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II. Accident and Health Insurance Basics

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A. Field Underwriting

1. 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. ***It requires the signature of the owner, insured and agent***. The agent signs the application as a witness to the signatures.

   - 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. Evaluation of the applicant is based on age, sex, amount of protection requested, moral habits, 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.***
   - *Life style, moral habits and personal characteristics are received by inspection reports.*
   - *Marital Status* is NOT an underwriting factor, in fact, applications do NOT ask if the applicant is married or single.
   - Standard Risk means a normal risk at a given age.
   - Preferred Risk means a healthier than normal risk and will pay a lower premium. Many companies still give a non-tobacco users discount.
   - Substandard Risk means not being as healthy as a normal risk and will usually pay a higher premium.

     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.

3. 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:

- 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 doctors office.

✓ Consumer Report/Credit Check (Fair Credit Reporting Act)… Consumers must be notified that a credit 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.

- 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.*

- 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, life style, and moral habits, etc.

- Attending Physicians Statements (a.k.a. APSs) 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.

- Producer's (Agent) Report: is used by the producer to document his personal observation concerning the proposed insured. The producer is considered an important source of information to the insurance company during the underwriting process so his report is important to the insurance company.

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. 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 premium have been collected.*

2) The Policy Effective Date is the *date of the application*, provided the insured is *insurable* (i.e., 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.

- 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 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

- *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.

Prospect makes an offer consisting of Application & 1st Premium to the Insurer	then.....	Insurer accepts offer. Policy is issued as applied for.	ending with.....	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…1,2,3

1

Modified Policy is Issued , i.e.:
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

- Sickness is an illness or disease that is not the result of an accident.
- Accidental bodily injury is defined as bodily injury which is the result of an accident (an occurrence which is unforeseen and unintended, independent of disease).

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 insureds salary, they will not be over-indemnified and won't 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 illness. 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

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.

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.

1. ***All long-term care insurance policies must be guaranteed renewable.*** .

2. 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 (i.e., 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.

3. 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*

4. 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.

4) Prescriptions

A **prescription drug** is a pharmaceutical drug that legally requires a medical prescription to be dispensed. In contrast, over-the-counter drugs can be obtained without a prescription. The reason for this difference in substance control is the potential scope of misuse, from drug abuse to practicing medicine without a license and without sufficient education. Different jurisdictions have different definitions of what constitutes a prescription drug.

The package insert for a prescription drug contains information about the intended effect of the drug and how it works in the body. It also contains information about side-effects, how a patient should take the drug, and cautions for its use, including warnings about allergies. Herbal preparations, amino acids, vitamins, minerals, and other food supplements are regulated by the FDA as dietary supplements. Because specific health claims cannot be made, the consumer must make informed decisions when purchasing such products

E. Limited Health Insurance Policies

1) Accidental Death and Dismemberment (A.D.& D.)

a) The Principal Sum pays for ***accidental death***, for the dismemberment of or loss of use of any two limbs, or for the total loss of sight or speech, or the total loss of hearing.

b) The Capital Sum (pays up to ½ of the principal sum) pays for loss of or loss of use of any one limb, loss of sight in one eye or one arm ***due to an accident***. The AD & D will have a *schedule* of benefits for other lesser types of dismemberments (e.g., loss of a finger).

- ***The Capital Sum may also pay for loss of an organ, such as a kidney or spleen, as long as the loss is due to an accident.***

c) Exclusions: AD & D policies will **not** pay if death or dismemberment occurs more than **90 days** after the accident.

These policies **will not pay** for death due to:

- illness, suicide, war, or intentional acts of the insured.
- air travel other than as a fare-paying passenger.
- ***the insured's illegal activities***, e.g., committing assault or felony.
- the use of any drugs (unless the insured is under a doctors' care).

Special Note: Should an insured die from a cause or situation which is "**excluded**" in the policy, no death benefit will be paid, **nor will there be any refund of paid premiums**.

2) Critical Illness Plans are used to cover high cost illnesses. They encompass a broad range of illnesses such as heart disease, cancer, stroke, kidney disease, etc., including benefits for MRIs, radiation treatment and chemotherapy. If the insured has a plan and is diagnosed with a disease listed, the plan will pay a lump sum to the insured. The money can be used to cover the costs not covered on the medical insurance, pay the deductible, pay a driver to bring the insured to and from treatment, etc.

- *These plans usually pay a lump sum benefit to the insured, such as $50,000 if the insured is diagnosed with cancer, or $25,000 for kidney failure*.
- Critical Illness Plans should be purchased as a supplement to the insured's other health plan. Since these plans are supplements, they will pay in addition to the insured's other health plans with no coordination of benefits.

3) Hospital Indemnity pays based on daily, weekly or monthly limits, regardless of the actual hospital expenses. Examples: $100 per day for the time spent in the hospital. This will not cover the hospital expenses, that's what your medical insurance is for. This can pay the premium or the deductible on your medical insurance. You can purchase amounts on you and family members. *This acts like a disability income for the amount of time one is hospitalized.*

4) Dental Insurance usually is offered only under group plans. It is most often excluded from medical expense insurance, therefore, the coverage must be added as an additional or optional benefit or purchased as a separate plan. Individual plans range from those like a traditional major medical or PPO's or HMO's. Individual Benefits offered may be on a ***scheduled or non-scheduled basis,*** or a combination plan of scheduled and non-scheduled benefits.

- A nonscheduled plan is paid on a usual, customary and reasonable basis (UCR).
- A scheduled plan has specific categories of dental treatment and dollar amounts for each category of dental care. A scheduled plan might include categories such as: preventive care, diagnostic care, restoration (fillings and crowns), and root canals.
- Most dental plans, as with most medical plans, have a deductible and a coinsurance provision. The deductible usually does not apply for preventive care. The plans will usually have a maximum limit per year (e.g., $1,000, $5,000).
- New plans will also have a probation period for certain items. For example, cavities may not be covered for 8 months. This is to help avoid adverse selection.

5) Vision Care includes eye exams and eyeglasses. Although not a very common benefit, it can be offered as an optional benefit under most group health plans. This optional benefit will usually pay either a specific (fixed) amount or the entire cost of eye exams. It normally covers all or part of the cost of prescribed eyeglasses.

6) Hearing

Even though hearing loss is one of the most common disabilities, it is also one of the most misunderstood and underestimated disability. Hearing testing may be covered on a health insurance policy, hearing aids may not be. It has been called the "invisible" condition because it is not possible to "see" a hearing loss directly, only its effects upon behavior and communication. The fact that these effects can be so variable depending upon the individual and the situation is what makes hearing loss such a confusing condition. We do not want to trivialize the impact that impaired communication can have upon the life and well-being of an affected person, regardless of the age. 80% of people who could benefit from hearing aids do not get them. It can be a covered item in insurance policies but the amount paid out is very limited and not enough to cover more than a small percentage of the total cost.

7) Credit Disability is a type of group coverage. A master policy is issued to a creditor (the bank) to insure persons who are debtors of the creditor. The creditor is the beneficiary to cover the **repayment of a loan** in the event the borrower (insured) becomes disabled before the loan has been repaid. To sell credit life or credit disability you need to take the exam for a Limited Lines Credit license.

F. Classification of Risks

- **Standard Risk** means a normal risk at a given age.
- **Preferred Risk** means a healthier than normal risk and will pay a lower premium. Many companies still give a non-tobacco users discount.
- **Substandard Risk** means not being as healthy as a normal risk and will usually pay a higher premium.