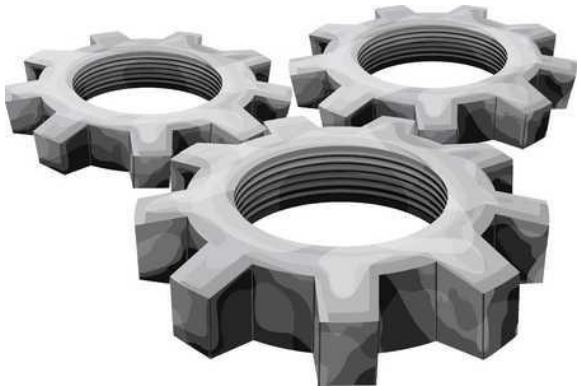
Buy-Sell Plans
Medicare
Cobra &
Life Concepts



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PART I

BUY-SELL PLANS

AGREEMENT FOR CONTINUATION OF BUSINESS

Business Owners Need a Buy-Sell

All individuals involved in business with partners should have a solid buy-sell agreement in place. Failure to implement a buy-sell agreement may leave an individual sharing his business with someone with whom he does not want to associate.

WHAT HAPPENS WHEN A PARTNER DIES

[1]One important rule to remember about partnerships is: the death of any partner automatically by law dissolves the partnership of which the deceased person was a partner. Upon the death of a partner the surviving partner faces two alternatives:

1. Quit the business and liquidate the assets of the partnership; or
2. Reach an agreement with new partners and restructure the business.

LIQUIDATION

[2]Neither the surviving partner nor the deceased partner's heirs can choose to reorganize the business, rather than liquidate it, without the consent of the other. Liquidation is the only choice available to the surviving partner that does not required the consent of the heirs. Liquidation can be demanded by either the surviving partner or the heirs.

[3]The decision to liquidate the partnership, made either by the surviving partner or the heirs, can be particularly disastrous for the surviving partner. Assuming that the partnership is the main source of income, liquidation may be financially catastrophic for the surviving partner.

REORGANIZATION

If the surviving partner and the heirs agree that liquidation is not advantageous,

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1

reorganization of the partnership in some form is the only alternative.

SURVIVING PARTNER IN BUSINESS WITH THE DECEASED PARTNER'S HEIRS

A reorganized partnership, which includes the heirs of the deceased partner, may be a satisfactory solution. However, there are issues that may make this alternative unacceptable.

Outside influences exerted by the heirs, as inactive partners, may interfere with the operation of the business. Internal conflict can arise as a result of the influence of heirs if the heirs believe the business is not being conducted properly. Also, the heirs may have no interest in continuing the partnership, hypothesizing that more income might be realized from the sale of their business interest than from liquidation. In doing so the second form of reorganization is accomplished: the buyer of the heirs' interest becomes a partner.

BUYER OF THE HEIRS' INTEREST BECOMES A PARTNER

[4]When a partner dies, the heirs generally turn first to the surviving partner as the purchaser of the inherited interest in the partnership. However, the heirs and the surviving partner may not be able to agree on a price, and the heirs then look to others to purchase their interest. If the potential purchaser is a competitor, this can be disastrous. Of course, the surviving partner can refuse to accept the new partner to whom the heirs wish to sell their interest. In some cases the heirs and the surviving partner agree upon an entity or individual to whom the heirs will sell their interest.

SURVIVING PARTNERS SELLS INTEREST

The third form of reorganization is for the surviving partner to sell his interest to the heirs. This situation occurs commonly when the surviving partner had less financial interest in the business than the deceased partner.

PURCHASE OF INTENT

Another form of reorganization entails the surviving partner purchasing the intent of the heirs. When a partner dies the preferred solution for the surviving partner is to purchase the heirs' interest in the partnership, provided the surviving partner is financially able to complete the purchase.

[5]Upon the death of a partner, it should be clear that any reorganization arrangement should meet three criteria:

1. The surviving partner acquires the deceased partner's interest;
2. The surviving partner continues the business; and
3. The estate acquires in cash the fair market value of that interest.

2

TWO TYPES OF BUY-SELL AGREEMENTS

Continuation of Business—Sole Proprietor

[6]Continuing a business after the death of a sole proprietor can be accomplished using one of two tools:

1. A living trust agreement; or
2. A buy-sell agreement.

LIVING TRUST AGREEMENT

[7]A living trust agreement provides for the sole proprietor's minor children or other living relatives to whom the owner wants to leave the business in the event these individuals would not be ready to take over that business immediately upon the death of the proprietor.

[8]The living trust agreement has advantages:

1. It allows the owner during his life to familiarize the trustee of the living trust agreement with the intricacies of operating the business successfully;
2. It gives the owner an opportunity to test the trustee's ability to run the business
3. It relieves the proprietor of the current burdens of sole management; and
4. After the death of the proprietor it protects the business from any complications related to his last will and testament.

There are also disadvantages to a living trust:

5. Determining the willingness and capability of the trustee administering such a trust;
6. If a corporate trustee is designated the sole proprietorship must become incorporated; and

7. Most trustees demand broad powers of control which may include:
   A. The power to sell the business; and/or
   B. The power to liquidate the business.

Buy-Sell Agreement — No Heirs

[9]If a sole proprietor has no children or other relatives as successors for the business, then the buy-sell agreement is indicated.

THE DESIRABILITY OF A BUY-SELL AGREEMENT

A proprietor may devote an entire lifetime to the goal of building a sound and substantial business. This business provides for the proprietor and his family and affords a good standard of living. Most take measures to prevent the dissolution of the business upon the proprietor's death.

Typically, upon the death of an owner the business:

A. Closes its doors; and
B. Disposes of all assets.

When a business owner dies the business is ripe for dissolution at a minimal rate of return. The assets are sold for pennies on the dollar and potential buyers or investors look for a bargain.

[10]If the business continues to operate while a buyer is sought, financial issues may arise. If the surviving spouse operates the business in the interim, in most cases they are either unqualified or unwilling to do so. In this instance, the spouse is vulnerable and may sell the business for a low market value to avoid continuing the business.

A proprietor should look for a logical successor while he is alive. When the successor is found the proprietor can:

1. Enter into a binding agreement with them; and
2. Have a successor purchase the business as a going concern.

By doing so, the buyer of the business will acquire a fully operating business and he will be able to pay its going-concern value, while the proprietor's estate avoids liquidation losses.

PARTIES TO THE BUY-SELL AGREEMENT

Prospective buyers for the business may be culled from the business owner's present employees. Present employees are:

1. Available;
2. Able to run the business;
3. Ambitious;
4. Familiar with the business; and
5. Often enthusiastic in response to this proposal.

[11]Should a proprietor wish to leave the business to a son or daughter he may find that the child is not interested, is unwilling, unable or incapable of running the business.

The bottom line: a buy-sell agreement requires both a willing buyer and a willing seller.

3

STRUCTURE OF THE BUY-SELL AGREEMENT

Provisions

The buy-sell agreement should be:

1. Formal in nature;
2. Written legally;
3. Properly signed; and
4. Properly witnessed.

[12]Insurance agents are not attorneys and do not practice law without a license. Insurance agents are not accountants and do not practice accounting if not qualified to do so.

[13]The role of the insurance agent in the buy-sell agreement is to provide the client with thorough, correct information, have products suitable for funding the agreement, and posses the knowledge necessary to suggest and sell those products.

MOTIVES TO SELL

A business owner may have a variety of reasons for selling his business:

1. Death of a principal;
2. Desire to retire;
3. Desire to minimize estate taxes;
4. Need for cash;
5. A move is desired; or
6. Profit-taking is desired.

MOTIVES TO BUY

The buyer of a business also has many motivations for wanting to buy the business:

1. The buyer hopes to make a profit on the purchase;
2. The buyer believes his talent or experience will enhance the business;
3. The buyer believes he is better suited to run the business;

4. A low down payment required; or
5. The price is right.

Conflicts Between Buyer and Seller

[14]When offering a business for sale, the seller often places unreasonable values on:

1. The age of the business;
2. The physical assets of equipment;
3. The physical assets of inventory; or
4. Goodwill.

[15]The biggest conflict often occurs regarding the value of goodwill. Goodwill is the great unknown. Goodwill is very difficult to measure. Goodwill can very easily become no will. Many times when a business is sold, goodwill leaves with the seller. For example:

- The customers were dealing with the business because of *who owned* it;
- The banks gave loans to the business because of *who owned* it; or
- Vendors that provided the business with goods at a reasonable price did so because of *who owned* it.

Goodwill may leave the business when the present owner leaves.

FUNDING THE AGREEMENT

[16]Many business owners draw up buy-sell programs prematurely, before the business is established. The buy-sell agreement is created before there are funds to back it. Until the agreement is funded and the money is there to consummate a buy-sell agreement in the event of death of one or more of the principals, there is nothing in place. Funding the agreement gives a contract life. Many buy-sell agreements are never funded simply because the owners cannot pay the premiums.

FINANCING THE BUY-SELL AGREEMENT

A buy-sell agreement between a proprietor and one or more of his key employees for the purchase of the business upon the proprietor's death sets up a pre-arranged market for the business.

Such an agreement, to be valid, must contain (1) a stipulated purchase price, or (2) A definite valuation formula that may be applied at death to produce a price.

The plan must go further—it must assure the purchaser has money with which to pay the

purchase price in full or nearly in full promptly upon the death of the proprietor. The only completely satisfactory method of financing an agreement wherein one or more key employees of a proprietorship purchase the business on the death of the proprietor is by means of life insurance carried by these employees on the life of the proprietor. The effect of such a financing arrangement is to set up an advance installment plan for the payment of the purchase price.

The amount of each installment is usually small, for example:

1. Approximately 2% for a proprietor age 37;
2. Approximately 3% for a proprietor age 47;
3. Approximately 4% for a proprietor age 55;
4. Approximately 5% for a proprietor age 59.

Installments can be made semiannually, quarterly or monthly.

By using the advance method to finance the purchase price, compound interest is put to work immediately in favor of the purchaser, with the result that only in exceedingly rare instances do the total payments equal the purchase price. In contrast, under a purchase arrangement calling for installments after death, compound works against the purchaser and must be paid in addition to the full purchase price. From the proprietor's standpoint, this plan of financing guarantees that his estate will receive the full going value of the business at once, in cash. For him, an immensely difficult estate problem is solved perfectly.

From the standpoint of the purchasing employee, the event that causes the purchase price to be due and payable will automatically cancel all future installment payments and will provide him with the full purchase price. For him, an operating, profitable, familiar business becomes his, free and clear.

[17]Life insurance carried on the proprietor by the purchaser in the amount of the purchase price, and which matches the purchaser's obligations regarding time of purchase and amount payable, is the most satisfactory method of financing a buy-sell agreement.

Life insurance, owned by the purchasing employee on the life of the proprietor in the amount of the purchase price, assures all parties to the agreement that cash with which to carry out the transaction will be:

1. Forthcoming when needed;
2. The most convenient method of purchase; and
3. The most practical method of purchase.

4

NON-INSURANCE METHODS

Funding the Employee Purchase

It would be rare for an employee of a proprietor to have sufficient money to pay cash for a business upon the proprietor's death. Eliminate this possibility. There are three possible methods open to the employee other than purchasing life insurance:

1. Save the money for the purchase price; or
2. Pay the purchased price in installments following the proprietor's death; or
3. Borrow the money at time of the proprietor's death.

SAVING THE MONEY

It is impractical to assume an employee could save the purchase price required. Years of saving would be required to obtain the necessary funds, and the entire amount is due upon the death of the proprietor.

INSTALLMENTS

It is difficult for the proprietor to determine the amount of installments, should the employee pay the purchase price in installments, as the installment amount depends upon the future fortunes of the business. And, it would be unwise for an employee to drain future income of the business for many years in order to make installments.

BORROWING

Borrowing the amount required to purchase the business would depend upon the credit standing of the employee at the time of the proprietor's death. The borrowing ability of the employee at that future, unknown date is uncertain. And, if a loan was secured, the required payments of loan interest, together with repayment of the loan principal, would be two factors against the purchasing employee.

Purchase by the Life Insurance Method

A buy-sell agreement needs the following in place:

1. A buyer

2. A seller
3. Good buying motives
4. Good selling motives
5. An attorney
6. An accountant
7. An insurance agent
8. An agreement
9. Funding

5

PROVISIONS OF A BUY-SELL AGREEMENT

Seven Basics

Since each buy-sell agreement is tailored by an individual's needs and desires, the following seven provisions are basics which may be added or subtracted from the individual's buy-sell agreement.

PROVISION NUMBER ONE

*Each party to the agreement agrees **not** to dispose of his interest during his lifetime without first offering it for sale to the other parties to the agreement.*

> ***Example***: What could happen if provision number one, above, was not part of the buy-sell agreement?
>
> Partner A's Partner, Partner B, is at a party one evening and a prominent businessman in town is introduced to him. The businessman tells Partner B that he has heard that "business is really good." The businessman then offers Partner B $500,000 in cash that evening for his interest in the business.
> Partner B jumps at the offer, accepts the money and tells Partner A in the morning that he sold his half and Partner A now has a new partner.
>
> Provision number one will prevent this from happening because Partner B will not be permitted to dispose of his interest without first offering it to Partner A.

PROVISION NUMBER TWO

[18]All parties to the agreement agree that the surviving parties will buy and the deceased's party's estate will sell to the survivors the interest of the deceased party.

> ***Example***: An individual's partner dies and the surviving spouse says: "I don't want to sell my half of the business. I'm counting on my half to provide an income to me and a college education for my three children."
>
> —OR—
>
> An individual's partner dies and the surviving partner advises the surviving spouse that he does not want to buy the surviving spouse's half of the business. He advises he does not have the money and had not counted on the partner's

untimely death.

Without provision number two there is no guarantee that:

1. The surviving part(ies) will buy; or
2. The deceased party's estate will sell.

PROVISION NUMBER THREE

[19]*An agreed upon purchase price is set to be paid by the survivors for the deceased party's interest, or a formula is established to be used at the time of death to determine a definite price.*

> ***Example:*** Partner A and Partner B agree that in the event of death of either partner, one-half of the business would be worth $500,000.00. Of course, this value was determined by an accountant as fair-market value for one-half of the business, to avoid any differences of opinion with the IRS. Twenty years pass and one partner dies. The estate of the deceased partner is entitled to $500,000.00. However; the business is now valued at $1,500,000.00 for one-half share.
>
> What will happen now? As a rule, there will be a lawsuit by the estate of the deceased partner demanding the additional $1,000,000.00 of value.

If provision number three is incorporated in the buy-sell agreement, a formula, designed by sound accounting practices to determine a fair and equitable price of one-half of the business at the time of death of one of the partners, is put in place.

PROVISION NUMBER FOUR

The parties agree to purchase and maintain life insurance in a stated amount for the purpose of financing the purchase of the deceased party's interest. The parties also agree to purchase and maintain long-term and short-term disability income insurance for the purpose of protecting their incomes from the business.

> [20]***Example***: One of the partners dies and his estate is entitled to $250,000.00 for his half-interest in the business. There was no life insurance in force. Where will the money come from? As a rule, it will come from the profits that the ongoing business produces, which result from the labor of the surviving partner. Not only does the surviving partner no longer have the services of the deceased partner, but the surviving partner must in effect do 100 percent of the work for 50 percent of the profit.
> Paying $250,000.00 to the deceased partner's estate could take years, and in fact may not take place at all if, for example, the business were to cease.
> On the other hand, assume one of the partners becomes totally and

permanently disabled for life. Now, the healthy partner is in the same circumstance in that he must produce 100 percent of the work and see to it that the disabled partner continues to receive a paycheck or money from his interest in the business.

The two examples, above, illustrate situations that not only cause financial strain on a business, but may destroy the friendship or camaraderie between the business owners. With provision number four in a buy-sell agreement the company will have the full purchase price of the deceased partner's interest available immediately and in full. Additionally, provisions can be made in the purchase of the life contract for future purchase options of additional amounts of insurance, without proof of insurability, to allow coverage for possible increased value of the business. Finally, with a sound buy-sell disability income contract, the company will receive funds from an insurance carrier to provide the disabled partner with his full income for a specified number of years without placing undue financial burden on the company.

PROVISION NUMBER FIVE

An agreement is made as to the ownership and control of the life insurance policies owned by the estate of the deceased, and the manner in which the policies are to be disposed.

Example: If ownership and control of the life insurance policy is not given to the company, but to the individual partner, the partner that owns the policy could:

1. Borrow on it without permission;
2. Cash it in without permission;
3. Allow it to lapse;
4. Not pay the premiums on time; and /or
5. Change the beneficiary without permission.

By naming the company as owner and giving control to the company as well as designating the beneficiaries as irrevocable, these issues are eliminated.

PROVISION NUMBER SIX

[21]*An agreement is reached as to the time and method of paying any balance of the purchase in excess of the insurance proceeds, or any refund in the event the purchase of the business is less than originally agreed upon. And, conversely, an agreement is reached as to the manner in which any proceeds in excess of the purchase price or refunds should be accounted.*

Example: The partners, through their accountant, and under IRS guidelines, establish that one-half of the business is worth $750,000.00. Upon the death of one of the partners, it is determined via a pre-established formula that one-half of the business is in fact worth $1,000,000.00. Without a buy-sell agreement, how can the deceased partner's estate expect to receive the other $250,000.00?

—OR—

Upon the death of one of the partners, it is found via a pre-established formula that one-half of the business is in fact worth $500,000.00. Without a buy-sell agreement how can the deceased partner's estate expect to get a refund of $250,000.00?

With provision number six, the buy-sell agreement includes a stipulated time-period and the method for paying any additional value to the deceased owner's estate; and, under provision number six, the buy-sell agreement also stipulates the time-period and the method for refunding any values to the deceased owner's estate.

PROVISION NUMBER SEVEN

An agreement is made that the survivors will take over all debts of the business, and release the deceased's estate from any obligation for same.

> ***Example:*** At the time of death of one of the owners, the business is heavily in debt. The surviving owner instructs the executor of the estate of the deceased owner that he expects the deceased owner's estate to continue to be responsible for half of the remaining debt until it is totally liquidated. Not only is the deceased owner's estate not receiving what it is entitled to, the deceased owner's estate may have absolutely no control over running the business.

With provision number seven in a buy-sell agreement, proceeds from the life insurance contract can be used to liquidate all existing debts at time of death and the balance of the life insurance proceeds can be used to buy out the deceased party's interest.

6

ADVANTAGES OF A BUY-SELL AGREEMENT DURING THE OWNER'S LIFE

Stability

A buy-sell agreement can assure business stability by guaranteeing both the continuity of the business and continuity of present management.

The buy-sell agreement can be structured to provide a retirement plan for the owners from cash values in the life insurance contracts. In this way, the buy-sell agreement provides excellent collateral for bank loans and establishes credit.

The plan can provide funds for business emergencies, demonstrates to the company's bank that the business is following sound management principles.

ADVANTAGES TO THE SURVIVOR(S)

1. The plan prevents the automatic intrusion of new, and perhaps, unwanted management interests. The intrusion of new or unwanted management interests may destroy a lifetime of business growth developed by the original owner.
2. The plan prevents a court reorganization of the business or reorganization directed by heirs. Court-ordered reorganization is expensive and time consuming, and the owner's heirs lose control of the operation of the business. As unsettling as a court reorganization is a reorganization directed by heirs who know absolutely nothing about the business.
3. The plan prevents business disruption by minority interests. Although minority interests of stockholders have very little power as individuals, they can, and do, very often band together to combine stock shares for clout. Minority interests can disrupt business with legal claims until their objectives are achieved, even though they had nothing to do with the success of the business.
4. The plan eliminates the need to bring a surviving spouse or other heirs into the business. Although the surviving spouse may be the closest family member to the deceased owner, that spouse may not be capable, either physically or mentally, to continue to properly run the business. Additionally, the spouse may have absolutely no interest in doing so. This also puts the spouse in a very weak position concerning the potential purchase price of the business. Heirs may be incapable of running the business or may have no

interest in doing so.

5. The plan eliminates disputes over salary to be paid to those who acquire the decedent's interest.
6. The plan allows current problems to be met in the most appropriate manner without explanation to those unfamiliar with the business.
7. The plan provides for business continuity. People are very quick to notice changes. If a business normally surrounded by cars and people closes temporarily because of the death of one of the partners, people notice that the business is closed. Once a business is closed and reopens, it takes ten times as long for passing traffic to notice the reopening then it did the closing. Business continuity is paramount to good employee relationships.
8. The plan preserves the morale of employees.

Example: Imagine calling 25 employees into a meeting following the death of a partner. Advise them that the business must close for three or four weeks to restructure and reorganize, but their jobs are safe and secure. Of course, during this time the business will be unable to pay them. What are the chances that these 25 employees will be there in three or four weeks?

9. The plan preserves the established goodwill of the business. Banks are conservative institutions. Often, money is loaned to businesses because of the relationship between the banker and the business owner. Goodwill is an establishment of faith and trust between customers and the business owner. The death of the business owner can affect the goodwill of lenders and customers.
10. The plan provides the purchasers with a firm contract assuring the right to buy the business interest at a predetermined price. The time to determine the price of a business is not after one of the principals has died. Pressure on the survivor increases and bargaining power is lost. And, it is difficult to negotiate a business deal while emotionally upset over the death of a loved one.
11. The plan provides the seller with a firm contract assuring the right to sell the business interest at a predetermined price. Negotiating prices should not take place when emotions are high and the pressure is on.
12. The plan allows for a fair price. Of all the advantages to the survivors this is probably one of the more important ones. It allows for a fair price to be established well in advance by professionals, without emotions or pressure entering into the picture.
13. The plan automatically produces money when it is needed, the number one advantage to the survivors.
14. The plan does not require that business assets be sold or credit obtained to generate funds for the purchase of the business interest. People attending estate sales have no concern for the financial well being of the surviving members of the family. They are bargain hunters willing to pay pennies on the dollar for what is being sold as business assets. The irony is that often assets and equipment that are needed to keep the business running are sold so that the business can be purchased. Imagine a printing company selling both of its presses in order to buy out the interests of a deceased owner.

ADVANTAGES TO THE ESTATE OF THE DECEASED OWNER

1. The plan makes it unnecessary for the surviving spouse to assume the responsibilities of running the business. It is a definite advantage to allow a spouse the *option* of assuming the responsibilities of running the business or not. At least the spouse has a choice and is not forced into a situation they are not capable of managing.
2. The plan eliminates potential friction between the family of the deceased owner and the surviving business owner. Friction between the family of the deceased owner and the surviving owner is common. Even the most loving families can argue over money matters.
3. The plan allows the surviving spouse to have adequate income so that time and talents can be directed to activities of greatest interest.
4. The plan avoids potential estate depreciation caused by forced sale of the business. Do not expect top dollar for items on a forced sale-basis. Forced sales attract bargain hunters interested in offering pennies on the dollar. They know the family may be desperate and take full advantage.
5. The plan provides the estate and the heirs with the full price, at once, in cash. The quickest, easiest and most amicable way to settle—with a check. Nothing takes the place of all the money, in full, at one time.
6. The plan shields the heirs from future business losses tied to a continuing business ownership. The heirs avoid being tied to a business losing money and depriving them of a decent standard of living due to the surviving owner running the business into the ground.
7. The plan avoids the necessity of hiring outside individuals to oversee the interests of the estate and heirs.
8. The plan saves probate and administration expenses by assuring prompt and efficient estate administration. With a buy-sell in place and funds readily available the heirs can be assured of prompt and efficient administration. Designating a named beneficiary will eliminate probate time and expense on the life insurance proceeds.
9. The plan immediately converts a non-liquid asset of less than certain value into cash that subsequently can be invested in other, more suitable assets. A business is considered a non-liquid asset simply because if sold, the asset disappears. Cash from life insurance proceeds enables the continuation of the business of a less than certain value into a business that will continue to thrive and prosper.

Validity of a Buy-Sell Agreement

To date, no case has been brought forward in which the validity of an agreement of the type discussed here has been challenged. The legal principles involved, however, are similar to those involved in agreements with the purchase and sale of corporation stock on the death of a stockholder.

COURTS COMPEL PERFORMANCE OF THE AGREEMENT

The courts will require the parties or the representatives to carry through the purchase and sale of the business that is the subject of the agreement. In a Maryland case, the top

court granted specific performance of a contract for the sale of a burial vault business. The court stated:

> *"It has been held that where the sale of personal property is incidental the sale of a going business, equity may afford relief."*

This is especially important to the purchasing employee. His future business career will be planned around the contemplated acquisition of the particular proprietorship business, with which he is familiar and has agreed to buy.

BENEFICIARY ARRANGEMENTS WITH A TRUSTEE

The buy-sell agreement must contain a statement naming the beneficiar(ies) of the insurance policies. There are several options:

- If the owner and purchasing employee decide to have a third party to the agreement such as a trustee, then the trustee should be the named beneficiary. It is also recommended that the ownership rights to the policy be given to the trustee.
- Another approach is to provide that ownership be retained by the owner of the business and purchasing employee jointly, or the purchasing employee alone. Since the trustee is not concerned with the payment of premiums, the arrangement for their payment is not changed by the adoption of a trust plan.

BENEFICIARY ARRANGEMENTS WITHOUT A TRUSTEE

If the parties to the agreement decide against a trust plan either because the amount involved is small, or for other reasons, then other beneficiary arrangements must be selected.

One option is to designate the purchasing employee as the beneficiary. By making this arrangement, the insurance money is paid to the person who has created the funds by paying the premiums, and it also balances the relationship between the purchasing employee and the deceased proprietor's estate upon the latter's death. The purchasing employee, obligated to buy and pay the purchase price for the proprietorship, holds title to the insurance proceeds. The proprietor's personal representative obligated to sell and transfer the deceased proprietor's interests holds title to the assets of that business.

Each party to the transaction holds something that he is obligated to exchange for something of equal value held by the other. The executor is in need of cash, and the surviving employee is in need of title to the business assets.

The agreement can also provide for the designation of the proprietor's estate as an insurance beneficiary, although this is not recommended. Such a beneficiary designation creates an imbalance between the purchasing employee and the estate of the

proprietor at the time of death for the obvious reason that the estate then holds both the insurance money and title to the business assets.

The courts stand ready, if necessary, to enforce the agreement specifically. It is recommended, as a deterrent to recalcitrance on the part of either side, to arrange for the meeting of the purchasing employee and the proprietor's personal representative on equal footing to conclude the transaction.

7

DISPOSITION OF THE BUSINESS

Alternatives

A business owner has three alternatives available regarding disposition of a business at the death of one of the owners:

- Keep the business;
- Liquidate the business; or
- Sell the business.

KEEP THE BUSINESS

If a business owner decides that he would like his heirs to retain the business upon his death, the following questions should be asked:

1. *For whom is the business being kept?* One business owner noted he was keeping the business for his grandson, but his grandson was only seven months old. Careful thought must be given to keeping the business for an individual.
2. *Who will run the business?* One business owner advised his son was going to run the business. His son was a medical doctor—but the man owned a gas station.
3. *Does that person **want** to run the business?*
4. *What are the new owners currently doing to earn a living?*
5. *Will the heirs and surviving owners be compatible?*
6. *Will profits suffer under the new management team?*
7. *Can yearly profit or loss in the business for the next five to ten years be estimated?* If not, bring in a competent accountant to prepare a profit-and-loss report.
8. *Is it possible to guarantee these profits to the heirs for a certain number of years following the death of the owner?* In order to do this, a substantial amount of life insurance is required. And, an important factor to consider is the ability of the owner to qualify for life insurance on the basis of his health.
9. *Are there any outstanding dollar needs that would be incurred at the time of death?* Take into account a serious final illness such as cancer that could run costs up over $100,000.00 prior to death.
10. *What arrangements have been made to see that objectives to keep the business are carried out?* The time to ask this question and prepare for an acceptable answer is not after the death of the

owner, but before.

LIQUIDATE THE BUSINESS

If a business owner decides that he would like his heirs to liquidate the business upon his death, the following questions should be asked:

1. *What is the going-concern value of the business today?* In other words, if there were a willing buyer and a willing seller, what would the price be? It is a good idea as a business owner to solicit an accountant to determine the value of the business. It is also important that the value is reasonable, to avoid any conflicts with the IRS upon the death of the owner.
2. *If a liquidation sale takes place upon your death, would you want to recapture that loss and pass it along to your heirs?* When a business is sold under stress or pressure because of the death of an owner, a liquidation sale usually produces a lot less money than is expected. That reduced amount is not something that is in the best interests of the owner's heirs.
3. *Have you calculated the possible loss your family would suffer if the business was sold in a forced liquidation instead of as a going concern?* Again, the same factors as mentioned in number 2,above, will come into play in this situation.
4. *Do you have any other business-related debts, and would you like to eliminate them at your death?* Careful consideration should be given to the indebtedness of the business and its affect on the heirs. Making provisions to fully eliminate debts enables the heirs to receive profits of the business immediately.
5. *What arrangements have you made to see that your objectives are carried out?*

SELL THE BUSINESS

If a business owner decides he would like his heirs to sell the business upon his death, the following questions should be asked:

1. *To whom would you sell your share of the business?* Typical answers to this question are spouse, son, daughter, uncle, or some other relative.
2. *For how much would you sell the business?* Many business owners have no idea what their business is worth, or over-estimate the value. The IRS is very strict in making certain that businesses are properly valued. The business owner and an accountant should determine in advance the proper selling price of the business, making certain that a formula has been devised to allow for future variances in its value.
3. *What would the method and terms of payment be to your family?* Cash is probably the most impractical of the choices unless, of

course, life insurance is involved. Without life insurance, very few people are in a position to come up with large amounts of cash. Cash payment completely settles the deal—the money is transacted and the business arrangement is complete. As a rule, the second best method is a substantial down payment of 25 to 50 percent of the business' value followed by monthly installments for a relatively short period of time. Remember, when allowing installments, the seller is tied to the continued success of the business in order to continue receiving monthly payments.

4. *Are the method and terms of payment enforceable?* The contract is only as good as the person who signs it. The last thing most families want to do is get the business back and have to resell it.
5. *Can the purchaser of the business get the money when necessary?* Evaluate the purchaser's ability to financially structure the purchase.
6. *Do you want to discount the purchase price of your business when you sell it?* All sellers want to avoid discounting the selling price. Discounting the sale reduces the amount of money to be provided to the seller's heirs.
7. *What arrangements have you made to see that your objectives are carried out?*

8

A CASE STUDY

Practical Applications of the Buy-Sell in Real Life

Excerpted from a true story, this scene illustrates the applications of the buy-sell agreement in 'real life':

> A family-owned business was run by a father who had two sons. The company was a manufacturing company with 23 employees and revenues of around $10,000,000.00.
>
> For many years Mr. Smith dreamed of turning over the thriving enterprise to his children. Smith had suffered a heart attack in 1981 and contemplated retiring so that he could spend more time on photography. Smith, being the wise businessman that he was, consulted his accountant, Mr. Jones, and his attorney, Mr. Casey. The discussion he had with Jones and Casey was about transferring control of his business to his sons, Matthew and Mark.
>
> Smith's accountant and attorney designed a buy-sell agreement that would compensate Smith while keeping taxes and his son's debt to him to a minimum.
>
> Smith then contacted an insurance agent and asked the agent to orchestrate insurance coverage and other necessary contracts to protect the Smiths, their business and the arrangement to change ownership. During that time Smith was negotiating with his sons Matthew and Mark regarding their differences of opinion about how the company would function after it was transferred, not so much about the transfer itself. Smith was a blue-collar, hands on worker. His sons, suit and tie clad, toured the company during the negotiations.
>
> The accountant, Casey, thought that the diverse goals and philosophies of the Smiths might thwart an ownership change. Logic eventually prevailed over emotions. The sons hired a lawyer to represent their interests in the purchase agreement to not only ensure a fair deal but also to help buffer emotions and calm disputes between the sons and father.
>
> The insurance agent commented that all too often, small business owners don't plan ahead for their retirement or death and that can spell demise for that company and headaches and heart aches for relatives.
>
> Smith felt he was fortunate that two of his five children wanted to operate his business. The son, Matthew, said that control of the business was a sticking point

because of his father's concerns about getting paid and Matthew and Mark's need to take charge. Matthew said his father "had the reins on us, and we didn't want that any more." There were lots of arguments. There were lots of tears. But once the agreement was made, the pressure was off.

Structured in the end to minimize Smith's taxes and preserve the company's financial stability and cash flow, the sale would occur in installments over the following seven years.

There are a few concerns with the story and the arrangements:

- What would have happened if Smith had died without a buy-sell agreement in place?
- What is going to happen to the future of this company without Smith around?
- Will Smith be forced to come back to save the company?
- Will Smith get paid over the next seven years?
- Will Smith suffer another heart attack because of displeasure with over how the company is being run by his sons?
- Is this a loving family or has the business and money taken a front row seat?

This is certainly a situation that required a solid buy-sell agreement. Smith sought the right professionals in that he employed an accountant, an attorney and an insurance agent.

Smith recognized the need for life insurance to fund the agreement and was wise to deal with his sons in a business manner.

9

DISABILITY BUY-SELL AGREEMENTS

Cross-Purchase and Entity Agreements

[22]There are two types of buy-sell agreements:

1. Cross-purchase agreements; and
2. Entity agreements.

[23]The buy-sell agreement can either be made between the owners, (cross-purchase), or between the owners and the business organization, (entity) for the sale and purchase of a disabled partner's interest. Regardless of which agreement is chosen, it should be funded by disability buy-sell insurance in order to provide for the orderly continuation of the business in the event of a partner's long term disability.

CROSS-PURCHASE AGREEMENTS

A cross-purchase agreement is structured so that the owner:

1. Owns the policies;
2. Pays the premiums; and
3. Receive benefits when an owner is disabled.

The agreement is made between the owners. It specifies that if one of them is disabled, the other owner will purchase his interest at the price contained in the agreement. This type of agreement typically is used when there are two, or at most, three owners. With more than three owners to a cross-purchase agreement, the need to have each principal be the owner and beneficiary of insurance on each of the other principals could create a large number of contracts and an administrative nightmare.

ENTITY AGREEMENTS

Under an entity agreement the business organization:

1. Owns the policies;
2. Pays the premiums; and
3. Receives the benefits when an owner is disabled.

Regardless of the type of agreement the owner chooses, it should be funded with a disability buy-sell policy.

The agreement is made between the owners and the business organization. It specifies that if one owner is disabled, the business organization will purchase his interest at the price contained in the agreement. This type of agreement is most commonly used when there are more than three owners.

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TAXATION ON BUY-SELL AGREEMENTS

[24]Taxation of Premiums and Benefits

[25]Taxation of premiums and benefits are treated the same, regardless of whether the buy-sell agreement is a cross-purchase agreement or an entity agreement:

- The premiums are not tax deductible
- The benefits are received income tax free

When the buy-out is between a corporate entity and a disabled owner and there is a total redemption of a shareholder's stock, the payments received will be treated as a capital gain or loss.

If the buy-out is a cross-purchase between the stockholder-employees, it will also be considered a capital transaction and be taxed accordingly.

When the buy-out is between a partnership entity and a disabled partner, which results in a termination of the disabled partner's interest, it is taxed as a liquidation of his or her interest.

When the buy-out is a cross-purchase between partners, it is taxed as a sale of the partners' interest.

TRIGGER DATE

Once the concept of disability buy-out has been accepted, the most difficult concept to resolve is how long should the owner be disabled before the buy out takes place. The date when the buy-out must occur is known as the trigger date.

Disability buy-sell policies usually come with a choice of three elimination periods:

8. 12-month wait;
9. 18-month wait; or
10. 24-month wait.

Satisfaction of the elimination period may, or may not, trigger the buy-sell agreement. If the policy provides for a lump sum payment, the trigger date will always be at the end of the elimination period. Once the elimination period has been satisfied, the buy-out is automatically triggered.

If the policy provides for installment payments, there are two ways the buy-sell agreement is put into effect:

11. Once the elimination period is satisfied, the buy-out is triggered. Payments will continue regardless of whether the insured has recovered or not. He is presumed to be disabled, and the buy-out takes place.

12. Once the elimination period is satisfied the installment payments begin. The buy-out is not triggered until all payments have been made.

If the owner returns to work before all payments are made, no buy-out has taken place and the benefits are taxed as ordinary income to the business. In this type of arrangement, the trustee is usually required by the insurance company to guarantee proper dispersal of the money. Establishing the trigger date at the end of the elimination period avoids conflict between the wants-disabled owner and the other owners. The question of recovery need not be addressed.

DEFINITION OF DISABILITY

Since the success of a disability buy-out provision is largely dependent on the insurance contracts used to fund it, the most logical definition of disability to use in the agreement is the definition contained in the insurance policy that will fund the buy-out.

Thus, the burden of determining the existence of total disability rests with the insurance company, avoiding the potential for disagreement among the participants.

Most companies define total disability as:

> *The inability to perform the duties of the insured's regular occupation or a reasonable occupation in the business. The individual's ability to contribute in a meaningful way to the business is what is being insured. Even if the owner can work outside the business, he should still be deemed totally disabled for the purposes of the buy-out because of the inability to work in the business.*

Since the definition of disability is a determining factor in whether the buy-out is triggered, it is important that the principals to the agreement be totally satisfied with the definition.

VALUATION

[26]One of the important provisions of a disability buy-out is how and when the business is to be valued. The value of the business is usually established by a formula based on:

1. Net worth;
2. Capitalization of earnings; or
3. A combination of the two.

There are two dates that can be used for establishing the value of the business:

1. The date the owner first becomes disabled; or
2. The trigger date of the buy-sell agreement.

The date the owner first became disabled is most favored, since the disabled owner will not suffer from a decline in the value of the business due to his extended absence. In establishing a method for the value of the business, attorneys and accountants for the company should be consulted.

An agent is not required to develop a method of evaluation; rather, an agent's responsibility is put a disability buy-sell policy in place that will provide the funds to secure the buy-out.

11

THE BASICS OF CORPORATIONS

Corporate Life

A corporation, as distinguished from a sole proprietorship or a partnership, is a separate legal entity. Legally, a corporation takes on the characteristics of an individual or person. It has a beginning, a life, and an ending all its own, regardless of the tenure of its officers.

Ownership in a corporation is comprised of shares of stock that are owned by shareholders. While most corporations establish a minimal par or initial value of their stock shares at formation, the actual value of shares varies by the same means as the values of other business entities. The affairs of a corporation are *defined* by its charter. While most corporate charters are quite broad in scope, the actual business activities of corporations are comparatively narrow and generally are easily determined by observation or in an initial fact-finding interview.

The affairs of a corporation are di*rected* by its officers, who are overseen by a board of directors. The officers and members of the board may or may not be shareholders. The liability of a shareholder is limited by the value of the stock held. While the liability of officers and directors may be greater than their salaries in some situations, absent product liability suits or other adverse legal action, the personal assets of shareholders, officers and directors are shielded from liability by the corporate form.

In many smaller corporations, however, the concept of limited liability is illusory. Since a smaller corporation often becomes the alter ego of its founder and principal executive, the executive and the corporation may be treated as one.

Without further discussion of the legal principle involved, and at the risk of oversimplifying, when an officer or executive treats the corporation as a personal extension, the 'corporate veil is pierced'. Piercing the corporate veil, for example, can occur when the founder borrows money from a bank and signs not only as a corporate officer, but also as a personal indemnitor.

Obviously, in this situation, the bank has recourse for payment of the loan to the corporation and also to the individual, so the concept of limited liability because of the corporate form is inapplicable. Other acts of a key executive, most often the founder and principal shareholder, can eliminate separate corporate liability.

TYPES OF CORPORATIONS

[27]Following the Tax Reform Act of 1986, there are now two basic types of corporations. "C" corporations, also referred to as regular corporations, follow the more traditional corporate format. C corporations are subject to a separate income tax on profits that are distributed. The highest current corporate income tax bracket is 34 percent. C corporations pay the corporate income tax, then individuals receiving the profits pay the appropriate personal income tax on the amount received.

An "S" corporation is popular with smaller businesses and with businesses that have only a few owners. An S corporation functions much the same for income tax purposes as does a partnership. That is, an S corporation is a conduit. It is not subject to separate income taxation. Instead, all distributions are taxed directly as personal income.

While it may appear on the surface that an S corporation would always be more advantageous because only individual tax rates are involved, such a conclusion would not always be correct. However, for smaller corporations with only one or a few owners, the income tax advantages of an S corporation have encouraged S corporation formation in recent years.

CLOSELY HELD VS. PUBLICLY HELD CORPORATIONS

Most, if not all, sales situations in which the life underwriter will be involved deal with closely held corporations.

Closely held corporations are those where the ownership is controlled by a small group of individuals. Usually these people are active in the management of the corporation as well. A close corporation does not necessarily have to be small. The name simply refers to the nature of stock ownership. A publicly held corporation, in contrast, is one in which the shares of stock representing ownership are widely held by the general public. The shares are made available through one of the stock markets. Usually public corporations are comparatively large.

When A Shareholder Dies

Any number of close corporations simply will disappear at the death of a major shareholder. The assets will be put up for sale, the debts paid, the corporation terminated and the proceeds distributed among the shareholders. Factors present in many corporations that may favor liquidation of that corporation and the end to the business at the death of a major shareholder include:

1. Lack of successor management;
2. Insufficient estate liquidity; and
3. Lack of working capital so there is little cash for either substantial or regular dividends.

An insured buy-sell agreement precludes the necessity to liquidate because cash will be

made available just when it is most needed for the continuation of the business.

THE CORPORATION

It is important to identify the needs of the client. The client's needs are the catalysts that will cause the client to look for and implement a solution. Death of a shareholder, when the corporate business form is involved, leads to several distinct needs requiring solutions.

It is not correct to assume that just because the corporate form continues at the death of a shareholder, all will continue as before. The death of a close corporation stockholder typically has significant consequences despite the fact that there is no legal effect on the life-span of the corporation.

In reality, many shareholders of a close corporation conduct themselves and their business affairs as though they were partners. For example, they work together as a team and their shareholder and director meetings resemble informal business sessions rather than formal gatherings. Decisions are usually reached quickly and unanimously. When a shareholder dies, the corporation usually loses an important member of the management team, regardless of whether the deceased shareholder held a majority or minority interest.

This loss may be a serious blow to the corporation because of the deceased's role as a key member of management. The business may suffer financially until the surviving shareholders can restore a balanced management team again.

In addition to these internal management problems, more serious external problems lie ahead. The deceased shareholder's interest is now owned by his family. In most cases, family members will not have been active in the corporation before the shareholder's death and may be unqualified to take part in the everyday management of the corporation. Yet the heirs may demand a voice in corporation affairs, even though they lack the experience and skill to contribute toward its profits and earnings.

Distributions from an S corporation are taxed similarly to those from a partnership. Death of a close corporation shareholder creates virtually the same problems as does the death of a partner.

In a close corporation, the surviving shareholders must either:
Accept the heirs of the deceased shareholder into the firm;
Accept the outside purchaser of the shares if the heirs sell them to a third party; or
Purchase the shares themselves.

There is only one reasonable business alternative. The surviving shareholders must purchase the shares of the deceased shareholder in order to assure the orderly conduct of business. The purchase requires cash. That is where the insured buy-sell agreement fits the need.

THE ESTATE

At the death of a shareholder, the shares he owned become part of his estate. However,

the shares are not liquid cash. Instead, they represent a portion of a going concern, which must be valued.

To meet IRS requirements, a valuation must satisfy the following standards:

(1) The business owner's estate must be obligated to sell;
(2) The price must be determined by the agreement, the price must be fair and adequate, not a gift, at the time the agreement is made; and
(3) The owner cannot sell his or her business interest to a third party during life without first offering it to the other party or parties to the agreement at the contract price.

For many estates, the need for immediate cash is critical. Further, the personal representative is charged with the responsibility of settling the estate. If the estate holds a minority interest in the close corporation, the other shareholders may simply choose to freeze the estate out of business affairs and continue business as usual, voting their shares as a block against those held by the estate. While there are a few legal remedies that can mitigate some of the long-term concerns, the option of legal action is expensive, time consuming and of uncertain outcome.

On the other hand, the heirs may not wish to be active in the business. Also, the heirs may not be suited by education or experience to play an active role in the business; that concern is particularly acute in closely held corporations where the deceased shareholder was a key personal contributor to the ongoing success of the corporation.

If the estate holds a majority interest in the close corporation, the heirs of the deceased majority shareholder, as new owners of the controlling interest of the corporation, are not actually in a position to determine corporate policy, while the minority shareholders are left to do all of the work. The heirs have the power to elect a board of directors and, indirectly, to select the corporate officers. The surviving shareholders, who may be officers of the corporation, may have their jobs at stake if they do not conform to the policies set forth by the heirs.

[28]The heirs also have the power to force a declaration of dividends regardless of any long-range growth program that the survivors, as executives of the corporation, deem essential for the health of the corporation.

Heirs who exercise their legal right to a controlling voice in the corporation usually are not making a deliberate attempt to destroy the surviving minority shareholders. On the contrary, it more often represents an honest effort to accomplish what the heirs think is best for the business. However, surviving minority shareholders can easily find themselves the victims of innocent and honest intentions of heirs whose lack of business ability and desire for dividends can ultimately spell an end to the business and to the jobs of the surviving shareholders.

For the value of the estate, the best option is almost always to sell the shares held at a fair

price promptly for cash. Again, the insured buy-sell agreement meets the needs of all involved.

12

STOCK REDEMPTION / CROSS PURCHASE

Stock Redemption Agreement vs. the Cross Purchase

Two most commonly used buy-sell agreements used in the close corporation setting are the stock redemption agreement and the cross-purchase buy-sell agreement. In the previous chapter the entity-purchase plan was outlined, where the business organization purchases the interest of the decedent. In the corporate setting, however, the entity-purchase plan is called a stock redemption plan. Under this plan, the corporation redeems or buys back its outstanding shares when it fulfills its obligation to purchase at a shareholder's death.

In a stock redemption agreement, the corporation agrees to buy and the shareholders agree to sell, at a pre-determined price, with right of first offer, the shares of any shareholder at death. The corporation purchases, pays the premium, and is the beneficiary, of life insurance on the life of each shareholder. This guarantees that the necessary funds are available to fund the purchase. This places full control and ownership in the firm, with no rights in the insured shareholder.

In a cross-purchase agreement, the shareholders agree to purchase each other's interest at death, also at a predetermined price and with right of first offer. However, in a cross-purchase agreement the corporation is not a party to the agreement. The agreement exists among the shareholders who have agreed to buy the decedent's interest on a pro-rata basis. The shareholders purchase life insurance on the lives of one another.

FACTORS INFLUENCING THE CHOICE OF AGREEMENT

The corporation may be restricted by law from purchasing its own shares. State law is controlling here, and the issue may be further complicated by the type of corporation. A professional corporation, for instance, may have more severe restrictions than a corporation chartered for general business purposes.

Some states restrict a corporation from purchasing its own shares absent sufficient surplus. Local law and corporate charter and by-laws must be examined. Because the purchase by a corporation of its own stock is normally prohibited by state law except out of its own surplus, a provision in the stock purchase agreement to the effect that the surviving shareholders will cause the corporation to take such actions as it can to create a surplus will lessen the impact of such law.

For example, the shareholders might vote to create a surplus by revaluing corporate assets or, alternatively, to recapitalize and reduce the par value of the corporation's stock,

thereby creating paid-in surplus (as long as it is not necessary to make the purchase out of earned surplus). However, if state corporate law creates problems, a cross-purchase arrangement may be the better choice.

Federal income tax considerations also may influence the choice of buy-sell agreement. If the corporate tax rate is lower than the individual tax rate, a stock redemption may be indicated because the after-tax cost to pay premiums would be correspondingly lower. However, when individuals pay premiums, only after-tax dollars are available.

If the individuals are in a higher tax bracket than the corporation, a cross-purchase is not indicated. If the individuals are in a lower personal income tax bracket than the corporation, and since life insurance premiums are not deductible by the corporation, the cost of funding by the cross-purchase method would be less. The salaries of shareholders may be increased to provide money for premium payments as long as they are still in a lower tax bracket than the corporation.

However, income tax rates are virtually certain to change in time for both corporations and individuals. Also, the alternative minimum tax may be a factor.

A stock redemption agreement often will be favored because of its simplicity and the fact that it is easily understood. When more shareholders are involved, more life insurance policies have to be issued in a cross-purchase agreement.

If ownership changes are fairly frequent now, or anticipated to be common in the future, a stock redemption agreement is more desirable because of the changes in policies a cross-purchase agreement that would be required.

If there is a wide variety in the ages of the shareholders, the younger shareholders may not have the resources or the desire to pay the higher premiums required to insure the lives of the older shareholders, who also may own more of the stock. Also, if one or more shareholders are in poor health and subject to rated insurance, the other healthier shareholders may feel a cross-purchase plan creates premium inequities for them. In such situations, a stock redemption plan is preferable.

If a purchase price is established by the agreement that values the shares at the time of death of the shareholder, a stock redemption agreement can provide an equitable result. If, however, pure equity is desired and a firm price established at some period prior to death is determined to be best, a cross-purchase agreement will provide the greatest equity.

If new life insurance policies are involved, either a stock redemption plan or a cross-purchase plan will work equally well. However, if existing life insurance policies are to be used, care must be taken not to violate the transfer for value rule. Thus, it is possible to change from a cross-purchase plan to a stock redemption plan without adverse income tax consequences. It is not possible, conversely, to change from a stock redemption plan to a cross-purchase plan. That action would fall within the transfer for value rule because a corporation would be transferring a policy to a shareholder.

A stock redemption plan allows the corporation the advantage of ready access to the

cash values of the life insurance policies that fund the buy-sell agreement. In a cross-purchase plan, however, the cash values are not as accessible to the corporation since the policies are owned by the individual shareholders.

Internal Revenue Code Section 2042(2) controls the inclusion of life insurance proceeds in the estate of a deceased shareholder. In a properly arranged stock redemption agreement, the value of the insurance is indirectly reflected in the purchase price the insured's estate receives for the redeemed shares. But the insurance values are not included in the decedent's estate because the corporation owned the policies, paid the premiums and designated the beneficiary.

On the other hand, the value of life insurance as part of a cross-purchase agreement that the deceased owned on the lives of others will be included in his estate at death, in addition to the value of the deceased's shares. Estate tax considerations, then, appear to favor the use of a properly structured stock redemption agreement.

No one solution will fit all situations. It is far more important to establish an insured buy-sell agreement than it is to weight the various factors so carefully that a decision to implement an agreement is postponed indefinitely.

The Alternative Minimum Tax

The Tax Reform Act of 1986 introduced the concept of the alternative minimum tax. Its alleged purpose is to make certain that all corporations pay at least some income tax, regardless of other deductions and credits. The alternative minimum tax adds certain deductions and credits, also known as tax preference items, back into the income tax computation.

The alternative minimum tax uses, among other factors, book income. Book income consists of all sources of revenue received during the corporation's taxable year. The annual increase in the cash value of a life insurance policy is classified as book income for purposes of the alternative minimum tax. Also, proceeds received by a corporation from a corporate owned life insurance policy in excess of the cash surrender value are book income. The tax on such proceeds will not be greater than ten percent prior to 1990, or 15 percent after that date. The formulas used for the calculations are rather complex. In any event, when the regular tax is higher than the corporate alternative minimum tax, or where book expenses are greater than book income, no minimum tax will be due. Premiums that are paid count toward book expenses.

If the prospective client is a C corporation, and if the alternative minimum tax is expected to become an issue in income tax planning, a cross-purchase agreement funded with life insurance may be preferable. If the prospective client is an S corporation, or if the alternative minimum tax is not expected to be relevant, either the stock redemption method or the cross-purchase method would be appropriate.

INSURABLE INTEREST

If there is an insurable interest at the time a policy is purchased by a corporation, current

case law holds that there is no danger the life insurance proceeds will be considered to be taxable income from a wagering contract. This result holds even if the insurable interest is not present at the time of death of the insured.

13

SALARY CONTINUATION PLANS AND INSURED BUY-SELL AGREEMENTS

Creative Solutions

When valuing a business interest, there are occasions in corporations where the business value fluctuates widely because of market conditions. There are other situations where the value simply may be too high for the owners to fund the full purchase price. There are times when a flow of income is more desirable to the heirs than a lump sum cash payment. Finally, stock redemption may be desirable at retirement rather than at death. Each of these four scenarios dictate a more creative solution to business continuation than a traditional insured buy-sell agreement.

An approach that has gained increasing popularity over recent years involves a two-step process. First, a minimum value is established for the shares. This minimum value becomes a floor that will generate at least that amount of cash for the heirs at the death of a shareholder in exchange for the shareholder's business interest. The customary insured buy-sell agreement is used for the first step.

Salary continuation plans are specifically designed for key executives, the very people likely to own shares in the corporation. These plans are designed with a wide degree of flexibility.

The second step involves establishing a salary continuation plan. A salary continuation plan is a non-qualified plan designed to benefit key executives of a corporation. When properly arranged, a salary continuation plan does not need to meet all of the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Instead, the corporate officers have discretion regarding who can be promised benefits and how large the benefits can be.

THE BASIC APPROACH

A promise is made, using a legally binding document (the plan agreement), that the corporation will pay pre-retirement death benefits of a given amount over a period of years, for example, 30 percent of final salary for life or 15 years certain. The plan agreement can contain the provisions, including the transfer of stock in exchange for the income stream of the plan. The plan agreement is a naked promise to pay benefits. The executive-shareholder only has the future profitability of the corporation as an assurance

that the promised benefits indeed will be paid.

Undoubtedly, most executive-shareholders will want additional security. The corporation can arrange to purchase life insurance on the lives of plan participants owning the policies, pay the premiums and the corporation can be the beneficiary of the proceeds. It is significant that there is no relationship between the amount of the policies on the executive and the actual promised benefit. In fact, it is important that no tie exist. This approach is known as *informal funding*. The policies, and the attendant cash values, are the assets of the corporation and are subject to the claims of general creditors. Non-qualified plan participants also are general creditors of the corporation as far as their promised benefits are concerned.

An additional degree of security for the executives can be provided by using a *rabbi trust*. The rabbi trust received its name from a trust established by a congregation that wanted to assure their rabbi that the promised benefits of the plan would be paid regardless of future intentions of the corporation. A rabbi trust is, in essence, benefits deferred to the trust. If the benefits are not paid or made available to the employee, for example, at retirement, then they are includable in the employee's income and taxed in that year. The approach of putting the insurance contracts into an irrevocable grantor's trust or rabbi trust, has now become an accepted practice. However, the plan assets are still subject to the general claims of corporate creditors.

In order for a salary continuation plan to function under current tax law, there must be a substantial risk or forfeiture of benefits. That element is provided, among other ways, by the plan document specifying that no, or limited, benefits are available prior to a given time, such as retirement at age 65. The life insurance premiums paid by the corporation are not income tax deductible. The plan assets, through the cash value, grow income tax free. Death proceeds are received income tax free. A portion of the death proceeds, in the event of death, or a portion of the cash value, in the event of retirement, are paid by the corporation to the executive or beneficiaries. Those payments are income tax deductible to the corporation at that time.

By paying benefits through the corporate tax bracket in the case of a C corporation, the corporation receives leverage on its funds. The same approach is used with an S corporation, but without the leverage of the payout through the corporate tax bracket because an S corporation functions as an earnings conduit.

Advantages of the Stock Redemption and Salary Continuation Combination

A combination of an insured buy-sell agreement and a salary continuation plan benefits the executive and the corporation in several ways.

BENEFITS TO THE EXECUTIVE

The executive, or the executive's heirs, may prefer to receive some lump sum cash and a stream of income over several years. That distribution of income may facilitate personal financial planning and budgeting. The proceeds are taxed as received, allowing normal deductions and exemption to spread the income tax burden over a period of years and perhaps resulting in a lower total tax than a lump sum distribution.

Some controversy has arisen over the ability to include death benefits from salary continuation plans in the executive's gross estate at death. On the whole, the IRS has been successful in its efforts to include death benefits in the gross estate, and annuities are included under Code Section 2039(a). As a rule, death benefits are includable annuities falling under Section 2039(a) if they meet the following three requirements:

1. Payments should arise form a *contract or agreement* with reference to the decedent's employment;
2. The beneficiary's right to the death payments arises solely because of the fact that he survived the decedent; and
3. At his death, the decedent had lifetime rights under the contract or agreement, either by virtue of having actually received an annuity attributable to the employer's contributions, or by having the right to receive such payments.

However, pre-retirement death benefits from salary continuation plans can be excluded from the executive's estate if the plan is properly arranged. The exclusion is applicable to the extent that the executive did not have a lifetime interest in the plan. Thus, the lack of a tie to the informal funding and the forfeiture provisions allow pre-retirement death benefits to be excluded under Internal Revenue Code Section 2039. Care must be taken in the drafting of the agreement to obtain this exclusion, however.

The two concepts, used together, may allow the executive, or the executive's heirs, to receive more for the stock than would have otherwise been possible.

BENEFITS TO THE CORPORATION

The corporation, at no current income tax cost to the corporation, provides the salary continuation arrangement. Further, through the use of plan design options, all of the premiums paid to informally fund the plan can be recovered, together with the cost of the money that made up the premiums. The only cost to the corporation, then, is the temporary loss of use of the premium payments. Most of those premiums will eventually show on the balance sheet as cash values, and the plan cost will ultimately be completely recovered by the corporation.

An additional use of life insurance that is beneficial to the corporation comes about when the face amount of the insurance is increased over what is required for the stock

redemption and salary continuation. This creates key employee coverage that indemnifies the corporation for the loss of the key employee's services to the corporation.

Because of the substantial risk of forfeiture provisions of the plan and the nature of the informal funding, premiums paid on life insurance policies on executives will not be constructive dividends. The corporation has simply made an unsecured promise to pay future benefits to executives. The use of life insurance is merely the way the corporation has chosen to be certain that adequate funds are available to honor the promise at the time specified. The corporation, through provisions in the plan document, receives the shareholder's stock, whether at the death or the retirement of the executive. That ownership interest is paid for under favorable terms to the corporation based on the buy-sell agreement while being completely fair to the executive.

QUIZ QUESTIONS PART I BUY-SELL PLANS

1. Upon the death of a partner, the reorganization should meet this criteria:
(a) The estate acquired in cash the fair market value of that interest
(b) The surviving partner continued the business
(c) The surviving partner acquired the deceases partners interest
(d) All of the above (Page 13-14)

2. If a sole proprietor has children and relatives that are successors for the business, then the buy-sell agreement would be indicated.
(a) True
(b) False (Page 16)

3. The role of the insurance agent in the buy-sell agreement is to provide the client with
(a) Thorough, correct information
(b) Have products suitable for funding the agreement
(c) Passes the knowledge necessary to suggest and sell those products
(d) All of the above (Page 18)

4. The value of Goodwill in a business sale is hard to gauge because of all except one of the following reasons.
(a) The bank gave loans to the business because of who owned it
(b) Business came in because of the person that owned it
(c) Reasonable price deals from vendors because of the owner
(d) Discounts provided by the owner (page 19)

5. There are two types of buy-sell agreements. Entity agreements and Cross-purchase agreements.
(a) True (Page 37)
(b) False

6. When a partner dies, experience has shown that the ____ generally turn first to the surviving partners to purchase the business.
(a) Banks
(b) **Heirs (Page 13)**
(c) Officers of the company
(d) Stockbrokers

7. Taxation on Buy-Sell Agreements are tax deductible.
(a) True (Page 39)
(b) False

8. The value of a business is usually established by a formula bases on
(a) Last tax return
(b) Net Worth
(c) Capitalization of earnings
(d) Both B & C (Page 42)

9. Liquidation is the only available to surviving partner that does not require the consent of the heirs?
(a) True (Page 12)
(b) False

10. Funding the buy-sell agreement is what gives the contract:
(a) A term of retirement period

(b) A face amount
(c) An effective date
(d) Life (Page 19)

11. All parties to a buy-sell agreement agree that the surviving parties will ____ the deceased party's interest in the business.
(a) Buy (Page 23)
(b) Sell
(c) Inherit
(d) Dispose of

12. Of the following choices, which is the most satisfactory method of financing a buy-sell agreement:
(a) Financing purchase
(b) Savings account
(c) Life Insurance (Page 20)
(d) Installment purchase

13. Taxation on Buy-Sell Agreement benefits received are income tax free.
(a) True (Page 39)
(b) False

14. After the death of a sole proprietor, the business's continuance can be provided for in one of two ways. Which one of the following is one of the two ways:
(a) Dissolving it
(b) Selling it to a bank
(c) Selling it to an insurance company
(d) Including it in a living trust agreement (Page 15)

15. After the death of a sole proprietor, the business's continuance can be provided for in one of two ways. Which one of the following is one of the two ways:
(a) Dissolving it
(b) Selling it to a bank
(c) Selling it to an insurance company
(d) Including it in a living trust agreement (Page 15)

16. The insurance industry launched an aggressive campaign to sell single-premium variable life insurance as one of the few remaining legitimate tax sheltered investments following the passage of the
(a) Tax Reform act of 1988
(b) Tax Reform act of 1985
(c) Tax Reform Act of 1987
(d) Tax Reform Act of 1986 (Page 43)

PART II

MEDICARE

1

SECTION ONE-MEDICARE

THE DEFINITION OF MEDICARE

[29]Medicare is a federal health insurance program for persons 65 or older, persons of any age with permanent kidney failure, and certain disabled persons.

It is administered by the Health Care Financing Administration within the Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.
[30]

[31]Medicare consists of Hospital Insurance protection (Part A) and Medical Insurance protection (Part B).

Part A provides institutional care, including inpatient hospital care, skilled nursing home care, home health care, and, under certain circumstances, hospice care. Part A is financed for the most part by Social Security payroll tax deductions which are deposited in the Federal Hospital Insurance Trust Fund. Medicare beneficiaries also participate in the financing of Part A by paying deductibles, coinsurance and premiums.

[32]Part B is a voluntary program of health insurance which covers physician 's services, outpatient hospital care, physical therapy, ambulance trips, medical equipment, prosthesis, and a number of other services not covered under Part A. It is financed through monthly premiums paid by those who enroll and contributions from the federal government. The government's share of the cost far exceeds that paid by those enrolled.

Catastrophic coverage was introduced in 1989 after Congress passed the Medicare Catastrophic Coverage Act of 1988 (MCCA). This legislation, however, was repealed by the Medicare Catastrophic Coverage Repeal Act of 1989. MCCA had expanded coverage for inpatient hospital care, skilled nursing facility care, hospice care and

home health care. It also provided coverage for all prescription drugs by 1991 and for home intravenous drug therapy, mammography screening and respite care.

The Department of Health and Human Services contracts with private insurance companies for the processing of payments to patients and health care providers. These private insurance companies are called fiscal intermediaries under Part A and are selected by the health care providers. Under Part B, these private insurance companies are called carriers and are selected by the Department of Health and Human Services.

WHO DIRECTS & ADMINISTERS MEDICARE?

The Health Care Financing Administration, whose central office is in Baltimore, Maryland, directs Medicare and Medicaid programs. The Social Security Administration processes Medicare applications and claims, but it does not set Medicare policy. The Health Care Financing Administration sets the standards which hospitals, skilled nursing facilities, home health agencies, and hospices must meet in order to be certified as qualified providers of services.

WHAT HOSPITAL INSURANCE PROTECTION DOES MEDICARE PROVIDE?

Persons protected have benefits paid for certain hospital and related health care services when they incur expenses for such services.

A person entitled to social security monthly benefits or a qualified railroad retirement beneficiary is automatically entitled to Hospital Insurance protection beginning with the first day of the month of attainment of age 65. An individual who is insured for monthly benefits need not actually file to receive the benefits. However, benefits are usually not paid for services furnished outside the United States.

Medicare does not pay for services covered under automobile medical, no-fault, or liability insurance. It also does not pay for services covered under an employer's group health plan if an employed individual (and his spouse) decide to be covered by the employer's plan while entitled to Medicare Hospital Insurance protection. In these cases, the employer's plan, or the automobile medical, no-fault, or liability insurance, pays its benefits first. Medicare may then pay for any services not covered in whole or in part by the insurance or the employer's plan.

WHAT MEDICAL INSURANCE PROTECTION DOES MEDICARE PROVIDE?

Persons protected have benefits paid for certain physicians' services (including surgery), home health services, and some other items and services not covered by Hospital Insurance protection.

Medical Insurance protection is financed through premiums paid by each person who enrolls (or by the state where the person is enrolled under a federal-state agreement) and through contributions appropriated from federal general revenues.

WHO IS PERMITTED TO PROVIDE SERVICES & SUPPLIES UNDER MEDICARE?

Health care organizations and professionals providing services to Medicare beneficiaries must meet all licensing requirements of state or local health authorities. The organizations and persons listed below also must meet additional Medicare requirements before payments can be made for their services:

- Hospitals
- Skilled nursing facilities
- Home health agencies
- Hospice programs
- Independent diagnostic laboratories and organizations providing X-ray services
- Organizations providing outpatient physical therapy and speech pathology services
- Facilities providing outpatient rehabilitation facilities
- Ambulance firms
- Chiropractors
- Independent physical therapists (those who furnish services in the patient's home or in their offices)
- Facilities providing kidney dialysis or transplant services
- Rural health clinics

All hospitals, skilled nursing facilities, and home health agencies participating in the Medicare program must comply with title VI of the Civil Rights Act, which prohibits discrimination because of race, color, or national origin.

Medicare does not pay for care received from a hospital, skilled nursing facility, home health agency, or hospice that is not certified to participate in the program. Such providers are referred to as non-participating. But Hospital Insurance can help pay for care in a qualified non-participating hospital if: (1) the patient is admitted to the non-participating hospital for emergency treatment, and (2) the non-participating hospital is the closest one that is equipped to handle the emergency. Under Medicare, emergency treatment means treatment that is immediately necessary to prevent death or serious impairment to health.
If the non-participating hospital elects to submit the claim for Medicare payment, Medicare will pay the hospital directly except for any deductible or coinsurance amounts. If the hospital does not submit the claim, the patient may submit the claim and receive payment. In this case, the patient would reimburse the hospital.

WHAT BENEFITS ARE PROVIDED UNDER THE HOSPITAL INSURANCE

PROGRAM?

(PART A)

[33]The program, which is compulsory, provides the following benefits for persons age 65 or older and persons receiving social security disability benefits for 24 months or more:

- The cost of inpatient hospital care for up to 90 days in each benefit period. There are also 60 additional lifetime reserve days with coinsurance.

- The cost of post hospital extended care in a skilled nursing facility for up to 100 days in each benefit period.

- The cost of an unlimited number of home health service visits made under a plan of treatment established by a physician.

- [34]The cost of hospice care for terminally ill patients.

WHAT BENEFITS ARE PAYABLE UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PLAN?

(PART B)

[35]The Supplementary Medical Insurance Plan is offered to almost all person's age 65 or over on a voluntary basis. In addition, the program is offered to all disabled Social Security and Railroad Retirement beneficiaries who have received disability benefits for at least 24 months. There is an annual deductible of $100, paid by the patient. Then the plan pays 80% of the approved charges above the deductible for the following services:

- Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, home, or elsewhere.

- [36]Home health care visits, if not covered under hospital insurance (but with no cost-sharing except for durable medical equipment, other than the purchase of certain used items).
- Diagnostic x-ray, diagnostic laboratory tests, and other diagnostic tests (no cost-sharing).

- Outpatient physical therapy and speech pathology.

- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, rental of durable medical equipment, etc.
- Ambulance transportation.
- The cost of blood clotting factors and supplies necessary for the self administration of the clotting factor.
- Services and supplies relating to a physician's services and hospital services rendered to outpatients; this includes drugs and biologicals, which cannot be self-administered.
- Dentists' bills for jaw or facial bone surgery, whether required because of accident or disease. Also covered are hospital stays warranted by the severity of a non covered dental procedure, and services provided by dentists which would be covered when provided by a physician. Bills for ordinary dental care are not covered.
- Comprehensive outpatient rehabilitation facility services performed by a doctor or other qualified professionals in a qualified facility. Therapy and supplies are covered.
- Antigens prepared by one doctor and sent to another for administration to the patient.
- The cost of pneumococcal vaccine (no cost-sharing).
- The cost of hepatitis B vaccine for high and intermediate risk individuals when it is administered in a hospital or renal dialysis facility.
- Certified nurse-midwife services.
- Partial hospitalization services incident to a physician's services.
- Screening mammography. Screening mammography is defined as a radiological procedure provided to a woman for the early detection of breast cancer, including a physician's interpretation of the results of the procedure.
- The cost of an injectable drug for the treatment of a bone fracture related to post-menopausal osteoporosis.
- [37]Eyeglasses following cataract surgery.
- Services of nurse practitioners and clinical nurse specialists in rural areas for the

services they are authorized to perform under state law and regulations.

[38]The cost of psychiatric treatment outside a hospital for mental, psychoneurotic, and personality disorders is covered. However, coinsurance is usually 50% instead of 20%.

WHAT ABOUT AN OVER-ALL LIMIT THAT A PERSON CAN RECEIVE UNDER MEDICARE?

[3940]Under the Basic Hospital Plan, benefits begin anew in each benefit period. In addition, there are no dollar limits under the Supplementary Medical Insurance Plan except for psychiatric care and independent physical and occupational therapy. Under the Basic Hospital Plan, care in a psychiatric hospital is subject to a lifetime limit of 190 days. (The time a patient has spent in a hospital for psychiatric care immediately prior to becoming eligible for Medicare counts against the special 150-day limit in the first hospitalization period, but not against the 190-day lifetime limit.)

Under the Supplementary Medical Plan, coverage of psychiatric treatment outside a hospital is subject to an annual benefit limit of $1,100 and services of independent physical therapists are reimbursable to no more than $750 per calendar year (as also applies to the services of independent occupational therapists).

Medicare may limit benefit payments for services for which other third party insurance programs (e.g., workers' compensation, auto or liability insurance, and employer health plans) may ultimately be liable. The Spending Reduction Act of 1984 establishes the statutory right of Medicare to:

1. bring an action against any entity which would be responsible for payment with respect to such item or service,
2. bring an action against any entity (including any physician or provider) which has been paid with respect to such item or service, and
3. join or intervene in an action against a third party.

AT WHAT TIME DO MEDICARE BENEFITS BECOME AVAILABLE?

Medicare benefits become available at the beginning of the month in which the individual reaches age 65. This is true even if the individual is still working. Medicare benefits are also available after the individual has been receiving Social Security disability benefits for two years or if the individual has chronic kidney disease. Every Medicare patient must be under the care of a physician.

WHEN IS A MEDICARE CARD ISSUED?

[41]A Medicare card is issued to a person after he becomes eligible for Medicare benefits. The card shows the person's coverage (Hospital Insurance, Supplementary Medical Insurance and Catastrophic Drug Insurance, or both) and the date protection started. The card also shows the person's health insurance claim number.

The claim number has nine digits and a letter. On some cards, there will be another number after the letter. The full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, they will receive separate cards and different claim numbers. Each spouse must use the exact name and claim number shown on his card.

Important points to remember:

- The patient should always show his Medicare card when receiving services that Medicare can help pay for.

- The patient should always write his health insurance claim number (including the letter) on any bills he sends in and on any correspondence about Medicare. Also, the patient should have the Medicare card available when making a telephone inquiry.

- The patient should carry the card whenever away from home. If it is lost, immediately ask a representative at any Social Security office for a new one.

- The patient should use his Medicare card only after the effective date shown on the card.

- Medicare cards made of metal or plastic, which are sold by some manufacturers, are not a substitute for the officially issued Medicare card.

- Never permit someone else to use your Medicare card.

IMPORTANT RULES REGARDING WHAT CARE IS COVERED UNDER MEDICARE

Medicare does not cover custodial care or care that is not "reasonable and necessary" for the diagnosis or treatment of an illness or injury.

Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For

example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if an individual is in a participating hospital or skilled nursing facility or the individual is receiving care from a participating home health agency, Medicare does not cover his care if it is mainly custodial.

If a doctor places an individual in a hospital or skilled nursing facility when the kind of care the individual needs could be provided elsewhere, the individual's stay is not considered reasonable and necessary. Medicare will not cover the stay. If an individual stays in a hospital or skilled nursing facility longer than he needs to be there, Medicare payments will end when further inpatient care is no longer reasonable or necessary.

If a doctor (or other practitioner) comes to treat a person or that person visits the doctor for treatment more often than is the usual medical practice in the area, Medicare will not cover the "extra" visits unless there are medical complications.
Note, however, that an individual will not be held responsible for paying for care if he could not reasonably be expected to know it was not covered by Medicare. This provision is called the "Waiver of Beneficiary Liability." The waiver provision applies only when the care is not covered because it was custodial care or was not reasonable or necessary for the diagnosis or treatment. Also, the waiver provision does not apply to Supplementary Medical Insurance claims unless the doctor or other person who furnished the services agreed to payment under the assignment method.

WHAT ARE PRO'S?

Peer Review Organizations (PROs) are groups of practicing doctors who are paid by the federal government to review hospital care of Medicare patients. There are PROs in each state to help Medicare decide whether inpatient care is reasonable and necessary, meets the standards of quality accepted by the medical profession, and is provided in the appropriate setting.

In addition, PROs respond to requests for review of hospital decisions or reconsideration of PRO decisions made about hospital stays. They also investigate individual patient complaints.

Whenever a patient is admitted to a Medicare-participating hospital, he will be given "An Important Message from Medicare," which briefly describes his appeal rights as a hospital patient and supplies the name, address, and phone number of the PRO in his state.

If a patient disagrees with the decision of a PRO, he can appeal by requesting a reconsideration. Then, if the patient disagrees with the PRO's reconsideration decision and the amount in question is $200 or more, he can request a hearing by an Administrative Law Judge. Cases involving $2,000 or more can eventually be appealed to a federal court.

Appeals of decisions on all other services covered under the Hospital Insurance Plan

(skilled nursing facility care, home health care, hospice services, and some inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries.

WHEN DOES THE FRAUD AND ABUSE HOTLINE BECOME NECESSARY?

If a person has reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services he did not receive, he can report evidence of fraud, waste or abuse to the Health Care Financing Administration by using a toll-free Hot Line. The toll-free number is 1-800-368-5779. In Maryland, call 1-800-638-3986. A person can send his complaints in writing to HHS, OIG, Hot Line, P.O. Box 17303, Baltimore, Maryland 21203-7303.

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SECTION TWO-ALL ABOUT MEDICARE

PART A—HOSPITAL INSURANCE PROTECTION

WHO IS ELIGIBLE FOR BENEFITS?

All person's age 65 and over who are entitled to monthly Social Security cash benefits (or would be entitled except that an application for cash benefits has not been filed), or monthly cash benefits under Railroad Retirement programs (whether retired or not), are eligible for benefits.

Persons age 65 and over can receive Medicare benefits even if they continue to work. Enrollment in the program while working will not affect the amount of future Social Security benefits.

A dependent or survivor of a person entitled to Hospital insurance benefits, or a dependent of a person under age 65 who is entitled to retirement or disability benefits, is also eligible for Hospital Insurance benefits if such dependent or survivor is at least 65 years old. For example, a woman age 65 or over who is entitled to a spouse's or widow's Social Security benefit is eligible for benefits under the Basic Hospital Insurance Plan.

A Social Security disability beneficiary is covered under Medicare after entitlement to disability benefits for 24 months or more. Those covered include disabled workers at any age, disabled widows and widowers age 50 or over, beneficiaries age 18 or older who receive benefits because of disability beginning before age 22, and disabled qualified railroad retirement annuitants.

A person who becomes re-entitled to disability benefits within five years after the end of a previous period of entitlement (within seven years in the case of disabled widows or widowers and disabled children) is automatically eligible for Medicare coverage without having to wait another 24 months.

Coverage will continue for 24 months after an individual is no longer entitled to receive disability payments because he has returned to work, provided he was considered disabled on or after December 10, 1980, and the disabling condition continues.

SPECIAL ELIGIBILITY RULES FOR PEOPLE WITH END-STAGE RENAL DISEASE

Insured workers (and their dependents) with end-stage renal disease who require renal dialysis or a kidney transplant are deemed disabled for Medicare coverage purposes even if they are working. Coverage can begin with the first day of the third month after the month dialysis treatments begin. This three month waiting period is waived if the individual participates in a self-care dialysis training course during the waiting period.

Medicare coverage based on transplant begins with the month of the transplant or with either of the two preceding months if the patient was hospitalized during either of those months for procedures preliminary to transplant. If entitlement could be based on more than one of the factors, the earliest date is used.

As of July 1, l991, coverage is provided for the self-administration of erythropoietin for home renal dialysis patients.

During a period of up to the first 18 months of entitlement, Medicare benefits are secondary to benefits payable under an employer's health benefit plan for individuals entitled to Medicare solely on the basis of end-stage renal disease. During this period, if an employer plan pays less than the provider's charges, then Medicare may supplement the plan's payments.

GOVERNMENT EMPLOYEES HAVE SPECIAL ELIGIBILITY RULES

Federal employees who were not covered under Social Security began paying the portion of Social Security tax that is creditable for Medicare purposes in 1983. A transitional provision provides credit for retroactive hospital quarters of coverage for federal employees who were employed before 1983 and also on January 1, 1983.

Beginning after June 30, 1991, state and local government workers who are not covered by a retirement system in conjunction with their employment, and who are not already subject to the Medicare Hospital Insurance tax, are also automatically covered and must pay such taxes. A retirement system is defined as a pension, annuity, retirement, or similar fund or system established by a state or by a political subdivision of a state.

Individuals are not automatically covered under Medicare if employed by a state or local government;

(1) to relieve them of unemployment;
(2) in a hospital, home, or institution where they are inmates or patients;
(3) on a temporary basis because of an emergency such as a storm, earthquake, flood, fire or snow;
(4) if the individuals qualify as interns, student nurses or other student employees of District of Columbia government hospitals, unless the

individuals are medical or dental interns or medical or dental residents in training.

State governments may voluntarily enter into agreements to extend Medicare coverage to employees not covered under the rules above.

IS MEDICARE A SECONDARY PAYOR? IF SO, WHEN?

Employers must offer employees age 65 or older the same health benefits offered to younger employees. Medicare will become the secondary payor for these employees age 65 or older. (This requirement does not apply to employers with less than 20 employees.) Medicare benefits are also secondary to benefits payable under employer health benefit plans for spouses age 65 or older of employed individuals of any age. Regulations issued by the Health Care Financing Administration state that Medicare is the secondary payor even if the employer health plan expressly stipulates that its benefits are secondary to Medicare. The regulations also include the federal government in the definition of an employer to which the secondary payment provisions apply.

An employee may reject the employer's plan and retain Medicare as the primary payor, but regulations prevent employers from offering a health plan or option designed to induce the employee to reject the employer's plan and retain Medicare as the primary payor.

[42]For persons who are not eligible for Social Security or Railroad Retirement benefits, Medicare is also the secondary payor: (1) when medical care can be paid for under any liability policy (including automobile policies), (2) in the first 18 months for end-stage renal disease under age 65 when private group health insurance provides coverage, and (3) when a disability beneficiary (under age 65) is covered under an employer plan as a current employee (or family member of an employee) for employers with at least l00 employees.

INELIGIBLE FOR SOCIAL SECURITY OR RAILROAD RETIREMENT?

QUALIFYING FOR HOSPITAL INSURANCE BENEFITS

Most persons age 65 or over and otherwise ineligible for Hospital Insurance may enroll voluntarily and pay a monthly premium if they are also enrolled for Supplementary Medical Insurance.

WHEN CAN AN INDIVIDUAL NOT ELIGIBLE FOR THE HOSPITAL INSURANCE PLAN BE ENROLLED?

An individual is eligible to enroll in the Hospital Insurance Plan if he:
1) has attained age 65,
2) is enrolled in the Supplementary Medical Insurance plan,
3) is a resident of the United States and is either (a) a citizen or (b) an alien lawfully admitted for permanent residence who has resided in the United States continuously for five years, and
4) is not otherwise entitled to Hospital Insurance benefits.

Disabled individuals under age 65 may also be able to obtain Medicare Part A coverage through monthly premiums. The Omnibus Budget Reconciliation Act of 1989 extended eligibility to individuals under age 65 who qualify for Part A benefits on the basis of a disabling physical or mental impairment, but who lose entitlement because they have earnings that exceed the eligibility limit for Social Security disability benefits and are not otherwise entitled to Part A benefits.

The premium for an individual who enrolls after the close of the initial enrollment period or who re-enrolls is increased by 10% if there were at least 12 months of delayed enrollment, regardless of how late the individual enrolls.

The increased-premium paying period is limited to twice the number of years an individual delayed enrolling. The premium then reverts to the standard monthly premium in effect at that time.

WHAT PART DOES THE HEALTH CARE FINANCING ADMINISTRATION PLAY?

The Health Care Financing Administration enters into agreements with state agencies and with fiscal intermediaries (such as Blue Cross and other health insurance organizations) to administer the Hospital Insurance Plan.

State agencies survey institutions to determine whether they meet the conditions for participation as a hospital, skilled nursing facility, home health agency, or hospice. They also help the institutions meet the conditions for participation.

Private organizations called intermediaries determine the amount of Hospital Insurance benefits payable to hospitals, skilled nursing facilities, hospices, and home health agencies; pay hospital insurance benefits to hospitals, skilled nursing facilities, hospices, and home health agencies out of funds advanced by the federal government; help hospitals, skilled nursing facilities, hospices, and home health agencies establish and maintain necessary financial records; serve as a channel of communication of information relating to the Hospital Insurance protection; and audit records of hospitals, skilled nursing facilities, hospices, and home health agencies, as necessary, to insure that payment of Hospital Insurance benefits is proper.

Each provider of services can nominate a fiscal intermediary to work with or can deal directly with the Health Care Financing Administration. Fiscal intermediaries are reimbursed for their reasonable costs of administration.

WHAT IS A PPS?

Beginning October 1, 1983, Medicare began basing most hospital payments on the patient's diagnosis at the time of admission rather than the costs the hospital incurred prior to discharging the patient.

This system of Medicare reimbursement is called the Prospective Payment System (PPS). Each patient is assigned to a diagnosis related group (DRG), and the hospital receives a corresponding flat-rate payment regardless of the number of days stayed or services received.

[4344]If the actual cost of a hospital stay is less than the DRG payment, the hospital keeps the difference; if the cost is greater, the hospital may lose the difference. A hospital can receive a payment higher than the DRG amount, but to do so it must show that the length of stay or the cost of treatment greatly exceeds the average for that DRG.

[45]After 1987, reimbursement for inpatient hospital services is based on uniform sums for about 475 Diagnosis Related Groups (varying between rural and urban facilities).

Health Maintenance Organizations (HMOs) are covered by special reimbursement provisions to reward them financially because of what is believed to be their more favorable operating experience.

Hospitals must provide inpatient care for Medicare beneficiaries as long as it is medically necessary. This must be done even when the cost of the beneficiary's care greatly exceeds the payment the hospital will receive from Medicare.

Despite the requirement to provide care for as long as it is medically necessary, the PPS provides hospitals with the possible incentive to refuse to admit patients for medical procedures that might not be reimbursed by Medicare. Hospitals also have the incentive to treat and discharge patients within or less than the time frame established by the reimbursement rate for a particular DRG.

The Health Care Financing Administration contracts with peer review organizations (PROs) in each state to conduct pre-admission, continued stay, and retrospective reviews of the services delivered by a hospital.

The reviews determine whether such services are reasonable and necessary. The PRO is also responsible for ensuring that the cost control incentives of the PPS do not adversely affect patients' access to hospitals or the quality of hospital care.

If the hospital, without consulting the PRO, recommends against admitting a patient, review of this decision may be obtained by the patient by writing the PRO in the patient's state. If the PRO participated in the pre-admission denial of the patient, then a reconsideration of that denial may be requested by the patient.

MUST THE BASIC HOSPITAL PLAN BE COMPULSORY?

Yes. Every person who works in employment or self-employment covered by the Social Security Act, or in employment covered by the Railroad Retirement Act, must pay the Hospital Insurance tax and will be eligible for Hospital Insurance benefits if fully insured when he reaches age 65, receives disability benefits for more than 24 months, or has end-stage renal disease.

HOW DO YOU FINANCE THE PLAN?

By a separate Hospital Insurance tax imposed upon employers, employees and self-employed persons. The tax must be paid by every individual, regardless of age, who is subject to the regular Social Security tax or to the Railroad Retirement tax.

[46]The maximum earnings base (the maximum amount of annual earnings subject to tax) is unlimited. There is a special federal (and generally following through to state) income tax deduction of 50% of the OASDI/Hospital Insurance self-employment tax. This income tax deduction, which is taken directly against net self-employment income, is designed to treat the self-employed in much the same manner as employees and employers are treated for Social Security and income tax purposes under present law.

WHAT SERVICES ARE PROVIDED?

Over and above the "deductible" and "coinsurance" amounts which must be paid by the patient, the following services are covered:

1) Inpatient hospital care for up to 90 days in each "benefit period."

2) Post-hospital extended care in a skilled nursing facility for up to 100 days in each "benefit period." The patient pays nothing for the first 20 days. After 20 days, the patient pays coinsurance.

3) An unlimited number of post-hospital home health services.

4) The patient pays nothing toward home health services.

5) Hospice care for terminally ill patients.

6) States are required to pay the Medicare premiums and cost-sharing for Medicaid recipients and other indigent persons who qualify for Medicare. States must also pay the Medicare deductibles, coinsurance, and the amount of the approved charge which must be paid under the Supplementary Medical Insurance plan for the indigent.

WHAT INPATIENT BENEFITS ARE PAID?

[47]Except for the "deductible" and "coinsurance" amounts which must be paid by the patient, Medicare helps pay for inpatient hospital service for up to 90 days in each "benefit period."

Medicare will also pay (except for a coinsurance amount) for 60 additional hospital days over each person's lifetime (applies to disabled beneficiaries at any age; others after age 65).

[48]Medicare pays for hospital care if the patient meets the following four conditions: (1) a doctor prescribes inpatient hospital care for treatment of the illness or injury, (2) the patient requires the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee or a Peer Review Organization (PRO) does not disapprove of the stay.

[49]The patient must pay a "deductible" for the first 60 days in each benefit period. If the stay is longer than 60 days during a benefit period, "coinsurance" must be paid for each additional day up to a maximum of 30 days.

After 90 days, the patient pays the full bill unless the lifetime reserve of 60 days is drawn upon. The patient must pay coinsurance for these 60 additional "lifetime reserve" days. [50]The coinsurance amounts are based on those in effect when services are furnished, rather than on those in effect at the beginning of the beneficiary's spell of illness (benefit period).

The 90-day benefit period starts again with each spell of illness. A "benefit period" begins the day a patient is admitted to a hospital. It ends when the patient has been in neither a hospital nor a facility primarily furnishing skilled nursing or rehabilitative services for 60 straight days. There is no limit on the number of 90-day benefit periods a person can have in a lifetime (except in the case of hospitalization for mental illness). However,

the "lifetime reserve" of 60 days is not renewable.

The following inpatient services are covered:

- Bed and board in a semi-private room (two to four beds) or a ward (five or more beds). Medicare will pay the cost of a private room only if it is required for medical reasons. If the patient requests a private room, Medicare will pay the cost of semi-private accommodations; the patient must pay the extra charge for the private room. The patient or family must be told the amount of this extra charge when a private room is requested. Normally, Medicare patients are assigned to semi-private rooms. Ward assignments are made only under extraordinary circumstances.

- Nursing services provided by or under the supervision of licensed nursing personnel (other than the services of a private duty nurse or attendant).

- Services of the hospital's medical social workers.

- Use of regular hospital equipment, supplies and appliances, such as oxygen tents, wheel chairs, crutches, casts, surgical dressings, and splints.

- Drugs and biologicals ordinarily furnished by the hospital.

- Diagnostic or therapeutic items and services ordinarily furnished by the hospital or by others (including clinical psychologists, as defined by the Health Care Financing Administration), under arrangements made with the hospital.

- Operating room costs, including hospital costs for anesthesia services.

- Services of interns and residents in training under an approved teaching program.

- Blood transfusions, after the first three pints. Patients must pay for the first three pints of blood unless they secure donors or the hospital receives the blood at no charge other than a processing charge. Medicare pays blood processing charges beginning with the first pint. The term "blood" includes packed aught blood cells as well as whole blood. If the blood deductible is satisfied under Part B of Medicare, it will reduce the blood deductible requirements under Hospital Insurance (Part A).

- X-rays and other radiology services, including radiation therapy, billed by the hospital.

- Lab tests.

- Cost of special care units, such as an intensive care unit, coronary care unit, etc.

- Rehabilitation services, such as physical therapy, occupational therapy, and speech

pathology services.

- Appliances (such as pacemakers, colostomy fittings, and artificial limbs) which are permanently installed while in the hospital.

The Basic Hospital Insurance Plan Does NOT PAY for:

- Services of physicians and surgeons, including the services of pathologists, radiologists, anesthesiologists, and physiatrist. (Nor does Part A of Medicare pay for the services of a physician, resident physician or intern—except those provided by an intern or resident in training under an approved teaching program.)

- Services of a private duty nurse or attendant, unless the patient's condition requires such services and the nurse or attendant is a bona fide employee of the hospital.

- Personal convenience items supplied at the patient's request, such as television rental, radio rental, or telephone.

- The first three pints of blood.

- Supplies, appliances and equipment for use outside the hospital, unless continued use is required (e.g., a pacemaker).

WHAT IS AN HMO?

[51]A Health Maintenance Organization (HMO) is a form of prepayment group practice providing service to its enrollees either directly or under arrangements with hospitals, skilled nursing facilities, or other health care suppliers. Generally, services include those covered under both the Basic Hospital Insurance Plan and the voluntary Supplementary Medical Insurance Plan, and are available to all Medicare beneficiaries in the area served by the HMO.

Qualified HMOs are paid on an estimated per capita basis. Such payments are made only to established HMOs, which are those: (1) with a minimum enrollment of 25,000, not more than half of whom are age 65 or older, and (2) which have been in operation for at least two years. Exception to the size requirement is provided for HMOs in small communities or sparsely populated areas (5,000 members and three years of operation).

HMOs which do not meet the requirements for fully qualified HMOs can contract for Medicare participation and be paid on a reasonable cost basis for their services.

[52]The Department of Health and Human Services designates a single 3 day period each year in which all HMOs in an area participating in Medicare must have an open enrollment period. During this 3 day period, HMOs must accept Medicare beneficiaries up to the limits of their capacity.

An individual may cancel enrollment from an HMO effective on the first day of the calendar month following the date on which he requested to be cancelled. Under previous law, changes in enrollment could not be effective until the first day of the second month following the date on which the individual requested the change.

HMOs must provide assurances to the Health Care Financing Administration that if they cease to provide items and services for which they have contracted, they will provide or arrange for supplemental coverage of Medicare benefits relating to a preexisting condition. This requirement applies to all individuals enrolled with HMOs who receive Medicare benefits. Items and services must be provided for six months or the duration of the exclusion period, whichever is less. HMO beneficiaries must pay the same Medicare premiums as other Medicare beneficiaries.

CAN YOU BE AN INPATIENT IN A PSYCHIATRIC HOSPITAL?

Yes, but benefits for psychiatric hospital care are subject to a lifetime limit of 190 days. Furthermore, if the patient is already in a mental hospital when he becomes eligible for Medicare, the time spent there in the 150-day period before becoming eligible will be counted against the maximum of 150 days available in such cases (including any later period of such hospitalization when he has not been out of a mental hospital for at least 60 consecutive days between hospitalizations). However, this latter limitation does not apply to inpatient service in a general hospital for other than psychiatric care.

WHAT ABOUT CARE IN A CHRISTIAN SCIENCE SANATORIUM?

Benefits are payable for services provided by a Christian Science sanatorium operated or certified by the First Church of Christ Scientist in Boston. In general, these institutions can participate in the plan as a hospital and the regular coverages and exclusions relating to inpatient hospital care apply. A Christian Science sanatorium may also be paid as a skilled nursing facility. However, extended care benefits will be paid for only 30 days in a calendar year (instead of the usual 100 days), and the patient must pay the coinsurance amount for each day of service (instead of only for each day after the 20th day).

ARE YOU ALLOWED TO CHOOSE YOUR OWN HOSPITAL?

[53]Except for certain emergency cases, Medicare will pay only to "qualified" hospitals, skilled nursing facilities, home health agencies and hospices. Use of a Mexican or Canadian hospital by a United States resident is authorized when such hospital is closer to his residence or more accessible than the nearest hospital in the United States. But such hospitals must be approved.

Medicare also authorizes payment for emergency care in a Canadian hospital when the emergency occurred in the United States or in transit between Alaska and other continental states. Necessary physicians' services in connection with such Mexican or Canadian hospitalization are authorized under Medicare's Supplementary Medical Insurance Plan.

IS DOCTOR CERTIFICATION FOR HOSPITALIZATION REQUIRED?

Initial certification is no longer required except for inpatient psychiatric hospital services and inpatient tuberculosis hospital services. For prolonged hospital stays, however, certification by a doctor will be required as often, and with such supporting material, as is stipulated in regulations under the law.

HOW DOES AN HMO OR HOSPITAL QUALIFY FOR MEDICARE PAYMENTS?

It must meet certain standards and must enter into a Medicare agreement with the federal government. However, provision is made for paying nonparticipating hospitals in cases of emergency.

HOW IS HOSPICE CARE COVERED?

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

[54]Hospice care is covered under the Hospital Insurance Plan when the beneficiary: (1) is eligible for Hospital Insurance benefits, (2) is certified as terminally ill (i.e., his life expectancy is six months or less), and (3) files a statement electing to waive all other Medicare coverage for hospice care from hospice programs other than the one he has chosen, and electing not to receive other services related to treatment of the terminal condition. (The beneficiary can later revoke the election.)

The following are covered hospice services:

- Nursing care provided by or under the supervision of a registered nurse.
- Physician's services.

- Medical social services provided by a social worker under a physician's direction.

- Counseling (including dietary counseling) with respect to care of the terminally ill patient and adjustment to his death.

- Short-term inpatient care provided in a participating hospice, hospital or skilled nursing facility.

- Medical appliances and supplies, including drugs and biologicals. Only drugs used primarily to relieve pain and control symptoms of the terminal illness are covered.

- Services of a home health aide and homemaker services.

The benefit period consists of two 90-day periods and one 30-day period.

The hospice benefit may be extended beyond the 210-day limit if the beneficiary is re-certified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice program.

The amount paid by Medicare is equal to the reasonable costs of providing hospice care or based on other tests of reasonableness as prescribed by regulations. No payment may be made for bereavement counseling, and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

Prescription drugs for symptom management and pain relief are covered, whether in or out of a hospice, with coinsurance of 5% of reasonable cost (but not more than $5 per prescription).

Respite care as an inpatient in a hospice (to give a period of relief to the family providing home care for the patient, available for no more than 5 consecutive days) is covered with coinsurance of 5% but not to exceed, in the aggregate in a period of respite care (which ends after 14 consecutive days when the hospice care option is not in effect), the amount of the hospital initial deductible in effect when the hospice benefits coverage began).

Persons must be certified as terminally ill within two days after hospice care is initiated. However, if verbal certification is provided within two days, certification may occur within eight days after care is initiated.

WHAT IS CONSIDERED A QUALIFIED SKILLED NURSING CARE FACILITY?

A skilled nursing facility may be a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital, or a section of a facility another part of which is an old-age home. Not all nursing homes will qualify; those which offer only custodial care

are excluded.

The facility must be primarily engaged in providing skilled nursing care or rehabilitation services for injured, disabled or sick persons. At least one registered nurse must be employed full-time and adequate nursing service (which may include practical nurses) must be provided at all times. Every patient must be under the supervision of a doctor, and a doctor must always be available for emergency care.

Generally, the facility must be certified by the state. It also must have a written agreement with a hospital that is participating in the Medicare program for the transfer of patients.

Skilled nursing care is care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled nursing care and skilled rehabilitation services must be needed and received on a daily basis (at least five days a week) or the patient is not eligible for Medicare coverage.

A skilled nursing facility must provide 24 hour nursing service and must employ a registered professional nurse during a day tour of duty of at least 8 hours a day, seven days a week. The facility must require that the medical care of every resident be provided under the supervision of a physician, and have a physician available to furnish necessary medical care in case of emergency.

Many residents of nursing homes will not qualify for Medicare coverage because coverage is restricted to patients in need of skilled nursing and rehabilitative services on a daily basis.

The initial determination of Medicare coverage is made by the nursing home, but the nursing home cannot charge the patient for care provided before it notifies the patient in writing that it believes Medicare will not pay for the care. The patient may not challenge the nursing home's non-coverage determination until a claim has been submitted to and denied by the Medicare intermediary. The patient does have the right to require a nursing home to submit its claim to the Medicare intermediary so that the intermediary can determine if the nursing home was correct in denying coverage.

Skilled nursing facilities must provide patients with the following rights:

(1) equal access and admission,
(2) notice of rights and services,
(3) transfers and discharge rights,
(4) the right to pre-transfer and pre-discharge notice,
(5) access and visitation rights,
(6) rights relating to the protection of resident funds, and
(7) certain other specified rights.

An institution which is primarily for the care and treatment of mental diseases or

tuberculosis is not a skilled nursing facility.

[55]Most nursing homes in the United States are *not* skilled nursing facilities and many skilled nursing facilities are not certified by Medicare.

PROVISIONS FOR CARE IN A SKILLED NURSING OR OTHER FACILITY

In order to qualify for extended care benefits, the patient must have been hospitalized for at least three days, and must have been admitted to the skilled nursing facility within 30 days after discharge from the hospital.

Legislation enacted in 1982 permits skilled nursing facility coverage without regard to the three-day prior hospital stay requirement if there is no increase in cost to the program involved, and the acute care nature of the benefit is not altered.

Persons covered without a prior hospital stay may be subject to limitations in the scope of or extent of services. The Department of Health and Human Services will decide when to lift the three-day prior hospital stay requirement but has not done so yet (and is not likely to do so).
Except for a coinsurance amount payable by the patient after the first 20 days, Hospital Insurance will pay the reasonable cost of post-hospital care in a skilled n0ursing facility for up to 100 days in a benefit period.

COVERED SERVICES

The following items and services are covered:

- Bed and board in semi-private accommodations (two to four beds in a room).
- Nursing care provided by, or under the supervision of, a registered nurse (but not private-duty nursing).
- Drugs, biologicals, supplies, appliances and equipment for use in the facility.
- Medical services of interns and residents in training under an approved teaching program of a hospital.
- Other diagnostic or therapeutic services provided by a hospital with which the facility has a transfer agreement.
- Rehabilitation services, such as physical, occupational, and therapy.
- Such other health services as are generally provided by a skilled nursing facility.

The following services are NOT COVERED:

- Personal convenience items that the patient requests, such as a television, radio, or telephone.
- Private duty nurses or attendants.

- Any extra charges for a private room, unless it is determined to be medically necessary.
- Custodial care, including assistance with the activities of daily living (i.e., walking, getting in and out of bed, bathing, dressing, and feeding), special diets, and supervision of medication that can usually be self administered.

Federal regulations include the following services for skilled rehabilitation and nursing care: (1) insertion and sterile irrigation and replacement of catheters, (2) application of dressing involving prescription medications and aseptic techniques, (3) treatment of extensive bed sores or other widespread skin disorders, (4) therapeutic exercises or activities supervised or performed by a qualified occupational or physical therapist, (5) training to restore a patient's ability to walk, and (6) range of motion exercises that are part of a physical therapist's active treatment to restore a patient's mobility.

A number of services involving the development, management and evaluation of a patient care plan may qualify as skilled services. These services are "skilled" if the patient's condition requires the services to be provided or supervised by a professional to meet the patient's needs, promote recovery, and ensure the patient's medical safety. For example, a patient with a history of diabetes and heart problems, who is recovering from a broken arm, may require skin care, medication, a special diet, an exercise program to preserve muscle tone, and observation to detect signs of deterioration or complications. Although none of these required services are "skilled" on their own, the combination, provided by a professional, may be considered "skilled."

To qualify for skilled nursing facility reimbursement, skilled physical therapy must be:

(1) specifically related to a physician's active treatment plan,
(2) of a complexity, or involve a condition, that requires a physical therapist,
(3) necessary to establish a safe maintenance program or provided where the patient's condition will improve within a predictable time, and
(4) of the necessary frequency and duration.

PATIENT COSTS FOR SKILLED NURSING

[5657]The patient pays nothing for the first 20 days of covered services in each spell of illness; after 20 days, coinsurance is payable for each additional day, up to a maximum of 80 days.
There is no lifetime limit on the amount of skilled nursing facility care provided under Hospital Insurance. Except for the coinsurance (which must be paid after the first 20 days in each spell of illness), the plan will pay the cost of 100 days' post-hospital care in each benefit period, regardless of how many benefit periods the person may have. After 100 days of coverage, the patient must pay the full cost of skilled nursing facility

care.

WHEN WILL PAYMENT BE MADE FOR THIS CARE?

Payment will be made for skilled nursing care only if the following conditions are met:

(1) The beneficiary files a written request for payment (another person may sign the request if it is impracticable for the patient to sign).

(2) A physician certifies that the patient needs skilled nursing care on an inpatient basis. Re-certification is required for extended stays.

(3) The facility is "participating" under Medicare law. Hospital Insurance cannot pay for a person's stay if he needs skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if a person does not need to be in a skilled nursing facility to get skilled rehabilitation services. And, Hospital Insurance cannot pay for a person's stay if the rehabilitation services are no longer improving his condition and could be carried out by someone other than a physical therapist or physical therapist assistant.

WHEN ARE POST HOSPITAL HOME HEALTH SERVICES PAID?

Hospital Insurance covers the cost of an unlimited number of home health visits made on an "intermittent" basis under a plan of treatment established by a physician. "Intermittent" is defined, in general, as care for up to six days a week, for up to three consecutive weeks (but not more than 35 hours per week).

A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in the home.

[58]Hospital Insurance can pay for home health visits if all four of the following conditions are met:

(1) The care provided includes intermittent part-time skilled nursing care, physical therapy, or speech therapy,

(2) The person is confined at home,

(3) A doctor determines the need for home health care and sets up a home health plan for the person, and

(4) The home health agency providing services is participating in Medicare.

A doctor must certify that the person is under a doctor's care, under a plan of care established and periodically reviewed by a doctor, confined to the home, and in need of: (1) skilled nursing care on an intermittent basis, or (2) physical or speech therapy, or has a continued need for (3) occupational therapy when eligibility for home health services has been established because of a prior need for intermittent skilled nursing care, speech therapy, or physical therapy in the current or prior certification period.

Home health aids, whether employed directly by a home health agency or made available through contract with another entity, must successfully complete a training and competency evaluation program or competency evaluation program approved by the Department of Health and Human Services.

Generally, a doctor may not make the determination in item 3 above for a patient with any agency in which the doctor has a significant ownership interest or a significant financial or contractual relationship. However, a doctor who has a financial interest in an agency which is a sole community health agency may carry out certification and plan of care functions for patients served by that agency.

IS POST-HOSPITAL HOME HEALTH COVERED?

The following post-hospital home health services are covered under Hospital Insurance:

- Intermittent part-time skilled nursing care.
- Physical therapy.
- Speech therapy.

If a person needs intermittent part-time skilled nursing care, physical therapy, or speech therapy, Medicare also pays for:

- Part-time services of a home health aid.
- Medical social services.
- Medical supplies.
- Durable medical equipment (80% of approved cost)
- Occupational therapy.

The patient pays nothing for home health visits.

Both Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) cover home health visits, but Hospital Insurance pays if the patient is eligible under both programs. There is no limit to the number of visits.

Medicare does *not* cover home care services furnished primarily to assist people in meeting personal, family, and domestic needs. These non-covered services include general household services, preparing meals, shopping, or assisting in bathing, dressing, or other personal needs. Medicare also does *not pay* for: (1) full-time nursing care at home, (2) drugs and biologicals, and (3) blood transfusions.

While the patient must be homebound to be eligible for benefits, payment will be made for services furnished at a hospital, skilled nursing facility, or rehabilitation center if the patient's condition requires the use of equipment that ordinarily cannot be taken to the patient's home. However, Medicare will not pay the patient's transportation costs.

A patient is considered "confined to the home" if he or she has a condition, due to illness or injury, that restricts the ability to leave home except with the assistance of another person or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the patient has a condition such that leaving home is medically unsafe. While a patient does not have to be bedridden to be considered "confined to the home", the condition should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

Infrequent means an average of five or fewer absences per calendar month, excluding absences to receive medical treatment that cannot be furnished in the home.

Short duration means an average of three or fewer hours per absence from the home within a calendar month, excluding absences to receive medical treatment that cannot be furnished in the home. Absences for medical treatment must be:

(1) based on and in conformance with a physician's order;
(2) by or under the supervision of a licensed health professional; and
(3) for the purpose of diagnosis or treatment of an illness or injury.

Home health agencies are required to provide patients with the following rights:

(1) the right to be informed of and to participate in planning care and treatment,
(2) the right to confidentiality of clinical records,
(3) the right to voice grievances,
(4) the right to advance notice, including notice in writing, of items and services for which payment will and will not be paid by Medicare,
(5) the right to have property treated with respect,
(6) the right to be fully informed in advance of Medicare rights and obligations, and
(7) the right to be informed of the availability of a state Home Health Agency Hot Line.

ARE OUTPATIENT COSTS PAID?

No, outpatient diagnostic services are covered under the Supplementary Medical Insurance Plan.

MUST YOU BE IN FINANCIAL NEED TO RECEIVE BENEFITS?

No, benefits are payable to rich and poor alike.

WILL THE DEDUCTIBLE & COINSURANCE REMAIN THE SAME?

No.

3

SECTION THREE-ALL ABOUT MEDICARE

PART B—MEDICAL INSURANCE PROTECTION

ELIGIBILITY UNDER THE SUPPLEMENTAL PROGRAM

[59]All persons entitled to Medicare Hospital Insurance may enroll in the Supplementary Medical Insurance Plan (Part B). Thus, Social Security and Railroad Retirement beneficiaries, age 65 or over, are automatically eligible. Other persons age 65 or over may enroll provided they are residents of the United States and are either: (1) citizens, or (2) lawfully admitted aliens who have resided in the United States continuously for at least five years at the time of enrollment.

Disabled beneficiaries (workers under age 65, widows aged 50-64, and children aged 18 or over disabled before age 22) who have been on the benefit roll as a disability beneficiary for at least two years are covered in the same manner as persons age 65 or over. (This includes disabled railroad retirement beneficiaries.) Disability cases are also covered for 36 months after cash benefits cease for a worker who is engaging in substantial gainful employment but has not medically recovered. (Disability benefits are, under such circumstances, paid for the first nine months of the trial-work period and then for an additional three months.) After 36 months, and during continued disability, voluntary coverage is available in the same manner as for non-insured persons age 65 or over.

Also covered are persons with end-stage renal disease who require dialysis or kidney transplant and are eligible for Hospital Insurance (Part A).

HOW DOES ONE ENROLL?

Those who are receiving Social Security and Railroad Retirement benefits will be enrolled automatically at the time they become entitled to Hospital Insurance unless they elect not to be covered by signing a form which will be sent to them. Others may enroll at their nearest Social Security office.

A notice of automatic enrollment is sent to persons automatically covered because of

entitlement to social security or railroad retirement benefits. A person must file the form rejecting coverage before coverage begins or, if later, within two months after the month in which the notice of automatic enrollment was sent to him.

[60]A person's initial enrollment period is a seven-month period beginning on the first day of the third month before the month age 65 is attained. If a person decides not to enroll in the initial enrollment period, he or she may enroll during a general enrollment period.

In order to obtain coverage at the earliest possible date, a person must enroll before the beginning of the month in which age 65 is reached. For a person who enrolls during the initial enrollment period, the effective date of coverage is as follows:

(1) If the person enrolls before the month in which age 65 is reached, coverage will commence the first day of the month in which age 65 is reached.

(2) If the person enrolls during the month in which age 65 is reached, coverage will commence the first day of the following month.

(3) If the person enrolls in the month after the month in which age 65 is reached, coverage will commence the first day of the second month after the month of enrollment.

(4) If the person enrolls more than one month, but at least within three months, after the month in which age 65 is reached, coverage will commence the first day of the month following the month of enrollment.

A seven-month special enrollment period is provided if Medicare has been the secondary payor of benefits for individuals age 65 and older who are covered under an employer group health plan because of current employment. The special enrollment period generally begins with the month in which coverage under the private plan ends.

Coverage under Supplementary Medical Insurance will begin with the month after coverage under the private plan ends if the individual enrolls in such month - or with the month after enrollment, if the individual enrolls during the balance of the special enrollment period.

WHAT HAPPENS IF I DECLINE TO ENROLL DURING THE AUTOMATIC ENROLLMENT PERIOD?

Anyone who declines to enroll during his initial enrollment period may enroll during a general enrollment period. There are general enrollment periods each year from

January 1st through March 31st. Coverage begins with the following July.

The premium will be higher for a person who fails to enroll within 12 months, or who drops out of the plan and later re-enrolls. The monthly premium will be increased by 10% for each full 12 months during which he could have been, but was not, enrolled.

If a person declines to enroll (or terminate enrollment at a time when Medicare is secondary payor to his employer group health plan, the months in which he is covered under the employer group health plan (based on current employment) and Hospital Insurance will not be counted as months during which he could have been but was not enrolled in Supplementary Medical Insurance for the purpose of determining if the premium amount should be increased above the basic rate.

CAN A STATE ENROLL ME?

A state may enroll and pay the premiums for a person eligible to enroll for Supplementary Medical Insurance and qualifying for welfare assistance if it requested an agreement to do so with the Department of Health and Human Services. The types of welfare assistance recipients the state agrees to enroll are called the "coverage group."

WHO FINANCES SUPPLEMENTAL MEDICAL INSURANCE?

Supplementary Medical Insurance is voluntary and is financed through premiums paid by people who enroll and through funds from the federal government.

Premium rates may be increased from time to time if program costs rise. In September of each year, the government will announce the premium rate for the 12-month period starting the following January.

[61]In the case of an individual who has the Supplementary Medical Insurance premium deducted from the Social Security check, if the amount of the cost-of-living adjustment is less than the amount of the increase in the premium, the premium increase will be reduced so as to avoid a reduction in the individual's net Social Security check.

The premium rate for a person who enrolls after the first period when enrollment is open, or who re-enrolls after terminating coverage, will be increased by 10% for each full 12 months he or she stayed out of the program.

These monthly premiums are, of course, in addition to the "deductible" and "coinsurance" amounts which must be paid by the patient.

Persons covered will have the premiums deducted from their Social Security, railroad

retirement or federal civil service retirement benefit checks. Persons who are not receiving any of these government benefits will pay the premiums directly to the government.

[62]Direct payment of premiums is usually made on a quarterly basis with a grace period, determined by the Secretary of the Department of Health and Human Services, of up to 90 days.

Public assistance agencies may enroll, and pay premiums for, public assistance recipients (Supplemental Security Income program). States must pay premiums for specified low-income persons.

If a person's Social Security or railroad retirement benefits are suspended because of excess earnings, and benefits won't be resumed until the next taxable year, the person will be billed directly for overdue Medicare premiums. If Social Security or railroad retirement benefits will be resumed before the close of the taxable year, overdue premiums are deducted from the Social Security or railroad retirement cash benefits when they resume.

Premiums must be paid for the entire month of death even though coverage ends on the day of death.

DETERMINATION OF APPROVED CHARGES

Medicare payments are based on the "reasonable charges" approved by the Medicare carrier. The Medicare carrier for an area determined the approved charges for covered services and supplies under a procedure prescribed by law. Each year, the carrier reviewed the actual charges made by doctors and suppliers in the area during the previous year. Based on this review, new approved charges were put into effect on October 1 of each year. First, the carrier determined the customary charge (generally the charge most frequently made) by each doctor and supplier for each separate service or supply furnished to patients in the previous calendar year. Next, the carrier determined the prevailing charge for each covered service and supply. The prevailing charge was the amount which was high enough to cover the customary charges in three out of every four bills submitted in the previous year for each service and supply. When a Medicare claim was submitted, the carrier compared the actual charge shown on the claim with the customary and prevailing charges for that service or supply. The charge approved by the carrier was either the customary charge, the prevailing charge, or the actual charge, whichever was lowest.

HOW ARE PAYMENTS MADE?

There are two ways payments are made under the Supplementary Medical Insurance

Plan. Payment can be made directly to the doctor or supplier. This is the assignment method of payment. Or, payment can be made to the patient.

The assignment method, in which the doctor or supplier receives the Supplementary Medical Insurance payment directly from Medicare, can save the patient time and money. When the assignment method is used, the doctor or supplier agrees that his total charge for the covered service will be the charge approved by the Medicare carrier. Medicare pays the doctor or supplier 80% of the approved charge, after subtracting any part of the $ 100 deductible the patient has not paid.

The doctor or supplier can charge the patient only for the part of the $100 deductible he has not met and for the coinsurance, which is the remaining 20% of the approved charge. Of course, a doctor or supplier also can charge the patient for any services that Medicare does not cover.

If a doctor does not accept assignment (nonparticipating physician), Medicare pays the patient 80% of the approved charge, after subtracting any part of the $100 deductible the patient has not paid. The doctor or supplier can bill the patient for his actual charge even if it is more than the charge approved by the Medicare carrier.

All Part B bills must be submitted to the carrier by the physician or supplier without charge, even if the physician or supplier does not take assignment. Claims must be submitted within one year of the date the service is provided.

Utilizing a doctor who accepts assignment under Medicare can make a big difference in a patient's out-of-pocket costs.

> ***Example***. Mrs. Smith has surgery after meeting the $100 deductible for Supplementary Medical Insurance. Dr. Jones, who is not a participating physician and does not limit his charges to the Medicare fee schedule, bills Mrs. Smith $1,200 for the surgery. The Medicare fee schedule sets the charge for this surgery at $1,100. Medicare will pay $880 (80 percent of the Medicare fee) and Mrs. Smith must pay the remaining $320 of the $1,200 fee.

If Dr. Jones was a participating physician under Medicare, Mrs. Smith would have to pay only $220 (20 percent of the approved charge of $1,100 that Medicare does not pay).

If a physician does not accept the assignment method, he must refund all amounts collected from Medicare beneficiaries on claims for services that are deemed not medically necessary. The Medicare carrier will send a notice to the beneficiary and physician advising them of the basis for denial, the right of appeal, and the requirement of a refund.

Physicians must give written notice prior to elective surgery for which the fee is $500 or more. The notice must state the physician's estimated actual charge, the estimated

Medicare-approved charge, the excess of the actual charge over the approved charge, and the applicable coinsurance amount. This requirement applies to non-emergency surgical procedures only. (Emergency surgery is surgery performed under conditions and circumstances which afford no alternatives to the physician or the patient and, if delayed, could result in death or permanent impairment of health.)

If the physician fails to make this fee disclosure, and the surgery was non-emergency surgery, the physician must refund amounts collected in excess of the Medicare-approved Part B charge. The physician is subject to sanctions if he knowingly and willfully fails to comply with this refund requirement.

DETERMINING IF DOCTORS ACCEPT ASSIGNMENT

Doctors and suppliers sign agreements in advance to accept assignment for all Medicare claims. They are given the opportunity to sign participation agreements each year.

The names and addresses of Medicare-participating doctors and suppliers are listed in the Medicare-Participating Physician/Supplier Directory. This directory is available for review in all Social Security offices and state and area offices of the Administration on Aging. Also, the directory can be purchased from any Medicare carrier.

Medicare participating doctors and suppliers may display emblems or certificates which show that they accept assignment on all Medicare claims.

WHAT IS A MEDICARE SUPPLIER?

Suppliers are persons or organizations, other than doctors or health care facilities, that furnish equipment or services covered by Supplementary Medical Insurance. For example, ambulance firms, independent laboratories, and organizations that rent or sell medical equipment are considered suppliers.

WHAT PORTION DOES THE PATIENT PAY?

The patient pays the first $1000 of covered expenses incurred in each calendar year. Medicare pays 80% of the balance of the approved charges (50% generally for out-of-hospital psychiatric services) over the $100 deductible. However, there is no cost-sharing for most home health services, pneumococcal vaccine, the costs of second opinions for certain surgical procedures when Medicare requires such opinions, and out patient clinical diagnostic laboratory tests performed by hospitals and independent laboratories which are Medicare-certified and by physicians who accept assignment.

HOW DO YOU FIND OUT HOW MUCH WILL BE PAID?

After the patient or the doctor or supplier sends in a Supplementary Medical Insurance claim, Medicare will send the patient a notice entitled Explanation of Medicare Benefits to explain to the patient the decision on the claim.

[63]This notice shows what services were covered, what charges were approved, how much was credited toward the patient's $100 annual deductible, and the amount Medicare paid.

WHAT SERVICES PERFORMED BY THE DOCTOR ARE COVERED?

Under the Supplementary Medical Insurance Plan, Medicare usually pays 80% of the approved charges for doctors' services and the cost of other services that are covered under the Hospital Insurance Plan after the patient pays the first $100 of such covered services in each calendar year.

The following doctors' fees and services are covered by this portion of Medicare:

- Doctors' services are covered wherever furnished in the United States. This includes the cost of house calls, of office visits, and doctors' services in a hospital or other institution. It includes the fees of physicians, surgeons, pathologists, radiologists, anesthesiologists, physiatrist, and osteopaths.

- Services of clinical psychologists are covered if they would otherwise be covered when furnished by a physician (or as an incident to a physician's services).

- Services by chiropractors with respect to treatment of subluxation of the spine by means of manual manipulation are covered.

- Fees of podiatrists are covered, including fees for the treatment of plantar warts, but not for routine foot care. The cost of treatment of debridement of mycotic toenails i.e., the care of toenails with a fungal infection) is not included if performed more frequently than once every 60 days.

Exceptions are authorized if medical necessity is documented by the billing physician. The Health Care Financing Administration is studying the cost effectiveness of covering therapeutic shoes for individuals with severe diabetic foot disease. The cost of such shoes, if prescribed by a podiatrist or other qualified physician, may be covered under Medicare.

- The cost of diagnosis and treatment of eye and ear ailments is covered. Also covered is an optometrist's treatment of aphakia.
-
- Plastic surgery for purely cosmetic reasons is excluded; but plastic surgery for repair

of an accidental injury, an impaired limb or a malformed part of the body is covered.

-
- Radiological or pathological services furnished by a physician to a hospital inpatient are covered.
-
- Immuno-suppressive drugs used in the first year of transplantation are covered.

IS POST-MENOPAUSAL OSTEOPOROSIS COVERED?

The cost of an injectable drug for the treatment of a bone fracture related to post-menopausal osteoporosis is covered under the following conditions: (1) the patient's attending physician certifies that the patient is unable to learn the skills needed to self-administer (or is physically or mentally incapable of administering) the drug, and (2) the patient meets the requirements for Medicare coverage of home health services.

ARE EYEGLASSES COVERED?

One pair of eyeglasses is covered following cataract surgery.

Additional Benefits

Additional benefits include:

- The cost of blood clotting factors and supplies necessary for the self administration of the
- clotting factor.
- Services and supplies relating to a physician's services and hospital services
- rendered to outpatients; this includes drugs and biological which cannot be self-administered.
- Radiation therapy with X-ray, radium or radioactive isotopes (including technician services).

WHEN DOES COST SHARING APPLY?

A patient does not have to pay the $100 deductible or the 20% coinsurance for the following services: (1) the cost of second opinions for certain surgical procedures when Medicare requires a second opinion, (2) the cost of home health services except the 20% coinsurance charge applies for durable medical equipment (except for the purchase of certain used items), (3) pneumococcal vaccine, and (4) outpatient clinical diagnostic laboratory tests performed by physicians who take assignments, or by hospitals or independent laboratories that are Medicare-certified.

IS BLOOD COVERED?

Both Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) can help pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration.

If a patient receives blood as an inpatient of a hospital or skilled nursing facility, the Hospital Insurance Plan can pay all of the blood costs, except for a deductible charged for the first three pints of whole blood or units of packed red cells in each benefit period. The deductible is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

The patient is responsible for the deductible for the first three pints or units of blood furnished by a hospital or skilled nursing facility in a calendar year. If the patient is charged a deductible, he has the option of either paying the deductible or having the blood replaced.

A hospital or skilled nursing facility cannot charge a patient for any of the first three pints of blood he replaces. Any blood deductible satisfied under the Supplementary Medical Insurance Plan will reduce the blood deductible requirements under the Hospital Insurance Plan.

Supplementary Medical Insurance can help pay for blood and blood components received as an outpatient or as part of other covered services, except for a deductible charged for the first three pints or units received in each calendar year. After the patient has met the $100 deductible, Supplementary Medical Insurance pays 80% of the approved charge for blood starting with the fourth pint in a calendar year.

QUIZ QUESTIONS PART II MEDICARE

1. HMO participants in Medicare must have an open enrollment period of how many days each year
(a) 3 (page 73)
(b) 5
(c) 30
(d) 45

2. Most nursing homes in the US are not skilled nursing facilities and many skilled nursing facilities are not certified by Medicare
(a) True (Page 78)
(b) False

3. Medicare Part B is:
(a) Required
(b) Mandatory
(c) Available only after age 50
(d) Voluntary (Page 56)

4. Which of the following best describes skilled nursing care:
(a) The highest and most expensive level of care (Page 77)
(b) The least expensive level of care
(c) The intermediate level of care
(d) The lowest level of care

5. Which of the following is NOT one of the three requirements to qualify for Medicare:
(a) Persons of any age with permanent kidney failure
(b) People age 65 or older
(c) People under age 65 with disabled children (Page 75)
(d) Certain disabled persons

6. When does one receive a Medicare card:
(a) When one request one in writing
(b) When one becomes age 70 or older
(c) When one submits their Social Security number to Medicare
(d) When one becomes eligible for Medicare benefits (Page 61)

7. Hospice provides benefits for those that:
(a) Qualify for long-term care
(b) Need adult day care
(c) Are terminally ill (Page 59)
(d) Are over age 65

8. Which of the following is NOT a mandated program required by law:
(a) Group health insurance (Page 67)
(b) Workers' Compensation
(c) Unemployment Compensation
(d) Social Security

9. Part B of Medicare is described as:
(a) Hospital Insurance Protection
(b) Major Medical Insurance
(c) Supplementary Medical Insurance (page 59)
(d) Medical Insurance Protection

10. For outpatient mental health services, Medicare pays ____% of the costs:

(a) 25
(b) 50 (Page 89)
(c) 75
(d) Zero

11. There is no lifetime limitation on the number of Benefit Periods allowed for:
(a) Beneficiaries
(b) Children under 12
(c) Each Medicare recipient (Page 71)
(d) The government

12. The benefit period starts over with each spell of illness.
(a) True (Page 71)
(b) False

13. Which part of Medicare covers durable medical equipment?
(a) Part A
(b) Part B (Page 59)
(c) Part C
(d) Part D

PART III

COBRA

1

SECTION ONE

COBRA MADE EASY

INTRODUCTION

Health insurance programs allow workers and their families to take care of essential medical needs. These programs can be one of the most important benefits provided by your employer.

There was a time when group health coverage was available only for full-time workers and their families. That changed in 1985 with the passage of health benefit provisions in the **Consolidated Omnibus Budget Reconciliation Act. (COBRA).**

Now, terminated employees or those who lose coverage because of reduced work hours may be able to buy group coverage for themselves and their families for limited periods of time.

[64]If you are entitled to COBRA benefits, your health plan must give you a notice stating your right to choose to continue benefits provided by the plan. You have 60 days to accept coverage or lose all right to benefits. Once COBRA coverage is chosen **you are required to pay for the coverage.**

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SECTION TWO

COBRA MADE EASY—CONTINUATION HEALTH LAW

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act health benefit provisions in 1985. The law amends the employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.

COBRA contains provisions giving certain former employees, retirees, spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer formerly paid a part of the premium. It is ordinarily less expensive, though, than individual health coverage.

The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local governments. The law does not, however, apply to plans sponsored by the Federal Government and certain church-related organizations.

Group health plans sponsored by private sector employers generally are welfare benefit plans governed by ERISA and subject to its requirements for reporting and disclosure, fiduciary standards and enforcement. ERISA neither establishes minimum standards or benefit eligibility for welfare plans nor mandates the type or level of benefits offered to plan participants. It does, though, require that these plans have rules outlining how workers become entitled to benefits.

For COBRA purposes, a group health plan ordinarily is defined as a plan that provides medical benefits for the employer's own employees and their dependents through insurance or otherwise (such as a trust, health maintenance organization, self-funded pay-as-you-go basis, reimbursement or combination of these). Medical benefits provided under the terms of the plan and available to COBRA beneficiaries may include:

- Inpatient and outpatient hospital care.
- Physician care.
- Surgery and other major medical benefits.

- Prescription drugs.
- Any other medical benefits, such as dental and vision care.
- Life insurance, however, is **not a benefit** that must be offered to individuals for purposes of health
- continuation coverage.

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SECTION THREE

COBRA MADE EASY—QUALIFYING FOR COVERAGE

There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plans, beneficiaries, and events which initiate the coverage.

Plan Coverage

Group health plans for employers with 20 or more employees on at least 50 percent of the working days in the previous calendar year are subject to COBRA. "Employees" include full-time and part-time workers, agents, independent contractors and directors, and certain self-employed individuals eligible to participate in a group health care plan.

Beneficiary Coverage

[65]A qualified beneficiary generally is any individual covered by a group health plan on the day before a qualifying event. A qualified beneficiary may be an employee, the employee's spouse and dependent children, and in certain cases, a retired employee, the retired employee's spouse and dependent children.

Qualifying Events

[66]"Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the required amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

QUALIFYING EVENTS FOR EMPLOYEES

[67]Types of qualifying events for **employees** are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct".
- Reduction in the number of hours of employment.

QUALIFYING EVENTS FOR SPOUSES

Types of qualifying events for **spouses** are:

- Termination of the covered employee's employment for any reason other than "gross misconduct".
- Reduction in the hours worked by the covered employee.
- Covered employee's becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

QUALIFYING EVENTS FOR DEPENDENT CHILDREN

Types of qualifying events for **dependent children** are:

- Termination of covered employee's employment for any reason other than "gross misconduct".
- Reduction in the hours worked by the covered employee.
- Loss of "dependent child" status under the plan rules.
- Covered employee's becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

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SECTION FOUR

COBRA MADE EASY—YOUR RIGHTS AS AN EMPLOYEE

NOTICE AND ELECTION PROCEDURES

COBRA outlines procedures for employees and family members to elect continuation coverage and for employers and plans to notify beneficiaries. The qualifying events contained in the law create rights and obligations of employers, plan administrators, and qualified beneficiaries.

Qualified beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

NOTICE PROCEDURES

GENERAL NOTICES

An initial general notice must be furnished to covered employees, their spouses and newly hired employees informing them of their rights under COBRA and describing provisions of the law.

COBRA information also is required to be contained in the Summary Plan Description (SPD) which participants receive. ERISA requires that SPD's containing certain plan information and summaries of material changes in plan requirements be furnished to participants in modified and updated SPD's. Plan administrators must automatically furnish the SPD booklet 90 days after a person becomes a participant or beneficiary or

within 120 days after a person becomes a participant or beneficiary or within 120 days after the plan is subject to the reporting and disclosure provisions of the law.

SPECIFIC NOTICES

Specific notice requirements are triggered for employers, qualified beneficiaries and plan administrators when a qualifying event occurs. Employers must notify plan administrators when a qualifying event occurs. Employers must notify plan administrators within 30 days of an employee's death, termination, reduced hours of employment, entitlement to Medicare or a bankruptcy. Multi-employer plans may provide for a longer period of time.

[68]The employee, retiree or family member should notify the plan administrator within 60 days of events consisting of divorce or legal separation or a child's ceasing to be covered as a dependent under plan rules.

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18 month period of COBRA coverage. These beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.

Plan administrators, upon notification of a qualifying event, must automatically provide a notice to employees and family members of their election rights. The notice must be provided in person or by first class mail within 14 days of receiving information that a qualifying event has occurred.

There are two special exceptions to the notice requirements for multi-employer plans. First, the time frame for providing notices may be extended beyond the 14 and 30 day requirements if allowed by plan rules. Second, employers are relieved of the obligation to notify plan administrators when employees terminate or reduce their work hours. Plan administrators are responsible for determining whether these qualifying events have occurred.

ELECTION

The election period is the time frame during which each qualified beneficiary may choose whether to continue health care coverage under an employer's group health plan. Qualified beneficiaries have a 60 day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.

A covered employee or the covered employee's spouse may elect COBRA coverage on behalf of any other qualified beneficiary. Each qualified beneficiary, however, may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a qualified beneficiary prior to the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

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SECTION FIVE
COBRA MADE EASY—COVERED BENEFITS

Qualified beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation coverage.

For example, a beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under single or multiple plans maintained by the employer. Assuming a qualified beneficiary had been covered by three separate health plans of his former employer on the day preceding the qualifying event, that individual has the right to elect to continue coverage in any of the three health plans.

If a plan provides both core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

Beneficiaries may change coverage during periods of open enrollment by the plan.

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SECTION SIX

COBRA MADE EASY—DURATION OF COVERAGE

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage **begins** on the date that coverage would otherwise have been lost by reason of a qualifying event and **end** when:

- The last day of maximum coverage is reached.
- Premiums are not paid on a timely basis.
- The employer ceases to maintain any group health plan.
- Coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary.

Special rules for disabled individuals may extend the maximum periods of coverage. If a qualified beneficiary is determined under title II or XVI of the Social Security Act to have been disabled at the time of a termination of employment or reduction in hours of employment and the qualified beneficiary properly notifies the plan administrator of the disability determination, the 18 month period is expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to qualified beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Some plans allow beneficiaries to convert group health coverage to an individual policy. In this case, you must be given the option to enroll in a conversion health plan.

You usually must enroll in the plan within 180 days before your COBRA coverage ends.

The premium is generally not at a group rate. The conversion option, however, is not available if you end COBRA coverage before reaching the maximum period of entitlement or it is unavailable under the plan.

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SECTION SEVEN

COBRA MADE EASY—PAYING FOR COBRA

[69][70]Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 percent of the costs to the plan for similarly situated individuals who have not incurred a qualifying event. Premiums reflect the **total** cost of group health coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus two percent for administrative costs.

[71]For disabled beneficiaries, the premium may be increased after 18 months to 150 percent of the plan's total costs of coverage for the last 11 months of continuation coverage.

Premiums due may be increased if the costs to the plan increase but generally must be fixed in advance of each 12 month premium cycle. The plan must allow you to elect to pay premiums on a monthly basis if requested by you.

[72][73]The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment must cover the period of coverage from the date of COBRA election retroactive to the date of the qualifying event. Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30 day grace period for payments. No payment, however, need be made earlier than 45 days after the date of the election.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January 1st and coverage for January could not be canceled if payment is made by January 31st.

Premiums for the rest of the COBRA period must be made within 30 days of the due date for each such premium or such longer period as provided by the plan.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to deductibles, catastrophic and other benefit limits.

8

SECTION EIGHT

COBRA MADE EASY—CLAIMS PROCEDURES

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures are to be included in the SPD booklet.

You should submit a written claim for benefits to whomever is designated to operate the health plan (employer, plan administrator, etc.). If the claim is denied, notice of denial must be in writing and furnished generally within 90 days after the claim is filed. The notice should state the reasons for the denial, and any additional information needed to support the claim and procedures for appealing the denial.

You have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the plan:

- Provides for a special hearing, or
- The decision must be made by a group which meets only on a periodic basis.

Contact the plan administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices. There can be charges of up to 25 cents a page for copies of plan rules.

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SECTION NINE

COBRA MADE EASY—ROLE OF THE FEDERAL GOVERNMENT

Continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private sector health plans. The United States Public Health Service administers the continuation coverage law as it affects public sector health plans.

The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements.

The Internal Revenue Service, which is in the Department of the Treasury, is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums. Both Labor and Treasury share jurisdiction for enforcement.

The U.S. Public Health Service, located in the Department of Health and Human Services, has published the Title XXII of the Public Health Service Act entitled "Requirements for Certain Group Health plans for Certain State and Local Employees".

Federal employees are covered by a law similar to COBRA. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

Conclusion

[74]Rising medical costs have transformed health benefits from a privilege to a household necessity for most Americans. The COBRA law creates an opportunity for persons to retain this important benefit.

Workers need to be aware of changes in health care laws to preserve their benefit rights. A good starting point is reading your plan booklet. Most of the specific rules on COBRA benefits can be found there or with the person who manages your plan. Be sure to periodically contact your health plan to find out about any changes in the type

or level of benefits offered by the plan.

QUIZ QUESTIONS PART III COBRA

1. Someone who qualifies for COBRA is referred to as a:
(a) Continuation coverage beneficiaries
(b) Benefit beneficiary
(c) **Qualified beneficiaries (Page 97)**
(d) Beneficiary recipients

2. How many days does one have to make the initial premium payment for COBRA following the election of COBRA by the qualified beneficiary?
(a) 10 days
(b) 30 days
(c) 45 days (Page 105)
(d) 60 days

3. Once entitled to COBRA benefits, you have _____ days to accept coverage or lose all rights to benefits.
(a) 10
(b) 30
(c) 50
(d) 60 (Page 100)

4. Which of the following can make an employee ineligible for COBRA coverage:
(a) Quitting
(b) Reduction in employee's pay
(c) Gross misconduct (Page 98)
(d) Changing job titles

5. When COBRA is elected, the premium increase cannot exceed which of the following percentages:
(a) 102% (Page 105)
(b) 103%
(c) 104%
(d) 105%

PART IV

LIFE CONCEPTS

1

THE LIFE INSURANCE POLICY

7576Life insurance is a contract between an individual and an insurance company. In this contract, the insurance company agrees to pay a stated amount of money to a beneficiary, under certain conditions, in exchange for a sum of money called the premium. It is important to note that a life insurance policy is in fact a legal contract. It is an agreement between two parties to do something in exchange for the premium that is paid to the company.

The Uses of Life Insurance

Life insurance is primarily used to function in personal and family situations. As a rule, a person's death creates an immediate need for money. The following is a list of some of the needs that might be created from an individual's death.

- Expenses created by final illness.
- Burial and funeral expenses.
- Debts due at time of death.
- Costs to administer the estate.
- Federal and state death taxes.
- Inheritance taxes.

Money may also be needed to provide for the following:

- Payoff mortgage or purchase a new home.
- Provide an education for children.
- Meet unexpected financial needs.

Life insurance can also provide benefits for business situations. Here are a few examples:

- Loss caused by death of a key employee.
- Collateral for loans.
- A business insurance fund.

- Buy-out business interest of a deceased owner.
- Fringe benefits for employees.
- Fund qualified retirement plans.

Life Insurance as a Property

Few people consider life insurance as property. Is it possible for a premium payment of $100.00 to create an immediate estate or property valued at $250,000.00? That is possible with life insurance. Here are some advantages of life insurance as property:

- As an asset, it is very secure.
- There is no managerial care.
- It can be purchased in any desired amount.
- It provides a reasonable rate of return.
- Proceeds are payable immediately.
- Policy owner chooses the method of payment for premiums.

The Life Insurance Application

[77]*THREE PARTIES TO AN APPLICATION*

[78]A life insurance application contains three parties:
- The proposed insured.
- The applicant.
- The policyowner.

[79]THE PROPOSED INSURED

The person whose life is being insured by the life insurance policy.

THE APPLICANT

[80]The person that is making application to the insurance company for the life insurance and may or may not be the proposed insured.

THE POLICYOWNER

The person that usually pays the premiums and the person who retains all rights to any values or options contained in the policy.

DEFINITION OF AN APPLICATION

In order for a person to purchase life insurance they must make a request to the insurance company of their choice. The form on which this request is made is known as an application.

Most companies now require that the proposed insured be physically present in front of the agent while the questions on the application are being filled out. The application is crucial in that it provides the data that the underwriters and insurance company will use to determine if a policy will be issued.

When the proposed insured signs the application, he is making a formal request to the company that a policy be issued on his life. In addition, the signature on the application indicates that the information is true and correct to the best of his knowledge.

MINOR APPLICATIONS

[8182]In most states, a person is not considered an adult until 18 years of age. As a rule, minors are not permitted to enter into contracts. However, life insurance is the exception in that a person is a minor only until age 15. In the event that the proposed insured is younger than age 15 one of the following persons must sign the application on behalf of that child:

- The mother or father of the minor child.
- A court appointed safeguard for the well-being of the minor.
- The grandparents of the minor child.

CORRECTING APPLICATIONS

[83]Should it be necessary to correct a mistake regarding information given on the application, the proposed insured must initial any and all changes on that application.

[84]Mistakes on the application can be costly, especially when the company is paying an outside reporting service to conduct an inspection. Any changes that are made on a completed application must have the approval of the proposed insured. The normal procedure is to return the incorrect application to the agent who in turn will take it to the insured to have the errors initialed.

INCORRECT/INCOMPLETE APPLICATIONS

Should an application contain incorrect or incomplete information it should not be taken lightly. In the event that the company has already made a decision on a risk, based on these inaccuracies, it could result in a serious loss.

[85]Should the error be discovered after the issuance of a policy the company can cancel or rescind the entire contract from the date of issue. Of course, this must take place before the incontestability clause of the contract takes effect.

REPRESENTATIONS/WARRANTIES

[8687]All statements on applications are regarded as representations. When an individual makes a statement, he believes to be true, he is making a representation of the truth. While it is possible that a representation may be found to be untrue, a person who makes a representation believes it to be true.

[88]A warranty on the other hand is a statement made with such absolute certainty that it is guaranteed to be true. No statement on an application is considered a warranty.

Misrepresentation - A false representation can be defined as a misrepresentation.

FRAUD

[89]There are three elements necessary to constitute fraud:

- A person makes an intentional misrepresentation of what is known to be a material fact.
- The person has intent to gain advantage.
- A person relies upon a second party that suffers a loss.

There can be no fraud unless there is intent.

CONCEALMENT

Concealment is close to misrepresentation when it comes to information included on a policy application.

While misrepresentation, as stated earlier, is something known to be untrue,

concealment is withholding of facts that the applicant should have given to the insurance carrier at the time of application.

CONDITIONAL RECEIPT

Always collect the first full premium from the applicant at the time of application. The receipt that is located at the bottom of the application is called a conditional receipt. The word "conditional" is very important because the agent is not guaranteeing that the policy will be issued. Issuance of the policy is subject to the full approval of the insurance carrier.

The conditional receipt serves two functions:

- It acknowledges the first full premium.
- It states in very clear terms that the policy acceptance is subject to the approval of the carrier.

SHOULD THE INSURED DIE

In the event the proposed insured dies before the policy is issued, according to the conditional receipt, the following will take place:

- If the insurance carrier would have issued the policy to the proposed insured, had they still been living, then the proceeds would be paid to the beneficiary.
- Should the above not be the case and the claim is denied the premium will be returned to the beneficiary.

POLICY EFFECTIVE DATE

Full protection takes effect as of the policy effective date. The policy effective date also begins the date on which the contestable period begins to run. The policy effective date also is the date on which the suicide clause begins to run.

There are three reasons why the policy effective date is important:

- Insurance begins on this date.
- The contestable period begins on this date.
- The suicide clause begins on this date.

BACKDATING POLICIES

Policies can be backdated, as a rule, a maximum of six months. Most companies allow backdating for several reasons:

- Ten-times backdating can save an age by one year of the proposed insured and this can result in a lower premium for the proposed insured.
- Backdating is useful to assist the policy-owner in coordinating dates to fit their income pattern. Perhaps the backdating may change the policy to closely match pay days.
- Occasionally some policy forms have minimum and maximum age limits and backdating may be able to put the applicant's age into the window of acceptable age limits.

How Much Life Insurance Do I Need?

The majority of families in America are inadequately insured. As a rule, individuals should carry life insurance equal to five or six times annual earnings.

USING THE NEEDS APPROACH TO LIFE INSURANCE

The following are a few of the more popular applications for life insurance to provide for a need that occurs as a result of a death.

ESTATE SETTLEMENT NEEDS

Cash is needed for burial expenses, installment debt, administration expense, estate tax and in some cases expense for the last illness.

READJUSTMENT PERIOD

Following the death of a head of family there is usually a one to two year period in which the family needs to continue to receive the same amount of income it would have received had the head of the family lived.

DEPENDENCY PERIOD

This period usually follows the readjustment period in that it lasts until the youngest child of the family reaches age 18.

BLACKOUT PERIOD

[90]This is the period when social security benefits to a surviving spouse are temporarily terminated. This occurs when the youngest child reaches age 16 and will not resume until the surviving spouse reaches age 60.

SPECIAL NEEDS

Special needs may consist of a fund to pay off the mortgage, education fund for the children's education or an emergency fund for unexpected expenses.

RETIREMENT FUND

The head of a family may also wish to provide the surviving spouse with funds for retirement.

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TYPES OF LIFE INSURANCE

Types of Life Insurance and What is Available

- Term Insurance.
- Whole Life.
- Universal Life.
- Variable Life.
- Adjustable Life.
- Modified Life.
- Family Life.

TERM INSURANCE

Term Insurance is the most basic type of life insurance. Some of its characteristics:

- [91]Term Insurance provides only temporary protection from one to 20 years or until the insured reaches a specified age. Should the insured be alive at the end of the term period the protection expires.
- Term Insurance has no cash value or savings element. It is strictly pure protection.
- Term Insurance can be renewable and convertible. Renewable means that you can continue the coverage for additional periods without proof of insurability. As a rule, the premium increases each time the policy is renewed based on the age of the insured at the time of renewal. Convertible means that the term policy can be exchanged for some type of cash value insurance without proof of insurability.

Term Insurance comes in a variety of policies. They are:

A. YEARLY RENEWABLE TERM - This is issued for a one year period and the policy owner has the right to renew coverage for successive one-year periods.

B. **FIVE, TEN, FIFTEEN, OR TWENTY YEAR TERM** - Term insurance can be purchased for a specific period such as five, ten, fifteen or twenty years, and in some instances even longer periods. The premium remains level during the policy term and should the policy be renewed at the end of the term the premium will increase.
C. **TERM TO AGE SIXTY-FIVE OR SEVENTY** - In this instance the term insurance is provided to a stated age. The premium remains level during the policy term and the insurance expires when the stated age is attained. As a rule the insured has the right to convert this term insurance to a cash value policy; however the policy must be converted sometime prior to the expiration date.
D. **DECREASING TERM** - With a decreasing term policy although the premiums remain level during the policy term the face amount of insurance gradually decreases over time. For example, a $100,000.00 policy issued for a decreasing term of 30 years could decline to $50,000.00 by the end of the twentieth year and zero by the end of the thirtieth year.
E. **REENTRY TERM** - This is a new type of term insurance that some companies make available. With this policy, the premiums are based on a low-rate schedule. Under the terms of this policy the insured must demonstrate evidence of insurability, usually everyone to five years.

WHOLE LIFE

Whole Life Insurance has level premiums and will provide protection until age 100.

Some examples of Whole Life Insurance are:

A. **ORDINARY LIFE INSURANCE** - Ordinary Life Insurance is a form of Whole Life. Lifetime protection is provided until age 100 and the premiums remain level. In the event the insured is still alive at age 100 the full face amount will be paid without death having to occur.
B. **LIMITED-PAYMENT LIFE INSURANCE** - This is another form of Whole Life Insurance. Although the premiums are level they are only paid for a certain number of years. After this payment period, the policy becomes paid up. Limited-Payment policies can be issued for ten, twenty or thirty years. A policy that is paid up at age sixty-five or seventy is still available. The premiums for a Limited-Payment policy are higher than an ordinary life insurance policy but the cash value is also higher.
C. **ENDOWMENT INSURANCE** - This is the third basic type of Whole Life Insurance. An endowment pays policy proceeds to the named beneficiary if the insured dies within a certain period. Should the insured survive to the end of the stated period, the policy proceeds are paid to the policyowner.

UNIVERSAL LIFE

Universal policies are sold as investments that combine insurance protection with savings. Actually, a Universal Life Policy can be defined as a flexible premium deposit

fund that is combined with monthly renewable term insurance.

Here's how it works:

- First, an initial specific premium is paid. Then expenses are deducted from the gross premium and the balance is credited to the policy's initial cash value.
- Second, a monthly mortality charge is conducted from the cash value to pay for the pure insurance protection.
- Finally, the remaining cash value is then credited with interest at a specified rate.

[92]Universal Life has the following basic characteristics:

- There are two forms available.
- Protection, savings, and expense components are separated.
- There is a stated investment return.
- Considerable flexibility.
- Cash withdrawals are permitted.

VARIABLE LIFE

With a Variable Life Insurance policy, the face amount of insurance varies according to the investment experience of a separate account that is maintained by the insurer. This is the perfect solution to the fact that inflation can quickly erode the real purchasing power of life insurance. Under the Variable Life Insurance policy, the premiums are invested in equities or other investments. Should the investment experience be favorable the face amount of insurance is increased.

However, should the experience be unfavorable the amount of insurance is reduced. In no event can the amount of insurance be reduced below the original face amount. The Variable Life Insurance policy was designed to maintain the real purchasing power of the death benefit.

ADJUSTABLE LIFE

This type of Whole Life policy permits changes to be made in the following areas:

- Amount of life insurance.
- Period of protection.
- Amount of premium.
- Duration of premium-paying period.

This type of insurance is frequently called "Life Cycle" insurance because policy changes may be made to conform to different periods in the insured's life. Within certain limits, the policyowner can make the following adjustments as the situations warrants:

- Reduce or increase the amount of insurance.
- Shorten or lengthen the period of protection.
- Increase or decrease the premiums paid.
- Lengthen or shorten the period for paying of premiums.

A cost of living provision can also be attached to the Adjustable Life Policy and this will in fact maintain the real purchasing power of the insurance.

MODIFIED LIFE

This is a type of Whole Life Policy in which the premiums are reduced for an initial period of three to five years and then the premiums increase thereafter. The initial or reduced premium as paid in the beginning is slightly higher than Term Insurance rates but substantially lower than the premium paid for an ordinary Life Policy issued at the same age.

There are different types of Modified Life Insurance:

One version of Term Insurance is used for the first three to five years and then automatically converts into an ordinary life policy at a premium that will be higher than what would have been paid for a regular ordinary Life Policy issued at the same age.

In another version of Term Insurance, the approach is to redistribute the premiums by charging lower premiums during the early years of the policy but higher premiums thereafter.

Modified Life Insurance can be attractive to individuals expecting increases in income.

FAMILY LIFE

Family Life is a Whole Life Policy designed to insure all family members in one policy. This policy is sold in units that state the amount and types of life insurance on the family members. One unit for example may consist of the following:

- $5,000.00 of Ordinary Life on the head of the family.
- $2,000.00 of Term to sixty-five on the spouse.
- $1,000.00 of Term Insurance on each child up to stated age.

As a rule, Term Insurance under the Family Life Policy can be converted to some form of

permanent insurance, typically the children's protection can be converted up to five times the face amount without proof of insurability.

Finally, there is no additional premium if another child is born and newborn children are usually automatically covered after a fifteen-day waiting period.

3

LIFE INSURANCE COMPANIES

Life insurance companies can be organized in several ways; however, most are organized either as stock companies or as mutual companies.

A **STOCK LIFE INSURANCE COMPANY** gets its name from its basic ownership characteristic. Its stockholders - people who have bought stock in the company, own a stock company. The stockholders may or may not also be policyowners. The sole function of the stockholders is to elect a board of directors who in turn will guide the operation of the company. If the company is successful financially, the stockholders will receive dividends that are paid for each share of stock owned. A stock life insurance company, like all other corporations, is in business to make a profit for the stockholders.

A **MUTUAL INSURANCE COMPANY** is also a corporation, and it also derives its name from its basic ownership characteristic. Unlike a stock company that is owned by its stockholders, a mutual company has no stockholders. Control in a mutual company rests with the policyowners who "mutually" own the company. The policyowners elect a board of directors, and any "profits" are returned as dividends to the policyowners in the form of reduced costs for insurance. It should be mentioned here that dividends from a mutual company are not profits in the mercantile or commercial sense but rather the return of an "overcharge" of premium.

For example, a mutual life insurance company might sell life insurance at one specific age for $20 per $1,000 of face amount. Once a dividend has been declared, each policyowner might then receive credit on the premium statement in the amount of $2 per $1,000. Thus, the resultant cost for the insurance is $18 per $1,000 of face amount.

While not true in every case, mutual insurance companies usually issue "participating" life insurance policies. The term participating means that if the company realizes a savings in death claims due to a lower mortality rate, or an increase in the interest earned, or if it realizes some efficiency in its operation, which reduces expenses, these savings or "profits", is passed along to the policyowner in the form of policy dividends. Thus, the policyowner in a mutual life insurance participates in any savings or "profits" enjoyed by the company.

Never imply to a client that a stock company is better from an organizational standpoint than a mutual company, or vice versa, or that participating policies are

better than non-participating ones. Both types of companies and both policies have merit.

Before any life insurance company can sell insurance in any state, it must be licensed to sell insurance or, as it is called, *admitted* to that state. An insurer that is admitted to a state is authorized to do business in that state. If an insurer is not admitted to a state, it is unauthorized to do business in that state.

Another type of insurer with which you should be familiar is the fraternal benefit society, also known as a "fraternal". A fraternal insurer is a social and benevolent organization that provides, among other services, life insurance benefits for members. Membership in such an organization is often based on factors such as a person's nationality, religion, or occupation, but whatever the criterion for membership, keep in mind that fraternals have functions other than providing insurance.

Each state defines and provides for the regulation of fraternal benefit societies in its insurance laws. But, although the exact definition of a fraternal may differ from state to state, an organization usually must have certain characteristics to qualify as a fraternal benefit society. First, the organization generally must exist only for the benefit of its members and of their beneficiaries and be non-profit. Second, it must be organized without capital stock.

A third characteristic is that the society usually is organized on a lodge system. This means that the organization must have local lodges or chapters that hold regular meetings to carry on the activities of the society. Ritualistic ceremonies are often a part of those activities.

Finally, the organization must have a representative form of government. There must be a governing body chosen by the members directly or by delegates, in accordance with the organization's bylaws or constitution.

GOVERNMENT INSURANCE PROGRAMS have been established for a variety of reasons throughout history. Social insurance programs have been created to allow the government to make compulsory a program lacking equity in order to cover fundamental risks and to redistribute income. Government insurance programs have been created when private insurers would have been subjected to adverse selection or were incapable of meeting society's needs.

By its administration of various Federal insurance programs, the U.S. government has become the largest insurer in the world. These various programs include Social Security, Medicare, and the Railroad Retirement, Disability, and Unemployment Programs.

RECIPROCALS are groups of individuals (called "subscribers") who are insured under an arrangement where each subscriber is both an insured and an insurer. In other words, the other members of the group insure each subscriber. However, the liability of each subscriber is limited.

The administrator of the reciprocal is the "attorney-in-fact". He or she is granted this power by the subscribers through a broad power of attorney, and receives a percentage of the gross premiums paid by the subscribers. Other than this payment to the attorney-in-fact and administrative expenses, the cost to the reciprocal is limited to the amount of the losses that occur. Any unused premiums are returned to the subscribers.

LLOYD'S OF LONDON is a name familiar to many in the insurance industry. However, perhaps the most interesting fact about Lloyd's of London is that it is not an insurer nor does it issue policies. Rather, Lloyd's of London is an association of members who write insurance for their own accounts. The New York Stock Exchange bears the same relationship to stock purchases as Lloyd's bears to the purchase of insurance.

Like the Stock Exchange, Lloyd's provides quarters for its members as well as procedures for business transactions. Though neither organization engages in trade, both provide facilities and rules that govern how its members will pursue trade. In addition, Lloyd's maintains worldwide underwriting information and a complete record of losses. It also aids in loss settlements and supervises salvage and repairs throughout the world.

At Lloyd's, an insurance transaction begins when a proposal is placed before the underwriting members, or their agents, by a licensed broker. The broker prepares the policy and submits it to the Policy Signing Office where the policy is examined. If the policy conforms to agreed-upon rules, it is submitted to the underwriters. Those underwriters who wish to participate in the policy affix their signatures or "underwrite" the risk. American Lloyd's associations operate under the same principles and methods as Lloyd's of London.

FINANCIAL STATUS OF INSURERS

Changing economic conditions and highly publicized failures of financial institutions (from savings and loan companies to insurance companies) have focused much attention on the financial status of private insurers. Independent rating services provide ratings consumers can use to measure the status of a company and compare it to others.

The two most popular rating services are *A.M. Best Company* and *Standard and Poors*. *A.M. Best Company* looks at profitability, leverage, and liquidity and assigns ratings from A++ (Superior) to C and C- (Fair) and below. *Standard and Poor's* focuses on the claims paying ability of an insurer and offers ratings from AAA (Superior) to D (Insurers placed under an order of liquidation).

In most cases, insurance companies pay a fee to be rated by a rating service. Other rating services include *Moody's Investors Service* (measuring financial strength), and *Duff and Phelps* (measuring claims paying ability and managerial soundness). In addition to private rating services the National Association of Insurance Commissioners

measures company performance and prepares analytical reports as part of the Insurance Regulatory Information System (IRIS). Agents have access to IRIS ratios that serve as indicators of a company's financial condition in various areas.

4

POLICY PROVISIONS OF LIFE INSURANCE POLICIES

Most agents have never read the required policy provisions that are contained in every policy sold. It is important to note that policy provisions are in fact contractual provisions and govern what the policyowner can and cannot do with the policy.

Here is an overview of some of the policy provisions:

- Ownership Clause.
- Entire Contract Clause.
- Incontestable Clause.
- Suicide Clause.
- Grace Period.
- Reinstatement Clause.
- Misstatement of Age.
- Beneficiary Designation.
- Change of Plan Provision.

OWNERSHIP CLAUSE

The owner of a Life Insurance Policy can be the applicant, the insured, or the beneficiary. In most cases, the applicant and insured are the same person. Under the Ownership Clause, the policyowner possesses all contractual rights in the policy while the insured is still alive. These rights include the selection of a settlement option, naming and changing the beneficiary designation, election of dividend options, and other rights. These contractual rights typically can be exercised without the beneficiary's consent.

In addition, the Ownership Clause provides for a change in ownership. The policyowner can designate a new owner by filling out an appropriate form with the company. The insurer may require that the Life Insurance Policy be endorsed to show the name of the new owner.

ENTIRE CONTRACT CLAUSE

The Entire Contract Clause states that the Life Insurance Policy and attached application constitute the complete contract between the insurer and policyowner. No statement can be used by the insurer to void the policy unless the statement is a material misrepresentation and is part of the application. In addition, the terms of the policy cannot be changed by any officer of the company unless the policyowner agrees to the change.

INCONTESTABLE CLAUSE

Under the Incontestable Clause, the company cannot contest the policy after the policy has been in force two years during the insured's lifetime. The insurance company has two years to discover any irregularities in the contract, such as a material misrepresentation or concealment. If the insured dies after that time, the death claim must be paid.

For example, if John conceals a cancer operation when the application is filled out and dies after expiration of the incontestable period, the death claim WILL be paid.

The purpose of the incontestable clause is to protect the beneficiary if the insurance company tries to deny payment of the death claim years after the policy is issued. Since the insured is dead, allegations by the insurer concerning statements made in connection with the application cannot be easily refuted. After the incontestable period has expired, with few exceptions, the company must pay the death claim.

SUICIDE CLAUSE

A typical Suicide Clause states that the face amount of the policy will not be paid if the insured commits suicide within two years after the policy is issued. The only payment is a refund of the premiums. The purpose of the Suicide Clause is to reduce adverse selection against the insurer by providing the insurer some protection against an individual who purchases a Life Insurance Policy with the intention of committing suicide.

GRACE PERIOD

[93]A Grace Period is another important contractual provision. A typical Grace Period gives the policyowner thirty-one days to pay an overdue premium. The life insurance remains in force during the Grace Period. If death occurs during the Grace Period, the overdue premium usually is deducted from the policy proceeds.

REINSTATEMENT CLAUSE

If the premium is not paid during the grace period, a life insurance policy may lapse for nonpayment of premiums.

The Reinstatement Clause allows the policyowner the right to reinstatement of a lapsed policy under certain conditions:

- The insured must provide evidence of insurability, a condition that insurers often waive for lapses of less than two months.
- All overdue premiums plus interest must be paid.
- A policy loan must be repaid or reinstated.
- The policy has not been surrendered for its cash value.
- The lapsed policy must be reinstated within five years.

If the policyowner wishes to continue the same type of life insurance coverage, it usually is more economical to reinstate a policy than to buy a new one. This is because a new policy is likely to have a higher premium, since it will be issued when the insured is older.

MISSTATEMENT OF AGE

The insured's age may be misstated in the application. Under the Misstatement Clause, the amount paid is the amount of life insurance that the premium would have purchased at the insured's correct age.

> ***Example:*** Assume that Mary's correct age is thirty but is incorrectly recorded in the application as age twenty-nine and the premium for an ordinary life application at age twenty-nine is $20.00 per $1,000.00 and $21.00 per $1,000.00 at age thirty. If Jane has $15,000.00 of Ordinary Life Insurance and dies, only 14/15ths of the proceeds will be paid, or $14,000.00.

BENEFICIARY DESIGNATION

The beneficiary is the person or party named in the policy to receive the policy proceeds. There are numerous Beneficiary Designations in life insurance such as:

- The Primary Beneficiary is the first party who is entitled to receive the proceeds at the insured's death.
- The Contingent Beneficiary is the beneficiary entitled to proceeds if the primary beneficiary is not alive.
- A Revocable Beneficiary designation means that the policyowner has the right to change the Beneficiary Designation without the beneficiary's consent.

- [9495]An Irrevocable Beneficiary designation means that the policyowner cannot change the beneficiary without the irrevocable beneficiary's consent.
- A Specific Beneficiary designation means that the beneficiary is named and can be identified. For example, Martha Smith may be specifically named to receive the policy proceeds if her husband should die.
- A Class Beneficiary designation means that a specific individual is not named but is a member of a group to whom the proceeds are paid. One example of a class Beneficiary Designation would be "children of the insured."

CHANGE OF PLAN PROVISION

The Change of Plan Provision allows the policyowner to exchange the present policy for a different one. If the change is to a higher premium plan, such as exchanging an ordinary life policy for an endowment at age sixty-five, the policyowner must pay the difference in cash values between the two contracts plus interest at a stipulated rate. Since the net amount at risk is reduced, evidence of insurability is not required. Some insurers also allow the policyowner to change to a lower premium policy, such as exchanging an endowment contract for an ordinary life contract. The insurer refunds the difference in cash values to the policyowner. However, evidence of insurability is required since the net amount at risk is increased.

5

PREMIUMS

SINGLE AND PERIOD PREMIUMS

There are two basic ways to purchase a life insurance policy. The first is by paying the entire cost in one lump-sum payment. This is the "single premium" method. The second method of purchasing a policy is by the payment of periodic premiums. Rather than making a single payment for the insurance, the policyholder makes annual, semi-annual, or more frequent payments.

A single premium policy is seldom purchased because of the large lump-sum payment that is generally required. The typical policyholder finds the periodic payments much easier to make.

A second reason why single premium policies are seldom purchased concerns the cost of the policy if the insured dies in the early years of the contract. In this situation, the amount paid for the insurance under the periodic method will be less than the single premium amount.

PARTS OF THE PREMIUM

There are three basic factors that affect the premium charged for a life insurance policy. The first is "mortality". Mortality refers to how many people within a given age group will die each year. The second factor is interest. Interest refers to the earnings the company receives on the premiums dollars it invests. The third factor is expenses. Expenses are, of course, all of the costs the company incurs in selling, issuing, and servicing its policies.

As an individual grows older, the cost of insurance increases., since growing older increases the chance of death. Insurance companies use mortality tables and other statistics to determine the number of insureds, within each age group, who will die each year. What happens if more people died in a year than the company predicted? The company will pay out more for death claims than was anticipated.

Another factor that influences the cost of insurance is the interest income that the company earns from its investments. Insurance companies receive millions of dollars each month in premium dollars. And, while each company has death claims and other expenses, the costs for these claims and expenses should be less than the total

premiums received.

By law, a life insurance company is permitted to invest this extra money to obtain additional revenue in the form of interest. Most life insurance companies invest in stocks, bonds, construction projects, and in a variety of other ventures designed to provide a return on their investment. The principal, as well as the interest earned, on these investments establishes a fund to pay all death claims as they occur and also helps to offset the cost of insurance.

In addition to savings which may result from lower than anticipated mortality, an insurance company may also realize income from investments. Naturally, the insurance company is not permitted to keep all the money it receives. Expenses, of course, have to be paid. And, in addition to death claims, expenses include such items as:

- Agent's commissions.
- Salaries.
- Advertising.
- Physical examinations.
- Legal costs.
- Policy issue costs.

Here is a very simple formula that indicates how these factors affect premium costs:

Death claims + other expenses - interest earned = premium to be charged.

Keep in mind that no company determines the premium to be charged by the simple method we have described above. This simplified approach merely describes the important relationship between these factors.

NET AND GROSS PREMIUM

The premium that a company charges for a life insurance policy is called the "gross" premium. When a company is calculating the premium for a policy, it begins by determining the "net" premium. Once the net premium has been computed, the company then adds the expense factor, or "loading", to this net premium to arrive at the gross premium.

MORTALITY AND INTEREST FACTORS

Two basic factors go into the calculation of the net premium—the mortality and interest factors.

An insurance company cannot predict when a particular insured will die. However, by using the mathematical concept of probability, the company can predict, with a great deal of accuracy, the number of insureds that will die each year. This prediction of

future mortality is made on the basis of past mortality experience and assumes that future experience will parallel past experience. But, if past mortality is to be a reliable basis for prediction, accurate data must be kept on a large group of representative individuals for a sufficiently long period of time.

Information on past mortality is analyzed and arranged in a table, called the "mortality table" which shows probable death or mortality rate at a specific age. Beginning with a given number of individuals at a given age, the mortality table shows the number of people out of the group who probably will die at each age and the number who will survive.

Even if the mortality rates and the mortality table are accurate, a company that wants a reliable estimate of future mortality must apply the rates to a large enough group of individuals for the "law of averages" to operate.

LEVEL PREMIUM CONCEPT RESERVES

Once the net single premiums are computed, the company then converts that premium into a "net level premium" since few policies are purchased by the single premium method

The early renewable term premium, also called a "natural or step-rate" premium, increases each year as the insured ages and the risks of mortality increases. The premium rises rather gradually during the younger ages, but increases sharply for the older ages. As a result, the premiums can become prohibitively expensive for most insureds at the older ages.

To overcome the problem of annually increasing premiums, companies develop the level premium plan. With this plan, the premium remains the same during the premium payment period rather than increasing as the probability of death increases. This level premium is higher than the natural, or yearly renewable term; premium in the early years of the policy but is lower than the natural premium in the later years.

Under the natural premium plan, the net premium charged policyowners each year is just sufficient to pay the expected claims for the year. This is not true for the level premium plan. The net level premium payments made in the early years of the contract are greater than the amount needed to pay the policy claims during those years.

By investing the excess part of the premium in the early years, the company accumulates funds to cover the deficiency that occurs in the latter years. These funds, which the company holds to meet future policy obligations, constitute the policy reserve or simply the "reserve". The reserve is the amount that, together with future premiums and interest earnings, will be sufficient for the company to pay all future policy claims, based on the company's mortality and interest assumptions. Thus, the reserve is a liability - future obligation to the company. Because a company's ability to

fulfill its contract obligations depends upon sufficient policy reserves, the state requires a company to maintain certain minimum reserves. [96]Most states now require that the insurance company become part of the legal reserve pool.

State laws specify the mortality table and the assumed rate of interest to be used in calculation of the legal minimum reserves. Because of these state regulations, reserves are often called "legal reserves".

INSURANCE AGE

Premiums charged for life insurance depend upon the insured's age. The mortality factor is one of the three basic elements of the premium and the mortality factor varies with an insureds age.

However, the age used to determine the premium is the insured's insurance age. The insured's insurance age may, or may not, be the same as his actual or chronological age.

A company may use one of two methods of determining an insurance age.

In the first method, an insured's insurance age is his age at the insured's nearest birthday. If the insured turned age 30 less than 6 months ago, the insured's age would be 30. However, if the insured's 30th birthday was more than 6 months ago, the insurance age would be 31 since the next birthday would be nearer than the last.

Although the nearest birthday is the more commonly used method, some companies may use the insured's last birthday to determine the insurance age. The insurance age under this method is the same as the insured's actual age, regardless of the number of months since his or her last birthday.

6

EXCLUSIONS AND RESTRICTIONS ON LIFE POLICIES

Although few exclusions or restrictions are placed on Life insurance policies the more common ones are:

- Certain activities that are considered dangerous such as flying, hang-gliding, auto racing or skydiving may either be excluded or covered if an additional premium has been paid.
- A Suicide Clause excludes payment of the face amount in the event of suicide within two years of the issue date.
- An Aviation Exclusion may be present in the policy and would exclude death coverage from an aviation accident other than as a passenger on a regularly scheduled airline.
- The War Exclusion is designed to control adverse selection during times of war and may be inserted to exclude payment if death occurs as a result of war.

PAYMENT OF PREMIUMS

The policyholder of a life insurance contract has a choice as to how they may pay premiums. Premiums can be paid annually, semiannually, quarterly, monthly direct or monthly bank draft.

The company usually offers a discount for paying the premiums annually. The most popular method of payment is monthly bank draft.

The method that causes the most lapses is quarterly followed by monthly direct billing. The method that best suits persistency is monthly bank draft followed by annually.

7

SETTLEMENT OPTIONS

When benefits are paid following the death of the insured the payments of benefits is referred to as Settlement of the Policy.

The following is an overview of the settlement options and then we will review them one at a time. They are:

- Lump sum settlement.
- Proceeds and interest.
- Fixed years installments.
- Life income.
- Joint life income.
- Fixed amount installments.
- Other mutually agreed methods.

LUMP SUM SETTLEMENT

This is when the beneficiary receives the policy proceeds in a single payment following the death of the insured.

PROCEEDS AND INTEREST

Under this option, the insurance company will hold the policy proceeds and make interest payments to the beneficiary.

The minimum interest rate is spelled out in the policy and the company may at its discretion to pay a higher rate. The beneficiary still has the right to withdraw all or part of the proceeds of the policy at any time.

FIXED YEARS INSTALLMENTS

With this option, the insurance company pays the proceeds in equal monthly payments. The recipient of the proceeds chooses the number of years for which payments will be made.

The amount received monthly depends on three factors:

- Policy proceeds.
- Number of years payments are to be made.
- Interest rate paid by the insurance company.

Again, under this settlement option, the beneficiary still has the right to withdraw all or part of the proceeds at any time.

LIFE INCOME

Under this settlement option, the beneficiary will receive equal monthly payments for the life of the beneficiary. The amount of monthly payments depends on four factors:

- Policy proceeds.
- Beneficiary's sex.
- Beneficiary's age at time payments begin.
- Period certain for which payments are guaranteed.

Should payments be guaranteed for a period certain, such as ten years, payments will be made for the specified number of years regardless or whether the beneficiary lives to the end of that period. Should the beneficiary die during the period certain payments will continue to the beneficiary's designated successor.

Example:

A beneficiary is going to receive $500.00 a month for 10 years certain. This means that should the beneficiary live the entire ten years he will receive $500.00 a month. After ten years there are no more benefits paid. However; if the beneficiary die in the sixth year, the remaining four years of $500.00 per month will go to his designated successor.

JOINT LIFE INCOME

When this option is chosen equal monthly payments will be made so long as either one or two payees is alive. This option may be used when a policyowner/insured contributes to the support of his or her parents. In the event of the insured's death, the parents, as beneficiaries, would receive monthly income for the rest of their lives.

The amount of the monthly benefits would depend on two factors that are:

- The policy proceeds.
- Parents' ages at the time they begin to receive benefits. However; under this option, the beneficiaries typically do not have the right to discontinue the monthly payments and receive the balance in a one-sum settlement.

FIXED AMOUNT INSTALLMENTS

Using this settlement option, the insurance company makes equal payments per month, or at longer intervals, in an amount chosen by the policyowner or beneficiary.

All proceeds held by the insurance company will earn interest. If the monthly payment is greater than the monthly interest earned, the balance of the proceeds held by the insurance company decreases each month until the total proceeds and interest due are paid out.

Under this option, the beneficiary may withdraw the unpaid balance at any time. If the beneficiary dies before the installments payments are completed, the unpaid balance is paid to the beneficiary's estate.

OTHER MUTUALLY AGREED METHOD

On occasion, a life insurance company may allow the policyowner to designate other payments methods if the insurance company agrees to them.

An example of this may be that the proceeds at interest are to be paid to the insured's spouse for the spouse's lifetime and, upon the spouse's death, a one-sum settlement is to be made to the insured's children.

8

NONFORFEITURE OPTIONS

Life insurance policies contain nonforfeiture options.

They are designed to give the insured ways in which he or she may gain continued value from a policy in the event the insured is unable to continue premium payments.

The five nonforfeiture options are as follows:

1. Cash Surrender Value
2. Reduced Paid-Up Insurance.
3. Extended Term Insurance.
4. Automatic Loan Provision.
5. Dividend Accumulations to Avoid Lapse.

CASH SURRENDER VALUE

A policyowner may surrender the policy and request that the company pay the cash surrender value of the policy, if any.

As a rule, most policies have no cash value whatsoever for the first two to three years.

The Cash Surrender Value usually consists of the following:

- The policy cash value.
- Cash value of paid up additions.
- Dividends.

The Cash Surrender Value can be reduced by any outstanding policy loans and accrued loan interest on outstanding policy loans.

It is important to know that all coverage ceases when the policy is cash surrendered. Payment is usually made in one lump sum and in some cases in accordance with one of the other policy settlement options already discussed.

REDUCED PAID-UP INSURANCE

Under this option the policyowner may request that the cash value of the policy be

used to keep a reduced amount of paid-up insurance in force under the same policy.

Usually the policy has a table contained in it that shows the amount of reduced insurance in any given year that the cash value that same year would purchase.

Although the policy has had its face reduced the policy will continue to earn cash value and pay dividends if applicable.

EXTENDED TERM INSURANCE

This option allows the same face amount of the policy to remain in effect for a specified number of years and days.

As with reduced paid-up insurance, the policy will contain a table showing how long in years and days the original face amount will remain in force during any given surrender year.

The length of time in years and days is calculated by taking the policy's cash surrender value, the insured's age and sex at the time premiums were discontinued and using that cash surrender value to purchase term insurance for a specified amount of years and days.

Under this option the policy does not continue to earn cash value or pay dividends if applicable.

AUTOMATIC PREMIUM PROVISION

[97]It is possible for the insured to authorize the insurance company to make an automatic loan from the policy's cash value to pay any premium not paid by the grace period.

DIVIDEND ACCUMULATIONS TO AVOID LAPSE

Should the policy pay a dividend, then the dividend accumulations may be applied to any premium not paid by the end of the grace period. In the event the amount of accumulated dividends is not enough to pay the entire premium, coverage will then be extended in proportion with the amount of premium paid by the accumulated dividends. As a result of this a new grace period will start at the end of extension coverage.

9

DIVIDEND OPTIONS

If a life insurance contract is a participating policy that means that the policyowner is entitled to an annual dividend paid by the insurance carrier. Participating policies affords the policyowner the opportunity to participate in the earnings of the insurance company through dividend payments.

The following are the ways in which a policyowner may use his or her dividends:

- Cash Payment.
- Reduction of Premium.
- Accumulation at Interest.
- Paid-up Additions.
- One-year Term.

CASH PAYMENT

Under this dividend option the insurance company sends the insured a check equal to the amount of the declared dividend payment.

REDUCTION OF PREMIUM

The premium due on the policy for the upcoming year will be reduced by the amount of the current year's declared dividend and the balance becomes the new premium due for the upcoming year.

ACCUMULATION OF INTEREST

The dividend may be held by the insurance company to accumulate with interest paid at the rate that is specified in the contract. The insured has the right to withdraw the accumulated dividends at any time. Should the accumulated interest and dividend be on deposit with the company at the time of the insured's death, the accumulated interest and dividend will be paid along with the policy proceeds.

PAID-UP ADDITIONS

This option enables the insured to receive additional amounts of life insurance by using the dividend to purchase paid-up additions. The additional insurance will be the same kind and subject to the same provisions as the original policy. Again, on the insured's death paid-up additions of insurance will be paid up along with the policy proceeds.

ONE-YEAR TERM

Some policies permit dividends to purchase one-year term coverage. The amount of the one-year term coverage would be added to the face amount of the base policy in the event of the insured's death.

10

LIFE INSURANCE POLICY RIDERS

In life and health insurance the word "rider" is used in lieu of endorsement. The effect is the same in that riders modify the coverage of the basic policy the same as an endorsement would.

The most commonly used riders in life insurance policies are:

- Waiver of Premium.
- Accidental Death and Dismemberment.
- Guaranteed Purchase Option.

WAIVER OF PREMIUM

This rider protects the insured in the event he becomes totally disabled. The waiting period usually is six months, and if the insured continues to be disabled after the six-month waiting period the premium payments on the policy will be waived. Many policies will also refund the premium that was paid by the insured during the six-month waiting period. The cost for this coverage is a bargain to say the least and no policy should be sold without this rider.

ACCIDENTAL DEATH AND DISMEMBERMENT

[98]The amount paid in the event of accidental death of the insured is usually the same as the policy's regular face amount. Therefore, if death occurs as the result of an accident the beneficiary receives twice the amount of the face value of the policy. Some agents may better recognize this benefit when it is referred to as "double indemnity."

As a rule, the accidental death rider is very carefully worded to define exactly under what circumstances this benefit will be paid. The most liberal of the definitions is "accidental bodily injury." The less favorable wording would be that death must occur "by accidental means."

For example, using "by accidental means" if an insured died from a broken neck after intentionally diving into the shallow end of a swimming pool the policy would not pay the accidental death benefit because the action of diving into this pool wasn't accidental. However, if the insured accidentally fell into the pool and drowned the benefit would be paid. Under the "accidental bodily injury" definition the intentional diving into the pool would have been paid.

Normally, the death caused by the accident must consummate itself within 90 to 180 days of the incident. Under the dismemberment rider payment is made to the insured rather than the beneficiary.

Benefits typically are paid for:

- Loss of Sight.
- Loss of Hand or Hands.
- Loss of Foot or Feet.

Regarding the loss of hand or foot, the loss typically must involve "complete severance through or above the wrist or ankle joint." Loss caused by amputation is excluded unless medically necessary and as the result of an accidental injury.

GUARANTEED PURCHASE OPTION

This option is used most frequently with whole life insurance rather than term insurance. Under this option the company guarantees the insured that he or she may purchase additional amounts of coverage without evidence of insurability. These additional purchases usually are made at specific time intervals or events that change your family status.

For example, some policies permit additional purchases of life insurance under the following circumstances:

- Every fourth policy anniversary year.
- The insured purchases a new home.
- The insured gets married.
- The birth of a new child.

The premium charge for the additional coverage is typically based on:

- The type of insurance purchased.
- The insured's age at time of exercising option.
-

11

LIFE INSURANCE UNDERWRITING

The purpose of life insurance underwriting is to develop a profitable book of business for the insurance company.

In order to accomplish this goal, the life insurance underwriter attempts to provide coverage for a diversified group of insureds where the expected death rate is the same or lower than what is expected of the population as a whole.

Underwriting Factors for Individual Coverage

Life insurance is priced on a class basis. Perspective clients of the insurance company are classed on the basis of a number of factors that help to predict expected mortality rates.

The principal rating factors are:

- Age.
- Sex.
- Health.
- Occupation and Avocation.
- Personal Habits.
- Foreign Travel or Recent Immigration.

AGE

Mortality rates are measured in terms of deaths per one thousand persons and this of course increases with age. Thus, the older you are, the more life insurance costs because you are closer to death than a younger person.

SEX

Women in the United States live seven years longer than men. Therefore, cost for life insurance on a woman is lower than on a man of the same age. For example, a thirty-year old male would pay the same premium as that of a 33 year old female.

HEALTH

The health of an individual as well as the health history of their family helps the underwriter to determine if the applicant presents an average or better than average risk to the insurance company.

In evaluating an insured's health, the company will consider whether the applicant or family members have had any of the following illnesses:

- Cancer.
- Heart Disease.
- Hypertension.
- Diabetes.

As a rule, persons whose health history include the above diseases will likely have a higher than normal mortality rate. Most insurance companies are now offering discounted rates to non-smokers due to the link between smoking and lung and heart disease.

OCCUPATION AND AVOCATION

Since certain occupations pose hazards such as flying and scuba-diving, applicants who engage in these hobbies are likely to have a higher than normal mortality rate.

PERSONAL HABITS

If a life policy exceeds $100,000.00 in coverage the insurance company will more than likely investigate the personal circumstances of the insured's life. For example, areas such as alcohol or drug use, poor driving record or financial problems may be taken into consideration.

FOREIGN TRAVEL OR RECENT IMMIGRATION

People who travel or reside outside the United States may be exposed to diseases not commonly found in this country. Additionally, mortality rates vary from country to country. Therefore, if a person is applying for life insurance shortly before leaving the country special medical tests or a postponement of coverage may take place.

Underwriting Actions

Based on the information that the underwriter receives from the applicant one of following three actions may be taken:

- Rate the applicant standard and charge the normal premium.
- Rate the applicant substandard and charge a higher premium.
- Decline the coverage.

In addition to the above three actions many insurance companies recognize preferred risks and they will actually reduce premiums.

12

DELIVERING THE POLICY

Policy Effective Date

The effective date of a life insurance policy is very important since this is the date on which coverage begins. The policy effective date may also have additional significance with regard to the incontestable and suicide clauses.

The incontestable clause gives the insurer, usually two years, that amount of time to contest the policy on the basis of material misrepresentation, fraud, or concealment in the application.

The suicide clause excludes coverage for death by suicide during the first two years of the policy.

To determine the effective date of the policy, we must examine the principal of contract law known as "offer and acceptance".

If a proposed insured signs the application and submits it with the first premium to the company, an offer to buy insurance has been made by the proposed insured.

If the insurance company issues the policy, as applied for, then the fundamental of offer and acceptance occurs. That is, the proposed insured has made an offer to purchase a life insurance contract, and the insurance company has accepted that offer.

It is assumed that the premium was submitted with the application. However, there are two other possibilities to consider regarding the effective date of the policy.

The first occurs when an application is submitted without the premium. In this case, no offer has been made by the applicant. The applicant has only extended an invitation to the company to make an offer.

The insurance company makes the offer when it issue a policy as applied for and delivers it to the applicant. Further, the offer is accepted when the applicant pays the premium, assuming any other conditions have been fulfilled and this date becomes the effective date of the policy.

In situations where the initial premium does not accompany the completed application, most companies state in the application that the proposed insured must be in good health at the time of policy delivery before coverage becomes effective. So, before accepting the initial premium and leaving the policy, the agent must obtain a signed statement of the prospective insureds continued good health. This statement and the initial premium are then transmitted to the company.

The final possibility occurs when the premium is submitted with the application but no receipt is given. If this is the case, then the policy's effective date is generally date that the policy is issued and delivered.

Delivery of the policy constitutes the company's acceptance of the applicant's offer - the application and initial premium.

A policy is considered delivered when:

- The policy is actually handed over in person.
- It is mailed to the policyholder.
- It is mailed to the agent for unconditional delivery to the policyholder.

Delivery, then, does not usually have to be accomplished by the manual transfer of the policy to the policyholder. Delivery accomplished by means other than a manual transfer is called "constructive delivery".

If a policy is not, or cannot, be delivered as defined previously, then the policy is not in effect, as policy delivery has not been accomplished. Two other situations need to be addressed.

10. **Inspection Receipt.** When the applicant wants to examine the policy for a time before paying the initial premium, and the policy is left with the applicant for inspection, he or she should sign a receipt for the policy referred to as an "inspection receipt". This acknowledges that the policy is in the insured's possession for inspection purposes only and that the initial premium has not been paid and that the insurance is not in effect.

11. **Backdating.** An applicant may ask the company to give the policy for which they are applying a date earlier than the application date. The reason for backdating is usually to obtain a lower premium. Premium paid for life insurance depends, among other factors, on the insured's age. So, in order to obtain a lower insurance age, and, as a result a lower premium, backdating is used.

AGENTS RESPONSIBILITIES

The agent should deliver the policy to the client as soon a possible after the policy is issued. This is especially important when no premium was submitted with the

application because the coverage will not become effective until the policy is delivered and the first premium paid during the continued good health of the proposed insured.

The agent also has a responsibility to explain the policy's provisions, riders, and exclusions. If the policy is rated, the agent should explain why the policy was issued that way.

13

Summing Up THE APPLICATION

Three terms with which an agent should become familiar are: Applicant, Insured, and Policyowner. The applicant is the person applying to the company for insurance, either on the applicant's own life of the life of another; the insured is the person whose life is covered by the policy; and the policy owner is the person who has the ownership rights in the insurance policy. The majority of policies are issued on the application of the person to be insured, who is also the owner of the policy.

In the typical situation, the policyowner, the applicant, and the insured will be the same person. There are, however, many policies issued where someone other than the insured applies for and owns the policy. The situation in which someone other than the insured is the policyowner is called "Third party ownership."

This type of arrangement is often found in family situations where, for example, a wife will insure her husband, or vice versa, or a parent will insure children. Third-party ownership is also often found in business situations, where a business insures the life of a key employee, for example. Another common third-party ownership arrangement is where a creditor owns a policy on the life of a debtor.

INSURABLE INTEREST

For a life insurance policy to be issued, an "insurable interest" between the insured and the policyowner must be present. In this regard, it is necessary to examine insurable interest from two standpoints. Look at the situation in which a person applies for insurance on the life of another; look at insurable interest when a person applies for insurance on his or her own life, and examine the conditions that must be present to satisfy the insurable interest requirements in each of these situations.

To purchase life insurance on the life of another, an insurable interest in the life of the proposed insured must exist. This means the policyowner must benefit, either emotionally or financially, by the insured continuing to live. Generally, for an insurable interest to exist, the potential emotional loss must arise from love and affection that grows from a close blood relationship, or marriage. And, of course, where ones' own life is concerned, each person has an unlimited insurable interest in his or her own life.

Suppose that a life insurance policy could be sold when no insurable interest

requirements existed. If a person could apply for insurance on the life of another without this interest, then the policyowner would stand to gain, and suffer no emotional loss, by the insured's death. As such, a life insurance policy would constitute a mere wager which would be clearly against public policy, and therefore illegal.

Remember, an insurable interest arises out of a close blood relationship. While this is basically true, being the relative of a potential policyowner does not automatically establish an insurable interest. For example, under most circumstances a person would probably find it difficult to establish an insurable interest in an aunt, uncle, or cousin unless the policyowner could show that a significant financial or emotional loss would result upon the death of the relative.

> ***Example:*** Assume George has loaned a substantial amount of money to his cousin. George wants to purchase a life insurance policy on his cousin's life. George will be the policyowner, and his cousin will be the insured.

POLICYOWNER AND CREDITOR

Another important aspect of insurable interest is the relationship between a policyowner and a creditor. This relationship brings about another type of insurable interest.

> ***Example:*** A creditor can establish an insurable interest with a debtor. For instance, assume a bank loans $5,000 to an individual. Obviously, the bank will suffer financially if the debtor dies before the loan is repaid. This fact establishes the insurable interest between the bank and the debtor. For this reason, the bank can purchase life insurance on the life of the debtor and receive the death benefit of the life insurance policy, but only in an amount which reflects the balance of the unpaid loan should the debtor die prior to repaying the loan. Insurance purchased by a creditor on the life of a debtor must be in an amount that approximates the size of the debt. So, if a debtor owes a creditor $1,000, it is unlikely that the creditor could purchase a $10,000 life insurance policy on the life of the debtor.

For this reason, most credit life insurance purchased on the life of a debtor has a reducing death benefit which keeps pace with the diminishing loan balance. Therefore, if a debtor owes $5,000 to be repaid over a period of five years, the death benefit might begin at $5,000 to match the original amount of the loan. However, this policy would eventually reduce to $0 at the end of five years when the loan has been repaid.

Completing the Application

The application is a life insurance company document containing questions and information which the company uses in evaluating the insurance risk and in properly preparing the policy, if one is issued. The agent completes the application by asking the applicant the questions.

The information requested on the application generally includes items such as the applicant's full name and address, age, sex, marital status, occupation, medical and family histories, present physical condition, and a description of the type and the amount of insurance applied for. It also includes the name of the person who is the beneficiary of the insurance along with data on other insurance owned and applied for, as well as whether or not the applicant was ever refused life insurance.

In view of the importance of the application, it is essential that the application be completed fully and accurately. If the application is incomplete, the underwriting process and policy issue will be delayed until the necessary information is obtained. And the company depends upon accurate information to make a proper evaluation of the proposed insured.

[99]Sometimes an agent will need to correct an application. There may be a mistake in completing the form, or the applicant may remember some fact that requires an addition to or change in the information already recorded. In such a situation, erasures, additions, or alterations of any kind MUST BE INITIALED BY THE APPLICANT.

CONCEALMENT, REPRESENTATIONS, AND WARRANTIES

As noted previously, the application is intended to reveal facts about the proposed insured that the company feels will be pertinent to making a decision about whether or not to insure the applicant. The insurance company uses the information supplied on the application, in large part, to make the decision about whether or not to issue the policy.

If the information submitted by the applicant is incorrect or incomplete, the insurance company may be forced to void the contract later on the grounds of a concealment, material misrepresentation, or warranty violation.

CONCEALMENT occurs when an applicant conceals or fails to disclose known facts. To void a contract in most states, the concealment of facts by the proposed insured must be material to the selection of the risk, and it must be done with the intent to defraud. If knowledge of the concealed fact would have influenced the company to accept or reject the risk, concealment has occurred and the contract may be voided.

MISREPRESENTATION is just what it implies. Any material misrepresentation made by the applicant can also provide grounds for the company to void the policy.

> Assume that an applicant tells the insurance company that she visited the doctor for the treatment of a cold. Instead, she visited the doctor for a heart condition. Assume also that her condition was serious enough for the company to have refused to issue the policy if all the facts had been known. Since she failed to correctly inform the company about the true reason for visits to her doctor, and since the misrepresentation is material, material misrepresentation has occurred.

There is a close relationship between the terms material misrepresentation and concealment. An easy way to distinguish them is to remember, if a material fact is omitted, that is concealment. If a material fact is not presented truthfully, that is material misrepresentation. And, for concealment and misrepresentation to exist, there must be generally be intent to defraud the insurance company.

Because of the harsh consequences of warranty rule enforcement, nearly all states now have statutes providing that all statements made by the applicant for life insurance are representations and NOT WARRANTIES. In simple terms, a representation is a statement that is true to the best of the applicant's knowledge.

OBTAINING NECESSARY SIGNATURES

After the application has been fully and accurately completed, the agent must obtain the necessary signatures on the application. The applicant must sign and so must the proposed insured, if someone other than the applicant. The proposed insured's signature in a third-party ownership situation is required to show his or her consent to being insured under the policy. The agent will also sign as witness to the applicant's (and proposed insured's) signature.

MINORS

A life insurance contract between a minor applicant and the life insurance company is binding on the company, but the minor can back out of the contract at his or her option and receive back at least part of the premiums paid for the insurance.

Because of this problem, many states have adopted statutes that provide that a minor of a certain age or older has the legal capacity to enter into a life insurance contract that is binding on both the minor and the company. The age limit can be as low as age 14. Generally, the special age limit applies only to insurance on the minor applicant's life. Also, the beneficiary usually must be a close relative.

In addition to the signatures on the application, other signatures will usually be required. The applicant generally must sign an authorization form allowing the company to obtain medical information from physicians, hospitals, etc.

Because of the confidential nature of such information and possible legal restrictions on giving out unauthorized medical information, a signed authorization is necessary before the company can have access to the data.

The rules of the Medical Information Bureau (MIB) and the Fair Credit Reporting Act require written notification to the applicant. The agent should explain these notifications. The applicant will be asked to sign receipts acknowledging that the notices were received. Depending on company practice, these receipts may be combined with the medical authorization.

In addition to signing as witness to the applicant's signatures, the agent will be required to complete and sign the agent's report which is commonly part of the application form. Also, if the initial premium is paid, the agent will generally issue a premium receipt to the applicant. The agent should complete and sign this receipt, carefully explaining its provisions to the applicant.

PREMIUM RECEIPT

When the applicant pays an initial premium at the time the application is completed, it is customary for the agent to give the applicant a premium receipt to show that the money was received. The premium receipt is significant because it is intended to provide coverage, under certain circumstances, before the policy is issued and delivered. The coverage provided by the premium receipt is, therefore, an incentive for the applicant to pay the initial premium when the application is completed, rather than waiting until policy delivery.

When the premium receipt is issued, the agent should explain its effect to the applicant. However, there are several different types of premium receipts, so it's important to understand each type and to recognize how the consequences of each of the receipts differ.

There are two major types of premiums receipts: (1), the conditional receipt, and, (2), the binding receipt, which is also called a temporary insurance agreement. Conditional receipts may be further divided into two types: (1) insurability, and (2) approval.

THE INSURABILITY CONDITIONAL RECEIPT provides that insurance will become effective as of the date the receipt is issue, IF the applicant is found to be insurable as of that date.

> ***EXAMPLE:*** The application for insurance is made on January 14th. The application and a check for the initial premium is submitted on that date. The insurance company subsequently determines that the applicant is insurable as applied for, and issues the policy on February 14th. The effective date for this policy is January 14th, the date the application and check were originally

submitted because the applicant was insurable on that date. Most companies use the insurability type of conditional receipt.

The **APPROVAL** type of conditional receipt also provides that the policy will become effective on the date of the receipt. However, it becomes effective only if the application is actually approved.

> ***EXAMPLE:*** An application is submitted on July 19, together with the initial premium. The applicant is given an approval type of conditional receipt on that date. If the applicant dies on July 23rd as a result of an accident, and the company had not approved the application by that date, the applicant would not be insured, even though he or she was insurable on the date of the application. The applicant has no life insurance protection during the period of time the company is determining insurability the approval type of receipt.

THE BINDING RECEIPT, also called a temporary insurance agreement. The temporary insurance agreement is given by the agent to the applicant when the initial premium is paid. However, the temporary insurance agreement provides life insurance coverage IMMEDIATELY, even though the company's underwriters have not as yet determined the insurability of the proposed insured.

If the proposed insured dies while the temporary coverage is in effect, the company will be liable for the full amount of the death benefit applied for, subject to any limitations as to maximum amount specified in the receipt.

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RISK SELECTION AND CLASSIFICATION

Once the agent submits the completed application to the life insurance company, the company must evaluate the proposed insured's acceptability for life insurance. If he is acceptable, the company must then decide if the insurance will be issued at the normal premium or, because of some increased risk of death, at a higher than normal premium.

It is important to keep in mind that risk selection begins before the application reaches the company. The process actually begins with the agent when the company instructs its soliciting agents on the classes of people it is willing to insure. If the prospective insured obviously does not meet the standards, no application should be completed.

The agent is very important in the selection process since the agent is often the only person connected with the company with any personal knowledge of the proposed insured.

Underwriting Factors

The first factor, closely related to mortality is **AGE**. As age increases, the chance of death increases. The **SEX** of the proposed insured is also a factor that affects longevity. Statistics show that women live longer than men generally speaking.

PHYSICAL CONDITION: The proposed insured's health also affects life expectancy. Actually, there are several health-related factors that a company will examine. One of these is the person's physical condition. Diseases such as heart disease, high blood pressure, liver disease of cancer can obviously affect life expectancy.

A person's height, weight, and weight distribution can also be a health related factor in underwriting. Generally, overweight has a more serious impact on underwriting than underweight. Overweight people have a higher than normal mortality rate and excess weight can also increase the dangers from conditions such as heart disease and high blood pressure.

Knowledge of the proposed insured's family history is another factor that is useful in selecting and classifying the risk. Statistical evidence indicates that longevity is linked to heredity. If the proposed insured's parents have lived to an old age, then there is and increased probability that the proposed insured will also have a long life.

On the other hand, if the family history shows a pattern of early deaths from heart disease, for example, and if the proposed insured suffers from some impairment that increases the danger of heart disease, such as excess weight or high blood pressure, the underwriters are going to carefully consider the potential for an early death.

OCCUPATION: A number of years ago, occupation was a primary factor in selection. With the advent of automation, industrial safety programs, and improved working conditions, the impact of occupation on mortality has decreased. And relatively few occupations today are listed by insurers as requiring an extra premium.

Even today, certain occupations with a high accident hazard, such as explosives handling, are associated with a greater than normal mortality. A second major group of occupations shows an additional hazard because of exposure to dust, poison, or radiation. The occupation of crop duster is one that is very dangerous. Thus, the insurance company generally has two choices available to it if a crop duster applies for life insurance. Issue the policy at an increased premium or decline to issue the coverage all together.

The proposed insured's hobbies can also affect the risk. Activities such as sky diving, skin diving or auto racing obviously have a bearing on insurability. The habits and morals of the proposed insured are also important in risk selection. Misuse of alcohol or drugs, for example, may cause the company to decline the coverage. The individual's personal reputation, character, and personal habits are also considered in evaluating the risk.

The financial situation of the proposed insured is also a factor. The company will examine not only the relationship between income and the amount of insurance to guard against the danger of overinsurance, but also to assess the proposed insured's ability to pay for the insurance requested.

Sources of Information

The application processed has been reviewed several times in this course, and it's importance in determining the acceptability of the proposed insured for life insurance has been discussed. The application is a primary source of information about the proposed insured's age, sex, marital status, occupation, and other items.

AGENT'S REPORT

Another source of information is the agent's report. Most companies require the agent who completes the application to fill out such a report. The agent's report is usually on the back of the application. The report generally contains questions about the agent's personal knowledge of the proposed insured and about the proposed insured's financial position.

Information about the purpose of the insurance and whether or not the insurance is intended to replace other coverage is commonly requested. The agent's report is obviously important in view of the fact, as mentioned, that the agent may be the only person connected with the company with any personal knowledge of the proposed insured.

MEDICAL EXAMINATION

Another source of information is the medical examination, which affects underwriting when an examination is required as a part of the selection process. A urine sample and/or blood test may also be required. The medical examiner will record the proposed insured's answers to questions about medical and family histories and otherwise report the findings of the physical examination. In cases where a medical examination is not required under the company's underwriting rules, the policy is issued "nonmedical" and the agent will ask the questions about the proposed insured's medical and family histories.

ATTENDING PHYSICIAN'S STATEMENT

If the company wants more detail about medical information revealed in the application or medical examination, it may obtain and attending physician's report or statement from the proposed insured's physician. The attending physician's report is only requested when elaboration on medical information is desired. This report is another insurability information source.

MEDICAL INFORMATION BUREAU

The "Medical Information Bureau" is another source of information. The MIB is a nonprofit organization that was established by life insurance companies to make possible the exchange of pertinent underwriting information among life insurance companies. The information is composed chiefly of medical facts, both favorable and unfavorable, about applicants for life insurance. A member company must report to the MIB if it finds certain specified impairments in the individual during the selection process.

In underwriting a policy, MIB information may be used only as an alert signal. Every member company is also required to make its own independent underwriting investigation. In addition, insurance cannot be denied nor can an extra premium be charged solely on the basis of information supplied by MIB.

MIB rules require that every applicant be given a written notice that (1) the company may make a brief report of information to the MIB, (2) if the applicant applies for insurance with another MIB member company or makes a claim to such a company,

the MIB will furnish information on the applicant to the company upon request, and (3) if requested by the applicant, the MIB will arrange disclosure of any information on the applicant in its files. However, medical information will be disclosed only to the applicant's physician.

If the applicant questions the accuracy of any information, he or she can seek a correction through the MIB. Further, the applicant must sign an authorization permitting MIB information to be disclosed to member companies.

INSPECTION REPORTS

Inspection reports come from various consumer reporting agencies. These are another source of underwriting information. These reports, called consumer investigative reports, cover credit information, as well as information about an applicant's personal habits, lifestyle, reputation, health, occupation, and so forth. Although company practice varies, these reports are often only obtained when larger amounts of coverage are involved. The information for the report is obtained through personal interviews with the individual's friends, neighbors, and associates.

The "Fair Credit Reporting Act" requires that the proposed insured be informed in writing that such an investigation may be made. The notice must also inform the person that, upon a written request, the company will furnish information concerning the nature and scope of the investigative consumer report. If coverage is denied or a higher premium charged as a result of such information, the proposed insured must be so notified and given the name of the consumer reporting agency.

Types of Risk

[100]Based on the insurability information obtained from the various sources, a company will usually classify a proposed insured in one of three ways; (1) standard risk, (2) a substandard risk (also called a special class, impaired, or under average risk), or (3) an unacceptable or uninsurable risk.

The great majority of proposed insureds are STANDARD risks. This means that they are exposed to a "normal" risk of death and are charged the regular or standard premium for the coverage. About 90% of proposed insureds are acceptable on a standard basis.

Some individuals who do not qualify as standard under a company's underwriting rules are declined coverage by the company because they have an unacceptable high probability of death. These are the UNINSURABLE risks.

Other proposed insureds are subject to higher than normal mortality rates but are still

acceptable risks. These are the SUBSTANDARD risks. Because of the greater mortality risk, members of the substandard group are charged a premium that is higher than the standard premium. The individual is charged extra premiums for the coverage because of the hazards applicable to that person. A hazard is a condition that increases the chance of loss. Among the factors that may cause an individual to be classified as a substandard risk are:

- An existing medical condition, such as a heart murmur or hypertension.
- Past medical history of a condition that may recur or may have adversely affected life expectancy.
- An occupation that involves an increased risk of accidents or subjects the workers to an unhealthy environment.
- The moral hazard, the existence of morals or habits, such as misuse of alcohol or drugs, that increase the chance of loss.

Some companies also use a "preferred risk" classification. A preferred risk might qualify for an even lower premium than a standard risk. Other companies, however, use the term "preferred" in reference to their standard risks. Agents must know the risk classification systems of the companies they represent.

Rated Policies

Consider the factors that impact an applicant's life span and how these factors are evaluated by life insurance underwriters to determine if a life insurance policy should be issued at standard rates. So long as an applicant is a standard risk, the company will issue the policy and charge a premium that is standard for others in the applicant's group.

If, because of health, age, occupation, or some other factor, the applicant is not a standard risk, then the company can choose one of two alternatives available. First, it can decline to issue the policy, or second, it can charge an increased amount for the insurance. A policy on which the company charges an increased amount is called substandard or RATED policy.

Although not as popular as it once was, another system for increasing the premium for a rated policy is called the "rate-up in age". Under this system, if an insured's true age is 40, the company might use the premiums based upon age 45. This increase in age requires the insured to pay more for insurance than those standard risks charged the usual amount for his age.

One final method of determining a premium for a substandard risk is the lien system. Under this method, the insured pays the standard premium for the age and plan, but the amount of insurance purchased by that premium is reduced. The policy has a lien against it, and the lien is deducted in case of death. The lien system, also called the graded death benefit, is seldom used in the United States except for money purchase pension plans. This method is used because, under the pension formula, the premium

for a participant cannot vary.

Reinsurance

Reinsurance is insurance for insurers. Insurance companies use reinsurance to protect themselves against the catastrophe of a large single loss or a large number of small losses caused by the same occurrence. In reinsurance, and insurer "cedes" part of a risk to a second insurer. The first insurer is known as the "direct writer" or "ceding company," while the second insurer is called the "reinsurer."

There are two types of reinsurance treaties:

FACULTATIVE: Under the facultative treaty, initially the risks are considered by both parties, with the direct writer carrying the entire risk. Each risk is submitted to the reinsurer on the option of the direct writer, and the risk is either accepted or rejected. The terms under which reinsurance will occur are enumerated, and once the risk is accepted, those terms apply.

AUTOMATIC: Under the terms of the automatic treaty, the reinsurer agrees to accept a portion of the direct line or of certain risks in advance. The direct writer is then obligated to cede the portion to which the treaty applies.

There are two important purposes that are served by reinsurance. First, reinsurance spreads the risk, allowing companies to protect themselves from catastrophic losses. Second, reinsurance serves a financial function by allowing the direct writer to be relieved of the obligation to maintain the unearned policy reserves of those policies reinsured. In essence, the excess capacity of the direct writer is transferred to the reinsurer.

QUIZ QUESTIONS PART IV LIFE CONCEPTS

1. Any changes that are made on a completed application must have the approval of:
(a) The underwriter
(b) The proposed- insured (Page 111)
(c) The insured and the agent
(d) The agent

2. All statements on an application are regarded as:
(a) Useless
(b) True
(c) Warranties
(d) Representation (Page 113)

3. The warranty is a statement made with such absolute certainty that it is ___ to be true.
(a) Never believed
(b) Believed
(c) Guaranteed (Page 152)
(d) Considered

4. Should it be necessary to correct a mistake on an insurance application, the applicant must:
(a) Complete an entirely new application
(b) Have the agent initial the changes
(c) Initial any and all changes on the original application (Page 151)
(d) Get the corrected application notarized

5. Which one of the following is NOT one of the three parties to an application:
(a) The proposed insured
(b) The applicant
(c) The insurance agent (Page 116)
(d) The policy owner

6. Life insurance is a contract between
(a) An individual and his relatives
(b) An individual and his accountant
(c) An individual and an insurance agent
(d) An individual and an insurance company (Page 110)

7. Can a risk be calculated in advance?
(a) Yes
(b) No (Page158)
(c) Only by an attorney
(d) Only by an Accountant

8. A life insurance policy may afford greater indemnity when the death is:
(a) Suicide
(b) Within two years of policy
(c) Accidental (Page 141)
(d) Within a month of policy

9. Adding a policy Equivalent Level Annual Dividend to its cost index allows one to compare total costs of similar policies
(a) After deducting dividends
(b) Before adding dividends
(c) After deducting dividends
(d) Before deducting dividends (Page 118)

10. Universal Life is kind of a cross between whole life and
(a) Single-premium Insurance
(b) Universal Insurance
(c) Permanent Insurance
(d) Term Insurance (Page 118)

11. The extended period of time in which the policy remains in full force despite the fact that the premium has not been paid is called the
(a) Over period
(b) Extended period
(c) Grace period (page 127)
(d) Term period

12. Term insurance can be purchased for
(a) 5 years
(b) 10 years
(c) 15 years
(d) All of the above (Page 117)

13. The grace period in a life policy is the time beyond the due date you are permitted to:
(a) Increase the face amount
(b) Add additional insureds
(c) Pay the premiums without penalty and without loss of coverage (Page 124)
(d) Change the method of payment

14. The grace period in a life policy is the time beyond the due date you are permitted to:
(a) Increase the face amount
(b) Add additional insureds
(c) Pay the premiums without penalty and without loss of coverage (Page 124)
(d) Change the method of payment