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Life Insurance Basics

Life Insurance has been transacted in the United States since the mid-1700s. The life insurance business began to have significant growth in the mid-1800s due to the agency distribution system. Studies show that less than 60% of Americans own individual life insurance, and many of those do not have enough coverage to meet the needs of the surviving family.

The chief function of life insurance is to ***create an estate***. When an insured dies, a definite sum of money will be paid to the beneficiary. The money can be used to: meet current obligations of the survivors such as funeral costs and medical bills; pay debts; pay for future expenses such as college education; pay in a settlement option or payout plan to take care of any dependents with physical or mental limitations; serve as continuing income for the spouse; etc. ***It is protection for the consumer***.

Another aspect is ***estate protection or preservation.*** Federal and State estate taxes can diminish an estate by a large percentage. A family-owned business (dairy farm, winery, etc.) may need to be sold to pay the tax debt if there are no liquid assets available. Life insurance in the proper amount will keep the business intact and the taxes will be satisfied.

The obligations and expenses listed above are ***death benefits***. Life insurance does provide **living benefits** as well. Some living benefits are provided by the cash value accumulations inside of permanent life insurance policies, others are provided by the carrier regardless of cash value. *These accelerated death benefits will be reviewed in the Provisions chapter.*

Life insurance is a legal contract between the owner and the insurance company. In return for premiums, the insurance company agrees to pay a death benefit on the death of the insured to a beneficiary. This is an income-tax-free amount paid to a beneficiary. Only the beneficiary decides what to do with the money – unless a settlement option was chosen by the owner. Settlement options are covered in the provisions chapter. If the death benefit is paid to an estate, it increases the value of the estate, potentially triggering estate taxes on it. Proceeds paid to an estate will be governed by the will, and creditors may put a claim against the money. There is no public record of whom the proceeds are paid to.

A. Insurable Interest is a relationship with a person (a spouse) or thing (a car) that will support the issuance of an insurance policy.

A person who has a reasonable expectation of benefiting from the continuance of another person's life is said to have an insurable interest in that life. Life companies will require that the owner/applicant have insurable interest in the insured.

- **For example:** Each of the following would probably have a financial loss should the other die, and therefore have an insurable interest: husbands and wives in each other; children in their parents; a creditor in a debtor; employees and owners in a business. A person always has insurable interest in themselves.
- ***Insurable interest must exist at the time of application.*** It need NOT remain for the duration of the life insurance or health insurance policy. For example, a wife may buy and own the coverage on her husband and maintain it even if they divorce. A business owner may purchase a policy on her partners and keep the policies after she sells her share of the business.

B. Personal Uses of Life Insurance

1. Survivor Protection is one of the main reasons for life insurance. A lump sum may be paid out, a payment plan may offer consistent income for the beneficiary, or a combination of both options.

a) Cash Needs are used to satisfy specific purposes. Some of these sums are intended to be used at the time the income earner dies, while others are set aside for future use. For example:

- Final Expenses including burial, funeral, final medical expenses, estate administration costs & taxes
- Pay off debts such as home and car mortgages
- Education and Emergency Fund

b) Liquidity – Income Needs are expressed in periodic amounts, usually a monthly figure. This monthly amount is intended to meet all of the family's regular living expenses. For example:

- Essentials such as food, clothing, gas, taxes, etc.
- Lifestyle income such as holiday celebrations, vacations, sports equipment, etc.
- Surviving spouse's immediate income and retirement income
- Even if the mortgage is paid there are still monthly bills, gas, electric, etc.

A settlement option with a monthly payout plan can do this, or an individual may elect to monitor it themselves.

2. Estate conservation is another valuable tool in the producer's bag. A client may be self-insured, meaning they don't need to create an estate since they have one, debts are paid, and family is cared for financially. This should not be a problem, but if the estate (everything you own minus everything you owe) is large, there are taxes. Federal and State estate taxes can diminish an estate by a large percentage. A family-owned business (dairy farm, winery, etc.) may need to be sold to pay the tax debt if there are no liquid assets available. Life insurance in the proper amount will keep the business intact and the taxes will be satisfied. It is important here to name a beneficiary since if the money is left to the estate, it could be counted as an asset and taxed accordingly.

C. Determining Amount of Personal Life Insurance

How much life insurance a person needs varies depending on what they need covered. There are two distinct approaches on how to get the magic number and both have advantages as well as disadvantages. The needs and life of an individual change over time and this may result in an adjustment in the face value of a policy. Basing an amount on what someone earns sounds fine until you consider a stay-at-home parent. They may not have an income, but they contribute enormously to the family unit. Their value cannot be easily measured so the first approach may not work, but the second one will.

1. **Human Life Value Approach:** This is the financial amount that you would expect a person to earn during the remainder of their working lifetime a.k.a. the income replacement approach. This is for creating an estate to care for dependents, not preserving an estate nor any other reason to purchase the coverage. It is not just a multiple of someone's current salary; inflation and cost of living increases should be factored in as well as career potential for advancement. In the case of young professionals such as lawyers or medical professionals, the projected income would outpace inflation.

2. **Needs Approach:** For families who need to create an estate, this looks at what the needs of the surviving dependents over time may be. It should take care of immediate expenses such as funeral costs, medical bills, estate taxes, and any other lump sum needs. The needs approach also looks at the long-term needs that differ over periods of time. There will be an adjustment period that should be covered with an income, then what? If the mortgage is paid there are still utilities, phone, cable, etc. Is income needed to replace the insured's income 100% or is 75% sufficient? Is there any additional debt to be taken care of, fund education, an emergency fund? How long should this income last?

In both cases, when a number is reached and agreed upon, look at the assets the client currently has. The amount agreed on for coverage less the amount of existing assets is the amount of life insurance needed. (For example, Mr. Kyle needs $750,000 to take care of his family with an income stream to replace his income for 40 years. He has $250,000 in a retirement plan. The net amount of coverage would be $500,000.)

For estate preservation: this is the easiest solution. Talk with an accountant and/or an estate attorney to determine the amount of inheritance taxes that will be due and write a policy to cover that amount. Keep in mind many estates grow over time.

D. Business Uses of Life Insurance can be varied. Businesses need to protect their assets. The most important assets a business has are the people, whether it is the owners or key persons. Protecting them as a benefit for themselves includes funding for various compensation arrangements such as split-dollar arrangements and nonqualified deferred compensation plans. To protect the business itself (employees, customers, partners) we have key employee/partner plans, and buy-sell agreements. The differences between the two policies are in a buy-sell arrangement the policy must be on an owner in an amount sufficient enough to buy out their share of the business. A key person policy may be on the owner, but it can also be on any employee who is considered key to the business.

1. **Buy/Sell Agreements** (a.k.a. Buy-Sell Agreements) spell out the terms of the sale of an owner's business interest upon his death. The buy/sell agreement is drawn up by an attorney or may be part of the articles of incorporation of a business. The agreement includes a provision for funding with life insurance. This assures that the money will be available to pay off the deceased partner's family, and the business will be owned solely by the surviving partner(s). There are two types of Buy/Sell Agreements: Cross Purchase and Entity Purchase.

   i. **Under a Cross Purchase Buy-Sell Plan, each partner owns, is the beneficiary of, and pays for the premiums for life insurance on the other partner or partners** in an amount approximately equal to their share of the business. Death benefits are received federal income tax-free by the partners and avoid taxation to the company. In a 2-person partnership, this works well. Any more owners will increase exponentially the number of policies required. *(e.g., Six partners, each one owns policies on each of the other five, creating thirty policies written.)*

   ii. **Under an Entity Buy-Sell Plan,** or a **Redemption Plan**, the deceased's interest is purchased from the deceased's estate by the partnership***. The Entity (the business) applies for, owns, pays for, and is the beneficiary of the policy.*** This interest then is divided among the surviving partners in proportion to their own interests upon the death of one of the partners. One policy per partner.

   Another option for funding this is a joint policy, first to die. There is one policy written on all partners and it pays when the first partner dies. In this type of buy-sell arrangement, the business itself purchases the ***shareholder's interest upon their death***. Death benefits are received federal income tax-free but may be subject to other taxes, have your client consult a tax attorney or a CPA.

2. **Key Employees/Partner Insurance** is purchased on the lives of a company's key employees to protect itself against their death. A key employee is anyone who is key to the running of a business and can include the owners. While it may be true that no one is irreplaceable, it can take time and effort, and this can cause financial hardship to the business. An easy example of a key person is a chef in a restaurant. If the chef were to die suddenly the restaurant needs a new chef recruited and hired. In a key employee policy, the *proceeds are paid to the business* to offset a drop in profits and help pay to recruit and train a suitable replacement. The insured is an individual and must prove insurability.

   The business is all of the following:

   - **the applicant,**
   - **the owner (third party owner),**
   - **the beneficiary, and**
   - **the payor of the premiums for the insured (key person/employee).**

3. **An Executive Bonus Plan** is an arrangement by which an employer can provide life insurance for selected employees. When covering employees with a noncontributory group plan, all employees have the same amount of coverage, the plan cannot discriminate. If the plan discriminates between key employees and all other employees, tax advantages are lost. The executive bonus plan allows the employer to choose selected individuals and the amount of coverage for each. It is also known as a Section 162 plan, which is the Internal Revenue Code that allows this to be tax deductible for the employer. It is taxed as income to the employee.

The employee, usually a key executive, purchases a policy on their life and names the beneficiary (cannot be the employer). The employer then pays a cash bonus to the executive each year equal to the insurance premiums or could pay directly to the carrier. The bonus is tax deductible for the employer and taxable to the executive. If the executive is uninsurable an annuity may be used. The coverage can be term, whole life, or universal. It is owned by the employee, so any cash values are available to them according to the policy itself. If the employee chooses a UL policy, they may put additional money in the cash value as desired.

E. Factors in Premium Determination

The exchange of values is an important part of a legal contract, like an insurance contract. The consideration from the insurance company to the consumer is the policy, it represents a promise to pay. The consideration from the consumer to the insurance company is the application and premium. What are the factors a company uses to determine the premium it will charge?

1. **Mortality** refers to the number of deaths within a given time or area. Based on past experience, the actuaries in insurance companies are able to predict how many insureds of a given age will die in any year. Multiple factors are evaluated, age, gender, race, education, income level, etc. Insurance companies use the **Law of Large Numbers,** which predicts the future of an event based on past experience. The higher the numbers, the more accurate the predictions are. Everyone is statistically dead at age 100, therefore the older you are when you purchase life insurance, the more you will pay.

2. **Interest**: Insurance companies have an idea of how much they will receive by investing the premiums received, they plan on annual premiums from all insureds. This is one of the reasons if you pay monthly your annual premium aggregate (12 x monthly) is higher than a single annual premium would be.

3. **Expense**: Insurance companies also have an idea of the cost of doing business. These business expenses can include commissions, billing, salaries, as well as claims. Since the primary source of income is premium, the policyholder is, in effect, paying these expenses.

- Net Premium = Risk - Interest
- Gross Premium = Risk - Interest + Expenses

F. Premium Mode As mentioned, insurance companies plan to receive the annual premium upfront. Insurers have calculated the amount of interest those funds will bring in for the company. Unless we are talking about a single premium policy, consumers have the option to pay:

💰 Annually > Semi-Annually > Quarterly > Monthly > Pre-Authorized Checking *(PAC)*

The amount of interest the company expects to receive will be charged to the consumer in the form of premium along with any billing expenses it might incur. Therefore, annual premium is often less than 12 monthly premiums combined.

A whole life policy is more affordable for the average consumer on a monthly premium payment plan to age 100, this offers the best value if the consumer dies soon. It is also the most expensive if you add up all the premiums paid from the start of the policy to age 100. Conversely, the single premium payment is quite large, once, but is the least expensive of all the plans **assuming the insured lives to be 100**.

G. Field Underwriting is what producers do. Producers are not doing underwriting as the company does. They are filling out the paperwork completely, collecting premiums, and gathering signatures on the application as well as all the other forms needed. These range from HIPAA release forms to replacement forms.

1. Application Procedures

The **Application** is a form on which the prospective insured states facts requested by the insurer on the basis of which, together with information from other sources, the insurer decides whether to accept the risk, modify the coverage offered, or decline the risk. It is a formal request to an insurance company to issue a policy based on the statements (a.k.a. representations) contained within the application. It is the most important source of information for the insurance company. It tells them who I am, what I want, how much of it I want, and a bit about me to assist in the underwriting.

- The application is part of the *consideration,* and a policy cannot be issued without it.

2. Signatures of the owner, the insured, and the agent are required.

The agent signs the application as a witness to the signatures.

- The insured, if other than the owner, needs to sign if they are of legal age. A spouse or business partner would need to sign, and a child under the age of 18 would not need to sign as they are not legally competent.
- ***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***. (Another option is starting over with a new application.) 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.
- ***Incomplete or incorrect applications*** delay the process. They will be sent back to the producer to complete with the client and there may be no coverage during this time. If changes are made the date on the application and any other disclosures also needs to be changed and initialed to reflect the conditional coverage new dates.

- ***Neither the agent nor the company can make a change in an application without the written approval of the applicant***. Written approval is the clients' initials on the paperwork next to the correction. The contract is the application, the policy, and any riders or endorsements. If the policy pays other than as expected and a change was made, everyone from the beneficiary to the lawyer to the judge is looking for the owner's initials next to that change.
- 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.

3. Underwriting

is the process of selection, classification, and rating of risks. Simply put, underwriting is a ***risk selection process***. *The selection process consists of underwriters evaluating information found on the application.*

✓ Avoiding adverse selection is a major priority for any underwriter. Adverse Selection means a selection of risks against the interests of the insurer. It is based on the fact that poor risks with higher chances of loss have a greater tendency to apply for insurance coverage than those who have very little chance of loss. For example, adverse selection would exist if only people in poor health applied for life insurance.

4. Replacement of a Policy

is legal, but most states have "Replacement" regulations. The purpose of the replacement regulation is to regulate the activities of insurers and producers with respect to the replacement of existing insurance contracts. This helps to protect the interests of the purchaser by establishing minimum standards of conduct to assure that the purchaser receives information with which a decision can be made in his or her own best interest to reduce misrepresentation.

A ***Notice Regarding Replacement of Insurance form*** must be completed by the producer when a new application is written, and an existing policy is replaced. The owner/insured and the agent sign this form. One copy is left with the applicant, the other copy goes to home office with the application.

5. HIPAA: The Health Insurance Portability & Accountability Act Privacy Rule's

primary purpose is to define and limit the circumstances under which an individual's health information may be used or disclosed to other parties. An entity may not use or disclose protected health information unless ***the individual who is the subject of the information authorizes it in writing.*** An attending physician statement, when requested by the underwriting department, must be accompanied by a HIPAA release form.

- The signed HIPAA form is permission from the applicant for the doctor/ surgeon/ hospital/ etc., allowing the questions from the insurer to be answered.

6. Representations… are found in an application, they are items in the past.

- A **representation** is a fact that an applicant represents as true and accurate to the best of his knowledge and belief.
- A **misrepresentation** is a statement by the applicant that is not true (a lie).
- A **concealment** is the withholding of facts from the insurer.

A Misrepresentation or Concealment discovered in the ***first two years of the life contract*** and found to be **material** could cause **the contract to be voided.** A *material fact* is information that, had it been known, would have caused the insurance company to reject the application or issue the policy on ***substantially different terms.*** (i.e., a rate-up or surcharge).

- This is found in the ***incontestability clause*.**

7. Warranty… Is found in a policy, they deal with future happenings.

- ***A* Warranty *is a written (expressed) guarantee in the policy that something is true in every respect and detail.*** Most warranties are found in property and casualty policies, for example, a hotel will *warrant* to the insurance company that its sprinkler system will be in operation 24 hours a day. The consumer warrants nothing in a life or disability application, we represent.
- In an insurance contract, the warranty given by the *insurance company* is their **promise to pay**. The circumstances under which the company will pay benefits are spelled out in the ***insuring agreement (clause)*** of the policy.

H. Policy Delivery is the producer's responsibility and it ***must be delivered within a reasonable period of time after issuance. (30 days is considered reasonable.)*** The producer is also responsible for explaining the policy to the insured and ***making the insured and owner aware of any changes.***

Delivering the policy in person will give the producer another chance to explain the benefits of the policy and reinforce the reason for buying it, which will in turn help to keep the policy from lapsing. A policy delivery receipt also should be obtained so that the producer can prove delivery which starts the free look period for the owner.

1. The Policy Effective Date is the ***date of the fully completed 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*** (sometimes called **pre-paid**).

- Remember that an incomplete application (***missing material information***) **does not** put coverage into effect.

2. Backdating an application may change the effective date of coverage from the actual application signing date to the date requested. This is only allowed in life insurance. Keep in mind, you need to be alive to do this so the carrier is not really taking a chance. Backdating may be allowed for up to 6 months and will only affect the premium due. Insurance companies do not use your age today for calculating premium, they may round to the nearest birthday.

For example, if someone filling out the application on January 10 has a birthday in March their premium will be calculated as though the birthday had already passed. If that someone was actually 60 and they were charged as though they were 61, that could have a huge impact on the total premium paid over the life time of the policy. Backdating the application would prevent that increase.

The premium for that backdated period would be due up front so you have to figure out if it is worth doing. This may or may not change the start dates of the 2-year incontestable and suicide clauses. Read your policy.

3. Policy Review does not have to be page by page of the entire contract but should include a few important items. Start with confirmation of the key items; who is covered, the amount of coverage and premium, the mode of premium payment, and review the application since any mistakes there could cause the policy to be voided (incontestability clause). A signature stating the policy was received is important, as is reviewing the incontestability clause and the suicide clause.

This is if the policy is issued as requested and coverage has started back at the application date. If there is a health problem or any other reason the policy would NOT issue as requested (such as hazardous hobbies or a hazardous occupation), the insurance company issues a **counteroffer**. There is NO coverage until the client accepts this counteroffer. If the client accepts the counteroffer, they must pay any additional premium as well as sign any counteroffer forms including a ***statement of continued good health.*** The policy effective date is when the client signs and, if necessary, pays.

Delivery of the policy may also be by USPS or electronic delivery. *This is quick and easy for both the client and the producer but there is no face-to-face contact and this can be a loss. You could lower or lose the chance to easily answer any questions they may have thought of, reconnect with them every so often to update and possibly increase their coverage, invite them to view other products, and ask for referrals.*

4. Modified/Amended vs. Issued as Requested... A policy can be issued by an insurance company as requested, with an elimination or exclusion rider, rated-up, a surcharge added, or declined. If a policy is issued differently than submitted (i.e., a counteroffer), a signature from the policy owner will be needed upon delivery of the policy. ***The policy will be in force when the counteroffer is signed, and the additional premium is paid*.** To sum it up, the policy effective date is when ALL the first premium has been paid and ALL signatures have been received.

5. Premium Collection with the application conditionally puts coverage into effect. If the policy issues as applied for, then coverage has been in effect from the signature date. Remember for a contract to be legal there must be an exchange of values. The premium and the application are from the consumer, and the policy *(promise to pay)* is from the carrier.

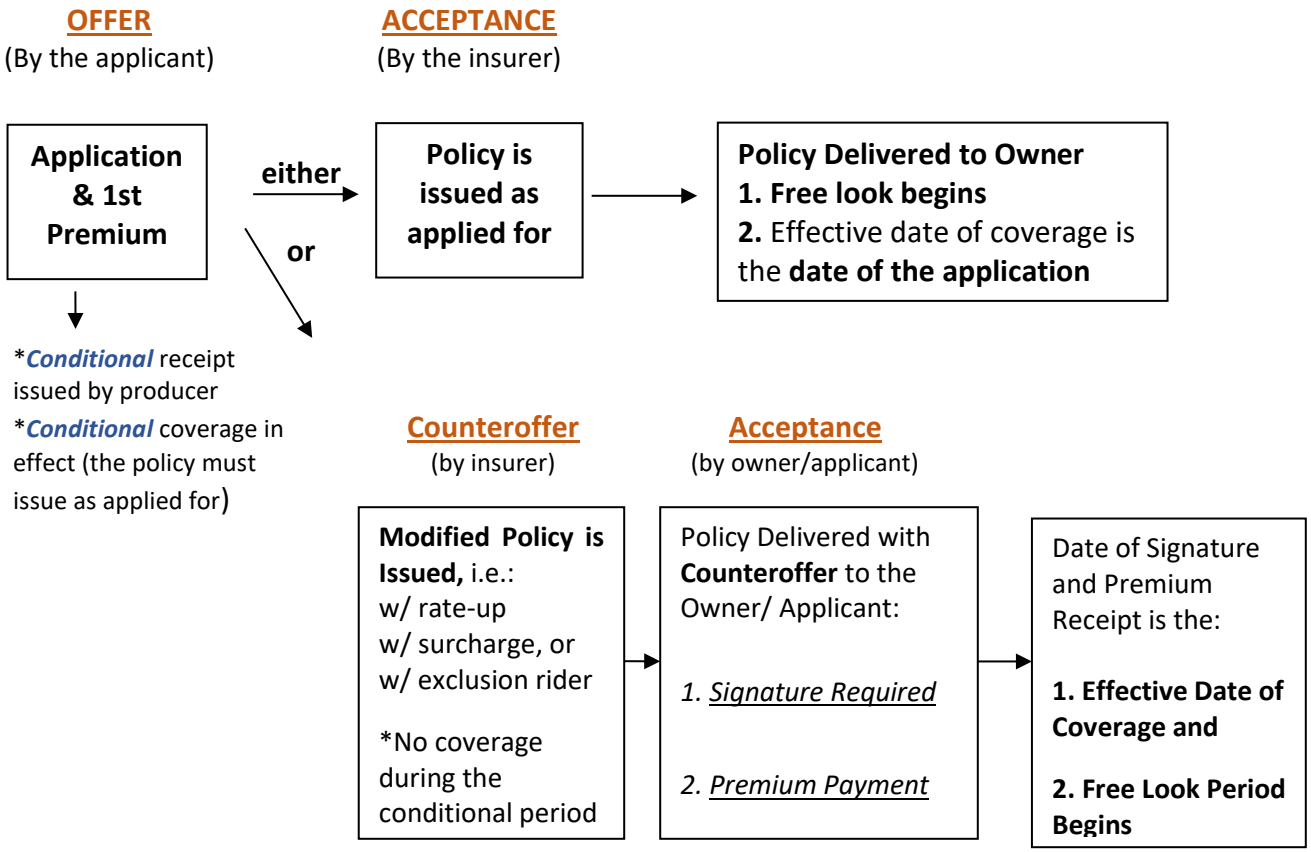
- A **Conditional Receipt (a.k.a. Temporary Insuring Agreement)** is issued by Life and Disability producers when money is collected with the application (sometimes called ***prepaid***) and ***is in effect until the policy issues.*** It provides coverage on a conditional basis, that is, on the condition 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.

*** For example:** if a producer collects the required premium, a fully completed, dated, and signed application from the applicant, the producer will give the applicant a **conditional receipt**. The insured is covered on a conditional basis.

Should the applicant die the next week, before the policy issues, the insurance company will complete the underwriting process just as if the applicant were still alive. If the policy is issued, the beneficiary would receive the death benefit check. However, should the insurance company reject the application for coverage, no death benefits would be paid but the premiums paid will be refunded. (Note: claims and underwriting do not meet and compare notes)

If there is a health problem or any other reason the policy would NOT issue as requested such as hazardous hobbies or hazardous occupations, the insurance company issues a **counteroffer**. There is NO coverage until the client accepts this counteroffer. If the client accepts the counteroffer, they must pay any additional premium as well as sign any counteroffer forms including a ***statement of continued good health.*** The policy effective date is when the client signs and, if necessary, pays.

With the initial premium paid:



Without the initial premium paid:

✓ If the insured dies during the underwriting period, there is NO death benefit payable.

- **Without the initial premium** (sometimes called ***non-prepaid***), 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.

6. Statement of Continued Good Health says "I am as healthy now as I was when I filled out the application." It is the insurer's method of avoiding adverse selection (by verifying that a person has not been diagnosed with a terminal illness). This signature date starts the coverage.

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

1. Insurance coverage actually begins
2. The contestable period begins
3. The suicide clause takes effect

I. Company Underwriting

1. Sources of Information

Reports for the underwriter come from several sources (Reporting Services). The insurance company needs permission from the applicant to order these reports. They include:

a) **Medical Examinations** when required, might include such things as a urine specimen, blood test, blood pressure check, or EKG. These exams can be done at the doctor's office but usually a paramedic service will go to the client's home to do the exams. The costs are covered by the insurance company and the results go to the company, the client's doctor if one is listed, and the client may be able to view them.

b) **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 for all reports ordered by the insurer.**
- ✓ ***An application for insurance cannot be denied solely based on the MIB report. The insurance company must fully underwrite the applicant.***

c) **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. Most companies' home offices manage the reports, yet some may have other organizations check on the insured's background, lifestyle, moral habits, etc.

d) **Attending Physician's Statements** (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 signed authorization includes a HIPAA release form. Without that signature, the doctors cannot even say if a person is or ever was a patient of theirs.

e) **Producer's (Agent) Report** is used by the producer to document his personal observation concerning the proposed insured. The producer is considered the most important source of information to the insurance company during the underwriting process, and their report is important to the insurance company. *This can be notes of a key person policy, why the owner is other than the insured and shows insurable interest, a note that was weight loss was due to a child being born – whatever the producer feels is important for the underwriters to know and is not addressed on the application.*

2. Classification of Risks

Evaluation of the applicant is based on age, sex, amount of protection requested, moral habits, lifestyle, occupation, hobbies, current health, and past health.

- **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.*** The insurance company may never discriminate based on race, color, religion, national origin, or the ability to read, write or speak English.

- *Lifestyle, moral habits, and personal characteristics are reviewed in inspection reports.*

  Yes, the insurance company judges us. They are not looking at if my dishes are done or my lawn needs to be mowed, rather they are looking to see if I am a moral hazard, felonies, multiple speeding tickets, etc. This is a higher-risk lifestyle than they may want to take on.

- *Marital Status* is **NOT** a life or disability insurance underwriting factor. Applications for life and disability insurance do not ask if the applicant is married or single.

- **Standard Risks** will live to normal life expectancy. Standard premium will be charged.

- **Preferred Risks** will live longer than normal life expectancy and will receive a discount.

- **Substandard Risks** may not live the normal life expectancy possibly due to either health issues or participation in hazardous sports. Due to this, they will pay a higher premium, this is known as a ***rated policy.*** A *rate-up* or *surcharge* are the terms used depending on how the company rates the policy, they would constitute a ***counteroffer*** by the insurance company, and would require a signature of acceptance from the policy owner as well as a Statement of Continued Good Health.

  1. ***Rate-up*** means the insurance company will charge a younger applicant the premium of an older aged applicant, such as a 30-year-old will pay the rate of a 35-year-old.

  2. ***Surcharge*** means an additional percentage of the original premium will be charged for the risk. For example, if a person has hypertension, instead of paying $1,000 for a policy, a surcharge of 25% ($250) might be added to the premium.

- **Declined Risks** do not qualify for coverage at all.