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Accident and Health Insurance Basics

A. Field Underwriting: The Application is a formal request to an insurance company to issue a policy based on its statements (a.k.a. representations). It is part of "consideration" and a policy cannot be issued without it.

1) Application Procedures start with the application being filled out completely and legibly.

- ***The application requires the signature of the owner, insured, and agent***. Note: if the insured is a minor their signature is not required
- The agent signs the application as a witness to the signatures. It is also the producer's attestation that everything is true to the best of their knowledge and belief.
- In filling out the application, if an error occurs, ***a single line should be drawn through the error and the insured should initial the error***. *If the error is discovered before being sent to the insurance company,* **the agent should take the application back to the insured for the correction.**
- ***Neither the agent nor the company can make a change in an application without the written approval of the applicant***.
- If the information supplied on an application is discovered to be incorrect after a policy is issued, the ***company may rescind or cancel the contract***. **This may only be done before the policy's incontestability clause takes effect.**

2) Disclosures and Privacy

The signatures on the application permit the carrier to order any reports needed. There may be state-required disclosures along with an application that are signed by the client or both the client and the producer.

A HIPAA disclosure permits the medical records to be released. This is signed by the applicant and has a limited period of time it is valid for, usually 6 months.

3) Underwriting requirements: Evaluation of the applicant is based on age, sex, amount of protection requested, moral habits, occupation, hobbies, current health, and past health.

- Health Insurance evaluation is age, gender, address, and tobacco or non-tobacco. Since the Affordable Health Care Act (ACA) eliminates pre-existing conditions from being excluded, applications don't ask any health questions.

- **No Unfair Discrimination**: No person or entity engaged in the business of insurance may refuse to issue any contract of insurance or cancel or decline to renew such contract unless ***bona fide statistical differences in risk or exposure have been substantiated.***
- *Lifestyle, moral habits, and personal characteristics are received by inspection reports.*
- *Marital Status* is **NOT** an underwriting factor. Most applications do not ask if the applicant is married or single.
- *Signatures on the application permit the carrier to order any necessary reports.*

4) Sources of Underwriting: Reports for the underwriter come from several sources (Reporting Services). The insurance company needs permission from the applicant to order a report. The reports include:

a) The application is the most important source of information to the underwriters. It tells them who wants coverage, a little bit about them, what kind of coverage, and the amount requested if applicable. This lets the underwriters know what other reports to order based on the information provided.

b) Medical Examinations might include such things as a urine specimen, blood test, blood pressure check, or EKG. A signed HIPAA release form is required for the lab to send results out to the insurance company or the doctor's office.

c) Medical Information Bureau (MIB) is a non-profit agency supported by hundreds of ***insurance companies***. It maintains files of information that applicants have submitted to other insurance companies and that physicians and others have submitted regarding a proposed insured. By sharing this information with other companies to whom an applicant has applied for coverage, information can be cross-checked and applicant fraud can be detected.

- ✓ **The applicant has the same rights that apply under the Fair Credit Reporting Act.**
- ✓ ***An application for insurance cannot be denied solely based on the MIB report. The insurance company must fully underwrite the applicant.***

✓ **Consumer Report/Credit Check (Fair Credit Reporting Act)…** Consumers must be notified that any report will be sought and told how it will be used. The consumer must be told how to obtain a copy of the report. The consumer has the right to know what is on the report. The consumer has the right to know the identity of anyone who has received a copy of the report in the past six months.

- ✓ Information can be disputed. If not proven ***by the reporting agency*** to be accurate, it must be removed from the person's file **within 30 days**.

d) Inspection Reports are used by insurance companies to verify information that appears on the application such as name, age, sex, place of residence, and occupation. Some insurers hire other organizations to check on the insured's background, lifestyle, moral habits, etc.

e) **Attending Physicians Statements** (a.k.a. APS) are used only when statements on the application reveal conditions, in the past or present, of the insured. The consent of the insured is needed and a copy of the signed authorization is sent with the APS. The consent is a HIPAA release form. The APS contains answers to questions the underwriters have regarding statements on the application from the doctor, hospital, clinic, etc.

f) **Producer's (Agent) Report:** is used by the producer to document their personal observations concerning the proposed insured. The producer is considered an important source of information to the insurance company during the underwriting process, so their report is important to the insurance company. Anything that you feel the underwriters should know regarding your client that is not addressed on the application may be noted here.

5) Warranties and Representations:

All statements on an application are deemed to be representations, something the client represents as being true to the best of their knowledge and belief, and not warranties, that are guarantees in writing. The warranty in a policy (not an application) is the promise to pay of the insurer. This is in the insuring agreement. Representations are for items asked about the past, warranties are for promises for the future.

6) Classifications of Risks

a) **Standard Risk** means a normal risk at a given age. *If premium has been paid the effective date of coverage is the application signature date.*

b) **Preferred Risk** means a healthier than normal risk and will pay a lower premium. *If premium has been paid the effective date of coverage is the application signature date.*

c) **Substandard Risk** means not being as healthy as a normal risk and will usually pay a higher premium. This can be done in the form of a rate up or a surcharge. The policy will be offered to the client in the form of a counteroffer. The client may accept the counter or turn it down. *The effective date of coverage is when the client accepts the counteroffer, signs the acceptance, signs a statement of continued good health, and pays any premium due.*

a) **Rate-Up** means the insurance company will charge premiums of an older age, such as a 30-year-old will pay the rate of a 35-year-old.

b) **Surcharge** means an additional percentage of the original premium will be charged for the risk. For example, if an insured is overweight, instead of the insured paying $1,000 for a medical policy, a surcharge of 25% might be added to the premium due.

- **Modified/Amended vs. Issued as Requested…** If a policy is issued with an elimination or exclusion rider, or issued with a rate-up or a surcharge (known as a counter-offer). ***The policy will be in force when the counter offer is signed and the additional premium is paid by the owner/applicant***. See policy effective date.

B. Policy Delivery

1) Policy Delivery and review is the agent's responsibility and the policy must be delivered **within a reasonable period of time after issuance**. Thirty days may be considered reasonable by companies. If a policy is mailed, the effective date of coverage will be the mail date. This is also the start of the 10-day free look period. The agent is also responsible for explaining the policy to the insured and making her aware of any changes. *If the policy is issued other than as requested, the agent must collect any extra premium as well as have the client sign a 'Statement of Continued Good Health." There is no coverage until the signatures and premiums have been collected.*

2) The Policy Effective Date is the ***date of the application***, provided the insured is ***insurable*** (e.g., all of the underwriting requirements must be completed, such as blood test, urine test, or EKG, to prove insurability) and the initial premium accompanies the application. Remember that an application not fully completed (***missing material information***) **does not** put coverage into effect.

The exception to this rule is for **health insurance policies**. With the Affordable Health Care Act, there are no exclusions for a pre-existing condition, there are no health questions on an application for health insurance at all. This rule does not apply to any other disability coverage, just health insurance. The underwriting (premium) is based on age, gender, tobacco or non-tobacco, and zip code.

An individual may not be turned down so, when applying, you choose your effective date. *It will be - in my experience - your choice of one of the next 2 months, whichever month is chosen, on the first as the due date.* The fact that they can't turn you down is also why you can only apply during open enrollment or due to a life event. A life event may include losing other coverage, getting married, or having a baby. *Otherwise, many people might 'policy hop,' e.g., paying a lower premium until a better plan is needed, hop on over to the better costlier plan until it is not needed then 'hop' on back.*

- A **Conditional Receipt (a.k.a. Temporary Insuring Agreement)** is issued by Life and Disability producers when money is collected with the application and ***is in effect until the policy issues.***
    - It provides coverage on a conditional basis, that is, on the condition that the insurer issues the policy as it was applied for.
    - If the policy issues as applied for, any claims incurred during the underwriting period will be covered.

- **There are three reasons why the effective date is important:**
    - ✓ **Insurance coverage actually begins**
    - ✓ **Any contestable period begins (time limit on certain defenses provision)**
    - ✓ **Any probation period begins**

3) Premium Collection (e.g., Electronic, Physical, EFT, ACH)

Generally, when an application is taken, the premium is paid. There are a few circumstances that a carrier has an application taken cash on delivery (COD). The problem with that is the conditions for coverage have not all been met. It not only depends on the underwriting finding the client acceptable but payment of at least one month's premium needs to be made. This can be in the form of a check to the agency or carrier, a form requesting a pre-authorized checking (PAC), electronic funds transfer (EFT), or automated clearing house (ACH), which is the primary EFT system used by agencies.

- ***Without the initial premium, the insured is* NOT *covered or insured***.
- Without the initial premium, the insurer issues the policy and ***offers*** it to the insured. The policy becomes effective when the insured ***accepts*** the policy, pays the first premium, and signs ***a statement of continued good health.*** If the applicant has developed a health problem, the issued policy probably will be rescinded (terminated) by the insurer.

4) Statement of Good Health - This is an attestation that the health of the insured has not changed between the time the application was taken and today. If the applicant has developed a health problem, the issued policy probably will be rescinded (terminated) by the insurer.

Prospect makes an offer consisting of Application & 1st Premium to the Insurer → **Insurer accepts offer. Policy is issued as applied for.** → **Policy Delivered to Owner**
1. **Free Look begins**
2. **Effective date of coverage is the date of the application**

**Conditional* receipt issued by Producer

**Conditional* coverage is in effect. If the policy issues as applied for, any claims made will be paid.

OR...

Prospect makes an offer consisting of Application & 1st Premium to the Insurer

But… the policy is not issued as requested (that amount of coverage for that price)

Then…

1 **Modified Policy is Issued,** e.g.:
w/ rate-up
w/ surcharge
w/ exclusion rider

*No coverage during the conditional period

2 Policy Delivered with **Counter Offer** to the Owner/ Applicant:

1. *Signatures Required*

Accept counter offer

Statement of Continued Good Health

2. *Premium Payment required*

3 Date of Signature and Premium Receipt is the:

Effective Date of Coverage

and

Free Look Period Begins

C. Definitions of Perils

1) Sickness is an illness or disease that is not the result of an accident.

2) Accidental bodily injury is defined as bodily injury which is the **result** of an accident (an occurrence that is unforeseen, unintended, independent of disease including continuous or repeated exposure to the same harmful conditions).

D. Types of Losses and Benefits

1) Loss of income from disability short-term/long term

Pure Loss of Income/ Indemnity Disability income insurance (a.k.a. *loss-of-time*) insurance is to replace income when a disability prevents an individual from working to earn an income. The maximum coverage is usually two-thirds (2/3) of the insured's gross income because disability income benefits are income **tax-free** (if the insured is paying his/her own premiums). With a limit set according to an insured's salary, they will not be over-indemnified and will not make more money staying home.

Group plans work similarly to individual plans with two notable exceptions. One difference is they do not cover work-related injuries or illnesses. The second difference is the benefit period. Individual plans are written for a certain benefit period, often until retirement age. **Group short-term plans** usually have a maximum benefit period of up to two years. **Group long-term plans** generally provide benefit periods of more than two years up to about five years.

2) Medical Expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.

Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Medical expenses include the premiums you pay for insurance that covers the expenses of medical care and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

3) Long-Term Care Expenses... Long-term care (LTC) is a general term that includes a wide range of services that address the health, medical, personal care, and social needs of people with chronic or prolonged illnesses, disabilities, and cognitive disorders (such as Alzheimer's). These services are most

typically required by the elderly but may also be used by disabled people of any age.

While people often think of long-term care as strictly nursing home care, the long-term care delivery system is changing at a rapid rate, and thus the term has expanded to include a variety of private and semi-private care situations and services aimed at assisting with activities of daily living. *Among them are home (in-home) health care, assisted living, adult day care, adult family homes, continuing care retirement communities, hospice care, rehabilitation, and more.*

Long-term care insurance (LTCI) is an agreement between the insured and an insurer. Generally, the insurer promises to pay a daily benefit toward the cost of long-term care (nursing home care, home health care, etc.) in exchange for premium payments. *Long Term Care policies can pay on a per-day basis up to a maximum amount or per day up to a total number of years: e.g., a policy may pay $150 per day until it has paid out for 5 years or $150,000, whichever is last.*

The type of long-term care required by the individual depends on his condition. **Types of long-term care can be divided into two broad categories - long-term health care (Skilled Nursing Care) and personal care (Custodial Care).**

- ***Skilled (Nursing) Care*** is required daily and must be performed by a skilled medical practitioner (e.g., nurse). A Registered Nurse must be *on duty* 24 hours a day.
- ***Custodial Care*** (a.k.a. Personal Care) is for people who do not need ongoing medical services, but rather need help with what are known as "**Activities of Daily Living**" (ADLs) - such as eating, dressing, bathing, toileting, transferring and continence as well as taking medicines. This is the type of care that is most needed by the elderly.

A **benefit trigger** starts the benefits under a long-term care policy. It is important that the insured know the requirements that must be met before a LTCI policy will pay any benefits.

Common types of benefit triggers found in long-term care policies include:

- The care must be a medical necessity and caused by illness or accident
- Cognitive impairment due to the loss of reasoning or inability to remember so that the insured needs assistance for his or her well-being or protection
- *The insured's inability to perform the activities of daily living (ADLs) without assistance*

Long Term Care policies can pay on a per day basis up to a maximum amount or per day up to a total number of years.