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Completing the Application, Underwriting, and Delivering Policies

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 the owner chose a settlement option. 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 to whom the proceeds are paid.

A. Completing the Application

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

The **Application** is a form on which the prospective insured states facts requested by the insurer based on 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 *consideration* and a policy cannot be issued without it.

1. Required Signatures — Signatures of the owner, the insured, and the agent are required.

The owner signs to affirm everything on the application is true to the best of their knowledge and belief. The owner's signature also is permission for the carrier to run any necessary reports for underwriting. The agent signs the application as a witness to the signatures and as an attestation that everything is true to the best of their knowledge and belief.

- 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, a child under the age of 18 would not need to sign as they are not legally competent.

2. Changes

- ***Neither the agent nor the company can make a change in an application without the written approval of the applicant***. Written approval is the client's 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.*
- ***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 correction.

3. Incomplete or incorrect applications

- These will delay the process. They will be sent back to the producer to complete with the client and there may be no conditional coverage during this time.
- If changes are made, the date on the application needs to be changed and any other disclosures also need to have those dates changed and initialed to reflect the conditional coverage new dates.
- 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.

4. Warranties and Representations

a) Representations… Are in an Application and is a fact that an applicant represents as true and accurate to the best of his knowledge and belief.

- *It is based on current or past events.*
- A **misrepresentation** is a statement by the applicant that is not true (a lie).
- **Concealment** is the withholding of facts from the insurer (a lie of omission).

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.*** *(E.g., a rate-up or surcharge.)*

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

b) Warranty… Is in a policy ***and 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. If a fire breaks out and the sprinkler system is not working, the insurer does not have to pay.
- The consumer warrants nothing in a life or disability application, we represent.
- Warranties are based on future events.
- 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.

5. Premium collection is done at the time of the application. One monthly premium is required for the policy to be conditionally in force. A conditional receipt explaining this is given to the client. What this means is if the policy issues as requested, the coverage effective date is the date of the application, if the policy issues with a counteroffer the effective date is when the policy is delivered, accepted, and the extra premium paid.

- 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 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.
- If the underwriting requirements are met *(e.g., blood, urine, and vitals are done and recorded)* and the client dies, the death benefit is paid out **if the policy is issued as requested**. *(Note: claims and underwriting do not compare notes.)*
- What if the underwriting requirements have not been met, the client does not schedule with the para-med or the doctor, and the client dies? The paid premium is refunded because the underwriting cannot be done without the medical testing completed. If the check bounces at the time of application? No conditional coverage, no death benefit.

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 tremendous impact on the total premium paid over the lifetime of the policy. Backdating the application would prevent that increase.

The premium for that backdated period would be due upfront, 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.

6. Replacement of a Policy

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. The top copy is left with the applicant, the bottom copy goes to the home office with the application. This notice is a page of questions that the insured should ask but may not know enough to do so. For example, does this start a new contestable period and suicide clause? What are the tax consequences? These are things an insured may want to consider but would not think to ask, so the industry (NAIC) asks for them. The questions are answered by the producer, and all parties sign the form. It is left with the client for them to review at their leisure.

7. Disclosures at the point of sale

a) HIV (Human Immunodeficiency Virus) consent form disclosure is to let the client know that any test will check for this virus and have their signature authorizing the test. It can have a spot for the client's doctor's name and address to pass any results along.

b) 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.

c) State disclosure forms: Each state may have separate disclosure forms for the client to have.

8. USA Patriot Act

The official title of the USA PATRIOT Act is "Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT) Act of 2001."

After the 9/11 attacks, our government realized the terrorist acts were often paid for with laundered money, so they passed this federal law to assist in detecting it, as well as identity confirmation. Money laundering has been going on for years, but all of a sudden it was linked to terrorist attacks and was in the spotlight. Money laundering is taking funds that have been obtained by illegal means and moving them around until they appear legitimate. How does that work for insurance? Payment with a counter check for a single premium policy, adding much more premium that required in a UL, then changing policies and companies more than once. These are examples of what could require a report. What you ALWAYS need to do is verify client identification.

The purpose of this act is to detect and deter terrorist acts and the financing of the same. To be compliant with this law, you must verify the identity of your clients with a government photo ID such as a driver's license or passport at the time of application. Any person who pays with large amounts ($10,000+) will have a Suspicious Activity Report (SARs) form completed to assist in avoiding money laundering.

9. Gramm-Leach Bliley Act (GBLA) Privacy

The Gramm-Leach-Bliley Act requires financial institutions - companies that offer consumers financial products or services like loans, financial or investment advice, or insurance - to explain their information-sharing practices to their customers and to safeguard sensitive data. A client has the opportunity to 'opt-out' of the information sharing that is done outside the corporation. The sharing between a carrier that has partner companies may not be opted out of.

B. Underwriting

B. 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 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 which have very little chance of loss. For example, adverse selection would exist if only people in poor health applied for life insurance.

1. Insurable Interest

1. 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 an insurable interest in the insured at the time of application.

- **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.

2. Sources of Information for the underwriter come from several sources (Reporting Services). The insurance company needs permission from the applicant to order these reports. This permission is obtained when the client signs the application. The reports can include:

- **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.

- **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.***

- **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 handle the reports, yet some may have other organizations check on the insured's background, lifestyle, moral habits, etc. *These are used to determine lifestyle risk.*

- **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 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. *The underwriters need to verify the client was in the hospital for rotator cuff surgery and not a triple bypass. One will affect the lifespan, the other will not.*

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

3. Fair Credit Reporting Act

… Protects information collected by consumer reporting agencies. It protects the consumer because we have a right to see what is in any report, dispute false information, and have it corrected.

Consumer Report / Credit Check says any report may be run by the insurance company when underwriting an application. However:

1. The consumer must be notified that a credit report or any other report will be sought and told how it will be used.
2. You must be told if any information in your file has adversely affected a decision.
3. The consumer must be told how to obtain a copy of their report. The consumer has the right to know what is in the report.
4. Information on the report can be disputed, and if the reporting agency cannot prove the disputed information is accurate, the information must be removed from the person's file within 30 days.
5. **A Bankruptcy will show for 7 to 10 years on your credit report (7 years if the debt was paid, 10 if it was not).**

4. 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 a 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.*
- *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. A 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** do not qualify for coverage at all.

5. Stranger-originated / investor-owned Life Insurance (STOLI /IOLI) are life insurance policies that are owned by a stranger or an investment group. There is no insurable interest for the stranger or investment group to purchase these policies, so the insured purchases coverage on themselves and sells the policy to a person or group for immediate payment. The Stranger or Investment group takes ownership, pays premiums, and collects the death benefit when the insured dies. Why would someone do this? Money. They get paid to purchase the policy and then they assign it to the stranger or investor group. This is not ethical since the group is using the life of a person as an investment, but they only get paid when the insured dies. They are also **not legal**, and many states have specific laws regarding them. Insurance companies will ask carefully to avoid selling a policy that is intended to become one.

Viatical settlements and other life settlements are policies that the insured has decided to sell after owning for at least 2 years. A STOLI is instigated by the third party with the intention of profit.

C. 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.)***

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

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

- An application with no premium also does not put coverage into effect. An application can be taken as Cash on Delivery (COD) but there is no conditional coverage for the client in the event something happens.

- Should the applicant die the next week, 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 or counteroffer, no death benefits would be paid, but the premiums paid would be refunded.

- 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, a statement of good health 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. (Consideration is complete.)**

b) 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 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 and 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 lose the chance to answer questions they may have thought of, you could lose the chance to reconnect with them in a few years to update the coverage, you lose the chance to invite them to view other products, and you lose the chance to ask for referrals.

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 should also be obtained so that the producer can prove delivery, which starts the free look period for the owner.

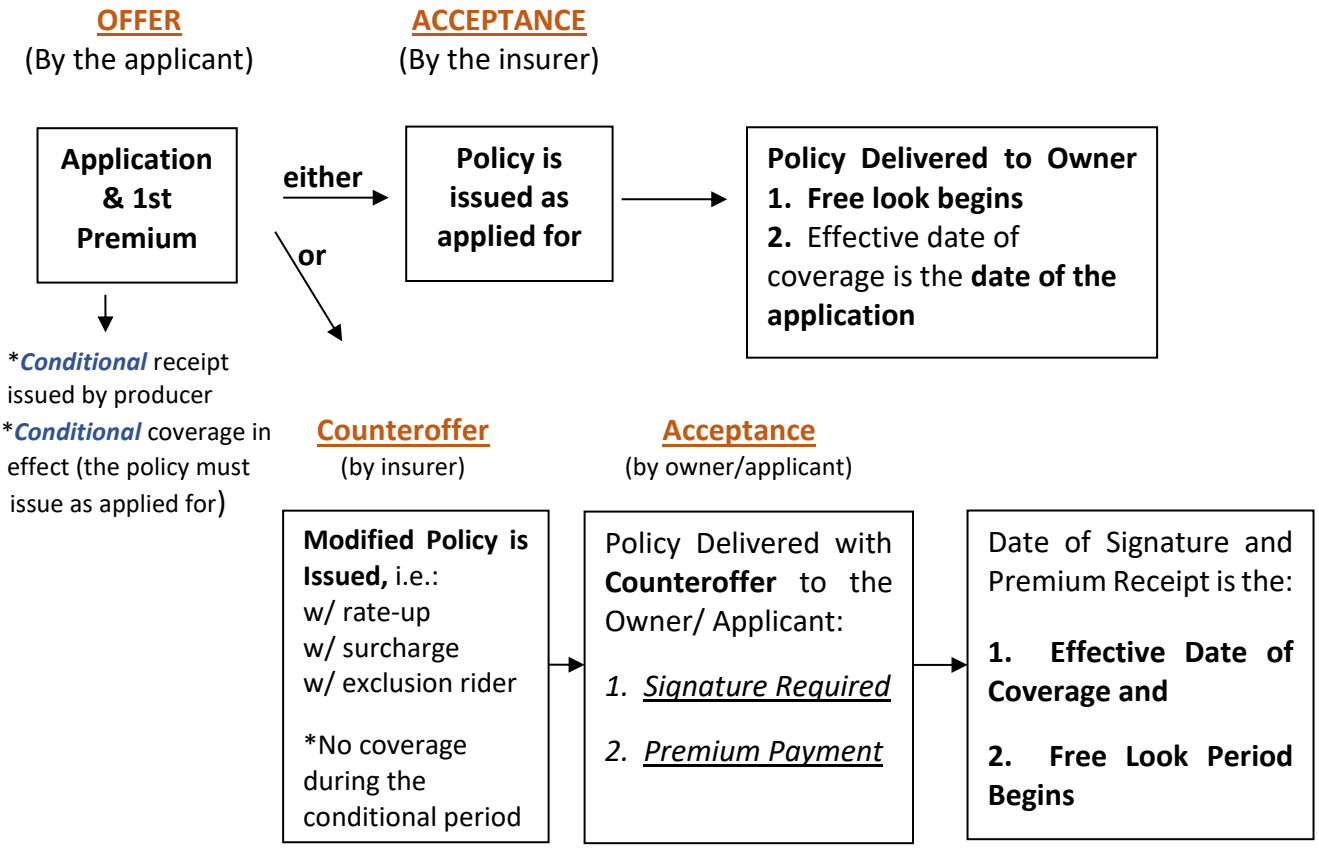
c) A Statement of Good Health is required for any counteroffer or cash-on-delivery (COD) policy. It is an attestation by the client that they are as healthy now as they were when the application was originally taken. It is signed in addition to their signed acceptance of the policy as issued.

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.

With the initial premium paid:



- 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

D. Elements of a Contract / Essential Elements

Insurance Contract… Insurance policies are legal contracts and are enforceable by law. The ***Entire Contract Provision*** states the contract consists of the application, the policy, and any riders or endorsements. All statements on an application are deemed to be representations, not warranties.

In order for the contract to be considered a legal and binding contract the following elements must be in place.

**** CCOAL: Consideration, Competent Parties, Offer, Acceptance, Legal Object**

1. Agreement or Offer and Acceptance

Offer and Acceptance together constitute an **agreement.** The agreement is meant to create a legal relationship.

a) Offer… The **applicant makes the *offer* to the insurance company**. Remember, the legal contract is between two parties, the insurer and the insured. One must make the offer, and the other accepts it. Insurance, even though advertised by a company, must be initiated by the client.

b) Acceptance… The insurance company ***accepts*** the ***offer*** by issuing the policy. A ***counteroffer*** is made by the insurance company if it issues the policy other than how it was requested. The applicant ***accepts*** the ***counteroffer*** when the additional premium is paid, and the counter-sheet is signed by the owner/applicant (insured).

2. Consideration… means that something of value must be exchanged by all parties for the contract to be legal. It is the signed and completed application, plus the premium from the insured. If there is no application, the company does not know what policy you need. The insurance company issues a contract (policy) that represents a promise to pay.

This consideration date is usually the effective date of coverage. *The company has the consumer's money and signatures, and the consumer has the policy or the promise of (conditional receipt for L&D or a binder for P&C).*

3. Legal Purpose / Object… For a contract to be legal, it must be for legal purposes only. This is why *insurance contracts do not cover intentional or criminal acts of the insured,* why there must be insurable interest, and why stolen property cannot be insured. A contract to commit a crime is not legal and cannot be upheld in a court of law.

4. Competent Parties… The insured must be of legal age, not be under the influence of intoxicants, and must be mentally able. Any person 18 years of age or older will be considered of full legal age and may contract for or with respect to insurance. A person under 18 years old will be considered a minor.

- Consent must be freely given in order to enter into the contract.
- The meaning of the contract must be certain.
- The contract must be possible. If the act is impossible or illegal, the contract is void.

E. Characteristics of an Insurance Contract:

1. Contract of Adhesion means that since ***the insurer prepares the provisions of the contract,*** and the policyholder simply **adheres** (or agrees) to them, a court will rule in favor of the **insured** if there is any ambiguity in the contract terms. The contract is issued as a take-it-or-leave-it proposition. The insured must accept it as is.

2. Unilateral Contract means that one party is required to perform under the contract. The insurer cannot demand that the **insured** make the premium payments, but if the premiums are paid, the **insurer** is obligated to pay.

3. Conditional Contract refers to the fact that insurance contracts are conditional. The insurance company is obligated to pay a claim based on the condition that premiums were paid and proof of loss was submitted to the insurance company.

4. Aleatory Contracts are agreements that have an ***unequal exchange* of values** and *an uncertain or random event determines the loss*. The insured will pay premiums but may never file a claim due to a loss, so the consumer is paying more than the insurer. If there is a claim, the insurer pays out to cover the loss and will pay out more than the premium it has received from that claimant.