislation, such as COBRA and HIPAA, make coverage available to many persons with prior employer-provided coverage. However, these laws do not address the issue of affordability.

More than half of the states have some type of high-risk pool, whereby persons turned down in the normal marketplace can obtain coverage through the pool. Benefits vary
among states, but basic major medical coverage is usually available. State subsidies often keep premiums lower than the level needed to fully cover expenses and claims costs.

6. HSAs can be established by employees, the self-employed, and anyone else who meets the following rules for qualification:

   - The individual must be covered by a high-deductible health plan. That plan may be insured or self-insured if offered by an employer, as long as it meets the criteria for a qualifying high-deductible plan.
   - The individual is not eligible to be claimed as a dependent on another person's federal income tax return.
   - With certain exceptions, the individual must not be covered by other health insurance. These exceptions are the same as those for Archer MSAs and include policies that provide coverage for specified disease or illness, accidents, disability, dental care, vision care, or long-term care, as well as those that provide a fixed payment for a period of hospitalization. An employer can establish HSAs for its employees, or an individual may establish his or her own HSA.

7. The following rules apply to HSAs:

   a. The account holders, the account holder's employer, or both may contribute to an HSA. Contributions by an employer are tax deductible to the employer and are not included in an employee's gross income or subject to Social Security and other employment taxes. Employee contributions are deductible in computing adjusted gross income. The amount of the annual deductible contribution to an employee's account is limited to a maximum amount that is subject to annual indexing. The amount varies, depending on whether the account holder has a self-only or family high-deductible health plan. Account holders aged 55 or older are also eligible for additional catch-up contributions. Employee contributions must generally be made by April 15 of the year following the year for which the contributions are made.

   b. An individual can take any part or all of the account balance from an HSA at any time. Subject to some exceptions, distributions of both contributions and earnings are excludible from an account holder's gross income for tax purposes if used to pay medical expenses of the account holder and the account holder's spouse and dependents, as long as these expenses are not paid by other sources of insurance. For the most part, the eligible medical expenses are the same ones that would be deductible, ignoring the 7.5 percent of adjusted gross income limitation, if the account holder itemized his or her tax deductions. Tax-free withdrawals are also permitted for the purchase of long-term care insurance, COBRA continuation coverage, or health insurance coverage while an individual receives unemployment compensation. Distributions for reasons other than paying eligible medical expenses are included in an account holder's gross income and are subject to a 10 percent penalty tax unless certain circumstances exist.

8. At death, the remaining balance in an HSA is includible in the account holder's gross estate for tax purposes. If the beneficiary of the account is a surviving spouse, the HSA belongs to the spouse and he or she can deduct the account balance in determining the account holder's taxable estate. The surviving spouse can then use the HSA for his or her medical expenses. If the beneficiary is someone other than the spouse, the HSA ceases to exist, and the beneficiary must include the fair market value of the account in his or her gross income for tax purposes. If no beneficiary is named, the tax is payable by the estate or the beneficiary of the estate.

9. Noncancelable policies are rare because of the uncertain nature and cost of future medical claims.

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10. The federal income tax situation for persons who buy individual medical expense (and dental) coverage can include premiums as expenses for purposes of determining whether the 7.5 percent threshold has been met. Expenses above this amount are deductible if a taxpayer itemizes deductions. As a result of trade legislation, some individuals are eligible for a tax credit.

Benefits are not subject to taxation unless they are for expenses deducted in prior years.
Chapter 14

Answers to Review Questions

1. At all working ages, the probability of being disabled for at least 90 consecutive days is much greater than the chance of dying. About half of all employees will have a disability that lasts at least 90 days during their working years, and one out of every ten persons can expect to be permanently disabled prior to age 65. In terms of its financial effect on the family, long-term disability is more severe than death. In both cases, income ceases. In the case of long-term disability, however, family expenses—instead of decreasing because the family has one fewer member—may actually increase due to the cost of providing care for the disabled person.

2. The sources of coverage that may protect your client against financial trouble in case of disability include the Social Security program, workers’ compensation, state temporary disability laws, unemployment compensation, employer-provided short-term disability plans, employer-provided long-term disability plans, individual disability income insurance, and sick-leave plans.

3. Sick-leave plans (often called salary continuation plans) are usually uninsured and generally fully replace lost income for a limited period of time, starting on the first day of disability. Almost all sick-leave plans are limited to permanent full-time employees. Most sick-leave plans are designed to provide benefits equal to 100 percent of an employee's regular pay. Most plans, however, provide a reduced level of benefits after an initial period of full pay. The most traditional approach used in determining the duration of benefits credits eligible employees with a certain amount of sick leave each year, such as 10 days.

4. In addition to being in a covered classification, an employee must usually work full-time and be actively at work before coverage under a group disability plan commences. Any requirements concerning probationary periods, insurability, and premium contributions must also be satisfied. Long-term disability plans often limit benefits to salaried employees; some long-term plans also exclude employees below a certain salary level. Long-term plans sometimes require that the employee be on the job for an extended probationary period (such as 30 days) without illness or injury before coverage becomes effective.

5. Group short-term disability plans typically define disability as the total inability of the employee to perform each and every duty of his or her regular occupation (an own-occupation definition). In contrast, group long-term disability plans contain a dual definition under which benefits will be paid for 24 (or 36) months "as long as an employee is unable to perform his or her regular occupation." After that time, benefits will be paid only if the employee is unable to engage in any occupation for which he or she is qualified by reason of training, education, or experience. The purpose of this dual definition is to require and encourage a disabled employee who becomes able after a period of time to adjust his or her lifestyle and earn a livelihood in another occupation. Under the short-term disability plan, coverage for nonoccupational disabilities and having different definitions of disabilities for different classes of employees are unlikely; those characteristics are more likely under the long-term disability plan.

6. Common exclusions under both short-term and long-term group disability income contracts specify that no benefits will be paid for any period during which the employee is not under the care of a physician, for any disability caused by an intentionally self-inflicted injury, and for any disability that commenced while the employee was not covered under the contract. Additionally, employers with fewer than 15 employees may exclude disabilities arising from pregnancy unless they are subject to state laws to the contrary.
Long-term disability contracts commonly deny benefits for disabilities resulting from
- war, whether declared or undeclared
- participation in an assault or felony (some insurers have expanded this to include
  the commission of any crime)
- mental disease, alcoholism, or drug addiction
- preexisting conditions

7. Benefit schedules classify employees and, for each class of employee, specify the
   amount of disability income to be provided, indicate the length of time that benefits are
   payable, and coordinate benefits with other available types of disability income. Benefits
   may be expressed as either flat-dollar amounts, varying dollar amounts by classification,
   or a percentage of earnings. Short-term disability income contracts commonly contain
   a waiting, or elimination, period. The typical short-term contract has no waiting period
   for disabilities resulting from accidents, but a 1- to 7-day waiting period for disabilities
   resulting from sickness. Long-term disability income plans have waiting periods of 3 to
   6 months. The waiting periods for sicknesses and accidents are the same under the
   long-term contract. Long-term disability income benefits may be paid for as short a period
   as 2 years or as long as the lifetime of the disabled employee.

8. To minimize the possibility of an employee's receiving total benefits higher than his or
   her predisability earnings, disability income plans commonly stipulate that benefits be
   coordinated with other sources of disability income. Benefits under short-term plans
   are generally coordinated with (1) workers' compensation benefits if the plan covers
   occupational disabilities, (2) temporary disability laws if they are applicable, and (3) Social
   Security benefits if the maximum benefit period is longer than 5 months.

   Long-term disability income benefits are usually coordinated with benefits provided
   under the following:
   - Social Security
   - workers' compensation laws
   - temporary disability laws
   - other insurance plans for which the employer makes a contribution or payroll
     deduction
   - pension plans for which the employer has made a contribution or payroll
     deduction to the extent that the employee elects to receive retirement benefits
     because of disability
   - sick-leave plans
   - earnings from employment, either with the employer or from other sources

   To prevent the coordination with other benefits from totally eliminating a
   long-term disability benefit, many plans provide (and some states require) that
   a minimum benefit be paid. Most plans also contain a provision freezing the
   amount of any Social Security reduction at the initial level that was established
   when the claim began.

9. The following additional benefits are sometimes included in group long-term disability
   income contracts:
   a. A disability income plan may have a COLA to prevent inflation from eroding the
      purchasing power of disability income benefits being received. Under the typical
      COLA formula, benefits increase annually along with changes in the consumer
      price index.
   b. A firm may treat disabled employees as if they were still working and accruing
      pension benefits. Such a provision requires that contributions on behalf of
      disabled employees be made to the pension plan, usually from the employer's
current revenues. However, some disability income contracts stipulate that the contributions necessary to fund a disabled employee's accruing pension benefits will be paid from the disability income contract.

c. Some long-term contracts continue payments to survivors after the death of a disabled employee. The disability income payments are continued, possibly at a reduced amount, for periods ranging up to 24 months to eligible survivors, who commonly are the spouse and unmarried children under age 21.

10. The tax consequences are as follows:

a. The benefits are received by Kevin free of income taxation.
b. The benefits are included in Patty's income for tax purposes.
c. Benefits attributable to contributions by Julie are received free of income taxation. Benefits attributable to employer contributions are includible in Julie's income for tax purposes.

11. Definitions of total disability fall into two broad categories—any occupation and own occupation. With an any occupation definition, total disability is usually defined as a condition that prevents a person from performing the duties of any occupation for which that person is reasonably suited by education, training, and experience.

Some insurers issue policies with an own-occupation definition of disability as was defined for group disability income policies. With such a definition, an insured is considered totally disabled if he or she is unable to perform the substantial and material duties of his or her regular occupation at the time of disability. Even if the person returns to work in another occupation, the insurer will still pay the full disability income benefits as long as the insured can no longer perform the duties of the former regular occupation. This own-occupation definition of disability was once more commonly available than it is currently. Today, insurers are more likely to use variations that are more restrictive. One variation is to terminate benefits at any time that the insured returns to work in any gainful employment position for which he or she is suited by education, training or experience. However, partial or residual disability income benefits may become payable at this time. This variation is sometimes referred to as a modified own-occupation definition of disability. Another variation is to use a dual definition of disability as is common in group insurance. An own-occupation definition is used for a limited period of time that might range from 2 to 5 years. After that time, an any-occupation definition is used.

Many insurers will use several of the definitions of total disability previously described. In their most preferred occupational classes, they may be willing to issue a policy with an own-occupation definition of disability as long as certain underwriting criteria are met. For other occupational classes, they may use a version of a dual definition of disability. For the least preferred occupational classes, they will use an any-occupation definition.

12. A residual disability is defined as a disability that results in the insured’s inability to perform some of the duties of his or her own occupation, resulting in a loss of income. It is typically coupled with an own-occupation definition of total disability. Residual disability benefits focus on the loss of income rather than on the physical limitations of the disability. The benefits can be paid if the insured returns to either full-time or part-time employment. Residual benefits continue until the end of the benefit period specified in the policy as long the insured continues to meet the definition of disability. The insurer starts the benefit calculation by comparing income before and after the disability to determine the percentage loss of income. This percentage is then multiplied by the benefit for total disability to determine the residual disability benefit.

13. In advising clients, planners might explain the following aspects in individual disability income policies:
a. Most disability policies define a specified period of recovery (usually measured by return to work) that automatically separates one disability from another. For disability policies with a limited benefit period, it can be advantageous to have each relapse classified as a new disability, which then starts with a full benefit period.

b. Guaranteed renewable contracts, which are high-quality contracts, give the policyowner the right to continue the coverage in force by paying the premium due. The premium may be increased on a class basis for all guaranteed-renewable policies in the classification, but it cannot be increased on an individual basis. The highest-quality contracts, noncancelable disability contracts, guarantee that the individual can keep the policy in force by paying the premium and that the premium will not increase. Low-quality cancelable disability insurance contracts offer very questionable protection for the insured because the insurance company can refuse renewal or can increase the premium.

c. Disability income policies generally have a waiting period before benefit payments begin. When selecting the waiting period for a disability income policy, the insured should consider his or her ability to pay living costs and other expenses during the waiting period, and whether the insured has other sources of funds available during short-term disabilities. Residual disability benefits specify a qualification period, which indicates the number of days of total disability that must be sustained before residual disability benefits are payable.

d. Disability income policies differ according to the duration of benefits that they provide once the individual becomes disabled. Disability contracts often provide choices such as 2 years, 3 years, 5 years, 10 years, to age 65 or 67, or even for the insured's lifetime. Policies with short benefit durations do not provide comprehensive protection against disability, but their main appeal is the premium savings associated with the relatively short maximum benefit period. Some policies differentiate between disabilities caused by injury and disabilities caused by illness. These policies may provide lifetime benefits if the disability results from injury but limit benefits to age 65 or 67 if the disability stems from illness.

Even policies purporting to provide lifetime benefits for disability include limitations on disabilities occurring after specified ages, such as 50, 55, or 60. Disabilities with their first onset after the specified age are often limited to benefit periods of 2 or 5 years or may terminate at a specified age, such as 65, 68, or 70.

Insurance companies are more restrictive in writing longer benefit duration policies than they are in writing policies of short benefit duration. Fewer occupations qualify for policies with long benefit durations than for policies of short benefit durations. Policies with long benefit durations are rarely available to any occupation that involves physical labor or direct involvement in dangerous processes.

e. Disability income policies specify the amount of monthly benefits payable during periods of total disability after the waiting period has been satisfied. At the time of policy issuance, the stated monthly benefit amount should be in line with the insured's income and provide fairly complete protection. However, over time, the stated benefit amount is likely to become inadequate as the insured's income increases because of inflation and job promotions. Disability income policies are available with provisions to counteract such erosion in benefit levels.

f. Premiums for disability income policies are based on the policyowner's age at the time of policy issuance and remain level for the duration of the coverage. Consequently, an individual can lock in lower premiums by buying a policy at a younger age and keeping it in force. Premiums must be paid on a timely basis to
keep the coverage in force, but the policies do contain a 31-day grace period for late premium payments.

14. Increased predisability benefits consist of provisions aimed at increasing the benefit level while the coverage is in force, but the insured is not disabled. There are basically three approaches to keeping disability income benefits in step with increased income for insured individuals who are not disabled:

- Purchase new policies to supplement the in-force policies incrementally as income increases. This is the oldest and least attractive method. The drawback is that evidence of insurability is required every time incremental amounts of coverage are obtained. If the individual's health deteriorates, additional coverage may not be available at any price.

- Adjust predisability benefit levels through a rider that guarantees the right to purchase additional coverage at specified future intervals up to some stipulated maximum age, such as 45, 50, or 55. This approach is similar to the first one in that additional coverage must be purchased every time an adjustment is needed, but the additional amounts can be acquired at the specified intervals regardless of the health of the insured. However, these incremental purchases are subject to underwriting requirements regarding the individual's current income.

- Use riders that automatically increase the base benefit amount on a formula basis, such as a stated flat-percentage amount at each policy anniversary. This is the most attractive way to adjust benefits upward for inflation while the insured is not disabled. But even this approach requires purchasing additional coverage, and the premium will increase appropriately. As with the second approach, the additional increment of coverage is purchased at premium rates based on the insured's attained age at the time it is added to the policy. The real advantage to this approach is that the changes are automatic unless they are refused by the policyowner.

15. Some insurance companies offer, on an optional basis, a policy provision that returns some portion of premiums at specified intervals, such as 5 or 10 years. For example, one company has an option that returns 60 percent of premiums paid at the end of each 5-year interval if no claims have been made during that period. This particular option can increase premiums by more than 40 percent over the base premium level. Other companies offer variations in the percentage of premium to be returned, such as 70 percent or 80 percent of the premiums paid, and in the duration of the interval over which the coverage must be without claims in order to collect the return of premium.

16. Disability income contracts often contain some additional benefits as standard contract provisions. Perhaps the most common is a provision is a rehabilitation benefit. The insurer’s role is determined by a written agreement with the insured, and the insurer pays benefits in accordance with this agreement. Even if a policy does not have a rehabilitation provision, the insurer may pay benefits for rehabilitation if it feels these benefits will lower the amount of a claim because the insured will return to work sooner.

A disability may occur if an individual donates an organ for transplant to another person. In the absence of a provision to the contrary, an insurer would not pay a disability income benefit because the disability did not arise from the insured’s injury or sickness. However, the majority of policies now treat a disability resulting from such a circumstance as a sickness, without any special limitations.

Some policies contain a transition benefit. With such a provision, benefits continue to survivors for a short period after an insured’s death.
Some policies pay a capital sum. This is a lump sum payable if the insured suffers a serious injury, such as the loss of sight in one eye with no possibility of recovery or the severance of a hand or foot above the wrist or ankle.

A few insurers build small annual benefit increases into their policies as a standard benefit.

A small number of insurers have classes of disability income policies that allow the insured to convert the policy to a long-term care insurance policy. The conversion is allowed at certain ages, even if an insured is disabled, with no medical evidence of insurability required.

17. Many insurance companies offer an optional provision that requires a separate extra premium to cover additional benefits payable when the individual is disabled under the base policy but does not qualify for Social Security disability benefits. The supplemental benefit is paid over and above the base disability benefit of the underlying policy. The maximum benefit available in the base policy can be supplemented under this rider so that the total benefits collected from the insurance company are essentially the same as would have been collected if the individual qualified for Social Security disability benefits.

18. There are numerous other riders that may be available to an applicant for disability income insurance. Some of the riders found in the marketplace include the following:

- return-of-premium rider. It refunds all or a portion of the premium paid if the insured’s claim experience is favorable.
- pension supplement completion rider. It provides an additional benefit to fund retirement income for the applicant.
- catastrophic benefit rider. It provides an additional benefit in certain situations in which an insured is so severely disabled that he or she is likely to incur significant extra expenses because of the disability.
- mental and nervous disorder riders. Some disability income policies limit the duration of disability benefits for mental or nervous disorders unless the insured is in a mental hospital or institution. Insurers who issue such policies may offer a rider that deletes the exclusion and treats such disabilities like any other disability. Most insurers, however, do treat disabilities from all causes in the same way. Some of these insurers may offer a rider that allows the insured to elect a shorter benefit duration for disabilities resulting from mental and nervous disorders.
- long-term care purchase option rider. A few insurers have a rider that permits the insured to purchase long-term care insurance at specified future dates without evidence of insurability.

19. To minimize the motivation for fraudulent claims as well as padding of legitimate claims by malingering, insurance companies limit the amount of coverage they will issue to any individual in relation to that individual’s income. Generally speaking, disability income coverage is not available for benefit amounts that exceed 60 or 70 percent of the individual’s gross earned income. In fact, as the level of income increases, the percentage of income replacement that insurance companies will issue decreases. High-income professionals are often limited to less than 50 percent of their income level in setting the maximum benefit level for their disability policies. Some experts advise that, for individuals providing full disclosure to the insurance company, the appropriate amount of disability income protection to purchase is the maximum amount available from an insurance company that provides quality coverage.

20. A business can use individual disability income policies in the following ways:

   a. Overhead expense policies cover many of the ongoing costs of operating a business while the business owner is totally disabled. These policies tend to
be limited to benefit durations of 1 or 2 years and have relatively short waiting periods. The intent is to keep the necessary staff and premises available for the resumption of business if the business owner recovers from the disability. The application must be accompanied by supporting financial statements to verify the stability of the business and to establish the appropriate level of insurable expenses. Actual expenses are reimbursed at the time of disability up to a maximum monthly indemnity selected at the time of policy issue.

b. Benefits from key employee disability policies are payable to the business entity when the insured key employee is disabled. Proceeds from key person disability policies can be used to replace lost revenue directly attributable to the key person's disability. Proceeds can also be used to fund the search for individuals to replace the insured person, the extra cost of hiring specialized individuals to replace the multiple talents of the insured, and the training costs that may be incurred to prepare replacements to carry out the duties the insured performed. The costs of training, hiring, and compensating are usually rather easy to ascertain, whereas estimating lost revenue is a very difficult and complex task. These policies are not designed to provide continuance of salary for the key employee.

c. Individual disability income policies can be purchased by the business entity to fund formal plans to continue the salary for the disabled owner or key employees. Formal plans can be set up in two different ways. The corporation can own the policy and be the beneficiary under the policy, or the corporation can pay the premiums on a policy owned by the employee to whom benefits will be paid. In some informal plans to continue salary, the corporation pays a large enough bonus to the employee for the employee to buy an individual disability income policy.

d. Buy-sell agreements triggered by the disability of an owner can be funded with disability insurance specifically designed for this purpose. These policies can fund either an installment purchase or a lump-sum buyout. The disability definition in the policy should be the same definition as that specified in the buy-sell agreement. The waiting period for a buy-sell policy is typically 1 year or longer to avoid triggering the buyout for disabilities that last less than 1 year. Most buy-sell policies pay the benefit in one lump sum.
Chapter 15

Answers to Review Questions

1. Some of the reasons there is a need for long-term care insurance include the following:
   • **demographics.** The population aged 65 and over is the fastest-growing age group.
   • **increasing costs.** Annual nursing home costs are nearly $80,000 on the average for private accommodations and may be much higher in some locations.
   • **inability of families to provide care.** Geographic dispersion, women in the workforce, and fewer children are just some of the reasons why it is increasingly difficult for families to provide full care.
   • **inadequacies of Medicare and medical expense insurance.** Custodial care is not covered well, if at all, under Medicare and Medicaid expense insurance.

2. There are several sources for providing long-term care other than insurance:
   • **personal savings.** Unless a person has substantial resources, this approach may force an individual and his or her dependents into poverty. It may also mean that the person will not meet the financial objective of leaving assets to heirs.
   • **relatives and friends.** These individuals may provide caregiving themselves or furnish financial support to purchase care.
   • **welfare.** The Medicaid program in most states will provide benefits, which usually include nursing home care, to the "medically needy." However, a person is not eligible unless he or she either is poor or has a low income and has exhausted most other assets (including those of a spouse).
   • **state programs.** These programs have attempted to encourage better coverage for long-term care. One aspect of these experiments has been to waive or modify certain Medicaid requirements if a person carries a state-approved long-term care partnership policy.
   • **continuing care retirement communities.** These facilities require an "entrance fee" that enables residents to occupy a dwelling unit but usually does not give them actual ownership rights. Residents pay a monthly fee that includes meals, some housecleaning services, and varying degrees of health care. If a person needs long-term care, he or she must give up the independent living unit and move to the nursing home portion of the facility, but the monthly fee normally remains the same. The disadvantages of this option are that the cost of a continuing care retirement community is beyond the reach of many persons, and a resident must be in reasonably good health and able to live independently at the time he or she enters the facility.
   • **long-term care benefits in cash value life insurance policies.** Some companies provide this benefit, which enables an insured to use a portion of death benefits while he or she is still living. However, any benefits received reduce the future death benefit. The benefit acceleration may result in the reduction of the death benefit to a level inadequate for accomplishing the purpose of life insurance—the protection of family members after a wage earner's death. In addition, the availability of an accelerated benefit may give the insured a false sense of security that long-term care needs are being met when, in fact, the potential benefit may be inadequate to cover extended nursing home stays.

3. Highlights of the criteria for policy provisions include the following:
   • Many words or terms cannot be used in a policy unless they are specifically defined in accordance with the legislation—for example, adult day care, home health care services, personal care, and skilled-nursing care.
• Renewal provisions must be either guaranteed renewable or noncancelable.
• Limitations and exclusions are prohibited except in the cases of preexisting conditions; mental or nervous disorders (but Alzheimer’s disease cannot be excluded); alcoholism and drug addiction; illness, treatment, or medical condition arising out of war, participation in a felony, service in the armed forces, suicide, and aviation if a person is a non-fare-paying passenger; and treatment in a government facility and services available under Medicare and other social insurance programs.
• No policy can provide coverage for skilled-nursing care only or provide significantly more coverage for skilled care in a facility than for lower levels of care.
• The definition of preexisting condition can be no more restrictive than to exclude a condition for which treatment was recommended or received within 6 months prior to the effective date of coverage. In addition, coverage can be excluded for a confinement for this condition only if it begins within 6 months of the effective date of coverage.
• Eligibility for benefits cannot be based on a prior hospital requirement or higher level of care.
• Insurance companies must offer the applicant the right to purchase coverage that allows for an increase in the amount of benefits based on reasonable anticipated increases in the cost of services covered by the policy. The applicant must specifically reject this inflation protection if he or she does not want it.
• Insurance companies must offer the applicant the right to purchase a nonforfeiture benefit. If the applicant declines the nonforfeiture benefit, the insurer must provide a contingent benefit upon lapse that is available for a specified period of time following a substantial increase in premiums.
• A policy must contain a provision that makes a policy incontestable after 2 years on the grounds of misrepresentation. The policy can be contested on the basis that the applicant knowingly and intentionally misrepresented relevant facts pertaining to the insured’s health.

4. HIPAA provides favorable tax treatment to tax-qualified long-term care insurance contracts, which are defined as insurance contracts that meet all the following requirements:
• The only insurance protection provided under the contract is for qualified long-term care services.
• The contract cannot pay for expenses that are reimbursable under Medicare.
• The contract must be guaranteed renewable.
• The contract does not provide for a cash surrender value or other money that can be borrowed or paid, assigned, or pledged as collateral for a loan.
• All refunds of premiums and policyowner dividends must be applied as future reductions in premiums or to increase future benefits.
• The policy must comply with various consumer protection provisions. For the most part, these are the same provisions contained in the NAIC model act and already adopted by most states.

5. With some exceptions, expenses for long-term care services, including insurance premiums, are treated like other medical expenses. Self-employed persons may exclude from income the premiums paid up to certain limits. Persons who itemize deductions can include long-term care insurance premiums, up to the same limit, for purposes of deducting medical expenses in excess of 7.5 percent of adjusted gross income. Limits are based on a covered individual’s age and subject to cost-of-living adjustments. Employer contributions for group contracts are deductible to the employer and do not
result in taxable income to an employee. Benefits received under a qualified long-term care insurance contract written on a reimbursement basis are received tax free by an employee. Under contracts written on a per diem basis, proceeds are excludible from income up to a specified figure that is indexed annually. Amounts in excess of this limit are also excludible to the extent that they represent actual costs for long-term care services.

6. Most companies have an upper age in the range of 79 to 84, beyond which coverage is not issued. Some companies have no minimum age, while others have a minimum age, such as age 40.

7. A long-term care insurance policy can cover one, several, or more types of care. The types of care include nursing home care, assisted-living facility care, hospice care, care in an Alzheimer's facility, home health care, care in an adult day care center, care coordination, and alternative plans of care.

8. The amount of benefits is usually limited to a specified amount per day or month. The same level of benefits is usually provided for all levels of institutional care. The applicant can sometimes select home health care limits from 50 to 150 percent of the benefit amount payable for institutional stays. The policyowner is usually given a choice regarding the maximum duration of benefits, which can range from 1 year to the insured's lifetime.

9. Under a tax-qualified plan, the insured must be chronically ill, which means that one of the following criteria must be met:
   - The insured is expected to be unable, without substantial assistance from others, to perform at least two of the six ADLs acceptable under HIPAA for at least 90 days due to loss of functional capacity.
   - Substantial services are required to protect the individual from threats to health and safety due to severe cognitive impairment.

   Many non-tax-qualified plans use the same criteria that are in tax-qualified contracts, except no time period applies to an expectation of the inability to perform ADLs. Some non-tax-qualified plans require the inability to perform only one ADL or extend the definition of ADLs beyond the six allowed by HIPAA. Finally, some non-tax-qualified plans make benefits available when a physician certifies medical necessity, regardless of whether other criteria are satisfied.

10. Factors that affect the premium include age, types of benefits, duration of benefits, inflation protection, elimination period, daily/monthly maximum, waiver-of-premium provision, marital status, tobacco use, and underwriting class.

11. Partnership programs are alliances between insurance companies and states. The states offer an incentive for the purchase of long-term care insurance by allowing persons who purchase such policies to protect a larger-than-usual amount of assets if they later are otherwise eligible for Medicaid. In most states, the additional amount of assets protected is equal to the policy benefits received. Partnership programs also protect a certain amount of assets from estate recovery programs. Partnership policies must meet certain requirements, such as being tax-qualified policies and automatically including inflation protection for applicants under the age of 76.

12. Differences between individually purchased long-term care insurance and group long-term care insurance include the following:
   - Eligibility for group coverage generally requires that an employee be full-time and actively at work. At a minimum, coverage can be purchased for an active employee and/or the spouse. Some policies also make coverage available to retirees and to other family members of eligible persons, such as minor children,
parents, parents-in-law, and possibly adult children and grandparents. There may be a maximum age for eligibility, but it is often age 80 or 85.

- The cost of group coverage is usually slightly less than the cost of individual coverage.
- An employee typically has less choice in benefit levels and the duration of benefits under a group policy. The amounts and duration of benefits are selected by the employer and normally apply to all employees. However, some policies do allow choice but to a lesser extent than is allowed under individual policies.
- If a participant leaves employment, the group coverage usually can be continued on a direct-payment basis, under either the group contract or an individual contract.
Chapter 16

Answers to Review Questions

1. Property loss exposures involve the possibility that a person or organization will sustain a property loss resulting from the damaging, destruction, taking, or loss of use of a house, car, or other property in which that person or organization has a financial interest. A liability loss exposure involves the possibility of a claim alleging a person's or organization's legal responsibility for injury or damage suffered by another party; one example is the possibility of causing an auto accident.

2. Named-perils policies contain a list of the covered perils. If a peril is not listed, losses resulting from that peril are not covered. In contrast, open-perils policies cover all losses to covered property unless the loss is specifically excluded.

3. The duties of the insured and insurer when a property loss occurs are as follows:
   a. A typical property insurance policy requires that the insured must promptly tell the insurer there has been a property loss, and the insured must cooperate with the insurer in showing that a covered loss occurred within the policy period. If property coverage is on a named-perils basis, the insured needs to establish that the loss was caused by one of the named perils. The insured also needs to cooperate with the insurer in establishing the value of covered property that has been lost or damaged.
   b. The insurance company has a duty to pay losses fairly and promptly once the coverage and the value of the property loss have been established. The insurance policy and/or state law might specify that losses are payable within a stated period, such as 60 days. The insurer will settle property insurance claims by paying the policyowner unless some other person with an insurable interest is also covered by the policy.

4. Jim would recover as follows:
   a. If Coverage A in his policy is $250,000 and Jim has the house repaired, Jim would receive $60,000, the replacement cost of the loss, because he carries insurance greater than 80 percent of the replacement cost of his home at the time of the loss (.80 x $300,000 = $240,000).
   b. If Coverage A in his policy is $220,000 and Jim has the house repaired, he would be paid only $55,000 because his amount of insurance is less than the 80 percent required ($240,000) but the amount calculated by the following formula is greater than the actual cash value of the loss:

   \[
   \frac{\text{Insurance carried}}{80\% \text{ of replacement cost of the house}} \times \text{Replacement cost of the loss} = \frac{$220,000}{\frac{\text{Replacement cost of the loss}}{\text{Replacement cost of the loss}}} = \frac{\text{Replacement cost of the loss}}{\text{Replacement cost of the loss}} = $55,000
   \]

   c. If Coverage A in his policy is $180,000, Jim would receive the actual cash value of the loss, $50,000, because it is larger than the amount produced by the underinsurance formula:
Insurance carried
\[
\frac{80\% \text{ of replacement cost of the house}}{\times \text{Replacement cost of the loss}}
\]
\[
= \frac{$180,000}{\frac{1}{2} \times $60,000} = $45,000
\]

5. The insurers would make these payments:
   a. If Policy A and Policy B both have pro rata other insurance provisions, Policy A
      would pay 55.56 percent ($100,000/$180,000) of the loss, or $50,000, and Policy
      B would pay 44.44 percent ($80,000/$180,000) of the loss, or $40,000.
   b. If Policy A is written on a primary basis and Policy B is written on an excess basis,
      Policy A would pay first up to a maximum of its limit and then Policy B would pay
      any unpaid loss up to a maximum of its limit. In this case, Policy A would pay
      $90,000 (the entire loss) and Policy B would not be required to pay.
   c. Policy B would pay $80,000 (its limit) and Policy A would pay nothing.

6. The types of liability losses are as follows:
   a. The cost of surgery, loss of income, and pain and suffering for the driver of the car
      that Billy hit are bodily injury liability losses.
   b. The cost to the phone company to repair its pole is a property damage liability loss.
   c. The suit by the driver of the other car that resulted from Billy slandering her with
      foul language in front of the witnesses at the accident scene is under personal
      injury liability.

7. For negligence to be proven, there must be (1) a legal duty to act, or not to act, depending
   on the circumstances and the persons involved, (2) a wrong, or voluntary breach of legal
   duty, based on a "prudent person" standard of conduct, (3) an injury or damage, and (4) a
   proximate relationship between the wrong and an injury or damage, where a continuous
   succession of events occurred, from the act to the final event that caused the injury.

8. The following are the applicable rules of law:
   a. Under imputed negligence, legal responsibility for injuries or damage is extended
      to other persons, such as employers. In this case, because the negligent party,
      Billy, acted in the capacity of employee or agent of Jones Dry Cleaners, both the
      wrongdoer and the owner of the property can be held liable.
   b. Under contributory negligence, anyone who is so negligent as to contribute to his
      or her own injuries or damage cannot recover from another for these injuries.
   c. Under comparative negligence, damages are diminished in proportion to the
      amount of negligence attributable to the person injured or to the owner or person
      in control of the damaged property.

9. The duties of the insured and obligations of the insurer are summarized below:
   a. Duties imposed on the insured typically include the following:
      • to give written notice as soon as practical to the company or its agent
      • to forward promptly to the insurance company every notice, demand,
        summons, or other process relating to the accident or occurrence
      • to assist the insurance company, at its request, to (1) make settlement,
        (2) enforce the insured's rights against others who may be liable to the
        insured, (3) help with the conduct of suits and attend hearings and trials,
        (4) secure and give evidence, and (5) obtain the evidence of witnesses
b. First, the insurer will provide a defense at its expense by a counsel of its choice, even if a suit is groundless, false, or fraudulent. Second, the insurer will pay up to the limit of liability for the damages for which the insured is legally liable.

10. The basic tax rules are as follows:

a. **deductibility of premium.** Premiums paid by individual taxpayers for personal property and liability insurance are not deductible. However, premiums paid for business coverage by an individual, partnership, or corporation are a deductible business expense.

b. **taxation of premiums for employees.** Group property and liability insurance as an employee benefit typically requires that an employee pays the full cost of his or her coverage, and the tax implications are the same as if the employee had purchased an individual policy. If the employer pays any part of an employee's premium, for either individual or group coverage, the employer can deduct this cost as a business expense. However, the employer must report this amount as taxable income.

c. **taxation of benefits.** Benefits paid under liability insurance policies do not result in taxable income to the policyowner or insured even if they are paid on their behalf. Under property insurance policies, benefits paid for direct loss to real or personal property result in a capital gain to the extent that a taxpayer receives reimbursement in excess of his or her basis in the property. However, the situation is treated as an involuntary conversion, and the gain can be postponed to the extent that a taxpayer uses the proceeds to purchase replacement property, and the purchase amount exceeds the taxpayer's basis in the lost or damaged property.

The situation for certain consequential losses is less clear. To the extent that benefits are paid for actual expenses incurred, there is no taxable income. Business interruption coverage, however, will result in ordinary income if it is written on a basis that insures the policyowner against loss of net profits.

d. **deductibility of uninsured losses.** The Internal Revenue Code allows a deduction for certain losses to the extent that they are not compensated for by insurance. Those losses must arise from fire, storm, shipwreck, or other casualty, or from theft. The maximum amount of the losses for tax purposes is the lesser of (1) the decrease in the fair market value of the property as a result of the casualty or theft or (2) the taxpayer's adjusted basis in the property. Losses can be deducted in full by businesses and by individual taxpayers if the loss is incurred in a trade or business or any transaction entered into for profit. Other losses of individual taxpayers are deductible only if the taxpayer itemizes income tax deductions and then only to the extent that (1) each separate loss exceeds $100 and (2) the total of all casualty and theft losses for the year exceeds 10 percent of adjusted gross income.

11. Property and liability insurance is important in financial planning for reasons that include the following:

- Families often spend more on property and liability insurance than on all other types of insurance.
- Failure to carry appropriate property and liability insurance can lead to uninsured losses that scuttle an otherwise sound capital accumulation and preservation plan.
- Property and liability insurance is complicated.
- Property and liability insurance planning is related to other planning issues, such as emergency funding and taxation.
• Coverage in standard policies is limited, and many options can be used to tailor coverage for specific client's needs.
Chapter 17

Answers to Review Questions

1. Frank and Ellen are covered, as the named insured and spouse. Elaine is covered as a relative residing in the named insured's household. Destiny, who is temporarily residing at college, is also a covered person.

2. An insured location includes

   - the residence premises. This includes a one- to four-family dwelling, other structures, and grounds where the policyowner resides as shown in the declaration.
   - that part of other premises, other structures, and grounds used by the named insured or spouse as a residence if it is shown in the declarations or if it is acquired during the policy year as a residence by the named insured
   - other premises not owned by an insured but where an insured is temporarily residing
   - vacant land, other than farm land, owned by or rented to an insured
   - individual or family cemetery plots or burial vaults of an insured
   - any part of a premises occasionally rented to an insured for other than business use

3. Nathan's HO-3 policy provides the following:

   a. Damage to Nathan's home done by vandals is covered under the open-perils Coverage A (as long as the house has not been vacant for more than 60 consecutive days preceding the loss).
   
   b. Damage to the inside walls and hardwood floors caused by rain water that blew in when Nathan accidentally left the window open during a storm is covered under the open-perils Coverage A because it is not excluded.
   
   c. Damage to the family room couch and end tables caused by rain water that blew in when Nathan accidentally left the window open during a storm is not covered under the named-perils Coverage C, because the windstorm peril does not cover the damage from rain that was not a result of direct wind or hail damage to the building.
   
   d. Damage to the walls of the house caused by an earthquake is excluded under Coverage A. Nathan would have to obtain coverage via a policy endorsement or a separate policy.
   
   e. Stains on the wall-to-wall carpet due to housebreaking the new family pet and the hole in the outside of the house cut by a woodpecker are excluded under Coverage A.
   
   f. Theft of the $2,000 cast aluminum porch furniture from the deck off the back of Nathan's home is covered under Coverage C, which includes the peril of theft.
   
   g. Only $200 of the $1,500 in cash burned in a fire in Nathan's home is covered under the typical HO-3 policy due to the special limits of liability for Coverage C.
   
   h. The damage to Nathan's wife's furs as a result of a fire is covered under Coverage C.
   
   i. Jewelry is covered property and theft is a covered peril under Coverage C, but recovery for the burglary claim is limited to $1,500 by special sublimit for theft of jewelry.
   
   j. The $1,000 of additional expense incurred while Nathan's family had to live elsewhere for 1 1/2 days after a small fire loss is covered under Coverage D. The limit for Coverage D is 30 percent of Coverage A (or $75,000 for Nathan).
k. The $2,000 loss is included under Coverage B, which provides insurance for other structures on the residence premises that are set apart from the dwelling by a clear space, such as Nathan's detached garage. Coverage B is open-perils and windstorm damage is not among the exclusions.

4. Sarah's coverage under her HO-3 policy is as follows:
   a. Assuming Sarah is legally liable for the explosion, the bodily injuries to Sarah's guests and the property damage to the side of the neighbor's house when Sarah's gas grill exploded during a cookout at her house would be covered up to the limit of Coverage E. The policy would also pay Sarah's defense costs in addition to the stated limit of liability.
   b. There was no coverage when Sarah accidentally injured a coworker when running a meeting at work, because both bodily injury and property damage arising out of or in connection with a business engaged in by the insured are excluded under Coverage E and Coverage F.
   c. There was no coverage when Sarah damaged another shopper's car at the mall while carelessly backing out of a parking space, because there is an exclusion for this type of loss that would be covered by auto liability insurance.
   d. Although intentional acts by an insured are excluded under Coverage E, there would be limited coverage under the additional coverages for Section II when Sarah's 3-year-old son, Matthew, ripped out some of the neighbor's flowers to make a Mother's Day gift.
   e. Without regard to fault, there was medical expense coverage under Coverage F for the injury to a team member when Sarah's daughter tossed a bat into the bat rack and it bounced and hit the teammate, cutting her head. Coverage E would also apply if a lawsuit were involved.

5. No, coverage does not apply. One exclusion in Doug's homeowners policy excludes coverage for liability arising out of the delivery of a controlled substance, and another excludes coverage for liability arising out of the transmission of a communicable disease.

6. Differences from the HO-3 coverages can be summarized as follows:
   a. HO-2 differs from HO-3 in that HO-2 Coverages A and B are written on the same named-perils basis as Coverage C. HO-2 is less comprehensive and therefore a little less expensive.
   b. HO-4 is often referred to as tenants homeowners insurance or renters insurance and is identical to HO-3 except that there is no Coverage A or Coverage B. The policyowner selects a limit for Coverage C, and Coverage D is 30 percent of this amount.
   c. HO-5 coverage, unlike HO-3 coverage, is written on an open-perils basis for Coverage C.
   d. HO-6 is designed to cover the loss exposures of a policyowner who lives in a condominium or cooperative unit. It is like HO-3 in that Coverage C is on a named-perils basis. The Coverage C limit is also the amount of insurance selected by the policyowner. Coverage D is 50 percent of this amount. HO-6 provides $5,000 for Coverage A on a named-perils basis. This amount also applies to other structures and can be increased if needed. There is no Coverage B.
   e. HO-8 has been written mostly on older homes where the replacement cost of a dwelling often significantly exceeds its market value. Providing replacement coverage might create a moral hazard because the policyowner could collect more under an insurance settlement than by selling the house. Perils insured against for all coverages are limited to fire, lightning, windstorm or hail, explosion, riot or
civil commotion, aircraft, vehicles, smoke, vandalism and malicious mischief, and volcanic eruption. Theft is covered only from the residence premises and up to a limit of $1,000. There are also other limitations. Loss settlements under Coverages A and B are based on common construction materials and methods that are functionally equivalent to the original construction. Settlements are limited to market value if repairs are not made, although some states require loss settlements to be on an actual cash value basis.

7. The endorsements provide the following:
   a. Home day-care coverage is for persons who conduct day-care businesses in their homes either for children or older adults. The endorsement provides coverage for personal property used in the day-care business and extends Section II liability coverage to home day-care services. However, liability is excluded for injuries arising out of motor vehicles, watercraft, and saddle animals and for liability arising out of sexual molestation and physical or mental abuse inflicted by an insured or an employee.
   b. The increased special limits of liability endorsement can be used to increase coverage for some of the items where limited amounts of protection are available under Coverage C. Examples of items for which coverage can be increased include currency, securities, jewelry and watches, firearms, and electronic apparatus for use in a motor vehicle.
   c. An earthquake endorsement can be used in most states to provide coverage for earthquakes and tremors that accompany volcanic eruption. In place of the regular deductible, there is an earthquake deductible equal to 5 percent of the limit of insurance that applies to Coverage A or Coverage C, whichever is greater. In California, earthquake coverage is sold by many insurers along with homeowners policies, but the insurer is a state agency established to make earthquake coverage available to homeowners.
   d. The inflation guard endorsement provides automatic increases for all Section I coverages by the annual percentage selected.
   e. The personal property replacement cost loss endorsement changes the loss settlement basis for personal property from actual cash value to replacement cost. Certain property, such as antiques, fine art and collectibles, is not eligible for replacement cost coverage.
   f. The scheduled personal property endorsement broadens coverage on specific categories of valuable personal property. Coverage is open-perils with few exceptions and applies worldwide except for fine art, that is covered only in the United States and Canada. There is also limited coverage for up to 30 days for newly acquired property in a category insured under the endorsement. Losses, except for fine art, are generally settled on an actual cash value basis.
   g. The business pursuits endorsement provides coverage for liability that arises out of or in connection with a business engaged in by an insured, and it is most commonly used by persons in sales, clerical, and teaching occupations. Coverage does not apply with respect to a business owned or financially controlled by an insured or in which an insured is a partner. There is no coverage for liability that arises out of professional services, with the exception of teaching.

8. For property owners to be eligible for flood insurance, they must live in a community that participates in the NFIP. These communities must agree to establish and enforce certain land use restrictions to minimize the community's exposure to flood losses.

A homeowner can purchase insurance on the dwelling, its contents, or both. Coverage is similar to that provided for other perils under the homeowners policy, with
some additional exceptions. Losses on the dwelling are settled on an actual cash value basis, but replacement cost coverage can be endorsed under some circumstances. Contents coverage applies only on the residence premises except when property is removed to protect it from flood, and there is an extensive list of property that is not covered under the policy.

9. Several alternatives for coverage are available, but policies can be more limited than those written in the normal marketplace. Some companies specialize in the substandard market and write coverage for a variety of properties but at higher-than-normal premiums.

Many states have taken a variety of actions to make coverage available, often at subsidized rates. State-run FAIR programs provide insurance for buildings and their contents if the property owner is unable to obtain coverage in the standard insurance market, for whatever reason. In most cases, coverage is written by a pool or syndicate of private insurers who are assessed for any losses of the plan if premiums are inadequate. Each state has its own FAIR plan, and the plans differ.

Some states, primarily in the Southeast and on the Gulf Coast, have beachfront and windstorm plans to provide protection that insurers are unwilling to write because of the loss exposure to hurricanes. Some of these plans cover only the perils of windstorm and hail, and property owners obtain protection for other perils in the normal insurance market.

Finally, the amount of insurance needed on an expensive home may exceed the limit an insurer is willing to write. In other cases, replacement cost substantially exceeds market value. Some insurers specialize in this market and have their own policies to meet the needs of the well-to-do. Other insurers tailor standard homeowners forms (such as the HO-3 with endorsements that were previously described).

10. Some characteristics of title insurance include the following:

   • The policy provides protection only against unknown title defects that have occurred prior to the effective date of the policy but are discovered after the effective date.
   • The policy is written on the assumption that losses will not occur because most title defects are known and listed in the policy.
   • The policy term is indefinite and continues until title to the property is again transferred. At that time, the new owner will need to purchase a new title insurance policy because the existing policy is not assignable.
   • The premium is paid only once—when the policy is issued—and the policy cannot be canceled by either party.
   • The insured is indemnified up to the policy limits if a loss occurs. However, there is no guarantee that possession of the property will be retained.
   • The amount of insurance is usually the initial purchase price of the property, and a potential loss in the future can be much higher than the policy limit because of inflation.
Chapter 18

Answers to Review Questions

1. Key problems include the large number of auto accidents, the high cost of auto accidents, uninsured and underinsured drivers, the difficulty of some persons in obtaining auto insurance, and the affordability of that insurance.

2. The client should consider purchasing uninsured and underinsured motorists coverage, because even in states with compulsory insurance laws:
   - Some drivers may not register their vehicles; others may drop insurance after a vehicle is registered.
   - A person may be injured by a hit-and-run driver, an out-of-state driver without insurance, a driver of a stolen car, or a driver of a fraudulently registered auto.
   - The required liability limits are relatively low, leaving some motorists underinsured.

3. Compulsory insurance requires the owners of autos to carry liability insurance (or to post a cash deposit, bond, or other security) before a vehicle can be registered. Shortcomings of this system were discussed in answer 2.
   Financial responsibility laws require proof of future financial responsibility by carrying insurance (or posting a cash deposit, bond, or other security) but only after some triggering event. Financial responsibility laws have the same shortcomings as compulsory insurance. In addition, they become effective only after an accident or serious offense and do not provide any compensation to the innocent victims of that accident.
   Unsatisfied judgment funds are established by the state to compensate persons who are unable to collect a legal judgment resulting from an auto accident. The injured person must obtain a legal judgment against the negligent party and show that the judgment cannot be collected. The maximum claim is usually limited to the state's minimum compulsory insurance requirement and is reduced by collateral sources of recovery. The collection process is slow and cumbersome, and some states' funds are inadequately funded.
   Uninsured motorists coverage provides the insured with the amount he or she would have collected from the insurer of an uninsured driver had that driver been carrying insurance. Uninsured motorists coverage does not apply if the negligent party carries insurance that has inadequate limits to fully indemnify the innocent party. The limits of coverage are equal only to the state's compulsory insurance or financial responsibility benefit unless the policyowner has purchased higher limits, and the insured must establish that the other party was legally liable. The coverage usually applies to bodily injury only. The cost of the coverage is borne by the innocent victim, not the uninsured driver.
   Underinsured motorists coverage provides protection to auto accident victims when a negligent driver has insufficient insurance limits to pay for the damages for which he or she is responsible. Shortcomings are similar to those of the uninsured motorists coverage.
   No-fault auto insurance provides first-party benefits to injured persons and imposes some restrictions on their rights to sue negligent parties. No-fault has not necessarily resulted in lower premiums. In addition, it restricts the right in some states to sue for pain and suffering, and it shifts some costs of auto accidents from negligent parties to innocent victims.

4. In each situation, the settlement would be handled as follows:
   a. In a state with compulsory liability insurance, John would sue the driver of the other car and, given the assumptions with regard to fault, receive payment for the $40,000 in bodily injury plus any pain and suffering to the extent of the liability
coverage on the other car. If the teenager had no liability coverage or less than the amount of John's uninsured and underinsured motorists coverages, those coverages in John's own policy would respond.

b. If the accident occurred in a state with a modified no-fault law containing a $5,000 threshold, John's own insurer would pay for lost wages and medical expenses from benefits available under his no-fault coverage. (Even if he is from a state without no-fault, his PAP will automatically provide no-fault coverage when he is driving in a no-fault state.) Because his bodily injuries exceed the $5,000 threshold, he can sue the other driver for bodily injury losses, including pain and suffering. His insurance company would be reimbursed to the extent that any of the amount from the legal judgment duplicates the no-fault benefits received. If the teenager had no liability coverage or less than the amount of John's uninsured and underinsured motorists coverages, those coverages in John's own policy would respond for the amount unpaid in excess of the no-fault benefits.

5. A personal auto policy can be written on eligible vehicles owned or leased by an individual or by a husband or wife residing in the same household. Vehicles with other forms of ownership can be insured with an endorsement. Eligible vehicles include private passenger autos, such as cars, vans, and sports utility vehicles, owned by the policyowner or leased under a written contract of 6 continuous months or longer. Also eligible are newly acquired autos, trailers, temporary substitute vehicles, and pickups with a gross vehicle weight rating of 10,000 pounds or less. Vans and pickups are ineligible for coverage under some circumstances when used for the transportation or delivery of goods and materials. Other vehicles, such as motor homes, motorcycles, golf carts, and snowmobiles, can be insured by endorsement in most states.

6. Answers:
   a. Pete would be covered up to a total of $100,000 for bodily injury to the other driver and property damage to the other driver's car. Pete's own car would be covered by the collision coverage subject to the $250 deductible as long as he notifies his company that he wants collision coverage on the new car within 14 days of purchase.
   b. Pete would have no coverage for this additional car since he did not report it to his insurer within 14 days of the purchase.

7. Tom's PAP would pay these amounts:
   a. With split limits, Tom's policy would pay the claim for $5,000 of bodily injury but only $50,000 of the property damage to the truck and its contents. Tom would have to pay the remaining $100,000 out of his pocket unless he has an umbrella liability policy.
   b. With a single limit of $300,000, all $155,000 of claims for bodily injury and property damage would be paid by Tom's PAP.

8. Betty's PAP provides coverage as follows:
   a. Unless Betty's business involves use of the vehicle as a public or livery conveyance hired out to carry persons or property, her liability coverage applies.
   b. Betty has liability coverage under her PAP only if she has added an endorsement to include liability coverage on this car.
   c. The friend's policy is primary because it covers an "owned vehicle," and Betty's insurance is secondary or excess because she is driving a "nonowned vehicle." Betty's policy will pay only on an excess basis after the limits of the owner's policy are exhausted.
9. If the friend's car is furnished for the client's regular use, the client's PAP provides no coverage; a court might need to determine whether the facts of this situation involve a car furnished for the client's regular use. Assuming coverage applies, when a person drives a friend's car, the first person is a named insured under his or her own PAP while driving another auto. He or she is also an insured under the friend's PAP as a person using the covered auto. In this situation, the friend's policy is primary because it covers an "owned vehicle," and the driver's insurance is secondary or excess because he or she is driving a "nonowned vehicle." The driver's policy will pay only on an excess basis after the limits of the owner's policy are exhausted.

10. Part B of the PAP provides payment for the reasonable and necessary medical expenses of an insured as a result of an auto accident. Benefits are paid regardless of fault. The insureds under Part B include the named insured, spouse, and any family members (1) while occupying either a motor vehicle designed for use on public roads or a trailer or (2) when struck as a pedestrian by such a vehicle or trailer. Any other person, such as a child being transported, who is injured while occupying a covered auto is also an insured. The answer to this question might be different in a state with a no-fault law.

11. The following coverages apply:
   a. Coverage under Part D, Coverage for Damage to Your Auto, applies to nonowned vehicles that are rented on a temporary basis, such as when an insured is on a trip. Damage to the nonowned auto caused by the impact of that auto with an object is covered under Part D's collision coverage.
   b. Damage to the nonowned auto caused by malicious mischief or vandalism is covered under Part D's other-than-collision coverage.
   c. Damage to the nonowned auto caused by the contact of that auto with an animal is covered under Part D's other-than-collision coverage.

12. A miscellaneous type vehicle endorsement is used to cover miscellaneous types of owned vehicles, including motorcycles and dune buggies. Each vehicle is listed in a schedule, and the same coverages that apply to autos in the PAP can be purchased. Likewise, a snowmobile endorsement can be used to insure snowmobiles.

13. Without an endorsement, the PAP does not provide coverage when an insured is driving in Mexico. Acceptable coverage must be obtained through a licensed Mexican insurance company prior to the trip. Driving in Mexico without such coverage is a criminal offense. Coverage can be purchased at the border. Alternatively, it may be possible to add this protection to an existing PAP if an insurance company is a member of a foreign insurance association; however, this endorsement is primarily used by people who live near the border and occasionally take brief trips to Mexico. The endorsement is effective only if the insured has also purchased liability insurance through a Mexican insurer and coverage is excess over that policy. The main advantage of the endorsement is the ability to have higher liability limits than the Mexican insurance, as well as other policy coverages.

14. Hard-to-insure drivers can usually find some coverage in the residual market, which consists of specialty insurers and state programs to make insurance available, though not necessarily affordable. State programs usually follow one of three models: auto insurance plans, joint underwriting associations, or reinsurance facilities. A small number of drivers with very poor driving records may still be unable to obtain insurance from any of these sources in some states.

15. Clients should evaluate the cost of coverage, the financial strength of the insurer, and the service from the company and its agents.

16. For some watercraft, liability coverage is available under a homeowners policy, which provides no protection for larger boats and little physical damage protection for any boat.
Boatowners policies, for smaller boats, and yacht policies, for larger boats, contain liability coverage, medical payments coverage, uninsured boaters coverage, and physical damage coverage. Also available are coverages for the legal obligation of the policyowner to remove a wrecked or sunken vessel, for liability arising out of transportation of the boat on land, for costs of towing and assistance if the boat is disabled, and for liability to crew members and other maritime workers.

Aviation policies for private aircraft pay for bodily injury liability that arises out of the insured's ownership, maintenance, or use of insured aircraft. Coverage also applies to bodily injury liability arising out of the location where the insured aircraft is stored. Medical payments coverage is available to cover passengers, and crew members can be covered for an additional premium. Physical damage coverage is open-perils.

17. A personal umbrella policy is designed to provide liability coverage for catastrophic legal claims or judgments. Without broad liability insurance of sufficiently high limits, individuals face the possibility of having assets and/or income seized to pay a legal judgment. The umbrella policy covers bodily injury and property damage liability, as well as personal injury liability. Most personal umbrella policies also pay defense costs not payable by underlying policies, and they provide other supplementary coverages similar to those in the homeowners and PAP policies (premiums on appeal bonds, expenses incurred at the company's request, and so forth).
Chapter 19

Answers to Review Questions

1. In addition to commercial property insurance on the building, the equipment, and inventory, the client is likely to need, or at least should consider the need for, the following:

   - business income insurance to cover lost profits, continuing expenses, and/or extra expenses to minimize the suspension of business after the occurrence of a direct physical damage loss to property
   - crime insurance, especially to cover employee dishonesty
   - inland marine insurance to cover goods in transit
   - equipment breakdown insurance to cover repairs or replacement of machinery that breaks down
   - commercial general liability insurance to cover premises and operations liability and products liability
   - business auto insurance for company vehicles
   - workers’ compensation and employers liability insurance to provide protection for injuries to employees
   - directors and officers liability insurance
   - employment practices liability insurance

2. The Business Income (without Extra Expense) Coverage Form covers the sum of (1) net profit or loss that would have been earned or incurred during a period of business suspension and (2) normal continuing business expenses, including payroll, during the suspension. The Business Income (and Extra Expense) Coverage Form provides for the same expenses, as well as expenses incurred to avoid or minimize the suspension of operations, even if they do not otherwise reduce the business income loss. The Extra Expense Coverage Form provides extra expense insurance for organizations that must remain in operation after a property loss and, therefore, are unlikely to have a significant decrease in revenue. However, the extra expenses of remaining open can be significant.

3. First, commercial crime forms typically cover money, which includes currency, coins, bank notes, checks, and money orders. Second, these forms also typically cover securities, which include both negotiable and nonnegotiable instruments, contracts that represent money or other property, tokens, tickets, stamps, and charge slips. Finally, these forms also typically cover tangible property other than money or securities; however, there are exclusions for certain types of property for which adequate coverage can be obtained under other types of insurance.

4. The following provisions are common to many crime forms:

   - There is no coverage for losses caused by the named insured or any of its directors, trustees, or authorized representatives. In addition, there is no coverage for losses caused by employees except under the forms that specifically cover employee dishonesty.
   - Coverage is for direct losses only. There is no coverage available for consequential losses that might result from criminal acts.
   - Most of the forms require the policyowner to notify the police if there is a reason to believe that a loss results from a violation of law.
   - The forms specify how settlements are valued. Currency is valued at its face value. If the currency is foreign, the insurer can pay the face value in the foreign currency or at its equivalent value in United States currency. Securities are valued as of the close of the business day a loss is discovered. The insurer can pay the value of the securities or replace them in kind. The insurer also has the option
of paying the cost of a bond that is required for the issuance of replacement securities. Other property is valued at its actual cash value, and any disputes over value are settled by arbitration.

5. Today, inland marine policies and forms are used to write coverage for

- goods in domestic transit, by mail, rail, truck, or aircraft. Commonly, these policies cover shipments within and between the continental United States, Alaska, and Canada, but coverage can be endorsed, for example, for shipments to Mexico. Depending on the terms of sale, the responsibility for goods being shipped can fall on the shipper, the carrier, or the recipient. Any of these parties can buy insurance as needed. Owners of property can purchase transit policies to cover property damage to their goods while in the course of transit by common carriers, contract carriers, or their own vehicles. Certain policies, such as motor truck cargo insurance, are used by common carriers or contract carriers to cover customers' goods when the carrier is legally liable for the damage. These policies do not cover damage for which the carrier is not liable, such as those arising from acts of God.

- mobile equipment and property that is often moved from one location to another

- property held by bailees, such as dry cleaners, repair shops, and public warehouses, who often have possession of significant amounts of customers' goods. A bailee liability policy can be purchased to cover damage to these goods when the bailee is legally liable. Many bailees purchase a bailee customers policy, which provides coverage regardless of whether the bailee is legally liable.

- property of certain dealers who own a significant amount of inventory that is likely to be transported, such as jewelry, furs, fine art, cameras, musical equipment, stamps, coins, and mobile and agricultural equipment

- instrumentalities of transportation and communication, which include bridges, tunnels, pipelines, television towers, satellite dishes, and power lines

- gaps left by a policyowner's other commercial insurance policies. The differences in conditions (DIC) insurance has open-perils coverage that can be used to provide earthquake and flood coverage, to provide higher limits than are otherwise obtainable, or to cover loss exposures not covered in basic policies.

6. The types of commercial liability coverage to recommend are as follows:

a. commercial general liability insurance (products liability)
b. commercial general liability insurance (business operations liability)
c. commercial general liability insurance (premises liability)
d. commercial general liability insurance (completed operations liability)
e. commercial general liability insurance (contingent liability)
f. commercial general liability insurance (premises liability)
g. commercial auto coverage (liability)
h. workers compensation and employers liability policy (employers liability under Part Two)
i. professional liability insurance, also known as malpractice insurance
j. professional liability insurance, also known as errors and omissions insurance
k. directors and officers liability insurance
l. employment practices liability insurance

7. Both excess liability insurance and commercial umbrella liability insurance provide additional liability limits for claims that are covered under specified underlying coverages. Under the excess liability policy, there is no drop-down coverage for claims excluded by
the underlying coverages. Unlike excess policies, commercial umbrella liability insurance often covers claims excluded by the underlying policies.

8. Unique characteristics of surety bonds pertain to

   - liability of the principal. Unlike an insured under an insurance contract, a principal who defaults on a bond is liable to the surety to the extent of any expenditure the surety incurs. The surety can require the principal to post collateral to repay the surety if the principal defaults.
   - expected losses. A surety generally expects to pay few losses and underwrites in a strict manner to determine whether the principal is capable of meeting any obligations.
   - coverage period. The coverage period under most surety bonds is indefinite, and the premium for the bond is paid only once. In most cases, neither the surety nor the principal can cancel the bond.
   - bond limit. A surety bond is written for a dollar limit, and that is the maximum amount of the surety’s obligation to the obligee. Some bonds, however, pay court costs and interest on judgments in addition to the bond limit.
   - statutory versus nonstatutory bonds. Governmental ordinances, regulations, or statutes require many bonds, and the provisions of these statutory bonds and the obligations of the parties are established by law. The obligation of the parties under nonstatutory bonds is established by contract between the obligee and the principal.

9. A businessowners policy is designed to provide property and liability coverage for small- to medium-sized businesses and organizations that meet certain eligibility requirements. Two property forms are available—named-perils coverage and open-perils coverage. Losses are paid on a replacement cost basis, and there is no coinsurance provision.

10. Edwin's major concern would involve any claim made directly against him in his role as a corporate director. This is a matter of increasing concern in view of the many financial scandals, accompanied by claims and suits, that have come to light in recent years. In addition to performing his duties diligently, Edwin should be sure the for-profit corporations have adequate directors and officers (D&O) liability insurance that would protect him against such claims. If adequate D&O coverage is not available, Edwin should seriously consider declining the positions.

    If the not-for-profit charity does not have D&O coverage, Edwin's personal umbrella policy might protect him if he receives no compensation for his service on the board. Umbrella policies vary, and he should check his policy carefully to determine what coverage it provides. If his current policy does not provide the necessary coverage, he might be able to obtain an umbrella from another insurer that includes this protection.
1. Ethics is both a field of study and a skill. As a field of study, ethics is a branch of philosophy that investigates how we should behave. Specifically, ethicists work to answer three questions:
   - What does it mean to characterize an action as a “good” action or a person a “good” person?
   - What do we owe to others (as well as other objects of moral concern, such as institutions, the environment and animals)?
   - How should we respond when the obligations we owe to others (and ourselves) come into conflict? In other words, which obligation should take priority?

2. It is helpful to reiterate a point that is often overlooked when people talk about ethics in business, and in the financial services industry in particular—ethics is not compliance. Simply put, fulfilling our legal obligations does not exhaust our ethical obligations. Ethics requires more that acting in accordance an additional set of rules. People acting ethically in business are, in some sense, doing something that is completely outside of a compliance framework. They are applying their moral beliefs (in the form of principles and values) to their business practice because they believe that it is good to do so, that is, they are acting well for its own sake. Ethics demands that people act well (that is, in accordance with their ethical principles and values) because it is the right thing to do. Under a compliance model, it is irrelevant why someone chooses to obey the law or adhere to the particular rule or regulation, although the assumption is that people will only act in accordance with regulations because they fear the punishment that would result if they were caught violating the rule.

3. The financial services industry, perhaps more than any other industry, is based on trust. But increasingly the confidence of the American public in the integrity and professionalism of the financial services industry is under threat. This level of public distrust is not only disheartening, it also real consequences. One of these consequences is an increased amount of government regulation as frustrated consumers and regulators look to try and enforce a higher standard of conduct. Increased compliance obligations, while irritating to ethical practitioners and their clients, can have more serious consequences such as the stripping of the ethical motivation for acting well. This is a process called ‘Ethical Fading.’ When this phenomenon occurs, we find ourselves in an arena of ‘perpetual compliance mentality. This does not mean that all regulation is bad or unnecessary. Regulation is vitally important to the efficient functioning of financial market and necessary to protect the interests of consumers. The Important point to make is that compliance cannot and should not be thought to take the place of ethics and when formal compliance rules (complete with sanctions and punishments) replace informally enforced ethical rules, the result is not always what one would anticipate.
4. Seven components found in most ethical codes include:

**Integrity** — Integrity is derived from the Latin word “integer” which means “completeness” or “wholeness”. To have integrity therefore, also means “to be always one”.

**Objectivity** — A second characteristic common to Codes of Ethics that govern the financial services industry is objectivity. The ideal of objectivity is grounded in the professional’s obligation to subordinate his or her own interests to the needs and interests of the client.

**Competence** — The principle of competence refers to the level of expert knowledge a professional maintains and builds upon through continued education and experience.

**Fairness** — Fairness revolves around three concepts. The first is the Principle of Equality, which requires like things to be treated in like ways. The second is the Golden Rule, which requires professionals to treat their clients in a manner in which they would like to be treated. The final concept is the obligation to give each person or constituency those things or that treat which is due to them.

**Confidentiality** — Most professions include a duty of confidentiality and therefore it is not surprising that all of the Code of Ethics explicitly mention a professional obligation to hold client information in confidence.

**Professionalism** — The principle of professionalism has two components. The first requires the professional to treat all persons with respect and consideration. The second requires professionals to act in a way that brings dignity to the profession. The final component of the principle of professionalism requires professionals to work towards improving the quality of services provided to the public.

**Diligence** — The principle of diligence means providing services in a “reasonably prompt and thorough manner.

5. **Accurately Define the Situation.** Moral perception is the ability to correctly recognize (and assign the appropriate weight) to the morally salient facts of a situation. A morally salient fact is one that reflects or impacts an ethical value or moral principle.

**Determine how the Situation occurred in the First Place.** Why is this relevant to our ethical decision-making? As a practical matter, we cannot develop a good solution to a moral problem (or any other problem) until we have accurately identified the cause of the problem.

**Determine relevant Stakeholders and how they will be Impacted.** Stakeholders are individuals or groups of individuals who are impacted by the result of a decision or who can impact the decision making
Prioritize Stakeholders Appropriately. While general moral responsibilities apply to human persons simply in virtue of being human, professional responsibilities are voluntary in the sense that we willingly assume them when we undertake the mantle of professionalism.

Check Your intentions. Your intention is the goal you hope to accomplish by performing an action. Intentions are relevant for two reasons:

1. They impact our assessment of the person who performed the action.
2. They impact how the action will be performed.

Try to Anticipate the Short-Term and Long-Term Consequences of your Actions. Most people acknowledge that consequences matter. While the short-term consequences of an action are often apparent, it can be challenging to think about the consequences of your action in the long-term.

Consider the Symbolic Potential of your Actions. Ethical norms are often conveyed through stories and what matters are whether or not people believe they are true.

Ask if you are Willing to Stand by Your Decision. Many people when asked to describe their ethical decision-making model respond with some version of the ‘publicity test’. A publicity test shows whether you believe that your action is in people
SAMPLE EXAMINATION—FUNDAMENTALS OF INSURANCE PLANNING

NOTE

Below are 100 objective questions to be used as an additional review and to familiarize you with the format of American College objective examinations. These questions are followed by an Answer Key and an explanation of the answers.

DIRECTIONS

Each of the questions or incomplete statements below is followed by four suggested answers or completions. Select the one that is best in each case and circle the letter that corresponding to that answer.

1. A loss exposure is defined as
   (A) a loss that might occur
   (B) an undesirable end result of a risk
   (C) the largest possible loss
   (D) the probability of a loss

2. Which of the following statements concerning the beneficiary provisions in a life insurance policy is correct?
   (A) Only one person may be named as a primary beneficiary, but several may be named as contingent beneficiaries.
   (B) The primary beneficiary's share of policy proceeds is generally reduced if the contingent beneficiary outlives the insured.
   (C) The estate of the insured is commonly named as beneficiary to avoid transfer taxes.
   (D) The contingent beneficiary will receive policy proceeds only if the primary beneficiary predeceases the insured.

3. Which of the following types of insurance is often sold by mortgage lenders to provide the funds necessary to pay off a 10-year mortgage loan if the insured dies?
   (A) decreasing term
   (B) increasing term
   (C) modified whole life
   (D) 10-year renewable term

4. Which of the following is most likely to be a condition that will result in the payment of unemployment compensation benefits?
   (A) unemployment because of a labor dispute
   (B) unemployment as a result of voluntarily leaving a job without good cause
   (C) unemployment resulting from discharge that was prompted by misconduct
   (D) unemployment that results from adverse economic conditions
5. Which of the following statements concerning inpatient hospital care under Part A of Medicare is correct?
   (A) There is a $200 annual deductible.
   (B) Benefits are paid in full after the 60th day of hospitalization.
   (C) There is a lifetime limit on the number of days of treatment in psychiatric hospitals.
   (D) There is coverage for up to 210 days of care in each benefit period.

6. Insurance policies that give the policyowner the right to renew coverage but do not guarantee future rates are referred to as
   (A) cancelable
   (B) guaranteed renewable
   (C) noncancelable
   (D) optionally renewable

7. The law of large numbers briefly states that as the
   (A) number of independent events increases, the likelihood increases that the actual results will be close to the expected results
   (B) degree of reliability placed on past experience increases, the likelihood increases that the expected results will be close to the past results
   (C) uncertainty surrounding the expected results decreases, the likelihood decreases that the range of outcomes will vary widely
   (D) average size of each loss varies from event to event, the likelihood increases that the next event will be close to the average

8. The workers' compensation benefits provided by a Workers Compensation and Employers Liability insurance policy are
   (A) specified by state law
   (B) scheduled in the policy
   (C) determined by the courts
   (D) subject to a dollar limit specified in the policy

9. The standard amount of insurance for loss of use (Coverage D) under an unendorsed HO-3 policy is what percentage of the amount of insurance for the dwelling (Coverage A)?
   (A) 10 percent
   (B) 20 percent
   (C) 30 percent
   (D) 50 percent
10. Ken has a personal auto policy (PAP) with coverage limits of $500,000 for liability (Part A), $15,000 for medical payments (Part B), $50,000 for uninsured motorists (Part C), and no underinsured motorists endorsement. If Ken receives $100,000 in bodily injuries as a result of an auto accident with another driver who has only the minimum state requirement of $35,000 of liability coverage, how would the two policies cover Ken’s injuries if the other driver was at fault?

(A) Ken’s PAP would cover the entire $100,000 under Part A because the other driver's coverage is inadequate to compensate Ken for his injuries.

(B) The other driver’s policy would pay its limit of $35,000 while Ken’s PAP would pay $15,000 under Part B and $50,000 under Part C.

(C) The other driver’s policy would pay its limit of $35,000 while Ken’s PAP would pay $50,000 under Part C with the remaining $15,000 not covered by either policy.

(D) The other driver’s policy would pay its limit of $35,000 while Ken’s PAP would pay $15,000 under Part B with the remaining $50,000 not covered by either policy.

11. King purchased an insurance policy that will pay $200 for each day he is hospitalized, regardless of the amount billed by the hospital. This insurance policy is considered which of the following?

(A) a bilateral contract

(B) a contract of indemnity

(C) a valued contract

(D) an impersonal contract

12. William is covered under his employer's major medical expense plan. The plan has a calendar-year deductible of $1,000, a 75 percent coinsurance provision that applies to the next $8,000 of covered expenses, and full coverage for any remaining covered expenses. If William incurs covered medical expenses of $15,000 during the year, how much will be paid by his employer's plan?

(A) $10,500

(B) $12,000

(C) $13,000

(D) $14,000

13. Which of the following statements describes factors that should be considered in the argument whether it is better to buy term life insurance or to buy permanent insurance and invest the premium difference?

(A) The cash value of a life insurance policy can readily be liquidated.

(B) People are less likely to pay a life insurance premium than they are to make a voluntary investment.

(C) The life insurance industry has a questionable solvency record.

(D) Increases in life insurance cash values are subject to federal income taxes as they accrue.
14. Susan has a personal auto policy (PAP) with a liability limit of $500,000. She also has a personal umbrella policy with a limit of $1 million and a self-insured retention (SIR) of $1,000. How much will each policy pay if an injured person obtains a judgment of $800,000 against Susan as a result of an auto accident?

(A) The PAP will pay nothing, and the umbrella policy will pay $799,000.
(B) The PAP will pay nothing, and the umbrella policy will pay $800,000.
(C) The PAP will pay $500,000, and the umbrella policy will pay $299,000.
(D) The PAP will pay $500,000, and the umbrella policy will pay $300,000.

15. Insurance Services Office (ISO) is which of the following?

(A) an advisory organization that develops standard policies for homeowners insurance and other lines
(B) a credit bureau that maintains and disseminates credit information on applicants for property and liability insurance
(C) a private organization that gathers and maintains medical information disclosed by applicants for life insurance
(D) a voluntary association serving state insurance commissioners

16. Jane, a restaurant critic on the staff of Local Newspaper, got a bad case of food poisoning while eating a tropical fruit salad at the Hungry Tiger restaurant she was reviewing. Because she was injured during the course of her employment, the insurance company providing Local Newspaper's workers' compensation insurance paid Jane's hospital expenses. That insurance company then sued Hungry Tiger, thereby exercising its legal rights of recovery under which of the following legal bases?

(A) doctrine of indemnity
(B) doctrine of subrogation
(C) law of the jungle
(D) principle of adhesion

17. Sam and Janet Evening wish to purchase an annuity that provides an income as long as at least one of them is alive. They have no children and no interest in passing their assets to heirs. Which of the following annuities is best suited for their purposes?

(A) cash refund annuity
(B) installment refund annuity
(C) joint-and-last survivor annuity
(D) joint-life annuity

18. The extension-of-benefits provision under a group medical expense policy applies to which of the following persons when coverage terminates?

(A) anyone who is aged 21 or under
(B) anyone who is totally disabled as a result of an illness or injury that occurred while the person was covered under the contract
(C) the employee and any dependents if the employee is eligible for unemployment insurance or public assistance
(D) any employee who has at least 10 years of service
19. As of this year, Brad, aged 35, has 36 credits of covered employment under the Social Security program. These credits were all earned in the last 40 calendar quarters. What is Brad's insured status under the program?
   (A) He is currently, fully, and disability insured.
   (B) He is disability insured, but neither fully nor currently insured.
   (C) He is currently and fully insured, but not disability insured.
   (D) He is currently insured, but neither fully nor disability insured.

20. Which of the following statements concerning business uses of disability income insurance is correct?
   (A) Benefits from key employee disability policies are designed to provide additional disability income to valuable employees.
   (B) When the policy is used to fund a buy-sell agreement, the definition of disability in the policy should be the same as the definition used in the buy-sell agreement.
   (C) Business overhead policies tend to have benefit durations of between 5 and 10 years.
   (D) When the policy is used to fund formal salary continuation plans, the business must be both the owner and beneficiary of the policy.

21. Which of the following statements is correct if the life income settlement option in a cash value life insurance policy is exercised?
   (A) The policy will provide an income to beneficiaries for as long as the insured lives.
   (B) The policy's death benefit will be increased.
   (C) The policy's death proceeds will be used to purchase a single-premium annuity for the beneficiary.
   (D) The policy's periodic premium will be increased.

22. Which of the following statements concerning the federal income tax treatment of insured group medical expense plans is correct?
   (A) All employee contributions under a contributory plan are tax deductible to the employee as a medical expense.
   (B) Benefits are taxable to an employee to the extent that the employer paid the cost of coverage.
   (C) Contributions by the employer for an employee's coverage create an income tax liability for the employee.
   (D) Contributions by the employer for an employee's coverage are generally tax deductible to the employer.

23. Which of the following is the standard inflation provision in most long-term care insurance policies?
   (A) a 3 percent simple annual benefit increase option
   (B) a 5 percent compound annual benefit increase option
   (C) a pay-as-you-go option without evidence of insurability
   (D) an automatic annual increase option based on the consumer price index
24. Which of the following statements concerning prescription drug plans is correct?

(A) Nonprescription drugs are typically covered as long as they are ordered by a physician on a prescription form.
(B) Benefits are usually provided for the administration of drugs that cannot be self-administered.
(C) Most plans have a copayment for each prescription.
(D) A reimbursement approach is usually used to provide benefits.

25. Ohm Insurance Company, incorporated in Springfield, Illinois, was formed in 1952 by a group of investors who own shares in the company. Ohm is currently licensed to sell life insurance in the states of Illinois, Pennsylvania, and Maryland. When Ohm is doing business in Pennsylvania, which of the following would be a correct classification of Ohm?

(A) alien insurer
(B) foreign insurer
(C) extraterritorial insurance company
(D) nonadmitted insurance company

26. Which of the following statements concerning the elimination period in a long-term care insurance policy is correct?

(A) Most comprehensive policies have separate elimination periods for facility care and home health care.
(B) A tax-qualified policy must have an elimination period of at least 90 days.
(C) The effect of the elimination period is to reduce a policy's maximum benefit period.
(D) The applicant typically selects the length of the elimination period from three to five available options.

27. Daisy does not own a car but occasionally borrows one from friends. The friends have little money, and if they have insurance at all, it is only for minimum limits. Daisy, on the other hand, is well-to-do. To protect herself against a liability claim while she is driving a friend's car, Daisy can purchase a personal auto policy (PAP) with a(n)

(A) auto loan/lease coverage endorsement
(B) coverage for damage to your auto (maximum limit of liability) endorsement
(C) miscellaneous type vehicle endorsement
(D) named nonowner coverage endorsement

28. Phantom Insurance Company employs claims representatives based in five Midwestern states but has no claims employees in California, where one of its policyowners is involved in a serious auto accident. Phantom will most likely use which of the following to adjust the claim?

(A) independent adjuster
(B) insurance agent
(C) public adjuster
(D) staff adjuster
29. Which of the following definitions of disability used in a group disability income plan is the most restrictive or harshest for the insured employee?

(A) the inability of the employee to perform each and every duty of his or her own occupation
(B) the inability of the employee to engage in any occupation for compensation
(C) the inability of the employee to engage in any occupation for which he or she is qualified by training, education, or experience
(D) the inability of the employee to engage in his or her own occupation for 24 months and any occupation for which he or she is qualified thereafter

30. Lynn owns the commercial building that houses her business. The property insurance policy covering the building has an 80 percent coinsurance clause. If the replacement cost of the building is $500,000 and Lynn has it insured for $300,000 on a replacement cost basis, how much would the insurance company pay (ignoring any deductible) if the building were to suffer fire damage with a replacement cost of $100,000?

(A) $60,000
(B) $75,000
(C) $80,000
(D) $100,000

31. A state requires prior approval of proposed rate changes only if they exceed 5 percent of existing rates. No prior approval is needed for proposed rate changes at 5 percent or less. This is an example of

(A) a use-and-file law
(B) a file-and-use law
(C) a flex-rating law
(D) open competition

32. An insurance company that has not gained approval to place insurance business from a department of insurance in the jurisdiction where it or a producer wants to sell insurance is known as a(n)

(A) unlicensed company
(B) unregistered party
(C) unapproved firm
(D) unauthorized entity

33. Insurance as a technique for treating risks is most suitable when used for risks that involve

(A) a low loss frequency and high loss severity
(B) a high loss frequency and low loss severity
(C) both a low loss frequency and low loss severity
(D) both a high loss frequency and high loss severity

34. Which of the following homeowners forms is designed for the owners of condominium units?

(A) HO-2
(B) HO-4
(C) HO-6
(D) HO-8
35. Which of the following types of life insurance allows the policyowner to increase or decrease premium payments to virtually any amount desired as long as there is sufficient cash value to cover mortality costs and expenses?

(A) current assumption whole life insurance
(B) variable life insurance
(C) universal life insurance
(D) ordinary life insurance

36. Robert sued Heather for injuries received in an auto accident. Based on the facts presented, the jury determined that Robert was 20 percent at fault and Heather was 80 percent at fault. Under a comparative negligence law, the jury award to Robert would be

(A) nothing
(B) 20 percent of his actual damages
(C) 80 percent of his actual damages
(D) 100 percent of his actual damages

37. Sarah lives with her mother and stepfather. She is an eligible dependent for medical expense coverage under both of their medical expense plans as well as under the plan of her father. There is no court decree that establishes responsibility for Sarah's medical expenses. Which of the following statements describes the priority of benefits if all three plans contain the usual coordination-of-benefit (COB) provisions?

(A) The mother's plan is primary, and neither the father's plan nor the stepfather's plan pays anything.
(B) The mother's plan is primary, the stepfather's plan is secondary, and the father's plan pays last.
(C) The father's plan is primary, the mother's plan is secondary, and the stepfather's plan pays last.
(D) The mother's plan and father's plan each pay 50 percent of the expenses.

38. In which of the following situations would life insurance policy proceeds be included in an insured's gross estate for federal tax purposes?

I. The policy beneficiary is the insured's estate.
II. The insured dies 25 months after transferring all incidents in ownership in the policy to his sister.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II
39. Which of the following statements concerning state high-risk pools for individual medical expense coverage is (are) correct?

I. As a result of state subsidies, premiums tend to be much lower than in the regular marketplace.
II. Benefits for preexisting conditions are often subject to a waiting period.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

40. Which of the following statements concerning the life insurance grace period is (are) correct?

I. It grants the policyowner an additional period of time to pay a premium after it is due.
II. Its standard length is 90 days.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

41. Which of the following statements concerning partial-disability benefits is (are) correct?

I. They tend to discourage persons returning to work before total recovery from a disability.
II. They are usually payable prior to the period for which an insured qualifies for total-disability benefits.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

42. Which of the following statements concerning premiums for individual medical expense insurance policies is (are) correct?

I. The total premiums for a year will be higher if paid in installments rather than a single annual premium.
II. If a premium is not paid within the grace period, the policy will lapse as of the end of the grace period.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

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43. Which of the following statements concerning group insurance is (are) correct?

I. The group insurance contract provides coverage to a number of persons.
II. Individual members of the group are usually not required to show any evidence of insurability when initially eligible for coverage.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

44. Methods of risk financing include which of the following?

I. risk retention  
II. loss prevention

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

45. Which of the following statements concerning the legal requirement of offer and acceptance in a life insurance contract is (are) correct?

I. The offer can be made in the form of an oral request by the prospect to the agent.
II. Acceptance typically occurs when the agent receives the offer and binds the coverage.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

46. Which of the following statements concerning the federal income tax treatment of premiums paid for property and liability insurance is (are) correct?

I. Premiums for policies on nonbusiness property are deductible as casualty expenses by individual taxpayers.
II. Premiums for policies on business property are deductible business expenses for a corporation.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II
47. Which of the following types of managed care plans permit those covered by the plan to elect, at the time medical treatment is needed, whether to receive treatment from practitioners associated with the plan or those outside the plan’s network?

I. preferred-provider organizations (PPOs)
II. point-of-service (POS) plans

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

48. Phil, aged 62, owns an individual flexible premium deferred annuity that currently has an accumulated value of $460,000. If Phil has paid $240,000 in premiums over the years, which of the following statements concerning tax treatment of benefits received from the annuity is (are) correct?

I. If Phil currently withdraws $150,000 from the annuity while it is still in its accumulation period to begin construction of a lakeside cabin for his retirement years, the $150,000 is treated as taxable income.
II. If Phil begins receiving monthly payments for life from the annuity, a portion of each monthly income payment will be treated as taxable income.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

49. Which of the following statements concerning the federal income tax treatment of tax-qualified long-term care insurance policies is (are) correct?

I. The first $100 of benefits received each day is subject to income taxation.
II. Premiums may be deducted in full as long as they are less than 7.5 percent of a taxpayer’s adjusted gross income.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

50. The Financial Services Modernization Act, also known as the Gramm-Leach-Bliley Act, addressed some issues involving the regulation of banks and insurance. Which of the following statements concerning this act is (are) correct?

I. State insurance regulators have primary regulatory authority for insurance activities of banks.
II. State insurance regulators have primary regulatory authority over the banking activities of banks that sell insurance.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II
51. Which of the following statements concerning the damages involved in liability claims is (are) correct?

I. Compensatory damages are designed to financially compensate a claimant who has suffered a loss.
II. Punitive damages are designed to indemnify a claimant for pain and suffering.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

52. Which of the following statements concerning health savings accounts (HSAs) is (are) correct?

I. The current year's contribution for a participant is reduced by a portion of any unused amounts in an HSA that are attributable to prior years' contributions.
II. The high-deductible health plans used with HSAs are permitted to waive the deductible requirement for preventive care.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

53. Many long-term care insurance policies provide the services of a care coordinator. Functions of such a person may include which of the following?

I. assessing an insured's condition  
II. periodically evaluating ongoing plans of care

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

54. Which of the following statements concerning insurable interests is (are) correct?

I. A property insurer often pays claims when an insured party suffers a loss to covered property in which that party lacks an insurable interest.
II. A bank or other mortgage holder that finances the purchase of real estate has an insurable interest in the mortgaged property.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II
55. Which of the following statements concerning NAIC model legislation for long-term care insurance that pertains to marketing is (are) correct?

   I. The policy must allow policyowners to have a 90-day free look.
   II. Insurers must establish procedures to prohibit excessive insurance from being sold.

   (A) I only  
   (B) II only  
   (C) Both I and II  
   (D) Neither I nor II

56. Which of the following statements concerning insurance company investments is (are) correct?

   I. The aggregate amount invested by property-liability insurers is much larger than the aggregate amount invested by life insurers.
   II. Liquidity is a major consideration for the investment of funds by most life insurers.

   (A) I only  
   (B) II only  
   (C) Both I and II  
   (D) Neither I nor II

57. Which of the following statements concerning a properly designed buy-sell agreement is (are) correct?

   I. It ensures that a businessowner's estate can sell the business for a reasonable price.
   II. It should specify how the purchase price will be established.

   (A) I only  
   (B) II only  
   (C) Both I and II  
   (D) Neither I nor II

58. Which of the following statements concerning Medicare Advantage plans is (are) correct?

   I. They require the insured to have a high-deductible medical expense policy.
   II. They may provide a higher level of benefits than the original Medicare program.

   (A) I only  
   (B) II only  
   (C) Both I and II  
   (D) Neither I nor II
59. Which of the following statements concerning reinsurance agreements is (are) correct?

I. Treaty reinsurance enables an insurer that is underwriting a policy to decide whether that specific policy will be reinsured.
II. With facultative reinsurance, some types of exposures are automatically reinsured.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

60. Which of the following statements concerning the operation of a variable annuity is (are) correct?

I. During the accumulation period, it is to the annuitant’s advantage for stock prices to be relatively high.
II. During the liquidation period, it is to the annuitant’s advantage for stock prices to be relatively low.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

61. Which of the following statements concerning the independent agency system in property and liability insurance is (are) correct?

I. Commission rates paid to an agent on the sale of new business tend to be less than those paid for renewals.
II. The agent owns the business and is able to place it with any one of several companies at renewal time.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II

62. Which of the following statements concerning managed care provisions in traditional medical expense plans is (are) correct?

I. Mandatory second surgical opinions typically apply to any surgical procedure.
II. Home health care benefits are typically provided indefinitely as long as they are ordered by a physician.

(A) I only  
(B) II only  
(C) Both I and II  
(D) Neither I nor II
63. Which of the following statements concerning the capital needs analysis approach to determining how much life insurance the family head should carry is (are) correct?

I. The amount of capital needed to meet an income objective is found by multiplying the income objective by the after-tax investment return rate.
II. The lower the after-tax investment return rate, the higher the capital fund needed to produce the income objective.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

64. Which of the following statements concerning an annuitant’s options at the maturity date of a deferred annuity is (are) correct?

I. The annuitant can elect to have the accumulation applied under any annuity form the company offers.
II. The annuitant can usually elect to take a lump-sum payment in lieu of an annuity.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

65. Astronomical Insurance Company accidentally issued a life insurance policy that had not been approved in Texas to a Texas man who wished to insure his life. Which of the following statements concerning this policy is (are) correct?

I. The policy is voidable at the option of the policyowner.
II. The insured’s beneficiary will be unable to collect benefits if the mistake is discovered after the insured’s death.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

66. Which of the following statements concerning the findings of behavioral psychologists on the subject of risk tolerance is (are) correct?

I. Most people are more risk tolerant than they are risk averse.
II. A person who is highly risk tolerant in physical or social activities is also highly risk tolerant in financial matters.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II
67. Which of the following statements concerning financing the Social Security and Medicare programs is (are) correct?

I. The tax rate for self-employed persons is equal to the combined tax rate for employees and employers.
II. The wage base on which taxes are paid increases quarterly based on changes in the rate of inflation.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

68. Which of the following statements concerning the appropriate use of life insurance in estate planning is (are) correct?

I. Life insurance may be used to provide a larger estate for the insured's heirs.
II. Life insurance may be used to pay death taxes.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

69. Which of the following statements concerning the definitions of terms used in an insurance policy is (are) correct?

I. Words or phrases defined in the policy typically appear in boldface type or quotation marks when they are used elsewhere in the policy.
II. Words not defined in the policy are given their ordinary or normal meaning.

(A) I only
(B) II only
(C) Both I and II
(D) Neither I nor II

READ THE FOLLOWING DIRECTIONS BEFORE CONTINUING

The questions below differ from the preceding questions in that they all contain the word EXCEPT. So you understand fully the basis used in selecting each answer, be sure to read each question carefully.

70. All the following statements concerning insurance underwriting are correct EXCEPT

(A) An insurer attempts to select applicants who will have loss experience comparable to the company's expected loss experience.
(B) The underwriting process often begins with the agent.
(C) Underwriting is independent of insurance pricing.
(D) Underwriters sometimes explain steps a borderline applicant can take to become acceptable.
71. All the following statements concerning the nonforfeiture options in life insurance are correct EXCEPT

(A) All states have laws that require insurers to provide at least a minimum nonforfeiture value to policyowners.

(B) The reduced paid-up option generally provides the same amount of death protection as the original policy, but for a reduced period of time.

(C) If a policy lapses for nonpayment of premiums and another option has not been selected, the extended term option usually goes into effect automatically.

(D) If a policy is surrendered for its cash value, all benefits under the policy cease.

72. Depending on the options in his or her area, a hard-to-insure driver may be able to find auto insurance coverage from any of the following EXCEPT

(A) the Federal Insurance Management Association (FIMA)

(B) a specialty insurer

(C) an automobile insurance plan

(D) a joint underwriting association (JUA)

73. All the following are reasons for demutualization of an insurance company EXCEPT

(A) to enable the insurer to raise capital quickly

(B) to enable the insurance company to diversify its activities by acquiring other insurers or other types of financial institutions through the issuance or exchange of stock

(C) to better protect the insurer from a hostile takeover

(D) to facilitate payment of certain types of noncash compensation to the insurance company's key executives and board members

74. All the following statements concerning life insurance dividend options are correct EXCEPT

(A) With the accumulation-at-interest option, dividends will be kept in the equivalent of an interest-bearing account for the benefit of the policyowner.

(B) With the cash option, dividends will be paid to the policyowner in cash.

(C) With the fifth dividend option, dividends will be used to purchase 1-year term insurance.

(D) With the paid-up additions option, dividends will be used to pay up the policy prior to age 65.

75. All the following statements concerning directors and officers (D&O) liability insurance are correct EXCEPT

(A) An insuring agreement in the policy covers directors and officers for their personal liability as directors and officers.

(B) Coverage applies to claims for bodily injury and property damage.

(C) An insuring agreement in the policy reimburses the corporation for any sum it is required or permitted to pay to indemnify directors and officers.

(D) D&O insurance is purchased by the corporation but its officers and directors are the insureds.
76. All the following statements concerning sources of financing for long-term care are correct EXCEPT
   (A) Medicaid is available to anyone aged 65 or older, regardless of financial resources.
   (B) A continuing care retirement community should be entered in advance of the need for long-term care.
   (C) Home equity may be accessed through a loan or a reverse mortgage.
   (D) The support of relatives may diminish because of their physical condition and financial needs.

77. Basic benefits that must be included in all Medicare supplement (medigap) policies include all the following EXCEPT
   (A) the first 3 pints of blood each year
   (B) the Part B percentage participation for Medicare-approved charges for physicians' and medical services
   (C) the hospital inpatient deductible under Part A of Medicare
   (D) 365 additional days of hospitalization coverage after Medicare benefits end

78. The steps in the risk management process include all the following EXCEPT
   (A) administration
   (B) regulation
   (C) identification
   (D) measurement

79. The cash value in a life insurance policy has all the following characteristics EXCEPT
   (A) It makes permanent death protection possible at affordable rates.
   (B) It serves as a major source of an insurer's investable funds.
   (C) It can serve as collateral when the policyowner applies for credit.
   (D) It increases the insurer's net amount at risk.

80. All the following statements concerning group disability income contracts are correct EXCEPT
   (A) The insurance company usually offers a conversion policy to any terminating employee who was covered under the contract for at least 2 years.
   (B) The insurance company has the right to have a disabled employee examined by a physician of its own choice.
   (C) The insurance company may provide a cost-of-living adjustment to prevent inflation from eroding the purchasing power of benefits being received.
   (D) The insurance company often allows a worker to enter a trial work period in rehabilitative employment without having benefits totally terminated.
81. All the following statements concerning title insurance are correct EXCEPT
   (A) The policy limit is usually the purchase price of the property, even if the value
       increases because of inflation.
   (B) The premium is paid only once.
   (C) The policy guarantees that the owner will keep possession of the property
       if a defect in the title is discovered.
   (D) The policy provides protection only against unknown title defects that have
       occurred prior to the effective date of the policy but are discovered after
       the effective date.

82. All the following statements concerning monthly Social Security benefits for family
    members of a deceased or retired worker are correct EXCEPT
   (A) The 15-year-old child of a deceased worker is eligible to receive 75 percent
       of the worker's PIA (primary insurance amount).
   (B) The 15-year-old child of a retired worker is eligible to receive 50 percent
       of the worker's PIA.
   (C) The 65-year-old spouse of a deceased worker is eligible to receive 75
       percent of the worker's PIA.
   (D) The 65-year-old spouse of a retired worker is eligible to receive 50 percent
       of the worker's PIA.

83. In order for a risk to be considered insurable, it must substantially meet all the
    following requirements EXCEPT
   (A) Losses must be accidental, rather than intentional, from the standpoint
       of insureds.
   (B) The insurer should be able to obtain reasonable projections of future losses.
   (C) The determination and measurement of losses should be clear and definite.
   (D) The amount of potential losses should be relatively unimportant to insureds.

84. All the following are insured persons under the medical payments coverage of the
    personal auto policy (PAP) EXCEPT
   (A) a friend of the named insured who is injured while occupying the named
       insured's covered auto
   (B) a pedestrian who is struck and injured by the named insured's covered auto
   (C) the named insured who is injured while occupying a friend's auto
   (D) a member of the named insured's family who is struck and injured by an
       auto while crossing the street

85. An HO-3 Special Form homeowners policy provides coverage that is broader
    in some respects than the coverage of an HO-2 Broad Form. All the following
    statements concerning the HO-3 are correct EXCEPT
   (A) The dwelling building is covered against loss by more perils in an HO-3 than
       in an HO-2.
   (B) Other structures are covered against loss by more perils in an HO-3 than
       in an HO-2.
   (C) The premium is higher for an HO-3 than the premium for comparable
       coverage in an HO-2.
   (D) Personal property is covered on a replacement cost basis in an HO-3, but it
       is covered for actual cash value in an HO-2.
86. All the following statements concerning the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA) are correct EXCEPT

(A) They apply only to insured plans.
(B) They require an employer to give persons losing group coverage a certificate that specifies the period of creditable coverage under the plan they are leaving.
(C) They allow a late enrollee in a plan to be subject to a preexisting-conditions period of up to 18 months.
(D) They put limitations on preexisting-conditions exclusions when an employee moves to another employer-related medical expense plan.

87. Compared with a lump-sum settlement, the advantages of a structured settlement for the injured party include all the following EXCEPT

(A) The settlement can never be prematurely exhausted because the income payments are guaranteed for life or for a fixed period.
(B) The risk that a settlement will be dissipated through mismanagement is significantly reduced when converted into periodic payments.
(C) A periodic income not only provides a degree of financial security but also allows benefits to be better matched with future needs.
(D) A settlement paid in a lump sum is taxable income, whereas a structured settlement paid as periodic income is tax free.

88. All the following statements regarding surety bonds are correct EXCEPT

(A) Judicial bonds are required under statutory law.
(B) Fiduciary bonds are often required of persons who act as administrators, trustees, and guardians.
(C) Litigation bonds require a person or organization seeking a court remedy to protect other parties from damages if the party seeking the remedy does not prevail.
(D) Bail bonds guarantee that a bonded person will appear in court at the appointed time.

89. Managed care plans are characterized by all the following EXCEPT

(A) unrestricted access to physicians and hospitals
(B) utilization review at all levels
(C) an emphasis on preventive care and healthy lifestyles
(D) providers of medical care sharing in financial results

90. Mr. Smith has health problems that reduce his life expectancy. All the following are methods life insurers use to provide coverage to persons like Mr. Smith EXCEPT

(A) assess a flat extra premium
(B) create a lien against the policy
(C) limit the policy's protection period
(D) rate the policy using an extra percentage table
91. All the following statements concerning joint-life insurance are correct EXCEPT:
(A) A first-to-die policy pays beneficiaries upon the death of any insured.
(B) A second-to-die policy must be a term insurance contract.
(C) A survivorship policy written on two individuals pays beneficiaries upon the death of the last insured.
(D) Joint-life policies are sometimes used to fund business buy-sell agreements.

92. All the following are ways in which Medicare prescription drug plans may differ from the standard benefit structure specified by federal law EXCEPT:
(A) lower initial deductibles
(B) the use of tiered copayments
(C) more extensive formularies
(D) fewer benefits in the coverage gap

93. All the following statements concerning individual disability income insurance policies are correct EXCEPT:
(A) Many policies contain a presumptive-disability provision for certain types of losses.
(B) Rehabilitation benefits may be provided over and above any periodic income benefits.
(C) Premiums generally increase at each annual renewal as an insured ages.
(D) Incontestability provisions are required by all states.

94. All the following statements concerning life insurance policy loans are correct EXCEPT:
(A) A policy loan accrues interest on the borrowed funds at either a fixed rate or variable rate depending on the option selected by the policyowner at the time of application.
(B) The policyowner is required to repay a policy loan before being permitted to surrender the policy for its cash value, make a withdrawal from the cash value, or take another policy loan.
(C) If the insured dies while a policy loan is outstanding, the insurer recovers the outstanding balance of the loan and accrued interest from the death benefits.
(D) A life insurance policy will terminate if the policy loan balance plus unpaid interest ever exceeds the policy's cash value.

95. All the following are covered autos under the liability part (Part A) of the personal auto policy (PAP) EXCEPT:
(A) a nonowned van driven by the insured on a regular basis
(B) a camper trailer owned by the named insurer
(C) a borrowed auto used by the insured as a temporary substitute for a covered auto that was stolen
(D) a newly acquired auto that replaces a covered auto listed in the policy
96. All the following statements concerning variable life insurance are correct EXCEPT
   (A) Agents who sell variable life policies must be licensed as both life insurance agents and securities agents.
   (B) Variable life policies provide guarantees of both the interest rate and a minimum cash value.
   (C) Variable life policies can be sold only after the prospective purchasers have had a chance to read the prospectus.
   (D) Variable life policies become more acceptable to consumers after a long period of stock market increases.

97. All the following are qualifying events under COBRA EXCEPT
   (A) The employee dies.
   (B) The employee is fired for gross misconduct.
   (C) The employee's hours are reduced so he or she is no longer eligible for coverage.
   (D) The employee and his or her spouse have legally separated.

98. Coverage E—Liability of a homeowners policy provides motor vehicle liability coverage for all the following motor vehicle exposures EXCEPT
   (A) a licensed Harley Davidson motorcycle while it is being ridden on the driveway at the insured location
   (B) a John Deere riding mower while it is being used to mow the insured's lawn
   (C) an unlicensed antique auto while it is in dead storage in the insured's garage awaiting restoration
   (D) an insured's motorized wheelchair while being used in a shopping mall

99. When using the net payment cost index to determine the cost of a life insurance policy, it is necessary to consider all the following factors EXCEPT
   (A) the policy's accumulated dividends
   (B) the policy's accumulated premiums
   (C) an interest rate
   (D) cash value

100. When a life insurance agent submits an application for a life insurance policy that replaces a client's existing policy, all the following must be done EXCEPT
    (A) The agent must accept a reduced first-year commission to remove the financial incentive for twisting.
    (B) The agent must include a statement with the application noting that the policy is a replacement.
    (C) The replacing insurer must give the applicant at least a 20-day free look at the new policy.
    (D) The replacing insurer must notify the other insurer of the proposed replacement.
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Explanation of Answers to Fundamentals of Insurance Planning Sample Examination

1. The answer is (A) by definition.

2. The answer is (D). (A) is incorrect because one or more people or entities may be named as either primary or contingent beneficiaries. (B) is incorrect because the contingent beneficiary receives nothing and all proceeds go to the primary beneficiary when the insured dies, unless the primary beneficiary predeceases the insured or loses entitlement to the benefits for some other reason. (C) is incorrect because transfer taxes may be incurred when the estate is the beneficiary.

3. The answer is (A). (B) is incorrect because the amount of insurance under an increasing term policy increases while the amount needed to pay off the mortgage decreases. (C) is incorrect because the amount of insurance under a modified whole life policy remains constant while the amount needed to pay off the mortgage decreases. (D) is incorrect because the amount of insurance under a 10-year renewable term policy remains constant for 10 years while the amount needed to pay off the mortgage decreases.

4. The answer is (D). (A), (B), and (C) are incorrect because common reasons for disqualification under unemployment compensation programs include involvement in a labor dispute, voluntarily leaving a job without good cause, and discharge for misconduct.

5. The answer is (C). (A) is incorrect because hospital benefits are not subject to an annual deductible. However, there is a benefit period deductible, and it is much higher than $200. (B) is incorrect because benefits are paid in full for only the first 60 days in each benefit period, subject to the initial deductible. (D) is incorrect because Part A pays for hospital services in full for up to 60 days in each benefit period after the deductible has been met. It provides benefits for an additional 30 days subject to a daily patient copayment. There is also a lifetime reserve of 60 additional days, but once these days are used, they are not available for future benefit periods.

6. The answer is (B). (A) is incorrect because the insurer has the right to cancel a cancelable policy during the period for which premiums have been paid. (C) is incorrect because future rates are guaranteed in a noncancelable policy. (D) is incorrect because the insurer has a right to refuse to renew an optionally renewable policy.

7. The answer is (A). (B), (C), and (D) are incorrect because the law of large numbers states that as the number of independent events increases, the likelihood increases that the actual results will be close to the expected results.

8. The answer is (A). (B) and (C) are incorrect because benefits are specified by state workers' compensation law. (D) is incorrect because the policy's dollar limits apply only to employers liability coverage.

9. The answer is (C). The standard limit for Coverage D is 30 percent of the Coverage A limit. Prior to 2000, the limit was 20 percent. The limit for Coverage B (other structures) is 10 percent of the Coverage A limit, while the limit for Coverage C (personal property) is 50 percent of the Coverage A limit.

10. The answer is (D). Ken would collect $35,000 from the other party's liability insurer. His own policy would also pay the full $15,000 medical payment limit. There is no coverage for the remaining $50,000 because Ken does not have coverage for underinsured motorists.

11. The answer is (C). (A) is incorrect because insurance is a unilateral contract. (B) is incorrect because payments under a contract of indemnity reflect the amount of the loss. (D) is incorrect because insurance is a personal contract.

12. The answer is (B). His employer's plan will pay $12,000. If William incurs $15,000 of covered medical expenses, he must pay $1,000 out-of-pocket to meet the deductible. Of
the remaining $14,000 of expenses, $8,000 of it is subject to the 75 percent coinsurance provision. This means that William must pay another $2,000 (.25 × $8,000 = $2,000) out-of-pocket for a total amount of $3,000 ($1,000 deductible + $2,000 coinsurance = $3,000). Subtracting $3,000 from $15,000 leaves $12,000 for the medical expense plan to cover.

13. The answer is (A). (B) is incorrect because people are more likely to pay a life insurance premium than they are to make a voluntary investment. (C) is incorrect because the life insurance industry has a solvency record unmatched by any other type of business organization. (D) is incorrect because increases in cash values are not subject to federal income taxes as they accrue, in contrast to the earnings in a separate investment program, which are often taxed as ordinary income.

14. The answer is (D). (A) and (B) are incorrect because the umbrella policy pays only after the limits of the PAP are exhausted because the PAP is primary. (C) is incorrect because the self-insured retention (SIR) does not come into play when there is an underlying policy paying for part of the loss.

15. The answer is (A). (B) is incorrect because ISO is not a credit bureau. (C) is incorrect because it describes MIB, Inc. (D) is incorrect because it describes the NAIC.

16. The answer is (B). (A) is incorrect because the doctrine, or principle, of indemnity refers to compensation that makes people whole following a loss. (C) is incorrect because the law of the jungle refers to unrestrained and ruthless competition. (D) is incorrect because the principle of adhesion deals with ambiguity in a contract.

17. The answer is (C). (A) is incorrect because providing a lump-sum cash refund to heirs is inconsistent with their goals. (B) is incorrect because providing an installment refund to heirs is inconsistent with their goals. (D) is incorrect because joint-life annuity payments would cease when either Sam or Janet dies, rather than providing an income as long as at least one of them is alive.

18. The answer is (B). (A), (C), and (D) are incorrect because the extension-of-benefits provision applies only to a covered employee or dependent who is totally disabled at the time of termination.

19. The answer is (A). Brad meets the criteria for being currently, fully, and disability insured.

20. The answer is (B). (A) is incorrect because key employee disability policies are designed to benefit the business that has lost the services of a key employee. (C) is incorrect because business overhead policies tend to be limited to benefit durations of 1 or 2 years. (D) is incorrect because either the business or the employee may be the beneficiary under a formal salary continuation plan.

21. The answer is (C). (A) is incorrect because settlement options are exercised when the insured dies. (B) is incorrect because the settlement option is a way of distributing the benefit, not of modifying its value. (D) is incorrect because settlement options are exercised after the insured dies, at which time no more premiums are payable.

22. The answer is (D). (A) is incorrect because employee contributions are tax deductible only for employees who itemize deductions and then only to the extent that expenses exceed 7.5 percent of the employee’s adjusted gross income. (B) is incorrect because medical expense benefits are not taxable income to the employee unless they exceed any medical expenses incurred. (C) is incorrect because employer contributions do not create any tax liability for an employee.

23. The answer is (B). (A), (C), and (D) are incorrect because these inflation provisions are much less common.
24. The answer is (C). (A) is incorrect because prescription drug plans normally cover only those drugs that are required by either federal or state law to be dispensed by prescription. One frequent exception, however, is injectable insulin. (B) is incorrect because no coverage is provided for the charges to administer drugs. (D) is incorrect because a service approach is usually used to provide benefits. Prescriptions are filled upon receipt of a prescription, proper identification, and any required copayment.

25. The answer is (B). (A) is incorrect because an alien insurer is based in another country. (C) is incorrect because extraterritorial refers to out-of-state coverage, not an out-of-state insurer. (D) is incorrect because Ohm is licensed in Pennsylvania.

26. The answer is (D). (A) is incorrect because most comprehensive long-term care insurance policies have a single elimination period that can be met with a combination of days from when an insured is in a long-term care facility or receiving home health care services. (B) is incorrect because a tax-qualified policy can have an elimination period of any length of time, assuming it is acceptable under state law. The only 90-day requirement is that the insured be certified as being unable to perform the required number of ADLs for at least 90 days. (C) is incorrect because the elimination period only postpones the date until benefits start. Once they start, the maximum benefit period applies.

27. The answer is (D). (A) is incorrect because the auto loan/lease coverage endorsement would provide "gap" coverage in the event the actual cash value of an auto Daisy owns or leases is less than the amount she owes on the auto. (B) is incorrect because the coverage for damage to your auto (maximum limit of liability) endorsement provides stated amount coverage on an owned auto. (C) is incorrect because the miscellaneous type vehicle endorsement is used to cover motor homes, motorcycles, all-terrain vehicles, dune buggies, and golf carts.

28. The answer is (A). (B) is incorrect because insurance agents usually adjust only small, uncomplicated claims. (C) is incorrect because public adjusters represent the public, not insurers. (D) is incorrect because staff adjusters are employees of the insurer, and according to the question, Phantom has no employees in California.

29. The answer is (B). (A) is incorrect because it is the most liberal definition for the employee, since the inability to perform one major duty would constitute disability. (C) is incorrect because it is more liberal for the employee than (B) but not as liberal as (A) because the employee could perform several different occupations based on qualifications even if he or she could not perform one of the major duties of his or her own occupation. (D) is incorrect because it is very liberal for a period of 24 months before becoming less so but still more liberal than (B).

30. The answer is (B). If the amount of insurance is less than 80 percent of replacement cost, the insurer will pay the portion of the cost to repair or replace the damage that the limit of insurance bears to 80 percent of the
replacement cost at the time of loss. This is explained by the following formula:

\[
\text{Loss payment} = \frac{\text{Limit of insurance}}{80\% \text{ of replacement cost}} \times \text{Replacement cost of the loss}
\]

\[
= \frac{$300,000}{80\% \text{ of $500,000}} \times $100,000
\]

\[
= \frac{$300,000}{$400,000} \times $100,000 = $75,000
\]

31. The answer is (C). (A) is incorrect because with a use-and-file law, rates are filed within a specified time after they are first used, and they may be disapproved. (B) is incorrect because a file-and-use law permits immediate use of filed rates without affirmative approval, although the commissioner may disapprove rates within a certain time period. (D) is incorrect because open competition relies on competition, rather than regulation, to set rates.

32. The answer is (D). An entity that has not gained approval to place insurance business from a department of insurance in the jurisdiction where it or a producer wants to sell insurance is referred to an unauthorized entity.

33. The answer is (A). (B) is incorrect because retention is most suitable for risks with high loss frequency and low loss severity. (C) is incorrect because retention is most suitable for risks with low loss frequency and low loss severity. (D) is incorrect because avoidance is most suitable for risks with high loss frequency and high loss severity.

34. The answer is (C). (A) is incorrect because HO-2 is designed for owner-occupants of dwellings. (B) is incorrect because HO-4 is designed for tenants of residential property. (D) is incorrect because HO-8 is designed for owner-occupants of dwellings.

35. The answer is (C). (A), (B), and (D) are incorrect because current assumption whole life, variable life, and ordinary life have fixed premiums. Truly flexible premiums are a distinctive feature of universal life insurance.

36. The answer is (C). Under a comparative negligence law, Robert would have his judgment reduced by 20 percent, which is the degree of his fault.

37. The answer is (B). Under the usual COB provision, the plan of the parent with custody is primary, the plan of the stepparent who is the spouse of the parent with custody is secondary, and the plan of the parent without custody is tertiary.

38. The answer is (C). Both I and II are correct.

39. The answer is (B). I is incorrect because premiums tend to be higher in state high-risk pools despite state subsidies.

40. The answer is (A). II is incorrect because the standard length of a grace period is 30 or 31 days in fixed-premium policies and 60 or 61 days in flexible-premium policies, such as universal life insurance.

41. The answer is (D). I is incorrect because partial-disability benefits tend to encourage a return to work prior to total recovery. II is incorrect because they are payable only after a person receives total-disability benefits for a specified period of time.

42. The answer is (A). II is incorrect because individual medical expense policies lapse at the beginning of the grace period unless the premium is paid within the grace period.
43. The answer is (C). Both I and II are correct.

44. The answer is (A). II is incorrect because loss prevention is not a method of risk financing but a method of risk control, which typically involves reducing the probability or severity of loss.

45. The answer is (D). I is incorrect because in life insurance the offer must be made in a written application. II is incorrect because in life insurance acceptance is held by most courts to occur when the applicant meets the normal underwriting standards of the insurer, including a medical examination if required.

46. The answer is (B). I is incorrect because nonbusiness property insurance premiums are not tax deductible.

47. The answer is (C). Both I and II are correct because they allow a member to elect treatment outside the provider network.

48. The answer is (C). Both I and II are correct.

49. The answer is (D). I is incorrect because benefits under qualified long-term care insurance contracts are received tax free with the exception of those paid under per diem contracts that exceed a specified daily limit that is indexed for inflation. II is incorrect because premiums for long-term care insurance are deductible only up to specified limits. In addition, persons other than the self-employed can deduct medical expenses, including long-term care premiums, only to the extent the expenses exceed 7.5 percent of adjusted gross income.

50. The answer is (A). II is incorrect because insurance commissioners do not regulate banking activities.

51. The answer is (A). II is incorrect because punitive damages are designed to punish a claimant whose outrageous conduct contributed to a loss. Compensatory damages may include indemnification for pain and suffering. II is incorrect because punitive damages are designed to punish a claimant whose outrageous conduct contributed to a loss. Compensatory damages may include indemnification for pain and suffering.

52. The answer is (B). I is incorrect because account balances are carried over, and the size of an HSA balance carried over from prior years has no effect on a current year's contributions.

53. The answer is (C). Both I and II are correct because they are functions of a care coordinator.

54. The answer is (B). I is incorrect because an insured party must have an insurable interest at the time of the loss in covered property that has suffered a loss.

55. The answer is (B). I is incorrect because NAIC model legislation requires a 30-day free look.

56. The answer is (D). I is incorrect because the aggregate amount invested by property-liability insurers is much smaller than the amount invested by life insurers. II is incorrect because liquidity is not a major consideration for most life insurers, since their investable funds will not need to be paid out until well into the future.

57. The answer is (C). Both I and II are correct.

58. The answer is (B). I is incorrect because there is no requirement that enrollees in Medicare Advantage plans must have a high-deductible medical expense policy.

59. The answer is (D). I is incorrect because treaty reinsurance is automatic and does not require a specific decision for each policy that is reinsured. II is incorrect because facultative reinsurance is optional and requires a specific decision for each policy that is reinsured.
60. The answer is (D). I is incorrect because the premiums purchase more accumulation units when stock prices are relatively low. II is incorrect because the value of each annuity unit decreases when stock prices are low, reducing the annuitant's dollar income.

61. The answer is (B). I is incorrect because the commission rates for renewal policies tend to be the same as for new policies.

62. The answer is (D). I is incorrect because mandatory second surgical opinions typically apply only to a specified list of procedures. II is incorrect because home health care benefits typically apply to a maximum number of visits per calendar year or to a period of time, such as 90 days after benefits commence.

63. The answer is (B). I is incorrect because the amount of capital needed to meet an income objective is found by dividing the amount of additional income needed by the applicable interest rate that represents the after-tax rate of investment return anticipated on the capital sum. I is incorrect because the amount of capital needed to meet an income objective is found by dividing the amount of additional income needed by the applicable interest rate that represents the after-tax rate of investment return anticipated on the capital sum.

64. The answer is (C). Both I and II are correct.

65. The answer is (A). II is incorrect because the beneficiary will be permitted to enforce the policy as though it complied with Texas law.

66. The answer is (D). I is incorrect because most people are more risk averse than they are risk tolerant. II is incorrect because the fact that a person is highly risk tolerant in physical or social activities does not necessarily mean that he or she is also highly risk tolerant in financial matters.

67. The answer is (A). II is incorrect because the wage base is adjusted annually.

68. The answer is (C). Both I and II are correct.

69. The answer is (C). Both I and II are correct.

70. The answer is (C). Underwriting involves both the selection and pricing of applicants.

71. The answer is (B). The reduced paid-up option produces a reduced death benefit for the life of the insured.

72. The answer is (A). FIMA administers the national flood insurance program, which provides coverages for dwellings and commercial buildings and their contents.

73. The answer is (C). Vulnerability to a hostile takeover is a disadvantage of demutualization.

74. The answer is (D). With paid-up additions, each dividend is used to purchase fully paid-up whole life insurance.

75. The answer is (B). D&O policies cover liability arising out of wrongful acts and exclude coverage for bodily injury and property damage, which should be covered under the firm's other policies.

76. The answer is (A). Medicaid provides benefits, which usually include nursing home care and home health care, to the "medically needy," and a person is not eligible unless he or she is either poor or has a low income and has exhausted most other assets.

77. The answer is (C). Although coverage for the Part A Medicare deductible is available in some plans, it is not one of the basic benefits that must be offered in all Medicare supplement (medigap) plans.

78. The answer is (B). The steps in the risk management process are risk identification, risk measurement, choice and use of alternative methods of treatment, and risk administration.

79. The answer is (D). The cash value decreases the insurer's net amount at risk.
80. The answer is (A). A conversion privilege is rarely included in group disability income contracts.

81. The answer is (C). Title insurance indemnifies the insured up to policy limits but provides no guarantee that the policyowner will retain possession of the property.

82. The answer is (C). The surviving spouse of a deceased worker is eligible to receive 100 percent of the worker's PIA at full retirement age.

83. The answer is (D). Because of the element of expense in carrying on the business of insurance, premiums include a charge to provide for this cost. In the case of risks that are of no great importance to insureds, the cost of handling the business would make the rate prohibitive. To make a risk insurable, the amount of future loss payments must be of such importance as to make them, rather than the insurer's expenses, the principal component in the premium charged.

84. The answer is (B). Medical payments provide benefits for a covered vehicle's occupants. It also covers the named insured or a family member who is a pedestrian struck by another vehicle.

85. The answer is (D). Personal property is covered for actual cash value in all homeowners policies. The personal property replacement loss settlement endorsement can be used to add replacement cost coverage on personal property.

86. The answer is (A). HIPAA applies to self-funded employer-provided group plans, as well as to insured plans.

87. The answer is (D). Neither a lump-sum settlement nor a structured settlement for bodily injury damages is taxable income.

88. The answer is (A). Judicial bonds are required by courts.

89. The answer is (A). One of the basic characteristics of managed care plans is controlled access to specialists and hospitals.

90. The answer is (C). The approaches described in (A), (B), and (D) make permanent insurance available to substandard applicants.

91. The answer is (B). Joint-life policies are usually some form of cash value insurance.

92. The answer is (D). The standard benefit structure does not provide benefits in the coverage gap, but some plans that provide more comprehensive benefits may provide such benefits.

93. The answer is (C). Premiums for disability income policies are based on the policyowner's age at the time of policy issuance and remain level for the duration of the coverage.

94. The answer is (B). The policyowner is not required to repay a policy loan.

95. The answer is (A). The PAP precludes coverage for any nonowned vehicle furnished for the regular use of an insured.

96. The answer is (B). Variable life policies provide no guarantee of either interest rate or minimum cash value.

97. The answer is (B). Termination for gross misconduct is an exception to the COBRA rules.

98. The answer is (A). Homeowners policies do not provide liability coverage for vehicles licensed for use on public roads.

99. The answer is (D). The 20th-year cash value is not subtracted in calculating the net payment cost index.

100. The answer is (A). Although high first-year commissions on new policies provide a financial incentive for twisting, there is no requirement that a reduced commission be accepted on a replacement policy.
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