Slater All Lines Insurance School

3717-196th Street SW, #214
Lynnwood, WA 98036
Ph: 425.771.4870 www.slaterinsuranceschool.com

Insurance Fundamentals

First Edition

24 CE credits
(includes 3 CE Ethics credits)

Course #624727

Produced by Slater All Lines Insurance School

Table of Contents

GENERAL WASHINGTON LAWS AND RULES (WA CODE)

WASHINGTON LAWS AND RULES *as they pertain to Property Insurance*

PROPERTY INSURANCE

CASUALTY INSURANCE

SURETY (BOND) INSURANCE

NATIONAL FLOOD INSURANCE

WASHINGTON LAWS AND RULES *As They Pertain to Life Insurance*

LIFE INSURANCE

1. Employee Group
2. Master Policies vs. Certificate of Insurance
3. Conversion Rights
4. Term Coverage
5. Credit Life Insurance

B. **Tax-Qualified Retirement Plans**
1. Individual Retirement Account (IRA)
2. Roth IRA
3. Keogh Plan (HR-10)
4. Tax Sheltered Annuity (TSA)
5. Simplified Employee Pension (SEP)

C. **Non-Qualified Retirement Plans/Section 457 of the IRC**

D. **Business Uses of Life Insurance**
1. Buy and Sell Agreements; Cross-Purchase vs. Entity Plan
2. Key Person Insurance; Third Party Ownership
3. Split Dollar Plan (Arrangement)

E. **Social Security Benefits**; Death, Survivors and Retirement.....167

F. **Federal Income Tax**
1. Premiums, Dividends, Cash Value
2. Death Proceeds
3. Withdrawals
4. Policy Loans
5. Section 79
6. Modified Endowment Contract

G. **Legal Concepts:** Insurable Interest, Misrepresentation, Concealment, and Warranty

IV. The Life Contract 169

A. Application:
Required Signature and Replacement
Correction of an Error
Effects of Incomplete Applications
Replacement of a Policy
HIPAA Privacy Rule
HIV Disclosure

B. Evaluation

C. Modified v. Issued as Requested

D. Policy Delivery

E. Report Services:
Medical Exams
Fair Credit Reporting Act (Credit Scores)
MIB (Medical Information Bureau)

F. Policy Effective Date

G. Do Not Call List

WASHINGTON LAWS AND RULES *As They Pertain to Disability Insurance*

A. Marketing Methods and Practices

1. An Outline of Coverage 172

2. The Washington Medicare Supplement Health Insurance Act
- Pre-existing Conditions
- Open Enrollment
- Medicare Buyer's Guide and an Outline of Coverage
- A Beneficiary May Not Have Two Medigap Policies at Once
- A Licensee or Representative May Not.....
- Guaranteed Renewable - 31-Day Grace Period - Free-Look Period

- No Permanent Exclusions, Impairment Riders, Rate-ups or Surcharges
- Outpatient Prescription Drugs vs. Medicare Part D

3. The Long-Term Care Insurance Act

- Institutional Care vs. Community Based Care
- Terminally Ill Care (Hospice Care), Chronic Care
- Convalescent Care (Rehabilitation)
- Alternative Care
- Activities of Daily Living (ADLs)
- Cognitive Impairment

Levels of Care: Skilled Nursing Care vs. Intermediate Care vs. Custodial Care

LTC Required Provisions: 174

- Must Be Guaranteed Renewable/31-Day Grace Period
- Disclosure Form and Case Management/Gatekeeper Provision
- Must Provide Benefits For Mental and Emotional Disorders
- Prohibited Provisions/The Producer May Not vs. The Carrier May Not
- Cost of Living Adjustment
- Benefits Paid on a Per-Day or Pool of Money
- Special Approved Eight-Hour (8) LTC Course
- Determining Suitability and Underwriting Considerations
- Medicaid in Relation to Long-Term Care

B. Policy Clauses and Provisions 176

- Standard (Mandatory) Provisions and Optional Provisions
- Newborns are Covered at Birth: Complications of Childbirth
- Proof of Notice: Cancellation, Nonrenewal and Renewal
- Conversion/Continuation Rights: Individual Disability Insurance Policies
- Coverage for Dependent Children: Handicapped Children
- Certificate of Coverage: One Certificate For Each Family
- Health Care Service Contractors (Service Organizations) and HMOs
- Chemical Dependency
- HMO: Employer's Responsibility
- Free Look
- Individual Accident-Only Policies May Not Contain Waiting Periods
- Nonrenewal and Cancellation of Disability Insurance Contracts
- Application Completion

C. Health Insurance Coverage Access Act (Washington Health Pool)

- Eligibility
- Reimbursement Contract; Major Medical/$1,000,000
- Lifetime Benefit/80-20% Co-Insurance/Deductible
- Double Coverage Prohibited
- Dependent Coverage
- Medicare Supplement (Persons Receiving Medicare Parts A and B)

D. Health Insurance Reform (RCW 48.43.001) 178

Definitions; Definition of Small Group Requirements:

1. Individual Health Benefit Plans - Preexisting Conditions
2. Group Health Benefit Plans - Preexisting Conditions
3. Individual Health Benefit Plans - Mandatory Benefits
4. Health Carrier Coverage of Emergency Medical Services
5. Patient Bill of Rights
6. Requirement to Protect Enrollee's Right to Privacy

DISABILITY (ACCIDENT & HEALTH) INSURANCE

4. Reinstatement10. Physical Exam and Autopsy
5. Notice of Claim11. Legal Actions
6. Claims Forms 12. Change of Beneficiary

B. Uniform Optional Provisions

1. Change of Occupation
2. Misstatement of Age/Gender (Sex)
3. Other Insurance w/This Insurer (Duplicate coverage - Over insurance)
4. Insurance w/Other Insurers (Duplicate coverage - Over insurance)
5. Relationship of Earnings
6. Unpaid Premiums
7. Cancellation
8. Conformity with State Statutes
9. Illegal Occupation

C. Common Provisions and Clauses 199

1. Pre-Existing Conditions
2. Free Look
3. Consideration Clause
4. Insuring Clause
5. Assignment
6. Occupational v. Non-occupational Coverage
7. Ownership Clause
8. Policy Continuation Rights: (Cancelable v. Non-cancelable contracts) (Optionally, Conditionally and Guaranteed Renewable contracts)
9. Period of Time (30, 60, 90 day policies)
10. Dependent's Rights to Convert
11. Eligible Expenses & Pre-Authorization Requirement
12. Usual, Customary & Reasonable
13. Copayments

III. Social Insurance 201

A. Medicare
B. Medicaid
C. Social Security

IV. Field Underwriting and Taxation.....202

A. Formation of the Disability Contract
B. Insurance Contract
C. Legal Concepts
D. Federal Taxation of Benefits

Long-Term Care Insurance

I. Introduction

II. Long-Term Care Insurance

ETHICS IN THE INSURANCE INDUSTRY

WASHINGTON STATE LAWS AND RULES

Washington Administrative Code (WAC) Title 284
Revised Code of Washington (RCW) Title 48

I. NATURE OF INSURANCE

A. **Insurance** is a social device for transferring **risk (specifically the financial impact of a loss)** to an insurance company. The funds to cover losses are raised by collecting small amounts of money (premiums) from a broad base and large number of people.

"***Insurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies.***"

- ***Risk*** is the uncertainty of a loss, specifically, a financial loss. Only ***pure risk*** is insurable (the chance of a loss, no gain). With a ***speculative risk,*** there is chance of gain as well as a chance of loss. However, a *speculative risk is not insurable*.

- A ***hazard*** is anything that increases the chance of a loss, i.e., a swimming pool, old wiring, sky diving, or smoking.

- ***Insurance transactions*** include:
  a. **Solicitation** - offering to sell insurance.
  b. **Negotiation** - quoting, selling and any analysis prior to execution.
  c. **Execution** - putting the policy in force, signing any documents, etc.
  d. **Transactions** after the sale such as adding or changing coverage, etc.
  e. **Any act of insuring** - individuals or companies ***who perform transactions*** must be licensed to do so.

- ***Insurer*** is the insurance company or other entity assuming risks and agreeing to pay claims or provide services. Written communications from insurance companies must be phrased in **simple language** and list ***the full name of the insurer and location of its home office or principal office***, if any, in the United States.

- ***Insured*** is the person, persons, or business covered by the insurance, who (usually) pays the premiums in exchange for protection against losses.

- ***Insurance Policy*** is a contract, a legal document, which establishes the terms of the agreement between the insurer and the insured. The policy must ***not be*** unintelligible, ambiguous, or likely to mislead the person who is purchasing or reading the policy.

- ***Producer*** is a term used to describe someone who sells insurance, such as an agent.

B. **Public Interest**…The business of insurance is affected by ***public interest*** which requires that all persons act honestly, fairly, and abstain from deception in insurance matters. **All parties** are responsible for the integrity and trustworthiness of the insurance transaction. Producers must always act in the ***public's best interest*** (acting in the Utmost of Good Faith).

II. THE INSURANCE COMMISSIONER

The Insurance Industry in Washington is regulated by the State of Washington. The Revised Code of Washington (RCWs) is comprised of State Laws (a.k.a. Statute Law) passed by the state legislature which governs the insurance activities in our state.

The ***National Association of Insurance Commissioners*** (NAIC) is the oldest association of ***state government officials.*** The primary responsibility of the Insurance Commissioner is to protect the interests of the insurance consumer.

A. The Commissioner is ***elected*** every ***four (4) years*** by ***the voters*** of the State of Washington. The Commissioner must supply a ***$25,000 Surety Bond*** conditioned upon the faithful performance of the duties of his office, and also **may require any of his deputies or employees to post the same bond**.

Washington's current commissioner is Mike Kreidler.

1. General Powers and Duties of the Commissioner:

- ***Administer and enforce*** the provisions of the Insurance Code.
- Make ***reasonable rules and regulations*** for effectuating any provision of the Insurance Code.
- Conduct investigations to determine whether any person or company has violated any provision of the Insurance Code.
- Take action against an insurance company or health care service contractor by ***revocation or suspension of its Certificate of Authority.*** A certificate of authority is a company's license to transact insurance in our state.
- ***Fine insurance companies and licensees, and revoke or suspend any insurance license***.
- The Commissioner may ***investigate*** grievances filed against any authorized insurance company (provider) or insurance producer.

2. Enforcement by the Commissioner:

- If the Commissioner believes any person is violating or is about to violate insurance law, he may issue a ***cease and desist order*** to a producer or company or bring an action in court to enjoin the person from continuing the violation.
- If the Commissioner believes any person has violated any penal provision of the Insurance Code or other insurance laws, he must certify the facts of the violation to the public prosecutor of the jurisdiction in which the offense was committed.
- The attorney general and prosecuting attorneys in Washington State will prosecute or defend all proceedings brought under this Code when requested by the Commissioner.

3. The Commissioner **<u>DOES NOT</u>**:

- Ø Put insurance policies together.
- Ø Restrict the number of insurance agents a company may have.
- Ø Make the code or decide on the constitutionality of the codes (statutes).
- Ø Endorse any insurance company.
- Ø Prosecute, arrest, sue or issue warrants against licensees but file the complaint through the courts.

B. **Rates and Forms…**Washington is a **prior approval state.** Every insurer must file with the Insurance Commissioner, ***before using***, every ***policy***, manual, form, rule, rate, and effective date, utilized in classifications. The Insurer must also stipulate why the classifications, premiums, rules, etc., are needed.

- ***The Insurance Commissioner is responsible for the regulation of rates and forms***. The Commissioner's approval of a form may be withdrawn at any time, and may ***order*** that the form no longer be used.

C. **Examinations…**The Commissioner must establish the Examinations Department headed by a Chief Examiner who has the responsibility for monitoring the Insurers' financial status.

- The Chief Examiner must examine each **insurance company holding a certificate of authority at least every five years** but may examine at ***any time***, and also has the responsibility for licensing applicants and checking their qualifications.

D. **Hearings…**The Commissioner must hold hearings if required by any provision of the court or for any purpose within the scope of this code and must hold a hearing upon written demand by any person.

- The Commissioner must grant **a 15 working days** notice to licensees prior to holding any hearing.

- This 15 working days gives the licensee a chance to get all his/her paperwork in order and to ***seek legal representation if necessary. If requested by the licensee, an attorney may accompany the licensee to the hearing***.

- A licensee may request that a hearing authorized under the law be presided over by an ***administrative law judge***. Such a judge does not sit as a law judge, and the power is essentially one of recommendation.

E. **Unlicensed Activities & Penalties…***"A person may not **act** as or hold himself or herself out to be a producer in this state unless licensed by the Commissioner. A person may not solicit or take applications for or procure or place for others any kind of insurance for which he or she is not then licensed."*

An "***act*** " is committed in this state if it is committed, in whole or in part, in the state of

Washington, or affects persons or property within the state and relates to or involves any insurance contract.

- Any person who knowingly violates this section is ***guilty of a Class B felony.*** For example, if a producer licensed to sell only life insurance sells an individual a disability income policy he or she could be charged with a **felony**.

- **The Commissioner may** issue a cease and desist order, suspend or revoke a license and/or ***assess a civil penalty*** of not more than ***$25,000*** for each violation. Fines collected by the commissioner must be paid to the State Treasurer for deposit in the general fund.

- Upon failure to pay a civil penalty in **not less than 15 days nor more than 30 days**, the attorney general may bring a civil action on behalf of the Commissioner.

F. **Public Access to Records**…The Insurance Commissioner must allow public access to records by appointing a *Public Records Officer*. The Officer must be located in the Commissioner's Office and will be responsible for implementing the laws. The Officer must help individuals by accepting written requests for information, helping obtain the appropriate description of the records, and assisting the public.

III. INSURER (Insurance Company, a.k.a. Carrier)

.....is a company that takes on the responsibility of transferring risk (chance of a loss) from the general public to itself through insurance contracts.

A. **Definitions**

1. **Classifications of Insurance Companies:**

   - **Domestic** companies are insurers formed under the laws of the State of Washington (a.k.a. domiciled). Examples are Safeco and Pemco.

   - **Foreign** companies are formed in the United States other than in the State of Washington. Examples include Farmers, State Farm and Aflac. **These companies need *three years* of insurance experience** before being "authorized" in our State.

   - **Alien** companies are formed under the laws of a nation other than the United States. An example is Sun Life of Canada. **These companies need *three years* of insurance industry experience** before being "authorized" in our State.

2. A **Stock Insurance Company** is an incorporated business organization organized as a profit making entity and is owned by the **stockholders. Dividends are paid to the stockholders**.

3. **Mutual Insurance Companies are owned by the policy owners.** Policy owners (a.k.a. members) vote for a board of directors which directs the affairs of the company. The board of directors elects how much of a ***dividend (profit) to pay to the policy owners***. Guaranteeing dividends is a form of ***illegal rebating.*** There are **no stockholders**.

4. **A Fraternal**, or Fraternal Benefit Society, is an incorporated society or order which is a nonprofit organization that operates on the basis of "lodge," with a representative form of government. **It is formed solely for the benefit of its members**. It issues ***assessable*** (premiums may go up) and *par* policies (pays dividends), and sells only life and disability insurance. Examples include Knights of Columbus and Thrivent for Lutherans.

5. **A Certificate of Authority** is issued by the commissioner and must specify the name of the insurer, the location of its principal office, and the kind of insurance it is authorized to transact in this state. It also shows the powers that an insurer grants to its producers. **This certification authorizes a company to sell insurance in our state.**

   - A Certificate of Authority ***renews annually on July 1st.*** Don't get this confused with a ***Producer's license which renews every two years on the last day of the Producer's birthday month.***
   - Once an insurance company receives a Certificate of Authority, they are known as an "***admitted***" insurer.
   - "An **unauthorized** insurance company **may not** transact business in the State of Washington. ***No producer may represent an unauthorized insurer***. Each violation is punishable by a **$25,000 fine**."

     Exception: If certain insurance coverage cannot be obtained from authorized insurers, such coverage which is known as ***surplus lines***, may be obtained through a ***surplus line broker***.
     The Commissioner may order replacement of policies improperly placed with an unauthorized insurer with policies issued by an authorized insurer.

   - The **burden of determining** whether a prospective insurer is ***authorized*** to transact business in our state is the ***responsibility of the producer who is soliciting, negotiating or procuring an application for the insurance.*** The producer selling the insurance must make a good faith effort to determine whether the entity that is issuing the coverage is "authorized" in Washington.

6. ***Every advertisement by or on behalf of an insurer*** *must include the name in full of the insurer and the location of its home office or principal office, if any, in the United States.*

   - Every advertisement by or on behalf of any insurer claiming to show its financial condition may be in a condensed form and must correspond with the insurer's last statement filed with the commissioner. No insurer may advertise assets except those actually owned by the insurance company.

7. **Discrimination…*It is illegal to <u>unfairly</u> discriminate*** between groups of people regarding premium rates, benefits, policy renewals, etc. However, insurance underwriting does rely on statistical evidence to determine the amount of risk associated with a particular group of people. For example, 16 year old male drivers are statistically higher-risk than 45 year old male drivers. Because there is valid evidence to show this increase in risk, the 16 year old driver will pay a much higher premium.

B. **Washington Insurance *Guaranty Association* (Property and Casualty) & Washington Life and Disability Insurance *Guaranty Association***

The purpose of the Guaranty Associations is the creation of funds arising from a premium tax assessment on all insurers **authorized** to **transact** insurance business in Washington. The funds are used to ***assure claim payments* should the insurer become insolvent.**

- Coverage limit is **$300,000** <u>per claim</u> for **Property & Casualty** ($100 deductible).
- Coverage limit is **$500,000** <u>per person</u> for **Life & Disability** ($100 deductible).
- Maximum limit of $5,000,000 for all benefits under group annuity contracts.
- The payment of a claim <u>will not</u> exceed the limit of the policy from which the claim arises.
- The Association will cover claims existing prior to the order of liquidation and arising within ***<u>thirty days</u>*** after the order of liquidation.
- It is run by the Commissioner and five to nine other officials who are elected by the insurance companies who pay the tax.
- **Domestic** insurer's claims are guaranteed in all states. If you ***reside in another state*** but are insured with a Washington domestic insurer, Washington's association is <u>excess</u> coverage to the other state's association. If you are a ***resident of this state***, Washington's association is <u>primary</u> coverage.

∅ **No Duplication of Benefits**: Whenever a payment of proceeds or benefits by the association is also provided for under a similar law jurisdiction or policy the Washington Association will act as secondary coverage. Only one recovery is allowed.

∅ **The Associations do not guarantee:** fraternal benefit societies, health maintenance organizations, health care service contractors, surplus lines or reinsurance business, variable contracts, title, workers compensation, ocean marine and ***surety*** (bonds)**.**

∅ ***Licensees and insurers <u>may not</u> advertise or mention this Association to the public (for the purpose of solicitation, sale or inducement of insurance).***

IV. THE INSURANCE CONTRACT

A. A **contract** is defined as an agreement enforceable by law. **Insurance Contracts** are considered two party contracts which include an agreement between the **first party** (the insured) and **second party** (the insurer/insurance company).

The **elements of a legal insurance contract include:**

- **Offer and Acceptance…** The applicant makes the "***offer***" to the insurance company. The insurance company "***accepts***" the ***offer*** by issuing the policy. A "***counter-offer***" is made by the insurance company if it issues the policy other than how it was requested.

- **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. ***The insurance company issues a policy that represents a promise to pay***.

- **Legal Object…** In order 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***, and why there must be insurable interest. ***An insurance company will cancel a policy and deny a claim due to fraud committed by the insured against the insurance company.***

- **Competent Parties…** The insured must be of legal age, not be under the influence of intoxicants, and not be mentally handicapped. Any person at least 18 years old will be considered of full legal age and may contract for property and casualty insurance.

B. **A binder** (a.k.a. unconditional receipt) is used to give **temporary-guaranteed** coverage prior to the policy being issued by the insurance company. **Premium is not required** for coverage to be in-force. **Binders are issued by Property and Casualty agents (because agents represent the insurance company)** and can be made effective up to a **maximum of 90 days.** A *binder may be extended* past 90 days with the permission of the Insurance Commissioner.

C. **A conditional receipt** is issued by Life and Disability producers **when money is *collected with the application***. It does not provide coverage on an unconditional basis as does a binder, but on a conditional basis, that is, on condition that the insurer issues the policy as applied for.

- Binders and Conditional Receipts are in effect only up to the time of issuance of the policy or application is rejected. When the policy is issued, coverage extends from the policy and all binders and conditional receipts are void.

D**. A signed premium receipt** for any insurance premiums received by the licensee must be delivered or mailed no later than the **next working day**. **The receipt must include:**

- The date, amount collected and name of the person who made the payment.
- Identity of the producer, including the producer's address.
- A brief description of coverage for which payment was received.
- The insurance company by its full legal name.
- The signature of the producer.

Special note: The issued date of the policy (often referred to as the policy inception date) does NOT have to be on a premium receipt.

V. LICENSING: PRODUCERS & ADJUSTERS

No one may act as or claim to be a producer or adjuster in Washington unless properly licensed, nor shall any person solicit, procure, take applications for, or place for others any kind of insurance for which he or she is not licensed.

A. Pre-licensing…Prior to transacting insurance, an applicant for a resident ***insurance producer's license*** must: take and ***pass the required examination*** for **each line** of authority to be applied for; submit an application form with the required attachments and fees; receive a license from the commissioner; and be appointed/affiliated with a company.

B To become a **producer** an individual must: maintain a lawfully established place of business in Washington State (except a non-resident producer); be 18 years old, be competent (pass the exam); and be trustworthy.

Special Note: A producer of insurance ***does not*** need to be a citizen of the United States. However, a non-citizen must have a social security number to become licensed. A producer may receive a license in one or more lines of authority, and are listed as follows: life, disability, property, casualty, variable life and variable annuity products, personal lines and limited lines insurance products.

C. Producers.... a Producer can be an Agent or Broker, or both:

1. **An Agent** is a producer who is ***appointed by an insurance company*** to solicit applications for insurance on its behalf, and when authorized to do so, collect premiums for the insurance policy, and essentially **effectuate** (put into effect) the insurance coverage. An agent can be an individual, partnership or corporation. An agent may be given ***binding authority,*** and represents the insurance company he is appointed with at all times.

   - **No bond is required for a producer who acts as an agent** because the agent is a legal extension of the insurance company with which he is appointed.

2. **A Broker** is a producer ***licensed to represent the insured*** and find the best ***(authorized)*** company and insurance for the **insured in the State of Washington.**

   - A bond for those producers acting in a **broker or surplus lines broker** capacity must be in place before writing any business. The bond amount is **$2,500 or five percent of the premiums brokered in the previous calendar year, whichever is greater, not to exceed $100,000,** in favor of the people of the State of Washington.

3. **A Surplus Lines Broker** is a type of broker who is hired to find "*unauthorized*" insurance companies that accept risks not otherwise insurable in the State of Washington.

   - A surplus lines broker needs to be licensed as a producer with property and casualty lines of authority, **pass the surplus lines broker's exam** and pay the required fees.

   - A surplus lines broker must maintain two bonds. One in the amount of **$2,500 or five percent of the premiums brokered in the previous calendar year, whichever is greater, not to exceed $100,000,** in favor of the people of the State of Washington. The second is a bond in the **penal amount of $20,000** in favor of the State of Washington.

   - ***Coverage may not be procured for securing lower premiums.*** Diligent effort first must be made to place the business with an authorized insurer in the State of Washington.

   - At the time of procuring any insurance, an ***affidavit stating the facts must be executed*** by the surplus lines broker and filed within 30 days at the Department of Insurance.

4. **Broker vs. Agent**

   - A broker needs to be bonded; an agent does not. A broker represents the consumer; an agent represents the insurance company.

- To sell insurance for a particular insurance company, an agent needs to be appointed by that company; a broker does not.
- A broker **does not have binding authority;** a property and casualty agent does have binding authority which is given to him from the company he sells for.
- A broker may take applications for insurance and collect premiums without being appointed by the insurer; an agent may not. **A producer may not act as a broker and an agent for the same insurance company through which he sells insurance.**

5. Charges for Extra Services: The commissioner may permit an insurance producer to enter into ***reasonable arrangements*** with any person to charge a fee in situations where services that are charged for are provided beyond the scope of services customarily provided in connection with the solicitation and procurement of insurance. The charge or fee to the individual or insured must be reasonable, taking into account receipt of commissions and their relation to the value of the total work performed.

- ***The individual or insured must be given written notice in advance of what the fixed charge will be, or the basis for determining the charge.***

6. Compensation: Insurance Producers (Agents and Brokers) — Disclosure

- ***Unless the agency-insurer agreement provides to the contrary***, an insurance producer may receive the following compensation:
    1) A **commission** paid by the insurer.
    2) A **fee** paid by the insured.
    3) A **combination of commission paid by the insurer and a fee paid by the insured** from which an insurance producer may offset or reimburse the insured for all or part of the fee.

- If the compensation received by an insurance producer who is dealing directly with the ***insured includes a fee***, for each policy the insurance producer must disclose in writing to the insured:
    1) The full amount of the fee paid by the insured
    2) The full amount of any commission paid to the producer; the full name of the insurance company that paid the commission
    3) An explanation of any offset or reimbursement of fees or commissions

- Written disclosure of compensation as required by this section must be provided by the insurance producer to the insured ***prior to the sale of the policy***. Written disclosure as required by this section must be ***signed by the insurance producer and the insured***, and the writing must be retained by the insurance producer for five years.

- In the case of a purchase over the telephone or by electronic means for which written consent cannot be **reasonably obtained**, consent documented by the producer will be acceptable.

D. General Requirements - Producers

1. A producer must respond to any inquiries from the Commissioner's office **promptly** and it must be in **writing**. **Promptly means within 15 business days** from the receipt of the inquiry.

    - "***Sending written notice***" means transmitting the required information in writing on forms designated by the commissioner via mail, commercial delivery company, electronic telefacsimile transmission (fax) or e-mail.

2. A producer must make actual physical delivery (mailing is acceptable) of a policy within a ***reasonable period of time after its issuance***. Insurance companies are held responsible for any delay resulting from the failure of their producers to act diligently.

- ***The producer may not obtain a receipt indicating a delivery and then retain the policy in his/her possession*.** A producer may secure the insured's policy for servicing or analysis, but **must** give a **policy receipt** and return the policy **promptly**.

3. **Illegal Dealings in Premiums…** "No person may willfully collect any sum as premium for insurance, which insurance is not then provided. No person may willfully or knowingly fail to return to the person entitled thereto within a reasonable length of time any sum collected as premium for insurance in excess of the amount actually expended for insurance applicable to the subject on account of which the premium was collected."

   - Each violation which does not amount to a felony constitutes a misdemeanor.

4. ***Producers, title insurance agents, and adjusters*** must keep records of ***all insurance transactions*** at the licensee's business address for ***five years***. This section of the law does not apply to life or disability insurance (because of the confidential treatment of the applicant's health information).

   - ***The Insurance Company must keep transaction records for three years***.

5. All funds representing **premiums and return premiums** received by a ***producer*** must be ***promptly deposited*** in a ***separate account (which may be interest bearing).*** The Separate Account Funds may be deposited in a checking or savings account ***located in the State.***

   A business entity may utilize one separate account for use by all of its affiliated persons.

   A producer may not deposit any funds, other than premium and return premium funds, into the separate account, with the following **exceptions…**
   A Producer may:
   - Deposit funds needed to pay bank charges due to the operation of the account.
   - Deposit funds for the purpose of having a reserve in the separate account to be able to advance premium or return premium funds to customers.
   - Combine Washington State premiums with premiums produced in other States.

Withdrawals from a separate account may be done for the following reasons:

- For bank charges for the operation of the separate account.
- For payment of premiums to the Insurer or to pay commissions to another producer.
- For payment of return premiums, and it must go directly to the Insured.
- For the transfer of ***fiduciary*** (confidential) funds to go directly to another account. ***Fiduciary*** refers to a person holding the funds of another in a position of trust.

Willful violation of this "separate account" regulation is a misdemeanor.

6. Funds representing premiums or return premiums must be **promptly paid** to the insured, insurer or insurance producer, as entitled. **Anyone diverting or misappropriating funds received in a fiduciary capacity to his or her own use is guilty of *theft by embezzlement (a.k.a. larceny)* and is subject to criminal punishment.**

7. **Place of Business.....** A producer's **office** must be accessible (open) to the public. ***This law does not apply for a producer who works out of his home, nor does it apply for life only or disability only producers.*** A licensee whose personal residence is shown on his license may obscure his residence address as long as the licensee's name can be seen clearly by the public.
   - A producer must **display his license in a conspicuous place** at his place of business.
   - A producer must advise the Commissioner's Office of any change in residence, mailing, business or e-mail address within **30 days.**
   - A producer must ***keep all his records, certificates and licenses at his place of business.***

- A producer maintaining more than one place of business in this state must obtain a duplicate license for each additional place, and pay the full fee.

8. **Appointments/Terminations…**A producer acting as an agent must be appointed by an authorized insurer before he can sell for that insurer. The insurer must notify the Commissioner in writing of the appointment and pay a **$20.00 appointment fee**.
   - ***Appointments renew every two (2) years on a date set by the Commissioner***.
   - An appointment may be done electronically through the **National Insurance Producer's Registry (NIPR)** or by submitting the appropriate form to the Commissioner's office.
   - An agent may act as a representative of an insurer before notifying the Commissioner of the appointment only if the notice of appointment is submitted electronically through the NIPR or through the Commissioner's web site.
   - An appointment with a company such as Farmers Insurance Group allows a producer to sell for all of its subsidiaries. Only one appointment will be needed!
   - If a producer is appointed by ***only one company or insurer,*** he is called a **captive or exclusive** agent. A captive agent does not own his accounts and renewals.
   - If a producer is appointed by ***more than one company***, he is called an ***independent agent.*** An independent agent owns a right to his accounts and renewals.
   - An insurance company may **terminate** an appointment by sending written notice of termination to the producer and to the commissioner. A producer may **terminate** an appointment by sending advance written notice to the insurance company and the Commissioner. The notices must state the effective date of termination.
   - If an insurance company or its authorized representative **terminates** the appointment of a producer "***for cause***," the insurer must notify the insurance commissioner within 30 days following the effective date of the termination by sending written notice of the termination. The "***cause***" for termination must be stated in the notice.
9. **Agent Licensing vs. Agent Appointment**:
   - A **license** is the authority granted by the State of Washington to act as an agent.
   - An **appointment** is the authority that you receive from the insurer to act on its behalf.
   - You cannot act as an agent for any insurance company without being appointed by that company and being licensed in the type of insurance transacted.
   - **Obtaining and maintaining the proper license is your responsibility**.
   - ***The renewal of your appointment is the responsibility of the insurer you represent*****.**

10. **Producer Authority…**Insurance producers have very broad powers because courts decide most contests over the existence of coverage in favor of the insured. The producer's overall authority stems from three separate sources:
    - **Expressed (Powers) Authority** — those expressly **written.**
    - **Implied (Powers) Authority** — sometimes called **customary powers**.
    - **Apparent (Powers) Authority** — if the producer does something that is apparent to the consumer that the producer has the authority to do, even if it is not expressed by contract, then the producer does have that power (protects the consumer).

11. **Variable Life and Variable Annuity Resident Licenses.....**Resident insurance producers who desire to sell, solicit or negotiate variable life and variable annuity products in this state must obtain and maintain a life insurance producer license and an appropriate securities license from the Financial Industry Regulatory Authority (FINRA) or the Department of Financial Institutions (DFI). Upon presentation of satisfactory evidence that the producer has fulfilled this requirement, the commissioner will issue a license with a variable life and a variable producer line of authority.

12. **Personal Lines License.....**This license is needed if selling property and casualty insurance to individuals and families for **non-commercial purposes only**. An individual must pass the pre-license personal lines state exam.

13. **Limited-Lines License.....**means the producer can sell **only one type of product.** No pre-license education or continuing education is required. **Limited licenses include:**

    - **Credit License** (must pass the credit exam) **includes coverage for Life, Disability, Property and Casualty…**Credit Life will pay off a loan if the insured dies. Credit Disability will make the loan payments for the insured should they become disabled. **Credit Property and Casualty is a license** for those who sell insurance covering mortgaged property (such as motor vehicles). This is also known as "collateral protection coverage" or "vendor single-interest" insurance.
    - **Surety License…**allows the licensee to sell bonds (must pass the Surety exam).
    - **Travel License…**issued to travel agents (does not need to pass any exam).

E. Obtaining and Renewing Licenses… In order to obtain a Washington Producers or Adjusters license, the applicant must be: **at least 18 years old, trustworthy, maintain a lawfully established place of business in Washington State, and must pass the appropriate state insurance examination (be competent)**.

1. A person can obtain a **Non-Resident Producer's License** if she does not live in Washington. The licensee must be licensed in her resident state and does not have to pass our State's license exam if she has passed a written exam in her current state.
    - Each licensed nonresident producer appoints the commissioner as her attorney to receive ***service of legal process*** issued against the producer in this state upon causes of action arising within this state.
    - The state of residence must reciprocate (***reciprocity***) with Washington in allowing Washington's producers and brokers to be nonresident licensees.

2. To take the state exam for a Producer's license, an applicant must sign up and pay the fee.

    However, **no exam is required if:**
    - the applicant is a **CLU** (Chartered Life Underwriter) or has such other designation approved by the Commissioner, **received within the past year**, he doesn't have to take the Life and Disability exam.
    - the applicant is a **CPCU** (Chartered Property and Casualty Underwriter) or other such designation approved by the Commissioner, **received within the past year**, he doesn't have to take the Property and Casualty exam.
    - the applicant has at least **two years of licensed experience in another state** in the same line or lines of insurance and was licensed **within the preceding 90 days**.
    - a person is applying for a non-resident license.
    - a licensee ***may renew his lapsed license within a one year period*** after expiration by submitting the necessary forms and paying the appropriate fee without having to take the state licensing exam.

3. A **Temporary License** can be granted by the Commissioner on an emergency basis for up to a ***maximum of 180 days*** without passing an exam.
    - The granted party must be *legally representing* the interests of the licensed producer that is disabled or deceased. This might be ***a spouse, executor, lawyer, employee, or person with power of attorney***. A temporary license ***may not*** be granted to a new prospective licensee.

4. **Renewal of a Producer's License** (after the first renewal)…Licenses expire every two years at midnight on the last day of the licensee's birth month. To renew a license, **a renewal application must be submitted by the producer and the fee (currently $55) must be paid to the Commissioner's office by midnight of the last day if the licensee's birth month.**

a. **Late fees apply if the renewal fee is not paid when due**:

- 1 to 30 days late = an additional **50%** surcharge penalty of the license renewal fee.
- 31 to 60 days late = an additional **100%** penalty of the license renewal fee.
- 61 days to twelve months late = **200%** surcharge of the license renewal fee. The license must be reinstated from 61 days - twelve months late.

  - ✓ **After 60 days from the expiration date,** all associated appointments and affiliations are ***terminated***. This means that the agent will need to secure a new appointment agreement with any insurance company he wishes to transact business through.

  - ✓ **If over one year**, the producer will have to begin the entire licensing process again, re-taking all applicable licensing exams, new fingerprint card and re-apply with the state.

b. **Twenty-four (24) hours of continuing education** (three of which must be in "Ethics") ***must be presented as a prerequisite for the renewal of a producer's license*.**

- ✓ **Exceptions:** This education requirement **does not apply** to limited-lines licensees or to resident adjusters. The continuing education may be waived for licensees in active military service, but a Letter of Mobilization and the name and address of the person authorized to act as the licensee's representative is required. A medical waiver with a letter from a medical provider describing the illness may also be issued for one renewal period.

c. **Retention of Certificates.....**A licensee ***must keep Continuing Education (C.E.) certificates for three years*** from the date on the certificate. An approved C.E. course may be repeated for credit after a period of 3 years from the previous completion date.

5. **New licenses will expire on the applicant's date of birth, plus one year, and every two years thereafter.**

For example:

- If Susie received her initial license on May 1 and her birthday is on June 25, she will have about 14 months before her first renewal is due (2 months plus 1 year).

- If Doug received his initial license on May 1 and his birthday is on March 25, he will have about 23 months before his first renewal is due (11 months plus 1 year).

New Licenses: License candidates have ***180 days to apply for a license after passing their exam***. A new licensee who acts as an agent cannot sell insurance until they have an appointment or affiliation but there is no time limit for the appointment or affiliation. A new licensee who acts as a broker cannot sell insurance until they have a bond, but there is no time limit for securing the bond.

F. An Adjuster is a person who, for compensation, fee or commission, investigates or reports to a company regarding claims arising under insurance contracts. In order to obtain a Washington Adjusters insurance license, the applicant must be ***at least 18 years old, trustworthy,*** maintain a lawfully established place of business in Washington, ***and must pass the appropriate state insurance examination***.

1. **Licensed/Self-Employed Adjusters** must pass an adjuster's exam and must have experience or special education or training with reference to the handling of loss claims.

   - **Independent Adjusters** are ***hired by insurance companies*** to settle claims. They charge the insurance company for settling the claim, and since they are working for the insurance company, no bond is required.

- **Public Adjusters** are ***hired by the insured*** for claims. They are employed by the insured and therefore bill the insured for settling the claim. A ***$5,000 bond*** is required. A public adjuster also may be licensed as an independent adjuster but may not work for an insured and an insurer on the same claim.
-
- **Non-Licensed Adjusters…**An attorney-at-law who adjusts insurance losses incidental to the practice of his or her profession, an adjuster of marine losses, or a salaried employee of an insurer (a.k.a. company adjuster) or of a general agent/producer is ***not*** considered an adjuster, and thus, does not need to be licensed as an adjuster. A producer may, from time to time, act as an adjuster without being required to be licensed as an adjuster, but only with the permission of the insurance company he is doing business with.

VI. UNFAIR TRADE PRACTICES

The Unfair Trade Practices Act is divided into two parts: **Unfair Marketing Practices and Unfair Claims Practices**. Statutes (laws) define and prohibit certain trade and claims practices which are unfair, misleading and deceptive.

No person or insurer engaged in the business of insurance may engage in unfair methods of competition or in unfair or deceptive acts or practices whether expressly written in the State Code or found by the commissioner to be unfair or deceptive.

Penalties for Non-Compliance

A. Suspension…The Commissioner can take the license away temporarily for a maximum of **one year** and it is returned without the producer having to retake an exam.

B. Revocation…The Commissioner can take the license away for a maximum of **one year**. The person must reapply for the license but it may not be approved. However, if the Commissioner does approve the application, pre-license education is required and the proper license exam must be passed again.

- Immediate revocation (without a hearing) of any insurance license is allowed upon the sentencing of the licensee for conviction of a felony, but only if the facts of the conviction demonstrate the licensee to be untrustworthy to maintain any such license.
- The Commissioner may suspend, revoke or refuse to renew a license with not less than **15-days written notice**.
- The Commissioner may suspend a license with not less than **three-day** written notice upon **finding** that the public safety requires this **emergency action**.

C. The Commissioner can fine a maximum of ***$1,000***, per offense, for a violation of the insurance code.

- **Fines and penalties must be paid in not less than 15 days nor more than 30 days after the receipt of the order to pay**.
- *Failure to pay will result in revocation of the insurance license and the fine recovered in a civil action through the courts on behalf of the Insurance Commissioner*.
- **Fines are paid to the State Treasurer for deposit in the general fund.**

- There is an **exception** that allows for a $25,000 civil penalty for anyone acting as a producer without being properly licensed to do so.

D. The licensee has the legal right to **appeal** fines, penalties, suspensions and revocations levied by the State Commissioner. The licensee can appeal any decision of the Commissioner or any deputy, assistant or examiner of the Commissioner.

- The licensee has **90 days** in which to appeal.

E. Illegal Dealings in Premium.....

- No one can willfully collect money as premium for insurance if insurance coverage is not provided or the premium for insurance is in excess of the amount actually due.
- A person must return any overpayment of money collected as premium, in a reasonable length of time, to the person who paid the premium.
- **Each violation of this section which does not amount to a felony constitutes a misdemeanor.**

F. A license and/or appointment agreement may be taken away for:

1. **Lying on the license application** (new licenses and renewals), or obtaining a license through misrepresentation or fraudulent means.

2. **Illegal Inducement…**It is unlawful for insurance personnel to **provide** or **promise** in a policy anything valued at more than an aggregate of ***$100.00 per year***, to any one prospective or current policyholder.

   - Offering any special advisory board contract, agreement or understanding of any kind, providing for or promising any profits or returns, is illegal inducement. Paying $101 for an individual's lunch at the time of procuring insurance is illegal inducement.
   -

3. **Rebating…**It is unlawful for a producer or insurance company to give any valuable consideration such as a rebate, discount, reduction of premium, shares of stock, etc., to induce a person to buy insurance.

   - The **insured** is subject to a $200 fine for accepting a rebate.
   - ***Guaranteeing to pay future dividends*** is an example of rebating.
   -

4. **Misrepresentation…**Telling a lie or deceiving anyone about *any aspect* of insurance, like false coverage, inflated benefits, unrealistic returns, etc.

Examples of material misrepresentations include:

- **Twisting…**No person can, by ***misrepresentations or misleading comparisons***, induce or tend to induce, any insured to lapse, terminate, forfeit, surrender, retain, or convert any insurance policy.

  - For example, this can occur when a producer wants a prospective customer to cancel and switch his/her current insurance policy over to the producer's company, and does so by giving misleading facts.

  - Another example of twisting is failing to give required ***replacement forms*** to an insured when replacing an existing life policy.
  -

- **Defamation of Insurer…**No person can make, publish or circulate any information or
- statement which is false or maliciously critical if designed to injure the reputation or
- business of any authorized insurance company (insurer).

5. **Illegal Dealings In Commission…**"A producer of insurance may not compensate any person other than another producer for procuring applications or placing insurance in this state." It is illegal to share commissions with anyone who **is not licensed** in the ***same line of insurance*** in which the insurance was

procured. For example, a life-only producer may not share commissions with a property and casualty producer.

- This does not affect salaries paid to unlicensed persons, as long as the salaries are not contingent on the volume of business transacted.

6. **Additional reasons for non renewal, suspension or revocation of an insurance license:**
   - Misappropriation or conversion to personal use
   - Illegal withholding of monies required to be held in a fiduciary capacity
   - ***Incompetence or failing to serve in the public's best interest***
   - Willful violation of any insurance law or order of the Commissioner

7. **Violation of Advertising Laws…** A producer may not commit false advertising in regard to an insurer's financial condition. The producer must not use unfair or deceptive practices in the sale, advertising or marketing of any type of insurance product. All advertising must be clear and understandable and contain the name and address of the insurance company. This includes mailings and brochures.

G. Specific Unfair Claims Settlement Practices:

1. Misrepresenting pertinent facts or insurance policy provisions.
2. Failing to acknowledge and act promptly upon communications regarding a claim.
3. Failing to implement standards for the prompt investigation of claims.
4. Refusing to pay claims without conducting a reasonable investigation.
5. Failing to affirm or deny coverage of claims within a reasonable time.
6. Not attempting in good faith to make a prompt, fair and equitable settlement of claims in which liability has become clear. If two or more insurers are involved, they should arrange to make payment to innocent third parties leaving to themselves the burden of apportioning it.
7. Compelling insureds to institute or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy.
8. Settling a claim for less than a reasonable amount a claimant is entitled to receive.
9. Making claims payments not accompanied by a statement setting forth the coverage under which the payments are being made.
10. Telling insureds or claimants that there is a policy arbitration award for the purpose of compelling them to accept less than the amount awarded in arbitration.
11. Delaying the investigation or payment of claims by requiring an insured or claimant to submit a preliminary claim report and then requiring subsequent submissions that contain the same information.
12. Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other insurance policy coverage.
13. Failing to promptly provide a reasonable explanation for denial of a claim.
14. Unfairly discriminating against claimants who are represented by a public adjuster.
15. Failure to expeditiously honor drafts given in settlement of claims.
16. Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established.
17. Delaying appraisals or adding to their cost through the use of appraisers from outside of the loss area.
18. Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.
19. Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent.

Special Note regarding Unfair Claims Settlement Practices:

- Insurance companies must acknowledge receipt of notification of a claim ***within 10 working days*** (15 days on group contracts).
- When the Commissioner requests information, the insurance company must respond ***within 15 working days***.
- Insurance companies must complete investigation of claims **within 30 days** after notification of claim.

H. False Claims… It is unlawful for any person to knowingly:

- Present a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under contract of insurance.
- Prepare, make or subscribe any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with the intent that it be presented or used in support of such a claim.
-

A violation of this section is a gross misdemeanor.
If, however, the claim is in excess of $1,500, the violation is a class C felony.

I. Permissible time limit for benefits payable because of accidental injury or death… It is an unfair practice not to pay benefits under accidental death or accidental injury policies if the covered death or injury occurs ***within one year (365 days)*** of the accident. The industry standard is 90 days.

Property & Casualty Insurance State Laws and Rules

A. Surplus Lines Broker.....A surplus lines broker is a type of broker who is hired to find "*unauthorized*" insurance companies that accept risks (insurance) not otherwise insurable in the State of Washington.

B. Renewal, Nonrenewal and Cancellation of Insurance… *When a notice of renewal, nonrenewal or cancellation is mailed, the insurance company is* **not required** *to prove that the insured actually received the notice. It is required to prove only that the* **written notice** *was mailed to the named insured at the mailing address on the policy.*

Nonrenewal of a policy requires a minimum **45-day** written notice (except auto—20 days).

Renewal of a policy requires the insurer to give a **20-day** notice of intention to renew. It is an unfair practice to use a 20-day notice to increase premiums, meaning an insurer must give a **21-**day notice or more to the insured to increase premiums.

Cancellation: A **10-day notice** is required for cancellation due to non-payment of premium, whereas a **45-day** notice is required for other reasons (except auto—20 days).

- ***45 days required for return of premium*** on a pro rata basis should the *insurance company cancel* the policy. **Pro rata** means *all unearned* premium must be returned but no service fee is allowed.

- ***30 days required for return of premium*** on a short rate basis should *the insured cancel* the policy. **Short Rate** means *all unearned* premium must be returned but a service fee is allowed to be charged by the insurer.

- If a ***notice*** of cancellation, nonrenewal or offer to renew is issued to an insured, a **copy of the notice or offer** must be provided to the producer or broker of record for the insured, ***within five (5) working days.*** When possible, the copy to the agent or broker may be provided electronically.

- Any notice must disclose the reason for cancellation or refusal to renew insurance. **The reason must be in clear, simple language**. It is not sufficient to state that the insured *does not meet the company's underwriting standards*.

C. 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.* ***Signatures of the producer and the insured are required***. The producer 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***.

D. A binder (a.k.a. unconditional receipt) is used to give **temporary-guaranteed** coverage prior to the policy being issued by the insurance company. **Premium is not required** for coverage to be in-force. **Binders are issued by *Property and Casualty agents*** and can be made effective up to a **maximum of 90 days.**

- A **binder may be extended past 90 days with the permission of the Insurance Commissioner.**

- When an agent **receipts premium money** at the time that coverage is bound,
- the receipt must state ***that it is a binder, a brief description of the coverage bound and the identity of the insurer in which the coverage is bound.***

E. Termination of Agency Contract … (this does not apply to life and disability agents/producers, surety, ocean marine or title insurance). If an insurer intends to terminate a written agency contract with an "**independent**" agent, the insurer may **give not less than 120 days advance written notice** of the intent to terminate the agency contract.

- **However, such notice is not needed if the termination is based upon the agent's:**
  1. **Abandonment of agency**
  2. **Gross and willful misconduct**
  3. **Loss of license by order of the commissioner**
  4. **Sale of or material change of ownership in the agency**
  5. **Fraud or material misrepresentation relative to the business of insurance**
  6. **Default in payments due to the insurer**

- During the 120 days, the independent agent may not bind or write any new business on behalf of the terminating insurer, other than to make routine adjustments (add a new car/change coverage).
- However, the terminating insurer may continue to ***renew all policies in the agent's book and pay commission to the agent*** **for a period of one year**.
- The appointment is terminated after one year. The terminated independent agent must have a reasonable opportunity to transfer affected policies to other insurers.

F. *Daycare…* It is an unfair business practice to deny homeowners' insurance or terminate a policy because the insured operates an ***incidental day-care*** facility at the insured location. The insurer may exclude or limit liability coverage for the insured's operation.

G. The state of ***Washington requires agents/producers who sell flood insurance to complete a flood insurance training course***. Three hours of continuing education credits can be earned by agents who complete this training. Slater All Lines Insurance School offers this **Basic Flood Insurance Course**.

H. Credit History or Insurance Scores…The insurance industry has used credit scores to set prices for many years. Companies have statistically shown that people with bad credit histories are more likely to file insurance claims.

To set premiums or deny coverage in Washington for property and casualty insurance, the insurance companies ***may not use:***

1. **The absence of credit history**.

2. *Collection accounts for medical bills*.
3. **Recent purchase of a financed home or vehicle**.
4. *A consumer's available line of credit*.
5. **The use of a particular type of credit card**.
6. *The number of credit inquiries made*.

An insurer may not **cancel or non-renew** personal insurance based on a consumer's credit history or insurance score.

1. An offer of placement with an affiliate insurer does not constitute cancellation or nonrenewal.

2. ***An insurer that takes adverse action against a consumer based on credit history must provide written notice to the named insured on why the credit history resulted in the adverse action*** and inform the consumer he is entitled to a free copy of his/her consumer report.

Consumer Report/Credit Check (Fair Credit Reporting Act)… Consumer 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.

1. 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**.

2. If a report is found to be inaccurate, the reporting agency must send the corrected information to all parties who had received the inaccurate information over the past two years.

Casualty Insurance State Laws and Rules

This section applies to four wheeled registered motor vehicles (not to motorcycles).

A. Auto Insurance

1. Personal Injury Protection (PIP) (a.k.a. *First Party Coverage*) pays for bodily injury, lost wages and lost services of a ***first party*** injured in an insured's auto, regardless of who is at fault. Payments are made on a per person, single limit, occurrence basis.

Who is the First Party?

- The named insured or any family member residing in the named insured's household who is injured while occupying a motor vehicle or a trailer which is designed for use on public roads.
- The named insured or any family member residing in the named insured's household who is injured if struck as a pedestrian by a motor vehicle or a trailer used for public roads.
- Anyone who is injured while occupying a covered auto. Occupying means in, on or out of.
-

Personal Injury Protection (P.I.P.) is required to be **offered** to every applicant for auto insurance in **Washington**.
If P.I.P. is rejected, a signature is required by the named insured.

MINIMUM LIMITS	COVERAGES	MAXIMUM LIMITS

$10,000 - payable for up to **three years**	**Medical payments**	**$35,000** (or more if the insurer wishes) payable for up to **three years.**
$10,000, max. $200/wk or 85% of insured's income (whichever is less) for a maximum of one year.	**Lost Income**	***$35,000***, max. $700/ wk or 85% of insured's income (whichever is less) for a maximum of one year.
$40/day (max. $200/wk) for one year, maximum of $5,000	**Loss of Services**	$40/day for one year (no other limits)
$2,000	**Funeral Costs**	$2,000

- The ***named insured*** is defined to include the individual named in the declarations of the
- policy and his or her spouse if a resident of the same household.

2. Underinsured Motorist, UIM, ***must be offered*** to all **new auto liability insurance applicants**. Each policy will include underinsured motorists coverage unless the named insured or spouse specifically rejects either the BI or PD portion of the coverage, or both, in writing, and must be part of the insurer's records.

- **Bodily Injury *must be offered for the same limit*** as the insured is covered for under coverage "A" of the auto policy. The insured may elect a lower limit on UIM than on coverage "A", but may not be insured for more on UIM than on "A". **Insurers must get a signed request for UIM limits that are lower than the third party liability limit (Coverage A) from the named insured or the named insured's spouse.** This rejection must be in writing and made part of the insurer's records (for 3 years).
- **Indemnifies for Bodily Injuries…**It pays the insured when injured by a driver who is uninsured or underinsured. It also pays the insured if hit by a hit-and-run driver, a phantom vehicle, or ***if the other insurer who should pay becomes insolvent***. A "phantom vehicle" means a motor vehicle which causes bodily injury, death or property damage to an insured and has no physical contact with the insured or the vehicle which the insured is occupying at the time of the accident, as long as there is a witness and the accident is reported within 72 hours after the accident.
- **The Insured** means the named insured and relatives living with the named insured and anyone occupying the insured's car. **Protection** extends to the named insured and family members while in their own car, while in someone else's car (excess only), or even walking down the street, if injured by another car.
- **Underinsured Motorist PD** protects the insured's covered auto if damaged by an uninsured, underinsured or hit-and-run motorist. There is a *$100 deductible* for all losses, except for damage caused by a hit-and-run or phantom vehicle, which has a *$300 deductible*. ***A signed request*** from the named insured is ***NOT*** needed when the named insured selects UIMPD limits that are lower than third party property damage liability limits (Coverage A).
- Insurance companies must include an insured's deductible in its subrogation demands. **Subrogation recoveries must be allocated first to the insured for any deductible incurred in the loss.**
- **Stacking Is Not Permitted…**The limit of liability for UIM coverage may be defined as the maximum limits of liability for all damages resulting from one accident, regardless of the number of vehicles involved in the accident or number of vehicles covered under the insurance contract.

Special Notice:

- All private passenger and commercial automobile insurers must also make Personal Injury Protection (PIP) coverage and Underinsured Motorist (UIM) coverage available to all policyholders at renewal of the policy.
- Existing insureds should receive a selection form and a policyholder notice regarding UIM and PIP on or before the renewal date of their policy.

3. Renewal, Non-Renewal and Cancellation of Insurance Coverage…

- **A <u>minimum 20-day written notice</u>** is required to be sent to the named insured for cancellation, renewal or non-renewal of an auto policy. The notice sent by the insurer must state the actual reason for the non-renewal or cancellation. **A <u>minimum 10-day written notice</u> is** required to be sent to the named insured for cancellation for *nonpayment of premium.*
- After the first **60 days** of an auto contract, cancellation is permitted only for nonpayment of premium, or **<u>suspension or revocation of the driver's license of the named insured</u>**, or any regular operator of an insured vehicle during the policy term, or during the 180 days immediately prior to the last policy renewal date.
- It is an unfair practice for any insurer to consider traffic violations or accidents more than **three (3) years past** in order to accept, reject, cancel, or refuse to renew a policy.
- No insurer can refuse to renew the liability and/or collision coverage of a policy on the basis that an insured has submitted one or more claims under comprehensive, road service or towing coverage. However, an insurer may decline to renew the coverage on the basis of claims submitted. The **<u>Commissioner in Washington may order the cancellation or nonrenewal of policies</u>** if an insurer has become insolvent, has violated the Insurance Code, has failed to pay a judgment against it, or has been ordered to liquidate its operations.

4. The Washington Auto Insurance Plan, (a.k.a. The Assigned Risk Pool)**…**This plan allows people with bad driving records who cannot secure auto insurance the opportunity to purchase coverage. The insureds are **apportioned** among the **authorized** insurers for a maximum of three years. All insurers licensed to write auto insurance in Washington must participate in the plan.

- Agents do not have binding authority in the plan and they must submit the application to the plan for approval and apportionment.
- The State's insurance industry administers, funds and sets the premiums for the Plan.

5. Fair Market Value…Damage to Your Auto, Part "D," (a.k.a. ***physical damage*** coverage), pays for damage to the insured's own auto. ***The insurer reserves the right to repair or replace the damaged car rather than make a cash settlement***.

- Following a total loss of the car the insurance company is required to indemnify on a **minimum Fair Market Value** (what the car could be sold for). NOT WHOLESALE!

B. Financial Responsibility Liability…This law requires that following an accident which involves bodily injury or losses above $750 of property damage (to a third party), proof of the ability to pay for damages must be provided. Proof is required whether the person involved was blameless or not. **Failure to demonstrate financial responsibility liability may result in loss of driving privileges, which could include vehicle registration and driver's license suspension, and/or a fine of about $550.**

- This law applies to both the <u>driver and the owner</u> of the vehicle.
- If a law enforcement officer stops a motorist, he may also check for proof of financial responsibility. An insurance certificate showing minimum limits and effective days is required, or if self-insured, a certificate of deposit or bond is required.
- **The minimum amount required is $60,000** ***or BI and PD limits on auto insurance of 25/50/10 is acceptable.*** The insured may post a bond or deposit $60,000 in cash with the state to satisfy the financial responsibility liability law.
- **<u>If a license is suspended</u>**, the license will not be renewed or issued until that person ***deposits the required security or <u>3 years</u> has passed***. After 3 years, the driver will have to provide the state with an SR-22 filing. ***An SR-22 filing is when the State requires a person to prove <u>insurance</u> on a continual basis***. If a driver cancels his insurance, the insurance company is required to notify the State.
- ***A person may be released from financial responsibility*** when he is <u>judged not to be liable in the accident</u>, or have obtained a <u>release from the other party</u>, ***or has paid all damages through a written agreement with the other party, or has paid any judgment***.

Vehicles exempt from the mandatory liability law include motorcycles, motor scooters, mopeds, specially-licensed antique vehicles over 40 years old and collector's vehicles over 30 years old, publicly-owned vehicles, and vehicles registered with the Washington Utilities and Transportation Commission as common or contract carriers.

C. Workers' Compensation Insurance (a.k.a. State Industrial - www.lni.wa.gov) is *compulsory* and *monopolistic* in the State of Washington. Workers' Compensation laws impose a form of ***absolute liability*** because employers are held liable for employees' work related injuries and sicknesses, ***regardless of fault.***

- ***Monopolistic*** means that Workers' Compensation may be purchased from **one source only**, the **Department of Labor and Industries** (a.k.a. ***exclusive underwriter***). However, larger businesses can be approved as **self-insurers**, paying the same benefits as the State, but funding the benefits themselves. Private carriers are permitted to write **excess coverage** for self-insurers, and some do purchase excess layers of coverage from the private sector.

- **The State Fund** means those funds held by the State or any agency of the State. The Washington **Industrial Insurance Fund** means the Department of Labor and Industries when acting as the agency to insure the industrial insurance obligation of employees. These two terms are synonymous when applied to the department's function of insuring employers.

- **Coverage "A"** pays the benefits required for the injured workers for: medical, disability income, death, and rehabilitation for ***work related injuries and sicknesses*.**

- **Employers Liability Coverage "B,"** a.k.a. "Stopgap," protects the employer against liability arising from work-related injuries or diseases **not** covered by the workers' compensation law. This is **not** written through the State of Washington's Fund, but added through a company's Commercial General Liability policy. **Once added to the CGL policy, it may also be included under the business Umbrella Policy.**

- **Other States Coverage "C",** provides automatic coverage in States which have non-monopolistic workers' compensation laws. It may be purchased at the employers' option. The state where the work will be done must be listed on the policy as soon as the business has workers there.

- **Your Duties If Injury Occurs** explains the duties of the insured when a loss occurs. These obligate the insured to give prompt notice of injury, claims, or suit to the insurer. They also require the insured to cooperate with the insurer, attend hearings and trials at the request of the insurer, and help secure witnesses.

- **Premiums** are paid ***by the employer to the Department of Labor and Industries*** (although the employer may charge up to one-half of the premiums to the employee).

    1. Premiums are based on the ***hours worked*** by the employee (loss experience rating and work industry also play a part in establishing the premium). Most states will use the gross payroll, however, Washington State is still one of the few states that use the "hours worked" calculation for establishing premiums.

    2. The per hour premium is established by state statute.

- The main purpose of the Department of Labor and Industries is to **provide a safer workplace for workers**, so inspections of a business may occur at any time.

State of Washington Worker's Compensation Definitions:

Acting in the Course of Employment means the worker acting at his or her employer's discretion or in the furtherance of the employer's business, including time spent going to and from work on the **job site** (not their normal place of business). **It is not necessary that at the time of injury the worker be doing the work on which his or her compensation is based**.

Acting in the Course of Employment **does not** include time spent coming to or going from work, or in commuter ride sharing, even if the employer participates in the arrangements.

Beneficiary means a husband, wife, child, or dependent of a worker who has a right to receive payment under workers compensation laws.

Child means every natural born child, stepchild, child legally adopted prior to the injury, child born after the injury where conception occurred prior to the injury, and dependent child in the legal custody and control of the worker, all while under the age of eighteen years, or under the age of twenty-three years while permanently enrolled at a full time course in an accredited school, and over the age of eighteen years if the child is dependent for support on that worker.

Dependent means any surviving spouse or child of a deceased worker. If there is no surviving spouse or child, dependent also includes any father, mother, grandfather, grandmother, stepfather, stepmother, grandson, granddaughter, brother, sister, half-sister, half-brother, niece, nephew, who at the time of the accident are actually dependent for their support upon the earnings of the worker.

Injury means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and such physical conditions result.

Occupational disease means such disease or infection arising naturally and proximately out of employment.

Permanent partial disability means the loss of either one foot, one leg, one hand, one arm, one eye, one or more fingers, one or more toes, any dislocation where ligaments were severed and where repair is not complete.

Permanent total disability means loss of both legs, or arms, or one leg and one arm, total loss of eyesight, paralysis or other condition permanently incapacitating the worker from performing any work at any gainful occupation.

Successor means any person to whom a taxpayer quitting, selling out, exchanging, or disposing of a business sells or otherwise conveys a major part of the property, tangible or intangible, of the taxpayer.

Wages includes the value of board, housing, fuel, or other consideration received from the employer, but does not include overtime pay. It also includes the employer's payment or contributions for health care benefits unless the employer continues payment for these benefits following the injury. Tips are also considered wages. The daily wage must be the hourly wage multiplied by the number of hours the worker is normally employed.

Worker means every person in this state who is engaged in the employment of an employer or who is engaged in the employment of or who is working under an independent contract.

State Laws and Rules Pertinent to Property Insurance

A. **Over-Insurance…** No person may knowingly issue or accept insurance which would result in over-insurance. No person may compel an insured or applicant to procure insurance in an amount in excess of the amount which could reasonably be expected to be paid in the event of a loss, whether the insurance is required in connection with a loan or otherwise.

B. The Washington F.A.I.R. Plan (Fair Access to Insurance Requirements)…The FAIR plan is administered at the state level and participation is mandatory for all insurers who are authorized to engage in property insurance in our state. In general, the FAIR plan makes property insurance **available and affordable** to individuals who might otherwise be uninsurable because of ***environmental hazards***.

- No application may be rejected simply because of environmental hazards which are beyond the insured's control.

- *Insurers are assessed to support the program*. The ***maximum limit*** of coverage which may be placed through this program on any one property is ***$1,500,000.*** **Agents do not have binding authority in the FAIR plan.**
- Coverage will become effective once the application is processed, inspection is completed, and the premium is paid. ***The premium is not considered paid and coverage will not begin until the Fair Plan receives payment.***
- **If the risk is accepted, the policy or binder must be delivered within two business days after receipt of premium.** If the risk is declined, the ***Facility*** will notify the applicant and Commissioner.
- **Policies are effective for a one year period**. Covers both the structures and contents of Dwelling and Commercial risks.
- Perils insured against: ***Fire, Lightning, Extended Coverage, and V&MM***. The FAIR Plan ***does not provide theft or liability*** coverage or time element coverage, such as loss of rents or business income.
- **The FAIR Plan will <u>not</u> cover <u>auto, farm or manufacturing property</u>.**

Property Insurance

I. Property Terms, Concepts and Policy Provisions

A. **Insurance** is designed to transfer the financial impact of a loss from an individual or company to an insurance company. In exchange for the protection (agreement of indemnification) of the insurance company, an insured must pay premiums.

- Property and Casualty Insurance Contracts are indemnification contracts. ***Indemnification*** means to restore a person to his or her original position before the loss, with no gain.

- ***Property Insurance*** indemnifies a person or business who has an interest in physical property for the loss or the loss of income-producing abilities.

- ***Casualty Insurance***, often referred to as Liability Insurance, indemnifies for a wide variety of financial losses due to a third party. Casualty Insurance protects the insured against losses including Liability, Auto, Workers' Compensation, Crime and Surety (Bonds).

B. **Insurable Interest** is the potential for financial or economic loss in a person or in a loss of property. Insurable interest (ownership) must exist at the time of the loss in property and casualty contracts. ***Indemnification can occur only when there is insurable interest.***

C. **Risk** is the uncertainty of loss. The purpose of insurance is to deal with the transfer of risk from the insured to the insurer. Without risk there is no need for insurance. Only ***pure risk*** is insurable. ***Pure risk*** means that only a chance of loss is present and no chance of gain.

D. **Hazard** is anything that increases the chance of a loss, such as:

- ***Physical***—dirty windshields, broken headlights or severely worn car tires.

- ***Morale***—carelessness of attitude or irresponsibility. This would include failing to lock the front door of a house, or failing to lock a drawer containing cash and other valuables, because any loss would be covered by insurance.

- ***Moral***—arises from people's habits and values. Dishonesty. Examples of poor moral risks include: intentionally setting a fire in order to collect the insurance, filing a false claim, having excessive speeding tickets, or having a poor credit report.

- ***Legal***—arises from liability losses or court actions against an individual or business. Insurance producers purchase Errors and Omissions insurance to protect themselves from this exposure. Doctors purchase Malpractice insurance for this protection.

E. **Peril** is anything that causes a loss, i.e., fire, wind, hail.

- Damage is caused when a hot water heater explodes. The peril is explosion and the hazard is an un-serviced water heater. Most policies will pay for the ***damage caused by*** the water heater exploding, but **will NOT pay for a new hot water heater**.

- ***"Act of God"…*** an event arising out of natural causes with no human intervention which could not have been prevented by reasonable care. For example: earthquake, flood, lightning or strong winds. ***Some "Acts of God" are covered and some are not***.

F. **Fire** is combustion accompanied by a visible light (a flame or glow). A ***friendly fire*** is intentionally set and remains within its container or intended limits. A ***hostile fire*** is one that escapes its intended limits. A fire in a fireplace is a friendly fire, but when a spark ignites nearby curtains, it starts a hostile fire. **Only hostile fires are covered under fire policies**.

G. **Loss Valuation** (a.k.a. ***loss settlement***):

1. **Actual Cash Value (ACV)** means the cost of repairing the damage, minus reasonable **depreciation** (wear and tear, deterioration and obsolescence).

2**. Replacement Cost** means the current cost, at the time of loss, to repair or replace the damaged property with new materials of like kind and quality, **without** deduction for depreciation, but not more than the policy limit.

3. **Guaranteed Replacement Cost** means the insurance company will indemnify losses even if the cost to repair or replace exceeds the coverage limit.

4. **Stated Value Coverage,** a.k.a. Agreed Value…Property is insured for a set value. The value is determined on the policy date, not at the time of the loss. This is usually accomplished by ***scheduling*** a particular item on the policy.

5. **Market Value** is a concept which does not usually apply to insurance settlements. *Market value means the selling value of the property*. The market value on real property would not be a good indicator of the insurable value for fire insurance.

H. **Direct Loss** means actual physical damage, destruction or loss of property. For example, a Homeowner's policy will cover direct fire damage to an insured's house including the ***water damage from putting the fire out.***

I. An **Indirect Loss (a.k.a. consequential loss)** is a loss which is a result of a direct loss and which occurs as a ***consequence of the direct loss***. An indirect loss usually involves ***money***, whether from loss of income, loss of business, or expenses for lodging and meals after a house fire. An ***indirect loss is paid only if the "direct loss" is caused by a covered peril***.

J. **Representation, Misrepresentation, Warranty, Concealment, and Fraud:**

1. **Representation** is a statement by the insured which he believes to be true. Statements made on an insurance application are deemed to be representations.

2. **Misrepresentation** is ***lying*** about information asked on the application. If the misrepresentation is material, it can void coverage. **Material** information has direct bearing on the decision to issue or not to issue an insurance policy.

3. **Concealment** is the withholding of material facts from the insurance company. Coverage may be voided if concealment is found to be of fraudulent intent.

4. A **Warranty** is a **written guarantee *(in all respects and details) in the policy***. A breach of a warranty may cause a ***suspension of the policy*** and may **void** all claims.

K. **Other Insurance** provision means that indemnity may be primary (pays first) or excess (pays after the primary coverage has been exhausted), or may be paid on a pro rata liability basis, should there be multiple policies with different companies, each company covering the same loss. *This provision prevents over-indemnification*.

- **Pro rata liability** means the ***distribution*** among several insurance companies for payment of a claim. For example, if an insured has an auto policy of equal coverage with Farmers and Allstate and a loss occurs, each company would pay ½ of the loss.

- If a building is insured for $1,000,000 with company A and $2,000,000 with company B, company A will pay 1/3 of any covered loss, company B will pay 2/3. Since company A has ***1/3 of the* total coverage**, they will pay 1/3 of the total loss.

L. A **Binder** (a.k.a. unconditional receipt) can be verbal or in writing and it provides **temporary-guaranteed** coverage prior to the issued policy. No premium is required for coverage to be in-force. Binders are good for a maximum of 90 days (may be extended with the **Commissioner's** written permission). ***The binder is in effect until the policy is issued***.

M. **Endorsements** are provisions added to a policy which broaden or restrict coverage or change a current provision. An endorsement is not valid unless signed by an executive officer of the company and must be attached to and made part of the policy.

N. **Cancellation vs. Non-renewal**…***Cancellation*** means termination of an insurance policy by the insured or the insurance company during the policy period. ***Nonrenewal*** means that coverage will be continued through to the policy's expiration date, but not beyond. To cancel or non-renew, a policy requires a written notice to the insured and mortgagee.

O. **Vacancy vs. Unoccupancy**…**Vacancy** means the absence of people and property from a building. **Unoccupied** means the absence of people only.

P. **Subrogation** is the transfer to the insurance company, by the insured, of the insured's rights to recover against a third party when the insurance company has paid for the loss. The insurer stands in the insured's place. ***Subrogation is very closely related to indemnification.***

Q. **Monoline vs. Package Policies…**One coverage policies are monoline policies and those with more than one line of coverage are package policies. (a.k.a. multi-line policies). A Homeowners Policy covers the building(s) and the liability and is a package policy. However, a Dwelling Policy covers just the building(s) and is considered a monoline policy.

R. **Deductible** is the amount that an insured pays first before the insurer pays. This can be a dollar amount or a percentage.

- ✓ **Per Occurrence** means an accident (***unintended, unforeseen or unexpected event***), including continuous or repeated exposure to the same general harmful condition. One deductible is charged regardless of the number of claims.

- ✓ A **Per Claim** deductible is charged for each claim in any one accident or occurrence. For example, a painter painting a house may cause damage to several cars from overspray. Each claim will require a separate deductible.

S. **Certificate of Insurance** represents ***proof that a policy and coverage exists***. A certificate will often list an outline of coverage or brief description of the coverage.

T. **Consumer Report…**The ***Fair Credit Reporting Act*** provides consumer protection in insurance transactions. The individuals' authorization **must** be obtained in order to run a credit check, **must** be advised that a report will be requested, provided the name and address of the reporting agency, and told how to get a copy of the report. Should any information on a consumer report be challenged by the consumer, and not proven by the reporting agency to be accurate**, the inaccurate information must be removed from the file within 30 days.**

U. **Rating and Premium Determination…**Common variables used in rating and determining premiums are: age, loss records, driving records, territory, coverage, limits, deductibles, value of the property, driving distance, and marital status.

- ✓ ***Experience rating*** provides for a modification of a class rate for an individual based on a comparison of his loss experience with the class. In property and casualty insurance for example, people with bad loss records will pay a higher premium than those with no losses. Adjustments (such as a rate increase) will usually apply to the next policy period upon renewal.

- ✓ The ***Actuarial and Statistical department*** is the "numbers" department. Using a tremendous amount of data generated by computer, together with statistics available from other companies, ***Actuaries*** determine the rates to be charged for various types of insurance coverage.

V. **Sources of Insurability Information…**When the application comes to the insurance company, underwriters review it for its acceptability to the company. In addition to the application, the insurance company may also evaluate by using the following sources: Inspection Services, Department of Motor Vehicles, Industry Bureaus such as Automated Property Loss Underwriting System, C.L.U.E. Report, financial information services such as Standard and Poor's, ***previous insurers and the company's own claim files.***

W. **Reporting and Non-reporting Forms…***Dwelling, Homeowners' and Auto Policies are non-reporting form policies*. Non-reporting policies usually have a fixed or flat premium. **Reporting form contracts** are issued when it is difficult to determine in advance the amount of coverage that needs to be purchased. Instead of a flat or fixed premium, a reporting form requires an advance premium or deposit premium, and then a report must be submitted to the insurer on which the correct premium will be calculated. This may result in a refund of premium or an additional premium being required. The insurer has the right to ***audit*** the reports given by the insured at any time to verify the figures.

X. **Liability** means being legally responsible or negligent for someone else's loss. This is also known as **third party coverage**. Legal liability is covered within the body of law called **Tort Law**. A tort is a legal wrongdoing **other than** a crime or breach of contract. Types of liability include absolute, strict, vicarious (a.k.a. imputed), and negligence. These terms will be discussed in more detail in more detail in the casualty section of the text.

1. ***Negligence*** is failure to use the proper care that is required to protect others from an unreasonable chance of harm. It is through negligence that someone becomes responsible or legally liable for someone else's loss. The **Prudent Person Rule** is a theory that says you are negligent when you have failed to do what a prudent person would do in similar circumstances.

   - ✓ The negligent act is the ***proximate cause*** of loss. The proximate cause of a loss is an action that, in a continuous sequence, **produced the loss**. This sequence is unbroken by any other factors or events, and *the loss would not have occurred without the proximate cause.*

2. **An *Accident*** is something **sudden, unintended and unexpected** which takes place at a **specific time and location**.

3. **An *Occurrence*** means an accident, including continuous or repeated exposure to the same harmful conditions, which results in bodily injury or property damage, which is neither expected nor intended by the insured. ***An occurrence does not have to be sudden and accidental.***

4. ***Bodily Injury*** means bodily harm, sickness or disease caused to a ***third party***. Bodily injury includes: required care, loss of services and death resulting from the bodily harm.

5. ***Property Damage*** is defined as physical injury to tangible property, including all resulting loss of use of that property.

6. ***Personal Injury*** includes false arrest, malicious prosecution, libel, slander, defamation of character, invasion of privacy, and wrongful eviction or entry.

Y. **Variations in Writing Limits**…Insurance limits may be written in a variety of ways. The ***limit of liability*** is the most the insurer is responsible to pay under the policy. The following terms refer to the manner in which the limits of insurance apply:

- ✓ **Specific Coverage** provides a specific amount of insurance for specific types of property. (A homeowner policy may cover personal property for a **blanket limit** of $50,000, however, cash has a **specified** coverage limit of $200 total.)

- ✓ **Scheduled Coverage** is used to provide different amounts of insurance for different types of property. (A homeowner policy will only cover the theft of a $5,000 ring for a **specified amount of $1,000**. By ***scheduling*** the ring for $5,000 on the policy [for additional premium] it would be covered for its proper and full amount.)

- ✓ **Blanket Coverage** provides a single amount of insurance that may apply to different types of property.

- ✓ **(Combined) Single Limit:** one figure shows the maximum the company will pay for all BI & PD liability arising from one occurrence, i.e., $100,000.

- ✓ **Split Limit:** three figures show the maximum the company will pay for liability resulting from one occurrence, i.e., 100/300/50 which means; $100,000 BI limit for each person, $300,000 BI total coverage for the accident, and $50,000 for PD.

- ✓ **Occurrence Limit** is the maximum amount available per accident.

- ✓ **Aggregate Limit** is the maximum amount available for the policy period.

Z. **Insurance Services Office (ISO)…**A not-for-profit organization established by insurance companies to write policy forms, compile rating information, etc. ISO is the principal rate-making organization for property and casualty insurers. *Our book is based on ISO standards*.

AA. In an insurance policy there are differences between a ***named insured*** and an ***insured.*** The *named insured* is the person, persons or business **actually named** as the named insured in the policy declarations. ***An insured is anyone who may be covered by the insurance***. A *named insured* generally has greater obligations and responsibilities under the policy. Commercial policies have started using the term ***first named insured***. The *first named insured* is the primary party responsible for carrying out contractual duties.

BB. **Dwelling and Homeowners:**

The **Dwelling Policy** was developed by the ISO in 1977. **Dwelling Policies** (a.k.a. Landlord Policies) are generally used to insure residential property that is rented to others or for homes which are under construction. The three dwelling property forms are Basic, Broad and Special.

A Homeowners' policy is a ***package*** policy because it combines property and casualty coverage in the same policy. ***Two major differences between the dwelling and homeowners policies are that homeowner forms provide slightly broader coverage and the combination of property and liability coverage is automatically included as part of the policy.***

Exam questions on the pre-license test are NOT based on a specific year or editions of the dwelling or homeowners forms, or rules which might be subject to change.

CC. **Risk Management** is a scientific approach to the problem of dealing with the ***pure risks*** faced by individuals and businesses. It is a function of the company's risk management to decide which risks are acceptable to insure and which ones are not acceptable to insure.

An individual can manage the risk of serious financial loss. One method would be to ***avoid the risk*** (chance of loss). To avoid a car accident don't drive a car. Another method is to ***prevent of loss*** or ***limit the severity*** of loss from occurring. By putting in a smoke alarm or a sprinkler system in a home it would limit the severity of any fire. A common method of managing risk it to ***transfer*** it to another party. This is insurance. If you were to get in a car accident or have a fire loss you would transfer the financial impact of the loss the an insurance company.

DD. **Professional Designations** ***CPCU*** means Chartered Property and Casualty Underwriter. To receive this designation an individual must complete 10 Property and Casualty Courses approved by the American College. ***CLU*** means Chartered Life Underwriter. To receive this designation an individual must complete 10 Life Courses approved by the American College. Other Property and Casualty designations include: AAI, ARM, and CIC.

EE. **Policy Provisions (Major Sections)**

Declarations Page contains the identity of the property covered, policy period, limits, deductible, premium, mortgagee, endorsements, and first named insured, etc.

Definitions section shows the insurance company's uses of words and how it defines them (i.e., "yours," "ours," "bodily injury," and "residence").

Insuring Agreement states what perils will be insured and what losses will be covered, i.e., **risks of direct physical loss or named perils coverage**. It says that the insurer will indemnify the insured as long as all of the provisions are met. The **conditions section** is where the requirements can be found. This is sometimes referred to as the heart of the contract. (The insurer will pay for losses.)

Exclusions provision lists what is not covered. These are common in all policies. (There are also some additional exclusions that are specific to certain types of policies. You will learn about these when we discuss those policies).

1. **Non-Accidental Losses** such as wear and tear or deterioration
2. **Losses Controllable By the Insured**
3. **Losses** due to ***war, flood, earthquake, and earth movement***
4. **Duplicate Coverage**…Losses covered by another type of policy would be excluded, e.g., vehicles and aircraft are not covered on a homeowner's policy
5. **Ordinance or law…**Laws or building codes may affect the reconstruction of a damaged building. The additional cost from such laws or codes is excluded

Conditions section describes the responsibilities and privileges of each party to the contract, such as cancellation or renewal rights, payment of claims, etc. For example:

1. **Insured's Duties after a Loss**:
   a. Notice of Claim**…**Notify the insurer immediately after a loss.
   b. Protect the property from further damage.
   c. Submit a proof-of-loss and inventory of damages within **60 days**.
   d. Make the property available for inspection.
   e. Submit to an examination under oath, if required.

2. **The Settlement Clause states that the insurance company:**
   - Has ***30 days to tell the insured their intention*** of how they will pay for the loss. For example, the insurer has the **right to repair, replace or give a cash settlement under property claims.**
   - Agrees to **pay the claim** within **60 days** ***after agreement*** with the insured, or a final judgment is made by the court, or appraisal is awarded.
   - **Does not** need the insured's approval to settle any liability claims. However, professional liability policies need the ***consent by the insured before settlement*** **of a claim**.

FF. ***Theft*** is any loss of property by stealing, including both robbery and burglary. Less obvious events also are covered when the circumstances at least show the likelihood that property was ***stolen and not merely misplaced***.

> ***Mysterious Disappearance*** means that insured property was lost but there is no likelihood that the property was stolen. Example: the insured cannot find one of their rings. Mysterious Disappearance is **NOT** an insured peril.
>
> ***Burglary*** is the breaking and entering into the premises of another with felonious intent**,** leaving ***visible signs of forcible entry or exit***.
>
> ***Robbery*** is the taking ***by force or fear of force*** of the personal property of another.

GG**. Property Forms Covered In This Text**

	Basic (Named Perils)	**Broad** (Named Perils)	**Special** (Open Perils)
Dwelling Property (ISO Dwelling Program)	DP 00 01 **DP1**	DP 00 02 **DP2**	DP 00 03 **DP3**
Homeowners (ISO Homeowner's Program)	HO 00 01 **HO1**	HO 00 02 **HO2**	HO 00 03 **HO3**
Commercial (ISO Program)	Causes of Loss Basic	Causes of Loss Broad	Causes of Loss Special

Property Dwelling Forms

COVERAGE (Direct Loss)	**Basic, DP1**	**Broad, DP2**	**Special, DP3**
A-Dwelling	The amount of the dwelling coverage is set by the insured		
B-Other Structures (10% of A)	Covered	Covered	Covered
C-Personal Property (10% of A)	Covered	Covered	Covered
D-Rental Value (indirect loss 10%)	Covered	Covered	Covered
E-Additional Living Expenses (indirect loss 10%)*	Not Covered	Covered	Covered
OTHER COVERAGE	Debris Removal, Betterments and Reasonable Repairs		
	—	Landscaping, Collapse & Glass Breakage	Landscaping, Collapse & Glass Breakage
PROPERTY REMOVAL	30 days	30 days	30 days
PROPERTY EXCLUDED	See Text		
PERILS COVERED	Fire, Lightning, Internal Explosion (Extended Coverage & VMM ***optional***)	Fire, Lightning, Internal Explosion, Extended Coverage, VMM, plus seven others	Risk of Loss = dwelling & structures Broad Form = perils for personal property
PERILS EXCLUDED	See text		
INDEMNIFICATION (loss settlement)	ACV (all coverage)	Building (A & B) = Replacement cost if insured at least 80% to value. Coverage C = ACV	Building (A & B) = Replacement cost if insured at least 80% to value. Coverage C = ACV

*Coverage E (additional living expense) may be added to the Basic Form by endorsement.

A. **Property Dwelling Forms (ISO Program)…** (a.k.a. landlord policies) are generally used to insure residential property that is rented to others for dwelling purposes. ***A Dwelling Policy may also be used to insure a home or dwelling which is under construction.***

The three forms which were developed include:

BASIC	**DP 00 01**	**DP1 - Named Peril**
BROAD	**DP 00 02**	**DP2 - Named Peril**
SPECIAL	**DP 00 03**	**DP3 - Open Peril**

The coverage form may be **Named Peril** or **Risk of Direct Physical Loss** (a.k.a. All Risk or Open Peril). **Named peril** coverage means that in order for a policy to cover a certain loss, the specific peril causing the loss must be listed on the policy. Under special form **(open peril)**, **all losses are covered unless specifically *excluded* in the policy.**

Dwelling Property insurance covers direct and indirect losses to tangible property. ***Theft is not a covered peril and there is no liability coverage under Dwelling Policies***. However, liability may be extended from the insured's homeowner policy.

- The ***Broad Theft*** endorsement adds coverage for theft of personal property to the Dwelling Policy.
- It may be written for an ***owner-occupied dwelling (nearly identical to the theft coverage and limitations found in a Homeowners' Policy).***

Coverage Available in DP Forms: Although all coverage "A" through "E" is preprinted in the DP policy form, ***the insured does not have to purchase each one***. For example, an insured who owns an unfurnished house that she rents to others might choose to purchase only Coverage "A" Dwelling and Coverage "D" Rental Value.

Dwelling coverage "**A**" includes structures attached to the dwelling, materials and supplies for use in construction or repair of the dwelling or other structure, and building or outdoor equipment used to service the premises. No retail sales, ***5 boarders maximum***, and 4 apartments or fewer.

Other Structures coverage "**B,**" (a.k.a. **appurtenant structures)**, includes buildings on the premises but not attached to the dwelling and not used for commercial purposes or farming. The coverage is limited to 10% of the dwelling (coverage "A").

Personal Property coverage "**C**" includes ***property of the insured*** other than "real" property (i.e., land) that belongs to an insured or any member of the insured's family residing at the insured location. The property of guests or servants may be added at the insured's request. Coverage amount is 10% of the dwelling amount (coverage "A").

Rental Value "**D**" (*indirect loss or consequential loss*) will extend 10% of Coverage A for rental income lost by the insured when the dwelling is uninhabitable for the renter.

Additional Living Expenses "**E**" (*indirect loss or consequential loss)* is not offered on the DP1 Basic Form. It pays extra expenses if the insured has to move for a short period of time due to a covered loss if the dwelling is uninhabitable.

Additional Coverage: ***included*** (**at no additional premium**) with Dwelling Property policy:

- ✓ ***Debris Removal…***If the loss to the insured property and cost of debris removal are more than the limit of liability for the property, the insurance company will pay an additional amount for debris removal. Pays up to 5% of coverage "A".

- ✓ ***Improvements*****,** alterations and additions made by the insured while he is the tenant. Pays up to 5% of coverage "A".

- ✓ ***Property Preservation*** (a.k.a. **property removal coverage**) covers loss to property removed from an endangering peril that occurs within 30 days. This coverage is broader than the normal coverage under the policy. ***It protects against any direct physical loss or damage and is not limited to the perils listed in the policy***.

- ✓ ***Reasonable Repairs*** made by the insured to protect property from a covered peril & to stop further loss.

- ✓ ***Landscaping*** is covered only on the Broad and Special Forms. Pays up to 5% of coverage "A," ***maximum $500 limit per tree, plant or shrub***.

- ✓ ***Collapse*** is covered only on the Broad and Special Forms. Pays if a loss is caused by any of the Broad Form perils or caused by covered perils of decay, hidden insects or vermin, or the weight of contents, including equipment, animals or people. ***Collapse*** that results from hidden decay or hidden insect or vermin damage is ***NOT covered*** if the insured knew about the damage before the collapse. (HO and DP contracts)

- ✓ ***Glass breakage*** is covered only on the Broad and Special Forms. ***Glass damage will be settled on a replacement cost basis, even if upgraded material is required by law***.

- ✓ **$500 for Fire Department service charges**.

Property EXCLUDED:

- ∅ Accounts, bullion, currency, money, securities, manuscripts, and evidence of debt
- ∅ Animals, including birds and fish
- ∅ Aircraft, motor vehicles, motor vehicle equipment and accessories (***except for those used to maintain or service the premises*** which are covered)
- ∅ Boats (except for rowboats and canoes which are on the premises are covered)
- ∅ ***Property of persons who rent from the insured or who rent rooms from the tenant***
- ∅ Land, structures used for commercial or manufacturing, including farm dwellings
- ∅ Losses caused by power failure
- ∅ Losses caused by neglect of the insured to use all means to save and preserve property
- ∅ Losses caused by any ordinance or law
- ∅ Intentional loss arising out of any act committed by or at the direction of an insured

	Basic DP1 Coverage (3 perils only)	Basic Form Options (for additional premium)
Basic Form DP1	**Fire, Lightning & Internal Explosion**	1) ***Extended Coverage*** (EC): ***REV. C. SHAW(acronym)*** **R**iot **E**xplosion **V**ehicle & **V**olcano **C**ivil Commotion **S**moke **H**ail **A**ircraft **W**ind 2) ***Vandalism & Malicious Mischief*** (**V & MM**)
Broad Form DP2	Fire, Lightning, Internal Explosion, both DP1 Options (EC, V & MM), plus **BIAFFECT*** (acronym): **B**urglary (damage caused by burglary) **I**ce (damage caused by weight of ice, snow or sleet) **A**ccidental (***sudden and accidental*** discharge of water) **F**alling Objects **F**reezing (damage to plumbing, heating, air conditioning or appliances) **E**lectrical (***sudden and accidental*** damage from artificially generated electricity) **C**racking* **T**earing* ***sudden and accidental*** tearing apart, cracking, or burning of steam, hot water, or air systems.	
Special Form DP3	This Form provides the most complete coverage. Coverage for the Dwelling and Other Structures (A & B) are provided against any loss (open perils) that is not specifically excluded. Personal Property (C) is insured against all of the Broad Form DP2 perils.	

Special Form Exclusions: **freezing** if the dwelling is vacant, unoccupied, or under construction, unless ***reasonable care*** was taken to avoid loss; **theft**; **V & MM** if the dwelling is vacant for more than ***60 consecutive days***; **war**; **intentional acts of the insured**; **flood, earth movement and earthquake**; **loss caused by birds, vermin, insects or domestic animals**; and **pollutants.**

- Insurance is designed to cover ***sudden*** and ***accidental*** losses, therefore gradual, preventable or expected losses such as wear and tear, mechanical breakdown, smog, rust, or corrosion are excluded. Mold, fungus, and wet or dry rot are also excluded (unless hidden from the insured in the ceilings, walls or floors, and such loss results from the accidental discharge of water or steam from within plumbing, heating, air conditioning or sprinkler systems).

Homeowner (HO) Forms (ISO)

Section I – PROPERTY **Coverage & Limits**	**Basic, HO1**	**Broad, HO2**	**Special, HO3**	**Tenant Broad, HO4**	**Condo Broad, HO6**
A-Dwelling	Covered	Covered	Covered	—	*($1,000) —
B-Other Structures	10% of A	10% of A	10% of A	—	—
C-Personal Property	50% of A	50% of A	50% of A	Covered	Covered
D-Loss of Use (indirect)	10% of A	20% of A	20% of A	20% of C	40% of C
Additional Coverage:	Removal coverage for 30 days; Costs for reasonable repairs; Fire Dept charge $500; $500 per tree, plant, and shrub; Debris removal; Credit card, forgery & counterfeit money coverage; Loss assessment ($1,000)	Same as HO1, plus collapse of a building	Same as HO1, plus collapse of a building	Same as HO1, plus collapse of a building, Building additions & alterations	Same as HO1, plus collapse. *The $1,000 dwelling coverage is for property **NOT** covered by the association (such as improvements).
PROPERTY EXCLUDED:	See text				
PERILS COVERED:	Fire, Lightning, E.C. (REV C SHAW), V&MM, Theft & Glass	Same as HO1, plus IAFFECT	Risk of Loss for Dwelling & Other Structures Broad Form perils for Personal Property	Broad Form perils for Personal Property	Broad Form perils for Dwelling (condo fixtures) Broad Form perils for Personal Property
PERILS EXCLUDED:	See text				
INDEMNIFICATION (loss settlement): Insurance company will give notice within 30 of a proof of loss of intentions on how they will pay for the loss. Upon agreement with the insured on the amount, the ***company will pay within 60 days*** of agreement.					
Replacement cost for coverage A & B	✓	✓	✓	—	—
All other property (ACV)	✓	✓	✓	✓	✓
Section II – LIABILITY **Comprehensive Personal Liability**	All forms are identical coverage and limits				
Primary Coverage	Coverage E - Personal Liability Coverage F – Medical Payments to Others				$100,000 per occurrence $1,000 each person
Additional Coverage	Insurance - Related: ***Claim Expenses***, ***First-Aid*** to Others, Damage to Property of Others, ***Loss Assessment*** ($1,000 per occurrence), ***Duty to Defend*** (the insured).				

B. Homeowner Policies (based on the **ISO Homeowners** Forms) are package policies because they include coverage for property and liability. Section I covers **property** while Section II covers **liability.**

- **A homeowner** may be held liable for damages arising from his/her home or yard, or for the actions of his/her children or pets. An individual can also be held liable for damages arising out of personal activities away from the home. All of these types of exposures are covered under Section II of the HO policy.

- The insurance: must be for residential purposes, **not** for commercial exposures; two-family (duplex) maximum and a maximum of ***two (2) boarders*** per residence; **no** farm use is covered. Certain incidental business and professional occupancies are allowed. These operations must be conducted by the insured and include such occupancies as beauty parlors, photographic studios and professional offices such as insurance and real estate agents.

- **Persons Insured** includes the named insured and ***all residents of the same household who are relatives of the named insured***, and **anyone who is under 21 years of age and in the care of any persons insured**. It also includes any loss caused by animals or watercraft owned by or in the care of the insured, except for any business uses.

HO Property Forms:

HO1 - Basic Form (HO 00 01)	**HO2 - Broad Form (HO 00 02)**
HO3 - Special Form (HO 00 03)	**HO4 - Renters Form (HO 00 04)**
HO5 - Comprehensive Form (HO 00 05)	**HO6 - Condo Form (HO 00 06)**
HO8 – Basic Form (HO 00 08) *but* ACV on losses*	

HO1, (Basic Form), covers the dwelling and personal property (A, B, C, & D). Perils covered: Fire, Lightning, Extended Coverage (EC), and V & MM. **Plus theft, glass and volcanic action**.

HO2, (Broad Form), provides the same coverage under the Basic HO, plus 6 others: falling objects, weight of ice, snow or sleet, freezing of plumbing, sudden and accidental rupture of heating, air or fire protective sprinklers, sudden and accidental damage from artificially generated electrical current, and accidental discharge of water or overflow from within plumbing or related systems.

HO3, (Special Form), provides Risks of (Direct Physical) Loss (a.k.a. Open Perils) coverage on the dwelling and other structures. However, Named Perils-Broad Form on personal property.

HO4 (a.k.a. Renters or Tenants), provides Named Perils coverage (same as on the HO2 and HO3) for Personal Property "C" (insured against broad form perils). **There is no dwelling coverage "A" and "B" because the insured doesn't own the premises.**

HO5, (Comprehensive Form), provides ***open peril coverage for both the dwelling and other structures and personal property***. Same as the HO3 with the HO15 endorsement.

HO6 (Condominium Form), is the **same coverage as on a Renters' Policy**. The dwelling coverage "A" & "B" is covered under the Condominium Owner Association's policy. Also, there is a $1,000 Dwelling "A" coverage for alterations, improvements and other owned building items. It can be increased for additional premiums.

HO-8 is the same as the HO-1, except losses are paid on an ***actual cash value basis***, not replacement cost. ***Owners of older homes, or elaborate homes with detailed designs or decorative architecture***, might have a replacement cost far in excess of the ACV or market value of their homes. The premium for such a home would be prohibitive. The HO-8 provides a practical package of coverage for owners of such dwellings.

Section I - Property - INCLUDED Coverage (standard $250 deductible):

"A" Dwelling (not included in HO4 & HO6) includes the dwelling, structures attached to the dwelling, and any material to be used to repair or build such structures if that material is located next to the dwelling.

"B" Other Structures (not included in HO4 & HO6) covers buildings separate from the dwelling by a clear space. These buildings may not be used for business purposes other than those described earlier under eligibility. This is an additional 10% coverage of the policy limit of coverage "A" (a.k.a. ***appurtenant structures)***.

"C" Personal Property covers 50% of coverage "A" in additional coverage. Personal property owned or used by the insured is covered **anywhere in the world**. The insured can also request that this coverage be applied to property owned by others or property of a resident employee while in any residence occupied by the insured.

"D" Loss of Use (**Indirect Loss**) pays for increased living expenses if the insured cannot occupy the residence following a loss by a covered peril. Or, the insured may be reimbursed for the *fair rental value* of the residence.

⊠ Percentage of coverage: 10% of "A" on HO1
20% of "A" on HO2 and HO3
20% of "C" on HO4
40% of "C" on HO6

Special Note: Coverage "E" Liability and Coverage "F" Medical are Section II coverage and are covered later in this chapter.

Additional Coverage INCLUDED…These coverages are **included with the policy** and require no additional premium by the insured (see Dwelling Section for more detailed definitions):

- ✓ Debris removal is the same as on the Dwelling Property forms. (5% of coverage "A")
- ✓ Reasonable repairs
- ✓ Landscaping (***$500 per tree, shrub and plants not to exceed 5% of coverage "A")***
- ✓ Fire Department service charge = $500
- ✓ **Property removed** (*Preservation of Property*) from the premises for up to 30 days to protect it from further loss, such as in a storage unit
- ✓ Credit card, fund transfer card, forgery and counterfeit money for up to $500
- ✓ **Loss assessment** by property owner's association for $1,000 for repairs made necessary by a covered peril
- ✓ Collapse (not covered on Basic Form)

Specific **(Internal) Property Limits** on indemnification includes the following:

Money, coins and precious metals other than tableware	**$ 200***
Securities, manuscripts, other valuable papers	**$ 1,000***
Watercraft, including the trailer and equipment (**on the premises only**!)	**$ 1,000***
Trailers	**$ 1,000***
Property **on** the premises used for business	**$ 2,500***
Property **away** from the premises used for business	**$ 500***
Specific property limits for the peril of theft only:	
Theft of jewelry, watches, furs, precious and semi-precious stones	**$ 1,000***
Theft of silverware, gold ware and pewter ware	**$ 2,500***
Theft of firearms	**$ 2,000***

Property EXCLUDED

- ∅ Animals, including fish and birds

- ∅ **Property of roomers, boarders or tenants not related to the insured**
- ∅ Motorized vehicles or aircraft, equipment and accessories. **Special Note**: ***Homeowners policies do cover vehicles which are not subject to motor vehicle registration, and which are used to service an insured's residence or designed to assist the handicapped***
- ∅ **Sound equipment in a motor vehicle**
- ∅ Land, including the land under the insured's residence
- ∅ Property that cannot be replaced with like kind and quality in the marketplace or obsolete property (such as a broken-down lawnmower or 8-track tape deck)
- ∅ Merchandise held as samples or for sale

COVERAGE FORMS (Perils Insured Against)

Special Notes:

Peril of Vehicle: ***Will NOT cover damage to fences, driveways and walkways when the vehicle is driven by an insured or resident of the insured's household***. It ***will cover*** damage to other types of property when the vehicle is driven by an insured or resident of the insured's household. This applies to all homeowners forms and dwelling property forms DP2 and DP3. The DP1 ***will not cover any losses*** caused by a vehicle owned by an insured or used by a resident.

Special Form *HO* and ***Special Form*** *DP*: covers (All) Risks of Direct Physical Loss or Open Perils coverage on the dwelling (coverage "A") and other structures (coverage "B"). The Personal Property (coverage "C") is insured on a broad form named perils basis.

You can add the **Special Personal Property Endorsement, HO 00 15 (HO15)**, to provide Risks of Direct Physical Loss on the personal property. However, this endorsement can only be added to an HO3, HO4 or HO6. The HO15 insures personal property items against "mysterious disappearance." ***An HO3 with an HO15 endorsement was formerly known as an HO5.***

Glass Breakage is always replacement cost and replaced up to "Code."

Volcanic Action covers volcanic blast or **airborne** shock waves, ash, dust or particulate matter, and lava flow. Volcanic Action does not cover damage to land, property in the open or in open sheds and buildings, and personal property in buildings not completely enclosed. All eruptions that occur within any 72-hour period will be considered the same volcanic eruption and subject to one deductible. ***Volcanic Action does not cover earthquake, land shock waves or tremors*.**

Perils EXCLUDED on Special Form - HO3

- ∅ Loss due to **ordinance or law** regulating construction, repair or demolition.
- ∅ **Earth Movement** means landslide, mudflow, earth sinking, rising or lifting, and ***earthquake*** including land shock waves before, during or after a volcanic eruption.
- ∅ Direct or Indirect Loss from **Water Damage**…Water damage means loss caused or contributed by: sewer or drain backup, water from below the ground including seeps or leaks through any part of the building, sidewalk, driveway, foundation or swimming pool. Water damage includes **flood,** surface water, waves, tidal water, overflow of a body of water or spray from any of these, whether driven by wind or not.

    - ❖ ***Concurrent Causation*** is a term referring to two or more perils acting concurrently (at the same time or in sequence) to cause a loss. Only the perils of fire, explosion, glass breakage, or theft, that results from earth movement or flood are covered under the concept of ***concurrent causation.***
        For example, should earthquake or flooding damage a home, generally this damage would not be insured because the peril causing the loss is excluded from coverage. However, should fire follow or act in sequence of an earthquake, the loss would be covered under the peril of fire (under concurrent causation).
- ∅ Loss due to power interruption whose source is **off** the premises.
- ∅ Loss due to **neglecting** to protect property after a loss.

- ∅ **War** and nuclear perils.
- ∅ Theft of personal property left in a building under construction. The coverage for discharge, overflow, vandalism and malicious mischief, theft, attempted theft, or damage to glass, is suspended whenever the dwelling has been *vacant* for more than **60 consecutive days**.
- ∅ Insurance is designed to cover ***sudden*** and ***accidental*** losses, therefore gradual, preventable or expected losses such as wear and tear, mechanical breakdown, smog, rust, or corrosion are excluded. Mold, fungus, and wet or dry rot are also excluded (***unless hidden from the insured*** in the ceilings, walls or floors, and such loss results from the accidental discharge of water or steam from within plumbing, heating, air conditioning or sprinkler systems).
- ∅ **Intentional Loss** committed by or at the direction of an "insured."
- ∅ The **freezing peril** is suspended whenever the dwelling is vacant, unoccupied, or being constructed, ***unless reasonable care was taken*** to maintain heat in the building or to shut off the water supply, drain systems and appliances.
- ∅ Losses caused by faulty, inadequate or defective planning, zoning, development, surveying, design specifications, workmanship, repairs, renovation, construction, remodeling, grading, or compaction.

Property Loss Settlement (How "We" Pay For Losses):

- **Deductible** is a standard $250. The deductible applies to all direct losses on an **occurrence** basis. The deductibles **do not** apply to the rental value, additional living expenses or the $500 Fire Department charge.
- DP1 (Basic Form) and HO8 are settled on an **Actual Cash Value** (**ACV**) basis for all the coverage.
- HO1, HO2, HO3, DP2, and DP3 (Broad and Special) indemnification is the same; **Replacement Cost** on coverage "A" (Dwelling) and "B" (Other Structures); Coverage "C" (Personal Property) is settled on an Actual Cash Value **(ACV)** basis.

Property Conditions and Provisions:

The **Policy Period** is the time period the policy is in effect. Fire policies have annual policy periods.

Insurable Interest and Limit of Liability means when more than one person has an insurable interest, the amount payable for loss will be no greater than the insured's interest at the time of loss, subject to the limit in the policy.

Co-Insurance Clause encourages the insured to insure her property for its full value by imposing a penalty on indemnification amounts if the property is insured for less than a given percentage of its value (usually 80%).

$$\frac{\textbf{Is}}{\textbf{Should Be (80\% of replacement cost)}} \textbf{ X (multiplied by) the loss = \$ amount of indemnification (minus deductible)}$$

Is **=** the amount of coverage the insured **is** carrying at the time of loss.
Should Be **=** amount of coverage, calculated by the replacement cost of the dwelling multiplied by 80% (Co-Insurance Clause). This is the amount of coverage that the insured **should be** carrying.

For example: If a house has a $100,000 replacement cost and the policy has an 80% coinsurance clause, the insured would be expected to carry at least $80,000 of coverage. As long as the amount of insurance is $80,000 or more, all losses up to the policy limit would be paid. **If the coverage is only $60,000 and a $20,000 loss occurs, the policy will pay only three-quarters of the loss.**

The **Salvage** Clause gives the insurer the right to take title to property after payment of a total loss, or ***may offer the insured an option to purchase the salvage back from the insurer.***

The **Abandonment** Clause prevents the insured from giving damaged property to the insurer in order to claim a total loss. **To claim a total loss is the option of the insurer**.

Recovered Property gives the insured the option to keep the loss payment or the recovered property, but not both.

Pair and Set Clause states that in case of loss or damage to a pair or set, the insurance company can either repair or replace any part to restore the value of the set or pay the difference between actual cash value of the property before and after the loss.

The **Subrogation Clause** (a.k.a. Transfer of Right of Recovery Against Others) allows the ***transfer to the insurance company of the insured's rights of recovery from a third party*** when the insurer pays for the losses. ***Relates to indemnification.***

The **Appraisal Provision** states that if the insurer and the insured cannot agree on an indemnification amount, either party may request an appraisal:

- ✓ Each party retains and pays for their own appraiser
- ✓ If the appraisers do not agree, they select an umpire and the cost is split between the insured and the insurer
- ✓ When agreement is reached between any two, the matter is settled

Arbitration Provision…Arbitration is a method *to* ***determine the rights and obligations of the parties to an insurance contract***. It is nearly identical to the appraisal provision; however, the arbitration provision usually doesn't apply to property losses, but to casualty losses.

Other Insurance applies when there is more than one policy covering a loss. This prevents ***"over indemnification."*** The policy will pay its pro rata share of a loss if there is more than one insurer covering the loss or will pay for a loss on an excess or primary basis if the duplicate coverage is with the same insurance company.

Suit Against the Insurer, by the insured, is permitted as long as ***all provisions and conditions have been met***, and no more than one year has passed since the date of the loss.

Insurer's Option is the right to ***repair, replace or give a cash settlement.*** **Loss payment** is the insurer's statement that they will pay the loss to the insured and/or mortgagee, and agrees to ***pay the claim within 60 days after settlement*** with the insured.

Your Duties After a Loss include **(*Notice of Claim*)**: notify the insurance company **immediately** after a loss; protect the property from further damage; submit a ***proof-of-loss*** and inventory of damages within **60 days**; make the property available for inspection; and submit to an examination under oath, if required.

Liberalization Clause states that if coverage under a policy is broadened because of a new law or ruling, all similar policies in force will automatically be broadened. Changes go into effect **without additional premium charge** and **without any endorsement** being required.

Changes conditions states that changes can be requested only by the ***named insured***, and made only by a written endorsement issued by the insurance company. The ***Entire Contract Provision*** states that the contract cannot be changed *unilaterally* by either party.

Bankruptcy of the insured will not relieve the insurer of its obligation to pay any claims.

Assignment is the transfer of the policy rights to someone other than the policyholder. ***Assignment is valid only with the written consent of the insurance company.***

Mortgage Clause (a.k.a. Mortgagee)…A provision attached to a property policy covering mortgaged property, stating that the loss must be payable to the mortgagee as his interest may appear and that the mortgagee's right of recovery may not be refused by any act of the insured.

- ✓ **A copy of any renewal, nonrenewal or cancellation notice sent to the named insured is required to be sent to the Mortgagee.**

- ✓ ***Duties of the Mortgagee***: 1) file **proof of loss** within 60 days if the insured fails to do so; 2) ***pay any premium not paid by the insured***; and 3) notify the insurance company of an increase in hazards (or if the risk has changed substantially).

Cancellation Condition..... Cancellation means termination of an insurance policy by the insured or the insurance company during the policy period. **The named insured may cancel at any time by returning the policy or by written notice to the insurance company.**

The insurer may cancel ***with a minimum of 10-days written notice for non-payment of premium*** and with a 10-day written notice within the first 60 days of underwriting. After the policy has been in force for over 60 days, the insurance company may cancel only for cause and with a **minimum of a 30-day (ISO) written notice**.

Cancellation Reasons (Cause):

1. ***concealment or misrepresentation*** of a material fact.

2. ***if the risk has changed substantially since the policy was issued.***

3. if the building is vacant or unoccupied for more than 60 consecutive days.

4. if repairs to the dwelling have not been in a progression of completion 60 days after receipt of funds from the insurer.

5. not furnishing heat, electricity, water, or sewer, for 30 consecutive days.

Cancellation Premium Refunds:

1. ***FLAT RATE*** cancellation means that all premiums are refunded within 45 days.

2. ***SHORT RATE*** basis refunds are made if the insured cancels the policy. All *unearned* premium minus a *service fee* must be **returned to the insured in 30 days**.

3. **PRO RATA** basis refunds are made if the insurer cancels the policy. All *unearned* **premium must be returned within 45 days** but no service fee is allowed.

Nonrenewal means that coverage will be continued through to the policy's expiration date, but not beyond. The **nonrenewal** of a policy requires a **minimum 30-day** (ISO) written notice.

Renewal of a policy requires the insurer to give a **20-day (ISO)** notice of intention to renew.

Special Note: Any written notice from the insurance company to cancel, renew or non-renew insurance must be sent to: the named insured, the mortgage company and the producer of record.

Common Property Endorsements

1. Scheduled Personal Property Endorsement (same as the *Personal Articles Floater*) provides insurance beyond the limits established in the Homeowner's policy. The items must be listed by description and value on the application.

There are nine optional classes of property coverage available: Jewelry (***most commonly used***), Furs, Cameras, Musical Instruments, Golf Equipment, Silverware, Fine Arts, Coins and Stamps.

- This endorsement provides coverage on a risks of direct physical loss basis. (a.k.a. open perils). Picks up ***mysterious disappearance*** losses.

- This endorsement establishes the value and details of the property ***before the loss***. *Keep in mind the value is determined at the time of the loss*. The company will indemnify the insured for the lesser of: ***actual cash value, the amount for which the insured could be expected to repair or replace the property with a substantially identical item, but never more than the stated amount of insurance***.

2. Personal Property **Replacement Cost Endorsement** provides indemnification for personal property based on replacement cost rather than ACV. **Replacement Cost** means the current cost, at the time of loss, to repair or replace the damaged property with new materials of like kind and quality, without deduction for depreciation but not more than the policy limit.

3. Guaranteed Replacement Cost of Dwelling will indemnify losses even if the cost to repair or replace exceeds the coverage limit. 100% of the replacement cost of the dwelling must be covered at the time of the application.

DWELLING COVERAGE

Replacement Cost	***Guaranteed* Replacement Cost**
• "To value" at the **time of loss**	• "To value" at the **time of application**
○ "To value" = **80%** co-insurance of the replacement cost	○ "To value" = **100%** of the replacement cost
▪ Will only pay **up to the policy limits**	▪ Will pay the **amount of the loss**, *even if it exceeds the policy limits*
✓ Inflation Guard must be added	✓ Inflation Guard **included**

4. Earthquake coverage may be endorsed on all property forms and covers damage caused by earthquake (which is excluded on property forms). The most common deductible today is **10%.** However, the deductible is a percentage of the amount of coverage NOT the amount of the loss. For example, a home insured for $300,000 has a deductible of $30,000 for earthquake loss. The insured may insure the dwelling only or may cover both the dwelling and personal property. The deductible applies to the dwelling and personal property separately. All earthquakes that occur within any 72-hour period will be considered the same earthquake and subject to only one deductible.

The sale of earthquake insurance will be suspended by an insurance company following an earthquake. People can't wait for a small earthquake then rush to purchase coverage, thinking that a bigger quake is about to occur.

Section II (Liability Coverage)

Coverage "E," (Comprehensive) Personal Liability Insuring Agreement, obligates the insurer to pay all sums for bodily injury and property damage to others, for which the law holds the insured responsible because of an occurrence.

- ✓ The insurer will also defend the insured, with counsel of the insurance company's choice, against any suit or claim. The company may also investigate, negotiate or settle any suit (a.k.a. ***settlement clause***).

- ✓ The insurer will not be obligated to pay any claim or judgment or defend any suit if the limit of liability has already been exhausted. Coverage E **has a standard limit of $100,000** per occurrence. This amount may be increased by endorsement.

1. Bodily Injury means bodily harm, sickness or disease, including required care, loss of services, (i.e., **wages, daycare, landscaping, housekeeping**, etc.) and death that results.

- ✓ It ***does not*** mean a disease which is transmitted through sexual contact, nor does it include the actual, alleged or threatened sexual molestation of a person, nor does it include physical or mental abuse.

- ✓ ***Personal Injury (PI) is not included*** under most ISO Homeowners' policies. **The Personal Injury endorsement amends the policy to include false arrest, malicious prosecution, libel, slander, defamation of character, invasion of privacy, and wrongful eviction or entry.**

2. Property Damage is defined as physical injury to tangible property, including all resulting loss of use of that property.

3. Persons Insured includes the named insured and all residents of the same household who are relatives of the named insured, and anyone who is under 21 and in the care of any person insured. It also includes any loss caused by animals or watercraft owned by or in the care of the insured, except for any business uses.

Coverage "F," Medical Payments to Others, will pay the necessary medical expenses that are ***incurred within three years from the date of an accident*** which has caused bodily injury to a third party, ***regardless of fault*****. This coverage does not pay benefits to the insured.** Coverage applies to any person on the insured premises with the permission of an insured, and to any person off the insured premises if the bodily injury is caused by:

- ✓ conditions on walk-ways adjoining the premise.
- ✓ the activities of an insured.
- ✓ a residence employee in the course of employment by an insured.
- ✓ an animal owned by or in the care of an insured.

Medical (Coverage F) has a **standard limit of $1,000 per person, per accident.** This amount may be increased by endorsement.

Section II, Standard Liability Exclusions

- ∅ Liability or injury or damage which is expected or intended by an insured. BI/PD arising out of business pursuits or failure to render professional services.

- ∅ Liability arising out of ownership, maintenance, use of aircraft or motor vehicles. **Exceptions** are made for the following non-registered vehicles, which **are** covered: vehicles in dead storage on the insured premises; ***vehicles used exclusively for assisting the handicapped or which are used exclusively to service the insured premises;*** a recreational motor vehicle owned or operated by the insured while **on the insured premises only;** and ***a golf cart while being used for golfing.***

- ∅ Property Damage to property owned by, used by or in the care of the insured.

- ∅ BI which is covered under Worker's Compensation.

- ∅ Bodily Injury for boats which do not meet the definition of a "watercraft." **Watercraft** means an inboard or inboard-outboard motor-powered boat owned by or rented to the insured that has 50 horsepower or less; sailing vessels of 25 feet or less; and any boat powered by an outboard motor of 25 HP or less.

- ∅ Medical payments to residence employees or boarders of the insured premise.

- ∅ Liability arising out of the use, sale, manufacture, delivery, transfer or possession of a controlled substance (does not apply to the legitimate use of prescription drugs).

Section II, Additional Coverage: included with the policy and requires no additional premium by the insured):

- ✓ **Claims Expenses**: defense expenses and taxes; premiums for bonds required in a suit the insurer defends; pre-judgment or post-judgment interest on the amount of the judgment the insurer is obligated to pay; reasonable expenses incurred by an insured at the company's request, including $50 a day for loss of earnings.

- ✓ **First Aid Expenses** reimburses the insured for expenses the insured incurs for giving first aid to others at the time of an accident. Note*: In Commercial General Liability, the first aid administered to others is covered under Medical Expense (Coverage C).*

- ✓ **Damage to Property of Others** provides coverage for property damaged or destroyed by the insured, **without regard to legal liability, for up to $1,000 per occurrence.**

- ✓ **Loss Assessment** *pays up to **$1,000** of the insured's share of any loss assessment charged against the insured by a corporation or association of property owners, when the assessment is made as a result of an occurrence to which Section II applies*, or the claim is based on the association's liability arising out of an act of an unpaid elected director, officer, or trustee of the association.

Section II, Liability Conditions:

- ✓ **Limit of Liability** means the insurance company will not be obligated to pay any more than the limit set in the declarations page for **any one** o**ccurrence** for coverage "E", regardless of the number of claims. The limit for coverage "F" (Medical) will pay **per person**, but only up to the limit on the declarations page.
- ✓ **Severability of Insurance** means each person insured is treated as if each has separate coverage under the policy; however, it will not increase the maximum coverage under any one occurrence. The limit of liability stated in the policy is not cumulative, regardless of how many claims or suits are brought.
- ✓ **Duties After Loss…**Give the insurer notice; promptly forward any notice, demand, summons or other process relating to the accident or occurrence; assist the insurer at their request; and under Damage of Property of Others, submit a proof of loss within 60 days, show the damaged property or submit a sworn statement under oath. The insured will not voluntarily make payment, assume obligations or incur expenses, other than to extend first aid to others at the time of bodily injury.
- ✓ **Medical Payment Made to Others** is not an admission of liability.
- ✓ **Suit Against "Us"** is allowed only if the insured has met all the policy provisions. There is a one year limitation to file the suit.
- ✓ **Death of an Insured** will automatically extend full coverage under this policy to a legal representative of the deceased, but only with respect to the property and premises of the insured.

C. Mobile Home owners can obtain coverage through policies developed specifically for mobile homes (also known as manufactured homes). *The coverage and sections are the **SAME AS** most regular Homeowner's forms*. For example, coverage "A" is the dwelling, "C" is coverage for the personal property of the insured, section II is liability coverage, etc.

- Coverage A - States the limit of liability for damage to the mobile home;
- Coverage B - Other covered structures (10% of Coverage A);
- Coverage C - **Personal property of the insured *(Note:*** Unlike the HO forms that provide 50% of the Coverage A limit, ***the Mobile Homeowners provides 40% of Coverage A.*** Usually, appliances, furniture, etc. come from the manufacturer and everything that comes in the unit from the dealer at the time of purchase is classified as Coverage A property.);
- Coverage D - Loss of use coverage; "E" - Personal Liability; "F" - Medical Payments

D. National Flood Insurance (**www.fema.gov/nfip).....**The federal government subsidizes and administers flood coverage, but the coverage is marketed by insurance agents. Coverage becomes effective **30 days** after application is made (***no waiting period after application for coverage on new loans or refinanced loans***). Flood coverage is required for mortgagees who have a lien on property which is in a *flood zone.*

- *Anyone may obtain this coverage, even if they are not in a flood zone, as long as the property is in a* ***participating community***. If the community agrees to adopt flood control measures and land use regulations, the community may apply for ***participation***.

Flood refers to a temporary, partial, or complete inundation of normally dry land areas by: an overflow of inland or tidal waters or spray from any of these, ***whether driven by wind or not***. Flood also includes unusual and rapid accumulation or runoff of surface water, and collapse of land as a result of erosion by flood.

- **Flood insurance is a single peril policy and covers losses to property** (***NOT THE LAND***) caused by flooding. Some of the things a standard flood policy will cover include: ***structural damage; furnace, water heater and air conditioner; flood debris clean up; and floor surfaces such as carpeting and tile.***

Maximum coverage under the regular program: Single Family Dwelling is $250,000 (loss valuation is RC) and Personal Property is $100,000 (loss valuation is ACV).

There are two types of Flood Insurance Policies: ***The Standard Flood Insurance Policy (SFIP) and the Preferred Risk Policy (PRP).*** The ***Preferred Risk Policy*** **(PRP)** offers lower-premium protection for homes and apartments in areas of **low-to-moderate flood risk.** (areas outside of floodplains.)

- **FYI: Write Your Own Policy Program (WYO)…**The WYO insurance companies issue and service the federally backed Flood Insurance Policies under their own names, collect premiums and pay claims. They are reimbursed for their services by FEMA.

III. Commercial Package Policy

Like a Homeowners' or Auto Insurance Policy, the Commercial Package Policy (CPP) combines two or more coverages into one policy. This reduces repetitive information, eliminates coverage gaps and can produce savings in premiums. However, the CPP is for business use.

The advantage to packaging a policy is *that there are fewer policies to buy and maintain. Packaging reduces the chance of delay in a loss settlement due to disputes between different insurers.* For example, a loss involving loading of automobiles sometimes falls in a "gray area" between auto liability and general liability. If one insurer provides both coverages, payment of a claim will not be delayed as it might be if each coverage were written by a separate insurer and each insurer felt the claim was covered under the other's policy.

CPP is made up of:

1. **Common Declarations**
2. **Common Conditions**
3. **Interline endorsements (if needed)**
4. **Two or more Coverage Parts**

Coverage Parts are commercial coverages which can be purchased and which make up the CPP. The Coverage Parts which we will be covering include:

1. Commercial Property
2. Farm (Property) (not covered in this text)
3. Commercial Marine (Property)
4. Equipment Breakdown (Boiler and Machinery) (Property)
5. Commercial Crime (Casualty)
6. Commercial Auto (Casualty)
7. Commercial General Liability – CGL (Casualty)

A CPP might also contain ***interline endorsements*** or endorsements that may be used with more than one line of insurance or more than one Coverage Part. They are prepared to eliminate redundancy and to minimize the number of endorsements in the commercial package policy.

When the property or casualty policy is issued, the licensed producer must ***countersign*** the policy. This will verify that a licensed producer sold the insurance and that he is licensed in the state in which the insurance was written.

CPP Common Declarations Page:

1. Policy number and policy period
2. Identity of the insurer and producer
3. Name and mailing address of the named insured
4. Description of the covered business
5. List of the coverage parts purchased and the premiums for each part
6. Total of all combined premiums
7. List of forms applicable to each coverage part
8. **Countersignature and the date of the signature**.

Commercial Package Policy Common Conditions Page:

Cancellation…The first named insured may cancel the policy by **giving written notice and returning the policy to the insurance company**.

If the insurance company cancels coverage, notice must be sent to the First Named Insured, producer of record and any mortgage company. A minimum **10-day notice** in writing is required for cancellation due to non-payment of premium, whereas a minimum **30-day written** notice is required to cancel for other reasons.

- ✓ If the notice of cancellation is mailed, the insurance company is not required to prove that the insured actually received the notice. It is required to prove only that the notice was mailed to the First Named Insured at the mailing address on the policy.

Changes condition states that changes can be requested only by the First Named Insured, and made by a written endorsement issued by the insurance company.

Premiums are the responsibility of the First Named Insured.

Examination of "your" books and records is allowed any time and for up to three **years** after the policy period. ***This provision is included because some commercial coverage is issued with estimated premiums***. The final premium is determined after the policy expires, based on: reported values of the insured property, the amount of the insured's sales, payrolls, or some other variable.

Inspection and surveys… The insurer may inspect or survey the insured premises at any time, report its findings and make recommendations for changes. ***This inspection will relate only to insurability, premiums, and to verify that any warranties are being met by the First Named Insured.*** The insurer does not warrant that conditions are safe or that the insured is in compliance with any specific regulations.

"Your" rights and duties under this policy **may not** be transferred to another party, but remain the rights and duties of the First Named Insured. The clause also provides for automatic transfer of coverage upon the death of a named insured to the named insured's legal representatives. This is often referred to as the **Assignment Clause.**

A. Commercial Property Coverage Part

The Building and Personal Property Coverage is a **form** that may be issued as a monoline policy or as part of a Commercial Package Policy. Every policy must have a commercial property coverage part which consists of: the commercial property declarations and conditions page, causes of loss forms (basic, broad, special, and earthquake) and one or more coverage forms (there are about 13 different property forms [not covered in this material])

Coverage (unlike the Homeowners policy, the following coverage must be added and purchased separately and is not automatically included with the commercial property policy):

- ***Building (Coverage "A"), purchased by the owner of the building.*** Covers: buildings, permanently installed fixtures; machinery and equipment; and additions, alterations, or repairs in progress, including supplies, equipment, and temporary structures **within 100 feet** of the described premises.

- ***Business Personal Property (Coverage "B"), purchased by the owner or tenant,*** includes: furniture, fixtures, machinery, equipment, stock, etc. This coverage includes property in the open or in a vehicle **within 100 feet** of the described premises.

- ***Personal Property of Others (Coverage "C"), purchased by the owner or tenant,*** provides for payment to third parties for their personal property while in the insured's care in the building or **within 100 feet** of the described premises.

Property Not Covered:

- ∅ Money and related property
- ∅ Animals, unless they are boarded or held for sale
- ∅ Autos for sale
- ∅ Contraband or property being illegally transported
- ∅ Property below the basement level or below ground level
- ∅ Land, water, growing crops or lawns
- ∅ Personal property over 100 feet from the described premises
- ∅ Pilings, piers, wharves, or docks
- ∅ Property which is airborne or waterborne
- ∅ The cost to restore information contained in valuable papers or records
- ∅ Vehicles licensed for road use, or principally used away from the premises (However, vehicles used for the maintenance of the premises **are covered)**
- ∅ Trees, shrubs, plants, any crops stored outside a building, any fences, antennas, or signs not attached to the building (**special note**: a limit of $1,000 for signs attached to the building is provided)
- ∅ Boilers and certain other heavy machinery (Equipment Breakdown Coverage)

Coverage may be extended to apply to ***outdoor property***, such as fences, signs (not attached to the building), trees, shrubs and plants. However, the insurer will pay not more than **$250** for any one tree, shrub or plant, and not to exceed a total of **$1,000.**

Additional Coverage: included with the policy and requires no additional premium.

- ✓ **Debris Removal** applies to the cost of removing debris of covered property resulting from a covered cause of loss during the policy period.

- ✓ **Preservation of Property** (a.k.a. Removal) covers any loss that occurs within 30 days to property removed from an endangering peril. This coverage is broader than the normal coverage under the policy.

- ✓ **Fire Department Service Charge -** up to $1,000 (no deductible).

- ✓ **Pollutant Clean-Up and Removal** - $10,000 limit per policy period in addition to the policy limit. It pays the insured's expenses to extract pollutants from land or water at the described premises if the loss was due to a covered peril.

- ✓ **Collapse** is covered only on **Broad and Special** Causes of Loss forms.

- ✓ **Property in Transit** is covered only on the **Special** form and for $1,000.

- ✓ **Glass Breakage -** covered for $100/plate, and $500/occurrence (**Broad & Special**).

Conditions are similar to that as found in the DPs and HOs:

Liberalization, **Policy Period, Coverage Territory, Salvage, Abandonment, Cancellation, Nonrenewal, Fraud, Pair and Set, etc.**

Transfer of Rights of Recovery Against Others (a.k.a. Subrogation)

Other Insurance (duplicate coverage under two or more different policies); Indemnification will usually be on a pro-rata basis.

Insurance Under Two or More Coverage Parts (duplicate coverage under the same CPP). Indemnification will usually be on a primary and secondary basis.

Legal Action (must be brought within ***two years after the date of the loss***).

No Benefit to Bailees… No one having custody of insured property, other than the insured, may benefit from the insurance. A bailee is someone, who for business reasons, has possession of a customer's property. If an insured sends covered property (such as office equipment) out for repair and it is damaged while in the bailee's possession, the insurance will not reduce or eliminate any obligations of the bailee.

Vacancy specifies that if a building is **vacant** for more than **60 consecutive** days before a loss, the insurer will reduce any payment by 15% for a covered loss. In addition, the insurer will **not pay** (a.k.a. **suspension of coverage**) for any losses due to:
vandalism, water damage, theft (*special form*) and attempted theft, building glass breakage, and sprinkler leakage.

Commercial Causes of Loss FORMS (Perils Insured Against)

Basic	Broad	Special	Earthquake
✓Fire and Lightning ✓EC: **R**iot **E**xplosion	✓Includes ALL of the Basic Form perils ✓Weight of ice, snow or sleet	✓ "Risks of Direct Physical Loss" (Open Perils) ✓Theft – loss by theft	✓Must be used with one other Causes of Loss Form

Vehicle **C**ivil Commotion **S**moke **H**ail **A**ircraft **W**ind ✓V & MM ✓Sprinkler leakage ✓Volcanic Action ✓Sinkhole Collapse	✓Falling objects ✓Water damage from freezing, cracking, tearing apart, or burning of hot water, air systems, and appliances or systems	has specific limits for certain kinds of property Note: ***Will not cover the dishonest acts of employees or loss of money and securities***	

➢ All ***volcanic actions and earthquakes*** that occur within any ***168 hour period*** are considered a single occurrence (only one deductible per occurrence).

➢ ***Dishonest acts of employees,*** loss of money & securities may be added under Crime Coverage.

💰 ***Co-insurance*** reduces payment for losses by the formula we discussed in the Homeowners and Dwelling policies section:

$$\frac{\textit{Is}}{\textit{Should Be}} \text{ (80\% of replacement cost)} \quad \textbf{X (multiplied by) the loss = \$ amount of indemnification (minus deductible)}$$

Is **=** the amount of coverage the insured **is** carrying at the time of loss.
Should Be **=** amount of coverage, calculated by the replacement cost of the dwelling multiplied by 80% (Co-Insurance Clause). This is the amount of coverage that the insured **should be** carrying.

EXCLUSIONS on Commercial Property Special Form

- ∅ War, flood and earth movement
- ∅ Wear and tear
- ∅ Delay, loss of use or loss of market
- ∅ Release, discharge or dispersal of contaminants or pollutants
- ∅ Rain, snow, ice or sleet damage to personal property in the open
- ∅ Agricultural smudging
- ∅ Dishonest or criminal acts of the named insured
- ∅ Losses caused by explosion of steam boilers, steam pipes, steam engines owned by, leased to, or operated by the insured and mechanical breakdown

Commercial Property Indirect Loss Coverage

Business Income Coverage Form…a form in the Commercial Property Coverage Part of a Commercial Package Policy that covers ***indirect losses***. For example, it would cover the **loss of income due to a suspension of an insured's business operations** following a direct covered loss to business property. Business income coverage is a "**time element**" coverage since time is a factor ("element") in determining the extent of the loss.

Business Income means the insured's net income that would have been earned and continuing operating expenses including payroll.

Coinsurance and Optional Coverage…Business income usually is written with a coinsurance requirement. However, this co-insurance requirement may be removed with any of the three coverages below.

1. ***Maximum Period of Indemnity*** waives the coinsurance requirement and limits indemnity to no more than the actual loss incurred during the first **120 days** following the direct loss or the **policy limit**, *whichever comes first*.

- ✓ **Example:** A business has annual net income and operating expenses of $100,000. At a 50% coinsurance requirement, the business should carry $50,000 of business income coverage. But suppose the business carries only $40,000 of coverage. Since this is only four-fifths of what the business should carry, the insurer will only pay four-fifths of any loss. If the business suffered a partial loss of $5,000 per month for four months, the insurer would pay $4,000 per month (four-fifths of the loss), for a total of $16,000. But, if the business chose **Maximum Period of Indemnity Coverage**, the coinsurance would be waived. The insurer would pay $5,000 per month (the entire amount of the loss) for ***a maximum of four months***, for a total of $20,000.

2. ***Monthly Limit of Indemnity*** waives the coinsurance requirement and pays the insured a **selected fraction of the policy's limits** each month following a direct loss. The fraction may be 1/6, 1/4, or 1/3.

- ✓ For example, if the fraction shown is 1/4 and the policy limit is $100,000, the maximum amount that the insured would recover for any thirty consecutive days would be $25,000 (or the amount of the loss, whichever is less).

3. ***Agreed Value waives the coinsurance provision*** if the insured submits a business income report showing financial data for the previous 12 months and estimated data for the next 12 months and the insured insures for the full value established in the report.

Extended Business Income is an additional coverage which is **included** in the Business Income Form. ***This indemnifies the insured for continuing losses in business income for up to 30 days after business is resumed***.

- The **Extended Period of Indemnity** option gives the insured Extended Business Income coverage for the number of days stated in the declarations. For additional premium, this option provides Business Income Coverage for longer than the 30 days already provided.

Extra Expense Coverage Form is ***indirect loss coverage*** added to the Commercial Property Coverage Part of the Commercial Package Policy. Certain businesses such as public utilities, insurance agencies, banks, and newspapers must continue to operate after a physical loss. They will still produce their normal revenue, but will have extra expenses in order to ***continue their operation after a covered loss***. There is no coverage for lost business income.

For example, a dairy could incur expenses for the cost of renting temporary quarters and the cost of moving to and from that location. ***Payment for overtime work and the cost of bringing in temporary employees would be covered***.

- ✓ **For example, if the coverage is written for 40/80/100**:
  40% maximum recovery for the first 30 days
  80% maximum recovery for 31-60 days
  100% coverage for over 60 days
- ✓ **The percent is a percentage of the face amount of the policy**.

- ✓ **Example:** A $100,000 policy would pay up to $40,000 (40% of the limit) if the period of loss lasted 30 days or less; $80,000 (80% of the limit) if the period of loss was 60 days or less; and $100,000 if the period of loss was longer than 60 days.

B. Inland Marine Insurance (Personal and Commercial)

Nationwide Definition…To help identify the kinds of risks which are eligible for either Marine Insurance and to limit the insuring powers of marine underwriters, the industry developed the *nationwide definition.* The definition lists six categories of eligible marine risks:

1. **Imports** (Ocean Marine)
2. **Exports** (Ocean Marine)
3. **Domestic Shipments** (Inland Marine)
4. **Instrumentalities of Transportation or Communication…**This category includes property such as bridges, tunnels, oil pipelines, loading docks, and radio/TV towers. While this property is not portable, it does have a direct connection with transportation and is subject to many of the same perils as property in transit. (Inland/Ocean Marine)
5. **Personal Property Risks** (Inland Marine)
6. **Commercial Property Risks** (Inland Marine)

Personal Inland Marine Forms (a.k.a. Floaters)

- **Personal Articles form (scheduled property)**
- **Personal Property form (unscheduled property)**
- **Personal Effects form (unscheduled property)**

1. Personal Articles Form *(floater)* is the same as the ***Scheduled*** **Personal Property Endorsement** on a Homeowners' policy and provides insurance beyond the limits established in the Homeowner's policy, with broader coverage. The items must be listed by description and by a stated value (***meaning they are scheduled items***). The most common use of the personal article form is for Jewelry.

- ✓ Provides coverage on a risks of direct physical loss basis (a.k.a. Open Perils) and picks up ***mysterious disappearance*** losses.
- ✓ Establishes the value and description of the property ***before the loss***.
- ✓ Personal Article Floaters Settlement: the value of the property is determined at the time of the loss. The insurance company will pay the lesser of: the **actual cash value of the property** or the **cost to repair or replace the property**, but never more than the stated amount of insurance.

2. Personal Effects Form is another policy that is used to insure ***unscheduled property*** on an all risk or open perils (***risks of direct physical loss***) basis. This floater covers only personal effects ***while traveling***.

3. ***Personal Property Form*** provides **open perils** (*risks of direct physical loss*) **coverage** on a **blanket basis** (unscheduled) for most kinds of personal property found in a typical home. The Personal Property form (floater) is most frequently issued to condominium or apartment dwellers who cannot obtain this open peril coverage under the HO-4 or HO-6.

Commercial Inland Marine insurance was first developed as an extension of Ocean Marine coverage to provide coverage for cargo traveling over land instead of by sea. **The characteristic which makes property eligible for Inland Marine coverage is an element of portability.** Generally, Marine forms **do not** cover such stationary property as real estate, furniture, fixtures or merchandise in the course of manufacture. Examples of Inland Marine coverage include:

- ***Contractors' Equipment Floater*** is a Commercial Property Floater that provides extensive coverage for a contractor's heavy machinery, equipment and tools that is not available through commercial property or auto policies. Vehicles designed for use principally on public roads are not eligible for the coverage.
- ***Bailees Customers' Coverage*** is a Commercial Property Floater that provides coverage for bailees (the temporary holder of customers' property) such as shoe repair shops, dry cleaners, and other businesses with a large amount of customers' goods in their possession. Coverage is provided even

if the insured is not negligent for the loss. This helps to retain the good will of a service type of business.

- ***Furrier Customers Coverage*** is a **Bailee's coverage** that will cover clients' furs that are within the Furrier's care, custody and control. A ***furrier*** is a business which stores furs on its premises.

C. Equipment Breakdown (Boiler and Machinery) Coverage Part

1. The **basic concept** of this coverage is to prevent potentially catastrophic losses as a result of explosion of steam boilers and other heavy equipment. The policy includes a loss control feature (known as **safety inspections**) which stresses **loss prevention.**

- A portion of each premium dollar is used for the inspections and control services.
- The Boiler Coverage have a unique provision that suspends coverage if the ***object*** is found to be defective.

2. The **Equipment Breakdown Insuring Agreement** agrees to pay for direct damage to covered property caused by a covered cause of loss, meaning ***an accident to an object*.**

- ***Accident*** means a sudden and accidental breakdown of an "object" that causes damage to the insured's property (i.e., boiler or machinery), and property damage to others in the insured's control. The policy also will pay for loss of income resulting from either of these losses.
- Bodily Injury and Damage to the Property of Others, not in the insured's control, is not covered. However, this coverage may be endorsed on the insured's Commercial General Liability policy.

3. The definition of ***object*** in an Equipment Breakdown Coverage Form is simply the **equipment** shown on the declarations. ***Object examples include***:

1) Turbine Objects **2) Pressure Objects**
3) Refrigeration Objects **4) Mechanical Objects**
5) Electrical Objects **6) Pumps and Production Objects**

4. **Coverage Extensions…**The Equipment Breakdown Coverage Form contains three extensions of coverage. These apply to expediting expenses, 90-day automatic coverage for newly acquired locations, and defense and supplemental payments which are virtually identical to those provided by the commercial general liability policy.

$25,000 in Expediting Expenses…The insurer promises to pay the reasonable extra cost of making temporary repairs, expediting permanent repairs, and expediting permanent replacement of damaged covered property.

5. **Common Exclusions**: war, ordinance or law, flood, earthquake, losses to objects while being tested, wear and tear, deterioration, and erosion.

D. Business Owner's Policy, a.k.a. B.O.P., is best for relatively ***small, one location businesses*** with easily predicted coverage needs. These might include: offices, apartment houses, residential condos and mercantile service type businesses. **Qualifications are:**

Apartments - maximum six stories and 60 units
Offices - maximum six stories and 100,000 square feet
Mercantile - 15,000 sq. ft. and gross sales of $1,000,000 or less

Business Owners' Policy (B.O.P.)

Property Section: Building - Coverage "A" & Business Property "B" & Property of Others "C"	**STANDARD FORM**	**SPECIAL FORM**
Additional Coverage:		
Debris removal (30 days), Fire Dept. charge ($1,000)	✓	✓
Business income & Extra expense (no $ limit – pays up to 12 months)	✓	✓
Pollutant clean-up ($10,000 each 12 month period)	✓	✓
Collapse of Building	No coverage	✓
Water Damage	No coverage	✓
Business personal property newly acquired (up to $10,000 – for **30 days**)	✓	✓
Business personal property off premises ($1,000)	✓	✓
Outdoor property **(check policy for limitations)**	✓	✓
Valuable papers & records ($1,000)	✓	✓
Perils:	**Named perils contract**: Fire, lightning, "EC" perils, vandalism (V&MM) , sprinkler leakage and sinkhole collapse	Building & Business personal property coverage pays on a "Risk of Direct Physical Loss" basis (**includes theft** but ***does not cover employee dishonesty or loss of money and securities***).
Limits:		
Signs attached to building	$1,000	$1,000
Automatic increase in building	8% annually	8% annually
Outdoor property: $250 per tree, plant and shrub	***$1,000 maximum***	***$1,000 maximum***
Deductible:	$250 (standard)	$250 (standard)
Fire Dept. service charge, business income, ext. exp.	0	0
Valuation: Building & Business personal property pays covered losses on a ***Replacement Cost*** basis.		
Vacancy (more than 60 consecutive days)- no coverage for vandalism, sprinkler leakage, building glass breakage, water damage, and theft or attempted theft. Amount for all other losses is reduced by 15%.		
Optional Coverage:		
Outdoor signs, Exterior-grade floor glass, ***Employee dishonesty***, Mechanical breakdown	✓	✓
Burglary and Robbery	✓	Already Covered
Money and Securities	No Coverage Available	✓

Business Owners' Liability Section (nearly identical to the Commercial General Liability coverage):

Covers liability due to **BI, PD, personal injury, and advertising injury**. Standard limit is $300,000, and may be increased for additional premiums. Also covers **medical payments** (regardless of fault) for $5,000, and may be increased to higher limits.

General Aggregate Limit applies to all liability and medical payments made for the policy period, except for the Products and Completed Operations, which has a separate limit.

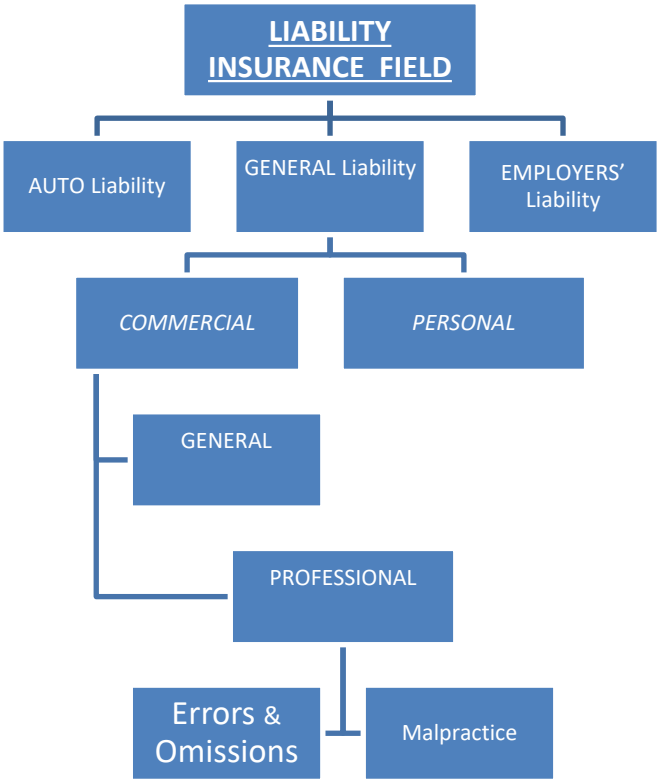
Separate Limit applies per occurrence for BI, PD and Medical. A **per-person limit** applies to personal injury, advertising injury and medical.

Includes "duty to defend" the insured.

Casualty Insurance

Casualty Insurance is that type of insurance that is primarily concerned with losses caused by injuries to persons, and the ***legal liability*** imposed upon the insured for such injury or damage to the property of others.

Liability Insurance undertakes to assume the obligations imposed on the negligent or responsible party in the event of legal liability. The liability policy agrees to pay the sums that the insured becomes ***legally obligated to pay***, up to the limits of the policy. It is commonly called ***third-party coverage*** since it undertakes to compensate someone who is not a party to the contract, the injured party, to whom the insured is liable. It is important to recognize that this ***third-party*** is **not an insured** under the policy.



I. Casualty Terms, Concepts and Policy Provisions

A. **Indemnification** means to restore a person to his or her original position before the loss, with no gain. **Property and Casualty** Contracts are contracts of indemnification.

B. **Risk** is the uncertainty of loss. The purpose of insurance is to deal with risk. Without risk, there is no need for insurance. ***Only pure risk is insurable***. Pure risk means that only a chance of loss is present and no chance of gain.

C. **Hazard** is anything that increases the chance of a loss, such as:

- ***Physical***—dirty windshields, broken headlights or severely worn car tires.
- ***Morale***—carelessness of attitude or irresponsibility. This would include failing to lock the front door of a house because any loss would be covered by insurance.
- ***Moral***—arises from people's habits and values…Dishonesty. Examples of poor moral risks include: intentionally setting a fire in order to collect the insurance, filing false claims, excessive speeding tickets, or poor credit report. ***A claimant may be charged with a Class "C" felony for filing a false claim***.
- ***Legal***—arises from court actions which increase the likelihood or size of the loss. For example, the growing tendency of people to file lawsuits and claim enormous sums for alleged damages.

D. **Insurable Interest** is the potential for financial or economic loss in a person or in a loss of property. Interest or ownership must exist **at the *time of the loss*.**

E. **Loss Valuation (Indemnification)** includes:

Actual Cash Value means replacement cost, minus depreciation.

ACV in auto insurance means the ***fair market value***.

Fair Market Value means what the property can be sold for.

Replacement Cost which means the current cost to repair or replace property of like kind quality, but not more than the policy limit.

F. **Representation, Misrepresentation, Warranty and Concealment:**

Representation is a statement by the insured which he believes to be true. Statements made on an insurance application are deemed to be representations.

Misrepresentation is lying about information asked on the application. If the misrepresentation is material, it can void coverage. **Material** information has direct bearing on the decision to issue or not to issue an insurance policy.

Concealment is the withholding of material facts from the insurance company. Coverage may be voidable if it is found to be of fraudulent intent.

A **Warranty** is a ***written guarantee* (in all respects) *in the policy***. A breach of a warranty may cause a ***suspension of the policy*** and may **void** a claim.

G. The **Other Insurance** condition is designed to ***prevent over indemnification***. With duplicate coverage, indemnification may be primary (pays first) or excess (pays after the primary coverage has been exhausted), or indemnification may be paid on a pro rata liability basis (multiple policies with different companies). **Pro rata liability** means the distribution of liability for payment of a claim among the several insurance companies.

H. A **Binder** (a.k.a. unconditional receipt) is **temporary-guaranteed** coverage prior to the issuance of the policy. However, a binder may be verbal and no premium is required for coverage to be in-force. A binder may be made good for a maximum of 90 days.

I. **Endorsements** must be attached to the policy. They broaden or restrict the coverage of the original policy.

J. **Subrogation** is the transfer to the insurance company, by the insured, the insured's rights to recover against a third party when the insurance company has paid for the loss. The insurance company stands in the insured's place. Subrogation is ***very closely related to indemnification***.

K. **Deductible** is the amount that an insured pays first, before the insurer pays. Most deductibles today are charged per occurrence basis (not per claim). **Per Occurrence** means an accident, including continuous or repeated exposure to the same general harmful condition. One deductible is charged, regardless of the number of claims.

L. **Certificate of Insurance** represents proof that a **policy and coverage exists**.

M. **Monoline vs. Package Policies**…One coverage policies are monoline policies and policies with more than one line of coverage are package policies. A homeowners' policy covers the dwelling **and** the liability making it a package policy.

N. **Deposit Premium/Audit/Reporting and Non-Reporting Forms…** Non-reporting policies usually have a fixed premium (such as a Homeowners policy). **Reporting form contracts** are issued when it is difficult to determine in advance the amount of coverage that needs to be purchased. Instead of a fixed premium, a reporting form requires an advance premium or deposit premium, and then a report must be submitted to the insurer on which the correct premium will be calculated. The insurer has the right to ***audit*** the reports given by the insured at any time to verify the figures.

O. **Rating and Premium Determination**…The most common variables used in rating and determining premiums are: age, past loss records, driving records, territory, type of coverage, limits, deductibles, value of property insured, driving distance, and marital status.

- ***Experience rating*** provides for a modification of a class rate for an individual based on a comparison of his loss experience with the class.

- **Insurance Services Office** (ISO)…A not-for-profit organization established by insurance companies to write and rewrite policy forms and compile rating information. ISO is the principal rate-making organization for property and casualty insurers. This text is based on ***ISO standards.***

P. A **Consumer Report** may also be run by the insurer when underwriting the policy. ***The Fair Credit Reporting Act*** provides consumer protection in transactions, including insurance.

- ✓ The applicant **must** be advised that a report will be requested and be provided the name and address of the reporting agency.
- ✓ **Should any information on a consumer report be challenged and, if found to be inaccurate, it must be removed from the file within 30 days.**
- ✓ The individuals' authorization must be obtained in order to run a credit check.

Q. **Sources of Insurability Information…**When the application comes to the insurance company, underwriters review it for its acceptability to the company. In addition to the application, the insurance company may also evaluate by using the following sources: Inspection Services, Department of Motor Vehicles, industry bureaus such as Automated Property Loss Underwriting Systems, financial information services such as Standard and Poor's, previous insurers and the company's own claim files.

R. **Liability** means being legally responsible or negligent for someone else's loss. This is also known as **third party coverage**. Legal liability is covered within the body of law called the "**Tort Law**." ***A tort is a legal wrongdoing other than a crime or breach of contract.*** Types of liability include Absolute, Strict, Vicarious (a.k.a. Imputed), and Negligence.

1. **Absolute and Strict Liability both** mean that someone can be held liable without regard to fault or negligence.

- ***Strict liability*** is most commonly applied in product claims. If a claimant can prove that a product was defective and that the defect caused the injury, the manufacturer can be held strictly liable.

- ***Absolute liability*** is imposed when conduct is so hazardous that public policy demands those engaging in it be held fully responsible for any resulting injuries or damages. **Absolute liability is where the claimant does not have to prove anything**. Examples of absolute liability would include anyone using explosives or keeping dangerous animals that could cause bodily injury or property damage. Workers' compensation laws impose a form of absolute liability because employers are held liable for employee's injuries and sicknesses, **regardless of fault**.

2. **Vicarious/Imputed Liability** means that someone is liable for the actions of **another person,** i.e., employers are liable for employees.

3. **Negligence** is the failure to use the ***proper care*** that is required to protect others from an unreasonable chance of harm. It is through negligence (generally **a *careless* act**) that someone becomes responsible or legally liable for someone else's loss.

- **Proving negligence** includes: **The Prudent Person Rule** is a theory that says you are negligent when you have failed to do what a prudent person would do in similar circumstances. ***It may consist of an act or a failure to act***. A **Degree of Care** is owed to most people.

- The **Four Elements of Negligence** required in all cases of negligence are:
  (1) there must be a legal duty to act or not to act
  (2) there must be a breach of that duty
  (3) there ***must be resulting injury or damage***
  (4) the breach of duty must be the **proximate cause** of the injury or damage

- **Proximate Cause** exists when there is an uninterrupted chain of events resulting from the negligent act that causes the loss. The negligent act must have been the cause without which the accident would not have happened.

4. **Degree of Care…**The **degree of care** that must be exercised depends on the status of the person coming onto the insured's land. **Common law,** which consists of past court decisions and is contrasted with **statutory law** or written law, such as statutes enacted by legislatures, recognizes four classes of persons with differing degrees of care due them: **trespassers, licensees, invitees, and children**.

- **Trespasser**—a person who comes onto the property without right and without consent of the owner or occupier. As a general rule, the land occupant has no duty to exercise care to protect the trespasser.

- **Licensee—**a person who comes onto the property with the knowledge or toleration of the owner but for no purpose of, or benefit to, the owner (insured). This classification would include door-to-door salespeople or solicitors. An occupant has a ***degree of care*** to protect such individuals from harm.

- **Invitee**—a person who has been invited onto the property for some purpose of the insured. This classification would include garbage collectors, mail carriers or other delivery people. The occupant has a duty to warn invitees of any dangers or make them safe. Any condition (or **careless act**) that could cause harm to an invitee is a possible source of legal liability.

- **Children**—require the ***greatest degree of care*** by the occupant. ***Attractive Nuisance*** is any condition or item on a premise that will draw children to investigate or use it. The owner may be held liable for any injury, even if the child trespassed on the property. The owner is charged with care in keeping children from coming to harm through such "attractions."

5. **Occurrence …***means an accident, including continuous or repeated exposure to the same harmful conditions, which results in bodily injury or property damage***, which is not expected, intended or foreseen by the insured**.

6. **Insured vs. Named Insured…**The *named insured* is the person, persons or business **actually named** as the named insured in the policy declarations. ***An insured is anyone who may be covered by the insurance***. A ***named insured*** generally has more coverage or a different type of protection, and also greater obligations and responsibilities under the policy than an insured. Commercial policies have started using the term **first named insured**. By making the **first named insured** and the insurer the primary parties responsible for carrying out contractual duties, the process of meeting policy obligations has been simplified.

7. **Bodily Injury** and **Property Damage** is the primary coverage of personal liability insurance.

- **Bodily Injury** (BI) means bodily harm, sickness or disease, including required care, loss of services, and death that results.

- **Property Damage** (PD) is the insured's liability for damage to the property of others or loss of use of other's property.

8. **Personal Injury** includes false arrest, malicious prosecution, libel, slander, defamation of character, invasion of privacy and wrongful eviction or entry.

9. **Variations in Writing Limits…**Casualty Insurance may be written on a specific, scheduled or blanket basis. The ***limit of liability*** means the maximum amount that the insurer is responsible to pay under an insurance contract. These limits may include:

- **Single Limit:** one figure shows the maximum the company will pay for all BI & PD liability arising from one occurrence, i.e., $100,000.

- **Split Limit:** three figures show the maximum the company will pay for liability resulting from one occurrence, i.e., 100/300/50

$100,000	$300,000	$50,000
BI to one person	BI to all persons	PD for all property

- **Occurrence Limit** is the maximum amount available per accident.

- **Aggregate Limit** is the maximum amount available for the policy period.

10. **Types of Damages: Compensatory vs. Punitive**

a. Compensatory Damages is a term which encompasses specific and general damages. Compensatory damages are intended to compensate someone for both the tangible and intangible elements of a loss. If someone destroys your property or causes bodily injury which results in medical expenses, specific losses have occurred (the value of the property or the amount of the medical bills). This would also include such things as pain and suffering for bodily injury, or harm to a person's or business's reputation resulting from libel or slander (general damages).

b. Punitive Damages are a form of punishment intended to serve as an example to others and to create disincentives that discourage certain behavior. Punitive damages are awarded in cases involving ***gross negligence*** or conduct which exposes members of the public to extreme hazards.

- ***Gross Negligence*** is willful and wanton misconduct. It is characterized by the lack of even the slightest degree of care.

S. Policy Provisions are similar to those found in the property policies: Declarations Page, Definitions, Insuring Agreement, Exclusions, and Conditions.

II. Personal and Commercial Automotive Coverage

A. <u>The Personal Auto Policy</u> (a.k.a. P.A.P.) was introduced in 1977. It was the first automobile insurance policy to be written in simple language and in a streamlined format, similar to the new homeowner's forms. It was designed to replace all earlier forms such as the special and family policies, and is now the most widely sold form of auto insurance.

Automobile insurance policies are primarily **"third party" contracts**. Under a third party contract on behalf of an insured, the ***insurance company agrees to pay to a third party the damages the insured is legally responsible for***. There is coverage for the insured such as Damage to Your Auto (physical damage), Medical, Personal Injury Protection and Underinsured Motorist. *Coverage applies on a per occurrence basis*.

Eligible vehicles include any private passenger auto, pick-up or van that has ***a gross vehicle weight of less than 10,000 pounds***. Usage must be for personal and certain service type businesses. The vehicles must be owned by an insured or leased under a long-term contract (**six months or more**).

- Vehicles used in the delivery, shipping or transportation of goods or materials are ineligible under the Personal Auto Policy.
- Vehicles rented to others, or used to carry passengers for a fee, are ineligible for coverage under a Personal Auto Policy.

The Personal Auto Policy has the following eight parts:

Declarations
Definitions page
Part "A" Coverage (Liability)
Part "B" Medical/Personal Injury Protection
Part "C" Underinsured Motorists
Part "D" Damage to Your Auto (a.k.a. Physical Damage Coverage)
Part "E" Duties after an Accident
Part "F" General Provisions

Declarations — The declarations section of the PAP identifies the ***named insured***, describes the auto insured, lists any endorsements attached to the policy, and summarizes the coverage, limits and premiums. It also identifies the insurance company, agent, policy number and ***policy period*** (coverage begins and ends at 12:01 a.m. Standard Time).

- Only the *<u>named insured</u>* may cancel or change coverage in the policy.

Personal Auto Coverage

This auto section applies to Preferred Auto and may not apply to High-Risk Auto Policies.

The "<u>Insured</u>"

The insured is the **named insured** (person listed on the declarations page <u>and the spouse living with the named insured</u>) and members of the named insured's family living with the insured while ***using any auto***. For example, the insured's 17 year old son who lives at home would be insured if he borrows a friend's car and has an accident. However, the parent's policy would be *excess coverage* to the friend's car policy which would be considered to be the *primary coverage*.

- **<u>The insurance coverage stays with the car.</u>**

- A family member means a person related to the named insured by blood, marriage, or adoption, including a foster child, who lives in the same household. ***A student temporarily away at school is still a family member.***

Anyone who uses the insured's covered auto…For example, a neighbor who borrows the insured's car and has an accident while driving it, is covered by the insured's policy.

Others who are legally responsible for the acts of an insured…For example, if an insured has an accident in her own car while running an errand for her employer, the employer is also liable (remember vicarious liability). The insured's policy covers the employer's liability. If a co-worker borrows the insured's auto to run an errand for her employer and has an accident, the policy will cover all three.

A "Covered Auto" is any vehicle shown on the declarations and includes:

Any trailer owned by the insured while it is being towed by a vehicle listed in the declarations. It covers the insured's **liability only (*no*** comprehensive or collision).

Any private passenger vehicle the insured acquires during the policy period.

1) If the vehicle replaces (trades a car in for another car) one shown on the Declarations, liability coverage is automatic, but for physical damage coverage to continue past 30 days, notification by the insured is required.

2) If the vehicle purchased is an "additional" or new car (instead of two cars you now have three cars), it is covered for the "broadest" coverage under any of the other "insured" cars. Notification is required within **30 days** for **any** coverage to continue.

- Most insurance companies will waive this automatic extension of coverage if the insured does not have all of her registered vehicles insured with the same company.

A non-owned auto or trailer while used as a **temporary substitute** for a covered auto is covered under the named insured's auto contract. A ***temporary substitute*** is any auto or trailer used by the insured in place of a covered vehicle or trailer which is out of use due to service, repair, breakdown, loss, or destruction.

Standard Coverage (Parts "A" through "D") pay on a per occurrence basis.

Liability, Part "A", provides protection against amounts an insured may become liable to pay as a result of causing bodily injury or property damage to another person in an auto accident. The policy will make "***supplemental payments***" which are over and above the limit of liability, including a "**duty to defend**" the insured in a lawsuit. *The insurer's duty to defend the insured ends when the policy's limits are exhausted.*

This additional supplemental coverage for the insured includes:

- 💰 Up to $250 for bail bonds
- 💰 Premiums on appeal bonds or bonds to release attachments
- 💰 Interest accruing on post and pre-judgments
- 💰 Up to $50 a day for earnings lost to attend court at the company's request
- 💰 Reasonable expenses incurred at the company's request

Liability Exclusions

- ∅ Bodily injury or property damage intentionally caused
- ∅ Damage to property owned or being transported by the insured
- ∅ Damage to property rented to or in the care of an insured
- ∅ BI to an insured's employees, (covered under Worker's Compensation)

- ∅ Ownership or operation of a vehicle used to carry persons (taxis) or property for a fee (pizza delivery)
- ∅ Use of a vehicle for business purposes. ***Exception to this exclusion; a private passenger vehicle may be used for a service type of business such as an insurance agent or realtor, however, a higher premium will be charged***
- ∅ Use of a vehicle without reasonable belief of being entitled to do so
- ∅ Use of vehicles with less than four wheels (motorcycles)
- ∅ It excludes coverage for ***regularly used non-owned autos*** and for owned autos which are neither declared on the policy nor acquired during the policy period

Limits of Liability

***Single Limit*:** one figure shows the maximum the company will pay for all BI & PD liability arising from one occurrence. $300,000 BI and PD per occurrence.

***Split Limit*:** three figures show the maximum the company will pay for liability resulting from one occurrence, for example: 100/300/100:

$100,000 /	**$300,000** /	**$100,000**
Maximum per person for **Bodily Injury (BI)**	Maximum to all persons for **Bodily Injury (BI)**	Maximum for all **Property Damage (PD)**

Auto Medical/Personal Injury Protection, Part "B" (First Party Coverage)

Who is the First Party?

- The named insured or any family member residing in the named insured's household who is injured while occupying a motor vehicle or a trailer which is designed for use on public roads.
- The named insured or any family member residing in the named insured's household who is injured if struck as a pedestrian by a motor vehicle or a trailer used for public roads.
- Anyone who is injured while occupying a covered auto. Occupying means in, on, getting into, or out of.

Medical Payments pays the ***First Party*** for reasonable and necessary medical expenses for **three years** from the date of the accident and funeral expenses, regardless of who is at fault. It pays on a per person single limit basis (a.k.a. The Insuring Agreement).

Personal Injury Protection (P.I.P), a.k.a. ***First Party*** Coverage, pays for bodily injury, lost wages and lost services of family members injured in an insured's auto, ***regardless of who is at fault***. Coverage extends to the insured, which is identical to Medical Payments listed above. Payments are made on a per person single limit basis.

Uninsured/Underinsured Motorist (UM or UIM), Part "C"

- **UM/UIM (*Bodily Injury*)** must be offered up to the same limit as the insured is covered for under coverage "A" (Liability BI and PD) of the Auto Policy. The insured may elect a lower limit on UM/UIM than on coverage "A," ***but may not be insured for more on UIM than on coverage "A" (Liability BI & PD).***
- **Indemnifies for bodily injuries**…It pays the insured when injured by a driver who is ***uninsured or underinsured***. It also pays the insured if hit by a hit-and-run driver, a phantom vehicle, or ***if the other insurer who should pay becomes insolvent***. A "phantom vehicle" means a motor vehicle which causes bodily injury, death or property damage to an insured but has no physical contact with the insured or the vehicle which the insured is occupying at the time of the accident.

- **The Insured** (***first party coverage***) means the named insured and relatives living with the named insured and anyone occupying the insured's car. **Protection** extends to the named insured and family members while in their own car, while in someone else's car or even walking down the street, if injured by another car.

- **Uninsured/Underinsured Motorist Property Damage** (***UMPD***) protects ***the insured's covered auto*** if damaged by an uninsured, underinsured, hit-and-run motorist or phantom vehicle.

Special Note*:** UM/UIM pays for ***bodily injury to the first party, and *UMPD pays for* ***property damage to the insured's auto***. They are separate coverage.

EXCLUSIONS for Medical/PIP and UIM:

- ∅ Loss in a vehicle with less than four wheels
- ∅ Loss when using an auto to carry persons or property for a fee
- ∅ Loss covered under worker's compensation
- ∅ Loss when a vehicle is used without permission to do so
- ∅ Vehicles used for business
- ∅ Loss if the vehicle is used as a residence or premises
- ∅ Loss in an auto, other than a **covered auto**, owned by the insured or furnished to the insured for his regular use

Damage to Your Auto, Part "D," (a.k.a. ***physical damage*** coverage), pays for damage to the insured's own auto or any non-owned auto. ***The insurer reserves the right to repair or replace the damaged car rather than make a cash settlement***. Following a total loss of the car the insurance company is required to indemnify on a **minimum Fair Market Value** (what the car could be sold for).

If there is a loss to a non-owned auto, the policy will provide the broadest coverage applicable to any covered auto. A **non-owned auto** is any private passenger auto, pick-up or van which is operated by or in the custody of, but not owned by or furnished for the regular use of, the named insured or a family member. A non-owned auto includes a temporary substitute.

- **Collision** pays for damage to a covered auto from upset or caused by its collision with another vehicle or object such as a rock, tree, bridge, etc. It does not cover bodily injury or property damage arising out of collision.

- **Comprehensive**, a.k.a. "Other Than Collision," pays for all losses not excluded and not covered by **collision** damage. Coverage includes damage **from** falling objects, fire, theft, contact with animals, glass breakage, earthquake, flood, etc.

- **Deductible**…There are no standard deductibles. An insured may purchase either Comprehensive or Collision alone or together. **A separate deductible applies to each coverage separately (on a per occurrence basis)**.

- Under Part "D," an insured will be reimbursed up to $15 per day, ($450 max.), for **Transportation Expenses** incurred when his car is stolen. There is a 48 hour waiting period before coverage takes effect and it will not pay after the stolen vehicle is returned or settlement is made.

EXCLUSIONS Under Physical Damage "D" Damage due to wear and tear, freezing, war, road damage to tires, and mechanical or electrical breakdown are excluded.

Other exclusion include:

- ∅ Cars used to carry people or property for a fee.
- ∅ Sound equipment unless it is **permanently installed** in an opening used by the auto manufacturer for such installations.

- ∅ Tapes, records, CDs, radar detection equipment.
- ∅ Vehicles used by the insured without permission to do so.
- ∅ Custom furnishings in a pick-up or van such as TV antennas, awnings, etc.
- ∅ ***Regularly used non-owned autos*** and owned autos which are neither declared on the policy nor acquired during the policy period an automobile confiscated by the government because of illegal activities.

PAP Duties after a Loss or Accident, Part "E"

- ✓ **Notice of Claim -** promptly notify the insurer of the claim or possible claim
- ✓ Cooperate with any investigation such as physical exams, sworn statements, forwarding notices and providing records
- ✓ Notify the police immediately
- ✓ Protect the car from any further damage
- ✓ Allow inspection of any damaged property

PAP General Provisions, Part "F" This part establishes conditions for coverage and sets the rules of conduct, duties and obligations for the insured and insurance company.

The policy applies only to accidents and losses which occur during the **policy period** shown in the declarations and within the policy territory. The **covered territory** ***includes the United States, its territories and possessions, Puerto Rico, District of Columbia, and Canada.***

Other provisions include bankruptcy, legal actions, fraudulent actions of the insured, changes, subrogation, assignment, multiple policies (other insurance) and renewal, non-renewal, and termination of coverage.

- ✓ The **Out-of-State** provision found in auto insurance says that coverage ***automatically*** will conform to other states' laws and rules (***without an addition in premium***), e.g., if you travel through a state where the financial responsibility laws require higher minimum coverage than is currently carried, the other state's laws take precedence.

- ✓ **Arbitration** provision states that *if the insured and the insurer do not agree that the person is legally entitled to damages from the owner or operator of a motor vehicle or as to the amount of payment, either that person or the insurer may demand that the issue be determined by arbitration*. In that event, the insured and insurer will select their own arbitrator. If the two cannot agree on a settlement, the arbitrators will select a third arbitrator. The insured person will pay for the arbitrator which he or she selects. The third arbitrator's expenses will be shared equally by the insured and insurer. **The agreement in writing of any two arbitrators will be binding** (same as Appraisal).

Renewal, Non-Renewal and Cancellation

The following are ISO standards and Washington State laws and rules:

- ✍ **A 20-day written notice** is required for cancellation, renewal or non-renewal of an ***auto policy*** by the insurer, with the actual reason given.
- ✍ **A 10-day written notice is** required for cancellation for *nonpayment of premium*. ISO allows a 10-day notice for cancellation for any reason in the first 60 days of underwriting.
- 💰 ***A return of premium is required in 45 days*** on a **pro rata** basis should the *insurance company cancel* the policy. **Pro rata** means all *unearned* premium must be returned but no service fee is allowed.
- 💰 ***A return of premium is required in 30 days*** on a ***short rate*** basis should *the insured cancel* the policy. **Short rate** means all *unearned* premium minus any applicable service fee.

COVERED AUTO

SPECIFIED Autos (including Trailers)	REPLACEMENT Autos (including Trailers)	ADDITIONAL Autos (including Trailers)	OWNED Trailers	TEMPORARY Substitutes
Covered as described in the Declarations.	Same coverage as the vehicle it replaces.	Broadest coverage of any insured car.	No need to specify in Declarations for Liability, PIP,	Same coverage as the car it replaces.
	Trailers are covered for BI & PD ONLY.			

	Notify insurer within 30 days to continue **physical damage.**	Notify insurer within 30 days to continue **any coverage.**	Medical, and UM/UIM.	

B. <u>The Commercial Auto</u> may be written monoline or as a coverage part of the Commercial Package Policy. The policy is designed to cover autos, trucks and trailers used in a business.

1. Business Auto Coverage Form is used to insure commercial automobile exposures arising out of owned, leased, rented, or borrowed vehicles. The insured may select which types of autos will be covered by the policy. Different types of autos may be given different coverage under the policy. For example, an insured may obtain liability coverage for all autos and physical damage coverage for only "owned" autos, or as listed below.

This policy uses a *<u>numerical description system</u>* for the types of autos covered which allows a business to tailor its policy to their needs. For example:

- **<u>Any Auto</u>** (symbol #1) covers ***any autos used by the business***, including autos that are owned, leased, hired, rented or borrowed. Liability coverage only.

- **<u>Owned Auto</u>** (symbol #2) covers only autos owned by the business for coverage other than liability coverage (comprehensive, collision, etc.).

- **<u>Hired Auto</u>** (symbol #8) covers those vehicles leased, rented or borrowed by the business. It **DOES NOT** cover vehicles belonging to employees or members of their household. Liability and/or Physical Damage (comprehensive and collision) coverage is available.

- **<u>Non-Owned Auto</u>** **(**symbol #9) covers autos belonging to employees or members of their household used in the insured's business or insured's personal affairs.

2. Garage Coverage Form is used to insure businesses engaged in selling, servicing, storing or parking autos, such as car dealerships, gas stations and parking garages. This form **will not cover** other peoples' property in the care, custody and control of the insured. *Garagekeepers* must be added to cover that exposure.

This policy uses a *<u>numerical description system</u>* for the types of autos covered which allows a business to tailor the policy to their needs. For example: **any** auto is symbol #21;
owned auto is symbol #22; hired auto is #28; and **non-owned** auto is symbol #29.

- **Garagekeepers Coverage** covers the insured's liability for damage by a covered cause of loss to an auto left in the insured's care while the insured is attending, servicing, repairing, parking, or storing the autos in the garage operation. ***Garagekeepers coverage is necessary because liability for such damage is excluded under the garage coverage form***. Like other types of liability insurance, garagekeepers coverage pays the cost to defend the insured against suits alleging covered losses.

- For additional premium**, garagekeepers** insurance can be modified to cover liability for damage to property of others while in the insured's care for servicing, ***regardless of legal liability***. This is sometimes referred to as "goodwill" type coverage because it can preserve good customer relations when a customer expects to be paid for a loss even though the garage is not legally obligated to do so.

3. Standard Coverage Commercial Auto:

Liability covers the named insured and others that use a covered auto with the permission of the insured party, any party that has vicarious liability for the actions of an insured party involving an auto, or anyone from whom a trailer is borrowed if such trailer is towed by a **covered** auto owned by the insured. It covers those listed above for legal liability, defense costs and supplemental payments ($250/day for lost wages, bail bonds for $250, etc.).

Physical Damage (a.k.a. damage to your auto) coverage includes:

- **Comprehensive** is all-risk coverage, excluding: upset and collision, and such things as wear and tear, etc.

- **Specified Causes of Loss** covers fewer perils than comprehensive coverage. It covers the vehicles on a "named perils" basis. It **does not cover** glass breakage, loss caused by hitting an animal, nor loss caused by falling objects, all of which are covered in comprehensive coverage. This coverage replaces comprehensive coverage and allows an insured to save money due to lower premium cost.

- **Collision** covers colliding with another object or upset of a covered auto such as the car rolling over. If the insured carries full coverage (Comprehensive and Collision), losses such as glass breakage, hitting an animal, or falling objects may be covered as comprehensive rather than collision in order to use the lower deductible.

- **Physical Damage Exclusions** include: sound reproducing or receiving equipment, tapes and records, wear and tear, freezing, mechanical or electrical breakdown, road damage to tires, war and nuclear events, or any intentional acts.

- **Physical Damage** includes an extension of coverage for **transportation expenses**. After a 48-hour waiting period, $15 per day for 30 days ($450 max.) will be paid if there has been a total theft of a covered vehicle.

There are several sections of the commercial auto policy that deal with covered vehicles such as liability coverage, physical damage coverage, conditions and definitions. **There is no mention of medical payments, personal injury protection or uninsured motorist's coverage in these sections. Why?**

✓ .....because worker's compensation coverage provided by the employer through the Department of Labor and Industries will pay for employee's accidental injuries which are job related.

III. Excess Liability vs. Personal Umbrella Liability

A. An **Excess Liability Policy** offers coverage over and above the limits of an underlying personal insurance policy. The common limit is $1,000,000. The common underlying limits are 100/300/100 for car policies and $100,000 for homeowners policies.

If the loss is covered under the underlying policy, then this **excess** policy is "triggered" when the underlying limits have been exhausted. If the loss is not covered under the underlying policy, then there is no coverage. A **straight excess** policy tracks the primary insurance policy in all respects such as coverage, conditions, definitions, exclusions, etc.

EXAMPLE: John rents a large van to move his furniture to a new house. He runs into a car causing $400,000 in injuries and damage. His auto policy does not cover vans of the size he was driving, and he did not purchase the optional insurance offered by the rental store. Therefore, he has no coverage under this excess policy.

B. A **Personal Umbrella Policy** gives an individual greater protection against liability than that afforded by their homeowners or auto policy. Umbrella liability policies offer higher limits, usually $1,000,000 or higher, as well as expanded coverage. At the time of purchase the insured must identify any underlying liability coverage he has. The umbrella is coverage over and above those underlying limits.

Self-Insured Retention…If an umbrella policy provides coverage for circumstances that are excluded by an underlying policy (such as Personal Injury under a Homeowners), the insured pays a selected **retention**

limit, typically between $250 and $10,000, which acts like a deductible, and the insurance company pays the loss over that amount.

Maintenance of Underlying Coverage conditions expresses the insured's agreement to maintain all required underlying coverage (and limits) in full force and effect during the policy period. If the underlying insurance is not maintained, the umbrella policy will apply as though the underlying limits ***had*** been maintained. That is, a claim that would have been covered by an underlying policy, had it been kept in force, will only be covered for the amount of loss that exceeds the *required limit* of the underlying policy.

> **Example:** Harriet is ordered to pay $250,000 to a man permanently injured when her dog crashed through her screened-in porch as the man approached the house to make a delivery. Her homeowner's policy will pay the underlying limit of $100,000. The balance of $150,000 will be paid by the umbrella policy.
>
> In the example at the top of this page with John, under an umbrella policy, he would be covered. His retention limit would be paid first, and then the umbrella would be "triggered" to pay the balance.

IV. Commercial Casualty Coverage

Commercial Package Policy

Like a Homeowners' or Auto Insurance Policy, the Commercial Package Policy (CPP) combines two or more coverages into one policy. This reduces repetitive information, eliminates coverage gaps and can produce savings in premiums. However, the CPP is for business use.

The advantage to packaging a policy *is that there are fewer policies to buy and maintain. Packaging reduces the chance of delay in a loss settlement due to disputes between different insurers.* For example, a loss involving loading of automobiles sometimes falls in a "gray area" between auto liability and general liability. If one insurer provides both coverages, payment of a claim will not be delayed as it might be if each coverage were written by a separate insurer and each insurer felt the claim was covered under the other's policy.

CPP is made up of:

1. **Common Declarations**
2. **Common Conditions**
3. **Interline Endorsements (if needed)**
4. **Two or more Coverage Parts**

Coverage Parts are commercial coverages which can be purchased and which make up the CPP. The Coverage Parts which we will be covering include:

1. Commercial Property
2. Farm (Property) (Not covered in this text)
3. Commercial Marine (Property)
4. Equipment Breakdown (Boiler and Machinery) (Property)
5. Commercial Crime (Casualty)
6. Commercial Auto (Casualty)
7. Commercial General Liability – CGL (Casualty)

A CPP might also contain ***interline endorsements*** – endorsements that may be used with more than one line of insurance or more than one Coverage Part. They are prepared to eliminate redundancy and to minimize the number of endorsements in the commercial package policy.

When the property or casualty policy is issued, the licensed producer must ***countersign*** the policy. This will verify that a licensed producer sold the insurance and that he is licensed in the state in which the insurance was written.

CPP Common Declarations Page:

1. Policy number and policy period
2. Identity of the insurer and producer
3. Name and mailing address of the named insured
4. Description of the covered business
5. List of the coverage parts purchased and the premiums for each part
6. Total of all combined premiums
7. List of forms applicable to each coverage part
8. **Countersignature and the date of the signature**

Commercial Package Policy Common Conditions Page:

Cancellation…The first named insured may cancel the policy by **giving written notice and returning the policy to the insurance company.**

If the insurance company cancels coverage, notice must be sent to the First Named Insured and any mortgage company. A minimum **10-day notice** in writing is required for cancellation due to non-payment of premium, whereas a minimum **30-day written** notice is required to cancel for other reasons.

- If the notice of cancellation is mailed, the insurer is not required to prove that the insured actually received the notice. It is required to prove only that the notice was mailed to the First Named Insured at the mailing address on the policy.

The ***Changes*** condition states that changes can be requested only by the First Named Insured, and made by a written endorsement issued by the insurance company.

Premiums are the responsibility of the First Named Insured.

Examination of "your" books and records is allowed any time and for up to three **years** after the policy period. ***This provision is included because most commercial coverage is issued with estimated premiums***. The final premium is determined after the policy expires, based on: reported values of the insured property, the amount of the insured's sales, payrolls, or some other variable.

Inspection and surveys… The insurer may inspect or survey the insured premises at any time, report its findings and make recommendations for changes. ***This inspection will relate only to insurability, premiums, and to verify that any warranties are being met by the First Named Insured.*** The insurer does not warrant that conditions are safe or that the insured is in compliance with any specific regulations.

"Your" rights and duties under this policy **may not** be transferred to another party, but remain the rights and duties of the First Named Insured. The clause also provides for automatic transfer of coverage upon the death of a named insured to the named insured's legal representatives. This is often referred to as the **Assignment Clause.**

Commercial General Liability (CGL)…The most widely used method of financing the liability losses of a business is the purchase of C.G.L. insurance policy.

The **Insuring Agreement** states that the insurer agrees to pay all sums for injury or damage for which the insured is legally responsible. The insurer has the right and ***duty to defend*** the insured in any suit but it may, at its discretion, investigate an ***occurrence*** and settle any claim or suit that may result. Coverage applies if the incident causing injury or damage in the ***covered territory*** and during the policy period.

BASIC HAZARDS (sources of exposure):

1. Premises and Operations covers the legal liability that results from the exposures generated by a business that has a "premises" exposure, such as Costco, or a business that has mainly an "operations" exposure, such as an electrical contractor working off of the premises.

Premises example: heavy boxes at Costco fall off a shelf and onto a customer.

Operations example: an electrical fire that results from activity at a job site where an insured is working as an electrical contractor when the insured negligently leaves electrical wires exposed.

2. Products and Completed Operations is separate from the premises and operations coverage but in reality extends that coverage. Under products and completed operations coverage, control of the product must be relinquished and it must be off the business premises (***the product does not have to be manufactured or sold by the insured to be protected under this coverage***). In the case of the "operation," the work must be completed and the worksite abandoned.

Product Example: a tool breaks and causes injury, or a Coke bottle explodes and injures a customer.

Completed Operations example: the same as the example mentioned above, except that the job would have to be completed and no further work required.

3. Independent Contractors Coverage is now automatically included on a CGL, unless specifically excluded. It is also known as Owners and Contractors Protective (OCP). It provides coverage for the liability of an owner or contractor resulting from work performed by an independent contractor.

The **OCP** form developed by ISO covers the named insured's liability for bodily injury or property damage that arises out of (1) the operations of the contractor at the specified locations, and (2) acts or omissions of the named insured in connection with the general supervision of such operations.

Example: the owner of a business hires a general contractor to build an addition to the premises. One of the general contractor's bulldozers hits a car driving by on the street. The owner of the premises may be sued as well as the general contractor.

4. Contractual Liability is another coverage **included in the current CGL policy**. All **insured contracts** are covered. ***Insured contracts*** include any contract that is a necessary part of the business. The coverage includes contracts such as leases, easements, railroad sidetrack agreements, and elevator maintenance agreements.

Contractual Liability is specifically meant for liability which is picked-up under a contract by signing a Hold Harmless Agreement. A ***Hold Harmless Agreement*** is one whereby one party assumes the liability inherent in a situation, thereby relieving the other party of responsibility. Contractual Liability has absolutely nothing to do with the doctrine of "Breach of Contract" (usually protected or covered using bonds).

<u>Commercial General Liability EXCLUSIONS</u>

- ∅ Ownership, maintenance, or use of steam boilers and other heavy equipment or machinery. This coverage may be added by endorsement.
- ∅ Ownership, maintenance, or use of autos, watercraft, or aircraft. This can be covered by the Commercial Auto, Marine, or Aircraft insurance.

- ∅ Injury of an employee on the job (<u>Workers' Compensation</u> coverage), insured or tenant of the insured.
- ∅ **<u>Intentional Actions</u>** of any insured which cause BI and PD to a third party.

- ∅ The **Liquor Liability Exclusion** is for a business that manufactures, distributes, sells, services, or furnishes alcoholic beverages. The Liquor Liability Endorsement may be added for this coverage.
- ∅ **Pollution** is excluded, with the exception of products and completed operations, where the risk is very small. Coverage for pollution resulting from operations or handling waste materials is available in a separate form. This coverage is available by endorsement.
- ∅ **Property** owned or leased by the insured. (Note: liability is third party coverage and the insurer's property is covered under property insurance, first party coverage).
- ∅ Damage to the **insured's own product resulting from poor workmanship.** The primary purpose of this exclusion is to avoid making the insurer a guarantor of the insured's work or product.
- ∅ **Impaired Property…**Impaired property is tangible property which cannot be used or has become less useful because it incorporates the insured's product or work which is defective or inadequate.
- ∅ **Expenses of recalling a product.**
- ∅ **Liability** arising out of the **transportation of mobile equipment** (covered under commercial Trucker's form). The mobile equipment off the premises is covered under Marine coverage.

Commercial General Liability (CGL) Coverage Forms

Coverage "A," BI and PD cover the Premises and Operations, Products and Completed Operations, Contractual Liability and Independent Contractors. The **insuring agreement** states that the insurer agrees to pay all sums up to the limits of insurance written that the insured becomes legally obligated to pay as damages, because of bodily injury or property damage to which the insurance applies. It **includes a duty to defend**.

The CGL Offers Two Coverage Forms, Occurrence Form and Claims Made Form:

1. ***Occurrence Form*** covers bodily injury and property damage liability from *occurrences during the policy period*, even if the claim is filed after the policy period ends. A claim made today for injury that occurred twenty years ago could be covered under an occurrence policy that was in effect twenty years ago. In recent years, many such long-tail claims have been made for latent injury caused by exposure to asbestos, lead-based paints or breast implants.

- A problem posed for insurers by these long-tail claims is that their ultimate cost cannot be accurately predicted when the insurer develops the premium for the policy. The insurer may not realize that the insured's product can cause latent injury, and the unanticipated claims, made many years in the future, may be subject to liberalized laws or inflated monetary values.

2. ***Claims Made Form*** provides coverage for bodily injury and property damage *that occurs after the retroactive date and before the policy expiration date.* Also, ***the claim must be reported before the policy expiration date*** (or before the expiration date of the Extended Reporting Period, if applicable).

- The **Claims Made Coverage Form** was developed to address the problem above that exists with an occurrence form. Instead of covering injury that occurs during its policy period without regard to when the claim is made, a claims-made policy covers only **claims first made against the insured during its policy period**.

- An additional requirement is that the injury or damage for which the claim is made must not have occurred before the policy's ***retroactive date***, if any, or after the end of the policy period. The retroactive date excludes coverage for earlier occurrences, usually because other insurance applies (usually occurs when the insured switches from an Occurrence form to a Claims Made form). The **retroactive date** is the date that coverage begins.

Commercial General Liability Coverage Forms-Coverage A

Claims which trickle in after the end of a policy period create an exposure known as a Claims Tail. Tail coverage is automatically built into the insuring agreement of occurrence forms. This is not the case with claims-made forms; the forms would be unacceptable if they left the insured exposed to serious insurance gaps that could not be covered. The ***extended reporting periods*** were designed to take care of certain gaps in coverage.

- **Extended Reporting Period (ERP),** is a period of time following the expiration of a claims-made policy during which claims filed will be covered if the occurrence took place before the policy expired. An ERP is used when a claims-made policy is being replaced by an occurrence policy.

The types of ERPs include:

a) A **Basic ERP (a.k.a. mini-tail),** begins automatically when the policy period ends and is activated when there is an interruption in claims-made coverage, that is, when the policy is canceled or non-renewed, or is replaced with an occurrence policy. Coverage is triggered for occurrences arising after the retroactive date but before the policy expiration, **if reported within 60 days following the expiration**.

b) A **Five-Year Basic ERP (a.k.a. midi-tail),** is also automatic and provided free of charge and covers only claims arising from occurrences reported by the insured before the mini-tail expires.

c) A **Supplemental ERP (a.k.a. maxi-tail),** covers all claims not covered by the basic ERPs, as long as the occurrence took place before the policy expired. Additional premium is charged for this ERP; however, ISO manual rules limit the additional premium to 200% of the annual premium of the CGL coverage part. Unlike the two basic ERPs, coverage of the Supplemental ERP Endorsement is reinstated back to the original policy limits. (See aggregate limits discussed later in this section.)

◎ In effect, an ***ERP*** is the transitional opposite of the retroactive date. The retroactive date excludes coverage for earlier occurrences, usually because other insurance applied. The extended reporting period preserves coverage for a given policy period, and maintains it for future claims arising out of that period because other insurance will not apply.

Comparison of the Extended Reporting Periods (ERPs)

	Mini-Tail (Basic ERP)	**Midi-Tail** (Basic 5-Year ERP)	**Maxi-Tail** (Supplemental ERP)
Automatic	Yes	Yes	Right to Purchase
Cost	Included	Included	Premium Up to 200%
New Aggregates	No	No	Yes
Time Limitation	60 Days	Five Years	No

Coverage "B," Personal Injury and Advertising Injury

- **Personal Injury** is injury to a person, other than bodily injury. For example: slander, libel, invasion of privacy, false arrest, malicious prosecution, wrongful entry, or wrongful eviction.

- **Advertising Injury** is personal injury caused by advertising, which includes slander, libel, and invasion of privacy, and also such things as copyright infringement or stealing someone's advertising idea.

Coverage "C," Medical Payments, covers medical expenses ***without regard to fault*** when an accident arises out of the insured's operations or occurs on or next to the insured's premises.

- The coverage applies to: ***reasonable expenses for first aid administered*** at the time of the accident; necessary medical, surgical, x-ray and dental services resulting from the accidental injuries; necessary ambulance, hospital and professional nursing services; and funeral services if death results from the injuries.
- The accident must occur during the policy period and expenses must be reported within **one year** from the date of the accident.
- ***Injuries to an insured or a tenant of the insured or employee of the insured are* NOT *covered*.**

Supplementary Payments pays in addition to payments made under Coverage "A" and "B," and the insurer will also pay the following, without a reduction in the policy limits:

- Reasonable expenses incurred by the insured to assist in defending the claim, including $250/day for lost income.
- Up to $250 for bail bonds, and the cost of bonds to release attachments.
- All costs levied against the insured in the suit, including but not limited to pre-judgment and post-judgment interest.
- ***Expenses incurred by the insurance company to defend the insured***.

Who Is Insured?

- In a sole proprietorship, you and your spouse ***while conducting business***.
- In a partnership, any members, partners, or spouses, all ***while conducting business.***
- In an organization, other than a partnership or joint venture, you, your executive officers and directors, with respect to their duties as officers and directors, and your stockholders with respect to their liability as stockholders.
- Employees, while acting within the scope of their employment.

LIMITS: The Commercial General Liability provisions below **come with** the CGL policy, however, they may be removed by endorsement:

1. The **General Aggregate Limit** is the most the insurer will pay for the sum of Coverage A, B, and C, other than for damages from the products and completed operations hazard.

2. There is a separate **Products and Completed Operations Aggregate Limit.** Amounts paid for this hazard do not apply toward the General Aggregate Limit. Once amounts paid for the products and completed operations hazards reach the limit, there is no more coverage, even if claims paid have not yet reached the General Aggregate Limit.

3. The **Personal Injury and Advertising Injury Limit** is the most the insurer will pay under Coverage "B," even if the General Aggregate Limit has not yet been reached. Once the General Aggregate is reached, no more coverage is available.

4. The **Each Occurrence Limit** is the most the insurer will pay for the sum of Coverage A and C for damages arising out of any one occurrence. This limit is subject to either the General Aggregate or the Products and Completed Operations limits.

5. The **Medical Expense Limit** (Coverage "C") is the most the insurer will pay for a third party's bodily injuries (on a no-fault basis), but is subject to the Occurrence Limit.

6. The **Fire Damage Limit** is the most the insurer will pay for property damage liability on rented premises as the result of any one fire, subject to the Occurrence Limit.

For the purpose of clarity in this example, the "each occurrence" limit is shown separately for the general aggregate limit and the products and completed operations aggregate limit. While the general aggregate limit and the products and completed operations limit can be different in amount, the each occurrence limit is usually the same amount for both coverage.

Commercial General Liability Example

Al's Boat Company purchases a commercial package policy from you, with CGL coverage.
Policy Period 1/1/2012 to 12/31/2012.

CGL Policy Limits Purchased:

1. General Aggregate	$ 300,000
2. Products & Comp. Operations	$ 200,000
	(this is also an aggregate limit)
3. Personal Injury & Advertising	$ 40,000
4. Each Occurrence Limit (each aggregate)	$ 100,000

5. Medical Expense Limit $ 10,000
6. Fire Damage Limit $ 50,000

The following claims happened in 2012:	Claim Amount Paid By Ins. Co.	Accumulation of Claim Payments
In January, Al's fire damage causes $112,000 to 3rd party. Al loses suit.	$ 50,000	***$ 50,000***
In March, Al's advertising injury owes $55,000.	$ 40,000	***$ 90,000***
In April, customer "A" was injured in Al's office incurs $10,000 in medical expense. "A" sues & wins a judgment of $95,000 for those injuries.	$100,000	***$190,000***
In May, CO. X sues Al's and wins $135,000 for property damage.	$100,000	***$290,000***
In July, CO. Y sues Al's and wins BI claim for $25,000 (remember the policy's General Aggregate Limit).	$ 10,000	***$300,000***
In Sept., customer Z sues Al's when injured by equipment made by Al's, $150,000 judgment (remember there are two separate aggregate limits). Products & Comp. has its own aggregate of $200,000.	$100,000	***$400,000***
Al's policy renews in 2015 and is quickly sued for Bodily Injury (BI) of $25,000.	$ 25,000	***$ 25,000***

CGL Policy Conditions:

Duties in the event of a claim or suit:

- ***Notice of Claim***: Promptly notify the insurer with all appropriate information.
- Immediately send copies of all demands, notices, or other legal papers received in connection with the claim.
- Assist and cooperate with the insurer in defense or settlement of the claim.
- Refrain from voluntarily making any payments, assuming any liability, or incurring any expenses without the insurer's consent, except for administering first aid.

Concealment or Misrepresentation (of material fact) would void the coverage**.**

- **Misrepresentation** is lying about information asked on the application. If the misrepresentation is material, it can void coverage. **Material** information has direct bearing on the decision to issue or not to issue an insurance policy.
- **Concealment** is the withholding of material facts from the insurance company. Coverage may be voided if it is found to be of fraudulent intent.

When We Do Not Renew Clause (a.k.a. Non-Renewal) states that the insurer will give the First Named Insured **30-days written** notice before the policy expires if it is not going to be renewed.

Bankruptcy of Insured will have no effect on the insurer's obligation to pay the third party.

Other Insurance (prevents over indemnification) states that the insurer will pay its "pro rata liability" basis of a covered loss or pay on a primary vs. excess basis.

Subrogation…the insured agrees to give his rights to recover under the policy to the insurance company so it can go after the other party for recovery.

Legal Action may not be taken against the insurance company unless all of the policy provisions are met. There is a <u>two year statute of limitations from the date of the loss</u>.

Assignment…the insured may <u>not</u> assign this policy or any of its rights or provisions without **written** consent from the insurance company.

The Covered Territory…Covered territory includes ***the United States, its territories and possessions, Puerto Rico and Canada***. The covered territory also includes ***all parts of the world*** if the injury or damage arises out of **goods or products made or sold** by the named insured in the covered territory.

- For coverage to exist, the responsibility to pay damages or settlement agreements must be determined **in the covered territory.**

B. <u>Workers' Compensation Insurance</u> (a.k.a. State Industrial) is *compulsory* (required) in most states. Workers' Compensation laws impose a form of ***absolute liability*** because employers are held liable for employee's **<u>work-related injuries and sicknesses, *regardless of fault.*</u>**

<u>Coverage Includes</u>:

- ✓ **PART I, Basic Coverage,** pays the benefits required for injured workers for: <u>medical, disability income, death, and rehabilitation</u> for ***work related injuries and sicknesses*****.**
- ✓ **PART II, Employers Liability Coverage**, a.k.a. "Stopgap," protects the employer against liability arising from work-related injuries or diseases **not** covered by the workers' compensation law. There is a minimum limit of $100,000 and it also pays the legal obligations the employer may incur for a person who is not an employee.
- ✓ **PART III, Other States Coverage,** provides automatic coverage in states which have non-monopolistic workers' compensation laws. It may be purchased at the employers' option. The state where the work will be done must be listed on the policy as soon as the business has workers there.
- ✓ **PART IV, Your Duties If Injury Occurs,** explains the duties of the insured when a loss occurs. These obligate the insured to give prompt notice of injury, claims, or suit to the insurer. They also require the insured to cooperate with the insurer, attend hearings and trials at the request of the insurer, and help secure witnesses.
- ✓ **PART V, Premiums,** are paid ***by the employer.*** Premiums are <u>usually</u> based on the employers' ***gross payroll*** (loss experience rating and work industry also play a part in establishing the premium).
- ✓ **PART VI, Conditions**…Provisions included: inspection (the main purpose of the inspections is to **provide a safer workplace for workers**), policy terms, assignment, and cancellation.

<u>Acting in the course of employment</u> means the worker acting at his or her employer's direction or in the furtherance of the employer's business, including time spent going to and from work on the job site. **It is not necessary that at the time of injury the worker be doing the work on which his or her compensation is based**.

<u>Acting in the course of employment does not</u> include time spent coming to or going from work, or in commuter ride sharing, even if the employer participates in the arrangements.

C. <u>Crime Insurance</u> pays an owner for the loss of property due to its wrongful taking by someone else through burglary, robbery or theft. Crime coverage can be a **part** of the Commercial Package Policy or may be written as a monoline policy.

- 💰 ***Burglary*** is the breaking and entering into the premises of another with felonious intent**,** leaving ***visible signs of forcible entry or exit***. Usually committed when a business is closed.

- ***Robbery*** is the taking ***by force or fear of force*** of the personal property of another. Usually committed while a business is open.

- ***Theft*** is any loss of property by stealing, including both robbery and burglary.

Note: Theft **does not** include employee dishonesty or mysterious disappearance.

Major Crime Policy Perils and Coverage Forms include:

Employee (Theft) Dishonesty, Coverage Form A, covers money, securities, and other property lost through the dishonest acts of employees.

- ***Blanket Coverage*** covers acts by any employee. To prove loss, the insured need not identify which employee was responsible, but a case must be made that it was an employee.
- ***Scheduled Coverage,*** a.k.a. named scheduled, covers acts of a specific individual named in the declarations.
- ***Position Coverage*** covers acts of individuals occupying the position described in the declarations.

Additional Employee Dishonesty Information:

- Coverage for an employee is cancelled immediately upon discovery by the insured of any dishonest act committed by that employee. The insurance company will not pay for a covered loss that is discovered **after one year** from the end of the policy period. ***This is known as the discovery period***.

- **Employee Theft** will not pay based on an ***inventory shortage or profit and loss computation.***

- **Employee Theft** loss can be written on a **per loss basis (a.k.a. blanket limit)**, which means the limit of insurance applies regardless of how many employees were involved in the loss, or on a **per employee basis,** meaning any loss caused by one or each employee.

- **Fidelity Bonds can also be used to protect an employer against the dishonest acts of employees**.
- A Fidelity Bond, which is NOT an insurance product yet is sold by insurance companies, is similar to Employee Dishonesty Insurance. Surety (bonds) will be covered in the next few pages.

Robbery and Safe Burglary, Coverage Form D, covers any combination of the following coverage which the insured may select:

- **Robbery of a custodian** covers loss of property of the insured, other than money and securities, of the insured (owner) or an employee who has custody of the property **within** the premises. ***In crime insurance, a "custodian" is the insured (owner) or a regular employee or partner of the insured.***
- **A custodian is NOT a watchperson or a janitor.**
- **Robbery of a messenger** covers loss of property of the insured, other than money and securities, by robbery of the insured, an employee or armored car, **outside** the premises. A "messenger" ***can be the insured (owner) or a regular employee or partner of the insured.*** **A messenger is NOT a watchperson or a janitor.**

- **Safe burglary** covers loss of property, other than money and securities, from within a locked safe by force or by removal of the entire safe. Lock manipulation is not covered.

Theft, Disappearance and Destruction, Coverage Form C, provides broad coverage for ***loss of money and securities***, which is excluded by the Premises Burglary and Robbery and Safe Burglary forms. It covers both inside and outside the premises.

- It **does not** cover employee dishonesty.

- **Destruction and Disappearance** refers to a broad range of perils including fire, flood, windstorm, etc., though coverage applies to money and securities only.

D. **Commercial Umbrella Liability** coverage is the same as the personal umbrella and personal excess policy but used for business exposures. Umbrellas are written to provide insurance on an excess basis, above the underlying insurance or a self-insured retention. Usually, commercial umbrella forms provide a minimum of one million dollars of insurance, but they are frequently written with limits of $10 - $50 million or more.

- **Underlying Coverage…**there must be an underlying policy providing commercial liability coverage. The umbrella policy pays ***after the underlying limit has been used***.

- **Self-Insured Retention** is the deductible which the insured will pay when the ***underlying policy will not cover the loss*** but the umbrella will.

- **Contrast with Straight Excess Liability…**an excess policy provides the same additional coverage. However, ***it will only pay if the underlying policy covers the loss***.

E. Surety and Fidelity Bonds (a.k.a. Suretyship)…Suretyship is the means by which one person or entity, the ***surety*** (a.k.a. guarantor), guarantees another entity, the ***obligee***, that a third entity, the ***principal (obligor)***, will do or will NOT do something.

1. Promise of the Suretyship…If the principal defaults, the surety pays the obligee, but then the surety has the right to recover (subrogate) its losses from the principal.

2. Three Parties to the Contract of Suretyship:

- **The Principal** (a.k.a. Obligor) - the person or business on whom the bond is written and whose performance is guaranteed.
- **The Surety (Guarantor) -** the party that guarantees the performance or faithfulness of another.
- **The Obligee** - the person or business who is protected by the bond. The obligee under a bond is the same as the insured under an insurance contract. In the case of a construction bond, the person for whom the building is being built is the obligee, and the builder is the principal.

3. Difference Between Suretyship and Insurance*:*

- Bonds are contracts between **three** parties; insurance between **two parties** (insured is the first party and the insurer is the second party).

- **Subrogation rights**: Sureties can go after the principal to recover any losses.

- **No subrogation rights**: Insurance companies cannot go after the insured for recovery of paid losses.

4. Surety Bonds guarantee that the principal ***will do something***.

Major types of surety bonds:

- **A Contract Bond** guarantees the fulfillment of contractual obligations. The following are types of Contract Bonds: Performance Bonds, Bid Bonds, Supply Bonds, Payment Bonds, and Maintenance Bonds.

- **A *Performance Bond* guarantees the obligee that work will be completed by the principal in accordance with the contract.**

- **A <u>Fiduciary Bond</u>** guarantees faithful performance of fiduciaries such as guardians, trustees, administrators, or executors.

- **A <u>Litigation Bond</u>** guarantees that principals will be able to pay damages and court costs, or that the principal will show up for court (bail bonds).

- **License and Permit Bonds** are required to obtain government licenses and permits.

- **A Public Official Bond** guarantees the performance of certain public officials.

5. <u>Fidelity Bonds</u> protect an employer against the <u>dishonest acts of employees</u>. Guarantees that the ***principal will <u>NOT</u> do something***. Fidelity bonds are similar to Surety Bonds such as the Parties to the Contract, the Promise-to-Pay Agreement and subrogation rights. They also are similar to Employee Dishonesty Insurance under Crime coverage.

6. <u>Contrast of a Surety Bond to a Fidelity Bond</u>:

- **A Surety Bond** guarantees that something **will happen**, that a job will be performed faithfully, that a payment will be made as agreed.

- A **Fidelity Bond** guarantees to the Obligee (like a bank) that something **won't happen** (like a bank teller steals money). A teller steals money, the bank is paid by the bonding company the amount stolen. The bonding company then will go after (subrogate) the teller for reimbursement.

- **Surety Bonds** are applied for and paid for by the principal, the one who wishes to guarantee his or her performance.

- **Fidelity Bonds** are applied for and paid for by the obligee, the party that wishes to have the performance of the principal guaranteed.

F. <u>Professional Liability</u> includes Errors and Omissions (E & O) coverage and Malpractice coverage.

<u>Professional liability insurance</u> ***covers the liability of rendering or failing to render professional services*****. It does not cover fraudulent, dishonest or criminal acts.**

1. **Professionals** such as doctors (called ***Malpractice Insurance*** for medical professionals), lawyers, insurance agents, and accountants (called ***Errors and Omissions Insurance***) etc., are held to a higher standard of performance because of their education and skills. Professional *recommendations* expose the professional to lawsuits for errors or omissions to clients or to an insured.

2. Most professional liability policies today are written on a "**claims made**" basis. **Claims made** coverage obligates the carrier of the policy in effect when a claim is made to cover the claim even if the negligent act or error occurred many years before.

3. Most professional liability policies provide for the ***<u>consent by the insured before settlement</u>*** **<u>of a claim.</u>**

Surety (Bond) Insurance - A Detailed Look

Introduction To Suretyship

Suretyship is a term meaning one person or entity (the surety), guarantees another entity (the obligee) that the third entity party (the principal) will or will not do something.

Suretyship (bonds) is one of the oldest forms of financial service. In ancient times a person might leave a family member as "surety" to another until an obligation or debt was discharged. Suretyship today is usually conducted by insurance companies and is evidenced by a written contract called a surety bond. Surety bonds are used to provide a wide range of guarantees. One type of surety bond may guarantee that a contractor will comply with all of the obligations set forth in a construction contract and another may guarantee that an importer or exporter will pay duties as required by the United States statutes.

A surety bond is a contract between **three parties**:

- **The principal** (a.k.a. **obligor**) – the party who has agreed to perform a contractual obligation.
- **The obligee** (the one protected) - the party who is the recipient of the obligation. The party for whose benefit the bond is written, and to whom payment is made if the principal defaults.
- **The surety** (a.k.a. **guarantor**) – the (insurance) company providing the bond and agreeing to pay damages if the principal defaults.

One key term in nearly every surety bond is the ***penal sum***. This is a specified amount of money which is the maximum amount that the surety will be required to pay in the event of the principal's default. This allows the surety to assess the risk involved in giving the bond; the premium charged is determined accordingly.
Examples of types of Surety Bonds (you do not need to memorize these for the state exam):

Bid Bond	Performance Bond	Advance Payment Bond
Retention Payment Bond	Maintenance Bond	Contractor License and Permit Court
Customs	Lost Securities	Money Transmitters
Mortgage Brokers	Motor Vehicle Dealers	Notary
Patient Trust Funds	Public Official	Tax Bonds
Subdivision	Utility Deposit	Public Warehouse
Supply Bonds		

A Fidelity Bond (Contract) is a type of bond that will reimburse an employer (the insured) for the dishonest acts of employees. Losses generally fall into one of the following categories of dishonest acts: Employee Dishonesty, Forgery, Burglary, Robbery and Theft. **Coverage for dishonesty and forgery is available for businesses under two different types of contracts. One is to obtain the coverage through an insurance policy, and the second is to obtain the protection through a fidelity bond.**

Examples of Fidelity Bonds:

ERISA	Business Service Bonds	Public Official	Manufacturers
Small Businesses	Non-Profit Organizations	Real Estate Managers	Title Agents
Financial institutions	Precious Metal Exposures	Armored Car	

I. CONTRACT PRINCIPLES

A. Essential Elements of a Contract… A **contract** is defined as an agreement enforceable by law. It is an agreement entered into by two or more persons under which one or more of them agree, for a consideration, to do or to refrain from doing an act in accordance with the wishes of the other party(s). In insurance, the agreement is between a company and an insured, where an insurer agrees, for a consideration, to provide benefits, reimbursement or provide services for an insured. Suretyship is a three party contract.

The **elements of a legal contract include:**

- **Offer and Acceptance…** The applicant makes the "***offer***" to the insurance company. The insurance company "***accepts***" the ***offer*** by issuing the policy or bond.

- **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. The insurance company issues a policy or bond that represents a promise to pay.

- **Legal Object…** In order for a contract to be legal, it must be for legal purposes only. This is why ***contracts do not cover intentional or criminal acts of the insured. An insurance company may cancel a policy and deny a claim due to fraud committed by the insured or principal against the insurance company or bonding company.***

- **Competent Parties…** The insured must be of legal age, not be under the influence of intoxicants, and not be mentally handicapped. Any person 18 years of age or older will be considered of full legal age and may contract for or with respect to insurance or bonds.

Special Note: Surety bonds, like other promises to be responsible for the debts or defaults of others, are subject to the statute of frauds and other common law and statutory requirements calling for certain types of agreements to be in writing. **Therefore, a surety bond is not enforceable unless it is in writing.**

B. Parties to a Surety Contract

- **The principal (obligor)** - the party who will be performing a contractual obligation.

- **The obligee** (the one protected) - the party who is the recipient of the obligation. The one who is protected.

- **The surety** (**guarantor**)– the party who ensures that the principal's obligations will be performed.

II. SURETY and FIDELITY CONTRACTS (Ref. RCW 48.28.010 to .050)

Suretyship is a term meaning one person or entity (the surety), guarantees another entity (the obligee) that the third entity party (the principal) will or will not do something. It differs from insurance by being a 3-party contract since insurance is a 2-party contract, although **most sureties today are insurance companies (insurers)**. There are two types of bonds in Suretyship; **surety bonds and fidelity bonds**.

Surety Bonds guarantee that a principal (third party) will carry out the obligation for which the principal is bonded. A surety bond is most often issued to a contractor, a person seeking a license or permit, or a person involved in a court case.

A Fidelity Bond is a type of surety bond that will reimburse an employer (the insured) for loss due to the dishonest acts of employees.

Requirements deemed met by surety insurer (RCW 48.28.010)… Whenever by law or by rule of any court, public official, surety bond, obligation, or undertaking is required or is permitted to be given, any such bond, recognizance, obligation, stipulation, or undertaking which is otherwise proper and the conditions of which ***are guaranteed by an authorized surety insurer*** shall be approved and accepted and shall be deemed to fulfill all requirements and no justification by such surety shall be necessary.

Fiduciary Bonds — Premium as lawful expense (RCW 48.28.020)… Any fiduciary required by law to give bonds, may include as part of his lawful expense to be allowed by the court or official by whom he was appointed, the reasonable amount paid as premium for such bonds to the authorized surety insurer or to the surplus line surety insurer which issued or guaranteed such bonds.

Judicial Bonds — Premium as part of recoverable costs (RCW 48.28.030)… In any proceeding the party entitled to recover costs may include therein such reasonable sum as was paid to such surety insurer as premium for any bond

or undertaking required therein, and as may be allowed by the court having jurisdiction of such proceeding. There are several different types of **judicial, or court-related, bonds**. These can protect businesses, communities and individuals in the face of criminal or civil tort acts and litigation. Here are several prominent types:

- **Injunction Bonds** are a specific type of judicial bond ensuring that if a person obtains an injunction under false pretenses, he or she will be liable for damages. These bonds protect people who are wrongly accused and take a financial hit because of a false injunction.
- **Appeal Bonds** are bonds that are typically filed by an individual who has lost in court and is seeking an appeal to a higher court. Appeal bonds guarantee the execution of the fiduciaries' duties in the event the appeal fails.

Official Bonds — Payment of premiums (RCW 48.28.040)… The premium for bonds given by such surety insurers for appointive or elective public officers and for such of their deputies or employees as are required to give a bond shall be paid by the state, political subdivision, or public body so served.

Release from Liability (RCW 48.28.050)… A surety insurer may be released from its liability on the same terms and conditions as are provided by law for the release of individuals as sureties.

A. Differences Between Surety/Fidelity Bonds and Insurance

1. **Loss Paying:** Differences between surety and insurance fields can be found with respect to indemnification and subrogation rights. Principals must indemnify the surety company for any losses and the surety has subrogation rights against the principal who purchased the bond. With insurance the insurer agrees to indemnify the insured or another party on behalf of the insured, and has no subrogation rights for paid losses against the insurer.

   In terms of risk of loss, a surety bond is designed to protect the bonding company while an insurance policy is designed to protect the insured. ***Losses are NOT expected in the surety field*** so premiums are not collected to pay losses but are actually paid for service fees. Insurance companies are expected to have losses and charge premiums for paying those losses.
   Promise of the Suretyship…If the principal defaults, the surety pays the obligee, but then the surety has the right to recover its losses from the principal.

   - In the event of a claim, the surety will investigate it. If it turns out to be a valid claim, the ***surety will pay it and then turn to the principal for reimbursement*** of the amount paid on the claim and any legal fees incurred. If the principal defaults and the surety turns out to be insolvent, the purpose of the bond is rendered void. Thus, the surety on a bond is usually an insurance company whose solvency is verified by private audit, governmental regulation, or both.
   - A key term in nearly every surety bond is the penal sum. This is a specified amount of money which is the maximum amount that the surety will be required to pay in the event of the principal's default. This allows the surety to assess the risk involved in giving the bond; the premium charged is determined accordingly.

   Promise of Insurance…Insurance is a contract between two parties (the insured and insurance company). It is a formal social device for **reducing risk** by ***transferring the risks*** of several individual entities to an insurer. The insurer agrees, for a consideration, (money/premium), to assume for a specified extent, the losses suffered by the insured. Insurance is a risk sharing device that expects losses based upon calculated probabilities. Though losses occur, bonds are structured and written with the expectation that few losses will occur and those that do occur are recoverable. A bond closely resembles a **bank letter of credit**. The **surety** is lending its credit to a person or organization to back their service or performance of an obligation.

	Surety	Insurance
Losses Paid by Company	Can be reimbursed by principal	Cannot collect from insured

		(no subrogation)
Party Agreement	**3**	**2**
Cancellation	120 days notice	10 -45 days notice
Losses to Company	No losses expected	Expects losses to occur

2. Parties to the Contract are Different Between Suretyship and Insurance: Bonds are contracts between **three** parties, insurance between **two parties**. Sureties can go after the principal for any losses. Insurance companies cannot go after (subrogate) the insured for reimbursement for losses they have paid.

3. Cancellation… Most bonds are continuous as long as premiums are paid. However, the Surety is required to notify both the Company and the Regulator by certified mail of its intent to cancel the bond.

- **The Surety cannot cancel the bond within 120 days of notifying the Regulator.**
- The Company has **90 days** to secure alternate financial assurance and obtain Regulator approval using one or more of the financial assurance mechanisms allowed.
- If the Company fails to provide alternate financial assurance and receive written approval of the new mechanism by the Regulator within 90 days, the Regulator can direct the Surety to pay up to the amount guaranteed by the bond into the standby trust fund.

B. Definition of Fidelity and Surety

Surety is a person (or entity), who is legally responsible for the contracts, debt, delinquency, or liability of another.

Surety Bonds are bonds where there is a three party agreement between a contractor (principal), the project owner (obligee), and the surety company. The bond insures that the contracted work will be completed on time and will cover any losses incurred by poor contract performance.

Fidelity means faithfulness to obligations, duties, or observances. It means adherence to right, careful and exact observance of duty, or discharge of obligations.

Fidelity Bonds are bonds that can protect business owners and employers from monetary or property loss at the hands of employees. Some businesses, including insurance companies, are required to utilize fidelity bonds. **Fidelity Bonds** are bonds issued to protect an employer from financial or property losses due to the dishonesty of employees.

C. Indemnification… Promise of the Suretyship… If the principal defaults, the surety pays the obligee, but then **the surety has the right to recover its losses from the principal (known as subrogation)**. The surety will not issue bonds unless it has received agreements from the principal and other indemnitors with sufficient assets, in the surety's opinion, to secure the surety from any claims that may be made against the bonds. This is done by an indemnity agreement to be signed by the principal and the individuals who will serve as indemnitors. The agreement is a contractual obligation that provides security for the surety. The indemnity agreement sets forth and expands upon the separate common law obligations between the principal and the surety. A separate indemnity agreement may be issued for each bond. However, more frequently, the parties enter into a general indemnity agreement covering any bonds that the surety may issue to that contractor. The indemnitors (the contractor and individuals who have pledged their assets to support the bonds) agree that they will indemnify (completely reimburse) the surety for any liabilities, attorney's fees, expenses, or damages the surety may incur as a result of its issuance of a bond to the principal. A surety that pays the debts or obligations of its principal is entitled to indemnification by the principal. ***The written indemnity agreement confirms the principal's obligation and extends the obligation to all the indemnitors.***

D. Obligation of the Surety… Subject to the limitations of the bond language, the surety agrees to indemnify the obligee in the event the bonded principal fails to perform its obligations to the obligee. **The surety owes no obligation to the obligee unless the principal fails to perform**. Thus, the surety's liability is secondary, and the obligee must establish the liability of the principal in order to seek recovery from the surety.

Surety Application: With a surety bond it is the **principal who will apply for and pays** for the bond.
With a surety bond all three parties are involved in forming the contract.

Fidelity Application: With a fidelity bond it is usually **the obligee (employer) who will apply for and pays** for the bond. ***The employees (principals) may not even know that a bond is in effect, so not all parties are involved in forming the contract***.

E. Parties to the Contract of Suretyship

The Principal (**a.k.a. obligor**) - the person or business on whom the bond is written, and whose performance is guaranteed by a bond.

The Surety (a.k.a. guarantor) - the party that agrees the performance or faithfulness of another. A surety can be either a corporation or an individual, but it is ***usually an insurance company***.

The Obligee - the person or business who is protected by the bond. The obligee under a bond is the same as the insured under an insurance contract. In the case of a construction bond, the person for whom the building is being built is the obligee, and the builder would be the principal.

F. Suretyship—Personal and Corporate—The means by which one person or entity, the surety, guarantees another entity, the obligee, that a third entity, the principal, will or will not do something. It differs from insurance by being a 3-party contract, but most sureties today are insurers.

1. A Personal Bond can be purchased to meet a state's minimum financial responsible liability laws when driving a vehicle. In Washington, the driver and owner of a vehicle must show the ability to pay for a liability claim. The requirement is $60,000. This can be met by purchasing a bond or insurance, or by depositing cash with the state.

2. Corporate Suretyships were first formed in the 1800s. Prior to that time, individual arrangements were risky and there were no guarantees that the assets of a backer would satisfy the obligation. Once organizations began to specialize in issuing surety bonds, formal contracts backed up by corporate assets became available to meet individual and business needs. **A surety (guarantor) can be either a corporation or an individual**, but it is ***usually an insurance company***.

G. Underwriting Considerations… The nature of bond underwriting is fluid and rapidly changing, given economic realities within a given industry and the market as a whole. **Unlike with insurance, there is little expectation of loss with surety bonds**. Because of that, the bond premium is typically meant to cover prequalification services, namely the underwriting.

Surety companies will examine contractors methodically before issuing a bond. They will typically scrutinize a company's ***financial strength*** and ***credit history***; its references, ***reputation and ability to perform current and future work***; and the ***firm's management structure*** and hierarchy.
Even those with bad credit can obtain surety bonds. But remember that high-risk bonds will often come with a significantly higher premium cost.

H. Terms of Obligations: Surety (WILL DO something) vs. Fidelity (WILL NOT do something)

1. Surety is a person (or company) who is legally responsible for the contracts, debt, delinquency, or liability of another. The surety bond insures that the contracted ***work will be completed*** on time and on budget and will cover any losses incurred by poor contract performance.

- **Surety bonds are usually applied for and paid for by the principal (obligor). All three parties are involved in the contract.**

2. Fidelity means faithfulness to obligations. It means adherence to right, careful and exact observance of duty, or discharge of obligations. **Fidelity Bonds** are bonds that can protect business owners and employers from monetary or property loss at the hands of employees.

- **Fidelity bonds are usually applied for and paid for by the obligee (employer). The principal is usually not aware of the bond placed on them.**

I. Claims (WAC 284-30-300 thru 380)… UNFAIR TRADE & CLAIM PRACTICES

The Unfair Trade Practices Act is divided into two parts—**Unfair Marketing Practices and Unfair Claims Practices**. In each state, statutes define and prohibit certain trade and claims practices which are unfair, misleading and deceptive.

No person or insurer engaged in the business of insurance (including Suretyship) may engage in unfair methods of competition or in unfair or deceptive acts or practices whether expressly written in the State Code or found by the commissioner to be unfair or deceptive.

Penalties for Non-Compliance

Suspension…The Commissioner can take the insurance license away temporarily for a maximum of **one year** and it is returned without the producer having to retake an exam.
Revocation…The Commissioner can take the license away for a maximum of one year. The person must reapply for the license but it may not be approved. However, if the Commissioner does approve the application, the proper license exam must be passed again.

- Immediate revocation (without a hearing) is allowed upon the conviction of any felony.
- The Commissioner may suspend, revoke or refuse to renew a license with not less than **15-day written notice**.
- The Commissioner may suspend a license with not less than **three-days** written notice upon **finding** that the public safety requires this **emergency action**.

Fines of Non-Compliance: The Commissioner can fine up to ***$1,000*** and/or up to one year in jail, per offense, for a violation of the insurance code. Fines must be paid within 30 days. Failure to pay will result in revocation of the insurance license and the fine recovered in a civil action. Fines are paid to the State Treasurer for deposit in the general fund.

- **$25,000 fine for anyone acting as a producer without being properly licensed to do so**.

A License and/or Appointment Agreement May Be Taken Away For:

1. **Lying on the License Application** (new licenses and renewals), or obtaining a license through misrepresentation or fraudulent means.

2. **Illegal Inducement…**It is unlawful for insurance personnel to **provide** or **promise** in a policy anything valued at more than an aggregate of ***$100.00 per year***, to any one prospective or current policyholder.

   - **Examples:** Offering any special advisory board contract, agreement or understanding of any kind, providing for or promising any profits or returns, is illegal inducement. Paying $101 for an individual's lunch at the time of procuring insurance is illegal inducement.

3. **Rebating…**It is unlawful for a producer or insurance company to give any valuable consideration such as a rebate, discount, reduction of premium, shares of stock, etc., to induce a person to buy insurance.

3. **Misrepresentation…**Telling a lie or deceiving anyone about *any aspect* of insurance, like false coverages, inflated benefits, unrealistic returns, etc. Examples include:

- **Twisting…**No person can, by ***misrepresentations or misleading comparisons***, induce, or tend to induce, any insured to lapse, terminate, forfeit, surrender, retain, or convert any insurance policy.
  - For example, this can occur when a producer wants a prospective customer to cancel and switch his/her current insurance policy over to the producer's company, and does so by giving misleading facts.

- **Defamation of Insurer…** No person can make, publish or circulate any information or statement which is false or maliciously critical if designed to injure the reputation or business of any authorized insurance company (insurer).

5. **Illegal Dealings In Commission…**"A producer of insurance may not compensate any person other than another producer for procuring applications or placing insurance in this state." It is illegal to share commissions with anyone who **is not licensed** in the ***same line of insurance*** in which the insurance was procured. For example, a life-only producer may not share commissions with a property and casualty producer.
    - This does not affect salaries paid to unlicensed persons, as long as the salaries are not contingent on the volume of business transacted.

6. **Illegal Dealings In Premium…**No one can willfully collect money as premium for insurance if insurance coverage is not provided. Also, no person can willfully collect any money as premium for insurance in excess of the amount actually due.
    - A person must return any overpayment of money collected as premium, in a reasonable length of time, to the person who paid the premium. **Each violation of this section which does not amount to a felony constitutes a misdemeanor.**

7. **Additional Reasons a Licensee Could Lose a License:**
    - Misappropriation or conversion of money to personal use
    - Illegal withholding of monies required to be held in a fiduciary capacity
    - ***Incompetence or failing to serve in the public's best interest***
    - Willful violation of any insurance statute, regulation or order of the Commissioner

7. **Violation of Advertising Laws…** A producer may not commit false advertising in regard to an insurer's financial condition. The producer must not use unfair or deceptive practices in the sale, advertising or marketing of any type of insurance product.

- All advertising must be clear and understandable and contain the name and address of the insurance company. This includes mailings and brochures.

Specific Unfair Claims Settlement Practices:

1. Misrepresenting pertinent facts or insurance policy provisions.
2. Failing to acknowledge and act promptly upon communications regarding a claim.
3. Failing to implement standards for the prompt investigation of claims.
4. Refusing to pay claims without conducting a reasonable investigation.
5. Failing to affirm or deny coverage of claims within a reasonable time.
6. Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims in which liability has become reasonably clear.
7. Compelling insureds to institute or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy.
8. Settling a claim for less than a reasonable amount a claimant would have believed he was entitled.
9. Making claims payments not accompanied by a statement setting forth the coverage with which the payments are being made.
10. Telling insureds or claimants that there is a policy of appealing arbitration awards only for the purpose of compelling them to accept settlements less than the amount awarded in arbitration.
11. Delaying the investigation or payment of claims by requiring an insured or claimant to submit a preliminary claim report and then requiring subsequent submissions that contain the same information.
12. Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other insurance policy coverage.
13. Failing to promptly provide a reasonable explanation for denial of a claim.
14. Unfairly discriminating against claimants because they are represented by a public adjuster.
15. Failure to expeditiously honor drafts given in settlement of claims.
16. Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established.
17. Delaying appraisals or adding to their cost through the use of appraisers from outside the loss area.

18. Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.
19. Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent.

Special Note Regarding Unfair Claims Settlement Practices:

- Insurers must acknowledge receipt of notification of a claim ***within 10 working days*** (15 days on group contracts), unless payment is made within that period.
- When the Commissioner requests information, the insurer must respond ***within 15 working days***.
- Insurers must complete investigation of claims **within 30 days** after notification of claim.

False Claims… It is unlawful for any person to knowingly:

- Present a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under contract of insurance.
-
- Prepare, make or subscribe any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with the intent that it be presented or used in support of such a claim.

A violation of this section is a gross misdemeanor.
If, however, the claim is in excess of $1,500, the violation is a Class C felony.

J. Power of Attorney… An instrument in writing by which one person, as principal, appoints another as his agent and confers upon him the authority to perform certain specific acts or kinds of acts on behalf of the principal. The purpose of a power of attorney is not to define the authority of the agent as between himself and his principal, but to evidence the authority of the agent to third parties with whom the agent deals.

- ***The bond agent who contracts with sureties to write bonds and sign on their behalf.***
- ***Principals give their power of attorney to the bonding agent to act on the principals' behalf.***
- **Authority Agreement… An agreement between the agent and the surety governing the use of the Power of Attorney.**

III. PURPOSE AND TYPE OF SURETY BONDS

What is the Surety's Job?..... To protect public and private interests against financial loss resulting from a company or individual's bankruptcy or failure to perform a contracted service.

A. License and Permit Bonds are bonds required to obtain a license or permit from a city, county, state, or occasionally the federal government. The purpose is usually to safeguard the public.

- **License and Permit Bonds** are a general class of surety bonds required of a person or entity to obtain a license or a permit in any city, county, or state. These bonds guarantee whatever the underlying statute, state law, municipal ordinance, or regulation requires. They may be requirements for a licensed driver to be present in the vehicle; for example, Judy is a licensed driver and her guardian is anywhere in the automobile, not necessarily in the front or back. Certain taxes and fees and providing consumer protection may be required as a condition to granting licenses related to selling real estate or motor vehicles and contracting services.

B. Public Official Bonds are bonds that protect against the dishonesty or lack of performance of duties by a public official. A Public Official is someone who holds a public office; i.e. mayor or school board official.

- **Blanket Position Public Official Bonds** are bonds which protect from loss due to dishonest acts of public employees. The bond is issued for a fixed amount and **each position** is covered for this amount.
- **Blanket Public Official Bonds** are bonds which protect from loss due to the **dishonest acts of all public employees.**

C. Court and Probate Bonds are bonds that guarantee proper performance of fiduciary duties (i.e. the execution of a will) and compliance with court orders.

- **Judicial Bonds — Premium as part of recoverable costs (RCW 48.28.030)**

In any proceeding the party entitled to recover costs may include therein such reasonable sum as was paid to such surety insurer as premium for any bond or undertaking required therein, and as may be allowed by the court having jurisdiction of such proceeding.

- **Fiduciary Bonds — Premium as lawful expense (RCW 48.28.020)**
  Any fiduciary required by law to give bonds may include as part of his lawful expense to be allowed by the court or official by whom he was appointed, the reasonable amount paid as premium for such bonds to the authorized surety insurer or to the surplus line surety insurer which issued or guaranteed such bonds.

D. Contract Bonds are bonds that provide financial security and construction assurance on building/construction jobs. It assures the project owner that the contractor ***will perform*** the contracted work and/or pay subcontractors, laborers, and suppliers. Types of contract bonds include:

- **Bid Bonds** are bonds meant to guarantee that a bidder of a contract (i.e. construction contract) enters that bid in good faith and will properly execute the contract if the bid is successful.
- **Payment Bonds** are bonds given to guarantee payment, usually of a contractor to sub-contractors and suppliers. This is frequently the only protection offered those supplying work or materials to a public job.
- **Performance Bonds** are bonds guaranteeing performance of the terms of a contract. These protect the owner of the contract from financial loss should the contractor refuse or be unable to fulfill the contract obligations.
- **Commercial Bonds** are bonds required by businesses (other than contractors) to guarantee completion of service.
- **Completion Bonds…**When a contractor borrows money to fund a construction project, the lender may require a guarantee that the project will be carried out and the contractor will be paid for the work. A completion bond guarantees the lender (obligee) that the contractor (borrower and principal to the bond) will apply the funds to the project and complete the project free of any liens or encumbrances.
- **Supply Bonds** are bonds that guarantee that a supplier will faithfully furnish supplies, materials, finished products, or equipment according to the terms of a supply contract.

IV. PURPOSE AND TYPE OF FIDELITY BONDS

A. Individual Bonds are bonds written in the ***name of a single employee*** for a specific limit of liability. If an employer has only one employee, or one employee with access to funds or the business's property, an individual bond could be used.

B. **Schedule Bonds** are bonds that schedule the coverage for acts of a ***specific named employee or by the employee's position or job title.***

- A ***name scheduled bond*** covers several specific individuals who are named on the bond, and allows the insured to list a separate limit of liability for each employee on the schedule.
- A ***position scheduled bond*** is similar to a name scheduled bond, except that it covers listed positions and does not mention the employees by name.

C. Blanket Bonds are bonds which protect an employer from loss due to dishonest acts of all employees. A maximum single limit of coverage for any loss.

- **Blanket Position Bonds** are bonds which protect an employer from loss due to dishonest acts of employees, including embezzlement. The bond is issued for a fixed amount and each position (rather than individual) is covered for this amount.
- **Blanket Position Public Official Bonds** are bonds which protect from loss due to dishonest acts of public employees. The bond is issued for a fixed amount and each position is covered for this amount.
- **Blanket Public Official Bonds** are bonds which protect from loss due to the dishonest acts of all public employees.

D. Financial Institutions… Financial institutions have special exposures because they receive and distribute funds and handle transactions for clients. ***Various bonds are available to cover bankers, credit unions, finance companies,***

insurance companies, and savings and loan institutions. Bonds for financial institutions provide broad coverage for multiple exposures and are similar to that provided by a commercial crime policy. One bond might be used to cover employee dishonesty, robbery, larceny, theft or hold-up on or off the premises.

E. Public Official/Faithful Performance (RCW 48.08, 48.28.040)…Public Official Bonds are bonds that protect against the dishonesty or lack of performance of duties by a public official. A Public Official is someone who holds a public office; i.e. mayor, school board official, president.

- **Blanket Position Public Official Bonds** are bonds which protect from loss due to dishonest acts of public employees. The bond is issued for a fixed amount and each position is covered for this amount.
- **Blanket Public Official Bonds** are bonds which protect from loss due to the dishonest acts of all public employees.

➢ **Official Bonds — Payment of Premiums (RCW 48.28.040)…** The premium for bonds given by such surety insurers for appointive or elective public officers and for such of their deputies or employees as are required to give bond ***shall be paid by the state, political subdivision, or public body so served***.

V. BAIL BONDS

While many defendants do not have cash on hand to pay bail, a bond is another option. A bond offers a defendant a chance to get out of jail for little money because the bond company contributes most of the cost. A bond will end up costing much more in the end though because bond companies charge interest rates.

A bond is some sort of property or money offered by a third party to guarantee the appearance of the defendant. Sometimes bond is arranged through a bond company, and sometimes it is offered by family or friends of the defendant. The defendant is expected to pay back the surety if necessary. If the defendant obtains a bond through a bond company, he will be responsible for paying back the bond plus interest if he does not appear at trial and does not get the value of the bond back.

When it comes to bail bonds, every defendant will have a different amount of money to pay in order to get out of jail on bail while waiting for his or her trial. The bail bond is a basic assurance that the defendant will return to court on the day of the trial. Bondsmen and bail bonding agencies that put up the bail for a defendant are responsible for ensuring that the defendant returns to court for the trial.

There are a number of different factors that are considered when a judge sets bail. Often, the bail determination begins with a rate schedule, which differs by locality. A judge will also take the following considerations into account when he sets bail:

1. Severity of the Crime
2. Prior Criminal History
3. Flight Risk

A bail bond agent, or bondsman, is any person or corporation which will act as a surety and pledge money or property as bail for the appearance of a criminal defendant in court. ***A surety bail bondsman utilizes the financial strength and backing of an insurance company.***

A. Surety Bail Bond… Use of a surety bond involves a series of contracts with a bail bond agent for the bail amount. The bail agent interviews the arrested individual and the guarantor prior to assuring that the accused will appear in court. This information provides the bail agent with a reasonable determination of whether the accused will make the designated court appearances. Contracts can also contain various conditions of guaranteeing the release, such as completing drug treatment.

Bonds are usually written for a premium percentage of the bail's full amount. Collateral from the guarantor is then used to secure the remaining bail amount. The bond agent is liable to the court for the full bail amount, in the event the accused fails to appear. This guarantee is made by using the assets and property of the bail agent's insurance, or surety, company. The surety company is usually licensed for operation by the insurance commission of the state. For additional information on surety bonds, consult a bail agent or an attorney.

B. Property Bail Bond… An individual may be able to use a property bail bond to gain release. The individual posts a property bond with the court. The value in the property may need to be twice as high as the bail amount. All owners of the property listed on the warranty deed or tax statement must sign in agreement to use their property as bail security. The court secures a lien against the property for the bail amount. In the event the person fails to appear for court proceedings, foreclosure action may be taken against the property. This allows the court to collect on the outstanding bail amount. A property bond is a less common way of securing bail so a defendant can be released from custody. During this process, real property (a house, building, etc.) is placed with the court as a guarantee that the defendant will show up to all necessary court proceedings. The court records a lien against the property for the bail amount, whatever it may be. If the defendant fails to show up to mandatory court appearances, the court can start the process of foreclosing on the property to obtain the full bail amount. However, if the defendant shows up to all court appearances, the court will then release the lien and take no action against the property.

C. Surety Bond Fee (premiums) vary from one surety to another, but can range from one-half of one percent to twenty percent of the contract amount, depending on the size, type, and duration of the project and the contractor. Typically, there is no direct charge for a bid bond, and in many cases, performance bonds incorporate payment bonds and maintenance bonds.

- Bond premiums vary greatly depending on the applicant, the bond type, surety, and the obligee. Just like other forms of credit, everyone does not receive the same rate. Standard market rates are typically anywhere from 1-3%, while higher risk markets can range anywhere from 5-20% of the bond amount.

D. Determination of Bail… When determining the amount of bail for an individual, the court will consider the following factors:

- Does this person have ties to the community?
- Is he employed in the community?
- Does he have family members in the community?
- Has he previously appeared for scheduled hearings or has he previously fled?
- How much can the defendant afford to pay?

An attorney will present facts regarding each of the these factors and may bring in more details regarding the defendant to show the court the defendant is not a flight risk. The court will then make a determination of bail. The bail amount can be changed if circumstances of the defendant change. If the defendant leaves the state, or does not show up for a scheduled hearing, bail may be reinstated or denied altogether.

E. Types of Bail Bonds:

1. Property Bond… Depending on the court jurisdiction, an individual may obtain release from custody by posting a property bond with the court. Here a court records a lien on property, to secure the bail amount. If the defendant fails to appear in court on his/her designated date, the court may start foreclosure proceedings against the property to obtain the forfeited bail amount.

2. Cash Bond… A cash bail bond is put up by a family if a judge determines an individual who is incarcerated to be a flight risk. To be released on cash bail, a person must post with the court the total amount of the bail, in cash, to secure his/her return to court on an appointed date, and thereafter until the case is finished. Full cash bonds are an incentive for defendants to appear at trial. If the defendant appears for his/her court appearances, the cash will be returned to him/her within 60-90 days. However, he/she fails to appear, the cash bond is forfeited to the court.

Cash bail is simply the amount of cash money that you must present in order to obtain the release of the defendant while his case is pending. As long as the accused makes all of his court appearances, you will get all (or nearly all) of your money back. Most people opt to use the services of a bail bond company because instead of paying the full amount of bail in cash, they need only pay a percentage of the bail. Typically 10% is the fee that a bail bondsman will charge. Another reason not to pay full cash bail is that the bail money will not be used to pay any fines or expenses imposed by the court.

3. Bail Bond… The alternative to cash bail is the posting of a surety bond which is also known as a bail bond. This process involves a contractual undertaking guaranteed by an admitted insurance company having adequate assets to satisfy the face value of the bond.

Once a defendant is released on a bail bond they will meet with an agent to be interviewed and go over the terms and conditions of bail.

OWN RECOGNIZANCE (OR)… Another method of release pending trial is through a county or law enforcement administered pre-trial release program. Typically a deputy or staff member of the jail will interview a defendant and will determine or recommend to the court regarding release of the defendant on their own recognizance.

F. Bail Piece… A certificate given by a judge or the clerk of the court, or other person authorized to keep the record, in which it is certified that the bail, became bail, for the defendant, in a certain sum, and in a particular case.

G. Acceptable Collateral… Collateral is something of value that is used to secure a debt or ensure payment. Sometimes a bail bond company will receive collateral in order to ensure that the defendant appears in court. **Most bail bond collateral is in the form of real estate or cash**. A bail company must return your collateral at the resolution of the case.

Collateral would be accepted in the form of a credit card payment, vehicle titles, assets on paper, mortgage deeds, or cars and other vehicles. The bail bondsman will hold all titles or charge the credit card, holding the cash until the defendant shows up in court. All collateral is returned once the defendant makes an appearance.

Function… Collateral is required for some crimes or repeat offenders who may be a flight-risk and may not show up to court. Friends or family who are willing to place their valuables or homes as security will surrender titles to the bail bondsman as collateral. All collateral is returned providing the defendant goes to court on the dates specified and doesn't skip or jump bail.

Identification… The person putting up bond for the defendant is called the indemnitor. If the defendant chooses to skip or jump bail, she will lose the collateral she put up; she will, however, have time to produce the cash in return for the collateral items.

Time Frame… Should the defendant miss his scheduled court appearances, there is a 120-day waiting period to allow the defendant or his attorney to set another court date for the hearing. If that time period should lapse without a court date being set, all collateral would be forfeited.

H. Appeal Bonds are bonds that are typically filed by an individual who has lost in court and is seeking an appeal to a higher court. Appeal bonds guarantee the execution of the fiduciaries' duties in the event the appeal fails. This is a guaranty by the appealing party insuring that court costs will be paid. An Appeal Bond ensures the loyal execution of the fiduciaries' duties and compliance with the orders of the court. When plaintiffs win a civil law suit, they are often awarded money as part of the judgment. The defendant, however, usually has the right to an appeal, and is not required to pay the award until the appeal is decided. In this situation, the defendant (who becomes the appellant) is required to post an appeal bond to cover the judgment.

Terms of the Appeal Bond… With virtually no exception, appeal bonds must be collateralized 100 percent. This means a defendant/appellant cannot put down a mere fraction of the bond amount and let the surety finance the remainder, as is the case in most surety bonds. ***An appeal bond must be backed entirely by cash and/or other valuable assets.*** In other words, surety companies don't want to assume the risk of the plaintiff not paying the judgment any more than a plaintiff does, and if they did, it might not be a useful deterrent against frivolous appeals.

I. Appointing Company's Underwriting Standard

Underwriting is a term borrowed from insurance. It is the decision making process by a company to determine whether to issue a bond or not to issue a bond. Different companies will have different standards for issuing bonds. One company may reject a bond on an individual while another may choose to issue a bond on the same individual.

- **For example**, this is a process where the Surety investigates the contractor's character, capacity and capital to determine if the contractor is qualified, by the Surety's standards, to undertake the project.
- **This process is very much like qualifying for a loan, line of credit or mortgage, or an insurance policy.**

Underwriting and Qualifications…Consider the following points to find out how you qualify for bond.

1. **How much is a bond**? If the judge sets the bail high, that increases the amount that needs to be paid for the bond. With any financial qualifying situation, the higher the price, the harder it is to qualify.

2. **What are the charges**? The more severe the crime, the higher the bail amount will be. Also, there are some cases where judges will be reluctant to issue bail.

3. **Who is the guarantor (surety) or indemnitor** (the person signing on behalf of the individual in custody)? If the guarantor has good standing in the community, good credit, hard assets (in case the individual in question should disappear before the trial), the individual applying for the bail bond has a greater chance of approval.

4. **The character of the person arrested is also brought into question**. Does he/she have a job? What is his/her prior criminal record? Does he/she have a family? Is he/she an American citizen? Does he/she have a passport (if yes, the passport is usually confiscated until the trial is over).

Special Note: Surety bonds, like other promises to be responsible for the debts or defaults of others, are subject to the statute of frauds and other common law and statutory requirements calling for certain types of agreements to be in writing. **Therefore, a surety bond is not enforceable unless it is in writing.**

J. Ethics (Public Interest) (RCW 48.01.030)… The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, their providers, and their representatives rests the duty of preserving inviolate the integrity of insurance.

- A Producer acting as an Agent or a limited lines Surety Agent is a representative of the insurance company in which he is appointed. However, ***all producers and licensees must always act in the public's best interest.***

Bond Definitions

- **Administrator Bond—**Guarantees that an individual or organization will safeguard assets of another that have been placed under their control.
- **Agent—A producer who is appointed to transact business through an authorized insurance company.** Only licensed, Property & Casualty insurance producers can solicit and sell surety bonds. Surety limited lines agents are licensees who specialize in surety bonds. Most surety agents operate as independent agents, representing several different Surety Companies.
- **Attorney In Fact—**The bond agent who contracts with sureties to write bonds and sign on their behalf.
- **Authority Agreement—**An agreement between the agent and the surety governing the use of the Power of Attorney.
- **Bid Bond—**Assures owner will be paid the bid bond amount if the contractor is awarded the job but later refuses to undertake the job.
- **Bond—**A contractual guarantee made up of three parties, each bound to the other for a specific business purpose. Differs from insurance as follows:
    1. The premium is a fee for the service provided and not "pooled" to pay losses.
    2. A bond guarantees credit, performance or integrity - not physical loss.
    3. The Surety is liable only after the principal is unable to complete a project or respond as promised.

- **Bond Back—**Occasionally the Surety will as part of their underwriting requirements require the General Contractor to have one or more of their major Subcontractors to be "bonded back" to the General, to reduce the risk of default.
- **Bond Line—**A Contractor will want to know how many and what size jobs the surety will bond over the course of a year. The surety may establish a **single bond size limit** and an **aggregate limit of all work they are willing to bond for a specified time.**
- **Bond Penalty—**The amount of the bond.
- **Bond Term—**May be a specific period of time or continuous until terminated by one of the parties to the bond.
- **Broker—**An intermediary that brings an application for a bond on behalf of a client to an agent or bonding company and receives compensation ONLY from the client.
- **Collateral—**Assets pledged to the surety to secure the principal's indemnity. The collateral will be cashed if a loss occurs.
- **Contract Price—**The amount of the contract. May not be the same as the bond amount.
- **Co-surety—**Two or more sureties on a bond.
- **Court Bond—**Guarantees that a judgment will be paid if an appeal is lost.
- **ERISA or Pension Bond—**Reimburses for theft of a pension or profit sharing plan's assets by the plan sponsor and administrator.
- **Executor Bond—**Guarantees that an individual or organization will safeguard assets of another that have been placed under their control.
- **Exoneration—**Exoneration is a surety term that describes when a bonded obligation on the part of the surety ends. This usually does not occur until the warranty period of a project had ended. Which means that the surety still has potential liability well after the project is complete. The surety actively seeks exoneration of all bonds from the owner/obligee.
- **Fidelity Bond—**Reimburses an organization for employee theft.
- **Fiduciary Bond—**Guarantees that an individual or organization will safeguard assets of another that have been placed under their control.
- **Guardian Bond—**Guarantees that an individual or organization will safeguard assets of another that have been placed under their control.
- **Indemnity—**The principal's guarantee to reimburse the surety for any loss it might sustain on a bond.
- **Judicial Bond—Court Bond—**Guarantees that a judgment will be paid if an appeal is lost.
- **License & Permit Bond—**Guarantees a person or organization will perform according to the laws and statutes of a particular business or industry.
- **Notary Bond—Public Official Bond—**Guarantees to the Local, State or Federal Government the honest performance of an elected or appointed government official.
- **Obligee—**The person or firm that is the beneficiary of the bond. The one who is protected.
- **Obligor—**The old name for the Principal. The party who is required to perform.
- **Payment Bond—**Guarantees a contractor will pay fees owed for labor and materials on a construction project.
- **Performance Bond—**Guarantees a contractor will perform according to the specifications in the construction contract.
- **Power of Attorney—**A legal instrument authorizing an agent of the surety to sign a bond on behalf of the surety as its attorney-in-fact.
- **Premium—**The premium is the cost of the bond, paid to the surety for providing the financial guarantee and for performing all underwriting. Unlike insurance, the premium is not based on a probability of loss. It

is strictly a fee for service. The premium charged is based on the Contract Amount, but may be a flat percentage rate. Premium rates vary by surety, but usually range from 1.5% to 3%.

- **Premium Adjustment—**If there is a change order issued on a contract the surety will issue a premium adjustment notice to charge or reduce premium if the contract goes up or down.
- **Principal—**The person or firm who is bonded to another entity by the surety.
- **Public Official Bond—**Guarantees to the Local, State or Federal Government the honest performance of an elected or appointed government official.
- **Reinsurance—**Like insurance companies, most Sureties will negotiate a contract with a large Reinsurance company. The Reinsurance Company will take a large portion of any major loss a surety might have. On large bonds the approval of the Reinsurance Company may be required.
- **Surety—**The entity guaranteeing the performance of the principal to the obligee.
- **Temporary Administrator Bond—Fiduciary Bond—**Guarantees that an individual or organization will safeguard assets of another that have been placed under their control.
- **Treasury Listing—**The US Government list of eligible sureties and the limits allowed to write a bond on federal contracts.
- **Underwriting—**A term borrowed from insurance. This is a process where the Surety investigates the Contractor's Character, Capacity and Capital to determine if the contractor is qualified, by the Surety's standards, to undertake the project. **This process is very much like qualifying for a loan, line of credit or Mortgage.**

Flood Insurance - A Detailed Look

Basic Flood Insurance Course

Section I - Introduction

Across the United States, flooding is the number 1 natural disaster, according to the Federal Emergency Management Agency. Flooding is generally defined as a temporary inundation of normally dry land, such as when a levee breaks, a river overflows its banks or water from springtime snow melts.

Heavy rains from late October through May mark the rainy season in the Northwestern U.S., bringing the majority of yearly rainfall to the region from intense storms over the Pacific Ocean. Western Washington and Northwest Oregon usually experience flooding each year during the rainy season. Rains cause riverbanks to overflow and levees to be breached, resulting in millions of dollars in damages. The situation is similar all over the United States, at different times of the year.

A homeowner's policy typically does not cover damage due to flooding, or what is known as "rising water." For that type of coverage, you need a separate flood policy, which is provided by the federal government's National Flood Insurance Program (NFIP) and is purchased through a local insurance agent. The distinction between the two types of coverages is that homeowner's insurance covers water falling from the sky; flood insurance covers water rising from the ground.

Many people may not think of flood insurance during the summer months. It is important to protect your property from flood damage all year-round. Winter flooding is a common and widespread natural hazard in the Northwest and threatens residents with thousands of dollars worth of damage to homes and businesses every year. Only flood insurance offers financial protection from flooding all year long.

Definitions Related to Flood Insurance

Act - The National Flood Insurance Act of 1968 and any amendments to it.

Actual Cash Value (ACV) - The cost to replace an insured item of property at the time of loss, less the value of physical depreciation.

Base Flood - The flood having a 1% chance of being equaled or exceeded in any given year.

Base Flood Elevation (BFE) - The elevation shown on the Flood Insurance Rate Map (FIRM) for Zones AE, AH, A1-A30, AR, AR/A, AR/AE, AR/A1-A30, AR/AH, AR/AO, V1-V30, and VE that indicates the water surface elevation resulting from a flood that has a 1% chance of equaling or exceeding that level in any given year.

Basement - Any area of the building, including any sunken room or sunken portion of a room, having its floor below ground level (subgrade) on all sides.

Breakaway wall - A wall that is not part of the structural support of the building and is intended through its design and construction to collapse under specific lateral loading forces, without causing damage to the elevated portion of the building or supporting foundation system.

Community - A political entity that has the authority to adopt and enforce floodplain ordinances for the area under its jurisdiction. In most cases, a community is an incorporated city, town, township, borough, village, or an unincorporated area of a county or parish. However, some states have statutory authorities that vary from this description.

Community Rating System (CRS) - A program developed by the FEMA Mitigation Division to provide incentives for those communities in the National Flood Insurance Program that have gone beyond the minimum floodplain management requirements to develop extra measures to provide protection from flooding.

Condominium - That form of ownership of real property in which each unit owner has an undivided interest in common elements.

Elevated Building - A building that has no basement and has its lowest elevated floor raised above the ground level by foundation walls, shear walls, posts, piers, pilings, or columns. Solid foundation perimeter walls are not an acceptable means of elevating buildings in V and VE zones.

Elevation Certificate - A certificate that verifies the elevation data of a structure on a given property relative to the ground level. The Elevation Certificate is used by local communities and builders to ensure compliance with local floodplain management ordinances and is also used by insurance agents and companies in the rating of flood insurance policies.

Emergency Program - The initial phase of a community's participation in the National Flood Insurance Program. During this phase, only limited amounts of insurance are available under the Act.

Enclosure - That portion of an elevated building below the lowest elevated floor that is either partially or fully shut-in by rigid walls.

Federal Emergency Management Agency (FEMA) - The federal agency within the Department of Homeland Security that is tasked with responding to, planning for, recovering from, and mitigating against man-made and natural disasters.

Federal Policy Fee - A flat charge that the policyholder must pay on each new or renewal policy to defray certain administrative expenses incurred in carrying out the National Flood Insurance Program.

Flood - A general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties (at least one of which is the policyholder's property) from one of the following:

- Overflow of inland or tidal waters
- Unusual and rapid accumulation or runoff of surface waters from any source
- Mudflow
- Collapse or subsidence of land along the shore of a lake or similar body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels that result in a flood as defined above

Flood Disaster Protection Act (FDPA) of 1973 - Made the purchase of flood insurance mandatory for the protection of property located in Special Flood Hazard Areas.

Flood Hazard Boundary Map (FHBM) - Official map of a community issued by the Federal Insurance Administrator, where the boundaries of the flood, mudflow, and related erosion areas having special hazards have been designated.

Flood Insurance Rate Map (FIRM) - Official map of a community on which the Mitigation Division Administrator has delineated both the special hazard areas and the risk premium zones applicable to the community.

Flood Zone (Zone) - A geographical area shown on a Flood Hazard Boundary Map or a Flood Insurance Rate Map that reflects the severity or type of flooding in the area.

Floodplain - Any land area susceptible to being inundated by floodwaters from any source.

Floodplain Management - The operation of an overall program of corrective and preventive measures for reducing flood damage, including but not limited to, emergency preparedness plans, flood control works, and floodplain management regulations.

Grandfathering - An exemption based on circumstances previously existing. Under the NFIP, buildings located in Emergency Program communities and Pre-Flood Insurance Rate Map buildings in the Regular Program are eligible for subsidized flood insurance rates. Post-Flood Insurance Rate Map buildings in the Regular Program built in compliance with the floodplain management regulations in effect at the start of construction will continue to have favorable rate treatment even though higher base flood elevations or more restrictive, greater risk zone designations result from Flood Insurance Rate Map revisions.

Group Flood Insurance Policy (GFIP) - Issued by the NFIP Direct Program in response to a presidential disaster declaration. Disaster assistance applicants, in exchange for a modest premium, receive a minimum amount of building and/or contents coverage for a 3-year policy period. An applicant may cancel the group policy at any time and secure a regular Standard Flood Insurance Policy through the NFIP.

Increased Cost of Compliance (ICC) - Coverage for expenses a property owner must incur, above and beyond the cost to repair the physical damage the structure actually sustained from a flooding event, to comply with mitigation requirements of state or local floodplain management ordinances or laws. Acceptable mitigation measures are elevation, flood-proofing, relocation, demolition, or any combination thereof.

Lowest Floor - The lowest floor of the lowest enclosed area (including a basement). An unfinished or flood-resistant enclosure, usable solely for parking of vehicles, building access, or storage in an area other than a basement area, is not considered a building's lowest floor provided that such enclosure is not built so as to render the structure in violation of requirements.

Mandatory Purchase - Under the provisions of the Flood Disaster Protection Act of 1973, individuals, businesses, and others buying, building, or improving property located in identified areas of special flood hazards within participating communities are required to purchase flood insurance as a prerequisite for receiving any type of direct or indirect federal financial assistance (e.g., any loan, grant, guaranty, insurance, payment, subsidy, or disaster assistance) when the building or personal property is the subject of or security for such assistance.

Manufactured (Mobile) Home - A structure built on a permanent chassis, transported to its site in one or more sections, and affixed to a permanent foundation. "Manufactured (mobile) home" does not include recreational vehicles.

Mitigation Division - A division under FEMA that manages the NFIP and oversees FEMA's mitigation programs.

Mobile Home - see entry for Manufactured Home

National Flood Insurance Program (NFIP) - A federal program enabling property owners in participating communities to purchase insurance protection against losses from flooding. This insurance is designed to provide an insurance alternative to disaster assistance to meet the escalating costs of repairing damage to buildings and their contents caused by floods.

National Flood Insurance Reform Act (NFIRA) - The purpose of the National Flood Insurance Reform Act of 1994 is to improve the financial condition of the NFIP and reduce federal expenditures for disaster assistance to flood-damaged properties. The act affects every part of NFIP, insurance, mapping and floodplain management. NFIRA also gives lenders tools with which to enforce requirements for flood insurance coverage mandated under the Flood Disaster Protection Act of 1973.

Non-Residential - Includes, but is not limited to: small business concerns, churches, schools, farm buildings (including grain bins and silos), pool houses, clubhouses, recreational buildings, mercantile structures, agricultural and industrial structures, warehouses, hotels and motels with normal room rentals for less than 6 months' duration, and nursing homes.

Non-Special Flood Hazard Area (NSFHA) - An area in a low to moderate risk flood zone (Zones B, C, X) that is not in any immediate danger from flooding caused by overflowing rivers or hard rains. However, it's important to note that structures within a NSFHA are still at risk.

Other Residential - Hotels and motels where the normal occupancy of a guest is 6 months or more; a tourist home or rooming house which has more than four roomers. A residential building (excluding hotels and motels with normal room rentals for less than 6 months' duration) containing more than four dwelling units. Incidental occupancies such as office, professional private school, or studio occupancy, are permitted if the total area of such incidental occupancies is limited to less than 25 percent of the total floor area within the building.

Participating Community - A community for which the Mitigation Division Administrator has authorized the sale of flood insurance under the NFIP.

Policy - The entire written contract between the insured and the insurer. It includes: the printed policy form, the application and Declarations Page, any endorsement(s) that may be issued, and any renewal certificate indicating that coverage has been instituted for a new policy and new policy term.

Post-FIRM Building - A building for which construction or substantial improvement occurred after December 31, 1974, or on or after the effective date of an initial Flood Insurance Rate Map (FIRM), whichever is later.

Pre-FIRM Building - A building for which construction or substantial improvement occurred on or before December 31, 1974, or before the effective date of an initial Flood Insurance Rate Map (FIRM).

Preferred Risk Policy (PRP) - A policy that offers fixed combinations of building/contents coverage or contents-only coverage at modest, fixed premiums. The PRP is available for property located in B, C, and X zones in Regular Program communities that meet eligibility requirements based on the property's flood loss history.

Probation Surcharge (Premium) - A flat charge that the policyholder must pay on each new or renewal policy issued covering property in a community that the NFIP has placed on probation under the provisions of 44 CFR 59.24.

Regular Program - The final phase of a community's participation in the National Flood Insurance Program. In this phase, a Flood Insurance Rate Map is in effect and full limits of coverage are available under the Act.

Replacement Cost Value (RCV) - The cost to replace property with the same kind of material and construction without deduction for depreciation.

Residential Condominium Building Association Policy (RCBAP) - Policy issued to insure a residential condominium building and all units within the building, provided that the building is located in a Regular Program Community and at least 75 percent of the total floor area is residential.

Single-Family Residence - A residential single family dwelling. Incidental office, professional, private school, or studio occupancies, including a small service operation, are permitted if such incidental occupancies are limited to less than 50 percent of the building's total floor area.

Special Flood Hazard Area (SFHA) - A FEMA-identified high-risk flood area where flood insurance is mandatory for properties. An area having special flood, mudflow, or flood-related erosion hazards, and shown on a Flood Hazard Boundary Map or a Flood Insurance Rate Map as Zone A, AO, A1-A30, AE, A99, AH, AR, AR/A, AR/AE, AR/AH, AR/AO, AR/A1-A30, V1-V30, VE, or V.

Standard Flood Insurance Policy (SFIP) - Policy issued to insure a building and/or its contents.

Submit-for-Rate - An application for flood insurance on a building for which no risk rate is published in the Flood Insurance Manual. Insurance coverage can be obtained only after the NFIP has approved the application and has established the risk premium rate.

2 to 4 Family Residence - A residential building (excluding hotels and motels with normal room rentals for less than 6 months' duration) containing no more than four dwelling units. Incidental occupancies such as office, professional, private school, or studio space are permitted if the total area of such occupancies is limited to less than 25 percent of the total floor area within the building.

Waiting Period - The time between the date of application and the policy effective date.

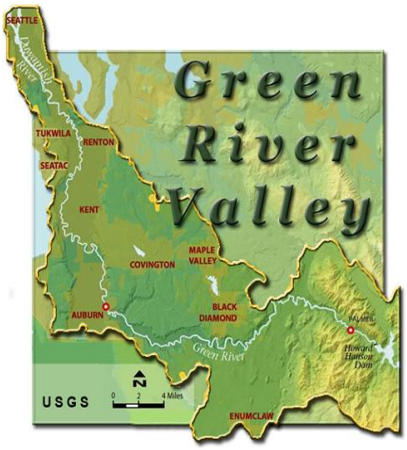
Wave Height Adjustment - A measurement that is added to the base flood elevation for V Zones shown on the Flood Insurance Rate Map published prior to 1981. For coastal communities, the base flood elevation shown on Flood Insurance Rate Maps published prior to 1981 are still-water elevations, which include only the effects of tide and storm surge, and not the height of wind-generated waves.

Write Your Own (WYO) Program - A cooperative undertaking of the insurance industry and FEMA begun in October 1983. The WYO Program operates within the context of the NFIP and involves private insurance carriers who issue and service NFIP policies.

Zone - A geographical area shown on a Flood Hazard Boundary Map or a Flood Insurance Rate Map that reflects the severity or type of flooding in the area.

Insurance Commissioner's Web site Offers Advice and Suggestions

In the event that a flood occurs or there is an area in danger of flooding, the Washington State Insurance Commissioner's office tries to provide educational information for residents on their Web site at www.insurance.wa.gov. Below is a posting from their Web site on June 2010:



Important note for property owners in the Green River Valley:

A weakened abutment adjacent to the Howard Hanson Dam means that the U.S. Army Corps of Engineers may have to release more water than usual to avoid stressing the dam.

Because of the heightened risk of flooding from these releases, our office is strongly recommending that property owners in the area consider getting federal flood insurance immediately. We've built this web page with information about federal coverage, typical costs, and disaster preparation tips.

Businesses in the area have also been struggling to find coverage above the federal commercial flood insurance maximum of $500,000 for buildings and $500,000 for contents. Insurance Commissioner Mike Kreidler has been urging insurers to continue selling policies in the area. Our office is also considering asking state lawmakers for more power to intervene in cases like this when an insurance market essentially dries up.

Also, Washington State's Emergency Management Division has extensive information about flooding and steps you can take to avoid damage and protect against losses. They've also posted a lengthy section with myths and facts about the National Flood Insurance Program, such as the myth that the NFIP won't cover anything in the basement. (It covers many things, including furnaces, water heaters, sump pumps, washers/dryers, staircases, some drywall, cleaning and the foundation.) The EMD also has extensive information on pumping out basements, what to do after draining it, mold, sandbagging, and how to protect a home from sewer backups during flooding.

The Washington Flood Market Assistance Plan (WFMAP)

This voluntary program helps match businesses seeking additional flood coverage with insurers selling it. All applications must be submitted by an insurance producer or broker.

Where should I start?

As a starting point, we're recommending that any businesses, renters, homeowners and other property owners strongly consider getting flood insurance through the National Flood Insurance Program, at www.floodsmart.gov or 1-888-379-9531.

What's the maximum federal flood coverage?

In general, it's $500,000 for a building and $500,000 for contents. And for many businesses, that's not enough. That's why we launched the Washington Flood Market Assistance Program: to help businesses in need get additional coverage.

Who can apply for the Washington Flood Market Assistance Plan?

Businesses in the Green River Valley that are at risk for flooding due to increased water release from the Howard Hanson Dam.

What sort of coverage is available?

The program is taking applications for excess flood and business interruption coverage.

How do I apply?

Applications must be submitted by an agent or broker. If you don't have one, the Market Assistance Plan administrator – the Surplus Line Association of Washington – can help refer you to one. Call (206) 682-3409 or e-mail them at WFMAP@surpluslines.org. Information is also posted on their website at www.surpluslines.org.

When will the program start accepting applications?

They're ready now.

Can you guarantee coverage?

No. Neither the insurance commissioner's office nor the program can guarantee that everyone will be able to get coverage. Some businesses still may not be able to qualify, or may not be able to afford the coverage they're offered.

How much will it cost?

It's impossible to say without knowing the details of your situation. Each of the participating companies can set its own premiums, and the cost also depends on how much coverage you want, where you're located, and other factors.

What is Covered by Flood Insurance – and What's Not

Generally, physical damage to your building or personal property "directly" caused by a flood is covered by your flood insurance policy. For example, damages caused by a sewer backup are covered if the backup is a direct result of flooding. However, if the backup is caused by some other problem, the damages are not covered.

Flood Facts:

- The average premium in Washington state is approximately $650 per year for $200,000 of coverage.
- In low-to-moderate risk areas, you can buy coverage for around $130 a year.
- To qualify for full replacement coverage, you must insure your primary home for 80% of its value, or the maximum amount, which is $250,000 for your house and $100,000 for its contents.
- There is a **30-day waiting period** from the time you buy a policy until you are covered – with a couple of exceptions. There is no waiting period when a lender makes, increases, extends or renews a home or business loan.
- When you close the loan, the lender will need a copy of the completed flood insurance application and a copy of the check or a paid receipt. There are no binders or certificates of insurance in flood coverage.
- A flood insurance policy also reimburses you up to $1,000 for the cost of reasonable actions you take to prevent flood damage and up to $1,000 for any property you move to safety when buildings are in danger of flooding.
- Floods and flash floods happen in all 50 states - Everyone lives in a flood zone.
- Most homeowner's insurance does not cover flood damage.
- If you live in a Special Flood Hazard Area (SFHA) or high risk area, your mortgage lender requires you to have flood insurance.
- Just an inch of water can cause costly damage to your property.
- Flash floods often bring walls of water 10 to 20 feet high.
- A car can easily be carried away by just two feet of floodwater.
- Hurricanes, winter storms and snow melt are common but often overlooked causes of flooding.
- New land development can increase flood risk, especially if the construction changes natural runoff paths.
- Federal disaster assistance is usually a loan that must be paid back with interest. For a $50,000 loan at 4% interest, the monthly payment would be around $240 a month ($2,880 a year) for 30 years. Compare that to a $100,000 flood insurance premium, which is about $400 a year.
- If you live in a low to moderate risk area and are eligible for the Preferred Risk Policy, the flood insurance premium may be as low as $130 a year, including coverage for the property's contents.
- Anyone is eligible to purchase flood insurance as long as the community participates in the National Flood Insurance Program.
- All claims and expenses of the NFIP are funded by insurance premiums, not tax dollars.

PREPARE

Residents in areas susceptible to winter flooding need to prepare in advance for flood conditions. Before the threat of flooding becomes imminent, residents should:

- Purchase a flood insurance policy if they do not already have one.
- Review their current insurance policy and become familiar with what is and is not covered.
- Make a flood plan. Plan evacuation routes. Keep important papers in a safe, waterproof place.
- Itemize and take pictures of possessions.

WINTER FLOOD RISKS

Coastal floods: Winds generated from intense winter storms can cause widespread tidal flooding and severe beach erosion along coastal areas.

Ice jams: Long cold spells can cause rivers and lakes to freeze. A rise in the water level or a thaw breaks the ice into large chunks that become jammed at manmade and natural obstructions. An ice jam can act as a dam, resulting in severe flooding.

Snowmelt: A sudden thaw of a heavy snow pack that often leads to flooding.

Mudflow (or debris flow): It develops when water rapidly accumulates in the ground, such as during heavy rainfall or rapid snowmelt, changing the earth into a flowing river of mud.

LEVEES AND FLOODING: PROTECTION WITH RISK

The West Coast has thousands of miles of levees—embankments along waterways, usually made of earth, designed to protect the lives and properties behind them from floods. However, no levee provides full protection from flooding and increased rains during the winter months can affect the ability of a levee to effectively contain rising waters. All levees are designed to provide a specific level of protection, and can be overtopped, or fail, in larger flood events. Levees also require regular maintenance to retain their level of protection. The fact is, levees can and do decay over time, and maintenance can become a serious challenge. When levees do fail, or are overtopped, they fail catastrophically—the flood damage may be more significant than if the levee was not there. For these reasons, the millions of people on the West Coast living behind levees need to understand the flood risks they face and take steps to address them.

If your community contains a levee, there are things you can do to protect yourself and reduce the impact of flood events. First, be sure you understand your risk for flooding. Local officials can provide more information about the levee and related flood risks based on the location of the property. Second, obtain flood insurance—it is critically important to financially protect your investment. Although areas behind levees that can be shown to protect against the one-percent-annual-chance flood will be shown on flood hazard maps as moderate-risk areas, FEMA strongly recommends flood insurance protection for all properties behind levees. Finally, please be aware of and always adhere to local evacuation procedures.

It is important to know that if someone has a federally backed mortgage on a home located in a high-risk area, federal law requires one to purchase flood insurance. Also, if you've received a federal grant for previous flood losses, you must have a flood policy to qualify for future aid.

Consumers can visit www.FloodSmart.gov or call 1-800-427-2419 to learn how to prepare for floods, how to purchase a National Flood Insurance policy and the benefits of protecting your home and property against flooding.

- Floods are the #1 most common natural disaster in the United States.

- In the past 10 years (1999-2008) the average flood insurance claim paid in the US was more than $49,529 per year.
- In the past 10 years (1999-2008) the NFIP paid over $27,639,087,687 to flood insurance customers.
- The average premium for a yearly flood insurance policy is around $558.
- 24.4% percent of all flood insurance claims are filed in moderate-to-low risk areas.
- The NFIP paid $3,202,783,762 in claims to-date to homeowners, business owners, and renters in 2008.

Significant Flood Events

1978 - February 29, 2012

A significant event is one with 1,500 or more paid losses, or occasionally one added for other reasons. Events have been named according to the most popular name at the time the events occurred, or if there is no apparent name, one has been created for this report. Event naming is a subjective thing; an event may begin as a hurricane, change to a tropical storm or be nothing but a heavy rain in some states. But this report attempts to use a single name, and include counties in federally declared disaster areas.

EVENT	YEAR	# PD LOSSES	AMOUNT PD ($)	AVG PD LOSS
MASSACHUSETTS FLOOD FEB. 1978	Feb-78	2,202	$20,145,418.33	$9,148.69
LOUISIANA FLOOD MAY 1978	May-78	7,343	$43,422,438.91	$5,913.45
WV, IN, KY, OH FLOODS DEC 1978	Dec-78	1,879	$11,934,511.73	$6,351.52
PA, CT, MA, NJ, NY, RI FLOODS	Jan-79	8,826	$31,487,015.13	$3,567.53
ND, MN FLOODS	Apr-79	2,141	$10,360,266.21	$4,838.98
TEXAS FLOOD APRIL 1979	Apr-79	1,954	$20,131,417.57	$10,302.67
FLORIDA FLOOD APRIL 1979	Apr-79	1,488	$2,029,162.54	$1,363.68
TROPICAL STORM CLAUDETTE	Jul-79	9,664	$147,295,362.98	$15,241.66
HURRICANE FREDERIC	Sep-79	2,947	$45,809,310.50	$15,544.39
TEXAS FLOOD SEPTEMBER 1979	Sep-79	6,261	$47,085,222.42	$7,520.40
NJ, CT & NY FLOODS APRIL 1980	Apr-80	2,159	$7,156,481.04	$3,314.72
LOUISIANA FLOOD APRIL 1980	Apr-80	12,831	$86,279,353.81	$6,724.29
HURRICANE ALLEN	Aug-80	3,636	$27,454,134.45	$7,550.64
TEXAS FLOOD EVENT JUNE 1981	Jun-81	2,143	$13,414,893.25	$6,259.87
TEXAS FLOOD AUGUST 1981	Aug-81	2,740	$20,958,041.97	$7,648.92
LOUISIANA FLOOD APRIL 1992	Apr-82	3,187	$20,785,521.50	$6,521.97
RI, MA, CT FLOODS JUNE 1982	Jun-82	2,189	$15,684,430.91	$7,165.11
THE 'NO-NAME STORM'	Jun-82	2,921	$10,474,434.61	$3,585.91
MO, IL FLOODS DECEMBER 1982	Dec-82	3,172	$29,851,938.25	$9,411.08
LOUISIANA FLOOD DECEMBER 1982	Dec-82	1,636	$12,917,414.94	$7,895.73
LOUISIANA FLOOD APRIL 1983	Apr-83	11,581	$104,833,840.57	$9,052.23
ALICIA	Aug-83	10,518	$119,388,680.96	$11,350.89
NEW JERSEY FLOOD MARCH 1984	Mar-84	4,096	$22,163,536.77	$5,411.02
NEW JERSEY FLOOD APRIL 1984	Apr-84	2,471	$33,300,119.43	$13,476.37
KENTUCKY FLOOD MAY 1984	May-84	2,654	$32,623,471.81	$12,292.19
ELENA	Aug-85	8,234	$81,322,382.63	$9,876.41
GLORIA	Sep-85	6,088	$39,194,422.25	$6,437.98
ISABEL OCTOBER 1985	Oct-85	1,612	$5,769,194.91	$3,578.91
JUAN	Oct-85	6,187	$90,987,477.71	$14,706.24
CALIFORNIA FLOOD FEBRUARY 1986	Feb-86	2,003	$34,838,405.74	$17,393.11
LOUISIANA FLOOD APRIL 1988	Apr-88	3,003	$17,124,219.43	$5,702.37

TEXAS FLOOD MAY 1989	May-89	2,562	$59,020,119.73	$23,036.74
TROPICAL STORM ALLISON 1989	Jun-89	3,127	$39,303,958.20	$12,569.22
HURRICANE CHANTEL	Aug-89	2,919	$39,510,677.40	$13,535.69
HUGO	Sep-89	12,840	$376,433,739.21	$29,317.27
LOUISIANA FLOOD NOVEMBER 1989	Nov-89	4,455	$48,911,212.86	$10,978.95
LOUISIANA FLOOD JUNE 1991	Jun-91	1,919	$15,832,141.33	$8,250.20
BOB	Aug-91	2,821	$49,707,690.10	$17,620.59
HALLOWEEN	Oct-91	9,541	$143,158,312.04	$15,004.54
DE, NJ, PR FLOODS JANUARY 1992	Jan-92	3,211	$30,087,520.84	$9,370.14
TEXAS FLOOD MARCH 1992	Mar-92	2,353	$50,956,062.51	$21,655.79
ANDREW	Aug-92	5,587	$169,113,346.96	$30,269.08
NOR'EASTER - 1992	Dec-92	25,142	$346,150,356.20	$13,767.81
MARCH STORM	Mar-93	9,840	$212,596,101.15	$21,605.29
MIDWEST FLOOD	Jun-93	10,472	$272,819,514.94	$26,052.28
TEXAS FLOOD OCTOBER 1994	Oct-94	6,226	$217,628,439.88	$34,954.78
CA FLOOD JANUARY 1995	Jan-95	3,410	$74,842,842.80	$21,948.05
LOUISIANA FLOOD	May-95	31,343	$585,071,592.53	$18,666.74
OPAL	Oct-95	10,343	$405,527,542.84	$39,207.92
NORTHEAST FLOOD - JAN 1996	Jan-96	12,523	$186,623,944.29	$14,902.50
NORTHWEST FLOOD	Feb-96	2,329	$61,903,974.17	$26,579.64
BERTHA	Jul-96	1,166	$10,388,363.93	$8,909.40
FRAN	Sep-96	10,315	$217,843,971.95	$21,119.14
HORTENSE	Sep-96	1,381	$20,215,202.17	$14,638.09
JOSEPHINE	Oct-96	6,512	$102,604,271.84	$15,756.18
NORTHEAST FLOOD - OCT 1996	Oct-96	3,480	$40,837,392.03	$11,734.88
CALIFORNIA FLOOD DECEMBER 1996	Dec-96	1,858	$39,699,758.98	$21,366.93
SOUTH CENTRAL FLOOD	Feb-97	4,529	$100,469,720.92	$22,183.64
UPPER MIDWEST FLOOD	Apr-97	7,398	$160,101,054.48	$21,641.13
PINEAPPLE EXPRESS	Jan-98	4,227	$57,680,410.10	$13,645.71
NOR'EASTER	Feb-98	3,212	$28,011,200.64	$8,720.80
HURRICANE BONNIE	Aug-98	2,675	$23,073,621.36	$8,625.65
TEXAS FLOOD SEPTEMBER 1998	Sep-98	4,876	$78,402,841.56	$16,079.34
LOUISIANA FLOOD SEPTEMBER 1998	Sep-98	5,176	$50,999,757.88	$9,853.12
HURRICANE GEORGES (KEYS)	Sep-98	3,437	$43,208,305.71	$12,571.52
HURRICANE GEORGES	Sep-98	9,097	$154,169,745.43	$16,947.32
HURRICANE GEORGES (PANHANDLE)	Sep-98	1,679	$23,137,642.05	$13,780.61
TEXAS FLOOD OCTOBER 1998	Oct-98	3,191	$143,784,089.40	$45,059.26
HURRICANE FLOYD	Sep-99	20,438	$462,281,155.94	$22,618.71
HURRICANE IRENE	Oct-99	13,682	$117,858,779.18	$8,614.15
FLORIDA FLOOD OCTOBER 2000	Oct-00	9,276	$158,283,181.69	$17,063.73
TROPICAL STORM ALLISON - 2001	Jun-01	30,663	$1,103,877,235.13	$36,000.30
TROPICAL STORM GABRIELLE	Sep-01	2,418	$34,836,088.37	$14,406.98
TEXAS FLOOD JULY 2002	Jul-02	1,896	$70,634,069.06	$37,254.26
TROPICAL STORM ISADORE	Sep-02	8,442	$113,691,962.38	$13,467.42
HURRICANE LILI	Oct-02	2,563	$36,902,124.97	$14,398.02
TEXAS FLOOD OCTOBER 2002	Oct-02	3,250	$88,984,769.13	$27,379.93
HURRICANE ISABEL	Sep-03	19,865	$493,291,519.30	$24,832.19

HURRICANE CHARLEY	Aug-04	2,608	$50,821,389.75	$19,486.73
HURRICANE FRANCES	Sep-04	4,963	$152,821,259.04	$30,792.11
HURRICANE IVAN	Sep-04	27,649	$1,586,783,562.52	$57,390.27
HURRICANE JEANNE	Sep-04	5,378	$127,785,308.92	$23,760.75
HURRICANE DENNIS	Jul-05	3,806	$119,805,748.02	$31,478.13
HURRICANE KATRINA	Aug-05	167,585	$16,246,557,388.32	$96,945.18
HURRICANE RITA	Sep-05	9,514	$472,092,332.33	$49,620.80
TROPICAL STORM TAMMY	Oct-05	4,116	$44,773,505.48	$10,877.92
HURRICANE WILMA	Oct-05	9,615	$365,061,170.03	$37,967.88
PA, NJ, NY FLOODS JUNE 2006	Jun-06	6,420	$228,414,751.74	$35,578.62
HURRICANE PAUL	Oct-06	1,507	$37,261,288.66	$24,725.47
NOR'EASTER APRIL 2007	Apr-07	8,638	$225,727,099.62	$26,131.87
TORRENTIAL RAIN JUNE 2008	Jun-08	3,364	$141,506,107.88	$42,064.84
HURRICANE GUSTAV	Sep-08	4,539	$112,249,205.03	$24,729.94
HURRICANE IKE	Sep-08	46,349	$2,649,609,508.16	$57,166.49
TORRENTIAL RAIN MARCH 2009 TX	Mar-09	3,300	$127,463,539.06	$38,625.31
TORRENTIAL RAIN SEPT 2009 GA	Sep-09	2,050	$120,710,927.30	$58,883.38
TROPICAL STORM IDA VA	Nov-09	5,661	$101,882,685.28	$17,997.29
2010 NOREASTER	Mar-10	10,080	$194,246,954.51	$19,270.53
TORRENTIAL RAIN - TN	Apr-10	4,104	$227,379,303.74	$55,404.31
TORRENTIAL RAIN - NJ	Mar-11	1,857	$36,124,777.60	$19,453.30
MID-SPRING STORMS	Apr-11	4,138	$128,354,180.77	$31,018.41
HURRICANE IRENE	Aug-11	42,143	$1,182,164,764.50	$28,051.27
TROPICAL STORM LEE	Sep - 11	9,399	$395,932,477.76	$42,124.96

Flood Basics

Floods are one of the most common hazards in the United States. Flood effects can be local, impacting a neighborhood or community, or very large, affecting entire river basins and multiple states.

However, all floods are not alike. Some floods develop slowly, sometimes over a period of days. But flash floods can develop quickly, sometimes in just a few minutes and without any visible signs of rain. A flash flood often has a dangerous wall of roaring water that carries rocks, mud, and other debris and can sweep away most things in its path. Overland flooding occurs outside a defined river or stream, such as when a levee is breached, but still can be destructive. Flooding can also occur when a dam breaks, producing effects similar to a flash flood.

The ***definition of flood*** is a general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties (at least one of which is the policyholder's property) from one of the following:

- Overflow of inland or tidal waters
- Unusual and rapid accumulation or runoff of surface waters from any source
- Mudflow
- Collapse or subsidence of land along the shore of a lake or caused by waves or currents of water exceeding anticipated similar body of water as a result of erosion or undermining cyclical levels that result in a flood as defined above.

Flood Insurance: What, Why and How

The causes of flooding are many and varied. Hurricanes and tropical storms cause floods that can create far more than strong winds. Nor'easters, or extra-tropical cyclones, also cause flooding. Heavy rains, winter storms, spring thaws, and overburdened or clogged drainage systems lead to property damage outside floodplains. Construction and new development affect natural drainage and cause flooding.

Floods often happen when bodies of water overflow or tides rise due to heavy rainfall or thawing snow. But you don't have to live near water to be at risk of flooding. A flash flood, which can strike anywhere without warning, occurs when a large volume of rain falls within a short time.

More and more buildings, roads and parking lots are being built where forests and meadows used to be, which decreases the land's natural ability to absorb water. Coupled with changing weather patterns, this construction has made recent floods more severe and increased everyone's chance of being flooded.

Dangerous or damaging floods don't always mean dramatic, rushing waters through the streets. Just a single inch of water can cause costly damage in areas that aren't accustomed to that rain.

> **Flash Flood Watch**: Flash flooding is possible. Be prepared to move to high ground; listen to NOAA Weather Radio, commercial radio, or television for information.
>
> **Flood Warning**: Flooding is occurring or will occur soon; if advised to evacuate, do so immediately.
>
> **Flash Flood Warning**: A flash flood is occurring; seek higher ground on foot immediately.

Flood insurance covers losses to your property caused by flooding. From structural and mechanical damage to flood debris cleanup and floor surfaces (like tile and carpeting), your investment is protected by a flood insurance policy, something that your homeowners policy does not offer.

In addition, you can purchase separate coverage that insures most of your personal property and belongings up to a specified limit, including:

- ✓ Clothing
- ✓ Furniture, house wares, bedding
- ✓ Decorative items, lamps and lighting fixtures
- ✓ Books, home electronics, computers
- ✓ Area rugs and draperies
- ✓ Clothes washers and dryers
- ✓ Air conditioners
- ✓ Food freezers and the food in them

Having flood insurance gives you many benefits. Not only is coverage there when you need it, but it also:

- ✓ Compensates for all covered losses.
- ✓ Compensates for flood damages even if federal disaster aid is unavailable.
- ✓ Pays for your covered losses, unlike interest-bearing loans through federal disaster assistance.
- ✓ Comes in low-cost policies for those who qualify.
- ✓ Guarantees compensation for flood damages because the Federal government backs NFIP flood insurance.
- ✓ Helps you move on – if your property is damaged by flood, your agent is there to help you handle your claim (note: most claims are paid within 30 to 60 days).

Purchasing Flood Insurance

Flood insurance policies are sold by the insurance industry through state-licensed property and casualty insurance agents and brokers who deal directly with FEMA and through private insurance companies with a program created in 1983 known as "Write Your Own" (WYO).

The WYO Program was started to increase the NFIP policy count and geographic distribution of policies by taking advantage of the private insurance industry's marketing channels and existing policy base to sell flood insurance. Many private insurance companies issue policies and adjust flood claims in their own names under the NFIP. The insurers receive an expense allowance and remit premium income in excess of this allowance to the Federal Government. FEMA pays losses through a letter of credit and sets the rates, coverage limitations, and eligibility requirements. The premium charged for NFIP flood coverage by a WYO Company is the same as that charged by the Federal Government through the direct program. Currently about 95% of the flood policies issued under the NFIP are written through the WYO Program.
The NFIP is not the only source of flood insurance. Businesses have been able to purchase flood insurance under Difference In Conditions policies from some insurance companies over the years. Flood coverage for residential homeowners has been more difficult to acquire from the private insurance market. The often catastrophic nature of flooding has kept most insurers, outside of the NFIP, from writing this coverage. There are companies, such as Lloyds of London, that will, on a limited basis, provide flood insurance to some properties.

NFIP Background

For decades, the national response to flood disasters was simply to provide disaster relief to flood victims. Efforts were also made to install flood-control constructions such as dams, levees, and seawalls.

Funded by citizen tax dollars, this approach failed to reduce losses. It also didn't provide a way to cover the damage costs of all flood victims. To compound the problem, the public generally couldn't buy flood coverage from insurance companies, because private insurance companies see floods as too costly to insure.

In the face of mounting flood losses and escalating costs of disaster relief to U.S. taxpayers, Congress established the National Flood Insurance Program (NFIP) in 1968. The goals of the program are to reduce future flood damage through floodplain management, and to provide people with flood insurance. More than 40 years later, the NFIP continues to offer flood insurance to homeowners, renters and business owners, provided their communities use the NFIP's strategies for reducing flood risk.

The National Flood Insurance Program (NFIP) is a federal program enabling property owners in participating communities to purchase insurance at reasonable rates to protect against losses from flooding. **This insurance is designed to provide an insurance alternative to disaster assistance** to meet the escalating costs of repairing damage to buildings and their contents caused by floods. The NFIP has an arrangement with private insurance companies to sell and service flood insurance policies. Many private insurance companies offer Excess Flood Protection, which provides higher limits of coverage than the NFIP, in the event of catastrophic loss by flooding.

The Mitigation Division, a component of the Federal Emergency Management Agency (FEMA), manages the National Flood Insurance Program (NFIP). The **three components of the NFIP** are:

- ***Flood Insurance***
- ***Floodplain Management***
- ***Flood Hazard Mapping***

Nearly 20,000 communities across the United States and its territories participate in the NFIP by adopting and enforcing floodplain management ordinances to reduce future flood damage. In exchange, the NFIP makes federally backed flood insurance available to homeowners, renters, and business owners in these communities.

Community participation in the NFIP is voluntary.

In addition to providing flood insurance and reducing flood damages through floodplain management regulations, the NFIP identifies and maps the Nation's floodplains. Mapping flood hazards creates broad-based awareness of the flood hazards and provides the data needed for floodplain management programs and to actuarially rate new construction for flood insurance.

Floodplain Management refers to an overall ***community program*** of corrective and preventive measures for reducing future flood damage. These measures generally include zoning, subdivision or building requirements, and special-purpose floodplain ordinances.

When a community chooses to join the NFIP, it must adopt and enforce minimum floodplain management standards for participation.

FEMA works closely with state and local officials to identify flood hazard areas and flood risks. Floodplain management requirements with Special Flood Hazard Areas (SFHAs) are designed to prevent new development from increasing the flood threat and to protect new and existing buildings from anticipated flood events.

Community Participation – A community is defined by the NFIP as any state, area, or political subdivision; any Indian tribe, authorized tribal organization, or Alaska native village; or authorized native organization that has the authority to adopt and enforce floodplain management ordinances for the area under its jurisdiction. In most cases, a community is an incorporated city, town, township, borough, or village, or an unincorporated area of a county or parish. However, some States have statutory authorities that vary from this description.

Emergency Program Defined – The initial phase of a community's participation in the National Flood Insurance Program. During this phase, only limited amounts of insurance are available under the Act.

Regular Program Defined – A federal program enabling property owners in participating communities to purchase insurance protection against losses from flooding. This insurance is designed to provide an insurance alternative to disaster assistance to meet the escalating costs of repairing damage to buildings and their contents caused by floods.

Community Rating System - The Community Rating System (CRS) is a program developed by the Mitigation Division to provide incentives for those communities in the Regular Program that have gone beyond the minimum floodplain management requirements to develop extra measures to provide protection from flooding. As a result, flood insurance premium rates are discounted to reflect the reduced flood risk.

Coastal Barrier Resources System and Other Protected Areas - The purchase of flood insurance is also limited in the Coastal Barrier Resources System. Congress passed laws limiting Federal expenditures in certain coastal areas and designating them as a part of the Coastal Barrier Resources System (CBRS) or as Otherwise Protected Areas (OPAs). In these areas, there is a prohibition for the expenditure of most Federal funds. These prohibitions refer to "any form of loan, grant, guarantee, insurance, payment, rebate, subsidy or any other form of direct or indirect Federal assistance," with specific and limited exceptions.

Older buildings constructed before dates established by the Coastal Barrier Resources Act of 1982 and the Coastal Barrier Improvement Act of 1990 remain eligible for Federal flood insurance while new construction or substantially improved structures located within these designated areas are not eligible for flood insurance.

If, at the time of a loss, it is determined that a policy has been inadvertently issued on new construction or substantial improvements located in a CBRS area, any claim will be denied, the policy canceled, and the premium refunded.

Eligible/Ineligible Buildings

Older buildings constructed before dates established by the Coastal Barrier Resources Act of 1982 and the Coastal Barrier Improvement Act of 1990 remain eligible for Federal flood insurance while new construction or substantially improved structures located within these designated areas are not eligible for flood insurance. If, at the time of a loss, it is determined that a policy has been inadvertently issued on new construction or substantial improvements located in a CBRS area, any claim will be denied, the policy canceled, and the premium refunded.

As a priority, the Flood Insurance Act of 1968 requires that flood insurance be made available to 1-4 family residential buildings, small businesses and churches. It also includes other residential properties, other business properties, agricultural properties, properties occupied by private nonprofit organizations, and properties owned by state or local governments.

Property owners in NFIP communities may purchase flood insurance whether the building or its contents is located in or outside the floodplain. In order to be eligible for flood insurance, a structure must have at least two solid walls and a roof, be principally above ground, and not entirely over water. This includes manufactured homes that are anchored to permanent foundations and travel trailers without wheels that are anchored to permanent foundations and are regulated under the community's floodplain management and building ordinances or laws. Contents of insurable walled and roofed buildings are insurable under the policy as a separate coverage.

Buildings entirely over water or principally below ground, gas and liquid storage tanks, animals, birds, fish aircraft, wharves, piers, bulkheads, growing crops, shrubbery, land, livestock, roads, machinery or equipment in the open, and generally motor vehicles are not insurable. Most contents and finishing building materials located in a basement are not covered. Similarly, this coverage limitation applies to enclosures below the lowest elevated floor of an elevated building constructed after the FIRM became effective.

FEMA can deny flood insurance "for any property which the Director finds has been declared by a duly constituted state or local zoning authority, or other authorized public body, to be in violation of state or local laws, regulations or ordinances."

Mandatory Purchase of Flood Insurance in High Flood Risk Zones

High Risk Areas - In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all A zones.

Coastal Areas - In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all V zones.

The law does not require flood insurance in low- to moderate-risk areas, however, during the life of the mortgage loan, if the flood maps are revised and the property is not in the high-risk area, the lender will notify the property owner that they must purchase flood insurance. If they do not purchase the flood insurance, the lender will force place it, which could be at a much higher rate. Also, even if you live in a low risk area, you are eligible to purchase a flood policy with the same coverage you would receive if you lived in a high-risk area, as long as the community participates in the NFIP, and possibly qualify for the Preferred Risk Policy which is a low cost flood insurance policy.

Purchase Recommended in Moderate and Low Flood Risk Zones

- Everyone lives in a flood zone.
- Most homeowners insurance does not cover flood damage.
- Dangerous or damaging floods don't always mean dramatic, rushing waters through the streets. Just a single inch of water can cause costly damage in areas that aren't used to that rain.
- If you live in a low to moderate risk area and are eligible for the Preferred Risk Policy, the flood insurance premium may be as low as $121 a year, and coverage for contents for as little as $39 per year.
- Federal disaster assistance is usually a loan that must be paid back with interest. For a $50,000 loan at 4% interest, the monthly payment would be around $240 a month ($2,880 a year) for 30 years. Compare that to a $100,000 flood insurance policy, which is about $400 a year.
- Roughly 25% of all claims paid by the NFIP (National Flood Insurance Program) are for policies in low-to moderate-risk communities.

Why Flood Insurance is Better than Disaster Assistance

Flood insurance is designed to provide an alternative to disaster assistance to reduce the escalating costs of repairing damage to buildings and their contents caused by floods. Flood damage is reduced by nearly $1 billion a year through communities implementing sound floodplain management requirements and property owners purchasing of flood insurance. Additionally, buildings constructed in compliance with NFIP building standards suffer approximately 80 percent less damage annually than those not built in compliance. And, every $3 paid in flood insurance claims saves $1 in disaster assistance payments.

Many people wrongly believe that the U.S. government will take care of all their financial needs if they suffer damage due to flooding. The truth is that Federal disaster assistance is only available if the President formally declares a disaster. Even if you do get disaster assistance, it's often a loan you have to repay, with interest, in addition to your mortgage loan that you still owe on the damaged property, and not compensation for losses.

When disaster strikes, flood insurance policyholder claims are paid even if a disaster is not federally declared. And flood insurance means you'll be reimbursed for all covered losses. Unlike Federal aid, it doesn't have to be repaid.

As long as a community participates in the NFIP, everyone in the community is eligible to purchase flood insurance. As a homeowner, you can insure a home up to $250,000 and its contents up to $100,000. A renter can cover belongings up to $100,000 and a non-residential property owner can insure the building and its contents up to $500,000.

Flood insurance policies are continuous, and are not non-renewed or canceled for repeat losses. In general, a policy does not take effect until 30 days after the purchase of the flood insurance. So, if the weather forecast announces a flood alert for a specific area, it's too late to purchase coverage.

Section II
Flood Maps and Zone Determinations

Flood maps are used to locate a property within a particular flood zone. When considering purchasing or renewing a flood insurance policy, you will need to know whether your property is in a low- to moderate or high-risk area to determine which policy is right for you.

Over the years, many of the government's flood insurance maps have become obsolete due to urban growth, changes to river flows and coastlines, and even flood mitigation efforts like drainage systems and levees. Accurate information is essential to inform property owners of emerging flood risks and to determine appropriate rates for insurance coverage.

Map Modernization is FEMA's response to the need to update and maintain flood hazard maps. This initiative is creating digital flood insurance rate maps (DFIRMs) for more than 20,000 communities across the U.S. In addition, the DFIRMs will become the platform for identifying other potential risks such as land erosion, deforestation and ice flows.

This five-year effort will transform flood maps into maps that are more accurate, easier-to-use and readily available to consumers. When Map Modernization is complete, you will be able to print and use these maps right from your desktop.

FEMA's commitment to this aggressive, multi-year initiative will save the government an estimated $45 billion over the next 50 years.

Flood Zones are geographic areas that the Federal Emergency Management Agency (FEMA) has defined according to varying levels of flood risk. These zones are depicted on a community's Flood Hazard Boundary Map or a Flood Insurance Rate Map (FIRM). Each zone reflects the severity or type of flooding in the area.

Moderate to Low Risk Areas

In communities that participate in the NFIP, flood insurance is available to all property owners and renters with moderate to low risk.

Zones B, C, and X

Areas with less than a 1% chance of flooding each year; areas that have less than a 1% chance of sheet flow flooding with an average depth of less than 1 foot; areas that have less than a 1% chance of stream flooding where the contributing drainage area is less than 1 square mile; or areas protected from floods by levees. No base flood elevations or depths are shown within these zones.

High Risk Areas

In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all A zones.

Zone A

Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. Because detailed analyses are not performed for such areas, no depths or base flood elevations are shown within these zones.

Zone AE and A1-A30

Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. In most instances, base flood elevations derived from detailed analyses are shown at selected intervals within these zones.

Zone AH

Areas with a 1% annual chance of shallow flooding, usually in the form of a pond, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.

Zone AO

River or stream flood hazard areas, and areas with a 1% or greater chance of shallow flooding each year, usually in the form of sheet flow, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Average flood depths derived from detailed analyses are shown within these zones.

Zone AR

Areas with a temporarily increased flood risk due to the building or restoration of a flood control system (such as a levee or a dam). Mandatory flood insurance purchase requirements will apply, but rates will not exceed the rates for unnumbered A zones if the structure is built or restored in compliance with Zone AR floodplain management regulations.

Zone A99

Areas with a 1% annual chance of flooding that will be protected by a Federal flood control system where construction has reached specified legal requirements. No depths or base flood elevations are shown within these zones.

High Risk – Coastal Areas

In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all V zones.

Zone V

Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. No base flood elevations are shown within these zones.

Zone VE and V1-30

Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.

Undetermined Risk Areas

Zone D

Areas with possible but undetermined flood hazards. No flood hazard analysis has been conducted. Flood insurance rates are commensurate with the uncertainty of the flood risk.

Flood Hazard Boundary Map (FHBM) – An official map of a community issued by the Administrator, where the boundaries of the flood, mudflow, and related erosion areas having special hazards have been designated.

Flood Insurance Rate Map (FIRM) – An official map of a community on which the Mitigation Division Administrator of FEMA has delineated both the special hazard areas and the risk premium zones applicable to the community. Each community that chooses to participate in the NFIP works closely with the Federal Emergency Management Agency (FEMA). Together, they collect the information needed to create an accurate Flood Insurance Rate Map (FIRM) and Flood Insurance Study (FIS) of the region. The FIRM and FIS will later be used to determine flood insurance rates for homeowners.

Pre-FIRM Defined– Referring to buildings, a Pre-FIRM building is a building for which construction or substantial improvement occurred on or before December 31, 1974, or before the effective date of an initial Flood Insurance Rate Map (FIRM).

Post-FIRM Defined – Referring to buildings, a Post-FIRM building is a building for which construction or substantial improvement occurred after December 31, 1974, or on or after the effective date of an initial Flood Insurance Rate Map (FIRM), whichever is later.

Special Flood Hazard Area Defined – A FEMA-identified high-risk flood area where flood insurance is mandatory for properties. An area having special flood, mudflow, or flood-related erosion hazards, and shown on a Flood Hazard Boundary Map or a Flood Insurance Rate Map as Zone A, AO, A1-A30, AE, A99, AH, AR, AR/A, AR/AE, AR/AH, AR/AO, AR/A1-A30, V1-V30, VE, or V.

Base Flood Elevation – BFE - The elevation shown on the Flood Insurance Rate Map (FIRM) for Zones AE, AH, A1-A30, AR, AR/A, AR/AE, AR/A1-A30, AR/AH, AR/AO, V1-V30, and VE that indicates the water surface elevation resulting from a flood that has a one percent chance of equaling or exceeding that level in any given year.

Zone Determination – A zone is a geographical area shown on a Flood Hazard Boundary Map or a Flood Insurance Rate Map that reflects the severity or type of flooding in the area.

Section III
Policies and Products Available

When you are a flood insurance policyholder:

- Unlike a homeowner's policy, **flood insurance is a single peril policy and covers losses to property** caused by flooding.
- Flood insurance compensates for all covered losses.
- Coverage is relatively inexpensive.
- You can depend on being reimbursed for flood damages, even if the President does not declare a Federal disaster.
- You do not have to repay a loan, as you might have to with many Federal disaster relief packages. Your covered losses are paid in full.
- You can count on your claim being paid in the event of a flood loss because NFIP flood insurance is backed by the Federal government.
- You can request a partial payment immediately after the flood, which can help you recover even faster.

Three important facts to remember about a flood insurance policy are:

1. Contents coverage must be purchased separately.

2. It is not a valued policy. A valued policy pays the limit of liability in the event of a total loss. For example: A home is totally destroyed by a fire and it costs $150,000 to rebuild. If the homeowner's insurance policy is a valued policy with a $200,000 limit of liability on the building, they would receive $200,000. **Flood insurance pays just the replacement cost or ACV of actual damages, up to the policy limit.**

3. It is not a guaranteed replacement cost policy. A guaranteed replacement cost policy pays the cost to rebuild the home regardless of the limit of liability. For example: The home is totally destroyed by a fire and it costs $200,000 to rebuild. If the homeowner's insurance policy is a guaranteed replacement cost policy with a $150,000 limit of liability on the building, they would receive $200,000. **Flood insurance does not pay more than the policy limit.**

There are two types of Flood Insurance Policies: The Standard Flood Insurance Policy (SFIP) and the Preferred Risk Policy (PRP)...

The Standard Flood Insurance Policy

The NFIP offers three different types of Standard Flood Insurance Policies. The forms for these policies provide policyholders with a description of their coverage and other important coverage information. The policy type is determined by how a building is occupied. You can download the following forms from the NFIP Web site.

Some of the things a standard flood policy will cover include:

- ***Structural damage***
- ***Furnace, water heater and air conditioner***
- ***Flood debris clean up***
- ***Floor surfaces such as carpeting and tile***

Contents coverage must be purchased separately to **cover the contents of the home**, such as furniture, collectibles, clothing, jewelry and artwork.

The Standard Flood Insurance Policy (SFIP) specifies the terms and conditions of the agreement of insurance between FEMA or a WYO company as the Insurer and the Insureds. Insureds in NFIP communities include owners, renters, and builders of buildings that are in the course of construction, condominium associations, and owners of residential condominium units.

Following are the three available policy forms depending on the occupancy of the building to provide coverage for the peril of flood:

1. The **Dwelling Form** is used to insure 1-4 family buildings and individual residential condominium units.

    - Detached, single-family, non-condominium residence with incidental occupancy limited to less than 50% of the total floor area.

- Two-to four- family, non-condominium building with incidental occupancy limited to less than 25% of the total floor area.
- Dwelling unit in residential condominium building.
- Residential townhouse.
- Manufactured mobile homes.

2. The **General Property Form** covers residential buildings of more than four families as well as non-residential risks.

- Apartment building
- Residential cooperative building
- Dormitory
- Assisted-living facility
- Shop, restaurant, or other business
- Mercantile building
- Grain bin, silo, or other farm building
- Agricultural or industrial processing facility
- Factory, warehouse
- Poolhouse, clubhouse, or other recreational building
- House of worship
- School
- Hotel or motel with normal guest occupancy of less than 6 months
- Licensed bed-and-breakfast inn
- Retail
- Nursing home
- Non-residential condominium
- Condo building with less than 75% of its total floor area in residential use
- Detached garage, tool shed
- Stock, inventory or other commercial contents

3. The **Residential Condominium Building Association Policy Form** insures associations under the condominium form of ownership.

- The Residential Condominium Building Association Policy Form is issued to residential condominium associations on behalf of association and unit owners.

- In participating NFIP Regular Program communities, it provides building coverage and, if desired, coverage of commonly owned contents for a residential condominium building with 75% or more of its total floor area in residential use.

Flood coverage limits for a standard flood policy are:

Coverage Type	Coverage Limit
One- to Four-family structure	$250,000
One- to Four-family home contents	$100,000
Other residential structures	$250,000
Other residential contents	$100,000
Business structure	$500,000
Business contents	$500,000
Renter contents	$100,000

Preferred Risk Policy – PRP

The Preferred Risk Policy – PRP - is issued on one of three available policy forms, depending on the occupancy of the building:

1. The **Dwelling Form** is used to insure 1-4 family buildings and individual residential condominium units.

2. The **General Property Form** covers residential buildings of more than four families as well as non-residential risks.

3. The **Residential Condominium Building Association Policy Form** insures associations under the condominium form of ownership.

The National Flood Insurance Program's **Preferred Risk Policy (PRP) offers lower-cost protection for homes and apartments in areas of low-to moderate-flood risk.** These areas outside of known floodplains are shown as B, C, or X zones on a Flood Insurance Rate Map.

Most single-family homes, town homes, and apartments in low risk areas are eligible for the lower PRP rates, as long as the building does not have a significant history of flooding. Most multi-unit condominium buildings do not qualify, though insurance for them is available at standard rates.

Flood damage is not covered under most homeowner policies, and there is no guarantee that federal assistance will be available when a flood occurs. If it is available, federal help may come in the form of a low-interest loan, which will have to be repaid. Applicants may be required to purchase a flood policy before being approved for federal assistance. The special Preferred Risk Policy only covers one-to four-family buildings. Insurance is offered at regular rates for buildings in higher risk areas and other types of properties.

The Preferred Risk Policy will not be issued if a property owner has received:

- Two flood loss payments of more than $1000 each.
- Three or more loss payments of any amount.
- Two Federal Disaster Relief payments of more than $1,000 each.
- Three Federal Disaster Relief payments of any amount.
- One flood insurance claim payment and one disaster relief payment of more than $1000 each (including loans and grants).

Structures are insured up to $250,000 and the contents of a home up to $60,000. Replacement cost coverage is also available for single-family, primary residences. Rates begin at around $120 per year for buildings without basements.

For Homeowners – Protecting Home and Its Contents

Several combinations of building and contents protection are available. You can buy $20,000 building coverage and $8,000 contents coverage for as little as $120 per year. Higher coverage combinations of up to $250,000/$100,000 are available. The following table is to be used as an example of costs, not as a rating device.

Family Residential Building & Content Coverage Combinations

With Basement/Enclosure			Without Basement/Enclosure		
Building	Contents	Premium	Building	Contents	Premium
$ 75,000	$ 30,000	$232	$ 75,000	$ 30,000	$207
$100,000	$ 40,000	$263	$100,000	$ 40,000	$233
$125,000	$ 50,000	$279	$125,000	$ 50,000	$249
$150,000	$ 60,000	$294	$150,000	$ 60,000	$264
$200,000	$ 80,000	$331	$200,000	$ 80,000	$296
$250,000	$100,000	$352	$250,000	$100,000	$317

For Renters – Protecting Personal Property

For as little as $39 per year, you can buy $8,000 of contents-only coverage. Higher limits up to $100,000 are available. (Coverage is not provided for contents located in basements only.) The following table is to be used as an example of costs, not as a rating device.

All Residential contents Only (1, 4)	
Contents Located Above Ground Level (More Than One Floor)	All Other Locations (Basement-Only Not Eligible)

Contents	Premium	Contents	Premium
$ 8,000	$ 39	$ 8,000	$ 61
$ 12,000	$ 53	$ 12,000	$ 86
$ 20,000	$ 81	$ 20,000	$116
$ 30,000	$ 93	$ 30,000	$131
$ 40,000	$105	$ 40,000	$146
$ 50,000	$117	$ 50,000	$156
$ 60,000	$129	$ 60,000	$166
$ 80,000	$153	$ 80,000	$181
$100,000	$177	$100,000	$196

1-Add the $50.00 Probation Surcharge, if applicable.
2-Premium includes Federal Policy Fee of $11.00.
3-Premium includes ICC premium of $1.00. Deduct this amount if the risk is a townhouse condo unit.
4-Contents-only policies are not available for contents located in basement only.

Condominium associations are not eligible for the Preferred Risk Policy. Individual condominium units are not eligible unless they qualify under one of the exceptions. The deductibles apply separately to building and contents. Building deductible, $500; Contents deductible, $500.

These figures change periodically. Please check the Web site at www.fema.gov/business/nfip/prphome.shtm for the most up-to-date figures.

Policies for Businesses

The National Flood Insurance Program's Preferred Risk Policy (PRP) protects commercial property in areas of low-to moderate-flood risk. They are the areas outside of known floodplains, shown as B, C, or X zones on a current Flood Insurance Rate Map. Most businesses, farm buildings, churches, and schools in these areas are eligible for the lower PRP rates, as long as the building does not have a significant history of flooding.

For Building Owner – Building and Contents Coverage

Building and contents protection is available at approximately 30% savings compared to a standard policy. You can buy $50,000 building coverage and $50,000 contents coverage for as little as $500 per year. Higher coverage combinations of up to $500,000/$500,000 are also available.

For Owner or Tenants – Contents Coverage

Even if you don't own the building where your business is located, you can protect your stock, equipment, and other assets. For as little as $121 per year, you can have $50,000 on contents-only coverage, with limits as high as $500,000 available. Note that coverage is not available for contents located only in basements.

Condominium associations are not eligible for the Preferred Risk Policy. Individual condominium units are not eligible unless they qualify under one of the exceptions. **The deductibles apply separately to building and contents.** Building deductible, $500; Contents deductible, $500. For a chart of the costs of covering Non-Residential Buildings and Contents, and Non-Residential Contents-Only Coverage, please go to www.fema.gov/business/nfip/prpbus.shtm.

What is Insured under Building Property Coverage?

- ✓ The insured building and its foundation.
- ✓ The electrical and plumbing systems.
- ✓ Central air conditioning equipment, furnaces, and waters heaters.
- ✓ Refrigerators, cooking stoves, and built-in appliances such as dishwashers.
- ✓ Permanently installed carpeting over an unfinished floor.
- ✓ Permanently installed paneling, wallboard, bookcases, and cabinets.
- ✓ Window blinds.
- ✓ Detached garages (up to 10 percent of Building Property coverage). Detached buildings (other than garages) require a separate Building Property policy.
- ✓ Debris removal.

What is Insured under Personal Property Coverage?

- ✓ Personal belongs such as clothing, furniture, and electronic equipment.
- ✓ Curtains.
- ✓ Portable and window air conditioners.
- ✓ Portable microwave ovens and portable dishwashers.
- ✓ Carpets not included in building coverage.
- ✓ Clothes washers and dryers.
- ✓ Food freezers and the food in them.
- ✓ Certain valuable items such as original artwork and furs (up to $2,500).

What is NOT Insured by either Building Property or Personal Property Coverage?

- ∅ Damage caused by moisture, mildew, or mold that could have been avoided by the property owner.
- ∅ Currency, precious metals, and valuable papers such as stock certificates.
- ∅ Property and belongings outside of a building such as trees, plants, wells, septic systems, walks, decks, patios, fences, seawalls, hot tubs, and swimming pools.
- ∅ Living expenses such as temporary housing.
- ∅ Financial losses caused by business interruption or loss of use of insured property.
- ∅ Most self-propelled vehicles such as cars, including their parts.
- ∅ Buildings entirely over water or principally below ground, gas and liquid storage tanks, animals, birds, fish, aircraft, wharves, piers, bulkheads, growing crops, shrubbery, land, livestock, roads, machinery or equipment in the open, and generally motor vehicles are not insurable.
- ∅ Most contents and finishing building materials located in a basement are not covered. Similarly, this coverage limitation applies to enclosures below the lowest elevated floor or an elevated building constructed after the FIRM became effective.

Definitions Pertinent To This Section:

Appurtenant Structure – A detached garage servicing a 1-4 family dwelling.

Loss Avoidance Measures – When an insured building is in imminent danger of being flooded, the reasonable expenses incurred by the insured for removal and return of insured contents to a safe location will be reimbursed. The purchase of sandbags and sand to fill them, plastic sheeting and lumber used in connection with them, pumps, fill for temporary levees, and wood will be reimbursed up to approximately $1000. No deductible is applied to this coverage. The removed property is covered at the new location for a period of 45 consecutive days from the date the moving process began. The personal property that is moved must be placed in a fully enclosed building or otherwise reasonably protected from the elements, and placed above ground level or outside of the special flood hazard area.

Debris Removal – The SFIP provides Other Coverage for Debris Removal, within the purchased policy limits.

Basement/Enclosure/Crawlspace - A basement is any area of a building, including a sunken room or sunken portion of a room, having its floor below ground level on all sides. An enclosure is the area below the lowest elevated floor that is either partially or fully shut in by rigid walls. A crawlspace is the area below a building which is elevated on foundation walls.

Mudslides vs. Mudflow - Mudflow is a river of liquid and flowing mud on the surfaces of normally dry land areas, as when earth is carried by a current of water. Other earth movements, such as landslide, slope failure, or a saturated soil mass moving by liquidity down a slope, are not mudflows, but mudslides.

Single Peril Policy – Flood Insurance Policies pay for damages for insured property when the **damage is caused by flood**. Earth movement caused by flood is excluded. This includes but is not limited to earthquake, landslide,

sinkholes, destabilization, or movement of land resulting from the accumulation of water in subsurface land areas, and gradual erosion.

Elevated Building – A building that has no basement and has its lowest elevated floor raised above the ground level by foundation walls, shear walls, posts, piers, pilings, or columns. Solid foundation perimeter walls are not an acceptable means of elevating buildings in V and VE zones. Elevating a structure on posts or pilings does not remove a building from the Special Flood Hazard Area. If the ground around the supporting posts or pilings is within the floodplain, the building is still at risk.

The Preferred Risk Policy offers multiple coverage combinations for both buildings and contents (or contents-only, for renters) that are located in low- to moderate-risk areas (B, C and X Zones). Preferred Risk Policies are available for residential or non-residential buildings also located in these zones that meet eligibility requirements based on the building's entire flood loss history.

Increased Cost of Compliance Coverage

All three policy forms provide Increased Cost of Compliance (ICC) coverage. ICC coverage provides for the **payment of a claim to help pay for the increased costs to comply** with State or community floodplain management laws or ordinances after a flood in which a building has been declared substantially damaged or repetitively damaged. When an insured building is damaged by a flood and the community declares the building to be substantially or repetitively damaged, thus triggering the requirement to comply with a community floodplain management ordinance, **ICC will help pay for the cost to elevate, relocate, demolish, or floodproof** (non-residential buildings only). This coverage is in addition to the building coverage for the repair of actual physical damages from flood under the SFIP, but the total paid cannot exceed the maximum limit set by Congress for that type of building.

The total amount the policyholder receives for combined physical structural damage from flood and ICC is always capped by the maximum limit of coverage established by Congress. The maximum amount collectible for both ICC and physical damage from flood for a single-family dwelling is $250,000.

ICC coverage is not included in all Standard Flood Insurance Policies. Insureds under the GFIP and insureds with condominium unit owner's coverage are ineligible for ICC coverage. All other policies include the coverage.

The maximum limit of $30,000 will help property owners insured under the NFIP to pay for a portion or, in some cases, all of the costs of undertaking actions to protect homes and businesses from flood losses. In addition, an ICC claim payment can be used to complement and supplement funds under other mitigation programs such as the Flood Mitigation Assistance Program and FEMA's Hazard Mitigation Grant Program and FEMA's Hazard Mitigation Grant Program to assist communities in implementing measures to reduce or eliminate the long-term risk of flood damage to buildings insured under the NFIP.

ICC claims are adjusted separately from flood damage claims. Policyholders can only file an ICC claim if their community determines that their home or business has been substantially damaged by a flood. This determination is made when they apply for a building permit to begin repairing their home or business.

Section IV

General Rules

Statutory Coverage Limits

Under the NFIP there are maximum amounts of coverage available under the Emergency Program and the Regular Program. Under the Emergency Program, non-actuarial, federally subsidized rates in limited amounts are available prior to completion of a community's Flood Insurance Study (FIS). Once more detailed risk data is provided to the community in the form of a FIRM and a FIS, the community is entered into the Regular Program and full limits of coverage are made available. Nearly all participating communities are in the Regular Program, and individuals can purchase flood insurance up to the following amounts:

Residential 1-4 family unit buildings and individual residential condominium units are written under the Dwelling Form and are eligible for up to $250,000 in building coverage and up to $100,000 in personal property coverage.

Residential buildings containing more than 4 units are eligible for up to $250,000 in building coverage and up to $100,000 in personal property.
Non-residential buildings are eligible for up to $500,000 in building coverage and up to $500,000 on personal property written on the General Property Form.

Under the RCBAP Form, a condominium association can purchase coverage on a building, which includes all the units within the building and the improvements within the units, up to $250,000, times the number of units within the residential building. Personal property coverage on the form is limited to $100,000 per building.

The average amount of insurance coverage purchased under the NFIP is around $140,000, which includes coverage for the building and its contents.

Actual Cash Value (ACV) – ***Actual Cash Value is Replacement Cost Value at the time of loss, less the value of its physical depreciation.*** Some building items such as carpeting are always adjusted on an ACV basis. For example, wall-to-wall carpeting could lose between 10-14% of its value each year, depending on the quality of the carpeting. This depreciation would be factored in the adjustment. Personal property is always valued at ACV.

Replacement Cost Value (RCV) - Replacement Cost Value (RCV) is the cost to replace that part of a building that is damaged (without depreciation). To be eligible, three conditions must be met:

1. **The building must be a single-family dwelling.**
2. **The building must be the principal residence, meaning you live there at least 80% of the year.**
3. **The building coverage is at least 80 percent of the full replacement cost of the building, or is the maximum available for the property under the NFIP.**

For single-family dwellings and residential condominium buildings, the NFIP provides for coverage at replacement cost, if several criteria are met. The unit must be the policyholder's primary residence; insured to at least 80 percent of the unit's replacement cost at the time of the loss, up to the maximum amount of insurance available at the inception of the policy term. Replacement cost coverage does not apply to manufactured homes smaller than certain dimensions specified in the policy. Losses are adjusted on a replacement cost basis for residential condominium buildings insured under the RCBAP. The principal residence and the 80 percent insurance to value

requirements for single-family dwellings do not apply to the RCBAP. However, coverage amounts less than 80 percent of the building's full replacement cost value at the time of loss will be subject to a co-insurance penalty.

Contents losses are always adjusted on an actual cash value basis. If the replacement cost conditions are not met, the building loss is also adjusted on an actual cash value basis. Actual cash value means the replacement cost of an insured item of property at the time of loss, less the value of physical depreciation as to the item damaged.

Co-Insurance Penalty in RCBAP – A penalty imposed on the loss payment unless the amount of insurance carried on the damaged building is at least 80 percent of its replacement cost or the maximum amount of insurance available for the building under the NFIP, whichever is less. **Coinsurance applies only to building coverage under the Residential Condominium Building Association Policy.**

Reduction and Reformation of Coverage – In the event that the premium payment received is not sufficient to purchase the amounts of insurance requested, the policy is deemed to provide only such insurance as can be purchased for the entire term of the policy for the amount of premium received. Complete provisions for reduction of coverage limits or reformation are described in the dwelling form, general property form and the RCABAP.

One Building Per Policy – No Blanket Coverage - Blanket coverage is a single amount of insurance applying to more than one building and/or contents. Blanket insurance is not permitted under the NFIP.

Building and Contents Coverage Purchased Separately -

Unlike a standard homeowner's policy, **flood insurance covers losses to property** caused by flooding. Contents coverage must be purchased separately.

Waiting Period/Effective Date of Policy - Unlike other property insurance, agents who write policies under the NFIP cannot "bind" coverage. A purchaser of flood insurance must wait **30 days from the date the application is completed and the premium presented** before the policy becomes effective. A change in the waiting period from 5 days to 30 days was included as part of the National Flood Insurance Reform Act of 1994. This addressed a problem encountered where individuals with properties on larger rivers could wait until properties many miles upriver were flooding before purchasing coverage.

There are, however, several exceptions to the ***30-day waiting period***. For example, the 30-day waiting period will not apply when a new flood insurance policy is required in connection with the making, increasing, extension, or renewal of a loan, such as a second mortgage. The 30-day waiting period ***will not apply*** when an additional amount of insurance is required during the 13-month period beginning on the effective date of a map revision. Also, the 30-day waiting period ***does not apply*** when a lender discovers that a loan that they have made is in a SFHA and is required to carry flood insurance under the Mandatory Flood Insurance Purchase Requirement.

Policy Term – The date and time specified in the Declarations for when coverage begins and ends. The policy term available is 1 year for both NFIP Direct business policies and policies written through WYO Companies. The policy expires at 12:01 a.m. on the final day of the policy term and premium must be received within 30 days of expiration date.

Cancellations/Assignment – Termination of an insurance policy by the insured or the insurance company during the policy period. A property owner's flood insurance building policy may be assigned in writing to a purchaser of the insured property upon transfer of title without the written consent of the NFIP.

Section V

Rating

Community Rating System - The National Flood Insurance Program requires communities to maintain a minimum level of floodplain management ordinances for its residents to be eligible to purchase flood insurance. To encourage communities to exceed these minimum requirements, the NFIP established the Community Rating System (CRS). CRS is a voluntary incentive program that recognizes and encourages community floodplain management activities that exceed the minimum NFIP requirements. In exchange for increasing flood preparedness and achieving a CRS rating, the community's residents are offered discounted flood insurance premium rates. The three goals of the CRS are:

- ***Reduce flood losses***
- ***Facilitate accurate insurance rating***
- ***Promote the awareness of flood insurance***

Communities are rated by class, of which there are 10:

Class 1 requires the most credit points and awards the highest premium reduction. **Class 10** receives no premium reduction and is any community in full compliance with the rules and regulations of the NFIP, but has not received a lower CRS rating.

The CRS identifies 18 creditable activities, organized under four categories. Each activity is assigned evaluation measures and a corresponding score. A community is rated on the total number of points generated during a particular evaluation.

Eligible floodplain management activities include:

- Public Information Activities –from elevation certificates, flood zone information and outreach projects to hazard disclosure, flood protection information and flood protection assistance.
- Mapping and Regulations-from detailed flood data and open space preservation to flood data maintenance and storm water management.
- Flood Damage Reduction Activities-from floodplain management and acquisition/relocation plans to flood protection and drainage systems maintenance.
- Flood Preparedness Activities-from flood warning programs to levee safety to dam safety.

The NFIP's Community Rating System (CRS) provides discounts on flood insurance premiums in those communities that establish floodplain management programs that go beyond NFIP minimum requirements. Under the CRS, communities receive credit for more restrictive regulations, acquisition, relocation, or flood proofing of flood-prone buildings, preservation of open space, and other measures that reduce flood damages or protect the natural resources and functions of floodplains.

The CRS was implemented in 1990 to recognize and encourage community floodplain management activities that exceed the minimum NFIP standards. Section 541 of the 1994 Act amends Section 1315 of the 1968 Act to codify the Community Rating System in the NFIP, and to expand the CRS goals to specifically include incentives for reducing the risk of flood related erosion and for encouraging measures that protect natural and beneficial floodplain functions.

Under the CRS, flood insurance premium rates are adjusted to reflect the reduced flood risk resulting from community activities that meet the three goals of the CRS:

1. **Reduce flood losses**

- ***Protect public health and safety***
- ***Reduce damage to property***
- ***Prevent increases in flood damage from new construction***
- ***Reduce the risk of erosion damage***
- ***Protect natural and beneficial floodplain functions***

2. **Facilitate accurate insurance rating**

3. **Promote awareness of flood insurance**

There are 10 CRS classes. For CRS participating communities, flood insurance premium rates are discounted in increments of 5%; i.e., a Class 1 community would receive a 45% premium discount, while a Class 9 community would receive a 5% discount (a Class 10 is not participating in the CRS and receives no discount).

Today, more than 1,000 communities participate in CRS and receive discounts on the cost of their flood insurance premiums based on their implementation of local mitigation, outreach, and educational activities that go well beyond minimum NFIP requirements. While premium discounts are one of the benefits of participation in CRS, it is more important that these communities are carrying out activities that save lives and reduce property damage, and protect the natural and beneficial functions of floodplains. These communities represent a significant portion of the nations' flood risk as evidenced by the fact that they account for over 66% of the NFIP's policy base. Communities receiving premium discounts through the CRS cover a full range of sizes from small to large, and a broad mixture of flood risks, including coastal and river lines.

Types of Buildings

Elevated Buildings – A building that has no basement and has its lowest elevated floor raised above the ground level by foundation walls, shear walls, posts, piers, pilings, or columns. Solid foundation perimeter walls are not an acceptable means of elevating buildings in V and VE zones. An **elevation certificate** verifies the elevation data of a structure on a given property relative to the ground level and it must be issued by a professional surveyor. Elevating a structure on posts or pilings does not remove a building from the Special Flood Hazard Area.

Buildings with Basements – Flood insurance covers your home's foundation elements and equipment that is necessary to support the structure. The NFIP's definition of "basement" includes any part of a building where all sides of the floor are located below ground level. Even though a room may have windows and constitute living quarters, it is still considered to be a basement if the floor is below ground level on all sides.

Coverage is provided for foundation elements including posts, pilings, piers or other support systems for elevated buildings. Coverage is also available for basement and enclosure utility connections, certain mechanical equipment necessary for the habitability of the building, such as furnaces, hot water heaters, clothes washers and dryers, food freezers, air conditioners, heat pumps, electrical junctions and circuit breaker boxes. **Flood insurance does not cover basement improvements** such as finished walls, floors, ceilings, rugs, furniture or personal belongings. **The NFIP encourages people to purchase both building and contents coverage for the most complete protection.**

When to Use an Elevation Certificate - Elevation is one of the four options to take to comply with a community's floodplain management ordinance to help reduce future flood damage. It raises a home or business to or above the flood elevation level adopted by the community.

An elevated building is defined as a non-basement building in which the lowest elevation floor is raised above ground level by foundation walls, shear walls, posts, piers, pilings or columns. Post-FIRM elevated buildings in certain SFHAs are subject to coverage restrictions specified in the SFIP. A manufactured (mobile) home may be an elevated building.

An elevation certificate verifies the elevation data of a structure on a given property relative to the ground level or base flood elevation; it must be issued by a professional surveyor.

Grandfathering – An exemption based on circumstances previously existing. Under the NFIP, buildings located in Emergency Program Communities and Pre-Flood Insurance Rate Map buildings in the Regular Program are eligible for subsidized flood insurance rates. Post-Flood Insurance Rate Map buildings in the Regular Program built in compliance with the floodplain management regulations in effect at the start of construction will continue to have favorable rate treatment even though higher base flood elevations or more restrictive, greater risk zone designations result from Flood Insurance Rate Map revisions.

Section VI

Claims Handling Process

If you have experienced a flood, contact your agent or insurance company immediately. They will assign a claims adjuster to help you evaluate your loss and file your flood insurance claim.

Have the following ready:

- The name of your insurance company.
- Your policy number.
- A telephone and/or email address where you can be reached at all times.
- If you will be going to a shelter or will not be easily reached, provide your agent with a trusted point-of-contact (friend, relative) who can reach you if necessary.
- If an adjuster has not been assigned to you within a few days of your phone call, contact your insurance agent or company again.
- Separate damaged from undamaged property. Do not throw out damaged property before your adjuster has seen it, unless it may be a health hazard or could impede local cleanup.
- If objects must be discarded, take photos and keep samples (fabric swatches, pieces of furniture, etc.) to help substantiate your claim.
- Take photos of standing water, both outside and inside your home or business.
- Photograph and videotape everything—from structural damage and flood water levels on building exteriors to building interiors and contents—to help prepare documentation of what the flooding damaged.
- Make a list of all damaged or lost items. Work with your adjuster to itemize your claim and calculate the value of the destroyed items by applying your detailed inventory against your damaged or lost property.

File a Proof of Loss within 60 days of the flood. Your official claim for damages is called a Proof of Loss. This sworn statement, made by you, substantiates the insurance claim and is required before the National Flood Insurance Program (NFIP) or insurance company can make payment.

Your adjuster should provide the form for you. However, it is your responsibility to provide your insurance company with a signed Proof of Loss within 60-days of the date of loss.

You must include a detailed estimate to replace or repair the damaged property, which you can obtain from your adjuster. You should both come to an agreement about the scope of damage and what needs to be repaired or replaced.

Your claim is payable after:

- You and the insurer agree on the amount of damages.
- The insurer receives your complete, accurate and signed Proof of Loss.

If major catastrophic flooding occurs, it may take longer to process claims and make payments because of the sheer number of claims submitted.

Remember, to stay covered, you must renew your policy each year.

The National Flood Insurance Program (NFIP) is your primary source for flood insurance in the U.S. If your community participates in the NFIP, you can purchase flood insurance from a licensed private insurance company or independent property and casualty insurance agent in your state.

Talk to your insurance agent if you have questions, would like additional information, and/or are ready to purchase a flood insurance policy. Your policy will take effect 30 days after your purchase.

If your insurance agent is unfamiliar with the NFIP or is not licensed to sell National Flood Insurance, you have several additional options:

Helping Your Client to File a Claim

As an agent, you can help your client file a claim quickly, so that the client will not have to put his life on hold if his property is damaged by a flood. You can even request a partial payment immediately after the flood, which can help your client recover even faster.

Once the community has determined that a flood has occurred, the insured's responsibilities in the event of loss are:

- Give written notice of loss to the NFIP or the applicable WYO Company or agent, as soon as practicable, using the NFIP Notice of Loss form or similar form.
- Exhibit all remains of the property, as required.
- If requested, submit to an examination under oath.
- Provide evidence and documentation to substantiate the loss.
- File a Proof of Loss within 60 days of the loss, unless this requirement is waived by FEMA.

A flood insurance policyholder should immediately report any flood loss to the insurance company or agent who wrote the policy. A claims adjuster will be assigned the loss, and the policyholder must file a "proof of loss" within 60 days of the date of loss. A policyholder whose policy is with a WYO company must follow the company's claim procedures. The 60-day time limit for filing a proof of loss remains the same.

An insured will never be paid more than the value of the covered loss, less the deductible, up to the amount of insurance purchased. Therefore, purchasing insurance to value is an important

consideration. The amount of insurance a property owner needs should be discussed with your client to determine which policy is right for him/her.

A minimum deductible is applied separately to a building and its contents, although both may be damaged in the same flood. Higher deductibles are available, and the consumer should be made aware of the choices. Optional high deductibles reduce policy premiums but will have to be approved by the mortgage lender.

Replacement cost coverage is available for a single-family dwelling, including a residential condominium unit that is the policyholder's principal residence and is insured for at least 80 percent of the unit's replacement cost at the time of the loss. Losses are adjusted on a replacement cost basis for residential condominium buildings insured under the RCBAP.

Contents losses are always adjusted on an actual cash value basis. If the replacement cost conditions are not met, the building loss is also adjusted on an actual cash basis. Actual cash value means the replacement cost of an insured item of property at the time of loss, less the value of physical depreciation as to the item damaged.

Flood insurance policies do not provide additional livings expenses, but only cover direct physical flood damage to the dwelling or contents.

Claims under the NFIP require, as in other insurance, that the insured file a Proof of Loss. This must be submitted within 60 days of the loss, unless waived by the Administrator of the FIMA. Claims can be adjusted using either an independent adjuster or an adjuster employed by a WYO company. Under all NFIP policies, the insured pays a portion of the loss through the application of a deductible. The NFIP does require documentation prior to paying a substantial damage claim under the ICC coverage of the Standard Flood Insurance Policy.

Appeals Process – A four-step process exists for homeowners to appeal decisions regarding a claim through the National Flood Insurance Program administered by the U.S. Department of Homeland Security's Federal Emergency Management Agency (FEMA). The process helps resolve claim issues, but can't give homeowners added coverage or claim limits beyond those in the NFIP policies.

Step 1

Homeowners should talk with their adjuster, who has more knowledge about the claim than anyone. If clients don't understand certain decisions regarding application of coverage, timing of the filing of proof of loss, or the damage estimate, they should first contact their adjuster.

Step 2

Clients who aren't satisfied with the adjuster's answers, or do not agree with the decisions, should get contact information for the adjuster's supervisor. The adjuster should provide contact information.

Step 3

If the adjuster's supervisor can't resolve the issue, clients should contact the insurance company's claim representative. The insurance agent or another company representative should provide assistance.

Step 4

Clients with questions or concerns after following the first three steps may contact FEMA in writing at:

FEMA-Mitigation Division-Room 433
Risk Insurance Branch
Attn: Director of Claims
500 C Street, S.W.
Washington D.C. 20472

The letter should be written by the named insured as it appears on the NFIP policy or by a legal representative such as a child handling a claim for an elderly parent. This representative should clearly identify their relationship to the named insured. A legal representative may be asked to provide authorization from the named insured or other legal documents verifying the relationship.

Six items should be in the letter:

1. The policy number, as shown on the NFIP policy's declarations page.
2. The policyholder's name, as shown as the named insured on the declarations page.
3. The property address, as shown on the declarations page. This is not the person's mailing address if it is different from the property address.

4. How the claimant can be contacted if they are out of the home.
5. Specific details of the claimant's concern.
6. The dates of contact and contact details for the persons with whom the claimant has spoken to while completing the first three steps of the appeals process.

Claimants should also enclose documentation of everything that supports their appeal such as a detailed list of damaged property and the value of individual items; supporting photographs; and a contractor's detailed estimate to repair damages. Comparing contractor and adjuster estimates in detail may help resolve differences. Claimants should not send original documents.

Claims Handbook – The insured's responsibilities in the event of loss are as follows:

1. Immediately notify the agent or the company of the flood loss.
2. As soon as reasonably possible, separate the damaged and undamaged property, putting it in the best possible order so that the adjuster can examine it and properly substantiate the loss.
3. Place all account books, financial records, receipts, and other losses in a safe place for examination and evaluation by the adjuster.
4. Within 60 days after the loss, submit an NFIP Proof of Loss form to the WYO or the NFIP Servicing Agent.

Section VII

Requirements of the Flood Insurance Reform Act of 2004

Point of Sales and Renewal Responsibilities

FEMA works closely with the insurance industry to facilitate the sale and servicing of flood insurance policies. Flood insurance under the NFIP is sold to owners of property located in NFIP communities through two mechanisms:

1) Through state-licensed property and casualty insurance agents and brokers who deal directly with FEMA; and

2) Through private insurance companies with a program created in 1983 known as "Write Your Own" (WYO), who issue policies and adjust flood claims in their own names under the NFIP.

State Departments of Insurance are taking various actions to establish training requirements for insurance agents who sell flood insurance as outlined in the Flood Insurance Reform Act 0f 2004. By taking this course, you are meeting the minimum requirements for the state of Washington. Licensed insurers must demonstrate to the commissioner, upon request, that their licensed and appointed agents who sell federal flood insurance policies have complied with the minimum federal flood insurance training requirements.

Notification of Coverages Being Purchased – There is an easy-to-write, low-cost, flood insurance policy for people in low-to-moderate flood risk areas. One option combines structure and contents coverage in one policy. It is perfect for people located in B, C, and X zones where 20-25% of all flood insurance claims occur. Contents-only coverage is available for renters and owners of eligible properties. The policy expires at 12:01 a.m. on the final day of the policy term and premium must be received within 30 days of expiration date.

Policy Exclusions That Apply – Loss of revenue or profit; loss of access; loss of use; business interruption; additional living expenses; coverage is not provided for the cost of complying with any ordinance or law except described in Increased Cost of Compliance; loss in progress; earth movement caused by flood; water, moisture,

mildew or mold damage; damage when drains back up; damage to the property from a roof leak; power failure when the source is off the insured location; or testing for or monitoring of pollutants.

Explanation Regarding How Losses Will be Adjusted (ACV vs. RCV)

Replacement Cost Value, or RCV, is the cost to replace the item on the date of the loss, without a reduction for depreciation. By this method of determining value, damages for a claim would be the amount needed to replace the property using new materials. For single-family residences, including doublewide manufactured homes, RCC is applicable only to building coverage. Under the RCBAP, a coinsurance clause requires the condo association to insure its buildings to at least 80 percent of the replacement cost value.

Actual Cost Value, or ACV, is the cost of repairing or replacing damaged property with property of the same kind and quality and in the same physical condition. It is what an item is actually worth on the date of the loss. This is often less than the replacement cost, since depreciation is deducted from the payment.

The insured residence must be the principal residence, meaning that at the time of loss, the insured lived there for at least 80 percent of the preceding year or 80 percent of the period of ownership if less than 365 days. Replacement cost applies only if the building is insured to 80 percent or more of its full replacement cost before a loss. When 80 percent of the replacement cost is more than the maximum amount of NFIP insurance available, compute as follows:

Amount of insurance purchased (over)
Maximum amount of NFIP ins. available
X (multiplied by) loss, less the deductible

The insured will receive the higher amount.

The types of property that are subject to Actual Cash Value Loss are:

- The insured's personal property
- Abandoned property that, after a loss, remains as debris at the location
- Outside antennas and aerials, awnings, and other outdoor equipment
- Carpeting and pads
- Appliances
- A manufactured home or travel trailer that is not at least 16 feet wide or have an area of at least 600 square feet within its walls

The adjuster does not have the authority either to deny a claim or to commit the NFIP or the WYO Company to pay a claim. All adjustments are recommendations only, subject to review by the NFIP Servicing Agency or the WYO Company.

The NFIP requires the adjuster to verify that all contents in the adjustment are covered under the SFIP, and to determine or verify accurate local replacement costs and reasonable actual cash value. Applicable depreciation must be shown separately for each item. Documentation supporting the claimed value must accompany the paperwork as appropriate. A Proof of Loss form signed by the insured is required on any claim on which payment is recommended. If the insured qualifies for replacement cost coverage, the adjuster must submit the Statement as to Full Cost of Repair or Replacement for the additional amount recoverable under the replacement cost provisions. Replacement cost, depreciation and actual cash value for each item must be shown on all claims, regardless of whether the claim is concluded on an RC or ACV basis.

Number and Dollar Amount of Claims for Property

Under the NFIP, federally-backed flood insurance is available to homeowners, renters and business owners in communities that adopt and enforce floodplain management ordinances to reduce future flood losses by regulating

new construction in high flood-risk areas. More than 4.7 million flood insurance policies exist in about 20,000 participating communities nationwide, representing nearly $793 billion worth of coverage. The NFIP is self-supporting: claims and operating expenses are paid from policyholder premiums, not taxpayer dollars.

More than 220,000 claims have been made since Hurricane Katrina struck August 29, 2005 and Hurricane Rita landed September 21, 2005, with more than $8 billion already paid and about 60 percent of claims closed. That includes about 40,000 claims not paid because damage suffered by homes wasn't caused by flooding or the amount suffered was below the homeowner's deductible.

Acknowledgement Forms – If the application or endorsement form and the premium payment are received at the NFIP within 10 days from the date of application or endorsement request, or if mailed by certified mail within 4 days from the date of application or endorsement request, then the waiting period will be calculated from the application or endorsement date.

If the application or endorsement form and the premium payment are received at the NFIP after 10 days from the date of application or endorsement request, or are not mailed by certified mail within 4 days from the date of application or endorsement request, then the waiting period will be calculated from the date the NFIP receives the application or endorsement.

Section VIII

Agent Resources

Write Your Own Company – In 1981, a strong effort was initiated by FEMA to reinvolve the insurance industry in a cooperative effort between FEMA and insurance company representatives that led to the creation of the Write Your Own (WYO) Program in July 1983. The WYO companies issue and service the federally backed Standard Flood Insurance Policies under their own names, collect premiums and pay claims. They are reimbursed for their services by FEMA. In August 1983, FEMA extended an invitation to all licensed property and casualty companies to participate in the WYO Program for fiscal year 1984.

The WYO Program now accounts for approximately 90 percent of all flood policies. The NFIP Bureau and Statistical Agency assists and advises the WYO companies. However, this does not diminish the authority of the WYO Company or relieve the Company of its obligations. The WYO Company still collects the premium, issues the policy, and provides adjustment and payment for claims.

FEMA Web sites: www.fema.gov/nfip www.floodsmart.gov

Flood Insurance Manual

The Flood Insurance Manual, Main Edition, contains the most current statistics, and revisions are added every six months. The Producer's Edition is to be used for easy reference or for training purposes. It does not include all of the information required to accurately rate a policy. The Main Edition zipped contains all of the PDF files to download the full manual to your desktop. A copy of the Flood Insurance Manual order form can be found under the Catalog button on the FEMA Flood Map Store Web site at www.fema.gov/business/nfip/manual.shtm.

WASHINGTON STATE LAWS AND *RULES for Life Insurance*

A. Marketing Methods and Practices

1. Replacement Regulation

✓ *Definitions*

"**Conservation**" means any attempt by the existing insurer or its agent or by a broker to try to dissuade a policy owner from cancelling their insurance policy or annuity to replace it with a new one. Conservation does not include such routine administrative procedures as late payment reminders, late payment offers or reinstatement offers.

"**Direct-response sales**" means any sale of life insurance or annuities where the insurer does not utilize a producer in the sale or delivery of the policy.

"**Existing insurer**" means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of "replacement."

"**Existing life insurance or annuity**" means any life insurance or annuity in force, including life insurance under a binding or conditional receipt or a life insurance policy or annuity that is within an unconditional refund period.

"**Replacing insurer**" means the insurance company that issues or proposes to issue a new policy or contract which is a replacement of existing life insurance or annuity.
"**Registered contract**" means variable annuities, investment annuities, or variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account, or any other life insurance contracts which are registered with the Federal Securities and Exchange Commission.

✓ **Purpose…**The ***purpose of the replacement regulation*** is to regulate activities of insurance companies and producers with respect to the replacement of existing life and annuity contracts; 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; and to reduce misrepresentation.

The **replacement** regulation requires that a **Notice Regarding Replacement of Insurance** form be completed by the producer when a new life application is written and an existing policy is either lapsed, terminated or surrendered. Using one of the non-forfeiture options or borrowing more than **25%** of the loan value in order to purchase a <u>new policy</u> would also constitute a replacement under this code.

- Violation of this code is considered ***twisting***.
- ***The form makes the insured aware of certain areas which may be of concern should an existing policy be replaced***.

<u>Following a replacement</u>:

a. The replacing insurance company has ***three days*** after receipt of the application or the date the policy is issued, whichever is sooner, to send the necessary forms, including a Policy Summary about the new proposed policy, to the **existing insurer**, along with the Notice of Replacement.

b. The **existing insurer** <u>must</u> try to save (conserve) the replaced policy. ***Conservation*** means any attempt by the existing insurer or producer to dissuade a policy owner from replacing an existing life insurance policy or annuity.

- The replacing insurer must provide in its policy or in a separate written notice which is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within ***20 days commencing from the date of delivery of the policy***.

c. Transactions **exempted** from this replacement code:

- Policy Conversions (within the same company, term to perm).
- Credit Life, all Variable Contracts (a.k.a. a ***Registered Contract***), Group Life and Group Annuities.
- Life Insurance within Employee Pension Plans (subject to ERISA, the Employee Retirement Income Security Act of 1974 [Federal guidelines]).
- Replacing life insurance issued by the same company writing the new policy.

d. **Duties of Producers:**

- ✓ Present the applicant with the notice of replacement, signed by the producer and the insured, and leave the original with the insured.
- ✓ Obtain a list of all existing insurance identified by the name of insurer, insured, and contract or policy number.
- ✓ Leave the applicant the written or printed items used in the presentation.
- ✓ Submit a copy of the replacement notice to the insurer.

2. Life Insurance Disclosure… The purpose of this regulation is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for the buyer's needs, improve the buyer's understanding of the features of the policy which has been purchased or is under consideration and improve the ability of the buyer to evaluate the relative costs of similar plans.

The insurer must provide a ***Buyer's Guide*** and a ***Policy Summary*** to any prospective purchaser upon request. The insurer must provide to all prospective purchasers a ***Buyer's Guide*** prior to accepting the applicant's initial application or premium.

- A **Buyer's Guide** helps the buyer find a life policy that meets his/her needs and fits into his/her budget. It also helps a buyer to decide how much and what type of life policy might be the best for the buyers' situation. The **Guide** explains to the consumer the use of ***cost comparison indices*** (which helps the consumer compare the **cost** of similar policies) and the use of the ***policy illustration***.

- A company must use the current Buyer's Guide no later than six months after approval by the National Association of Insurance Commissioners (N.A.I.C.).

- A **Policy Summary** means a ***written statement*** describing the elements of a Life Insurance policy. For example: the premiums, benefits, values, credits, or charges under a policy of life insurance.

    - A policy summary must be delivered with or prior to delivery of a policy, provided, however, if a policy illustration (see #3) is used in the sale of a policy, a policy summary does not have to be provided.
    - **There may be no reference to a dividend or nonguaranteed element in the summary.**

- ***Failure To Comply…*** Failure of any insurer or a producer to provide a Buyer's Guide, a policy summary or policy data, constitutes an unfair method of competition and an unfair act or practice.

- **This regulation does not apply to** annuities, credit and group life insurance, life insurance policies issued in connection with pension plans (subject to the Employee Retirement Income Security Act of 1974 [Federal guidelines]) and **variable life and annuity contracts** (these are ***registered contracts*** and must include a prospectus to all individuals who apply for information).

3. If a **Policy Illustration** (usually a computer printout) *is used* in the presentation of life insurance, a copy of the illustration (signed by the applicant) must be submitted with the application to the insurance company.

- If an illustration is not submitted with the application, a ***certification of non-illustration*** must be signed by the producer and applicant in place of the illustration. One certificate is to be left with the applicant and the other submitted with the application.

- The producer certifies that no ***printed illustration*** was shown to the applicant, that any non-guaranteed elements of the policy applied for are subject to change, and that an ***illustration*** conforming to the policy issued will be provided ***on or before the date the policy is delivered.***

Life Disclosure General Rules:

Each insurer must maintain at its home office or principal office, for a **period of three years,** a complete file containing one copy of each document authorized by the insurer for use under this regulation. A producer must inform the prospective purchaser, prior to commencing any presentation, that it may lead to the sale of life insurance. In sales situations in which a producer is not involved, the insurer must identify its full name.

Terms such as financial planner, investment advisor, financial consultant or financial counselor may not be used by a producer unless the producer is generally engaged in an advisory business.

There may be no reference to a dividend or nonguaranteed element in the policy summary.
Any statement regarding the use of the life insurance cost comparison indices must include an explanation to the effect that the indices are useful only for the comparison of the relative costs of two or more similar policies. If a test is performed for the detection of HIV, an HIV disclosure form must be **signed by the insured and the producer**, and the original left with the insured. ***This consent form allows the insurer to notify the insured's doctor if the test is positive and to explain the confidential treatment of the test results***.

B. Policy Clauses and Provisions

1. ***Free Look*** regulation gives the policy owner a ***minimum*** of 10 days to examine the policy from the date it is ***received by the policy owner***. **All premium** must be refunded within 30 days or the insurance company must pay an additional 10% penalty to the owner should the policy be returned.
2. ***Policy Loans…***After ***three full years of premiums being paid***, the owners of policies that build cash value may make use of the ***equity*** in their policies without cashing them in, through a policy loan. If the total **indebtedness** (the loan plus interest) equals or exceeds the cash value, the policy will terminate, **provided a 30-day notice is given to the owner.**

   - ✓ A **fixed loan** interest rate may not exceed 8% per year.

   - ✓ A **variable loan interest** rate may not be less than 4% nor more than 8% per year. A ***30-day notice is required*** to be given to the policy owner of any changes in the interest rates.

   - ✓ The insurance company ***MAY NOT*** defer loans and/or cash payments to the policy owner for more than ***six months*** following the owner's request. If the loan is for making the premium payment, the loan must be made immediately.

   - ✓ **Nonpayment of Policy Loans** results in the insurance company either deducting the loan plus interest from cash value upon surrender, or if the insured dies, the loan plus interest will be subtracted from the proceeds paid to the beneficiary.

3. ***Life Settlement: Death Benefits must be paid immediately upon proper proof-of-loss***. However, proceeds may be held from the beneficiary if death is due to an illness or disease, or suspicion of suicide within the first two years of the contract.

   If the insurance company holds off paying the beneficiary after the death of the insured, **a minimum 8% interest** or the "current" rate being paid by the insurer, whichever is greater, must be paid on the proceeds. If the proceeds are not paid to the beneficiary within 90 days of notification of death, on the 91st day, an **additional 3% penalty** (meaning 11%) must be paid on the proceeds.

- ✓ **Interest accrues** on proceeds from the **date of death (day one)**.
- ✓ The insurance company must notify the beneficiary if it intends to investigate.

C. Group life insurance policies must insure the lives of more than one individual**.** Insurance under any group life insurance policy may be extended to insure the spouse and dependent children of each insured employee in amounts in accordance with a plan and which insurance on the life of any one family member including a spouse must not be in excess of the amount on the life of the insured employee.

Dependent coverage under a group life insurance policy may be extended to insure the eligible dependents of the insured employee. **Insurance on any one family member, including a spouse, must** not exceed 50% **of the amount on the insured member**.
Eligible Life Insurance Groups:

Employee Group: An employee group must cover **at least 10 employees** at the date of issue. The amount of insurance under the policy must be based on some plan that prevents individual selection either by the employees or by the employer or trustees. Standard participation requirements apply **(75% for contributory groups and 100% for noncontributory groups).**

Debtor Group (a.k.a. Credit Life): A debtor group policy is issued to a creditor (the policyholder) to insure persons who are debtors of the creditor. The group must receive at least 100 new entrants each year. Seventy-five percent participation is required or the insurance company may require evidence of individual insurability.

The amount of life insurance coverage on the debtor (insured) may not exceed the amount of the debt owed to the creditor. The premium for the policy must be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both.

Labor Union Groups: The lives of a group of individuals may be insured under a policy issued to a labor union, which must be deemed the policyholder, to insure members of such union for the benefit of persons other than the union officials. ***The policy must cover at least 25 members at date of issue and have 75% participation.***

- The premium for the policy must be paid by the policyholder, either wholly or partly from the union's funds, or from funds contributed by the insured members specifically for their insurance.

Public Employee Associations: The lives of a group of public employees (at least 25 persons insured at date of issue) may be insured under a policy issued to the departmental head, or issued to an association of public employees formed for purposes other than obtaining insurance. Seventy-five percent participation is required.

- The premium for the policy must be paid by the policyholder, in whole or in part, either from salary deductions authorized by the insured employees or members specifically for the insurance, or from the association's own funds, or from both.

Trustee Groups: The lives of a group of individuals may be insured under a policy issued to the trustees of a fund established by two or more employers or by two or more employer members of an employers' association, or by one or more labor unions. The trustees are the policyholders, to insure employees for the benefit of persons other than the employers. The premium must be paid by the trustees, the employer or by the union. The policy must cover at least 20 persons at date of issue.

Insurance Agent (Producer) Groups: The lives of a group of individuals may be insured under a policy issued to a principal, or if such principal is a life insurer, by or to such principal, covering when issued **not less than 25**

insurance producers or 75% of the number of eligible producers, whichever is greater. The premium on the policy must be paid by the principal or by the principal and the insurance producers jointly.

Washington State Patrol Groups: The lives of a group of individuals may be insured under a policy issued to the commanding officer, which commanding officer must be deemed the policyholder, to insure not less than ***25 of the members*** of the Washington State Patrol. The policy is for the benefit of beneficiaries as designated by the individuals so insured, and the premium thereon may be paid by such members. Seventy-five percent participation is required.

Financial Institutions: The lives of a group of individuals may be insured under a policy issued to a state or federally regulated financial institution, which financial institution must be deemed the policyholder. The purpose of the policy must be to insure the depositors or depositor members of the financial institution for the benefit of persons other than the financial institution or its officers.

1. The persons eligible for insurance under the policy must be the depositors or deposit members of such financial institution.

2. The policy must cover at least 100 persons at the date of issue. The amount of insurance under the policy must not exceed the amount of the deposit account of the insured person or $5,000, whichever is less.

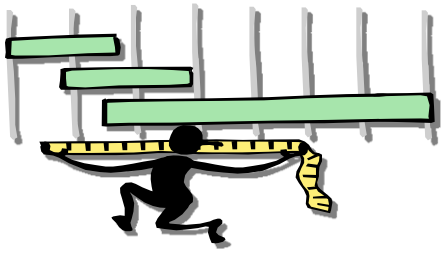
Special Note:

Agent, Washington State Patrol, Credit Union, Labor Union and Public Employee groups: *75% of eligible members must be insured*, and the policy must cover ***at least 25 members at the date of issue***.

Group Conversion Rights for insured ***individuals and dependents*** guarantees that coverage can be continued should the employee leave employment. The insured has **31 days to convert** to a ***permanent and individual insurance policy***. ***No evidence of insurability is required***. This conversion right must be offered if the enrollees were covered under the group policy for at least five years.

Group Assignment of Benefits…A person whose life is insured under a group insurance policy may assign to his spouse, children, parents, or a trust, the ownership, rights and interest under such policy.

LIFE INSURANCE



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 50% of Americans own individual life insurance.

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 for future expenses such as college education, or; serve as continuing income for the spouse. ***It is protection for the consumer***.

The obligations and expenses listed above are ***death benefits***. Life insurance does provide **living benefits** as well. These benefits usually are provided by the cash value accumulations inside of permanent life insurance policies. These benefits include policy loans, using the policy for collateral on loans, retirement income, cash withdrawals and **accelerated death benefits.**

We will examine two types of insurance contracts:

1. **Life Insurance, such as:**
   - Term Life
   - Whole Life
   - Universal Life
   - Endowment
2. **Annuities**

Before going any further, here are some basic terms which should be reviewed:

Applicant - The person who makes the application for insurance and who is proposed to be the policy owner.

Beneficiary - The party (i.e., person, company, trust or estate) who will benefit from the insurance coverage.

Death Benefit (a.k.a. Death Proceeds) - The amount received by the beneficiary upon death of the insured, and is received by the beneficiary income tax free.

Hazard – Anything which increases the chance of a loss, i.e., occupation, hobbies, past health, or driving record.
Insurable Interest - The applicant/owner must have interest in the continued life of the insured. The insurable interest range includes relatives and business associates.

Insurance - A social device for ***protecting the consumer*** (insured) by spreading the financial impact of a loss among a sufficiently large number of similar risks. Life insurance is used to offset the ***financial impact*** of premature death.

Insured - Individual covered by the insurance. Usually, the insured must qualify (health wise) for the coverage.

Mortality Tables express the chance of loss, that is, the possibility of living or dying at any given age. Based on past experience, insurance companies are able to predict the number of deaths among a large number of people at some given age. Everyone is statistically dead at age 100. ***Whole life insurance policies endow at age 100***.

Payor - The person or entity who pays the premium.

Policy owner (a.k.a. policyholder and is usually the applicant) - The party who has the right to exercise the rights in the contract. The owner may be a different party than the insured, who then would be known as a third party owner.

Premium Variations (the insured's ***consideration*** to the insurer):

1. **Fixed (a.k.a. level)** premium refers to the premium paid which remains the same throughout the life of the contract. It is a method of leveling off the cost of insurance so as not to have it increase each year until it might become unaffordable.
2. **Flexible** premium means the policy owner is permitted to adjust or change the premium.
3. **Adjustable** (sometimes called ***indeterminate***) premium means the premium may be adjusted by the insurance company to reflect the insurance company's loss or profit experience.
4. **Gross Premiums** = Mortality (charge), Interest (credit) and Expenses (a.k.a. load charges). Producers sell gross premium policies and aren't even aware of the net.
5. **Net Premiums** = premium ***without*** the expenses added in.

Producer – The name generally given for an individual such as an agent, solicitor or broker who sells insurance products.

Risk - The probability (chance) of loss for an insured or prospect. Types of risks include: standard, impaired or substandard, and preferred. Only pure risk, the chance of a loss, no gain, is insurable.

Third-Party Ownership - A person other than the insured, who has ***insurable interest***, may apply for and own a policy covering the insured and is entitled to the benefits and other rights provided. The **first party** is the insured; the **second party** is the insurance company; and the **third party** is the owner of the contract, if other than the insured. For example, to prevent the financial impact of death, parents will purchase and own policies on their children, or business partners will insure one another.

I. Types Of Individual Life Insurance

A. Term Insurance

1. **Term Life Insurance** (a.k.a. Pure Protection) is the **least expensive** of all life contracts. It provides protection for a limited number of years, the face amount being payable upon the death of the insured and nothing in case of survival**.**

2. **Basic Types of Term Contracts:**

   a. **Level Term** provides protection that remains constant for the term of the contract. The premiums may increase upon renewal due to an increase in the insured's age. For example, the premium on a five year term policy will be level for 5 years, but premiums will increase should the policy be renewed.

   b. **Decreasing Term** provides protection which decreases each year. ***The most common use for decreasing term is to cover needs that will decrease over time, such as mortgages and other loans.*** The premiums stay **level,** meaning the premium paid remains the same throughout the life of the contract. It is a method of leveling off the cost of insurance so as not to have it increase each year until it might become unaffordable.

   c. **Increasing Term** provides protection which increases each year. It is never sold as a separate contract. Primarily, it is used as a rider in connection with a combination or package policy. We will discuss some of these policies later in this text. The premiums stay **level** even though the coverage increases.

3. **Features on Term Life Insurance:**

a. **The Renewability Provision** in a policy ***guarantees*** that the insured will be able to renew the policy at the end of its term **without** providing ***proof of insurability***. In order to be renewable, this provision must be in the policy. Premiums can go up because the *attained age* (a.k.a. current age) is used to calculate the premium.

b. **The Convertibility Provision** allows the insured to convert the policy from term to permanent insurance **without** requiring ***evidence of insurability.*** This provision is not included in every policy. A Convertibility Clause needs to be in the policy for this privilege to exist. **Attained age** (current age) is used for calculating the **gross** premium. The ***conversion*** is with the same company and for the same amount of coverage.

c**. Hierarchy of Premium**: **the more benefit to the insured, the more premium.**
* 1 year term (the least favorable policy for the insured - the least expensive)
* 1 year renewable term
* 1 year renewable and convertible term (the best policy - the most expensive)

B. Whole Life Insurance (***Traditional Life, once was called Ordinary Life)...***Whole life insurance lasts for the insured's *whole (entire) life* and builds **cash value**. The policy owner pays a level premium for a limited period of time, until he dies or reaches age 100.

1. Basic Features of Traditional Whole Life Insurance include:

a. The cash value ***accrues tax deferred*** until **surrender**. Under the ***Cost Recovery Rule***, the amount included in the policy owner's taxable income upon policy surrender is the excess of the cash value received over the cost basis (premiums paid). Only **after** the policy owner's premium is fully recovered are additional amounts received treated as taxable interest or gain in the policy.

- For example: $10,000 is in the cash value of a policy, and the paid premiums total $2,000. Should the owner decide to cash in the policy (a.k.a. surrender the policy) the $8,000 gain would be taxed as ***ordinary income*** to the owner. $10,000 (CV) - $2,000 (premiums) = $8,000 (taxable gains)

b. The death benefits are received by the beneficiary **income tax free**.

c. Premiums are ***bundled on traditional WL policies.*** This means the policy owner does not see for what each premium dollar is used or how it is distributed, such as cost of insurance and expenses. However, most policies today are what we call "transparent" meaning that all elements of the contract are given to the owner of the policy.

d. At age 100 the policy **endows** (the cash value will equal the face value) and the face amount of the policy is paid to the owner.

e. There are three forms of Whole Life (WL) insurance: ***Straight Life*** (a.k.a. continuous premium WL), ***Limited Payment WL*** and ***Single Premium WL***.

2. Basic Types of Traditional Whole Life Contracts:

a. **Straight Life, a.k.a. Continuous-Premium Whole Life** has a level premium which is payable to age 100 or the insured's death, whichever comes first. The premiums are said to be bundled and will never change.

b. **Limited-Pay Life** is a form of Whole Life characterized by premium payments being made for a specified or **limited** number of years. Premiums are paid-in over a shorter period of time so premiums are **higher** than for straight life. However, **cash values build more quickly**. The shorter the period of premium payment, the more the premium and the faster the cash values will grow.

c. **Single-Premium Whole Life** is the extreme form of limited-payment life insurance. Such policies have substantial cash values immediately, and are fully paid up from the inception of the policy. The income from this cash goes to pay the cost of the insurance protection. A single premium life policy is considered "***over funded***" by the IRS and is subject to the **Modified Endowment Contract Rule** (covered later in this text).

3. Adjustable Life Policy is a flexible-premium, adjustable-death-benefit type of permanent cash value insurance. ***It is essentially a hybrid combination of universal life and traditional level-premium whole life insurance***. Adjustable life policy elements are "***bundled***" (meaning the pure protection and savings components are <u>not segregated</u>). The policy owner may:

- ***increase or decrease the premium***
- ***increase or decrease the face value***
  (an increase in face value requires proof of insurability by the insured)
- ***lengthen or shorten the premium payment period***
- ***change from a whole life to a term life, and back to whole life again***

<u>C. Interest Sensitive and Variable Life Products</u>

1. **Variable Products** are security products **(a.k.a. *Equity Products or Registered Contracts*)** and include Variable Life, Variable Annuities and Variable Universal Life. To sell a variable product, both a ***security license and a life insurance license are required***. Variable products have the same characteristics as other life policies; however, these policies use a ***separate account*** (the investment feature) for accruing cash value (known as ***accumulation units***) instead of the general account of the insurer. Features of variable products include:

   - ***Higher risk***, i.e., stocks, bonds, mutual funds, etc., with ***no guaranteed cash value*** (therefore, it is not guaranteed to endow).
   - ***Dual regulation:*** Securities and Exchange Commission (SEC) and the Insurance Industry. The producer must be registered with the Financial Industry Regulatory Authority (FINRA).
   - The policy owner chooses the level of risk he desires and bears the *investment risk.*
   - Policy reports are usually sent to the insured on a quarterly basis.
   - The value of a variable contract is expressed in terms of **units**. The use of ***accumulation units*** is simply an accounting measure to determine a contract owner's interest in the separate account during the accumulation period. For example, if Mary owns 1000 units and the value of one accumulation unit is $20, then Mary's interest (cash value) in the separate account equals $20,000.
   - After the accumulation period, the **units** serve to determine the amount of each payment to the annuitant during the payout period of a settlement.
   - ***A Registered Contract*** means a contract issued by a life insurance company which is registered with the Federal Securities and Exchange Commission.
   - Variable contracts are designed primarily to provide the consumer with a ***hedge against inflation*** and insurance protection***.***

     a. **Variable Life (a.k.a. Variable Whole Life)** has most of the same characteristics as the whole life policy; however, these policies use a **separate account** (investment feature) for accruing cash value instead of the general account of the insurance company.

The ***premium is fixed***, but the face amount of the policy varies up and down, subject to a minimum guarantee, which is the original amount of insurance. The cash value of the policy is not guaranteed and fluctuates with the performance of the separate account. The insurer (management company) offers the policy owner a choice of investments.

Actual Death Benefit = Separate Account + Guaranteed Death Benefit

b. **Variable Universal Life** (VUL), a.k.a. Universal Life II, is a *security* life product. With a few exceptions, ***the characteristics of a VUL are identical to the Universal,*** except that it uses a *separate account* for accruing interest on cash value and offers no guarantee for the cash value accumulation.

c. **Variable Annuity**…discussed later with the annuities section.

2. Universal Life (a.k.a. UL) is the newest life insurance product and was introduced in the late 1970's. It is a *flexible-premium*, *current-assumption*, *adjustable-death-benefit* type of cash value life insurance, sometimes referred to as a ***term coverage and tax deferred savings account.***

The term **flexible premium** means the policy owner is permitted to select whatever premium she wishes to pay, within limits, and later to adjust or change the premium.

Policy owners may even skip premium payments as long as the cash value is sufficient to cover policy charges. The term adjustable death benefit means that policy owners are permitted to raise or lower their policy death benefits. However, increases may require evidence of insurability. The policy is set to endow at 95, but is not guaranteed like a traditional whole life policy. Features include:

- An ***annual report*** is sent to the insured each year that shows the death benefit, cash value, surrender value, premiums received, expense charges, cost of insurance (which is **based on term rates**) and interest credited, meaning that it is a **transparent product.**

- **Withdrawals** and **loans** are permitted. Loans have to be repaid and interest is charged by the insurance company, but withdrawals **do not** have to be repaid and therefore accrue no interest. However, the death benefit is reduced by the amount of the withdrawal. The insured may also ***drop-in additional money directly into the cash value.***

- **Cash Value surrender or Withdrawals - Under the Cost Recovery Rule** the amount included in the policy owner's gross income upon policy surrender or withdrawal is the excess of the cash value received over the cost basis (premiums). Only **after** the policy owner's premium is fully recovered are additional amounts received treated as taxable interest or gain in the policy.

- **Current Assumption** Interest Rate = the guaranteed rate (usually 3.5% - 5.0%) plus excess interest earned by the Insurance Company. The excess interest is not guaranteed.

- The Universal policy owner has a choice of **Two Death Benefit Options**:

  Option "A" Death Benefit is similar to a whole life policy in that it offers a fixed death benefit (a.k.a. ***level***). As cash values grow larger, the net amount risk (or pure insurance) is reduced to keep the total death benefit level.

Option "A" Corridor: If the cash value increases to an amount equal to or in excess of the policy's face amount, then the ***death benefit will automatically be increased***. Under current laws, if the universal life policy is to maintain its status as life insurance and thus provide a tax-free death benefit, there must be a degree of mortality risk until the insured is age 95. This is the reason for the automatic increase in the death benefit if the cash value equals or exceeds the policy's face amount. This buffer or *corridor* between the death benefit and the cash value must be maintained.

Option "B" Death Benefit is an increasing death benefit contract. The death benefit at any time is equal to face amount of pure insurance (term insurance) plus the policy's cash value at the time of death. Therefore, the ***death benefit increases*** as the cash values grow.

3. Interest Sensitive Whole Life (a.k.a. **Current Assumption** Whole Life) is essentially a hybrid of traditional cash-value whole life insurance and a universal life contract. At the time of issue, the premium and death benefit are level, similar to traditional whole life policies. However, ***the insurance company does reserve the right to increase or decrease*** the premium (a.k.a. **adjustable premiums**) within a certain range and at certain times (if the assumptions under the contract are higher or lower than expected).

As with Universal Life, the C.A.W.L. is a **transparent contract**. **Withdrawals** are permitted for the **excess** cash value accumulated over the minimum guarantee.

D. Endowments are used for quick cash value build-up such as for college, mortgage payoff or a retirement fund. They are the most expensive of all life policies. Endowments are ***not widely sold anymore*** because the cash value faster than allowed for a life insurance policy. It is considered to be over funded under the Modified Endowment Contract Rule. Under this Rule any withdrawals are treated as interest withdrawals and subject to income tax, plus if the withdrawal occurs prior to age 59 1/2 there will be an additional 10% tax penalty.

The primary difference between a whole life policy and an endowment policy is that the endowment policy matures earlier (at a stated period or specific date) so the cash value must build more rapidly and the premium must be higher. The endowment is primarily used as a living benefit contract.

E. Variations of Life Insurance Coverage

A rider can be a provision in a policy or an additional policy attached to the original policy. Most riders will expire on a certain date or age of the insured and will usually cost additional premium. Riders are often used to cover certain specific needs of an insured or the insured's family or business. Most of the riders available will be discussed later in this material.

1. A **Term Insurance Rider** is a term insurance policy which is used in combination with another insurance policy. The rider can be renewable and convertible term insurance coverage. The rider may cover a child, spouse or business partner.

2. **Juvenile Life Insurance** coverage can be purchased as a ***term rider*** (often called a child rider or family rider) added to the parents policy or can be written as a **separate permanent life insurance policy**. The juvenile rider or separate life insurance policy is usually written on children under the age of 15.

- **Payor Waiver Rider**: A juvenile policy is issued on the application of the child's legal guardian (usually parents or grandparents) who usually pays the premiums on the policy. This person who applies for the child's insurance can add the Payor (Applicant) Waiver Benefit Rider. When added to the **Juvenile Policy**, the Payor Waiver provides that premiums will be waived in the event the premium payor dies or becomes disabled, or until the insured (the child) reaches a specified age.

- ***A nice feature of the child or juvenile rider is that any newborns are added automatically without having to show evidence of insurability. Adopted children are treated the same as newborns.***

- At an age listed in the rider (usually between 18 to 25) the juvenile will drop off the rider**.** However, the insured can keep life insurance by converting the coverage to a permanent life policy. **Without showing evidence of insurability, the juvenile will be able to increase the original face amount by five times**.

3. **The non-family rider does not** add coverage for an additional insured on the owners policy like a spouse rider, but ***will allow for the change of the person or persons being insured on the policy.*** It is commonly used on Key Person policies when the key person or employee leaves employment and a new employee is hired in their place. Any new insured added need to show proof of insurability.

- For example, assume a business has a joint policy covering two key employees. Should the business hire a third employee who they consider a key employee, the business (owner) could add them to the joint policy of the other two. The new employee would have to show proof of insurability. The Change of Insured Rider would allow this addition to the same policy covering the other two employees without the two employees having a new policy or coverage or having to show insurability.

4. A **Joint Life Insurance** policy covers two or more insureds under one policy. Two Types:

First to Die covers two or more insureds with one policy (usually term life due to the low premium), with benefits being paid to a beneficiary upon the **first-to-die**. If one of the insureds dies, the **joint policy allows the surviving insured to purchase permanent coverage without evidence of insurability.**

Second to Die (a.k.a. Last Survivor or ***Survivorship Life***), is a **joint** policy which covers two insureds and pays the proceeds after the second insured dies. This is a type of ***joint whole life policy***, usually used for **estate planning**.

A joint policy averages the risk factors (i.e., age and sex) to establish the premiums. That is why a joint policy is less expensive for covering two individuals than purchasing two separate policies. Two separate policies would also give greater total coverage than a joint policy.

F. Annuities…An **annuity** is a contract which calls for a systematic liquidation of an estate. By liquidation we mean to convert an estate into a ***systematic stream of cash payments***. The person who receives these payments is called an **annuitant.**

1. ***When Do Benefits Begin?***

Immediate Annuity…one where income payouts are to begin soon after the contract is purchased (***must be in one year or less***). Contracts are paid for with a lump sum.

Deferred Annuity…one where payouts to the annuitant are delayed or deferred from the date of the contract until some future date (usually retirement). The payments made to the deferred annuity are called premiums (a.k.a. the ***accumulation phase).***

- The interest earned on a deferred annuity is **tax-deferred** (until withdrawn). However, there is a **10% *early withdrawal penalty charged by the IRS*** on the earned interest if the money is withdrawn before age 59½ (some exceptions do apply). If money is withdrawn from an annuity, ***interest accumulation is withdrawn first***.

2. ***Different Ways To Fund A Deferred Annuity***
   - **Single,** a.k.a. **Lump Sum,** is an annuity purchased with a single premium payment or lump-sum. The annuity is paid in full.
   - **Level/Fixed Installment** are equal payments at regular intervals over a deferral period.
   - **Flexible** premium payments allow the owner of the contract to vary premium payments from year to year.

3. ***Fixed vs. Variable Annuities***
   - **Fixed Annuities** have a minimum guaranteed rate of return; however, some may pay more than the stated guaranteed amount (called excess). The *guarantee* combined with the *excess* is called the *current* rate of interest.

   - **Equity Index Annuities** are a ***hybrid product*** that offer a minimum guaranteed return (such as 2%) and the opportunity to participate in the upside potential of the equity markets by using indices such as the Standard & Poor's 500. ***An Index Annuity can use two or more indices for funding the Annuity.*** They first came to the market in 1995 and have been sold as insurance, without SEC or FINRA supervision.

- **Variable Annuities** are securities because the investment return depends on the performance of that separate account. A securities license is required to sell these; the annuitant assumes the investment risk; and there is ***no guarantee*** on the increase in value of the contract.

  - ✓ During the accumulation phase, the contract is valued in terms of **accumulation units.**

  - ✓ ***During the payout (liquidation) phase, the accumulation units are converted into annuity units***.

4. ***Payout (Settlement) Options*** **of Immediate Annuities**

Life Annuity Options vs. Annuity Certain Options

a. Life Annuity Options…the payout amounts will be determined by the annuitant's age, gender and option chosen. Life options **may not** be surrendered after the contract is purchased.

Life annuities are ideal for retirement because their primary purpose is to provide an income you cannot outlive. Once a life annuity payout (liquidation) begins, the insurance company guarantees that the payment will continue no matter how long the annuitant lives, a true "***lifetime guarantee.***"

There are five life options:

1) **Life (Straight/Pure) w/No Refund** is one where the annuitant receives a specified amount for as long as he/she lives. The insurance company's obligation ends upon death. There is no beneficiary.

2) **Life w/Refund** provides income to the annuitant for life and payment to the ***beneficiary*** if the annuitant dies prior to receiving an amount equal to the full amount paid for the annuity (a.k.a. Principal).

3) **Life w/Period Certain** provides a life income for the annuitant. If the annuitant dies within a specified period (such as 5, 10, or 20 years), the same annuity payments will continue to the named ***beneficiary*** until the end of the stated period.

4) **Joint Life Annuity** pays an income to two annuitants (with one check) and terminates when the first annuitant dies. There is no beneficiary.

5) **Joint Life w/Survivorship** pays an income to two annuitants (with one check), but will continue to pay the second annuitant when the first annuitant dies. The annuitant chooses the amount of the continued payout, such as 1/2, 2/3, etc., of the original payout, at the time the annuity contract is purchased. However, **when the survivor (annuitant) dies, all payouts stop.** The survivor is not a beneficiary.

b. Annuity Certain Options (Fixed)…The fixed option ***guarantees*** payout of all the principal and interest and allows the annuity owner to cash-out the contract. ***The negative aspect of the fixed option is that the annuitant could outlive the annuity.***

1) The ***Fixed Time Annuity*** payout option ***guarantees*** all of the principal plus interest to the annuitant ***over a period of time*** (a.k.a. Period Certain). **The annuitant could**, **however, outlive the annuity payout**. This option will pay equal installments of an amount that will exhaust the principal and interest during the fixed period (i.e., 20 years). If the annuitant dies before the 20 years is over, the ***beneficiary*** will receive the same installments for the balance of the 20 years.

2) ***Fixed Amount Annuity…***Under this settlement option, the annuitant receives benefit payments of a ***set amount*** for as long as the ***annuity's accumulation value plus interest lasts.*** If Mrs. B has an accumulation value of $200,000, under this settlement option, she could elect to receive a monthly benefit payment of $3000 (or any other amount she prefers). The insurance company would send her a check each month for as long as the accumulation value and interest would support the benefit. After the funds in the annuity were

exhausted, Mrs. B would not receive any further benefits from the annuity contract. In the event of Mrs. B's death before the funds in the annuity have been used up, the remainder generally is paid to her ***beneficiary***.

II. Policy Provisions

A. General (Standard) Provisions

1. **Entire Contract** provision states that the contract is made up of ***the policy itself, the attached application, and any riders or endorsements.*** The contract cannot be changed *arbitrarily or unilaterally* by either party after the contract has been issued. All statements made by the applicant on the application are deemed to be ***representations*** (statements believed to be true) and ***not warranties*** (statements guaranteed to be true).

- No changes are valid unless approved and endorsed by an executive officer of the insurance company. Producers *do not have authority to change the policy or waive policy provisions*.
- A "last will and testament" ***does not*** supersede an insurance contract.

2. **Insuring Agreement (a.k.a. Heart of the Contract)** tells the policy owner that the insurer agrees to pay the death benefit to the beneficiary upon the death of the insured. The insuring agreement (clause) is on the ***first page*** of the life policy and lists the benefits and obligations of the parties to the contract. This provision represents the ***insurance company's promise to pay***

3. **The Owner** (a.k.a. **owner/applicant**) of the insurance contract is usually the insured. An exception is a third party owner such as Business Insurance or a Juvenile Policy. ***The owner's rights include***: determining the disposition of proceeds, assignment, rights to the policy's cash value, choosing the premium payment mode, choosing or changing the beneficiary, canceling and renewing the policy and deciding how dividends will be used. (a.k.a. **Ownership Clause**.)

4. **Incontestability Clause** (consumer protection) states that after a policy has been in force for ***over two years***, the insurance company cannot contest or void the policy **except for fraud committed by the insured or nonpayment of premium**.

If there is a ***misrepresentation*** (a lie) or a ***concealment*** (withholding of facts) discovered in the first two years, it must be ***material*** for the insurance company to deny coverage or to cancel the policy.

a) **Material** means that it is a fact that is important enough that had the insurance company known it, it could have changed either the decision to issue the insurance policy, or to issue the policy on ***substantially different terms***. The misstated information is said to be material only if the truth would have resulted in the insurer making a different underwriting decision. (i.e., rate–up, a surcharge, or exclusion rider).
b) Lying about smoking, age, or gender is ***NOT*** considered material. However, the coverage will be adjusted if one lies about age or gender, and the non-smoking discount will be removed if one lies about smoking.
c) The insurance company must ***return all of the premiums*** (**no interest**) paid if a claim is denied or a policy is canceled during the first two years of the contract.

5. **Grace Period** states that if the premium is not paid within **31 days** after the due date, the policy may be canceled with a **10-day written notice**. Death proceeds are paid to the beneficiary if the insured dies in the grace period, but the insurance company subtracts out the past due premium (***no interest charge***).

6. **Reinstatement** allows a canceled policy to be put back in force:
a) The owner must pay **all back premiums plus interest**.
b) The insured must ***show proof of insurability***.
c) **If the policy is reinstated**, it is usually reinstated back to the age of the insured when the policy was issued.
d) No more than three years may have passed from lapsed date.
e) Reinstatement starts new incontestability and suicide clauses.

f) Reinstatement is **not** available if the policy has been surrendered for its cash value or the period of any extended insurance has expired.

7. **Misstatement of Age or Gender (Sex)** provision states that if the age or sex of the insured is found to have been misstated, ***the amount of insurance will be adjusted*** to the amount which would have been purchased by the premium had the correct age or sex been known.

- For example, John purchased a life policy for $50,000 issued at age 35 at an annual premium of $900. When John dies, the true age of John when he purchased the policy is discovered to have been 38, not 35. The $50,000 death benefit will be lowered to that which would have been purchased by the $900 in premium had the correct age been known. Had John's age actually been 30, the death benefit would have been increased.

- This clause ***does not*** have the two year contestability limit for discovery.

- A misstatement of age or sex is *not material* and will not cause the voiding of a claim or cancellation of a policy.

8. **Assignment…**the policy owner transfers the rights in a policy to another.

- ***A <u>Collateral</u>*** assignment transfers **part** of the rights to supply security (collateral) for a loan. This is a ***<u>temporary and partial</u>*** assignment; only ***some of the "incidents of ownership"*** are transferred.

- ***An <u>Absolute</u> assignment*** transfers **all** of the rights to another. Used for giving life insurance as a gift so that a tax deduction, in the amount of the cash value, may be taken by the owner. This is a ***<u>permanent and complete</u>*** assignment and ***all "incidents of ownership"*** are transferred.

9. **Free-Look** regulation gives the policy owner a ***minimum*** of 10 days to examine the policy from the date it is ***received by the policy owner***. **<u>All premium</u>** must be refunded within 30 days or the insurance company must pay an additional 10% penalty to the owner should the policy be returned.

10. **Conformity with State Statutes…** "*This policy is subject to the laws of the state where the insured resides. If any part of the policy does not comply with the law, it will be treated by us as if it did."*

11. The **Suicide Clause** excludes death due to suicide for a maximum of **two years** from the ***effective date of the coverage***. All premiums paid (***no interest***) must be refunded to the beneficiary if the insured commits suicide within the first two years of the contract.

- The suicide clause is intended to prevent adverse selection. That is, the two year limit lets the company protect itself financially against situations where life insurance would be purchased in direct contemplation of suicide.

B. <u>Policy Exclusions</u>…The ***exclusion*** section spells out circumstances under which the policy proceeds would not be paid. Types of exclusions may include but are not limited to:

∅ The ***War Exclusion*** excludes coverage if death is a ***result of war,*** whether declared or undeclared. Its main purpose is to control adverse selection.

∅ ***Aviation Exclusion*** excludes coverage if death occurs while flying **other than as a fare-paying passenger on an airplane**.

∅ ***Hazardous Occupation or Hobby Exclusion***

∅ ***Foreign Travel or Residence Clause***

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**.

C. Loan Provisions…The owners of policies that build cash value may make use of the ***equity*** in their policies without cashing them in; they may do so through a policy loan.

1. **Loan Interest…**The company assumes that funds will earn a certain rate of return when it designs its policies. If money is withdrawn from the company in the form of a loan, it is no longer available for investment. Therefore, the company must charge interest on the funds it loans in order to meet its obligations.

2. The maximum amount which can be borrowed from a permanent life policy is the ***amount of the cash value***. Should the loan plus interest meet or exceed the cash value, the policy will terminate.

3. **Nonpayment of Policy Loans** results in the insurance company either deducting the loan plus interest from cash value upon surrender, or if the insured dies, the loan plus interest will be subtracted from the proceeds paid to the beneficiary.

D. Non-forfeiture Provisions (NFO) must be included in the policy under the ***Standard Non-forfeiture Law*** which prescribes that a policy's cash values must be made available to a policy owner should he stop paying the premiums on his policies.

A permanent policy must have cash value by the end of its third year. As the cash value builds each year so do the values associated with the non-forfeiture options. The common options in cash value policies include: **Cash Surrender, Reduced Paid-Up Insurance and Extended Term Insurance.**

1. **Cash Surrender** allows the owner the option to surrender the policy (send back to the company) at any time in return for its cash value. This in effect terminates the policy and ends the promise to pay a death benefit. The insurance company does have up to six (6) months to pay the cash to the owner. This is known as the Delay Clause. A policy surrendered for its cash value cannot be reinstated.

2. **Reduced Paid-Up Insurance** (the same as dividend paid-up):
   - **The Cash Value is used as a single (NET) premium to buy paid-up coverage on a non-medical basis.** *The policy owner will receive a policy that is paid in full for life.* **Premium is based on the insured's attained age.**

3. **Extended Term Insurance**, a.k.a., **Automatic Option:** The policy owner uses cash value (minus any loan amounts) as premium to purchase **term insurance** in the original face amount for as long as the cash value lasts.
   - Insured's attained age is used to calculate the premium each year.
   - Net premium is used to purchase term coverage on a non-medical basis.
   - ***This option goes into effect automatically if no other option is chosen by the policy owner.***

E. Dividends…When a policy participates in the favorable investment, mortality, and expense experience of the insurer, the policy owner receives *dividends* as a refund of an *overcharge* in premiums. Dividends are **not** taxable since they are a return of after-taxed dollars. Dividends ***cannot be guaranteed*** (constitutes **illegal rebating**) because a company's profit is not guaranteed. Companies which pay dividends are also called ***participating companies***. The most common types of participating companies include Mutual and Fraternals.

The Right to Elect or Change Dividend Options rests with the ***policy owner***. The options include **Four Basic Options + The Fifth Option:**

1. **Cash** is paid annually on the anniversary date.

2. **Accumulation of Interest** means the dividend stays with the insurance company and earns a competitive interest rate. The money **is not** put into the cash value account so it can be withdrawn at anytime without affecting the cash values. **The interest earned on the dividend is taxable.**

3. **Paid-Up Additions *(no evidence of insurability is needed)*:**

- Dividends are used as a single (NET) premium to purchase additional coverage that is fully paid for. The coverage is the same as the original policy. The option uses attained age for premium calculation.
- Can only use current or future dividends to purchase paid-up additions. Previously paid options cannot be changed.

4**. Reduced Premium Option**

5. **One-Year Option** (a.k.a. Fifth Option) is used to buy 1 year term insurance coverage. Usually the amount of the term coverage is limited to the cash value in the policy. The option uses attained age and net premiums.

- ***No evidence of insurability is required.***
- ***This term coverage is <u>not</u> renewable or convertible***.

F. <u>Settlement Options</u>…This **policy provision** works the same as the annuity payout options. While about 98% of death benefits are made in a lump sum, a portion of death proceeds are disbursed in other ways. These optional disbursements are known as settlement options.

1. **Settlement Options and Their Uses**:

- **Interest Only** Option—The insurance company holds the proceeds and pays the interest earned to the beneficiary. **<u>The interest is taxable</u>**.
- **Fixed Period** Option is the same as the installment annuity option. The beneficiary receives equal payments of both principal and interest over a designated period.
- **Fixed Amount** Option is the same as the installment amount annuity. The beneficiary receives payment of a predetermined amount consisting of both principal and interest.
- **Life Income** Option is the same as the Life Annuity Option:
  - **<u>Straight</u>** or Pure Life w/No Refund
  - Life <u>w/Refund</u>
  - Life <u>w/Period Certain</u>
  - <u>Joint Survivor Life Income</u> pays one check to two people and the survivor continues to receive a payment until death

2. **The Right to Elect or Change Options** rests with the policy owner. The policy owner may choose any option under which the proceeds will be distributed to the beneficiary, regardless of the beneficiary's wishes. If the owner does not choose an option, the beneficiary has the right to decide how to receive the proceeds.

G. <u>Beneficiary Designations</u>

1. **Categories:**

a. **Named Party** specifies a person by name to receive the death proceeds when the insured dies.

b. **Class** designates a group rather than an individual name. This saves having to change beneficiary designations if someone in the group dies or because of additions due to birth.

- **Per Capita** (per head) means the proceeds go to <u>all surviving</u> <u>beneficiaries</u> when the insured dies. This is the way that most policies will read if more than one beneficiary is listed.

- **Per Stirpes** (per the root) means that the death benefits will go to the heirs of a <u>deceased beneficiary</u> when the insured dies.

c. An **Estate, Trust or Company** may be named as a beneficiary to receive the policy proceeds. There are drawbacks as well as advantages to these designations.

d. A **Minor as Beneficiary** is not wise because minors are not legally competent to receive policy proceeds. Proceeds can be paid to a properly appointed guardian or trustee for the minor. If the insurance company holds the proceeds, it must pay interest on the proceeds.

e. **Primary/Contingent/Tertiary** = First/Second/Third in line to receive the death benefits. The ***primary beneficiary*** is the first in line to receive the death proceeds when the insured dies. The ***contingent beneficiary*** only gets the death benefit if the primary beneficiary dies ***before*** the insured dies. The ***tertiary beneficiary*** is third in line for the death benefits in the event that both the primary and contingent beneficiaries predecease the insured.

- *If there is no beneficiary, the death benefit will go to the insured's estate.*

f. **Revocable** beneficiary may be changed at anytime by the policy owner, in writing, to the insurance company. The contract is changed by an endorsement to the policy.

g. **Irrevocable** beneficiary may only be changed with written consent from the irrevocable beneficiary **and** the policy owner. **No assignment, loans, withdrawals or cash dividends are allowed** without the written consent of the irrevocable beneficiary.

- The irrevocable beneficiary has a vested right in the Face Value only and may ***continue to make the premium payments to keep the policy in force if it lapses, and is entitled to a copy of the policy***. However, the irrevocable beneficiary has no ownership rights in the contract.

2. **Simultaneous Death Act** states that if the insured and primary beneficiary die in the same accident and there is **no evidence** that the primary beneficiary outlived the insured, proceeds will go to the **contingent beneficiary**. To avoid any court action from the heirs of the primary beneficiary who may feel they are entitled to the proceeds, it will be assumed that the primary beneficiary ***died first.*** If the primary beneficiary survives the insured, even for one minute, the proceeds will be paid to the beneficiary's estate, and not necessarily to the person the insured wanted to benefit, which is usually the contingent beneficiary.

3. Common Disaster Provision (is part of the Uniform Simultaneous Death Act) states that as long as the beneficiary dies within a certain period of time following death of the insured, it will still be treated as if the beneficiary dies first. The provision contains a ***short-term survivorship*** clause which states that if the insured and primary beneficiary die due to the same accident but the primary beneficiary dies within a certain number of days after the insured (10, 20 or 30 days and is stated in the life insurance policy), then the contingent beneficiary will receive the proceeds just as if the **primary beneficiary had died first.**

4. **Special note**: Since a beneficiary has no ownership rights in the life insurance contract, a beneficiary's signature **IS NOT** needed on the application for insurance. A life insurance contract does not require a beneficiary even be listed on the application. With no beneficiary, any proceeds would go to the insured's estate.

H. Premium Payment (sometimes found in the Consideration Clause)**…**identifies the fact that the policy owner must pay premiums and submit a fully completed application as value to the insurance company for the insurer's promise to pay. ***It also states the mode and amount of the premium payment.***

The more often premium payments are made (12 installments will cost more than just one, up-front payment), the more costly to the insured. When the company designs its policies, it expects the annual premium up-front.

Automatic Premium Loan (APL) is used on a **Whole Life Policy,** which authorizes the insurer to borrow policy cash value to pay premium to keep the policy in-force. This option must be added at the request of the policy owner. The loan plus interest must be paid back.

1. With the APL, the policy will avoid going into the Non-forfeiture Automatic option (extended term option) if the insured does not pay the premiums of the policy.

2. ***The APL is not needed on the Universal Life*** because if no premium is paid (flexible premium), the insurance company will automatically take out the cost of insurance and expenses from the cash value.

I. <u>Additional Policy Rights, Riders and Benefits</u>:

1. **Accidental Death**, a.k.a. AD Rider, pays an additional amount beyond the face amount of the policy (double or triple indemnity) if the insured dies **accidentally**.

2. **Accidental Death and Dismemberment** may be written as a separate policy or as a rider on another life or disability policy. The **Principal Sum** pays for accidental death, or for the dismemberment of or loss of use of any two limbs, or for the total loss of hearing, sight or speech. The **Capital Sum** (which pays ½ of the Principal Sum) pays for loss of or loss of use of any one limb, for loss of sight in one eye or partial loss of hearing. The AD & D will usually have a *schedule of benefits* for a lesser type of dismemberment, such as the loss of a hand or finger.

AD & D policies and AD riders will **not** pay if death or dismemberment occurs **more than 90 days** after the accident. These policies will not pay for death:

- ∅ due to any illness
- ∅ due to suicide or any intentional acts
- ∅ due to any war or warlike action (military duty)
- ∅ due to air travel other than as a fare-paying passenger
- ∅ which happens while committing assault, felony or riot
- ∅ due to the use of any drugs (unless the insured is under a doctors' care)

If an insured commits suicide, an AD & D policy <u>will not</u> refund any premiums nor will it pay any death proceeds, as intentional acts are excluded.

3. **Guaranteed Insurability Option** (a.k.a. GIO, GIB or GIR) guarantees the insured the opportunity to purchase additional permanent insurance coverage. Usually, the options range from a minimum of $5,000 and a maximum of $50,000.

- **Gross Premium** is charged and the insured's **attained age** is used.
- **Purchase Dates** are the ages when an option to buy additional insurance can be made ***<u>without proof of insurability</u>***.
- An insured can **move-up** in G.I.O., but can **never go back**.
- **Advance Purchase Dates** allow the insured to **move-up** and take the next option date available. The Advance Options include: upon the birth of a child or upon marriage.

4. **Waiver of Premium Rider…**Almost all companies offer a waiver-of-premium benefit. It provides that in the event the insured becomes totally and permanently disabled before age 60 or 65, premiums on the contract will be waived during the continuance of disability beyond a specified <u>waiting period</u>, usually six months.

- The operation of the contract continues just as if the policy owner were paying the premiums. Thus, dividends continue to be paid, cash values continue to increase, loans may be secured, and so on.

- **Waiver of Premiums with a Disability Income Rider** works the same way the waiver of premium works but ***pays a regular monthly income to a policy owner who becomes totally disabled***. There is a <u>waiting period</u> which is the same as the <u>waiver of premium</u> rider before any benefits are paid.

5. **Payor Waiver (Benefit) Rider…**When added to the **<u>Juvenile Policy</u>**, this provides that premiums will be waived in the event the premium payor dies or becomes disabled, or until the insured (the child) reaches a specified age. Evidence of insurability must be furnished by the premium payor before the clause can be added to the contract.

6. **Cost of Living Rider** gives the policy owner the option to purchase additional coverage to keep pace with inflation, as measured with the ***CPI (Consumer Price Index).*** Increases in coverage must be paid for with increased premiums. However, the option to increase coverage requires ***no evidence of insurability*** on the part of the insured. Decreases in the CPI do not decrease coverage.

7. **Accelerated Death Benefit Rider** (a.k.a. Life Settlement)… With this rider, part or all of the policy face amount may be paid in advance on the diagnosis of certain dread diseases or in the event of circumstances significantly affecting the insured's longevity and quality of life, such as a major organ transplant or entering a nursing home.

- Accelerated death benefits paid to the chronically ill and terminally ill are treated as death benefits and will NOT be taxed as income.

- A **disclosure statement** must be provided to the applicant of an individual or group life insurance policy at the time of application. ***The disclosure statement must be provided which contains a statement that receipt of accelerated benefits may be taxable and that assistance should be sought from a personal tax advisor.***

8. **Change of Contract** provision allows the policy owner to change the type of policy, for example, Whole Life to Limited Pay or Universal to Variable Life. The change is within the same company, for the same amount of coverage, and no proof of insurability is required.

- **1035 Exchange**: The Internal Revenue Code does provide for an exchange of one life contract for another, subject to certain requirements, in Code section 1035. If the requirements are met, the policyholder may exchange one contract for another (***including moving the cash value***) without incurring any current income taxation.

9. The **Right of the Insurer to Defer Clause**, (a.k.a. ***Delay Clause***), gives the insurance company the right to defer loans and/or cash payments to the policy owner for up to 6 months following the owner's request. This provision is intended to protect the company against *runs* on the company's cash reserves.

- This provision (clause) does not apply to death benefits which must be paid immediately upon proper ***proof-of-loss***. A ***Proof of Loss*** is a formal statement made by a policy owner to an insurer regarding a loss. For example, a claim form along with doctor's bills or a death certificate submitted to the insurance company would constitute a ***proof-of-loss.***

III. Group, Business Uses of Life Insurance & Misc.

A. Group Insurance is the youngest and fastest growing branch of the life insurance business. Premiums are usually based on ***annual term life.*** The coverage can be based on length of service and/or salary. ***Group underwriting is usually written on a non-medical basis, meaning that no proof of insurability is required by the enrollees.***

1. Employee Group is where a single employer gets coverage on its employees. Employee groups (the most common) now account for almost 90% of all group life coverage in-force.

- **Employment Probationary Period** (usually 90 days) is nothing more than a period of time established by the employer for all new employees before the employee will be eligible for any group benefits.

- **Eligibility Period** is 31 days following the end of the "probation" period in which the employee is entitled to enroll in the group plan. However, some group plans have an Open Enrollment Period which allows an employee to sign-up for benefits after the eligibility period. Under "noncontributory" plans, enrollment is automatic.

  ***The eligibility period is the same as a grace period. If a loss occurs during the eligibility period and the enrollee has not signed up for a plan, the minimum coverage available under the Master Policy will be provided*.**

- **Participation Requirement**…A ***contributory*** group is where the employee contributes some of the premium. With this type of group, the insurance company requires that at least ***75%*** of eligible employees and their dependents be enrolled in the group plan. A ***noncontributory*** group is where the employer pays all of the premiums. With this type of group, the insurance company requires that ***100%*** of eligible employees and their dependents be enrolled in the plan.

2. Master Policy vs. Certificate Of Insurance…The employer receives the master policy; enrollees receive certificates of insurance. The insurer will issue to every insured an individual certificate regarding insurance protection, benefits, and rights. The certificate must summarize the essential coverage features of the policy and to whom benefits are payable.

3. Conversion Rights for employees and dependents **guarantees** that coverage can be continued (at the insured's option) should the employee leave employment. The insured has **31 days** to convert to a ***permanent and individual insurance policy***. Premium is based on attained age with ***no evidence of insurability required***. These rights apply for all dependents.

4. Term Insurance… Almost all group life insurance is annual renewable term insurance. Premiums may fluctuate from year to year, depending on the number of employees and the average age of the group.

5. Credit Life 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) dies before the loan has been repaid. ***The amount of life coverage on the insured may not exceed the amount of the debt owed***.

B. Tax-Qualified Individual Retirement Plans…Recognizing the necessity for working people to provide for their retirements, the government offers some significant tax benefits for certain kinds of retirement plans. These are called ***Qualified Retirement Plans***. In order to be qualified, a retirement plan must meet certain requirements of the Internal Revenue Code with respect to participation, funding, benefits, vesting, and so on.

Qualified Retirement Plans:

- ✓ Must be formally written and communicated to employees.
- ✓ Must be permanent.
- ✓ Must be approved by the Internal Revenue Service (IRS).
- ✓ Must have a vesting requirement.

Once ***qualified***, a retirement plan offers significant tax advantages:

- Generally, contributions are tax-deductible. *Exception:* Roth and Education IRAs are not tax deductible.
- Interest earned on contributions is tax-deferred (until withdrawn), and since the accumulated funds are 100% vested, they may be withdrawn at any time.
- There is an early withdrawal penalty by the IRS of 10% if the funds are withdrawn before age 59½ (subject to a few exceptions).
- There is a late withdrawal penalty of 50%. Funds need to start being liquidated by age 70½ and the 50% penalty applies only on the funds which should have been withdrawn and not on the entire account.
- ***Deferred Annuities*** may be used to fund ***individual*** qualified plans.

1. Traditional IRA (Individual Retirement Account)…Contributions are generally tax deductible for the individual (depending on IRS qualifications). If the individual or the individual's spouse, if married and filing jointly, has available to them an employer-maintained retirement plan, contributions are deductible if adjusted gross income (AGI) is less than a certain amount.

2. Roth IRA…The ***Roth IRA*** is treated the same as a traditional IRA with a few exceptions. ***No tax deduction is allowed*** for any contribution to a Roth IRA. Unlike traditional IRAs, contributions to Roth IRAs are permitted after the individual has reached age 70½. Further, the mandatory distribution rules do not apply; thus, required minimum distributions need not begin by April 1 of the year following the year the individual attains age 70½. ***Qualified distributions from Roth IRAs are tax-free, not*** **tax-deferred as with Traditional IRAs.**

Maximum contributions for both the Traditional IRA and Roth IRA: **For the year 2012, $5,000 per individual** and **$10,000 total for individual and spouse,** plus an additional $1,000 for individuals age 50 and older.

3. HR10 (Keogh Plan)…Anyone with **income from self-employment** (*not corporations*) may establish an HR10 plan. This includes sole proprietors, partnerships or professionals such as doctors, lawyers, and insurance agents, who are **not incorporated**. The maximum contribution is 100% of earned income, up to a certain maximum, whichever is less.

4. T.S.A (Tax Sheltered Annuity) ***(a.k.a. 403b or 501C-3 Plans)…***Employees of tax exempt, charitable, educational, ***nonprofit or religious organizations*** may have a portion of their income put into a TSA. The maximum contribution is 100% of earned income up to a certain maximum, *whichever is less*. TSAs may be funded with annuities or mutual funds.

5. S.E.P. (Simplified Employee Pension)…This is similar to a traditional IRA except that the insured can save more of his earned income. It is often considered an extension of the IRA. The SEP was established for ***small businesses*** with the intention of simplifying the administration and reporting requirements for the employer. The maximum contribution is 25% of the employees' earned income, up to a certain maximum, whichever is less.

Individual Qualified Retirement Plans…Annual Contributions

IRA	S.E.P.	T.S.A. (403b)	HR 10
$5,000 max/per person	SEP-IRA	Charitable, Religious and Teaching organizations	Keogh Plan (self-employment income)
$10,000 max/per married couple	25%*	100%*	100%*

***Percentage of annual income for that year, or maximum contribution for that year, whichever is less.**

C. Nonqualified Retirement Plans

Section 457..... Plans that are used for saving money for retirement but do not meet the requirements of the IRC are known as **nonqualified plans**. Nonqualified plans do not enjoy the tax advantages of qualified plans. ***Section 457*** of the IRC provides rules governing all ***nonqualified deferred compensation plans of state and political subdivisions of a state,*** such as a city or township, and any agency of a state, such as a school district and some organizations exempt from federal income tax.

Two popular non-qualified plans are the ***Deferred Compensation and Salary Continuation plans***. Deferred compensation plans pay a worker in the future (usually retirement) for work done today. The obvious purpose is to lower income (thus taxes) today, and pay the deferred monies out tomorrow (retirement) when the employee is hopefully in a lower tax bracket.

Life insurance may be used to fund certain retirement programs such as Split Dollar, Deferred Compensation and Executive Bonus Plans. Split Dollar and Executive Bonus Plans are discussed under business uses of life insurance.

D. Business Uses of Life Insurance

1. **Buy/Sell Agreements** spell out the terms of the sale of an owner's business interest upon his death. **The agreement should include a provision for funding with life insurance.** This assures that the money will be available to pay off the deceased partner's family (heirs), and the business will be owned solely by the surviving partner/partners. **There are two types:**

a. 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 his share of the business.

b. Under an **Entity Buy-Sell 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 death of one of the partners. One policy per partner.

2. **Key Person/Partner** insurance is purchased on the lives of a company's key employees to protect itself against their death. The ***proceeds are paid to the business*** to offset a drop in profits and help pay to recruit and train a suitable replacement. **The business is: the applicant, the owner (3rd party owner), the beneficiary, and pays the premiums for the insured (Key Person/Employee).**

- **Third-Party Ownership…**A person other than the insured, who has ***insurable interest***, may apply for and own a policy covering the insured and is entitled to the benefits and other rights provided. The **first party** is the insured; the **second party** is the insurance company; and the **third party** is the ***owner of the contract.***

3. **Split Dollar** life insurance is an arrangement between an employer and an employee (not a policy). The purpose of a *split-dollar* arrangement is to make the purchase of life insurance affordable and provide a fringe benefit for the employee. Basically, the employer subsidizes the premiums of the insured (the employee).

E. Social Security is a benefit program run by the Federal Government. The ***Old Age, Survivors', Disability, and Health Insurance Program*** protects eligible workers and their dependents against the financial losses associated with death, disability, and sickness in old age (Medicare). The retirement benefit is a fundamental element in the Social Security program.

- **Fully Insured** generally means that the person has at least **40 quarters** of coverage. A quarter of coverage generally means a calendar quarter in which the worker had a specified minimum level of earnings. ***All benefits are available if an individual is fully insured.***
- **Currently insured** means the person has at least six quarters of coverage in the last 13 quarters. Only death benefits and child benefits are available.

1. ***Retirement Benefits*** are expressed as a percentage of the ***Primary Insurance Amount*** (PIA). The **PIA** is based on the average level of earnings of the insured.

For example a person will receive:

- **100%** of his PIA if he is fully insured and retires at his "**Normal Retirement Age**" (currently about 66 years of age).
- **Less than 100% if he retires early** (currently 62 years of age).
- **More than 100% if he accepts benefits later than the normal retirement age.**

2. ***Survivorship Benefits*:**

- $255 lump sum ***death benefit*** paid to the surviving dependents.
- ***Widows or widowers*** of any age who have dependent children in their care are entitled to a monthly benefit of 75% of the PIA. When the youngest child reaches 16, this benefit terminates. However, the spouse's survivor benefits will start again when he or she reaches age 60. The time period between when the children all reach 16 and when the spouse reaches 60 is called the ***black-out period*** because the spouse is not eligible for any benefits for that period of time.
- ***Children*** under 18 who remain unmarried are eligible for a monthly payment equal to 75% of the deceased parent's PIA.

3. ***Medicare and Disability Income benefits are discussed in the Disability Text.***

F. Federal Tax Treatment Of Life Insurance

1. **Premiums** are ***not income tax deductible*** from the insured's income. **Cash Values** accrue ***tax-deferred*** (paying tax on surrender of the policy, on any amount over and above the premiums paid). **Dividends** are received ***tax free***. However, *Dividend interest is taxable the year earned.*

2. **Death Benefits** (**Proceeds)** are ***federal income tax free to the beneficiary*** but are added to the policy owner's estate and thus, may be subject to federal estate tax.

3. **Withdrawals** are another means of obtaining funds from the cash value account. A ***partial withdrawal*** (available on universal life policies) does not have to be repaid to the policy, and therefore, no interest is charged on a withdrawal. Premiums are allowed to be withdrawn first from the cash value, so any withdrawals that exceed the premiums paid will be taxed. On the other hand, loans have to be repaid and they do accrue interest.

4. **Policy Loans**...A cash value loan from a life policy is **NOT** taxable as income to the insured, and the interest paid on the policy loan **IS NOT** tax deductible.

5. **Section 79** (IRC)…For group life insurance, the **premiums** paid by the employer are deductible for the employer. The premiums are **not** considered as taxable income to the insured. This applies only up to the **first $50,000 of coverage**. Premiums paid for coverage over the $50,000 are taxable as income to the employee. The maximum amount of life coverage on the spouse may not exceed ***50%*** of the working spouse's coverage. **Children's maximum coverage is $2,000**.

- ***Coverage in "excess" of these limits will cause a tax on the premiums paid for those benefits.***

6. **Modified Endowment Contracts** (a.k.a. MECs)**…**To counteract what was perceived as an abusive use of single-pay, limited-pay, and universal life policies as short-term, tax-sheltered, cash accumulation or savings vehicles, Congress passed legislation, effective in 1988, modifying the tax law definition of a life insurance contract, and created a new class of insurance contracts called MECs.

The test for MEC status is called the ***Seven-Pay Test***. A contract fails to meet the seven-pay test if it accumulates amounts paid under the contract at any time during the first seven contract years exceeding the sum of the "net level premiums." The IRS considers such contracts "***over funded,*** "such as single premium whole life.

The basic difference between MECs and other life contracts is the federal income tax treatment of amounts received during the insured's life. When received from MECs, certain distributions under the contract that are not

generally subject to tax when received from other life contracts are subject to income tax and, in some cases, a 10% penalty. The 10% penalty applies to distributions taken before age 59½. **Amounts received under MECs are treated as income-first**, such as loans, withdrawals and cash dividends (they are taxed the same as "deferred annuities").

G. Legal Concepts

1. **Insurable Interest…**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. ***Insurable interest must exist at the time of application.***

2. On an application, **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.

3. **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*****.**

4. **Warranty *is a written (expressed) guarantee in the policy that something is true in every respect and detail.*** For example, a hotel will *warrant* to the insurance company that its sprinkler system will be in operation 24 hours a day. In any insurance contract, the warranty given by the *insurance company* is their promise to pay. This is found in the ***insuring agreement (clause)***.

5. **Third party ownership** is a legal term used to identify the person or entity that owns all the rights in the policy, but is NOT the insured. Policies involving a third party owner includes business insurance, like buy - sell policies where each business owner owns a policy on the other business owner or for insurance on juveniles in which the parents own the policy.

IV. The Life Contract: Application, Underwriting, Delivery, and Misc.

A. **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. ***Signatures of the owner, the insured and the agent are required***. 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.

- ***Underwriting*** is the process of selection, classification and rating of risks. Simply put, underwriting is a ***risk selection process***. The selection process consists of evaluating information and resources to determine how an individual will be classified such as standard, preferred or sub-standard.

- ***Replacement of a Policy*** is legal but most states have "Replacement" regulations. The purpose of the replacement regulation is to regulate activities of insurers, agents and brokers 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.

The replacement regulation requires that a ***Notice Regarding Replacement of Insurance form*** be completed by the agent when a new application is written and an existing policy is either lapsed or terminated. The form makes the insured aware of certain areas which may be of concern should an existing policy be replaced.

- **Disclosure: HIPAA Privacy Rule…**The primary purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected 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*****.**

- **HIV Disclosure: any test for HIV must be disclosed to the applicant.** A disclosure form must be filled out by and signed by the producer, and also signed by the insured. The original must be left with the insured and a copy sent to the insurance company. The form makes the insured aware of the confidential treatment of the test results.

B. **Evaluation** of the applicant is based on age, sex, amount of protection requested, moral habits, occupation, hobbies, current health, and past health. **Unfair discrimination is not allowed**. No entity engaged in the business of insurance can refuse to issue any contract of insurance or cancel or decline to renew such contract of the insured or prospective insured when ***bona fide statistical differences in risk*** or exposure ***have not*** been substantiated.

- **Standard Risks** will live to normal life expectancy. A non-tobacco user discount may be available.
- **Preferred Risks** will live longer than normal life expectancy and will receive a discount. A non-tobacco user discount may be available.
- **Substandard Risks** will not live the normal life expectancy and will pay a higher premium. A *rate-up* or *surcharge* would constitute a ***counter-offer*** by the insurance company, and would require a signature from the policy owner.

    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.

C. **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 counter-offer), a signature from the policyowner will be needed upon delivery of the policy. **The policy will be in force when the counter offer is signed and the additional premium is paid.**

D. **Policy Delivery** 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 the insured and owner aware of any changes.*** Delivering the policy in person will give the agent 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 receipt also should be obtained so that the agent can prove delivery (minimum 10 day free look in Washington).

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

- **Medical Examinations**, when required, are conducted by physicians or paramedics. An exam might include such things as a urine specimen, blood test, blood pressure check, or EKG.

- **Consumer Report/Credit Check (Fair Credit Reporting Act)…** Consumer 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.

* 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**.

- **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. Most company's home offices handle the reports, yet some may have other organizations check on the insured's background 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 the most important source of information to the insurance company during the underwriting process so his report is important to the insurance company.

F. **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***.

- 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 agents 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. 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, no death benefits would be paid but the premiums paid will be refunded.

- 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.

- There are three reasons why the effective date is important:
  1) Insurance coverage actually begins
  2) The contestable period begins
  3) The suicide clause begins

G. **Do-Not-Call Registry…**was established by the FCC together with the Federal Trade Commission (FTC). The registry is nationwide in scope, applies to all telemarketers (with the exception of certain non-profit organizations), and covers telemarketing calls. Commercial telemarketers are not allowed to call you if your number is on the registry.

- *Violators could be fined up to $11,000 per incident*. Telemarketers are required to search the registry *at least once every 31 days* and drop from their call lists the phone numbers of consumers who have registered. ***An individual can register a phone number for free and it will remain on the national do-not-call list unless you direct the Federal Trade Commission (FTC) to remove it. The FTC no longer requires people to sign up every five years.*** A phone number can be removed from the list at any time.
- Contact www.donotcall.gov or call 1.800.382.1222.

WASHINGTON LAWS AND RULES *for Disability Insurance*

A. Marketing Methods and Practices

1. An Outline of Coverage is required to be given on all disability insurance policies ***at the time of application*** and acknowledgement of receipt provided to the insurer. The outline includes a description of benefits, any limitations, the insurer's renewal rights, and a statement telling the insured to ***read the policy***.

2. The Washington Medicare Supplement Health Insurance Act…
Medicare Supplement (a.k.a. Medigap) policies are sold by ***insurance companies*** to pay for what Medicare approves but does not pay. ***Applicants must be at least 65 years of age and covered under Part A and Part B of Medicare.***

Note: The Washington Insurance Coverage Access Act (health pool for people who have been denied coverage) guidelines also apply to Medigap policies.

- **An exclusion for pre-existing conditions** is allowed for a maximum of ***three months (90 days)***. A pre-existing condition is a condition for which medical advice was given or treatment was recommended within three months before the date of coverage.

  Note: **No exclusions** are permitted when replacing an in-force Medigap policy. Should an in-force policy be replaced, a replacement form is required to be filled out, signed, and the original left with the beneficiary.

- ***Open enrollment*** **guarantees that for six months immediately following enrollment in Part B, persons age 65 and older cannot be denied Medigap insurance.**

- The insured must be given a **Medicare Buyer's Guide** and an **Outline of Coverage** no later than the time of application.

- An agent/producer **may not** sell a Medigap policy when another Medigap policy is to remain in-force.

- ***A beneficiary may not have two Medigap policies at once***.

- A licensee or representative of an insurer or organization MAY NOT:

  ∅ ***Complete the medical history portion of any form or application for the purchase of such a policy*** (the medical history questions must be completed by the applicant, applicant's spouse, legal guardian, or physician).
  ∅ ***Knowingly sell a Medigap contract to any person who is receiving or applying for Medicaid.***

- Policies must be **guaranteed renewable** and have a ***31-day grace period***. ***A 30-day*** free-look period ***is required*** from the date the policy is ***delivered to the beneficiary***. This gives the beneficiary the right to return the policy for a ***full refund***.

- No Medicare supplement policy may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions (e.g., no permanent exclusions, impairment riders, rate-up or surcharges).
-
- A Medicare supplement policy may **NOT** be issued with benefits for outpatient prescription drugs. If a policyholder enrolls in Medicare Part D, a policy may **NOT** be renewed with benefits for outpatient prescription drugs. However, the premiums must be adjusted to reflect the elimination of the drug coverage.

3. **The Long-Term Care Insurance Act**

- ***Institutional Care*** means care provided in a hospital, skilled or intermediate nursing home which provides
- 24-hour nursing services on its premises or in facilities available to the institution on a formal prearranged basis.

- ***Community Based Care*** means services outside an institutional setting, including: home-delivered nursing services, custodial or personal care, day care, and nutritional in-home services; skilled, intermediate or custodial care.

- ***Terminally Ill Care*** *or* ***Hospice Care*** means care for an illness, disease, or injury which the patient has a life expectancy of six months or less.

- ***Chronic Care*** or maintenance care means care that is necessary to support an existing level of health and is intended to preserve that level from further failure or decline.

- ***Convalescent Care (Rehabilitation)*** is care received during the period of recovery from an illness or injury when improvement can be anticipated.

- ***Alternative Care*** is care or services that are not specified in a policy, but that may be provided if agreed upon by the insurance company, the insured person, and his or her physician. The alternative care benefits are provided in lieu of normal contract benefits, such as placing a person in an adult family home instead of a nursing home.

- ***Activities of Daily Living (ADLs)*** such as ***eating***, ***dressing***, ***bathing***, ***transferring*** (ability to move in and out of a wheelchair, bed or chair), ***toileting*** (ability to perform associated hygiene), and ***continence*** (ability to control bowel or bladder functions).

    - ***In order to get a LTC policy you must be able to perform the ADLs***. However, if you have a LTC policy you will not be able to receive any benefits unless you are ***unable to perform the ADLs***. A long-term care contract may not require a deficiency of more than three of the six ADLs as a benefit trigger for the insured.

- ***Cognitive Impairment*** is a deficiency in the ability to think, perceive, reason or remember, and which results in the inability of individuals to take care of themselves without assistance or supervision of another person.

Levels of Care…A Long-Term Care contract ***must cover*** skilled, intermediate and custodial care, whether benefits are for institutional or community based care.

- **Skilled Nursing Care** is required daily and must be performed by a skilled medical practitioner. A Registered Nurse must be on duty 24 hours a day.

- **Intermediate Care** is similar to skilled care but is required only occasionally by a medical practitioner and by doctor's orders.

- **Custodial Care** (a.k.a. Personal Care) ***provides nonmedical help with the ADLs***. Must be by doctor's orders but does not need a skilled practitioner. This is the type of care most needed by the elderly.

Required Provisions:

1. **LTC must be guaranteed renewable** and have a **31-day grace period.**

2. Long-Term Care insurers must deliver a **disclosure form** to the applicant at the time of
3. solicitation. The form must be left with the applicant and the insurer also must keep a copy. It must include:

   - ✓ Information about the carrier, producer and coverage.
   - ✓ The statement: "This is **not** a Medicare Supplement Policy."
   - ✓ A **Free Look** provision (***30 days if purchased from an agent***, ***60 days if purchased through direct response companies)*** allows the policyholder to examine the newly issued policy and surrender it in exchange for a full refund of premium if not satisfied for any reason. A direct response insurer is any
   - ✓ insurer who sells insurance to the public without the use of a producer.
   - ✓ A definition of usual, customary or reasonable, if used in the policy.
   - ✓ A description of any *gatekeeper* provisions such as recommendations of the
   - ✓ attending physician or a ***Case (Care) Manager***.

4. ***Case Management or Gatekeeper Provision:***

   "Care (Case) Manager" means an individual qualified by training and/or experience to coordinate the overall medical, personal and social service needs of the long-term care patient. Such coordination activities include ***assessing the individual's condition to determine what services are necessary***.

   "***Plan of Care"*** means a written, individualized plan of services approved by the case manager that specifies the type, frequency, and providers of all formal and informal long-term care services required for the insured.

5. LTC must provide benefits for all forms of mental and emotional disorders.

6. A producer or other representative of an insurer or organization ***MAY NOT:***

   - ∅ ***Complete the medical history portion of any form or application for the purchase of such a policy*** (the medical history questions must be completed by the applicant, the applicant's relative or legal guardian, or a physician). Special Note: All health statements and health questions to the consumer must be
   - ∅ clear and unambiguous. It is the producer's responsibility for making sure that the application is completed correctly and completely.
   - ∅ ***Knowingly sell a long-term contract to any person who is currently applying for or receiving Medicaid benefits.***
   - ∅ Use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of long-term care contracts.

7. **Prohibited Provisions for Long-Term Care - The carrier *MAY NOT:***
   - ∅ Use riders, waivers or endorsements to limit or reduce coverage or benefits (e.g., no surcharges, rate-ups, permanent exclusions, or impairment riders).
   - ∅ Indemnify sickness losses on a different basis than accident losses.
   - ∅ Cancel or non-renew based on age, health, mental or physical conditions.
   - ∅ ***Exclude a preexisting condition for more than* six months**. A pre-existing condition is a condition for which medical advice was given or treatment was recommended within **six months** before the effective date of coverage.

- ∅ ***Offer a benefit period of less than one year***.

8. A **Cost of Living Adjustment** allows the benefit to increase each year to keep pace with inflation.

9. In Washington, a **C.O.L.A. is required to be offered** *with all LTC policies*.

10. **Benefits are paid** on a *per-day* basis (e.g., $150/day) with a waiting period (e.g., 20 or 100 days). Some companies now offer a set dollar amount to be paid, such as $200,000. Once $200,000 has been paid for the insured's long-term care, no more benefits are available. ***Benefits under long-term care contracts always pay secondary (excess) to other contracts***.

11. Producers engaged in the transaction of long-term care insurance are currently required to take a ***special approved eight-hour (8) LTC course.*** After the first course, a four-hour refresher course per renewal is required. The approved LTC courses count towards the required twenty-four hours of continuing education for renewal of licenses.

12. **Suitability…** Insurance producers must use the suitability standards developed by the issuer in all marketing or solicitation of long-term care insurance. Every issuer or other entity marketing long- term care insurance must:
    - Develop and use suitability standards to determine whether the purchase of long-term care insurance is appropriate for the needs of the applicant; and
    - Train its insurance producers in the use of its suitability standards.

- ✓ To determine whether the applicant meets minimum standards, the producer and the issuer must develop procedures that take the following into consideration:
    - The ability to pay for the proposed coverage
    - The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs
    - The benefits and costs of the applicant's existing insurance, if any, when compared to the benefits and costs of the recommended purchase

- ✓ The presentation to the applicant must include the "**long-term care insurance personal worksheet**" and a disclosure form entitled "***things you should know before you buy long-term care insurance***."

13. **Underwriting Considerations…**Long-term care **classifies risks** according to a persons' ability to perform the activities of daily living (ADLs) such as eating, dressing, bathing, transferring and personal hygiene. **Underwriting** is based upon age and sex of the prospect, and the *ability to perform the ADLs*. LTC underwriting is concerned with the same factors as health insurance, but the ***emphasis is on the likelihood of prolonged confinement in a nursing home.***

- ❖ For example, a person who has a heart condition that may require surgery may not be a good prospect for life insurance or health insurance, but might be accepted for LTC insurance because the condition probably would not result in a nursing home stay.

14. **Medicaid in relation to Long-Term Care…**At no time can any policy state or have the appearance of representing that the insured will be guaranteed to be automatically eligible for Medicaid or that Medicaid will deliver the same benefits as the insured's long-term care policy.

B. Policy Clauses, Provisions and Miscellaneous…The commissioner establishes minimum standards for full and fair disclosure with regard to renewability, eligibility, non-duplication of coverage, dependents, pre-existing conditions, insurance termination, etc.

1. **Standard (Uniform - Mandatory) Provisions**

2. **Optional (Uniform) Provisions**

3. **Newborns *are covered at birth on all individual and group disability insurance policies.*** The insured must pay the premium and fill out the necessary forms within **60 days or lose the coverage.** **Adopted children are treated the same as newborns.**

    - ***Complications of childbirth are covered as normal care, even if the insured is not covered by maternity benefits***.

4. **Proof of Notice…**If any notice is mailed, the insurer is not required to prove that the insured actually received the notice. It is required to prove only that the notice was mailed to the insured at the last known address.
    - The notice by the ***insurer must disclose*** the reason for cancellation, denial or refusal to renew insurance. ***The reason must be in clear, simple language,*** and may not state simply that the insured does not meet the company's underwriting *standards*.

5. **Conversion/Continuation Rights…** ***Individual disability insurance policies*** must provide that the covered spouse and/or dependents may ***continue*** the policy coverage ***without evidence of insurability*** if they cease to be a qualified family member because of divorce or death of the insured.

    - To obtain the conversion policy, a person must ***submit a written application*** and the first premium payment not later than **31 days** after the date the person's coverage ends. The conversion policy will become effective, without lapse of coverage, following termination of coverage under the previous policy.

    - The insurer determines the premium for the conversion policy in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under the policy, and the type and amount of benefits.

6. **Coverage for Dependent Children…**Handicapped children ***may not be removed from the parents' policy***. Proof of incapacity for continuance of benefits for disabled or handicapped dependents must be given within 31 days from when the dependent reaches the limiting age.

    - The insurer may require proof anytime for the first two years and once per year after that.
    - The dependent must be incapable of self-sustaining employment and chiefly dependent upon the parents for support and maintenance.

7. **Certificate of Coverage**… If family members are covered under a group disability (health) contract, ***only one certificate of insurance need be issued for each family***.

8. **Health Care Service Contractor (Service Organizations) and Health Maintenance Organizations** (HMO) definitions:
    - **Health Care Service Contractor** means any corporation, cooperative, group, or association sponsored by or connected to a provider which accepts prepayment for *health care services* and not otherwise engaged in the insurance business.
    - **Health Maintenance Organization** is an organization that provides *health care services* to participants on a ***per capita prepayment or prepaid basis***.
    - **Health Care Services** means medical, surgical, dental, ***chiropractic***, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health and other therapeutic services.

9. **Chemical Dependency Benefits…**Each group contract that is delivered or issued must contain provisions providing benefits for the treatment of chemical dependency (includes alcohol) to covered persons. Treatment must be in an "approved treatment program."

    An approved treatment program means a treatment program certified by the department of social and health services as meeting standards adopted under Washington law.

The ***benefit payable for alcohol and chemical dependency treatment*** must be no less than $15,000 (exclusive of deductibles and coinsurance) in a 24-month period; and there may be no lifetime maximum limit. Each year the benefit increases in increments of $500.

- **Chemical Dependency** ***means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages.*** It includes a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use. The user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

10. **HMO**: **Employer's Responsibility** states that if the employer has at least ***50 employees*** covered under a health plan, and there is an HMO operating in the geographic area, and at least ***25 of the employees*** request an HMO as an alternative coverage plan, then the employer must make it available for its employees.

- For example: If a company has 200 employees, has a health plan covering those employees, and if there is an HMO operating in the area, and at least 25 employees request the HMO coverage, then the employer must make the plan available.

11. **Free Look…** this provision gives the owner a ***minimum*** of **10 days** to look at the policy from the date the policy is ***delivered to the owner***. This provision gives the owner the right to return the policy for a ***full refund***. The insurance company has **30 days to refund** the paid premiums or pay an additional **10% penalty** to the insured.

12. **Individual accident-only policies** may ***not*** contain probationary or waiting periods and must state on the **first page** of the policy that ***this is an accident only policy and does not pay benefits for loss from sickness***.

13. **Nonrenewal and Cancellation**: No insurer may refuse to renew an individual disability policy because of a change in the physical or mental health of any insured person. An individual disability policy ***may not be cancelled*** by the insurer except for ***nonpayment of premiums***.

- **This does not affect the right of the insurance company to increase rates** (premiums). With the permission of the insurance commissioner, a rate increase must be on a classification basis, not on an individual basis.
- This does not affect the right of the insurance company to rescind the policy for fraud.

14. **Application completion.** If any insurer intends to rely on an applicant's or enrollee's answers to health questions in an application to determine eligibility for coverage or the existence of a preexisting condition, ***such questions must be clear and precise***. Simply asking whether the applicant has been under the care of a physician during the preceding year, for example, is not sufficient to require a "yes" answer where the applicant has been using medications that were prescribed prior to the start of the preceding year and the applicant has not seen a physician for more than a year.

C. Health Insurance Coverage Access Act (a.k.a. Washington Health Pool)…

Anyone who is a resident in the State of Washington and can show evidence that they have been denied, rated-up, surcharged, or had benefits limited on a health insurance policy (***including Medigap***) may enroll in the Washington Health Pool.

- **Reimbursement coverage, same as a Major Medical; $1,000,000 maximum lifetime benefit; 80-20% co-insurance after the deductible.**

- **Double coverage prohibited**…The pool may not issue a pool policy to any individual who already has coverage or who would be eligible for such coverage if he or she elected to obtain it at a lesser premium.

- **Dependent coverage**…Coverage is applicable to children of the insured including adopted and newborn children.

- **Medicare supplement** policies also may be offered to persons receiving Medicare Parts A and B.

D. Health Insurance Reform Act (RCW 48.43.001)… It is the intent of the legislature to ensure that all enrollees in managed care settings have access to adequate information regarding health care services covered by health carriers' health plans, and provided by health care providers and health care facilities. It is only through such disclosure that Washington state citizens can be fully informed as to the extent of health insurance coverage, availability of health care service options, and necessary treatment.

Definitions

1. "**Adjusted community rate**" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in costs attributable to geographic region, age, family size, and use of wellness activities.

2. "**Basic Health Plan of Washington**" means the system of ***enrollment and payment*** for basic health care services, administered by the plan administrator through participating managed health care systems.

3. "**Basic Health Plan Subsidy**" means the amount of premium the administrator makes to the health care provider on behalf of the subsidized enrollee. An employer, with prior approval of the **administrator**, may pay the premium on behalf of the subsidized or nonsubsidized enrollee.
    - The powers, duties and functions of the Washington basic health plan is the responsibility of the **Washington state health care authority**. All references to the ***administrator*** mean the Washington state health care authority (basic health plan).

4. "**Basic Health Plan Services**" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

5. "**Catastrophic health plan**" means:
    - In the case of a policy covering a ***single enrollee***, a health benefit plan requiring a calendar year **deductible** of, at a minimum **$1,750** and an annual out-of-pocket expense required to be paid for covered benefits of at least $3,500, both amounts to be adjusted annually by the commissioner; and
    - In the case of a policy covering ***more than one enrollee***, a health benefit plan requiring a calendar year **deductible** of, at a minimum **$3,500** and an annual out-of-pocket expense required to be paid under the plan for covered benefits of at least $6,000, both amounts to be adjusted annually by the commissioner.

6. "**Certification**" means a determination by a review organization that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

7. "**Concurrent review**" means utilization review conducted during a patient's hospital stay or course of treatment.

8. "**Covered person**" or "**enrollee**" means a person covered by a health plan including an enrollee, subscriber, policyholder or beneficiary of a group plan.

9. "**Dependent**" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

10. "**Emergency medical condition**" means the onset of a symptom, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention.

11. "**Emergency services**" means covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency room.

12. "**Enrollee point-of-service cost-sharing**" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

13. "**Grievance**" means a written complaint submitted by a covered person regarding: denial of payment for medical services or service delivery issues, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude.

14. "**Health care facility**" or "**facility**" means hospices, hospitals, rural health care facilities, psychiatric hospitals, nursing homes, community mental health centers, kidney disease treatment centers, ambulatory diagnostic, treatment, or surgical facilities. It also includes drug and alcohol treatment facilities and home health agencies.

15. "**Health care provider**" means a person licensed to practice health or health-related services in this state consistent with state law; or an employee or agent of a person acting in the course and scope of his or her employment.

16. "**Health care service**" means that service offered or provided by health care facilities and providers relating to the prevention, cure, or treatment of illness, injury, or disease.

17. "**Health plan**" or "**health benefit plan**" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services. It DOES NOT INCLUDE long-term care insurance, Medicare supplemental health insurance, limited health care services offered by limited health care service contractors, disability income, property or casualty liability insurance policies such as automobile personal injury protection coverage and homeowner guest medical, dental only coverage, employer-sponsored self-funded health plans, and vision only coverage.

18. "**Material modification**" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

19. "**Preexisting condition**" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

20. "**Premium**" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan.

21. **Review organization** means an insurer or health organization affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

22. "**Small employer**" or "**small group**" means anyone engaged in business that employed an average of ***at least two but no more than 50 employees***, during the previous calendar year and employed at least two employees on the first day of the plan year, is not formed primarily for purposes of buying health insurance.

23. "**Utilization review**" means the assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility.

24. "**Wellness activity**" means an explicit program of an activity consistent with health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, weight reduction, exercise and nutrition education.

Requirements under the Health Insurance Reform Act:

1. ***Individual Health Plans*** **- Exclusion of Preexisting Conditions**

- Under an individual health benefit plan a waiting or exclusion period for a preexisting condition can be **no more than nine months.** A preexisting condition is a condition for which medical advice was given, recommended or treated by a health care provider **within six months prior** to the effective date of the plan.

- No health insurance carrier may impose a waiting period or exclusion for any preexisting condition for an individual who is ***eligible under the federal HIPAA portability law***.

  HIPAA (Federal Law) applies to groups of two or more employees. If the individual signs up for the new group plan **or individual plan** within ***63 days*** of losing coverage and was ***covered under the old plan for at least 18 months***, the new plan may not reject the application for coverage and cannot exclude coverage for any of the insured's preexisting conditions, hence the word ***portability***.

- Individual health benefit plan ***preexisting condition waiting periods may not apply to prenatal care services.***

- A health carrier may require any person applying for an individual health benefit plan or basic health plan to complete the standard health questionnaire.

2. ***Group Health Plans*** - **Exclusion of Preexisting Conditions…** If the applicant had coverage under a **health plan 90 days before the date of application** for the new group plan and such coverage was similar and ***continuous for at least three months***, then the carrier may ***NOT impose*** *a waiting period for coverage of preexisting conditions* under the new health plan.
   - This Washington law regarding excluding or having a waiting period of an individual's preexisting conditions under group health plans is better for the consumer than the Federal HIPAA guidelines above!

3. **Individual Health Benefit Plans - Mandatory Benefits**: All individual health benefit plans, other than catastrophic health plans must include benefits for:

- ***Maternity services*** that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, hospital services, operating rooms, radiology and laboratory services, appropriate medications, and anesthesia.

- ***Prescription drug benefits with*** **at least a $2,000 benefit** ***payable by the carrier annually.***

4. **Health Carrier Coverage of Emergency Medical Services:** A health carrier must cover emergency services necessary to screen and stabilize a covered person if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a health carrier must not require prior authorization of such services. Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles.

5. **Patient Bill of Rights:** It is the intent of the legislature that enrollees covered by health plans receive quality health care designed to maintain and improve their health. The purpose is to ensure that health plan enrollees:
- Have improved access to information regarding their health plans
- Have sufficient and timely access to health services, and choice among health providers
- Are assured that health care decisions are made by appropriate medical personnel
- Have access to a quick and impartial process for appealing plan decisions
- Are protected from unnecessary invasions of health care privacy
- Are assured that personal health care information will be used only as necessary to obtain and pay for health care or to improve the quality of care

6. **Requirement to Protect Enrollee's Right to Privacy or Confidential Services:** Health carriers and insurers must adopt policies and procedures that conform administrative, business, and operational practices to protect an enrollee's right to privacy or right to confidential health care services granted under state or federal laws.

7. Any carrier that offers a health plan and any self-insured health plan subject to the jurisdiction of Washington State **must designate a medical director**.

8. **Carrier Required to Disclose Health Plan Information:** A carrier that offers health insurance must provide the following information before the purchase of any such insurance:

- A listing of covered benefits, including prescription drug benefits, if any, a copy of the current formulary, if any is used, definitions of terms such as generic versus brand name, and policies regarding coverage of drugs, such as how they become approved, and how consumers may be involved in decisions about benefits;

- A listing of exclusions, reductions, and limitations to covered benefits, and any definition of medical necessity criteria upon which they may be based;

- A statement of the carrier's policies for protecting the confidentiality of health information; the cost of premiums and any enrollee cost-sharing requirements; and a summary explanation of the carrier's grievance process.

9. **Access to Appropriate Health Services - Enrollee Options…** Each carrier must allow an enrollee to choose a primary care provider who is accepting new enrollees from a list of participating providers. Enrollees also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the enrollee's request for the change.

- **Each carrier must provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic health care without the necessity of prior referral.**

10. **Delegation of Duties - Carrier Accountability:** Each carrier is accountable for and must oversee any activities that it delegates to any subcontractor. No contract with a subcontractor executed by the health carrier or the subcontractor may relieve the health carrier of its obligations to any enrollee for the provision of health care services or of its responsibility for compliance with statutes or rules.

11. **Requirement for Carriers to Have a Comprehensive Grievance Process…** Each carrier that offers a health plan must have a fully operational, comprehensive grievance process that complies with the requirements of this section. Each carrier must implement procedures for registering and responding to complaints in a timely and thorough manner.

- Each carrier must provide written notice to an enrollee and the enrollee's provider, of its decision to deny, modify or terminate payment, coverage, or provision of health care services or benefits, including the admission to or continued stay in a health care facility.

12. **Independent Review of Health Care Disputes:** There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee.

- An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, reduce or terminate coverage or payment for health service.

DISABILITY (ACCIDENT AND HEALTH) INSURANCE

In the State of Washington, the term ***Disability Insurance*** is very broad in the sense that it describes various types of coverage such as hospital, medical, surgical, major medical, comprehensive major medical, accidental death and dismemberment, long-term care, Medigap insurance and disability income (sometimes called *loss-of-time* benefits). ***In most states these benefits are known as Health Insurance or Accident and Health Insurance.***

Disability Insurance (health insurance) originated in the United States in the mid 1800s. It was provided by casualty insurance companies, often as a rider to life insurance policies. The earliest policies protected railroad travelers due to accidental injuries. Due to the agency system, disability insurance has grown steadily and has become a part of the American household.

Most Disability Insurance policies such as health insurance and disability income insurance are ***indemnification*** contracts. This means that the insured will be paid or reimbursed what was paid for the loss, with **NO GAIN**.

For example, having three major medical policies will NOT allow you to collect triple for your broken arm. You will only be reimbursed for the loss due to your broken arm. In this case, each company would probably pay 1/3 of the loss. Being ***over insured*** makes it profitable to collect benefits or to stay disabled rather than go back to work.

I. Types of Accident & Health Policies

A. Disability Income Insurance

1. The **purpose of disability income** (a.k.a. *loss-of-time*) insurance is to replace income when a disability prevents an individual from working to earn an income. The ability to work and earn an income is a person's greatest insurable asset. 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). Premiums paid by individuals for disability income insurance are **not tax deductible**.

2. **Insuring Agreement…**As long as all of the provisions of the policy are met (i.e., the insured must be under a doctors' care and meet the definition of disability), the insurance company agrees to pay periodic payments as stated in the policy. ***Payments must be at least monthly.*** The best policies provide benefits for ***accident and sickness***.
    - **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).

3. The **definition of total disability…** This definition will vary from policy to policy. The definition is important because it will determine whether the insured is totally disabled and thus eligible for benefits.
    - **Own Occupation…**The most protective of your needs is the *own occupation* definition for disability. ***Total disability*** means that you are unable to perform the important duties of your "own" or "regular" occupation, and you are under the regular and personal care of a physician. For example, if a surgeon is unable to perform surgery, but can still be a doctor, the insurer **still must pay** the entire benefit.

- **Any Occupation** (a.k.a., income replacement insurance) is the insured's inability to perform any occupation for which the insured is **reasonably suited** by education, training or experience. It is much more restrictive than the own occupation contract.

- **Combinations** of the above definitions are common. Since the "Own Occupation" definition is less restrictive, it is more desired by an insured; however, the cost is more expensive. Some policies will have a two year Own Occupation and thereafter have an Any Occupation provision, thus lowering the premium.

4. **Partial Disability Provision** states that if an insured cannot perform one or more of the duties of his occupation due to a disability but can still go back to work and earn a partial income, the provision will pay 50% of the monthly benefit payable for a maximum period of **six months** (in addition to the partial income).

5. **Residual Disability Provision** coverage applies when an insured returns to work at a reduced income following a period of total disability. Benefits are payable in proportion to the reduction in the insured's earnings before the onset of the disability. This provision is more beneficial than the Partial Disability clause.

    - For example, an insured returns to work and, due to the disability, only earns 2/3 of his pre-disability income. Since the insured lost 1/3 of his pre-disability income, the residual benefit will pay 1/3 of the insured monthly disability income benefit. These benefits are limited in time to the benefit period of the contract.

6. **Recurrent Disability Provision** states if the insured goes back to work after a period of disability appears to be over but becomes disabled again from the same problem (or a disability arising out of the original disability), the insured will be able to receive benefits again **without having to meet a new elimination period**. However, ***the disability must recur in a certain time frame, usually six months from the insured's return to work***.

    - For example, the insured owns a five year disability income policy and is disabled for two years. He returns to work but the disability recurs within six months and he is unable to work again. The insured will still have three years of benefits remaining and ***will not need to meet another elimination period.***

    - If a disabled insured (with a 90 day elimination period) returns to work after being disabled only 30 days and the disability recurs, the disabled insured will only need to meet an additional 60 days of disability before receiving benefits, not the full 90 days due to the recurrent provision.

7. **Probationary Period Provision** is the time period in which there is ***no coverage for sickness*** (usually 30 days) and begins when a policy goes into effect. This provision helps the insurer to avoid paying benefits for losses due to illness contracted before the policy was issued (***adverse selection***).

8. **Elimination Period, a.k.a. Waiting Period,** is the period of time between the onset of a disability and the beginning of the benefit period. This acts like a ***time-deductible***. **The longer the waiting period, the lower the premium.** Insurers offer a variety of elimination periods such as 30, 60, 90 days, or longer.

    - ***The length of the waiting period should be used to help fit the policy to the insured's financial means***.

    - ***Benefits are paid in arrears***. This means that the insured will receive his first check approximately 30 days after the benefit period begins. For example, if an insured selects a 30 day elimination period, he will receive his first benefit check around the 60th day. If an insured has a 90 day elimination, the first check will be received around the 120th day.

9. **Benefit Period** is the length of time during which benefits will be paid, i.e., 5 years, 10 years, benefits payable to age 65, or normal retirement age.

Special Note Regarding Benefit Payments:

- ***Most policies will reduce the amount of the policy benefits, dollar for dollar, for benefits received from other sources*** **(sometimes called non-duplication of benefits)*.***

- ***If Workers' Compensation or other types of disability income benefits are paid to the insured, the disability income policy will pay secondary (excess) over other benefits paid.*** For example, if a policy benefit was $4,000 per month, and the insured started receiving $1,000 in Social Security benefits, the policy benefit paid to the insured would be reduced to $3,000 ($4,000 minus $1,000).

10. **Optional Disability Income Benefits:**

- **Presumptive Disability** means a disability which is presumed to be total and *permanent* in cases involving the loss of sight, hearing, speech, or loss of any two limbs. Under these circumstances the insurance company does not require the insured to submit to periodic examinations to prove continuing disability. Companies will waive the waiting period and pay benefits immediately, or may pay benefits in a lump sum.

  a. Permanent Disability is defined as a disability that eliminates the insured's ability to work for the rest of his or her life. Permanent disability results from injury to a limb or an organ, and the person is not expected to recover from the injury. Examples are loss of use of an eye, hand or foot.

  b. Temporary Disability occurs when an insured is unable to work while recovering from an illness or injury, but is expected to recover fully from that illness or injury, such as a broken foot.

- **Cost of Living Adjustment** (COLA) is a rider that makes an adjustment in the benefits being received. The CPI, Consumer Price Index, is used by the insurer to make annual adjustments for the following year.

- **Guaranteed Insurability Option** (a.k.a. Future Increase Option, FIO) guarantees that an insured can purchase additional disability coverage to correspond with the insured's increase in income, **without evidence of insurability.** The insured must pay the premium for the increase in coverage.

- **Multiple Indemnity Rider** is a provision that provides that some or all of the benefits under the policy will be ***increased by a stated multiple***, such as 100% or 200%, in the event that a peril occurs in a specific way. For example, an accident policy may pay 300% of the benefit if the accident is due to plane travel or 200% if the accident is due to public transportation, such as train or bus travel (also known as ***common carriers***).

11. **Business Uses of Disability Insurance:**

- **Buy-Out,** a.k.a. **Buy-Sell,** is an agreement to buy out the interest of a partner or a persons' interest in a firm, following a disability. A Disability Income policy would **fund** the buy-out agreement***. Disability Buy-Sell coverage can be designed to provide benefits to a corporation to buy out a disabled stockholder's or director's share of the business***. The policy will generally pay an installment benefit to the corporation for up to a year and then finally ***pay out a lump sum benefit to the corporation so it can buy out the disabled partner.***

  Premiums are **not tax-deductible**; however, the **benefits are received tax free.**

- **Business Overhead Expense…** Disabled individuals not only suffer a loss of income but also may incur a loss because of continuing business expenses. This situation frequently arises among self-employed persons such as doctors, lawyers and insurance producers.

  Business Overhead Expense is designed to cover routine overhead (e.g., ***rent or lease payments, utilities, advertising, etc.) and wages***. The purpose is to allow the business to keep its doors open and the business intact until the owner returns or is able to sell the business. Benefits usually are paid for 1 or 2 years. BOE premiums **are tax-deductible** to the business, and thus the disability benefits received are taxable to the business. However, the taxable benefits are then used to pay tax deductible expenses.

- **Key Person/Partner** insurance protection replaces the income lost when an essential employee, who can also be the owner, is unable to work. ***The policy pays benefits directly to the business to help fund the hiring and training of a replacement***.

  * The policy is owned by the business
  * The premium is paid by the business, but is NOT tax deductible
  * The business is the beneficiary, and receives an income tax free benefit
  * The person (usually an employee) is the insured
  * The key person (insured) must qualify for the coverage

12. **Policy Continuation Rights:**

- **Guaranteed Renewable** restricts an insurer from canceling or non-renewing a policy except for **non-payment** of premium. However, premiums may be increased on the basis of an entire classification, such as occupation or zip code.
-
- **Non-cancelable** (a.k.a. non-cancelable and guaranteed renewable) is the most beneficial for the insured. The insurer **cannot** cancel or non-renew a policy, nor are they allowed to increase the premium (meaning the premiums are fixed).

13. ***Non-occupational*** coverage will **not pay** for work related sickness or accidents. ***Occupational*** coverage (a.k.a. ***full coverage***) pays benefits for **on and off the job** sickness or accidents.

14. **Waiver of Premium Provision** is included in disability income policies. The provision waives premium payments after the insured has been disabled for a period of time.

15. **Group Disability Income** Plans may be written on a group basis as well as on an individual basis. The differences in group plans and individual plans include:

- Group plans usually specify the benefits based on a percentage of the worker's income, while individual policies usually specify a flat amount of benefit.

- Group short-term plans usually provide maximum benefits of 13 to 26 weeks, with weekly benefits of 50% to 100% of the individual's income. Individual short-term plans usually have a maximum benefit period of six months to two years.

  - Group long-term plans provide benefit periods of more than two years, with monthly benefits usually limited to 60-70% of the individual's income.

  - Group disability plans also have minimum participation requirements, and the employee must work for 30 to 90 days (a.k.a. employment probation period) before they become eligible for the coverage.

  - Group plans do not cover disabilities for job related accidents and illnesses (non-occupation coverage), however, individual plans will cover on and off the job disabilities (occupational coverage).

B. <u>Accidental Death and Dismemberment (A.D.& D.)</u>

1. 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.

2. The **Capital Sum** (which pays ½ of the principal sum) pays for loss of or loss of use of any one limb, loss of sight in one eye or partial loss of hearing ***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). It may also pay for loss of an organ, such as a kidney, ***due to an accident***.

3. **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).

C. **Traditional Medical Expense Insurance** provides benefits for medical care. Contracts may provide for payment of medical expenses incurred on a/an:

- ***Reimbursement basis*** *(paying benefits to the insured, e.g., Major Medical and Comprehensive Major Medical).*
- ***Service basis*** (paying those who provide the services directly, like *Service Organizations.*
- ***Indemnity basis*** *(paying a set amount* (a.k.a. Stated Value) *regardless of the actual charge for the medical expenses, e.g., Basic Medical).*

1. **Basic Medical Expense Insurance** provides protection against the financial losses incurred for hospital, medical and surgical expenses. These three basic coverages may be sold separately or together and usually pay on an ***indemnity*** basis. Features include ***low limits and no deductibles*** (first dollar coverage).

   a. **Hospital (Indemnity) Expense Policy**
      - **Room and Board** pays on a dollar amount basis, that is, a pre-established amount (stated value) per day for a maximum number of days, ***regardless of the amount of actual hospital expenses***. For example, if an insured has a $200 a day room and board limit and spends 10 days in the hospital, the policy would pay $2,000 total, regardless of actual charges.
      - **Intensive Care** pays a multiple of the semi-private room rate of the hospital. The number of days of coverage also is limited to a stated number of days.
      - **Miscellaneous Charges,** a.k.a. Ancillary Coverage, covers such expenses as convalescent care, nurses, medical expenses, charges to cover non-surgical hospital expenses other than room and board, X-rays, lab fees, supplies, operating and treatment rooms.

   b. **Surgical Expense Policy…** covers surgeons' fees and related costs such as anesthesiologists and operating rooms. Indemnification is paid on a **Scheduled Benefits basis,** meaning on an amount stated in the contract. For example, $1,000 on any one surgery or $2,000 for Gall Bladder Surgery.

   c. **Medical Expense Policy…**This basic policy covers charges for ***non-surgical services*** provided by a physician. Some policies cover visits by a physician while in a hospital, and others limit the benefits per visit and/or the number of visits. Other medical expenses which may be covered with this policy include maternity benefits, home or outpatient care.

2. **Major Medical Expense Insurance…**The **purpose** of major medical insurance is to provide more complete coverage than purchasing numerous separate medical expense policies. ***Major medical has a deductible, high limits, co-insurance and stop loss provisions.***

   a. **Major Medical Coverage** extends to Hospital, Medical and Surgical expenses incurred by the insured. Even though the usual maximum lifetime limit is $1,000,000, there are ***internal limits*** within the policy, e.g., ambulance service, speech therapy, x-rays or nursing benefits. The ***Benefit Period*** usually begins and ends each calendar year.

   b. **Deductible…**A provision in an insurance policy that requires the insured to pay the first specified dollars of expense which will not be reimbursed by the insurer. Expenses above the deductible then will be paid by the insurer as indicated in the policy.

- ***The purpose of the deductible is to eliminate coverage for small losses***, minimize the abuse of insurance, and to lower premiums.

- **Per Injury or Sickness vs. Cumulative Deductible…**Under the per sickness type, a.k.a. per cause, a deductible is charged for each sickness or injury. Under the cumulative type, a.k.a. all cause, a deductible is charged for that calendar year.

- The **Common Accident/Sickness** provision provides that only one deductible has to be met if two or more family members are injured in the same accident or have the same illness.

- The **Family Maximum** provision waives any further deductibles once any two or three of the family members have reached their deductibles in the same year.

c. **Coinsurance…**The insured pays for a percentage of the expenses in excess of the deductible (e.g., 80-20 or 90-10). A ***stop loss*** (a.k.a. out-of-pocket) limits the total out-of-pocket expense that the insured must pay each calendar year. ***The purpose of the coinsurance feature is to prevent over use of the contract benefits by making the claimant pay part of the claim.***

d. **Maximum Limit** is the largest amount which will be paid for an injury or illness period over the insured's lifetime. Some policies have no limits, meaning that they will pay an infinite amount for medical expenses. After a major loss, used benefits may be restored to the original lifetime amount under the ***Restoration of Benefits Provision*** (under certain circumstances).

3. Comprehensive Major Medical is nothing more than the combination of the **Basic Plan plus Major Medical**. These are ***cost reimbursement plans. These plans represent the broadest coverage plans available to help pay for medical expenses.***

Common Exclusions for Basic, Major and Comprehensive Major Medical Plans

- ∅ **Pre-existing conditions are usually excluded for 12 months (industry standard).** A pre-existing condition means any medical condition, illness or injury for which medical advice or treatment was recommended or received from a health provider before the effective date of coverage.
- ∅ Self-inflicted injuries.
- ∅ Injuries or illness from acts of war, or while on active military duty.
- ∅ Maternity (special note: ***Complications of childbirth are covered as normal care***, even if the insured is not covered by maternity benefits).
- ∅ Dental and vision care.
- ∅ Benefits payable under workers' compensation.
- ∅ Injury while committing a crime.
- ∅ ***Injury or illness while under the influence of intoxicants or narcotics***.
- ∅ Well-baby care.
- ∅ Cosmetic surgery, routine physical exams.
- ∅ Most nervous disorders and *experimental* services.
- ∅ **Naturopathic care**, i.e., acupuncture, aroma therapy .
- ∅ ***Custodial care*** (help with the Activities of Daily Living).

D. Traditional Insurers vs. Health Maintenance Organizations vs. Service Organizations vs. PPOs

1. Traditional Insurers (sometimes called Commercial Insurers) include such companies as Mutual of Omaha and Hartford. The traditional system in the United States has been a ***fee-for-service approach*** which involves physicians, usually in a solo practice, and the hospitals. The providers operate on a ***cost reimbursement system*** based on a charge for each item of service. ***Reimbursement plans pay benefits directly to the insured***. Recent developments in response to the need for cost control include the Preferred Provider Organizations and Health Maintenance Organizations.

2. **Service Organizations** (a.k.a. Health Care Service Contractors) are any corporation, cooperative, group or association sponsored by or connected to a provider which provides health care services. Examples are Blue Cross (Hospitals) and Blue Shield (Doctors).

   Service Organizations:
   - ***pay directly to the doctors and hospitals (not to the insured)***
   - may be profit or non-profit associations
   - ***refer to insureds as subscribers or members.***

Special Note: Service Organizations (The Blues) are different from traditional (commercial) insurers in the following three ways:

- The Blues provide their benefits on a ***service*** basis rather than on a ***reimbursement*** basis (this means that the insurer pays the provider directly for medical treatment instead of reimbursing the insured).

- The Blues have contractual relationships with the hospitals and doctors, whereas the traditional insurer's contract is with the insured.

- Service Organizations are usually nonprofit organizations and traditional insurers are usually profit making companies.

3. **Health Maintenance Organizations** (HMOs) provide for comprehensive health care in return for a pre-negotiated sum (a.k.a. pre-paid) or periodic payment. Key characteristics of the HMO include:

   - Insurers are often referred to as "subscribers."

   - ***Preventive care (such as physicals, well-baby care and immunizations) on a pre-paid*** basis.

   - **Pays 100%** of expenses minus any co-payments. A co-payment is the dollar amount which an insured must pay each time he goes to visit a doctor (usually around $20).

   - **A gatekeeper system** in which a member must select a **Primary Care Doctor** (a.k.a. Provider) who oversees the insured's care and must approve any treatment by other providers before it is given (a.k.a. ***Managed Health Care***).

   - **Managed Care** imposes controls on the use of health care services and the providers of health care services, usually through health maintenance organizations or preferred provider arrangements.
   - Operate within a specified geographical area known as the ***service area***.

   - Some HMOs pay the doctor a ***capitation fee,*** a fixed monthly amount per subscriber, **regardless of whether services are used or not.** Under **Capitation,** if the cost of care exceeds the capitation fee, the provider will usually be paid by the plan for the extra care.

   - **HMOs are required to provide basic benefits**: Physician services, diagnostic lab services, out-of-areas coverage, Preventive Care, Emergency Care, Hospital In-Patient Care and Out-Patient Care.

   - All HMOs are required to have a complaint system, often called a grievance procedure, to resolve written complaints by members.

   - An HMO wants to identify health problems early; encourage early treatment; and encourage out-patient treatment for health problems.

4. **Preferred Provider Organizations** (PPOs) are groups of health care providers within a certain area who agree to provide services for less money than they might charge otherwise. They make up for the low charges by increasing their volume of patients. For pre-set fees, all of the enrollees in a group plan are given a list of names of the PPO's doctors and hospitals which must be used by the insured for their care.

    - ***If the insured does not use the prescribed doctors or hospitals, the insured will be required to pay a larger portion of the approved medical bills***. For example, instead of 80-20 co-insurance, the insurer may pay on a 50-50 basis, or may double the deductible.

    - **PPOs** were developed as a compromise between the benefits of the HMO and the traditional reimbursement plan offered by commercial insurers. Commercial insurers implemented PPOs as an answer to some of the negative aspects of HMOs, such as a limited choice of physicians.

    - ***A PPO is a form of Managed Care, but pays on a fee-for-service basis***.

E. <u>Other Health Plans</u>; HDHP, HSA, HRA, MSA, and Misc.:

1. **High Deductible Health Plan (HDHP)…**A High Deductible Health Plan with a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA), or (Archer) Medical Savings Account (MSA) provides ***traditional medical coverage*** and a tax free way to help build savings for future medical expenses. ***The HDHP/HSA, HDHP/HRA or HDHP/MSA gives greater flexibility and discretion over how to use health care benefits***. You can then personally manage your healthcare dollars, making it possible to cut expenses and save money.

Once the deductible has been met, the participant's health plan coverage begins.

A health plan will qualify as a high deductible health plan (HDHP) if it has an annual deductible of **at least** a certain dollar amount, say $1,200 for example, for individual coverage and **at least** $2,400, for example, for family coverage. This amount will change every year, as defined by the I.R.S.

The benefits for the HSA, HRA and MSA are:

- **Tax deduction** for contributions made to your account.
- Contributions to your account made by your employer **may be excluded** from your gross income.
- The contributions **remain in your account from year to year** until you use them.
- The interest or other earnings on the assets in the account are **tax free,** as long as the distributions are used to pay for **qualified medical expenses**.
- These accounts are "portable" so they stay with you if you change employers or leave the work force.

If you do not use a distribution from your "account" for qualified medical expenses, you must pay tax on the distribution and possibly ***an additional tax penalty on your taxable distribution***.

2. **Health Savings Accounts (HSAs)**…A Health Savings Account lets the self-employed (and unemployed) save and pay for medical expenses using money that's tax deductible. As long as it is used for qualified medical expenses, the money also stays tax free when it is withdrawn. **The HSA is simply a tax-free bank account that is designed to work together with a high-deductible health plan.** The HSA covers routine medical expenses while the accompanying insurance policy protects against major medical or catastrophic events.

    At age 65 you can withdraw funds for any reason without an added tax penalty. Distributions will be subject to ordinary federal income tax.

3. **Health Reimbursement Arrangements or Accounts (HRAs)…**These accounts are also referred to as personal savings accounts, personal care accounts, defined contribution plans or consumer driven health care plans. ***This is an employer-provided medical reimbursement account.*** A health reimbursement arrangement (HRA) must be ***funded solely by an employer*** and not by an employee. The most common use of the HRA is in combination with a High Deductible Health Coverage (HDHC) Plan. ***Reimbursements from the HRA are not taxed to the employee, and are deductible by the employer***.

4. **Medical Savings Accounts** (**MSAs**)…This is an **account tied to a *high deductible health plan*** (HDHP). Employers contribute to the MSA for the employee. If the employer does not make a contribution for the employee, then the employee (or if the insured is self-employed) may contribute to the MSA. Both the employer and employee **CANNOT** make contributions to the MSA in the same year.

   Employees (or if self-employed) can use the contributions in the account to pay for health care expenses throughout the year and at the end of the year may withdraw whatever remains in the account as (taxable) cash.

   MSAs were created to help self-employed individuals and employees of <u>small businesses</u> (50 employees or less) and dependents.

5. **Point of Service (POS) plans** look like an **<u>HMO and PPO combination</u>**. The distinguishing characteristic of the plans is the designation of a primary care physician. ***This designated physician is the referral source for all your other medical professionals***.

   The employee selects a ***primary care physician*** from the list of practitioners that are acceptable to the plan administrators. The problem with this approach is that if you're in a small geographic area, the choice of primary physicians may be very restricted or nonexistent. ***If an insured doesn't like that physician, he or she can choose to go to a doctor outside of the POS plan, but would need to pay a deductible and coinsurance percentage.***

6. **Flexible Spending Arrangements** (FSAs) allow employees to be reimbursed for medical expenses. ***FSAs are usually funded through voluntary salary reduction agreements with an employer***. No federal income taxes are deducted from the employee's contribution. The employer may also contribute.

   The benefits of an FSA are:
   - Contributions made by an employer can be excluded from gross income.
   - No employment or federal income taxes are deducted from the contribution.
   - Withdrawals may be tax free if you pay qualified medical expenses.
   - You can withdraw funds from the account to pay qualified medical expenses.

   There is no limit on the amount of money contributed to the accounts.

   Self-employed individuals are **NOT** eligible for a flexible spending arrangements.
   - ***Distributions from a Health Flexible Spending Account must be paid only to reimburse you for qualified medical expenses you incurred during the period of coverage***.
   - ***A Flexible Spending Account (FSA) is a "use-it-or-lose-it" plan***. This means that amounts in the account at the end of the plan year ***cannot be carried over to the next year***.

7. **Consumer Driven Health Plans (CDHPs)…**are designed to ***make the consumer more responsible*** for their care and to prevent abuse. CDHPs are kind of a half-way point to HSAs. Some companies consider HSAs and HRAs consumer driven health plans because insureds personally manage their healthcare dollars (with a high deductible), making it possible to cut expenses and save money over the cost of a traditional health insurance policy.

   Some CDHPs pay 100% for the first several health provider visits. For example, the first 4 visits per insured, the deductible is waived. On the fifth visit, the insured will pay the deductible and start paying his or her coinsurance.

8. **Worksite (Employer Sponsored) Plans…** These are sometimes referred to as Voluntary Benefit Plans. ***The premium is paid by the employer***, but is not taxable as income to employees. Worksite Employer Sponsored plans would cover ***on-site screenings*** for such things as cholesterol, heart disease, blood work and blood pressure, cancer, and wellness programs, etc. Other benefits could include Vision and Dental care, Critical Illness or Cancer plans, and Accidental Death and Dismemberment plans.

F. Cancer Plans pay for losses due to cancer only.

G. Critical Illness Plans (a.k.a. Dread Disease Policies)… These policies are usually for high cost illnesses. They are basically the same as Cancer Plans but they encompass a broader range of illnesses such as heart disease, cancer, stroke, kidney disease, etc., including benefits for MRIs, radiation treatment and chemotherapy.

- ***These plans usually pay a lump sum benefit to the insured, such as $20,000 if the insured is diagnosed with cancer, or $35,000 for kidney failure***.

- **Cancer and 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.

H. Group Insurance In order the qualify for group insurance, the group of individuals must have come together other than for securing group insurance. The most common type of group coverage is called an employee group or an employer sponsored group.

1. Employee groups (employer sponsored). An employer provides coverage for his employees. Since group policies are issued on a ***non-medical*** basis, adverse selection Could be a problem. The following are steps taken to avoid adverse selection:

- **Employment Probationary Period** (usually 90 days) is nothing more than a period of time established by the employer for all new employees before the employee will be eligible for any group benefits.

- **Eligibility Period** is a specified period of time, usually 31 days, following the end of the "probation" period during which the employee is entitled to enroll in the group plan. The eligibility period is the same as a grace period. If a loss occurs during the eligibility period and the enrollee has not signed up for a plan, the minimum coverage available under the Master Policy will be provided.

- **Participation Requirement:**
  A ***contributory*** (a.k.a. participating) ***group*** is where the employee contributes some of the premium. With this type of group, the insurance company requires that at least ***75%*** of eligible employees and their dependents be enrolled in the group plan.

  A ***noncontributory*** (a.k.a. nonparticipating) ***group*** is where the employer pays all of the premiums. With this type of group, the insurer requires that ***100%*** of eligible employees and their dependents enroll in the plan.

2. Master Policy vs. Certificates of Insurance…The employer is the master policyholder and is responsible for all administration duties, enrolling employees, collecting premiums, and informing the employees of benefits. The enrollee will receive an individual certificate of insurance regarding insurance benefits, rights and conditions under the plan.

3. Coordination of Benefits Provision (COB) … It is common for family members to be covered by more than one health care plan. This often happens when a husband and wife both work and choose to have family coverage through both employers or when both employers offer non-contributory health plans.

The Coordination of Benefits Provision designates one insurer as **primary carrier** and the other insurer as **secondary** (excess) **carrier,** when a family is covered under two group plans. ***This provision prevents over insurance***.

- With a husband and wife, ***the primary insurer is the one that covers the claimant as an employee.*** The other spouse's insurer will be secondary. This gives an insured 100% coverage, after the deductible.

- ***The primary coverage for children that have duplicate coverage will be the plan of the parent whose birthday occurs first in the year***. This is known as the "birthday rule."

4. **COBRA**, the Consolidated Omnibus Budget Reconciliation Act of '85, is a Federal Regulation that **requires** that group plans (of ***20 or more employees***) **give** c**ontinuation and conversion privileges** to those who lose their health coverage.

    - **Continuation** of benefits ranges from **18 to 36 months** depending on the **qualifying event**, such as the death or divorce of an employee. In these events, the dependents will be offered 36 months of continued coverage. ***Being fired, resigning or being laid-off would qualify an insured for 18 months of continued coverage***.

    - The employer keeps the employee and/or dependents on the group enrollment and pays the premium to the insurance company. The employer usually bills 100% of the premium to the enrollee. Premiums ***may not be increased*** except that an extra 2% premium may be charged to cover the employer's costs.

    - **Continuation rights** must be requested within ***60 days*** from the date the employer gives the employee proper notification.

    - **Conversion** means changing from a group policy to an individual policy, ***without evidence of insurability.***

    - At certain ages ***children are eligible to convert*** because children are removed from the policy at those stipulated ages.

    - COBRA **does not** apply if the employee is fired due to ***gross misconduct***, hasn't met his or her ***employment probationary period, or qualifies for other group health insurance or Medicare.***

5. **HIPAA…**The Health Insurance Portability and Accountability Act of 1996 addresses health insurance portability, but from an entirely different perspective than COBRA. COBRA builds a coverage bridge from the old policy; HIPAA requires the new group policy to accept most new entrants regardless of their health (portability).

    HIPAA applies to groups of two or more employees. If the individual signs up for the new group plan **or individual plan** within ***63 days*** of losing coverage, and was ***covered under the old plan for at least 18 months***, the new plan may not reject the application for coverage and cannot exclude coverage for any of the insured's preexisting conditions.

    - Portability means moving from one health plan to another without having to prove insurability and not being held to any waiting period for preexisting conditions to be covered.

    Special Note: The main reason for HIPAA is to help keep personal information ***confidential***. Proper disclosure is required under the HIPAA Privacy Rule.

    - **Disclosure: The HIPAA Privacy Rule's** purpose is to define and limit the circumstances in which an individual's protected health information may be used or disclosed to other parties. No ***entity may*** use or disclose health information unless ***the individual authorizes it in writing***.

6. **Workers' Compensation Insurance…**Every state has workers' compensation laws that require specific benefits be paid to injured workers. Workers' Compensation laws impose a form of ***absolute liability*** because employers are held liable for employee's **work-related injuries and sicknesses, *regardless of fault.***

    - **Workers' Compensation** pays the benefits required for workers for**: medical, disability income, death, and rehabilitation.**

7. **Subrogation…**The legal process by which an insurance company seeks from a third party, who may be responsible for a loss, ***recovery of the amount paid to the insured***. One company might pay their insured medical benefits, but they have the right to sue the party at fault or his or her insurance company for reimbursement for the benefits paid. This kind of lawsuit is called **subrogation.**

8. Comparison Between Individual and Group Insurance Plans:

Individual	vs.	Group
Anyone can apply for coverage.		Must be a group member.
Each person has a policy.		There is one master contract.
Individual selects coverage.		Benefits are the same for members.
Individual's health is evaluated.		Group as a whole is evaluated.
Coverage is renewable at the option of the insured.		Coverage stops when employee leaves (With COBRA and "***portability***" exceptions.)
May pay on a ***full-coverage*** basis. (on and off the job – a.k.a. occupational coverage)		Pays on a ***non-occupational*** basis. (only off the job)

I. <u>Long-Term Care</u> …Long-term care insurance (LTC or LTCI) is an agreement between the insured and an insurer. The insurer promises to pay a benefit toward the cost of long-term care (nursing home care, home health care, etc.) in exchange for premium payments.

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.

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 and personal care. <u>Personal care is also sometimes called custodial care</u>**.

<u>Personal care</u> or custodial care is for people who do not need ongoing health or medical services, but rather only need help with what are known as "***Activities of Daily Living***" (ADLs)—eating, dressing, taking medicine, bathing, toileting, transferring and continence. Household chores are also considered personal care.

Medicare covers only small amounts of skilled health/medical care. It does not cover personal/custodial care in a nursing home, and covers only small amounts of care at home under stringent conditions.

Service Days vs. Calendar Days:

> **Service Days** are the number of days that you receive **<u>outpatient care</u>**, i.e., home nursing, hospice, services outside a facility (some per calendar year, some lifetime total).
>
> **Calendar Days** are the number of days allowed that you are in **<u>in-patient care</u>**.

J. <u>Medicare and Medicare Supplement Insurance</u>

Medicare is the United States' version of national health insurance for the elderly and disabled. This is a Federal program which gives **hospital** (Part A, no premium) and **medical** (Part B, requires a monthly premium) benefits to those who are eligible. People covered under Medicare are called "***beneficiaries***." (**www.medicare.gov)**

Traditional Medicare benefits are based on a ***fee-for-service approach*** which involves physicians, usually in a solo practice, and the hospitals. The providers operate on a ***cost reimbursement system*** based on a charge for each item of service. ***Reimbursement plans pay benefits directly to the beneficiary (insured)***.

1. **Medicare Eligibility:**
   - Persons age ***65 or older*** are ***automatically eligible if they are eligible for Social Security***. If not eligible for Social Security, persons age 65 or older may receive benefits by paying a monthly premium.
   - Persons who have been receiving ***Social Security disability benefits for 24 months***.
   - Persons with ***end stage renal disease*** (kidney failure).

2. **Medicare Enrollment,** for those eligible, begins on the 1st day of the month in which the person turns age 65.

3. **Part "A" Hospital**, pays all reasonable charges, minus deductibles and co-payments. Medicare pays **primary** to other valid coverage such as Medicare Supplements, Long-Term Care and Medicaid. However, if the insured is covered under a group health plan, Medicare will usually be **secondary** coverage.

   a. **Inpatient Hospital Care**: semi-private room, meals, regular nursing care, drugs taken in the hospital, tests, medical supplies and operations. ***Part "A" will pay 100% (after the deductible) for the first 60 days in the hospital***. **Hospital Coverage includes**:

      - Has a deductible per **benefit period,** a.k.a., ***Spell of Illness***. The benefit period begins upon hospital admission and ends 60 days after discharge. Readmission during the 60-day period after discharge is considered part of the same benefit period. A **new benefit period and a new deductible begin after 60 days**.

   b. **Skilled Nursing Care *pays 100% for the first 20 days, but for days 21-100*** Medicare requires a co-payment of $144.50 per day for 2012 and increases every year. It also requires that the care be approved by a doctor, in a Medicare approved nursing facility, there is a prior hospital stay of three days or more, and improvement must be anticipated.

4. **Part "B" Medicare Medical,** pays for doctor's services, out-patient hospital care, diagnostic tests, medical equipment, ambulance service, etc. The doctor's services are covered under Part "B" no matter where you receive them; at home, at the doctor's office, in a clinic or in a hospital. The **deductible** is a flat $140 per year for 2012 and increases every year, with an **80-20 co-insurance provision**.

   - **Part "B" Does Not Cover:** cosmetic surgery, routine physical exams, dental or vision care, hearing aids, physician charges above Medicare's approved amount, private duty nursing, and any expenses not necessary. Custodial, intermediate care and coverage outside of the United States are also excluded (Part "A" and "B").

5. Part "C" (used to be called Medicare Plus Choice)… All beneficiaries have a choice of different health plans and a variety of options for receiving health care, instead of the Traditional Medicare A & B. These options will complement the original Medicare plan and make health care choices for Medicare beneficiaries similar to those available to younger people.

   - If a beneficiary decides to join a Medicare Advantage Plan, he does not need a Medigap Policy, because the plan generally covers many of the same benefits that a Medigap policy will cover. Medicare Advantage Plans are health plan options that are part of the Medicare Program. Generally, these plans offer extra benefits and lower copayments than the Traditional Medicare Plan. However, you may have to see the doctors and hospitals that belong to the plan to get services.

6. **Part "D" Medicare Drug Coverage…** Anyone on Medicare with either Part A or Part B is entitled to drug coverage, regardless of income. No physical exams are required, and nobody can be denied for health reasons. ***Enrollment is voluntary***.

7. **Medicare… Duplicate coverage**... If an individual becomes eligible for Medicare, federal law states that the primary coverage benefits will be paid under the employer sponsored group plan, ***Medicare will act as the secondary coverage***.

In 2025, Part "A" Hospital (Medicare) benefits are shown below:

SERVICE	MEDICARE PAYS	YOU PAY
In-patient hospital, days **1 through 60**	After first $1,632, 100% of approved charges	$1,632 (deductible)
In-patient hospital, days **61 through 90**	Approved charges over and above $408.00 per day	$408 per day
In-patient hospital, days **91 through 150***	Approved charges over and above $816.00 per day	$816 per day*
Skilled nursing facility, days **1 through 20** (If the beneficiary has been admitted to the hospital for 3 consecutive days. *Note: it is possible to be in a hospital and NOT be admitted.*)	100% of approved charges	Nothing
Skilled nursing facility, days **21 through 100**	Approved charges over and above $204.00 per day	$204 per day

*These lifetime reserve days may only be used once in a lifetime (they may be used over multiple benefit periods).

In 2025, Part "B" Medical (Medicare) benefits are shown below:

SERVICE	MEDICARE PAYS	YOU PAY
Doctors, outpatient hospital care, durable medical equipment, other services	80% of approved charges after $240 deductible (each year)	20% of approved charges after $240 deductible (each year)
Diagnostic testing	100% of approved charges	100% of services not covered
Lab services	100% of approved charges	Nothing

Medicare Supplement Insurance is sold by ***insurance companies*** to pay for what Medicare approves but does not pay for, i.e., deductibles and co-payments. These plans fill the gaps of Medicare, a.k.a. Medigap Insurance, meaning, ***Medicare Supplement plans pay secondary (excess) to what is paid by Medicare.***

- ✓ The beneficiary must be ***covered under both Parts A & B of Medicare*** and be at least 65 years old.

- ✓ The Centers for Medicare and Medicaid Services (CMS) requires that the states implement any updated amendments made by the NAIC.

Under the Omnibus Reconciliation Act of 1990 (OBRA), Congress passed a law that authorized the NAIC to develop a standardized model for Medicare Supplement policies (a.k.a. Medigap). This act requires that Medigap plans meet certain requirements. The purpose of this law was to eliminate questionable marketing practices and to provide consumers with a degree of protection and to standardize the coverage available through the insurance industry.

The ***requirements include:***

1. **Exclusion for pre-existing conditions** is allowed for a maximum of 180 days. A pre-existing condition is any condition the beneficiary had, advised to have treatment for or had treatment for in the past 180 days.

    - **No exclusions** are permitted when ***replacing*** an in-force Medigap Policy. If an in-force Medigap Policy is replaced, a replacement form is required to be filled out, signed by the agent and the insured, and the original left with the beneficiary.

2. ***Open enrollment guarantees*** that for six (6) months following enrollment in **Part B**, persons age 65 and older cannot be denied Medigap insurance because of their health.

3. The insured must be given a **Buyer's Guide (a.k.a. Medicare and You)** and an **Outline of Coverage** no later than the time of application.

4. A producer **may not** sell a Medicare supplement (Medigap) policy when another policy is to remain in-force. **A beneficiary may not have two Medigap policies at once**.

5. No producer or other representative of an insurer may:

    - ***Complete the medical history portion of any form or application for the purchase of a Medicare supplement policy*** (the medical history questions must be completed by the applicant, the applicant's spouse, relative, legal guardian, someone with power of attorney or a physician).

    - ***Knowingly sell a Medigap contract to any person who is receiving or applying for Medicaid.***

6. Medigap policies must be **guaranteed renewable** and have a ***31 day grace period***.

7. **A minimum 30 day free-look** provision gives the owner a chance to return the Medicare supplement policy for a full refund.

8. No Medigap policy may use waivers to exclude, limit, or reduce benefits for specifically named or described preexisting diseases or physical conditions. Meaning **no** restrictions in coverage or higher premium is allowed because of the beneficiary's health.

9. **A Medicare Supplement Policy may not provide benefits for outpatient prescription drugs.**

Medigap Plans K and L, were introduced in 2005: Plan K and Plan L offer different benefits and lower premiums than Medigap Plans A through J. However, the insured who purchases Medigap K and L will have to pay higher out-of-pocket costs than the other Plans.

Students should be aware that there are ***12 standard plans available for Medicare beneficiaries;*** however, you do not need to memorize the coverage in all of the 12 plans.

Each of the ***standard*** 12 plans has a letter designation ranging from "A" to "L." Insurance companies are not permitted to change these designations or to substitute other names or titles. Companies are not required to offer all of the plans, but they all must sell Plan "A" if they sell any of the other plans.

II. Accident and Health Insurance Policy Provisions

The Uniform Policy Provisions Law, developed by the National Association of Insurance Commissioners (NAIC). The law includes 12 ***mandatory provisions*** that **are required** to be included in individual disability (health) insurance policies. Uniform ***optional provisions*** were also developed by the NAIC, but **are not required** to be included in the policy.

- ***The insurance company may reword the Uniform provisions so long as the new wording is more beneficial to the insured.***

A. Uniform Mandatory Provisions (a.k.a. ***Standard Provisions***) make disability (accident and health) policies conform to certain standard regulations. These provisions were put together with the intention of ***protecting the insured (consumer).***

1. The **Entire Contract** provision states that the contract is made up of the policy, application, endorsements, and riders. All statements in the application will be deemed ***representations*** (statements believed to be true) and not *warranties* (statements in the policy guaranteed to be true).
    - The contract may not be changed unilaterally once it is issued. No changes are valid unless approved and endorsed by an executive officer of the insurer.

2. **Time Limit on Certain Defenses**, a.k.a. Incontestability Period, states that after a policy has been in force for **two years**, the insurer cannot contest or void the claim, nor can it cancel the policy other than for **non-payment of premium or fraud committed by the insured such as filing a false claim**.

    Reasons the policy can be canceled in the first two years:

    - If a policy is canceled or a claim is voided for a **material misrepresentation or concealment,** all paid premiums must be refunded (**no interest**) to the policy owner.

    - ***Concealment*** is the ***withholding of facts*** from an insurance company. An example is not telling the insurer at the time of the application that you are leaving the field of accounting (a low risk occupation) and will be starting your logging business (high risk occupation) in the next few months. *A lie* told by the applicant to the insurance company is a ***misrepresentation***.

    - ***Material fact*** is information that, had it been known, would have caused the insurer to reject the application or issue the policy on ***substantially different terms*** (e.g., a rate-up or surcharge, or exclusion rider).

    - Lying about using tobacco, age, or gender is ***NOT*** considered material.

3. **Grace Period** extends coverage past the due date. Claims are still covered minus the past due premium, but ***no interest is charged*** to the insured. The Grace Period must be no less than **seven days** for weekly payment plans, **10 days** for monthly payment plans and **31 days** for payment plans over 30 days.

4. **Reinstatement** allows a lapsed policy to be put back in force. However, an application for reinstatement might be required. The insurer must respond within 45 days of the reinstatement application or the policy is automatically reinstated.

- A ***reinstated policy establishes a new* 10-day *probation period for sickness*** and a new **two year** time limit on certain defenses. *A policy reinstated on the 1st, coverage for sickness, would not be in effect until the 11th day (immediate coverage for accidents).*

5. **Notice of Claim…**A written notice of claim must be given to the insurer within **20 days** after the date of loss, if reasonably possible. Notifying the agent is acceptable. In the event of legal **incapacity,** this provision will be waived.

6. **Claim Forms** are used by the insured to file a proof of loss. The insurer should send the claim form within **15 days** after notice of claim. If the forms are not furnished, the insured may submit a written statement to the insurance company to satisfy the proof of loss.

7. **Proof of Loss** states that the insured or claimant has **90 days** to file a proof of loss with the insurer from the date of loss. In the event of legal **incapacity,** this provision could be extended for up to one year or waived entirely.

8. **Time of Payment of Claim** states that the insurer must pay claims ***immediately*** after receipt of proof of loss, except for claims involving periodic payments, such as disability income policies. Disability income (*loss-of-time*) benefits must be paid **at least monthly**.

9. **Payment of Claims** will be made to the owner, beneficiary, or to the insured's estate if there is no beneficiary. Indemnity for loss of life will be paid to the designated beneficiary. Indemnities for hospital, nursing, medical, or surgical services may be paid directly to the health care provider (a.k.a. Assignment of Benefits).

10. **Physical Exam/Autopsy** states that the insurer may require a physical exam of the insured at **reasonable** intervals (usually every six months) should the insured be receiving benefits. ***In the event of the death of the insured, an autopsy may be sought at the insurance company's expense, unless prohibited by law.***

11. **Legal Actions** provision requires that ***no legal action be started*** against the insurance company to collect benefits sooner than **60 days** *after the proof of loss is filed with the insurer.* This waiting period allows the insurer time to evaluate the claim. The statute of limitations is **three years** from the date the proof of loss is filed with the insurer.

12. **Change of (Revocable) Beneficiary** is the policy owner's right. For the change to be effective, it must be in writing by the owner and approved by the insurer in the form of an endorsement. A beneficiary is the person to whom the benefits of a policy are payable.

    - **Primary/Contingent** Beneficiary.... When an insured dies, the primary beneficiary receives the death benefit check. The contingent beneficiary only gets the death benefit if the primary beneficiary dies ***before*** the insured dies. ***If there is no beneficiary, the death benefit will go to the insured's estate****.*

B. Uniform Optional Provisions *protect the carriers*. These provisions need not be in the policy, however, as they are the insurer's option. If they are used, they must conform to the following standard **industry language**.

1. **Change of Occupation** provision states that by changing to a more hazardous occupation, the insured is entitled only to the indemnities the original premium would have purchased in a policy written for that more hazardous occupation. This means the **income benefit will be lowered.** By changing to a less hazardous occupation, the insured is entitled to **a reduced premium** and a refund of premium.
    - Special Note: ***As long as there is no material misrepresentation or concealment, the policy cannot be canceled or the claim denied.***

2. **Misstatement of Age/Gender (Sex)** provision states that **benefits will be adjusted** so the insurer pays for the benefit the premium would have purchased had the correct age or sex been known. ***Time Limit on Certain Defenses does not apply to this provision***.

3. **Other Insurance w/This Carrier *(prevents over indemnification)…***Being **over insured** makes it profitable to collect benefits rather than go back to work if you can get paid double. Excess coverage over the amount to which the claimant is entitled would be void, and unearned premium would be refunded. Usually, the lesser premium policy will pay benefits and the higher premium policy will refund a portion of the premium.

4. **Insurance w/Other Carriers** prevents over indemnification by limiting the insurer's liability to its **pro-rata** share of the payable benefits. The (pro-rata) amount payable will be determined by dividing the amount of coverage that the insurer has by the total of all available benefits. A portion of the premium will also need to be refunded to the insured.

5. **Relationship of Earnings To Insurance** limits benefit payments so that they will not exceed the insured's monthly net earnings at the time of disability, or will take the insured's average last two years earnings and will pay for whichever is greater.

6. **Unpaid Premiums** may be deducted from the claim being paid.

7. **Cancellation** means termination of coverage in advance of the renewal date. The insurer must return(refund) *premiums* within **five days from the date of cancellation**.

   - If the insurance company cancels the policy, the refund must be on a ***pro-rata basis =*** no service fee may be charged.
   - If the owner of the policy cancels his policy, the refund will be on a ***short rate basis*** = a service fee will be subtracted (charged) from the refund.
   - The cancellation of a policy by the insurance company ***will not prejudice any valid claim*** by the insured that originated while the policy was in force.

8. **Conformity with State Statutes** says that any policy provision which is in conflict with state laws is automatically amended to conform to the minimum statutory requirements.

9. **Illegal Occupation (Activities)** states that insurance companies are not liable for any loss incurred during the insured's commission of a crime.

C. Other (Common) Provisions are not required to have industry standard language as are the Mandatory and Optional Provisions.

1. **Pre-Existing Conditions Provision…**A preexisting condition can be excluded from coverage, usually for 12 months. This would be for any health condition the insured had, was treated for or was advised to have treatment for prior to the effective date of the policy. A disability contract may also be issued with an ***exclusion or impairment rider***, which eliminates or excludes coverage due to a particular health condition (***impairment)***, occupation or hobby from **ever** being covered.
2. **Free-Look Provision** gives the owner a ***minimum*** of **10 days** to look at the policy from the date the policy is ***delivered to the owner***. This provision gives the owner the right to return the policy for a ***full refund***. The insurer has 30 days to refund the paid premiums or pay an additional 10% penalty to the insured.

3. **Consideration Clause** (could be called the **Premium Clause**) identifies the fact that the policy owner must pay premiums as value to the insurance company for the insurance company's promise to pay***. It also states the mode and amount of the premium payment***.

4. **Insuring Clause** (a.k.a. agreement) represents ***the insurance company's promise to pay*** under the conditions stipulated in the policy. This clause performs the following functions: ***describes the general scope and limits of coverage, provides any definitions required, and sets forth the conditions under which benefits will be paid***.

5. **Assignment** means giving away the policy owner's rights in a policy, such as when an insured allows the hospital to bill the insurance company for expenses incurred by the insured.

6. **Non-occupational vs. Occupational Coverage…Non-occupational** (mostly found in **group contracts***)* coverage means that ***no benefits will be provided for losses due to an occupational cause***. If a worker is injured on the job or has a work related illness, benefits are provided by workers' compensation. **Occupational** coverage is basically ***full coverage***, ***providing coverage 24 hours a day, on and off the job.***

7. The **Ownership Clause** states the rights of the owner of the insurance contract. The owner is usually the insured. An exception is a third party owner such as business insurance or insuring children. The owner has the right to:
   - Determine the disposition of proceeds or benefits.
   - Assign the policy.
   - Request an increase or decrease in coverage.
   - Choose or change the premium payment mode.
   - Choose or change the beneficiary.
   - Cancel or renew the policy.

8. **Policy Continuation/Renewable Provisions:**

   a. A **Cancelable** policy ***means that an insurance company may cancel a policy at any time***, for any reason, but must return the *unearned premiums* within five days from the date of cancellation. If the insurer cancels refund will be on a ***pro-rata basis =*** no service fee.

      - ***Cancellation will not prejudice any valid claim*** by the insured that originated while the policy was in force. This policy would be ***the least beneficial to the insured***, however, it would have the least expensive premium.

   b. **Optionally Renewable** means that the insurer may elect to *non-renew* a policy for any reason, but only on the renewal date. **Nonrenewal** means that coverage will be continued through the policy's expiration date, but not beyond.

   c. **Conditionally Renewable** means that the carrier may elect to *non-renew* the policy on the renewal date, but may do so only under specific conditions listed in the policy. A condition such as age, or a change in occupation or hobbies may allow a carrier to non-renew. However, ***the condition cannot be related to the insured's current health***.

   d. **Guaranteed Renewable** restricts an insurer from canceling or non-renewing a policy except for non-payment of premium. Premiums may be increased on the basis of an entire classification, such as occupation or zip code. The insurer may regain the right to cancel or non-renew when the insured reaches age 65. For example, a major medical plan may end at the insured's age of 65 because the individual is eligible for Medicare.

   e. **Non-cancelable** (a.k.a. Non-cancelable and Guaranteed Renewable) is ***the most beneficial for the insured***. However, this contract will have a higher premium. The insurer **cannot** cancel or non-renew a policy, nor are they allowed to increase the premium (***premiums are fixed***). The insurer has the right to cancel or non-renew when the insured reaches age 65 (or normal retirement age) or for non-payment of premium.

9. **Period of Time**… Some companies offer coverage for a **"Period of Time" (sometimes called Short-Term Medical).** For example, a six month major medical plan would cover an insured for six months and then coverage would terminate. Some companies offer 30, 60, 90 or 180 day medical contracts. An example of a period of time policy, sometimes called a "term" policy, is flight insurance. Coverage begins when the flight starts and terminates when the flight is over. The policy will not renew.

10. **Dependent's Rights to Convert in Family Policies…** A dependent spouse or child eventually may lose coverage under a family policy, either because of death, divorce or because the child reaches age 19, or age 23 if a full-time student. The person whose family coverage ends may convert to a similar individual policy ***without giving evidence of insurability*** (non-medical), ensuring that a dependent with health problems can still be covered. ***This right is good for 31 days from the limiting date***.

    - ***In most States, newborn children are automatically covered from the moment of birth*** (whether or not the parents have maternity coverage.) **The parents must notify the insurance company within 60 days after birth and pay any premiums.**

11. **Eligible Expenses …** Medical expenses are the costs of diagnosis, cure, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. **Eligible expenses** are also the **usual, customary and reasonable charges** for medical services and treatment prescribed as necessary by the provider of health care or the insurance company.

    - **Pre-certification,** a.k.a. **pre-authorization**, allows an insurance company to review the expected hospital costs before the patient enters the hospital. This "estimate" is usually given by the hospital and/or the doctor. The insurer may recommend outpatient services instead of hospitalization.

12. **Usual, Customary and Reasonable (UCR)…**When surgical benefits are not listed by a specific dollar amount in a schedule, a policy will pay on the basis of what is considered usual, customary and reasonable (UCR) in a certain geographical area. This type of indemnity is most often found in major medical and comprehensive medical policies.

    Under this type of arrangement, the definition of UCR is based on the amount physicians in the area usually charge for the same or similar procedures. These nonscheduled plans allow policies to stay apace of inflation and to avoid policy restructuring every time medical costs increase. The insurer still reserves the right to agree or disagree that a particular charge is usual, customary and reasonable.

    Following is an example: Suppose Policy A has a scheduled maximum surgical benefit of $20,000 per procedure. Policy B pays the usual, customary and reasonable benefit. If the insured has a $30,000 open-heart procedure, and the insurer agrees this is a reasonable charge, Policy B provides the better coverage. Policy B would pay the full usual, reasonable and customary fee while Policy A would pay only its $20,000 maximum.

13. **Copayment…**the dollar amount which an insured must pay each time he or she goes to visit a doctor (usually between $5 to $20). Most common with the HMOs, but could be part of a traditional health plan with a deductible.

III. Social Insurance

A. **Medicare** is the Federal government's hospital and medical expense insurance, funded by payroll taxes and premiums. Traditional Medicare is a ***cost reimbursement (fee-for-service) system*** (www.medicare.gov).

1. **Eligible persons**:
    - ✓ ***Are 65 or older if they are eligible for Social Security.***
    - ✓ Who have been receiving ***Social Security disability benefits for 24 months.***
    - ✓ With ***end stage renal disease*** (kidney failure).
    - ✓ A person's PIA (primary insurance amount) is NOT an eligibility factor!

2. **Part "A" Hospital Insurance** has no premium, ***100% coverage for the first 60 days, after a deductible***, and co-payments after 60 days. **Part "B" Medical Insurance** has a premium and pays for doctor's services.

B. **Medicaid** (a.k.a. Welfare) is a government-sponsored health care program for the financially needy (the poor) and certain other individuals. ***It helps pay for part or all of a person's medical expenses.*** It also covers the costs not covered by Medicare and helps pay for nursing home care, including **custodial care**.

- Medicaid ***will not*** replace a person's lost income due to a disability.

- Medicaid is funded by State and Federal moneys, but is ***administered by the States (Department of Social and Health Services [D.S.H.S.])***

- It is ***fraud*** for an agent or broker to write a Medigap or Long-Term Care policy on anyone who is currently on or applying for Medicaid.

C. Social Security pays benefits when a covered worker retires (Medicare and retirement benefits), dies or becomes disabled. It is funded by Social Security taxes and Old Age Survivor Disability Health Insurance, OASDHI. To be eligible for benefits, a person must become "insured" as defined in the Social Security law.

1. ***Fully insured*** generally means that the person has at least 40 quarters of coverage. A quarter is a calendar quarter in which the worker has a minimum level of earnings.

2. To qualify for **Disability Income Benefits,** the beneficiary must be unable to engage in **any gainful occupation** for which he is reasonably suited by education or training to perform, and the disability is expected to last for 12 months or longer, or to result in death. There is a ***five-month waiting period***. The benefit is a percentage of the worker's **primary insurance amount**.

   - For example, if a worker is disabled after age 50, the benefit payable would be 80% of the worker's PIA beginning after the ***sixth month after being disabled***.

   - **The Primary Insurance Amount (PIA)** for a worker is based on his or her average level of earnings and is updated and published annually in tables by the federal government. ***Most types of Social Security benefits are a percentage of the individual's PIA.*** (www.ssa.gov)

IV. Field Underwriting and Taxation

A. Formation of the Accident and Health Contract

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.**

   - ***Underwriting*** is the process of selection, classification and rating of risks. Simply put, underwriting is a ***risk selection process***. The selection process consists of evaluating information and resources to determine how an individual will be classified such as standard, preferred or sub-standard.

   - ***Replacement of a Policy*** is legal but most states have "Replacement" regulations. The purpose of the replacement regulation is to regulate activities of insurers, and producers, with respect to the replacement of existing insurance contracts, 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.

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

   Unfair discrimination is not allowed. No entity engaged in the business of insurance can refuse to issue any contract of insurance or cancel or decline to renew such contract of the insured or prospective insured when ***bona fide statistical differences in risk*** or exposure ***have not*** been substantiated.

- **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-smokers" (non-tobacco users) discount.

- **Substandard Risk** means not being as healthy as a normal risk and will 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% will be added to the premium due.

- **Modified/Amended vs. Issued as Requested…** If a policy is issued with an elimination or exclusion rider or rated-up, a surcharge will be added (known as a counter-offer) and a signature from the policy owner will be needed upon delivery of the policy. ***The policy will be in force when the counter offer is signed and the additional premium is paid.***

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**, when required, are conducted by physicians or paramedics. An exam might include such things as a urine specimen, blood test, blood pressure check, or EKG.

- **Consumer Report/Credit Check (Fair Credit Reporting Act)…** Consumer 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. Most company's home offices handle the reports, yet some may have other organizations check on the insured's background 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 the most important source of information to the insurance company during the underwriting process so his report is important to the insurance company.

4. **Policy Delivery** 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.

5. 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 agents 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.

   - 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.

   - **There are three reasons why the effective date is important:**
     a) insurance coverage actually begins
     b) any contestable period begins (time limit on certain defenses provision)
     c) any probation period begins

B. Insurance Contract…Insurance policies are legal contracts and are enforceable by law. The **Entire Contract** provision states that the insurance contract is made up of the ***policy, attached application, endorsements, and riders.*** All statements in the application will be deemed ***representations*** (statements believed to be true) and not *warranties* (statements guaranteed to be true).

◎ **Elements of a Legal Insurance Contract:**

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

- **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. Without any of these there is no legal contract. The insurance company issues a contract (policy) that represents a promise to pay.

- **Legal Object…** In order 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.

  Special Note: ***An insurance company may cancel a policy and deny a claim due to fraud committed by the insured against the insurance company.***

- **Competent Parties…** The insured must be of legal age, not be under the influence of intoxicants and not be mentally handicapped. 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.
  - **Exception:** In a Life or Disability Contract, the ***minimum age is 15 years old,*** meaning that at age 15 the child is also required to sign all forms. A person ***is not considered a minor*** for purchasing this insurance.

◎ **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.

C. Legal Concepts

1. **Insurable Interest…**A person who has an emotional or financial tie in another person's life is said to have an insurable interest in that life. Insurance companies will require that the owner/applicant have insurable interest in the insured. ***Insurable interest must exist at the inception of the policy (time of application)!***

2. On an application, **representations** are facts that an applicant represents as true and accurate to the best of his knowledge and belief. A **misrepresentation (a lie)** is a statement which is not true. A **concealment** is the ***withholding of facts*** from the insurer.
   - **Misrepresentation or concealment** discovered in the first two years of the contract and found to be ***material*** could cause the contract to be voided. *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***. (Time Limit on Certain Defenses provision).

3. A **warranty** is a ***written guarantee (in all respects) in an insurance contract***. For example, a hotel will *warrant* to the insurance company that its sprinkler system will be in operation 24 hours a day to help prevent damage from fire. A breach of a warranty is a breach of the contract and will cause the voiding of a claim.

   - In any insurance contract, the warranty given by the *insurance company* is their promise to pay. This is found in the ***insuring agreement***.

D. Federal Taxation of Benefits

1. **Disability Income Benefits** received by an insured are ***not taxable*** if the insured pays his/her own premiums, because individual policy premiums are **NOT tax deductible**. This does not relate to Social Security disability income benefits. In general, benefits received under Social Security are NOT taxable to the recipient.

2. **Medical Expense Benefits** (including dental) are not taxed as long as they do not exceed the expenses incurred. They are considered a reimbursement of expenses.

3. **Deductibility of Premiums…**Premiums paid by *employers* are deductible to the business to the extent that they pay for employees' benefits. Premiums paid by *employees* for group medical care may be deducted by the insured if they exceed 7.5% of the insured's adjusted gross income.

4. **Deductibility of Premiums for the Self-Employed…** Generally, partnerships, S Corporations and sole proprietors are self-employed individuals, not employees. The self-employed may deduct 100% of the premiums paid for insurance during a taxable year which provides medical care for the self-employed individual, his spouse and dependents.

   - Premiums paid by individuals for disability income insurance are **not tax deductible**.

Long-Term Care Insurance

I. Introduction

The average American living in 1900 could expect to live just under 50 years. The current average life expectancy is almost 80 years, and a life span exceeding 100 years may become commonplace. Today there are approximately 75,000 Americans age 100 or older; by the year 2030, this number is expected to reach 450,000. At the same time, the number of retired people in the United States will reach 65 million; double the current number.

Most older Americans will be cared for at home. Family and friends are the sole caregivers for 80 percent of the elderly. A study by the U.S. Department of Health and Human Services says that people who reach age 65 will likely have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home will stay there five years or more and the average stay in a nursing home is 2.4 years.

As of May 2010, eight million Americans own long-term care insurance policies, according to a study released by the American Association for Long-Term Care insurance. The study reported that the average age of buyers dropped below 60 for the first time. The average age of Americans purchasing individual long-term care insurance protection is now 57. Increased public understanding of the importance of planning prior to retirement and lower costs available at younger ages are factors impacting the trend. For a daily benefit of $150 per day, a person 55 years old would pay $1000 per year and that person 65 years old might not qualify for the good health savings and would pay $1900 per year. Women account for slightly over two-thirds of individuals currently receiving benefits under a long-term care insurance policy. The average daily benefit for long-term care insurance protection purchased is $154.00. The average cost of one year of care is $74,000.

The following information is based on the outline described in RCW 48.83.130 pursuant to legislation passed in 2008. In the state of Washington, all life and disability agents who want to transact Long-Term Care policies must complete the required 8 hour course. After answering the questions and returning the answer sheet to us, we will grade it and if you pass with a 70% or better, we will issue you a certificate of completion for 8 hours for Long-Term Care. After completing the initial 8 hour LTC course, a 4 hour LTC refresher course is required during each license renewal term. Both of these courses may be used as hours towards your 24 hour continuing education requirement for license renewal. Please visit our web site at www.slaterinsuranceschool.com **for further information.**

The first part of this book discusses Long-Term Care on a less formal basis.

The second half of this book is based on the Washington Revised Code of Washington and the Washington Administrative Code as they relate to Long-Term Care Insurance, including the new 2012 LTC Partnership Plan.

A. What is Long-Term Care Insurance?

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 (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 (CCRCs), hospice care, rehabilitation therapy and more.

Services that help people live outside of a nursing home, often in their own home, have become increasingly common and desirable options as the focus of the industry has changed. Keeping the elderly and disabled as independent as possible outside of a nursing home is becoming the preferred goal of long-term care, as opposed to institutionalization. There are also LTC services called respite care, to give relief to those who provide informal care, such as spouses, other relatives and friends.

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 and personal care.** Personal care is also sometimes called custodial care. Personal care is for people who do not need ongoing health or medical services, but rather only need help with what are known as "Activities of Daily Living" (ADLs)—eating, dressing, taking medicine, bathing, toileting, transferring and continence. Household chores are also considered personal care.

A nursing home that provides long-term skilled nursing care (under the supervision of licensed medical personnel) is called a skilled nursing facility. Medical care often requires a nursing home, although it can be given at home. If medical or skilled nursing care is given at home, it may be called home health care. Home health care is NOT the same as home care, even though the two terms are sometimes mistakenly used interchangeably. Home care is personal care. It often deals with maintaining people in their homes by providing what's often called chore services. It can be thought of as care of the person's surroundings and living conditions.

Medicare covers only small amounts of skilled health/medical care. It does not cover personal/custodial care in a nursing home, and covers only small amounts of care at home under stringent conditions.

The National Association of Insurance Commissioners (NAIC) has developed certain **standards** to aid consumers in selecting appropriate insurance coverage. For long-term care insurance, the NAIC recommends looking for a policy that includes the following:

- At least one year of nursing home care or home health coverage, including intermediate and custodial care. Nursing home or home health care should not be limited to skilled care.
- Coverage for Alzheimer's disease.
- An inflation protection option:
    - Automatic increases to the benefit level on an annual basis, or
    - A guaranteed right to increase your benefit level periodically without providing evidence of insurability.

- An "outline of coverage" which systematically describes the policy's benefits, limitations, and exclusions, and allows you to compare the policy with others.
- A long-term care insurance "shopper's guide" which helps you decide whether long-term care insurance is appropriate for you.
- A guarantee that the policy cannot be canceled or otherwise terminated because you get older or suffer deterioration in physical or mental health.
- The right to return the policy for any reason within 30 days after you purchase it, and to receive a refund of premiums paid (often call a "free look" provision).
- No requirement that you be hospitalized before receiving nursing home benefits or home health care benefits.
- No requirement that you receive skilled nursing home care before receiving benefits for intermediate or custodial nursing home care.
- No requirement that you receive nursing home care before receiving benefits for home health care.

It is important to understand:

- the differences between types of long-term care services
- the types of providers that deliver them
- the types of care most likely to be wanted, needed, or used most effectively
- comparative costs of these services
- types of care and care providers that are available in the area
- where the services can be delivered to the patient (e.g. home, assisted living, nursing home)

Key points to remember when purchasing a long-term care policy:

- Long-term care insurance policies cover a wide range of medical, personal and social services
- Be aware of what benefit triggers must happen for a policy to begin paying benefits
- Understand the elimination period
- Understand the daily benefits provided
- Know what is covered and what is excluded
- Match your need for long-term care with your need to protect assets and pay premiums
- Understand how much premium you must pay and how often you must pay it
- Your premium may increase after your purchase
- If you cannot afford the premium, you may not receive benefits for the amount you paid in the past. Make sure you know if the policy offers a reduced premium for less coverage.

B. Before we go any further, please read the following TERMS and DEFINITIONS:

"Activities of daily living (ADL)" - Measure of a person's level of independence/dependence. Includes individual tasks such as bathing, transferring, dressing, toileting, eating, and maintaining continence. Long-term care classifies risks according to a persons' ability to perform these daily activities.

"Acute care" means care provided for patients who are not medically stable. These patients require frequent monitoring by health care professionals in order to maintain their health status.

"Actual loss ratio" is a retrospective calculation and may be calculated as the "benefits incurred" divided by the "premiums earned," both measured from the beginning of the "calculating period" to the date of the loss ratio calculations.

"Adult day care" - Daytime, *community-based programs* for functioning impaired adults that provides a variety of health, nutrition, social, and related services in a protective setting to those who are otherwise being cared for by family members. Its purpose is to enable individuals to remain at home and in the community and to encourage family members to care for them by providing relief from the burden of constant care.

"Adult day health care" means a program of community based social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the individual's home.

"Adult day services" - An umbrella category which includes both Adult Day Care and Adult Day Health Care.

"Alternative plan of care"- Alternative care is care or services that are not specified in a policy, but that may be provided if it is appropriate and is agreed upon by the insurance company, the insured person and his or her physician. The alternative care benefits are provided in lieu of normal contract benefits. The care is usually more desirable to the individual and may be less costly to the insurance company. One example would be placing a person in an adult family home instead of a nursing home.

People's needs and desires for long-term care situations are changing, reflecting changes in the culture. Conventional nursing home situations are less appropriate and desirable for many people today—and are more expensive and provide a higher level of care than is necessary in many cases. However, some insurance—and some thinking in the insurance industry—still clings to the conventional model, as reflected in some policies' benefit structures. The Office of the Insurance Commissioner has worked at changing rules and regulations so that future policies will be required to allow more flexibility. Some long-term care policies require an "alternative plan of care"—a written designation of what care will be provided, who will provide it and for how long—in order for alternative care to be covered.

Policies may specify not only that a plan of care is required, but that it must be written or certified by a specific person, such as a physician or case manager.

Key Points of the OIC's definition of the alternative plan of care are:

- No requirement to be confined in a nursing home before alternative plan is allowable.
- The alternative plan of care must be agreed to the insured's caregiver, the issuer of the policy, and the insured.
- The alternative plan of care must be part of a plan of care developed by a designated health care professionals.
- It's important to note that state regulations allow for each operative day of a plan of care to be counted as one day of service, even if no benefits are given that day. For example, a claimant with a two-month plan of care might receive care only every other day. In this way, during a two-month period, the claimant would receive only 30 days of care, but would use up 60 days of policy benefits. For this reason, it is best to keep a plan of care short so it can be reevaluated.

Some examples of care which are still considered "alternative" care options:

- Nutritional counseling, speech therapy, physical therapy, occupational rehabilitation and/or laboratory services.
- Other services include structural changes to a home including ramps, guard rails, and others that might enable a person to remain independent in the home.
- LTC services can be combined. For example, a family can provide basic and primary care with community support such as respite care (short-term care while the family caregiver takes time off) or part-time adult day care.

"Assisted living" - Residential care settings providing *personal care* services, shopping, housekeeping, and transportation. Assisted living also may be called Board and Care, Personal Care, Domiciliary Care, or Residential Health Care.

"Bed reservation"-Pays to reserve the nursing home bed space left temporarily by the policyholder if he needs to go into the hospital, usually up to a designated maximum number of days.

"Benefit maximum" - Amount of money or days of care beyond which a LTC insurance policy will not pay benefits.

"Benefit period" means the period of time for which the insured is eligible to receive benefits or services under a contract. A benefit period begins on the first day that the insured is eligible for and begins to receive benefits of the contract. The benefit period ends when the insured is no longer eligible to receive benefits or has received the maximum benefits available. Such benefit period must be stated in terms of days rather than in terms of months of benefit.

"Benefit trigger" - Point at which criteria used to determine eligibility for benefits is met. In Washington State, triggers can be based on ADLs, cognitive impairment, physician certification or a combination of all three.

"Benefits incurred" may be the "claims incurred" plus any increase (or less any decrease) in the "reserves."

"Calculating period" may be the time span over which the pricing actuary expects the premium rates whether level or increasing, to remain adequate in accordance with his best estimate of future experience and during which the pricing actuary does not expect to request a rate increase.

"Care manager" or "Case coordinator" means an individual qualified by training and/or experience to coordinate the overall medical, personal and social service needs of the long-term care patient. Such coordination activities will include but are not limited to: Assessing the individual's condition to determine what services and resources are necessary and by whom they might most appropriately be delivered.

"Case management services" includes, but is not limited to, a comprehensive individualized face-to-face assessment conducted in the insured's place of residence which takes an all-inclusive look at the patient's total needs and resources, and links the patient to a full range of appropriate services using all available funding sources. The assessment is reevaluated at least once every six months. When desired by the insured and when it is determined to be necessary by the case manager, case management services will include coordination of appropriate services and ongoing monitoring of the delivery of such services.

"Chronic care" or "Maintenance care" means care that is necessary to support an existing level of health and is intended to preserve that level from further failure or decline. The care provided is usually for a long, drawn out or lingering disease or infirmity showing little change or slowly progressing with little likelihood of complete recovery, whether such care is provided in an institution or is community-based and whether such care is skilled or custodial/personal.

"Claims" means the cost of health care services paid to or provided on behalf of covered individuals in accordance with the terms of contracts issued by health care service contractors or health maintenance organizations or capitation payments made to providers of long-term care.

"Claims incurred" means: Claims paid during the accounting period; plus the change in the liability for claims which have been reported but not paid; plus the change in the liability for claims which have not been reported but which may reasonably be expected. The "claims incurred" may not include expenses incurred in processing the claims, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, or profit.

"Cognitive impairment" - Problems with attention, memory, or other loss of intellectual capacity that *requires supervision to help or protect the impaired person*.

"Community based care" means services including, but not limited to: home delivered nursing services or therapy custodial or personal care day care home and chore aid services nutritional services, both in-home and in a communal dining setting respite care adult day health care services and other similar services furnished in a home-like or residential setting that does not provide overnight care.

"Continuum of care" - Interrelated and connected range of services, from home and community-based programs to institutionalization, needed by older adults at various stages of disability.

"Contract" means long-term care insurance policy or contract, regardless of the kind of issuer, unless the context clearly indicates otherwise. The term specifically includes any policy, contract, certificate, rider, or endorsement delivered, issued for delivery or that provides coverage to a resident of this state, if that contract claims to provide asset protection under Washington Long-Term Care Partnership Act, chapter 48.85 RCW.

"Convalescent care" or "Rehabilitative care" is non-acute care which is prescribed by a physician and is received during the period of recovery from an illness or injury when *improvement can be anticipated*, whether such care is skilled or custodial/personal, and whether such care is provided in an institutional care facility or is community-based.

"Coordination of benefits" - Method of integrating benefits payable under more than one health insurance source so that the insured's benefits from all sources do not exceed 100 percent of allowable expenses.

"Custodial care" or "Personal care" is *non-medical* care that provides help with the ADLs. This level of care may be provided by persons without professional skills or training. Examples are help in walking, getting out of bed, bathing, dressing, eating, meal preparation, toileting and taking medications. Such care is intended to maintain and support an existing level of health or to preserve the patient from further decline. Custodial or personal care services are those which may be recommended by the care adviser in consultation with the patient's attending physician and are not primarily for the convenience of the insured or the insured's family. ***This is the type of care that is most needed by the elderly***.

"Direct response insurer" means an insurer who, as to a particular contract, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent.

"Elimination period" is the amount of time that needs to pass after the individual begins receiving a long-term care service before the policy begins to pay (somewhat like a deductible).

The most common elimination periods (though there are others) are:

- **Zero days (payment starts on the first day of nursing home confinement)**
- **20 days (payment starts on the 21st day of confinement)**
- **100 days (payment starts on the 101st day of confinement)**

"Expected loss ratio" is a prospective calculation and may be calculated as the projected "benefits incurred" divided by the projected "premiums earned" and may be based on the pricing actuary's best projections of the future experience within the "calculating period."

"Estate recovery" refers to the federal and state estate recovery program which requires recovery by the state from the insured's estate after the death of the insured, certain costs of services paid by the state during the lifetime of the insured. The rules of the federal and state estate recovery program change from time to time; the rules in effect at the date of the insured's death will govern the estate recovery process.

"Gatekeeper provision" is any provision in a contract establishing a threshold requirement which must be satisfied before a covered person is eligible to receive benefits promised by the contract. Examples of such provisions include, but are not limited to the following: A three-day prior hospitalization requirement, recommendations of the attending physician and recommendations of a case manager.

"Guaranteed renewable"-A policy may only be cancelled for **non-payment of premiums.** In the State of Washington, all long-term care, Medicare supplement and health insurance policies **MUST** be "***guaranteed renewable***."

- **Guaranteed Renewable** restricts an insurer from canceling or non-renewing a policy except for non-payment of premium. Premiums may be increased on the basis of an entire classification, such as occupation or zip code. Rates ***may not*** be increased due to health or number of claims.

"Home care services or personal care services" are services of a personal nature including, but not limited to, homemaker services, assistance with the activities of daily living, respite care services, or any other non-medical services provided to ill, disabled, or infirm persons which services enable those persons to remain in their own residences consistent with their desires, abilities and safety. An insurer may require that services are provided by or under the direction of a home health care agency regulated by this state, or that services are administered in accordance with a plan of treatment developed by or with the assistance of health care professionals.

"Home health aide" is a person who is providing care under the supervision of a physician, licensed professional nurse, physical therapist, occupational therapist, or speech therapist. Care provided may include ambulation and exercise, assistance with self-administered medications, reporting changes in a covered person's condition and needs, completing appropriate records, and personal care or household services needed to achieve medically desired results.

"Home health care" means any of the following health or medical services: Nursing services, home health aide, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional services, medical or social services, and

medical supplies or equipment services. An insurer may require that services are provided by or under the direction of a regulated home health care agency regulated by this state, or that services are administered in accordance with a plan of treatment developed by or with the assistance of health care professionals.

"Hospice care" means care for the terminally ill. The patient has a life expectancy of six months or less.

"Inflation protection"-This feature provides a way to help cushion today's LTC policy buyers from the full effects of future increases in long-term care costs. This may be important to people who are buying a policy many years before they will use it. While an inflation protection feature is unlikely to fully cover the inevitable increase in costs that will occur over the life of the policy, it can at least cushion the impact of inflationary increases.

"Institutional care" means care provided in a hospital, nursing home, or other facility certified or licensed by the state primarily affording diagnostic, preventative, therapeutic, rehabilitative, maintenance or personal care services. Such a facility provides twenty-four hour nursing services on its premises or in facilities available to the institution on a formal prearranged basis.

"Instrumental activities of daily living (IADL)" - Measure of a person's level of independence/dependence. Includes activities such as ability to do housework, prepare meals, manage money, and use the telephone.

"Insured" means any beneficiary or owner of a long-term care partnership or long-term care contract, regardless of the type of insurer.
"Insurer" includes insurance companies, fraternal benefit societies, health care service contractors and health maintenance organizations unless the context clearly indicates otherwise.

"Intermediate care" means technical nursing care which requires selected nursing procedures for which the degree of care and evaluation is less than that provided for skilled care, but greater than that provided for custodial/personal care. This level of care provides a planned continuous program of nursing care that is preventative or rehabilitative in nature.

"Issuer" means any entity that delivers, issues for delivery or provides coverage to a resident of this state, any contract that claims to provide asset protection under the Washington Long-Term Care Partnership Act, 48.85 RCW. Issuer as used here specifically includes insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations.

"Levels premiums at age of entry"-Policies with this benefit will consider you to be the age at which you purchase your policy for the life of the policy. For example, if you purchase the policy at age 65, for all intents and purposes, you would be treated as age 65 for the life of the policy. Any class rate increases or new underwriting would be based on you being 65 years old, even 10 or 15 years after purchase.

"Long-term care contract" means a contract that is primarily advertised, marketed or designed to provide coverage for or resulting from long-term care services over a period of time. Services provided may range from direct skilled medical care performed by trained medical professionals as prescribed by a physician or other primary care provider, or a qualified case manager, in consultation with the patient's attending physician or rehabilitative services or assistance with the basic necessary functions of daily living for people who have lost some or complete capacity to function on their own.

"Long-term care partnership contract" (WAC 284-85-015) means a contract of long-term care insurance that claims to provide asset protection under the Washington Long-Term Care Partnership Act, chapter 48.85 RCW to a resident of this state.

"Long-term care total disability" means the functional inability due to illness, disease or infirmity to engage in the regular and customary activities of daily living which are usual for a person of the same age and sex.

"Loss ratio" means the incurred claims plus or minus the increase or decrease in reserves as a percentage of the earned premiums, or the projected incurred claims plus or minus the increase or decrease in projected reserves as a percentage of projected earned premiums, as defined by the commissioner.

"Managed long-term care delivery system" means a network of providers arranged or controlled by a managed long-term care plan. Such systems provide a range of long-term care services with provisions for effective utilization controls and quality assurance. In the case of provision of long-term care in the managed care environment, a case manager or other qualified individual may be used to develop and coordinate a care plan of appropriate long-term care services.

"Managed long-term care plan" means a plan which on a prepaid basis assumes the responsibility and the risk for delivery of the covered long-term care services set forth in the benefit agreement. Actual services are rendered by the plan through its own staff, through capitation or other arrangements with providers. Managed long-term care plans may include but are not limited to those offered by health maintenance organizations, and health care service contractors, if their services are provided through a managed long-term care delivery system.

"Means test" - Measure of income and assets to determine eligibility for government benefit programs.

"Medicaid" means Title XIX of the United States social security act. Financial help for hospital and medical bill for the financial needy. Including nursing home care.

"Medicaid eligibility" means that an insured has exhausted the benefits of his or her long-term care partnership contract and it has been determined, in accordance with Medicaid rules, that the insured is eligible for a Medicaid program as determined by the state department of social and health services, or as provided in WAC 388-505 through -519 WAC.

"Noncancellable" means that renewal of a contract may not be declined except for nonpayment of premium, nor may rates be revised by the insurer.

"Nonforfeiture benefit"-A high percentage of people stop paying premiums and lose policy benefits. A nonforfeiture benefit keeps the policyholder from forfeiting all benefits should he decide to drop the coverage. A policy with this feature will continue to provide reduced benefits even after the policyholder stops paying premiums, in compensation for the money already paid in. The feature may be usable only after a policy-specified number of years of paying premiums.

"One period of confinement" means consecutive days of institutional care received as an inpatient in a health care institution, or successive confinements due to the same or related causes when discharge from and readmission to the institution occurs within a period of time not more than 90 days or three times the maximum number of days of institutional care provided by the policy to a maximum of 180 days, whichever provides the covered person with the greater benefit.

"Overall loss ratio" may be calculated as the "benefits incurred" divided by the "premiums earned" over the entire "calculating period" and may involve both retrospective and prospective data.

"Plan of care" means a written, individualized plan of services approved by the case manager that specifies the type, frequency and providers of all formal and informal long-term care services required for the insured. Changes in the plan of care must be documented to show alterations which have been agreed to and are required by a change in the situation or condition of the insured.

"Policy limits"- Policy limits refers to the maximum that will be paid for a covered loss. You must refer to your policy or call your agent to find out if the limit is a lifetime limit or a per occurrence limit. For example, a policy may pay a $150 per day benefit limit, but may also limit the time it will pay the $150 per day to only 5 years. A policy may have a policy limit which is the maximum it will pay. For example, if you have a policy with a $100,000 lifetime policy limit, the policy expires once the $100,000 has been paid out.

After the **benefit triggers** have been satisfied so that a policy begins to pay the claim, the policy's specific benefits are available—but there may be further limitations, often relating to where care is received and from whom (provider types, licensing and certification).

Each long-term care policy or contract will specify what kinds of services will be covered, in what settings, and by which type of provider. Benefits can be denied unless the claimant is receiving care in the appropriate location and from the appropriate personnel. If the types of eligible providers specified in the policy are not available in a claimant's geographic area, the benefit may be unusable.

Licensing and certification of providers may also create requirement issues. For example, to be eligible for payment, nursing homes providing skilled or custodial care must be licensed as nursing home facilities by the Department of Social and Health Services. Congregate care facilities must be licensed as "boarding homes" by the Department of Social and Health Services if people live there and receive care. Home health agencies generally must be Medicare-approved or state-certified.

Some LTC contracts require enrollees to use facilities with which they have a contract—also called participating providers—to qualify for benefits. Participating providers have agreed to provide the necessary services, and to look to the insurance company for payment, except for co-payments, deductibles, and expenses that are not covered.

If the policyholder does not use the facilities or providers with whom the insurer has a contract, there may be reduced benefits. The company may even deny the claim. This is an important limitation and should be carefully reviewed so the consumer understands that they may only use certain providers if they want to be assured of receiving LTC benefits under that policy or contract.

In Washington, all long-term care policies must meet the following standards:

a. No contract can limit benefits to an unreasonable period of time or an unreasonable dollar amount. For example, a provision that a particular condition will be covered only for one year without regard to the actual amount of the benefits paid or provided, is not acceptable. Policies may limit in-patient institutional care benefits to a reasonable maximum dollar amount, and, as for example in the case of home health care visits, to a reasonable number of visits over a stated period of time.

b. If a fixed dollar indemnity fee for services rendered long-term care contract contains a maximum benefits period stated in terms of days for which benefits are paid or services are received by the insured, the days which are counted toward the benefit period must be days for which the insured has actually received one or more contract benefits or services. If benefits or services are received on a given day, that day may not be counted. Waiver of premium may not be considered a contract benefit for purposes of accrual of days and long-term care total disability may not operate to reduce the benefit.

c. If a contract of a managed care plan contains a maximum benefit period, it must be stated in terms of the days the insured is in the managed care delivery system. The days which are counted toward the benefit period may include days that the insured is under a care plan established by the case manager, or days in which the insured actually receives one or more benefits or services.

d. A long-term care contract must cover skilled, intermediate, and custodial (personal) care, whether benefits are for institutional or community based care.

e. No contract may restrict or deny benefits because the insured has failed to meet Medicare beneficiary eligibility criteria.

f. No insurer may offer a contract form which requires prior skilled or intermediate care as a condition of coverage for institutional or community based care.

g. No insurer may offer a contract form which requires prior hospitalization as a condition of covering institutional or community based care.

h. No long-term care contract may restrict benefit payments to a requirement that the patient is making a *steady improvement* or limit benefits to *recuperation* of health.

"Preexisting condition" as defined by RCW 48.84.020, means a medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.

"Premium" means all sums charged, received or deposited as consideration for a contract and includes any assessment, membership, contract, survey, inspection, service, or similar fees or charges as paid.

"Premiums earned" mean the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

"Prior hospital stay"- LTC policies cannot require a prior hospitalization as a condition of coverage.

- ✓ Often, policyholders were assured by insurance salespeople that a doctor would put them in a hospital long enough to satisfy the policy requirements, or that they could pay for a hospital stay themselves. However, physicians will not do this, no matter what promises were made. If a policy requires hospitalization, the days in the hospital must be "medically necessary."

- ✓ It is increasingly difficult to fulfill a prior hospital requirement due to changes in Medicare and because much care is now provided on an outpatient basis. Often an individual goes directly into a nursing home or receives home health care benefits without a prior hospital stay. An Alzheimer's patient, for example, usually does not require hospitalization, but gradually deteriorates until long-term care services are necessary.

"Reduction of coverage"- People who have purchased long-term care insurance have the right to reduce the benefits of the policy or contract without providing evidence of insurability (i.e., without undergoing underwriting as if they were purchasing a new policy). The policyholder can make changes such as a longer elimination period, a lower daily benefit, or a shorter benefit period (assuming the insurer offers policies with these lesser benefits) resulting in a smaller premium.

"Reinstatement"-Long-term care insurance policyholders in Washington State have the right to reinstate coverage after a lapse or termination due to nonpayment of premiums, if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity, and if reinstatement is requested within five months after the policy lapsed. (The policy's requirement for proof of cognitive impairment or loss of functional capacity for reinstatement cannot be any more stringent than the proof requirement for benefit eligibility.)

"Respite care" is short-term care which is required in order to maintain the health or safety of the patient and to give temporary relief to the primary caregiver from his or her caretaking duties.

"Restoration of benefits"- If the insured receives benefits then later gets well and does not enter a new claim period (make any more claims) for a specified amount of time, the benefits that were used may be restored—that is, they become once again available, not counted as used.

"Return of premium"-A return of premium is not allowed in Washington State for long-term care insurance (or any other insurance except for disability insurance). A return of premium refers to the refund of all premiums paid minus any benefits/claims paid during the life of the policy, in the event of a lapse in the policy due to nonpayment of premiums. This is not allowed because subtracting the amount of claims paid from the refund could reduce it drastically and make it virtually worthless.

"Skilled care" means care for an illness or injury which requires the training and skills of a *licensed professional nurse*, is prescribed by a physician, is medically necessary for the condition or illness of the patient, and is available on a twenty-four hour basis.

"Skilled nursing facility" - Institutional but not inpatient hospital care, requiring limited medical attention, that is provided under supervision of registered nursing personnel or physician.

"Spell of illness" is also known as "one period of confinement." It defines the time that will be allowed between the end of one period of medical treatment and the start of another, in order for the more recent instance to be covered without having to satisfy a new elimination period.

"Spend down" - Depletion of assets to pay for LTC after which a person becomes eligible for Medicaid.

"Spousal discounts" -There are policies with premium discounts if both spouses purchase coverage from the same company (usually, the same coverage at the same time).

"Terminally ill care" means care for an illness, disease or injury which has reached a point where recovery can no longer be expected and the attending physician has certified that the patient is facing imminent death, or has a life expectancy of six months or less.

"Third party notice of lapse"- All policies must permit the insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium, in case the premium is not paid by its due date, and the coverage cannot lapse until at least 30 days after the notice is mailed to the third-party designee (this is 60 days for insureds paying a premium through a payroll or pension deduction plan). This protects the policyholder from lapse or termination in case cognitive impairment or loss of functional capacity results in nonpayment of premiums.

"Waiver of premium"- A waiver of premium allows the policyholder to stop paying premiums after a designated time following the start of policy-covered care. Some policies will waive premiums after a certain number of "days in facility." Others will waive premiums after a certain number of "covered benefit days." If a policyholder has a 90-day waiver of premium, after 90 days of covered care, he will no longer have to pay policy premiums after 90 days. (If the policy also had a 20-day elimination period, however, it would be 110 days before policy premiums no longer need to be paid.)

C. Types of LTC Services and Providers of Care

- assisted living facilities
- congregate care facilities
- home health agencies
- adult family homes
- hospice centers
- adult day care centers
- adult day health care
- respite centers
- continuing care retirement communities
- chore workers
- social workers
- family caregivers
- nursing homes
- life care communities
- Alzheimer's units
- hospital sub-acute units

Long-term care may also involve other professional services. Nutritional counseling, speech therapy, physical therapy, occupational rehabilitation and/or laboratory services may be adjunct services used in one of the care situations listed above, or they may be stand-alone services.

Other services include structural changes to a home including ramps, guard rails, and others that might enable a person to remain independent in the home.

LTC services can be combined. For example, a family can provide basic and primary care with community support such as respite care (short-term care while the family caregiver takes time off) or part-time adult day care.

If a long-term care insurance policy or contract is used to pay for costs, it will specify which kinds of services are covered, and by which type of provider, and under what circumstances.

Some of the community options listed above are still considered "alternative" options. Many in the field hope that alternative service settings and providers—as long as they are licensed, certified and otherwise qualified—will become the standard as long-term care evolves. These options are better for many people, often more personalized and flexible, and often cost everyone less.

It is important to understand:

- the differences between types of long-term care services
- the types of providers that deliver them
- the types of care they are most likely to want, need, or use most effectively
- comparative costs of these services
- types of care and care providers that are available in the area in which they live
- where the services can be delivered to the patient (e.g. home, assisted living unit, nursing home)

D. What Private Long-Term Care Insurance Covers… Like most insurance policies, the details of services covered and benefits paid will vary from policy to policy. However, there are some minimum standards for what all LTC policies must cover if sold in Washington State, and rules and regulations written and enforced by the Office of the Insurance Commissioner to which all policies must conform. It is the differences between policies, and types of policies, that you will want to evaluate, as well as the financial stability of the insurance companies.

The services addressed by LTC insurance include nursing home care, home health care (medical care administered in the person's home by a qualified professional), home care and community-based care. Community-based care encompasses many of those alternative options listed under What is Long-Term Care and Types of Care and Providers of Care—such as assisted living, adult day care, adult family homes, continuing care retirement communities and hospice care. ***All long-term care policies sold in Washington State must cover all levels of care in a nursing home, whether custodial (personal) or skilled.*** They also must cover care for mental and emotional illness—including Alzheimer's disease and senility—as well as for physical conditions.

Other long-term care benefits do vary widely by policy. For example, some policies may:

- pay a fixed benefit amount per day.
- have daily limits on payouts.
- have a ceiling on total benefits.
- require full payment for some services.
- impose elimination (deductible) periods, in which the policyholder must pay for care for an initial designated time period before benefits begin.
- cover alternatives such as assisted living, adult day care or home health care (or other alternatives agreed upon by patient, doctor, and insurer).
- allow you to stop paying premiums once you are receiving care paid by your policy benefits.
- offer an inflation option that ensures coverage will keep pace to some extent with the rate of inflation (a good idea for those with pensions that don't have cost-of-living increases).
- offer restoration of benefits when a certain amount of time passes with no care.
- impose conditions such as length of stay in a facility or length of time receiving care before the policy begins to pay.

E. What Long-Term Care Insurance Doesn't Cover…All LTC policies contain certain limitations and exclusions, because a policy that covers every conceivable condition and type of care would carry astronomical premiums. Although the specific limitations and exclusions in any given policy vary, the following items are excluded from coverage under LTCI policies:

- Alcoholism
- Drug abuse
- Care necessitated by an act of war
- Care necessitated by an intentionally self-inflicted injury
- Certain mental and nervous disorders
- Care provided outside the US and Canada

F. When to Buy Long-Term Care Insurance… If you are between the ages of 40 and 84, there's no time like the present. Most insurers do not write policies for individuals under age 40 or over age 84. Premium costs rise dramatically if you wait until you are older to purchase a policy, because the likelihood that you will need it is directly related to age. For example, a 65-year-old purchasing LTCI might pay three times more than a 50-year-old would pay for a policy providing the same benefits. An 80-year-old might pay ten times more than a 50-year-old for the same level of coverage.

Once purchased, you will always pay the same rate as someone who is currently as old as you were when you purchased the policy. The insurance company can increase your premiums, but only if they raise the rates for an entire class of policyholders. For example, if the policy is purchased at age 50, you'll always pay the same rate as a 50 year old buying a new policy.

G. Who is Buying Long-Term Care Insurance & Why People Buy Long-Term Care... Recent studies indicate that 40 percent of Americans over age 65 will need nursing home care at some point during their lives. With Americans living longer every year, this figure is likely to increase. The national average cost of a year in a nursing home is estimated at over $75,000. In the Washington state area, the average cost is $60,000 per year. Nursing home care is not covered by regular health insurance, and Medicare covers only minimal nursing home expenses. Consider, also, that 90 percent of long-term care services are provided outside of a nursing home setting: in homes, adult day care centers, assisted living facilities, etc. Medicare provides little or no coverage for these types of care.

H. Who Needs And Who Is A Good Candidate For A Long-Term Care Policy… The need for long-term care arises due to a chronic or terminal illness, or general debility. In such cases, the person may need care for the rest of his or her life. It may also come from frailty that renders the individual incapable of performing activities of daily living without assistance (such as bathing alone). For others, the need for care may be shorter-term. Injuries and acute conditions—even short stays in the hospital—can also leave people temporarily needing care and services they cannot provide themselves.

The need for long-term care services is expected by many sources to continue increasing. There are a number of reasons attributable to this.

1. For one thing, people are living longer, but not necessarily healthier. An increase in lifespan does not always come with an improvement in quality of life. Certain lifestyle and health factors, such as smoking, excessive alcohol consumption, obesity, a high-fat diet, and being sedentary, are known risk factors for a number of disabling diseases/conditions (stroke, heart disease, arthritis, diabetes, to name a few), and thus can increase the odds of needing long-term care at some point. Some of these risk factors are common to the American lifestyle.

2. Another reason is change in society and the family structure. Previous generations planned very little for long-term needs. Traditionally, daughters or the families of daughters took care of aging parents. Other family members, too, were often able to provide care for a spouse or sibling. But this type of care is less feasible today. The majority of daughters are in the workforce or have moved far away from their parents. Divorce and long-distance family separations greatly reduce the likelihood of family members being able to tend to one another. So the care of aging family members has become more professionalized, turned over to social service agencies and retirement homes.

3. A third reason is that people are no longer staying in hospitals to recuperate from an illness or an operation because Medicare limits payments to hospitals. After short stays for treatment or surgery, people often must be moved to nursing homes until they are well enough to return to their own dwellings.

4. Finally, the demand for long-term care services—and ways to pay for them—is expected by many sources to continue to increase as the population itself ages. It is projected that in the first half of the 21st century, many of those people known as "baby boomers" (the large population of people born between 1946 and 1964) may find they need this type of continuing care—as their parents do right now. Some sources expect the need for long-term care services to nearly double by the middle of the next century.

Who Is A Good Candidate For A Long-Term Care Policy

A long-term care insurance policy may be right for a person who:

- has assets that he would like to protect or leave to others, that have sentimental value, or that will involve large capital gains consequences if given away.

- is able to afford monthly premiums.
- would be unable to pay out-of-pocket for a long duration of long-term care if the need arose.
- is not currently disabled or seriously ill, but has a health history and lifestyle strongly suggesting risk for disabling disease or injury.
- wants to maintain independence and control over his money and assets.
- wants to protect his family members and their lifestyle from the burdens of providing long-term care to a family member.
- has an income level too high to qualify for Medicaid.

The client who is a good candidate for a long-term care policy will usually (but not always) save money by buying the policy sooner rather than later. Premiums are based on age at the time of purchase and will increase each year you wait to purchase, regardless of health status.

Long-term care insurance is an ongoing commitment. The policyholder must be able to continue to pay the premium for many years—not just now—until they may need LTC. A high percentage of people who buy policies stop paying premiums; many of them lose policy benefits and the money spent on past premiums.

I. Who Should Not Buy A LTC Policy

A long-term care insurance policy <u>may not</u> be right for a person who:

- Has few or no assets to protect (less than the cost of one year in a nursing home, about $60,000 is one rule of thumb that may be used).
- Is unable to afford insurance premiums, either now or in the future (client should not have to use assets to pay for premiums, or compromise current lifestyle).
- Is already disabled or has a serious health problem (and would probably not pass the medical underwriting required to get coverage).
  Has an income level that meets Medicaid eligibility limits.
  Has enough assets to be self-insured.
- Has no children, grandchildren, or favorite causes to whom to leave assets.

J. What Long-Term Care Costs… Long-term care is expensive. While long-term care is not necessarily always a drain on finances (depending on resources and who provides care, where, and for how long), services other than those provided by family members (e.g., care provided by professionals) can be very costly, especially if the duration is long. The cost of nursing home care is increasing by five to ten percent per year. The average stay in a nursing home is 2½ years. In Washington, private assisted living facilities and adult day care can run more than $160 per day.

K. Ways to Pay For Long-Term Care

- Medicare (only extremely limited nursing home coverage on a short-term basis)
- Long-term care insurance (either conventional or a special type of long-term care policy called a Partnership policy, and plans qualified for special tax treatment)
- Medicaid (state-sponsored health care for impoverished residents; recipients must meet certain income and asset limits, and singles may have to "spend down" any assets over a certain dollar amount
- Self-funding (which means paying for care with your own funds—"out-of-pocket"—with personal or family money, pensions, benefits, savings or investments)
- Limited Veterans' Administration funds (may provide long-term care for service-related disability, or for a limited number of eligible veterans and/or their spouses)
- Investments (including the use of special investments such as accelerated life insurance benefits, reverse mortgages, or trusts—
- Life Settlements

Following in more detail are ways to pay for long-term care:

1. Savings/Personal Money—You could use personal savings to pay for long-term care, should the need arise (self-insurance). If this option is chosen, you'll have to estimate how much money you might need to cover long-term care expenses and start an appropriate savings plan. There is a good chance that the amount you will have to put aside each month to cover future medical expenses will equal or exceed what you would pay for LTCI premiums. However, in some cases, buying LTCI is not an option—for example, if a preexisting condition prevents you from qualifying for coverage. If you choose to self insure, you could save a lot of money, but there is always the chance that your savings won't be adequate to cover the actual long-term care expenses.

Self-pay for long-term care involves use of personal or family money to pay for care should the need arise, including savings and investments, assets, pensions, benefits, and contributions from children or other relatives, as well as reverse mortgages, annuities, and trusts. Younger individuals who have the income to save a substantial amount each year and can do so for 20 to 25 years prior to the likely need for LTC are probably the best candidates for self-pay plans. Self-pay also works better when it is a conscious choice—an advance plan is made specifically to cover LTC in this manner—rather than waiting until there is no other choice but to use one's own funds and expend assets. Such plans are best made with the advice of an ***Elder Law attorney*** (familiar with Medicaid eligibility and estate planning) and perhaps an estate planner.

Because self-pay for LTC can result in exhaustion of all assets, eventually leading to Medicaid eligibility—and because some people actually expect this to happen and plan to transfer (or give away) assets in order to qualify for Medicaid—it is impossible to completely separate a discussion of self-pay from the discussion of Medicaid.

2. Medicaid... is a medical assistance program that is jointly funded by state and federal government. It is administered by state government (the Department of Social and Health Services) with federal assistance (the Health Care Financing Administration of the Department of Health and Human Services).

Medicaid assistance, including for long-term care, is available to people whose income and assets are below certain levels.

Medicaid is an extremely intricate and complex subject with many angles, many possible variables and many legal and financial ramifications. It is important to be familiar with basic aspects of Medicaid, but it is equally important to know that you are not required to be an expert on all the details involved in Medicaid.

Medicaid is not insurance; it is government-funded assistance (technically, what some people call "welfare"). It is important for you to know that you are not associated with the state agency that administers or regulates Medicaid, and that you are not responsible for details regarding the program.

3. Reverse Mortgages and Annuities... was brought to life in 1978 when an economist garnered support for the idea from the American Association of Retired Persons (AARP), The Department of Housing and Urban Development (HUD), and the Federal National Mortgage Association (FNMA or "Fannie-Mae"). A demonstration program called the Home Equity Conversion Mortgage (HECM) was completed in 1984 and introduced to Congress. It was passed in 1989 and renewed in 1996 for another five years. HUD recently introduced a new bill to make it a permanent HUD program.

How The Reverse Mortgage Concept Works...With a "forward" mortgage, the kind of loan most of us have on our homes, payments are made on a loan balance that compounds interest. This balance over a period of time is reduced by our payments (usually in monthly installments), until it is finally paid off.

- ✓ A reverse mortgage, true to its name, reverses that process. That is, it is a loan against a home's equity (the net worth of a home—what it's worth minus what is owed to it) in which there are no payments required, so the principal balance actually increases. (Interest is added to the principal loan each month.) The balance, however, is guaranteed never to exceed the net value (equity) of the home.

- ✓ This enables the "house rich, cash poor" older homeowner to utilize the equity in his or her home, turning it into spendable cash with no monthly repayments on that loan, while owning and living in the home for as long as desired.

- ✓ The loan is not paid back until the borrower dies, moves or sells the home. The property itself pays off the loan at the time of sale.

- ✓ The borrower remains in title (retains ownership of the home), as with any other mortgage, and remains responsible for taxes, repairs and maintenance.

How Can The Cash Be Used? The cash generated by the reverse mortgage is not taxable income. It does not affect Social Security, Medicare benefits, or—in most states—Medicaid benefits. Interest on a reverse mortgage is not deductible for income tax purposes until the loan is paid off.

- ✓ The money may be used for any purpose the borrower wants, including long-term care (or even insurance premiums). Although many of the first reverse mortgages written were for people in a state of crisis, this mortgage can allow seniors to plan for contingencies at this period of their lives and maintain dignity and autonomy. Some of the uses that have been suggested for a reverse mortgage are nest eggs, travel, supplementing monthly income, purchases, home repairs, chore services, and tax payments. From the point of view of long-term care, the money could be used to cover either care at the time it is needed, or premiums for a long-term care insurance policy in anticipation of possibly needing care.

How Is The Cash Received? The amount of money available to each borrower is based on a formula that uses the younger borrower's age, the property's appraised value, and the current interest rate. The loan cost is also a factor. The organizations who write these loans and HUD-approved housing counseling groups use software to calculate the amount of money available. Loan fees reduce the amount of cash available. The loan fees are not due until the loan is paid back; they are financed—added to the total loan amount.

- ✓ These funds can be drawn out in a number of different ways, and these ways can be combined: lump sum, monthly advances, or a line of credit. Reverse mortgages are usually adjustable rate mortgages, or ARMs. Interest accrues according to an interest rate that adjusts annually, within a limited margin.

How Is The Loan Paid Back? When the borrower no longer occupies the home—whether because he moves, sells or dies—the loan must be paid off as would any other mortgage. The loan is then due with interest and loan fees. It is paid off by the proceeds of the sale, or through refinancing as a regular (forward) mortgage by heirs.

- ✓ If the borrower has to leave for illness or injury, there is a 12-month grace period before the lender would require an explanation. In the case of couples, both persons would have to be permanently relocated for the grace period to start. If one member of a couple were to leave, this would not affect the other.

- ✓ At the end of 12 months, if it is determined that the borrower(s) have permanently relocated, steps would be taken to refinance the property. There is incorporated into most reverse mortgages a repair escrow hold-back in the event that there are deferred repairs. If it is determined that repairs are needed, an evaluation of repair costs is performed, and funds sufficient to complete the repairs are held back at the closing of the loan. The remainder of the funds due to the borrower will be refunded at the same time.

Reverse Annuity Mortgages...There is also a fixed rate loan that is annuity-based. With this loan, some of the funds are used to pay the premium for a competitively-priced annuity. For a certain period of time the borrower(s) receive monies from the reverse mortgage portion of the loan; then the annuity kicks in and continues the monthly payments for as long as the borrower lives. The borrower can still receive lifetime monthly payments, even if not occupying the home.

Who Is Eligible For A Reverse Mortgage? To be eligible for a reverse mortgage, the youngest borrower must be 62 years of age or older, the home must be owner-occupied, and there must be accessible equity in the property. The borrower does not need to have any income to qualify, but must own the home free and clear, or close to it. Individual loans may have other requirements.

- ✓ Condos and manufactured homes with FAA approval are eligible, but motor homes and co-ops are not. The borrowers will usually undergo a consumer education session with an approved agency not affiliated with the lender. Often this can be done by phone and there is no charge to the borrower.

What Are The Disadvantages Of Reverse Mortgages? If you do not reserve some of the equity in your home, you could be left with little or no money after you pay off the loan balance. If you use up all the equity and the repayment occurs at death, there would be little or no money left for your heirs. If repayment occurs because you move, or go into a nursing home or alternative living situation, there will be no cash equity left over for you.

- ✓ Even if you do not tap all of the equity in your home, you will still have fewer assets to leave your heirs in the future.

4. Accelerated Death Benefits Accelerated death benefits in a life insurance policy may be used to obtain cash out of the policy while the policyholder is still alive. Under an accelerated death benefit option, the insured and the insurance company agree that if the insured later meets specified medical conditions relating to imminent death, the insured may elect to have either a percentage of the death benefit or the whole benefit paid out ("accelerated") during the lifetime.

Exercising this option can work one of three ways:

a) Lien against the amount. A portion of the face amount, up to a maximum percentage specified in the policy, may be advised as a loan against the policy amount. The loan must be paid back. The amount on the loan is considered a lien against the remainder of the face value (the amount left in the policy after the loan) and the loan amount cannot exceed the amount that remains in the policy after the advance (i.e., no more than 50% of the face amount). Interest accrues on the amount advanced. Administrative charges of up to $500—as a kind of loan fee—may be added to the loan; the administrative fee must be specified in the policy.

b) Discounted face amount. The amount that is allowed to be accelerated according to the policy or rider is discounted—that is, the advance is reduced by a percentage that is determined using loan rates or current yield on treasury bills. Despite the use of these rates, the advance in this case is not a loan and does not need to be repaid. The discount taken from the advance is used by the company to cover administrative costs. The remainder of the advance may be paid to the policyholder in a lump sum or in monthly payments, as specified in the policy.

c) Premium payment. The insured pays a premium for the accelerated death benefit rider attached to the policy; this premium finances the administrative costs of the rider, so there is no discount taken from the advance and no other processing fees may be charged for the accelerated benefits. (This type of policy is rare.)

In all three types of accelerated benefit payments listed above: The policyholder still owns the policy and must continue to pay premiums (which are lower than before, since the face value of the policy is reduced) and whatever value remains in the policy is still paid to the beneficiary at the time of the policyholder's death.

Both cash value and term policies may be written with an accelerated death benefit provision. Specific provisions vary from policy to policy. There are restrictions regarding who can qualify for an accelerated payout (based on medical diagnosis of life expectancy) and how much money may be advanced. Usually, evidence must be submitted showing that the reasonable medical certainty of life expectancy for an incurable terminal illness will result in death within a specified time period (no less than six months and no more than 24 months). This time period may restrict the usefulness of accelerated death benefits for the purpose of paying for long-term care (accelerated death benefits are more commonly used by terminally ill people, with the AIDS crisis having focused more attention on the need for financial relief in many such cases). However, to pay for long-term care services at the end of an extended period of long-term care, or when it is likely the care will not be needed for more than 24 months, this option may be useful.

Summary: To illustrate how the three different types of accelerated benefits policy features work, let's look at Mr. Wilson. He has a whole-life policy whose face amount is $100,000. He wants to accelerate the maximum amount of benefits, which in all three examples would be 50 percent of the face amount, or $50,000.

If his policy is the lien type, Mr. Wilson can "borrow" $50,000 from the policy. He will have to pay back the $50,000 plus interest based on current adjustable loan interest rates or yield on ninety-day treasury bills. If he is unable to repay the loan later, the company will place a lien on the remaining face amount of the policy. The company may also add up to $500 to the loan for administrative costs.

If it is a discounted face amount, Mr. Wilson can have $50,000 "accelerated"—advanced from the policy"—but his $50,000 will be "discounted" by a percentage based on current adjustable loan interest rates or the yield on ninety-day

treasury bills. If the current loan interest rate is 8%, Mr. Wilson's $50,000 will be discounted by 8%, or $4,000. The company keeps that to cover processing, and Mr. Wilson gets $46,000 of his benefits accelerated.

If Mr. Wilson has a premium type of accelerated death benefits rider, part of the premium he has been paying all along for the policy will have included the premium for that benefit. The company may not take any further administrative costs for Mr. Wilson's accelerated benefits.

In all three cases, Mr. Wilson is left with a $50,000 life insurance policy on which he continues to pay premiums. His policy premiums are reduced accordingly since the new face value of the policy is reduced.

5. Life Settlements …In a life settlement, the insured sells all rights in the policy to the life settlement company. The payment is computed with reference to the face value of the policy and the insured's likely survival. The insured typically retains no further ownership in the policy—the life settlement company becomes the owner, paying the premiums and collecting the proceeds (the face amount of the policy) upon the death of the insured, thus recovering the initial investment and a substantial profit. The insured's original beneficiary gets nothing.

Life settlements are often available on terms and under conditions that an accelerated death benefit would not be, such as a longer life expectancy. Thus, if an individual's life expectancy is 24 months, a life settlement may still be possible.

The insured who wishes to transfer his policy to a life settlement provider can shop around for the best terms. Under Washington State regulations, life settlement firms and agents have to register with the Insurance Commissioner's office and comply with consumer-protective rules. Washington is one of only a handful of states that regulates these companies.

- Life settlements and accelerated death benefits paid to the ***chronically and terminally ill*** may be treated as death benefits, **thereby avoiding income tax on the amount paid to those individuals.**

6. Medicaid… Medicaid is a medical assistance program that is jointly funded by state and federal government. It is administered by state government (the Department of Social and Health Services) with federal assistance. Medicaid assistance, including for long-term care, is available only to people whose income and assets are below certain levels.

Medicaid is an extremely intricate and complex subject with many angles, many possible variables and many legal and financial ramifications. It is important to be familiar with basic aspects of Medicaid, but it is equally important to know that you are not required to be an expert on all the details involved in Medicaid.

Medicaid is not insurance; it is government-funded assistance. It is important for you to know that you are not associated with the state agency that administers or regulates Medicaid, and that you are not responsible for details regarding the program.

7. Veteran's Benefits... Veteran's Benefits may provide long-term care for service-related disability, or for certain eligible veterans and/or their spouses. For more information, contact the Veteran's Administration.

8. Continuing Care Retirement Communities…Continuing Care Retirement Communities (CCRCs) provide housing, health care, and social services. In the same community, there may be individual homes or apartments, an assisted living facility, and a nursing home. Where you live depends on the level of care you need. The monthly maintenance fee usually ranges from $650-$3500 and may increase from year to year due to inflation. CCRCs also include buy-in or entrance fees that range from $38,000 to $400,000. The fees vary based on: if you own or rent living space, the size of the residence, the amenities you choose, number of people, service plan, and current risk for needing intensive long-term care. Some CCRCs offer a "life care contract." This means that if you need care in the assisted living facility or in the nursing home, then you are guaranteed to pay the same entry fee and monthly fee as someone who lives in an individual home or apartment.

II. Long-Term Care Insurance (LTCI) and related topics, i.e., Medicare and Medicaid

The Washington State Insurance Commissioner is responsible for regulating long-term care policies sold in Washington State and some group LTC policies sold from outside the state to state residents. Each state insurance commissioner's office regulates insurance products sold in its own jurisdiction, although the benefits can be used in any state.

New rules have been and are continually established by the Insurance Commissioner governing long-term care insurance to make it more flexible and easier to understand and to buy. Rules adopted by the Insurance Commissioner beginning in 1988 have brought about some uniformity in policy standards and definitions.

Here is a look at long-term care's transition through regulation—a transition that continues today. This history will help you understand the differences between older policies and new policies and how the long-term care industry has changed.

A. The Early Years Of LTC Policies… From 1966 to 1985, long-term care insurance sold in Washington state was primarily for skilled nursing home care—"nursing home insurance"—with many limitations on the kinds of benefits received (benefits were based on stringent Medicare "gatekeepers" or triggers). There was little insurance law specifically addressing nursing home or long-term care coverage until 1986.

The term "nursing home insurance" in this manual refers to most policies that were sold before January 1, 1988. They did not meet the standards as defined in the new LTC insurance code, so they are not properly called long-term care policies.

B. 1986-1988: Long-Term Care Insurance Act… In 1986, the Washington State Legislature enacted the Long-Term Care Insurance Act. It substantially changed long-term care insurance coverage offered in this state. Regulations dealing with the new statutes were adopted in 1987. They applied to all long-term care contracts sold on or after January 1, 1988.

The key features included mandates for:

- Guaranteed renewability
- Benefits for all forms of mental and emotional disorders, regardless of origin
- Coverage for all levels of care in nursing homes, ranging from skilled to custodial/personal care
- 30-day "free look" on all policies sold in this state; 60 days if sold by direct response

The regulations also stipulate that:

- Riders, waivers or endorsements may not be used to reduce coverage
- Agents are prohibited from completing the medical history portion of the application
- Illness and accidents must be paid on the same basis
- No contract may restrict benefits because the insured does not meet Medicare criteria for payment of skilled nursing clients

C. 1994-1995: New Consumer-Protective Rules… More rules adopted by the Commissioner in this period gave further uniformity and minimum standards to policies sold in this state, representing the Commissioner's stated commitment to consumer-protective. The new rules were not retroactive, therefore, previously issued policies did not change.

In 1994, rules were adopted (taking effect on policies sold on or after August 1995) that:

- Defined adult day care
- Required coverage for all levels of care in home and community-based settings (previously this only applied to nursing homes)
- Prohibited pre-existing waiting periods in replacement policies
- Extended benefits (policy must pay for duration of benefit period if the policyholder cancels while receiving benefits)
- Required a compounding inflation option on all policies (either increases automatically annually or guarantees period increases or guarantees increases in percentage of charges)
- Eliminated "small print" for home health care and community-based benefits
- Required a minimum standard if home and community-based benefits are included: the dollar amount of these benefits must be equivalent to at least half of the annual institutional benefit.

In 1995, rules were adopted (taking effect on policies sold on or after January 1, 1996) that:

- Re-defined and standardized community-based, home and institutional care (such as "nursing" is 24 hour nursing services; "home/community" is a home-like, residential setting that does not provide overnight care)
- Set standards for definitions in all LTC contracts (uniformity in policy language); **required a disclosure form (with definitions) to be delivered at the time of initial solicitation**
- Set minimum standards for and defined three benefit triggers:
    1. ***physician certification***
    2. ***activities of daily living***
    3. ***cognitive impairment***
- Allowed for reduction in coverage without evidence of insurability
- Provided for non-duplication with state or national health care benefits
- Limited lapse due to insured's cognitive impairment or loss of functional capacity
- Standardized the format for information furnished **(disclosure form)**

D. 1995: The Long-Term Care Partnership (RCW 48.85) This program, modeled after a Connecticut pilot program, that has since been implemented in a handful of other states, authorizes special long-term care insurance products to provide incentives to protect families' assets with insurance. The special asset protection provided by these policies is designed to be an incentive for Washington residents to participate in the financing of their care.

The Partnership refers to a collaboration between state government, private insurance companies, and the private sector, who have agreed to develop long-term care insurance products that meet special requirements and standards. The Washington State Office of the Insurance Commissioner, the Department of Social and Health Services, and the long-term care insurance industry cooperate to make this partnership concept work.

1. How Will A Partnership Policy Work? A partnership policy is designed to offer certain key advantages over and above the care benefits provided by the policy itself. The policy is a combination of insurance coverage and asset protection not available through regular policies.

The person who buys a partnership-approved policy becomes subject to special, more favorable rules for Medicaid eligibility. The holder of a partnership policy can keep or give away some or all of his assets and still qualify for Medicaid to pay for care. He does not have to be impoverished to qualify for Medicaid assistance.

Specifically, Medicaid will allow the Partnership policyholder to keep that portion of assets that equals the amount the policy has already paid. Dollar for dollar, the amount for which you are insured is the amount of assets that are exempt (protected). The higher the benefit amount purchased, the more of your assets will be protected should you reach a point where the cost of your care depletes your policy.
If, for example, someone is insured by a LTCP policy for $100,000 in benefits, he is protecting $100,000 worth of assets. If he requires care for a long enough period to exhaust that $100,000 in benefits, when the policy runs out he could apply for Medicaid (all other qualifications for Medicaid eligibility would additionally have to be met). Assuming he met other Medicaid eligibility requirements, that $100,000 in personal assets would not disqualify him. It will be protected; he will not have to "spend it down."

This differs from a traditional LTC policy. With a regular policy (or no policy), there is no asset protection if the policy runs out. A regular long-term care policy certainly offers protection, but if the policy runs out (i.e. cost of care exceeds policy benefits), all assets will have to be used to pay for care, until the assets are depleted to the Medicaid resource limit and Medicaid eligibility is reached.

It's important to note that this asset protection feature doesn't necessarily mean the policyholder will not have to spend anything. The policyholder just won't have to spend the assets protected by the policy. Again, the amount protected is only equal to the amount of benefits purchased. If you had $100,000 in assets, but bought a policy that pays $50,000 in benefits, only $50,000 of your assets are protected. The remaining $50,000 would have to be spent down before you could qualify.

2. Other Benefits of The Partnership

- ***Savings To Government.*** The partnership program is expected to help contain Medicaid expenditures by encouraging consumers to plan ahead and take some responsibility for the cost of their care, relieving the government of some of these costs. By purchasing insurance through the partnership, policyholders will be helping to cover some, if not all, of their long-term care costs before state funds have to be used. This discourages the reliance on government to pay for all long-term care expenses.

- ***Peace of Mind To Consumer.*** By purchasing insurance through the partnership, consumers will spend less than they will if they wind up uninsured and paying for long-term care out of pocket—and they will have the peace of mind of knowing they are covered.

- ***Better Policies, Better Industry.*** The program establishes high minimum standards for policy features and for greater flexibility in choices among a wide range of home and community based services.

3. What About Partnership Cost?...If a LTCP policy costs significantly more, the client will have to decide if the difference is worth it. How likely is the scenario of exhausting all the benefits of a regular policy, then having to spend down to go on Medicaid? Is there a substantial amount of assets to be protected, and is there an intention for those assets to be passed on to family members or other parties (charities, companies, etc.)? Would the client qualify for Medicaid income limits?

4. Standards Related To Rates… In order to assure stability of premiums and rates for long-term care partnership contracts, rates must be designed to remain level over the life of the policy and must be based on the insured's age at the time of application. Every rate filing of an insurer must be accompanied by a detailed explanation of how the insurer intends to comply with this section.

5. What Kind Of Consumer Benefit From The LTCP?... The LTCP policies offer unique advantages for some people, but they will not be the best choice for everyone. A Partnership policy may be **inappropriate** for the person who:

- has limited assets
- can't afford the premiums
- would not qualify for Medicaid income limits
- already has a serious health problem and would not pass the medical exam required to get coverage
- is planning to move out-of-state (a LTC insurance policy will still pay benefits no matter where you go, but the special Medicaid asset protection is not portable if you move to another state).
- has special needs better met by other long-term care insurance with special policy features
- has no heirs or special causes to whom he wishes to leave assets

✓ **Middle class people are most at risk of depleting their resources** when the need for long-term care arises. They don't have the cash reserves that wealthier Americans do to pay for care out-of-pocket, and they don't have low enough income to qualify for Medicaid. Partnership policies are designed and regulated to help people of moderate means protect their assets from the financial devastation of long-term care costs.

6. Applications for Long-Term Care Partnership Coverage… Every application must be signed by the applicant and producer and must certify that:

- The person received a description of the Washington long-term care partnership, the disclosure pamphlet and a description of the state's asset recovery program;
- The person understands that eligibility for Medicaid upon exhaustion of the benefits of the partnership policy is neither guaranteed nor automatic;
- The person understands that the benefits provided under Medicaid may not be the same as those provided under the long-term care partnership contract;
- The person agrees to permit the issuer to release information included in the application to the commissioner, solely for the purpose of data collection in preparation of the commissioner's report to the legislature, which release will advise the person that the issuer will act to preserve confidentiality.

- If a person elects to purchase nursing home-only coverage, that person understands that he or she has voluntarily waived coverage for home and community-based care.

7. Consumer Education Program… Issuers must demonstrate to the satisfaction of the commissioner that they have and use procedures to provide notice to each purchaser of long-term care partnership insurance about the state's long-term care consumer education program. The program will include information regarding the need for long-term care, the methods of financing long-term care, the availability of long-term care insurance, the availability and eligibility requirements of the state's asset protection program, and the impact of this state's estate recovery rules.

8. Continuing Education Requirements…Resident and nonresident licensees engaged in the transaction of long-term care insurance, long-term care partnership insurance or both, are required to take an initial approved **eight-hour long-term care course and every two years thereafter a required four-hour refresher course.** The approved courses may count towards required Washington state agent's continuing education credit hours.

9. Standards for Education of Licensees Soliciting Long-Term Care Partnership… Every insurer must annually certify to the commissioner that each resident and nonresident licensee involved in the transaction of long-term care partnership insurance has initially completed an approved eight-hour long-term care course and every two years thereafter a required four-hour refresher course.

10. Form for Annual Filing of Compliance... Insurance companies must file a copy of the following certification report with the commissioner on or before March 31 of each year.

STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

Annual Filing of Compliance for Long-Term Care Education Requirements
WAC 284-17-262

To be filed with the Washington Insurance Commissioner each year by **March 31**.

For the period of January 1 to December 31 of _____.
Company Name:
Address:

List any other company name used to issue Long-Term Care policies in Washington:

I hereby certify that all appointed agents involved in the transaction of each long-term care policy we issue in Washington have fulfilled the requirements of RCW 48.83.130. I certify that to the best of my knowledge, we did not accept or process any applications that involved the participation of a licensee who was not in compliance with RCW 48.83.130.

Return Certification Form to:

Licensing and Education Program Manager
Office of Insurance Commissioner
P.O. Box 40257
Olympia WA 98504-0257

Signature of Officer: _____ Date: _____
Name and Title of Officer: _____
Prepared By: _____
Phone: _____ E-mail: _____

Medicare As It Relates To Long-Term Care

A. The Medicare Myth Regarding Long-Term Care...Despite a persistent myth to the contrary, hardly any long-term care costs—about 2 percent—are covered by Medicare, Medigap policies or any other regular health insurance.

Medicare is the Federal government's hospital and medical expense insurance, funded by payroll taxes and premiums. It is administered by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services.

Medicare Part A will help pay for care in a Medicare-approved skilled nursing facility when the patient meets ALL of the following conditions:

- Patient is admitted to a hospital for at least 3 consecutive days (not counting day of discharge).
- The physician certifies that the patient needs skilled nursing or skilled rehabilitative services on a daily basis.
- The patient goes to a Medicare-participating facility for skilled nursing care within 30 days after release from the hospital, for the same condition (or a related condition) for which he was hospitalized, and receives the needed skilled nursing or skilled rehabilitative services on a daily basis.
- The patient is in a Medicare-designated bed in a Medicare-approved skilled nursing facility.

✓ If ***all*** the conditions listed above have been satisfied, Medicare will help pay for a maximum of 100 days.

✓ If the patient leaves a skilled nursing facility and is re-admitted within 30 days—for further daily treatment of the condition(s) treated during the last stay at the facility—he does not need a new three-day hospital stay for care to be covered. The patient is considered to still be in the same benefit period. If some of that benefit period's 100 days still remain, Medicare will pay as shown on the following pages.

B. Medicare Pays Only For Skilled Health Care...Earlier we discussed the differences between health care and personal/custodial care, and the differences between home health care and home care**. Although the majority of people who need LTC actually need personal/custodial care** (such as help with bathing, dressing, walking, toileting, and eating).

✓ It is extremely important to note that the fact that a patient is in a qualified skilled nursing facility does not mean that they are receiving skilled nursing care. A skilled nursing facility (SNF) is equipped to provide medical care under the supervision of licensed nursing personnel. That means that such care is available there—it doesn't mean it is necessarily required and being provided. All nursing homes in Washington are skilled nursing facilities, but many provide custodial care as well as medical care. It is possible to receive only custodial care at a SNF.

✓ Medicare pays based on type of care administered—not the type of facility. Medicare will not pay for a stay in a nursing home or skilled nursing facility if the care provided is mainly personal or custodial care.

C. Will Medicare Cover Care Provided In The Home? Medicare will cover home health care—skilled nursing care in the home—if a physician certifies that the patient is confined to the home and needs skilled nursing care or rehabilitative therapy on an intermittent basis (at least once every 60 days.) A plan of care must be established and reviewed at least every 62 days by a physician. The care must come from a Medicare-approved agency.

If the patient qualifies for home health services, Medicare will cover the home health services on either a part-time or temporary basis. Part-time means up to and including 28 hours per week for less than eight hours per day. (Additional time up to 35 hours per week may be approved by Medicare on a case-by-case basis.)

Intermittent care is subject to the same weekly limit of hours, but is usually not provided on a daily basis. Intermittent care can also mean up to eight hours per day of daily care on a temporary, not indefinite, period of up to 21 days.

There is no limitation on the number of home health visits, and there is no prior hospitalization requirement.

✓ **Home health care includes health monitoring, medical treatment, administering medications, physical or speech therapy, and other services provided by professional nurses, therapists or paraprofessionals.** It does not include personal/custodial home care services, household chores such as laundry, cleaning and meal preparation; or escorted transportation and shopping.

D. Hospice Care…Hospice care is not long-term care. It is covered by Medicare under certain conditions. Hospice care is a special way of caring for a patient with an incurable illness **whose life expectancy is six months or less** if the disease

runs its normal course—often at the end of a long-term illness. Patients receive a full scope of palliative medical and support services for their illnesses, but treatment is not aimed at curing and counteracting the disease. The main goal of hospice is to make the dying patient comfortable in his or her last months.

Medicare beneficiaries certified by a physician to be terminally ill may elect to receive hospice care from a limited network of Medicare-approved hospice programs. Under Medicare, hospice is a comprehensive program that provides medical and support services for managing a terminal illness at home or in a skilled nursing facility.

E. Medicare Eligibility:

1. Persons age **65 or older** are eligible ***automatically if they are eligible for Social Security***. Federal Government employees who are covered under Civil Service Retirement, the Railroad Retirement Act or other similar retirement programs are qualified for Medicare. If not, people age 65 or older may receive benefits by paying a monthly premium.

2. Persons who have been receiving Social Security disability benefits for **24 months**.

3. Persons with **end stage renal disease** (kidney failure).

F. Medicare Enrollment:

1. Enrollment in Part "A" and Part "B" is automatic for those eligible for Social Security. Coverage begins on the 1st day of the month in which the person turns 65.

2. Beneficiaries may decline Part "B" by signing a form declining the coverage. Those who decline Part "B" may enroll in the future during the enrollment period.

G. Medicare Part "A" Hospital Insurance... pays all reasonable charges, minus deductibles and co-payments. Medicare pays primary to other valid coverages such as Medicare Supplements, Long-Term Care and Medicaid. However, if the insured is covered under a group health plan, Medicare will be secondary coverage. Hospital Coverage covers 5 types of care:

1. **Inpatient Hospital Care**: semi-private room, meals, regular nursing care, drugs taken in the hospital, tests, medical supplies and operations.

- ✓ Has a deductible per benefit period, a.k.a., Spell of Illness (SOI). The benefit period begins upon hospital admission and ends 60 days after discharge. Readmission during the 60-day period after discharge is considered part of the same benefit period. After the 60 days, a new period begins with a new deductible.

- ✓ The **Diagnostic Related Groupings** (DRGs) were implemented by Medicare in an effort to better control expenses and fees charged by medical providers. The DRG's state how much will be paid for each procedure and it will not pay more than that amount. When a provider is approved by Medicare as a *participating provider*, it agrees to accept the amount reimbursed by Medicare as full payment and cannot charge the patient for any difference between the amount paid and the actual bills. If a hospital is a *non-participating provider*, it may bill the patient for any excess expenses that are not paid by Medicare.

2. Skilled Nursing Care ***pays 100% for the first 20 days, but for days 21-100 Medicare requires a co-payment ($144.50 in 2011) per day. It also requires:***

3. **Home Health Care** provides public and private skilled and therapeutic services in a patient's home. This is very limited, part-time and skilled care coverage.

4. **Hospice Care** provides support services to terminally ill patients (expected to die within the next 6 months). This includes "respite" care for the caregiver.

5. **Psychiatric Hospital Care** pays for a lifetime benefit of 190 days of inpatient care in a freestanding psychiatric hospital. If this care were received in a regular hospital it would come under inpatient hospital care coverage.

H. *Medical Insurance* Part "B" pays for doctor's services, out-patient hospital care, diagnostic tests, durable medical equipment, ambulance service, etc. The doctor's services are covered under Part "B" no matter where you receive them; at home, at the doctor's office, in a clinic or hospital. The deductible is a flat amount per year, with an 80-20 co-payment.

1. **Benefits Not Covered:** immunization, cosmetic surgery, routine physical exams, dental care, vision care and any expenses not necessary. There is no coverage for prescription drugs taken out of the hospital. Custodial, intermediate care and coverage outside of the United States are also excluded (Part "A" and "B").

2. **Assignment** of Medicare benefits is permitted. Doctors and other providers who agree to accept assignment will accept Medicare's approved amounts as full payment and cannot legally bill the patient for anything above that amount. Doctors who accept ***assignment*** are referred to as ***participating physicians.***

3. **Limiting Charge**. If a provider does not accept assignment and charges more than Medicare approves, the excess charge must be paid by the beneficiary, as well as the 20% co-payment and deductible. However, there is a limit to how far over the approved charge a provider may go. This is called a limiting charge. Non-participating physicians may not charge more than 115% of the Medicare approved amount for a covered service.

I. *Medicare Part "C", Advantage Plans* are privately run, government-paid, health plans that a beneficiary can sign up for instead of the Traditional Medicare A & B.

Part "C" Medicare Advantage Plans

- Medicare Advantage Plans are health plan options that provide hospital, medical and prescription coverage for the insured beneficiary, and are part of the Medicare Program. Generally, these plans offer extra benefits and lower copayments than the Traditional Medicare Plan, and often offer drug coverage and such extra benefits as eye or hearing care, dental care, wellness classes or health-club memberships.

- When a beneficiary signs up for a Medicare Advantage Plan, Medicare will send a premium to the plan for the beneficiary. Most plans are 100% paid for by Medicare, however, some plans will require a small premium to be paid by the beneficiary.

- If a beneficiary decides to join a Medicare Advantage Plan, he does not need a Medigap Policy, because the plan generally covers many of the same benefits that a Medigap policy will cover.

- The beneficiary may have to see the doctors and hospitals that belong to the plan to get services.

J. Medicare Part D… Prescription Drugs are a critical part of medical treatment. As we get older, the number of drugs we need and the cost of those drugs can increase substantially. A sudden illness can result in higher drug costs that are impossible to predict. Like other forms of insurance coverage, Medicare prescription drug insurance can protect you and your family against high and unexpected costs.

In addition, you cannot be turned down for Medicare prescription drug coverage. You can shop around for the best-priced Medicare drug plan in your area that meets your needs.

Unless you qualify for extra help, you will need to pay a monthly premium, an annual deductible and co-payments that will vary according to the plan you choose and where you live. Under the standard plan, individuals will need to pay a monthly fee and a deductible. After you pay about $3,600 for your prescriptions for the year, you will only have to pay 5% of the discounted cost of each prescription.

If your needs change, so can your coverage. Each year, there will be an open period in which you can review your plan choices for the coming year and either rejoin in your current Medicare drug plan or choose a new one. You may also have another opportunity during the year to switch plans under limited circumstances. For example, if you move out of the service area of your plan, you'll have an opportunity to choose another plan that serves your new area.

WWW.MEDICARE.GOV

K. Medicare Supplement Plans or policies are sold by ***insurance companies*** to pay for what Medicare approves but does not pay for, i.e., deductibles and co-payments. These policies fill the gaps of Medicare and are also known as **Medigap policies**.

- ✓ The beneficiary must be ***covered under both Parts A & B of Medicare*** and be at least 65 years old.
- ✓
- ✓ The Centers for Medicare and Medicaid Services (CMS) requires that the states implement any updated amendments made by the NAIC.

Under the Omnibus Reconciliation Act of 1990 (OBRA), Congress passed a law that authorized the NAIC to develop a standardized model for Medicare Supplement policies (a.k.a. Medigap). This act requires that Medigap plans meet certain requirements. The purpose of this law was to eliminate questionable marketing practices and to provide consumers with a degree of protection and to standardize the coverage available through the insurance industry.

The ***requirements include:***

1. In Washington, a maximum three months exclusion for pre-existing conditions is permitted. (180 days industry, OBRA '90). No exclusions are permitted when replacing an in-force policy.
   - In Washington, a "preexisting condition" is a condition which the beneficiary has, was treated for, or advised to have treatment for within the past three months (180 days industry standard).
   - Should an in-force Medicare Supplement be replaced, a replacement form is required to be filled out, signed by the agent and the insured, and the original left with the beneficiary.
2. **Open enrollment** (OBRA '90) guarantees that for 6 months immediately following enrollment in Part B, persons age 65 and older cannot be denied Medigap insurance because of health.
3. The insured must be given a **Medicare Handbook (Medicare and You)** and an **Outline of Coverage** no later than the time of application. (OBRA '90)
4. An agent **may not** sell a Medigap policy when another Medigap policy is to remain in-force. A beneficiary may not have two Medigap policies at once.
5. No agent, broker, or other representative of an insurer or organization may:
   - complete the medical history portion of any form or application for the purchase of such a policy. The medical history questions must be completed by the applicant, the applicant's spouse, relative, legal guardian or a physician.
   - knowingly sell a Medigap contract to any person who is applying for or receiving Medicaid.
   - use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of Medigap contracts.
6. Medigap policies must be guaranteed renewable and have a 31-day grace period.
7. **Medigap policies must provide for a 30 day free-look**.
8. No Medigap policy may use waivers to exclude, limit, or reduce benefits for specifically named or described preexisting diseases or physical conditions. Meaning no restrictions in coverage or higher premium is allowed because of the beneficiary's health.
9. A Medicare Supplement Policy may not provide benefits for outpatient prescription drugs.

Medicaid, Nursing Home And Copes Program

(Please note: any dollar figures and/or requirements are subject to change at any time. Please check with Medicaid or an elder law attorney for the most current updated figures before giving any details to your client.)

Summary of the New Medicaid Rules (the DRA)

On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005 (DRA), which was designed to cut $40 billion from Medicare, Medicaid, and other programs over a five year period. The new law places severe new restrictions on the ability of the elderly to transfer assets before qualifying for Medicaid coverage of nursing home care. The DRA made significant changes to Medicaid's long-term care rules; including the look-back period; the transfer penalty start date; the undue hardship exception; the treatment of annuities, state long-term care partnership programs, etc.

A. The Medicaid Program... is a state and federally funded medical assistance program for certain people, including the elderly and disabled, who have income and assets below specified standards. It provides comprehensive medical coverage for persons in the federal welfare categories and for various classes of persons including those in nursing homes.

At the federal level, Medicaid is administered by the Health Care Financing Administration (HCFA) which is part of the Department of Health and Human Services (HHS).

For institutionalized persons and other disabled persons, states are generally prohibited from using eligibility criteria more restrictive than those used by the Supplementary Security Income program.

At the state level, Medicaid is administered by the Medical Assistance Administration (MAA) of the state Department of Social and Health Services (DSHS). The state Medicaid program is authorized by RCW 74.09.500 and the state regulations are found in the Washington Administrative Code (WAC). DSHS also has internal manuals. The old "Manual F" has been replaced by a new manual called "Eligibility A-Z."

1. The Medicaid Application Process...Applications for Medicaid can be requested and submitted by mail or in person. Medicaid nursing home applications are processed through the Home and Community Services Offices of DSHS. In King County the address to write to for applications is P.O. Box 94107, Seattle, WA 98124-6407. The street address is 1737 Airport Way South, at the intersection of S. Holgate Way and Airport Way South.

When an application is submitted, DSHS makes two determinations:
- ✓ first, whether the applicant meets the financial eligibility criteria and
- ✓ second, whether the applicant needs the level of care provided in a nursing home.

Financial eligibility involves meeting both resource (asset) and income tests.
- ✓ Resources are determined as of the first moment of the first day of the month.
- ✓ Income is what is received **after** that first moment and before the first moment of the next month.

The level of care determination is made by DSHS using its "Comprehensive Assessment." Medicaid nursing home coverage can only begin as of the date a DSHS assessment of the institutionalized individual's need for nursing home care is requested, or an application is submitted, whichever is earlier. Otherwise eligible applicants cannot be billed by a nursing home where Medicaid coverage is delayed due to the nursing home's failure to initiate the assessment process.

Regulations require DSHS to approve or deny an application within 45 days of receipt of a completed application, although this requirement is frequently not met. Medicaid nursing home and medical assistance coverage can be retroactive for up to 3 months prior to the month of application, provided that all eligibility criteria were met in each of the prior months.

When an application is approved, DSHS will send the applicant a notice called an "award letter." This letter will advise the applicant that he/she has been approved for Medicaid benefits and will specify how the applicant's income must be spent each month.

2. Medicaid Nursing Home Benefits (WAC 388-513)

For persons eligible for nursing home coverage, Medicaid requires that all income, after the special allocations described below, be paid to the nursing home. The amount that the Medicaid recipient pays to the nursing home each month is called "participation." Medicaid will then pay the nursing home the difference between the recipient's participation and the Medicaid reimbursement rate for the facility.

The Medicaid reimbursement rate is based on the facility's costs to provide care and varies with each facility but is always less than the private pay rate. A typical Medicaid reimbursement rate in King County is about $4,000 per month. When a person qualifies for nursing home coverage, Medicaid also provides coverage for most medical expenses, such as prescriptions and physician bills.

3. COPES (WAC 388-515-1505; 388-15-600)... is a Medicaid program designed to help persons avoid institutionalization. It is operated under a waiver from the federal Health Care Financing Administration, meaning that limits are placed on the program which are different than those for other Medicaid services.

With a few exceptions, which are described below, COPES has the same financial eligibility rules as the Medicaid nursing home program. In addition, applicants must either (1) currently be in a nursing home or (2) establish that they are likely to be institutionalized without COPES but can safely reside at home (or in a residential facility) with COPES services. DSHS makes the assessment as to whether a person's care needs qualify for COPES, and this can be done on a "fast track" basis for those who face imminent institutionalization.

For eligible persons, COPES will pay up to about $1,800 per month for someone to come into the home to provide assistance in daily living activities and personal care, such as bathing, toileting and dressing, and some household maintenance tasks. COPES may pay up to an additional $1,400 per month for other services including home delivered meals, home health aides, skilled nursing care, night support, and training. COPES can also cover care, at a higher rate, in a licensed Adult Family Home, Congregate Care Facility, Boarding Home or Assisted Living facility. For an assisted living facility, the COPES maximum ranges from about $1,900 to $3,000, depending on the level of services required and the county where the services are provided. As with institutional coverage, recipients get coverage for most medical expenses.

B. Medicaid Eligibility Rules For Single Persons

- ✓ ***Income Eligibility(WAC 388-513; 388-15-610)…***In a nursing home, a single individual's income must be less than the private pay rate in the facility plus the applicant's regularly recurring monthly medical expenses. (WAC 388-513-1315). If an applicant's income is above the Medicaid rate and below the private pay rate, the applicant will be certified as eligible for Medicaid and will only have to pay the Medicaid rate; in this case, however, the applicant must spend down the excess income over the Medicaid rate on medical costs before they will be eligible for Medicaid coverage for other medical expenses.

- ✓ ***Resources Eligibility (WAC 388-407)…***A single recipient of either nursing home or COPES coverage cannot have more than $2,000 in non-exempt resources, and a couple may have $3,000 in non-exempt resources. (Exempt resources are defined below)

- ✓ Resources are valued according to the fair market value of the applicant's equity interest in the resource. Mortgages and liens against resources are deducted when determining value. Joint bank accounts are presumed owned entirely by the applicant unless the applicant establishes a different ownership distribution. Assets owned jointly by spouses are presumed owned proportionately, unless a different ownership allocation can be established.

- ✓ The following are common examples of resources which, if they exceed $2,000, will make a person ineligible: vacation property; boats; recreational vehicles or additional vehicles; stocks, bonds, and certificates of deposit; the cash surrender value of insurance policies (except life insurance with a face value less than $1,500); and funds in retirement (e.g. IRA and KEOGH) accounts even if subject to early withdrawal taxes and penalties. Amounts held in revocable trusts (which includes most "living trusts") are also counted.

- ✓ Resource eligibility is always determined at the first moment of the first day of any month for which coverage is sought.

C. Exempt Resources (WAC 388-513-1360; 388-470)

A **home** (including a mobile home or a condominium) of any value is exempt if the applicant states that he/she intends to return home. A home includes all contiguous property, even if this includes several lots, legal descriptions or tax parcels, and includes all buildings on the property. Proceeds from the sale of a home are exempt if used within three months of the receipt of the proceeds to purchase another home.

Rent from the home will be income to the recipient, which generally must be paid toward the cost of nursing home care. However, certain expenses such as interest (but not principal) on home mortgage debt, taxes, insurance, and maintenance expenses for the home can be offset in calculating countable income from rent.

Approximately $900 of a Medicaid nursing home resident's monthly income may be used for up to 6 months to pay actual home maintenance costs if a physician certifies that it is likely the recipient will return home in that period.

Medicaid will usually have a lien against the Medicaid recipient's interest in the home at the time of death of the Medicaid recipient for most costs paid by Medicaid after the recipient turned 55.

An **automobile** with a blue book value below $5,000 is exempt. A more valuable car will be exempt if the car is needed to obtain medical care or is modified for use by a handicapped person.

Household furnishings and personal effects of any value are exempt. This includes clothing, appliances, furniture, personal jewelry and other items typically found in a home.

A **Burial Plot or Urn space** is exempt regardless of value.

Amounts to cover **burial expenses** can be exempt in one of two alternative ways:

- ✓ A **Burial Fund** of not more than $1,500 is exempt if it is established as a separate account in any financial institution. Also exempt is any interest or appreciation in the $1,500 burial fund account after it is designated. The amount that can be set aside for a burial fund will be reduced by the face value of all life insurance policies if this face value is less than $1,500.

- ✓ Instead of a $1,500 Burial Fund, a single person can purchase an irrevocable prepaid burial plan or establish an irrevocable burial trust. The amount of the plan or trust must be reasonable in light of anticipated burial costs, but substantially more than $1,500 can often be deemed reasonable.

Life Insurance is exempt if the total face value of all policies is less than $1,500. If the face value is greater than $1,500, the total cash surrender value is a countable non-exempt resource. The amount that can be set aside for life insurance will be reduced by the amount set aside for burial expenses.

Sales contracts, including Real Estate Contracts, entered into before December 1, 1993 are considered exempt; payments received under such contracts (including both income and principal) are counted as income in the month of receipt. Sales contracts entered into after December 1, 1993 are exempt only if the contract was for the sale of the applicant's principal place of residence, the principal amount equals the fair market value of the property sold, the contract carries a market interest rate, and the term of the contract does not exceed 30 years. Transfer of a contract (other than to a spouse) is subject to the transfer penalties discussed below.

The amount insured for under a **Long-Term Care Partnership Insurance Policy** is exempt after the policy coverage has been exhausted. Thus, if one purchases a $100,000 Long-Term Care Partnership policy, and the policy pays $100,000 for actual long-term care expenses for the policy holder, $100,000 in otherwise non-exempt assets will be deemed exempt.

Resources that **can't be converted to cash in 20 working days** are *disregarded* until sold as long as the applicant is making an ongoing bona fide effort to convert them to cash. The proceeds from the sale of such resources are not exempt and will often make the Medicaid recipient ineligible in the month following the sale unless spent or invested in exempt resources. However, such ineligibility is prospective only; the recipient is not required to pay Medicaid back for coverage provided before the proceeds were received.

An **annuity** which has no cash surrender value and which is not assignable for value during life is not considered to have any value as a resource. The income from the annuity, including both interest and principal, is countable income

to the recipient when received -and will generally have to be participated toward the cost of care. If an annuity is purchased which has a payout period longer than the life expectancy of the recipient, DSHS will deem the purchase, in part, an uncompensated transfer subject to the transfer penalties. (The notion is that one is, in effect, creating a remainder interest for one's heirs.) The amount of the uncompensated transfer is the purchase price less what the purchase price would have been for an annuity with a payout period equaling the life expectancy of the recipient.

Because all annuity income paid to a **single** Medicaid recipient must be paid toward the cost of care, converting excess resources into an annuity will not make much economic sense for single persons as a method to establish eligibility.

Although Congress authorized, but did not require, federal regulations to treat annuities as an available resource under the trust rules, the federal Health Care Financing Administration has chosen not to do so. HCFA has validated the approach now used in the state of Washington as described above.

D. Eligibility Rules For Married Couples

Overview Of Couple Eligibility Rules

Medicaid has a number of rules that are designed to protect the income and assets of one spouse, often called the "community spouse," when the other spouse goes into a nursing home or begins to receive COPES benefits. These rules are designed to avoid the "impoverishment" of the community spouse.

These Medicaid eligibility rules for a married couple apply only when one spouse is in the nursing home or on COPES. If both spouses are in a nursing home (or on COPES), even if they share a room, they will be treated as though they were single and the Medicaid income and resource rules for single persons, discussed above, will apply for each. The federal Medicaid statute expressly preempts state community property law for purposes of determining the ownership of income and assets. Medicaid determines ownership according to the name in which income is received or the title of an asset.

Income Eligibility (WAC 388-513-1325-1350,1395)

For one spouse of a married couple to receive Medicaid coverage for nursing home care, the income of that spouse must be less than the facility's private pay rate plus his/her regularly recurring monthly medical expenses. The nursing home spouse's income is determined by first seeing what income comes in the name of that spouse. If this amount exceeds the eligibility standard, the person under certain circumstances may still be eligible if one-half of the income of both spouses is less than the eligibility standard.

For COPES, the monthly income of the spouse receiving COPES assistance cannot exceed about $2,000. Here again, either:

- ✓ the income coming in the name of the COPES spouse or
- ✓ one-half of the couple's income can be used to determine eligibility.

There is no income limit for the spouse not receiving COPES, although this may affect cost participation, as explained below.

Resource Eligibility (WAC 388-513-1350)

All resources of both spouses are considered in determining eligibility, regardless of which spouse owns what resource or whether the property is considered to be separate or community property. Prenuptial and Separate Property Agreements are disregarded. Transfers between spouses before application have no effect on this initial eligibility determination.

The same resource rules and exemptions described above for single persons apply to couples, with the following additions:

- ✓ The community spouse is allowed between $40,000 to $109,00 in non-exempt resources in addition to the $2,000 in non-exempt resources allowed the institutionalized spouse. The actual amount depends on the date of institutionalization and the couple's total resources at the time of the applicant's institutionalization. See WAC 388-513-1350. The community spouse will be allowed more than $109,000 if additional resources are necessary to bring the community spouse's income up to the minimum spousal income allocation level described below.

  All but $2,000 in non-exempt resources must be transferred into the name of the community spouse before the first regularly scheduled eligibility review, which is usually 12 months **after** initial eligibility is determined. Thereafter, the non-exempt resources of the nursing home spouse must always remain below $2,000. However, **after** eligibility for one spouse is established, that eligibility is unaffected if the non-exempt assets of the community spouse later exceed $109,000.

- ✓ Each spouse is allowed to have a $1,500 burial fund, subject to the same life insurance/irrevocable burial trust rules explained above for single persons.

- ✓ The home (regardless of value) is exempt if the community spouse resides in the home. Further, if the home is transferred into the name of the community spouse, it will not be subject to Medicaid estate recovery unless the spouse on Medicaid later regains title to the property.

- ✓ One car per couple is exempt regardless of value.

Note: Purchasing an annuity for the community spouse, or establishing a trust for the sole benefit of the community spouse with excess resources, can immediately establish eligibility irrespective of the amount of excess resources. However, the distributions to the spouse from the annuity or trust often will reduce the income allocation the community spouse would otherwise receive from the nursing home spouse.

E. Transfer Of Asset Rules And Alternatives For Reducing Excess Resources

1. How Transfers Of Assets May Affect Eligibility (WAC 388-513-1365) Medicaid's transfer of asset rules *delay* eligibility for nursing home coverage or COPES for a period of time after some transfers. This is called the transfer penalty. A transfer may result in a transfer penalty if each of the following conditions is met:

- ✓ The transfer is for less than fair market value.
- ✓ The transfer is to other than a spouse or disabled child.
- ✓ The transfer is for the purpose of qualifying for Medicaid.
- ✓ The transfer is made during the "look-back" period.

2. The Look-Back Period... Only transfers within a certain period of time before application is made, called the "look-back period," are subject to the transfer penalty. For outright gifts, the look-back period is the 36 month period before the month in which an application is made. For transfers into irrevocable trusts, the look-back period is the 60 month period before the month in which an application is made. Transfers not within the look-back period have no effect on Medicaid eligibility. Thus, if a person gives away $1 million 4 years before applying for Medicaid, that gift will not be considered in determining eligibility.

3. Penalty Period Calculation Methodology for Gifts... The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the state. For example, a transferred asset worth $100,000, divided by a $5,000 average monthly private-pay rate, results in a 20-month penalty period. There is no limit to the length of the penalty period. ($100,000 divided by $5,000 = 20 months

- ✓ **No Maximum Penalty Means Application Should Be Delayed Until Look Back Period Expires**
- ✓
- ✓ **No Penalty At Time of Application If Monthly Gifts Less Than About $5000**

4. Transfers Which Cause No Penalty

- Gifts not in the "look-back period," i.e., outright gifts made more than 36 months prior to the month of application and gifts transferred into a trust more than 60 months prior to the month of application. Transfer of the home to a child of the applicant who has lived in the home and provided care to the applicant for the two year period immediately prior to institutionalization or COPES eligibility.

- Transfer of the home to a sibling of the applicant who has an equity interest in the home and who has lived in the home for the one year period immediately prior to institutionalization or COPES eligibility.

- Transfers to a spouse or to a trust for the sole benefit of a spouse or transfers into an annuity for the sole benefit of a spouse. See WAC 388-513-1365 (4) which says that such a trust mandate distribution of the entire corpus to the beneficiary spouse within that spouse's actuarial life expectancy.

- Transfers to a minor or disabled child or to a trust for a minor or disabled child. See WAC 388-513-1365 (4) which says that such a trust mandate distribution of the entire corpus to the beneficiary within the beneficiary's actuarial life expectancy.

- Transfers to a trust for the sole benefit of any disabled person under 65 years of age. See WAC 388-513-1365 (4) which says that such a trust mandate distribution of the entire corpus to the beneficiary within the beneficiary's actuarial life expectancy.

- Transfers supported by fair market value consideration. With respect to payment to a family member for the provision of services, see the specific requirements of WAC 388-513-1365 (1)(f) and (3).

- Situations where gifts are returned to the Medicaid applicant.

- Transfers of exempt resources other than the home.

- Transfer of assets which are exempt due to the purchase of a Long-Term Care Partnership Insurance Policy.

✓ **Waiver Of Penalty…**DSHS must waive the application of the transfer penalty where it will create undue hardship. This would typically occur where the property transferred cannot be recovered, and the applicant faces loss of shelter, food, clothing, or health care without DSHS assistance. Note, however, that civil penalties may be asserted against the recipients of the gifts for situations where the penalty is waived.

F. Options To Reduce Excess Resources

1. Options For Single Person

a. Giving Away Approximately $9,000 Each Month

If no prior gifts have been made that have established a period of ineligibility, one can giveaway approximately $9000 in any month and only be ineligible in that month. This can be done after one enters a nursing home and is paying for care at the private pay rate. This approach assures that one will not be left without enough money to cover nursing home care at the same time one is ineligible for Medicaid because of a transfer penalty. Care should be taken not to apply until after any month in which a gift of $9000 is made, and to apply for prospective benefits only.

If the asset to be transferred is the home, it could be sold on a sales contract, with the principal on the contract forgiven at the rate of $4,450 per month. Because the contract is exempt, and there is no penalty for monthly transfers of this amount, the forgiveness of principal on the contract can continue even after Medicaid eligibility is established.

b. Lump Sum Gift and Waiting Out the Look-Back Period... For a person with a substantial amount of excess assets who is concerned about Medicaid nursing home coverage, it may be advantageous to transfer assets as quickly as possible to start the clock running on the 36 month look-back period. There is no limit on the amount that can be given away if the gift is not within the look-back period at the time of application, though applying before the end of the look-back period can have disastrous consequences. For this approach to work, it is critical to hold back enough funds to fully cover care during the 36 month look-back period.

c. Purchasing Exempt Resources... The Medicaid applicant can purchase or invest in exempt resources. The mortgage to the family home can be paid off or down, the home can be repaired or remodeled, or the home can be sold and a

new, more expensive home or condominium purchased. Excess resources can also be used to purchase household furnishings or appliances or a new car if one of the exceptions to the $5,000 value limit applies. Note that these exempt resources will be subject to a Medicaid lien upon the death of the single recipient.

d. Consuming Excess Resources... Medicaid applicants can always spend excess resources on themselves. Nothing will be accomplished if other countable resources are purchased, but the excess resources can be spent on long-term care as well as vacations, entertainment, additional help around the home, or other services.

e. Transfer of Home to Certain Children or Siblings... Always determine whether a penalty-free transfer of the home may be made, for example, to a child who has lived in the home and cared for the applicant for the two year period immediately prior to institutionalization or a sibling who has lived in the home for one year and has an equity interest in the home or a disabled child.

f. Trust for Disabled Persons Less Than 65 or For Disabled Child of Any Age... As discussed above, there is no penalty for transfers to trusts for the sole benefit of disabled children of the Medicaid applicant or for the sole benefit of any disabled person under 65.

2. Additional Options For Married Couples… There are certain additional options for married couples which can dramatically expedite Medicaid eligibility.

a. Annuity for Community Spouse... Excess resources can be used to purchase an immediate annuity for the community spouse that provides for periodic income payments. The annuity must be irrevocable, non-transferable, have no cash surrender value, and the payout term cannot exceed the life expectancy of the Medicaid applicant or spouse. (DSHS uses its own tables to determine life expectancy). If these requirements are complied with, no transfer penalty will be assessed for the purchase of the annuity and the value of the annuity income stream will not be counted toward the resource limit for Medicaid eligibility.

By purchasing such an annuity for the community spouse, any amount of excess non-exempt resources can be reduced to the qualification level for the month after the annuity is purchased. The annuity should be purchased in the month before application is made, and any right to revoke the annuity (often called a “free look” period) must expire prior to the first day of the month of application. As long as eligibility is established in the month of application, the fact that the annuity payments later increase the community spouse’s assets well above the eligibility level will not affect the ongoing eligibility of a continuously institutionalized spouse.

The annuity payments will be income to the community spouse and may affect an income allocation from the nursing home spouse. But, as discussed above, there is no maximum limit on the amount of income of the community spouse.

b. Trust for Community Spouse...A married couple can transfer excess resources to an irrevocable trust for the sole benefit of the community spouse. The trust will not be deemed an available resource, and no transfer penalty will be incurred, if the trust provides that the entire trust will be distributed to the community spouse within the life expectancy of the community spouse. A fair number of such trusts have been used in recent years in Washington to qualify one spouse.

As with annuities, distributions from the trust to the community spouse are treated as income to the community spouse and may reduce the amount of income allocated to the community spouse from the nursing home spouse.

G. Treatment of Income...The basic Medicaid rule for nursing home residents is that they must pay all of their income, minus certain deductions, to the nursing home. The deductions include a $60.00 a month personal needs allowance, a deduction for any uncovered medical costs and in the case of a married applicant, an allowance for the spouse who continues to live at home if he or she needs income support. A deduction may also be allowed for a dependent child living at home.

For a single person living at home, COPES allows the first $800 or so of income to be retained for living expenses, with all remaining income allocated in the same order as for nursing home residents. For a single person residing in an assisted living facility, congregate care facility or an adult family home, COPES allows the first $60.00 or so to be retained for personal needs, with all remaining income allocated in the same order as for nursing home residents.

For couples at home, COPES has the same income allocation rules as are used by Medicaid for nursing homes, except that the spouse receiving COPES is entitled to an initial allocation of approximately $600 instead of the $60.00 allowed nursing home residents. Because the spouse of a COPES recipient is entitled to a minimum monthly maintenance allowance, there is no cost participation required of a couple where one spouse is on COPES in the home unless their combined income exceeds a certain amount. If the spouse not receiving COPES receives income in his/her name exceeding the spousal maintenance allowance amount, this excess is not required to be participated toward the cost of COPES care; although in this case, all of the income of the spouse on COPES in excess must be used for COPES cost participation.

Where a married COPES recipient is residing in an adult residential care facility, adult family home or assisted living facility, the COPES spouse is allowed a certain amount as a personal needs allowance, but must pay the excess over $60.00 toward their cost of care. If this leaves the community spouse with less than the minimum monthly maintenance allowance, an exception to policy can be requested.

H. Medicaid Estate Recovery (RCW 43.20B.080; WAC 388-527-2710)

1. Basic Rule…DSHS has a statutory Medicaid lien in certain cases where Medicaid benefits have been paid. The Medicaid lien attaches to the estate of the Medicaid recipient at his or her death. The Office of Financial Recovery of DSHS pursues the enforcement of the Department's lien rights. The DSHS address for this:

DSHS, Office of Financial Recovery P. O. Box 9501, Olympia, Washington 98507-9501

2. Specific Estate Recovery Rules

a. The Medicaid lien only arises at the death of the Medicaid recipient.

b. The state only recovers for Medicaid benefits under the COPES or nursing home programs and related hospital and prescription drug services for those people. The Medicaid lien rules will be applied to the state funded Chore, Adult Family Home and Congregate Care programs and the Medicaid Personal Care Program.

c. The state only recovers for benefits paid for recipients age 55 or older. There is no age restriction for the recovery rules applied to the state funded long-term care programs (Chore, Adult Family Homes, Congregate Care).

d. The Medicaid lien only applies to the "estate" owned by the Medicaid recipient at death. In 1997, 1egislation was passed which now allows estate recovery for assets that pass to the surviving spouse pursuant to a community property agreement. Under this definition of "estate" the Medicaid lien rules will cover property passing at death by joint tenancy with rights of survivorship, living trusts, life estates and payable on death accounts.

e. Life insurance owned by the Medicaid recipient is not considered part of the recipient's "estate" unless the recipient's estate is named as the beneficiary.

f. There is the potential of Medicaid estate recovery even if the recipient dies with a surviving spouse, minor child or a disabled child. However, estate recovery will be deferred until the death of the community spouse and when there are no surviving minor or disabled children. **The lien will not apply to the property in the name of the community spouse.**

g. Medicaid recovery may be waived where it will cause "undue hardship."

Features and Requirements of Long-Term Care Insurance Coverage

First we will define basic policy types and elements and how they work. Then we will go through a standardized checklist of questions for policy evaluation, whose answers will determine the key features and benefits of the policy and any requirements (called benefit triggers or gatekeepers) that must be satisfied before benefits can be paid.

A. Types of Coverage…

- Nursing home coverage is coverage for confinement in a nursing home for any level of care.
- Home health coverage is coverage for home health and/or home care (chore) services.
- Comprehensive or integrated coverage offers benefits for nursing homes and home health, community-based and/or alternative care. The most effective policy of this type does not stipulate any order in which care must be given. **(Policies that require a nursing home stay before home care will be covered are no longer legal to be sold in Washington State.)**

B. Methods of Calculating/Distributing Payment…

- Actual Cost Up To Daily Maximum: This type of policy will pay less than the daily maximum if the actual cost is less. If the actual cost is higher than the daily maximum purchased, it will only pay the daily maximum.
- Indemnity: This type pays the actual amount of benefit in the policy, regardless of the cost of services. For example, if a $100-a-day benefit was purchased, the policy will pay $100 even if actual cost was $75 or $125.
- Coinsurance or percentage of cost: Pays a set percentage of the cost of services.
- Lump sum: Establishes the total sum of money that can be used for covered LTC services. It usually includes a daily limit.

C. Benefit Triggers… **Terms and conditions that must be met before the policyholder can receive policy benefits are called benefit triggers** (sometimes they are also called **gatekeepers**). These define specific parameters for the individual's type and degree of impairment as the basis for when benefits will be paid.

Virtually all long-term care policies have these provisions. They help the company to limit the number of eligible claims, thus helping companies manage their risks, and control their losses. Therefore, the more restrictive the number and/or nature of a policy's gatekeepers, the cheaper the policy is to buy.

There are now only three benefit triggers that are currently allowed in Washington State (federally "qualified" plans that provide for special tax treatment under the new health insurance law may contain other triggers):

1. **ADLs Requirement**

The number of ADLs (and sometimes the types) required to trigger benefits depends on the policy. However, OIC rules do not allow any policy to require more than three of six ADLs to have failed before benefits are triggered. Who must certify the need for care may be a part of the ADLs benefit trigger. In such a case, a physician may have to certify that the ADLs have failed before the policy will pay benefits.

2. **Physician Certification**

If a policy has a physician's certification benefit trigger, a physician must certify that the level of care being received is necessary and appropriate. In the past, most insurance companies required that a doctor authorize or prescribe all long-term care services. However, it is now becoming common for insurers to specify that the long-term care plan of care must be approved by a "case manager." Case managers often are hired by the insurance company, though they may also be totally independent. They assess needs and coordinate services. They evaluate the claimant's medical, social and family situation to determine the most appropriate level of and location for care.

3. **Cognitive Impairment**

Cognitive impairment is commonly described as deterioration or loss of intellectual capacity as shown by measurable deficits in the areas of memory, orientation and reasoning. Alzheimer's disease and similar forms of senility or dementia are conditions that can produce these deficits.

D. Exclusions…No contract may limit or exclude coverage by type of illness, accident, treatment, or medical condition, EXCEPT with the respect to the following:

- Intentionally self-inflicted injuries or conditions resulting from attempted suicide
- Nursing care covered by workers' compensation insurance
- Treatment for chemical dependency, alcoholism, or drug addiction
- Benefits provided under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law
- Benefits provided by Medicare or other governmental programs (excluding Medicaid)
- Stays in government facilities, unless the insured person is legally obligated to pay
- Services performed by a member of the covered person's immediate family
- Services outside the US or its territories
- Conditions arising out of war or an act of war (whether declared or undeclared)
- Conditions arising out of participation in the commission of a felony or riot
- Services for which there is no charge in the absence of insurance
- Chemical dependency
- Experimental treatments, supplies or services
- Rest cures and routine physical examinations

E. Prohibited Provisions…No long-term care insurance policy or benefit contract may:

- use riders, waivers, endorsements, or any similar method to limit or reduce coverage or benefits
- indemnify against losses resulting from sickness on a different basis than losses resulting from accidents
- be canceled, non-renewed or segregated at the time of relating solely on the grounds of the age or the deterioration of the mental or physical health of the covered person
- exclude or limit coverage for preexisting conditions for a period of more than one year prior to the effective date of the policy or contract or more than six months after the effective date of the policy or contract
- differentiate benefit amounts on the basis of the type or level of nursing home care provided
- contain a provision establishing any new waiting period in the event an existing policy or contract is converted to a new or other form within the same company.

F. Unfair or Deceptive Acts…RCW 48.84.910 authorizes the commissioner to prohibit particular unfair or deceptive acts in the conduct of the advertising, sale, and marketing of long-term care policies and contracts. The purpose of this section is to define certain minimum standards which insurers should meet with respect to long-term care. If the following standards are violated with such frequency as to indicate a general business practice by an insurer, it will be deemed to constitute an unfair method of competition or a deceptive act by such insurer and a violation of this section:

- Misrepresenting pertinent facts or insurance contract provisions.
- Failing to acknowledge and act reasonably promptly upon communications with respect to communications arising under insurance policies or contracts.
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies or contracts.
- Refusing to pay claims or provide benefits without conducting a reasonable investigation.
- Failing to affirm or deny coverage of claims within a reasonable time.
- Compelling an insured to institute litigation to recover amounts due under an insurance contract by offering substantially less than the amounts ultimately recovered in actions brought by such an insured.
- Attempting to settle a claim for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.
- Making claims payments to an insured or beneficiaries not accompanied by an explanation setting forth the coverage under which the payments are being made.
- Failing to promptly provide a reasonable explanation of the basis in the insurance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

- Asserting to an insured or claimant a policy of appealing from arbitration awards in favor of an insured or claimant for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.
- Delaying the investigation or payment of claims by unreasonably requiring an insured, claimant, or the attending physician of the patient to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.
- Failure to expeditiously honor drafts given in settlement of claims within three working days of notice of receipt by the payor bank except for reasons acceptable to the commissioner.
- Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established.
- Issue checks or drafts in partial payment of a loss or claim under a specific coverage which contain language which appear to release the insurer from its total liability.
- Failure to reply to the insurance commissioner within fifteen working days of receipt of an inquiry, such reply to furnish the commissioner with an adequate response to the inquiry.
- Failure to settle a claim on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions as permitted.
- Making statements which indicate the rights of persons may be impaired if a form or release is not completed within a given time unless the statement otherwise is provided by policy provisions or is for the purpose of notifying that person of the provisions of an applicable statute of limitations.

G. Disclosure Rules…

- The commissioner must adopt rules requiring disclosure to consumers of the level, type and amount of benefits provided and the limitations, exclusions and exceptions contained in a long-term care insurance policy or contract. In adopting such rules the commissioner will require an understandable disclosure to consumers of any cost for services that the consumer will be responsible for in utilizing benefits covered under the policy or contract.

- Each long-term care insurance policy or contract must include a provision, prominently displayed on the first page of the policy or contract, stating in substance that the person to whom the policy or contract is sold will be permitted to **return the policy or contract within 30 days of its delivery.** In the case of policies or contracts solicited and sold by mail, the person may return the policy or contract within **60 days.** Once the policy or contract has been returned, the person may have the premium refunded if, after examination of the policy or contract, the person is not satisfied with it for any reason. An additional ten percent penalty may be added to any premium refund due which is not paid within thirty days of return of the policy or contract to the insurer or agent. If a person, pursuant to such notice, returns the policy or contract to the insurer at its branch or home office, or to the agent from whom the policy or contract was purchased, the policy or contract will be void from its inception, and the parties will be in the same position as if no policy or contract had been issued.

H. Prohibited Practices…No agent, broker or other representative of an insurer, contractor or other organization selling or offering long-term care insurance policies or benefit contracts may:

- complete the medical history portion of any form or application for the purchase of such policy or contract
- knowingly sell a long-term care policy or contract to any person who is receiving Medicaid
- use or engage in any unfair or deceptive act or practice in the advertising, sale or marketing of long-term care policies or contracts.

I. Separation of Data Regarding Certain Policies…Commencing with reports for accounting periods beginning on or after January 1, 1998, all insurers, fraternal benefit societies, health care services contractors, and health maintenance organizations must, for reporting and record keeping purposes, separate data concerning long-term care insurance policies and contracts from data concerning other insurance policies and contracts.

J. Insurance Policy Criteria-Rules…

1. The insurance commissioner will adopt rules defining the criteria that long-term care insurance policies must meet to satisfy the requirements of this chapter. The rules must provide that all long-term care insurance policies purchased for the purposes of this chapter:
    - be guaranteed renewable
    - provide coverage for nursing home care and provide coverage for an alternative plan of care benefit as defined by the commissioner
    - provide optional coverage for home and community-based services. Such home and community-based services will be included in the coverage unless rejected in writing by the applicant
    - provide automatic inflation protection or similar coverage for any policyholder through the age of seventy-nine and made optional at age eighty to protect the policyholder from future increases in the cost of long-term care
    - not require prior hospitalization or confinement in a nursing home as a prerequisite to receiving long-term care benefits
    - contain at least a six-month grace period that permits reinstatement of the policy or contract retroactive to the date of termination if the policy or contract holder's nonpayment of premiums arose as a result of a cognitive impairment suffered by the policy or contract holder as certified by a physician.
    -
2. Insurers offering long-term care policies for the purposes of this chapter must demonstrate to the satisfaction of the insurance commissioner that they:
    - have procedures to provide notice to each purchaser of the long-term care consumer education program
    - offer case management services
    - have procedures that provide for the keeping of individual policy records and procedures for the explanation of coverage and benefits
    - agree to provide the insurance commissioner, on or before September 1st of each year, an annual report containing information derived from the long-term care partnership or long-term care insurance uniform data set as specified by the office of the commissioner.
    -

K. Consumer Education Program…The insurance commissioner will, with the cooperation of the department of social and health services and members of the long-term care insurance industry, develop a consumer education program designed to educate consumers as to the need for long-term care, methods for financing long-term care, the availability of long-term care insurance, and the eligibility requirements of the asset protection program provided under this chapter.

L. National Standards for Long-Term Care Insurance…The National Association of Insurance Commissioners (NAIC) has developed certain **standards** to aid consumers in selecting appropriate insurance coverage. For long-term care insurance, the NAIC recommends looking for a policy that includes the following:

- At least one year of nursing home care or home health coverage, including intermediate and custodial care. Nursing home or home health care should not be limited to skilled care.
- Coverage for Alzheimer's disease, should you develop it after purchasing the policy.
- An inflation protection option. You should be able to choose from among the following options:
    - Automatic increases to the benefit level on an annual basis, or
    - A guaranteed right to increase your benefit level periodically without providing evidence of insurability.
- An "outline of coverage" which systematically describes the policy's benefits, limitations, and exclusions, and allows you to compare the policy with others.
- A long-term care insurance "shopper's guide" which helps you decide whether long-term care insurance is appropriate for you.
- A guarantee that the policy cannot be canceled or otherwise terminated because you get older or suffer deterioration in physical or mental health.
- The right to return the policy for any reason within 30 days after you purchase it, and to receive a refund of premiums paid (often call a "free look" provision).
- No requirement that you be hospitalized before receiving nursing home benefits or home health care benefits.
- No requirement that you receive skilled nursing home care before receiving benefits for intermediate or custodial nursing home care.
- No requirement that you receive nursing home care before receiving benefits for home health care.

M. Policy Benefits and Limitations in Washington State…

- No contract may limit benefits to an unreasonable period of time or an unreasonable dollar amount. For example, a provision that a particular condition will be covered only for one year without regard to the actual amount of the benefits paid or provided, is not acceptable. Policies may limit in-patient institutional care benefits to a reasonable maximum dollar amount, and, as for example in the case of home health care visits, to a reasonable number of visits over a stated period of time.
- If a fixed dollar indemnity, fee for services rendered long-term care contract contains a maximum benefits period stated in terms of days for which benefits are paid or services are received by the insured, the days which are counted toward the benefit period must be days for which the insured has actually received one or more contract benefits or services. If benefits or services are received on a given day, that day may not be counted. Waiver of premium may not be considered a contract benefit for purposes of accrual of days under this section and long-term care total disability may not operate to reduce the benefit.
- If a contract of a managed care plan contains a maximum benefit period, it must be stated in terms of the days the insured is in the managed care delivery system. The days which are counted toward the benefit period may include days that the insured is under a care plan established by the case manager, or days in which the insured actually receives one or more benefits or services.
- A long-term care contract must cover skilled, intermediate, and custodial (personal) care, whether benefits are for institutional or community based care.
- No contract may restrict or deny benefits because the insured has failed to meet Medicare beneficiary eligibility criteria.
- No insurer may offer a contract form which requires prior skilled or intermediate care as a condition of coverage for institutional or community based care.
- No insurer may offer a contract form which requires prior hospitalization as a condition of covering institutional or community based care.
- No long-term care contract may restrict benefit payments to a requirement that the patient is making a *steady improvement* or limit benefits to *recuperation* of health.
- Washington State regulations prohibit : requiring hospitalization or nursing facility care prior to community based care, no skilled care prior or simultaneous to receiving other community based care, requiring custodial home care services be provided by licensed nurses or therapists, requiring an acute condition prior to community based care, limiting services to Medicare certified providers, excluding coverage for adult day care services, the agent to fill out the health statement for the insured.
- The maximum daily benefit is currently approximately $40-$280 per day with maximum benefit periods of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 years. Unlimited benefit periods are available and maximum benefits can be expressed in total dollars instead of years. Washington State Regulations require at least a one year benefit.

N. More Benefit Limitations…After the benefit triggers have been satisfied so that a policy begins to pay the claim, the policy's specific benefits are available—but there may be further limitations, often relating to where care is received and from whom (provider types, licensing and certification).

Each long-term care policy or contract will specify what kinds of services will be covered, in what settings, and by which type of provider. Benefits can be denied unless the claimant is receiving care in the appropriate location and from the appropriate personnel. If the types of eligible providers specified in the policy are not available in a claimant's geographic area, the benefit may be unusable.

Licensing and certification of providers may also create requirement issues. For example, to be eligible for payment, nursing homes providing skilled or custodial care must be licensed as nursing home facilities by the Department of Social and Health Services. Congregate care facilities must be licensed as "boarding homes" by the Department of Social and Health Services if people live there and receive care. Home health agencies generally must be Medicare-approved or state-certified.

Some LTC contracts require enrollees to use facilities with which they have a contract—also called participating providers—to qualify for benefits. Participating providers have agreed to provide the necessary services, and to look to the insurance company for payment, except for co-payments, deductibles, and expenses that are not covered.

O. Unintentional Lapse…The long-term care policyholder must receive notice of lapse for nonpayment of premiums at least ***thirty days prior to the termination*** of coverage and has a limited right to reinstate the coverage if the policy lapsed unintentionally by a person with a cognitive impairment or loss of functional capacity.

The following are minimum standards for "unintentional lapses."

a. Every insurer must permit an insured to designate **at least one additional person to receive notice of lapse or termination for nonpayment of premium,** if the premium is not paid on or before its due date.

- The notice must provide that the contract or certificate will not lapse until at least **30 days** after the notice is mailed to the insured's designee.
- Where a policyholder or certificate holder pays premiums **through a payroll or pension deduction plan,** the insurer must permit the insured to designate a person to receive notice of lapse or termination for nonpayment of premium within **60 days** after the insured is no longer on such a premium payment plan.

b. Every insurer must provide a limited right to reinstate coverage in the event of lapse or termination for nonpayment of premium, if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity and reinstatement is requested within the five months after the policy lapsed or terminated due to nonpayment of premium.

- The standard of proof of cognitive impairment or loss of functional capacity will be no more restrictive than the benefit eligibility criteria for cognitive impairment or loss of functional capacity contained in the contract or certificate.
- Current good health of the insured must not be required for reinstatement if the request otherwise meets the requirements of this section.

c. An insurer must permit an insured to waive his or her right to designate an additional person to receive notice of lapse or termination for nonpayment of premium.

- The waiver must be in writing, dated, and signed by the applicant or insured.
- No less frequently than once in every 24 months, the insured must be permitted to revoke this waiver and to name a designee.

d. **Designation** by the insured to receive notice of lapse or termination for nonpayment of premium does not constitute acceptance of any liability on the part of the designee for services provided to the insured or applicant.

Group Long-Term Care

A. Individual Policies vs. Group Coverage

An individual policy of insurance is a contract written directly between an insurance company and an insured person. Washington state law requires all individual policies delivered in the state to conform to its requirements.

If a client purchases an individual or group LTC policy in another state, there is no guarantee it will meet the consumer-protective Washington requirements.

With group insurance, the insurance company issues the insurance policy to the group, which is legally the "policyholder" (sometimes referred to as the master policyholder). The covered members of the group are "insureds". The insureds (sometimes called certificate holders) do not have a policy (contract) directly with the insurance company. Instead, they receive a certificate of coverage that explains their benefits, rights and obligations under the policy.

Types of groups that may be policyholders include: employers, labor unions, professional, trade or occupational associations, and associations formed for purposes other than the purchase of insurance.

When dealing with group insurance, it is important to know:

- The type of group
- In which state the master policy holder is located

These two elements determine to what extent the Washington state LTC requirements and solvency protection apply to Washington State certificate holders.

When a policy is issued to a group policyholder that is located in Washington State, all LTC requirements must be met, and Washington insurance regulations protecting the consumer apply regardless of the type of group, and regardless of the location of the insurance company. However, if the policy is issued to a policyholder that is domiciled or located in another state, then it is called an "out-of-state group" and Washington state requirements and regulations protecting the consumer may or may not apply.

Also be aware that some out-of-state groups may have their insurance written by an insurer not authorized to transact insurance business in Washington State. In this case, protection from the Washington Life and Disability Guaranty Association may not be available. (The guaranty fund will pay claims in the event that the insurer becomes insolvent. All companies with a certificate of authority to do business in Washington State contribute to this fund on behalf of every policyholder if an insurer becomes insolvent.)

B. Differences Between Individual and Group Policies

An individual LTC policy must be issued on a "guaranteed renewable" basis. This means that the policy cannot be canceled except for nonpayment of premiums, and the insurer cannot change any provision of the policy without the consent of the insured person.

The insurance company may change the premium if it is changed for all persons of a particular class, such as all policyholders in the state.

Generally, group policies are not issued on a guaranteed renewable basis (though they are guaranteed continuable, meaning the insurance company reserves the right to cancel the contract, but not the individual coverage). The insurance company also reserves the right to change premiums, and to decide what benefits are in the policy.

Group policies issued in Washington are required to provide a continuity of coverage (no break in coverage) for the individual insured (or certificate holder). That means if the group coverage ends, the company must make some sort of arrangement to take care of the insureds. The insureds (or certificate holders) may be permitted to purchase individual coverage at different rates, or may be permitted to continue the group benefits by paying the premium directly to the insurance company.

Many large companies "self insure" and use a division of an insurance company to administer their plans. Self-insured programs need not comply with current Washington regulations.
Most group long-term care insurance coverage delivered to residents of this state must meet Washington standards.

Some groups, such as the American Association of Retired Persons (AARP), do not meet Washington regulations and choose not to sell in Washington. Some group insurers do not want to comply with selected Washington benefit requirements, and do not sell their insurance in Washington.

An agent soliciting Washington consumers to purchase policies that do not meet Washington requirements may be in violation of RCW 48.84.060, Prohibited Practices, and may be risking revocation of license as well as a $1,000 fine for each violation.

If an old group policy will be offered to new groups on or after January 1, 2009, that old master group contract must be amended, endorsed, or re-filed for compliance with the new requirements before it can be offered to new groups.

C. Public Employees Benefits Board...Until now, only a limited amount of group long-term care insurance has been available in this state. This has changed since the state's Public Employees Benefits Board (PEBB) rolled out long-term care plans. A group LTC plan is now available to eligible state employees, retired public school employees as well as eligible dependents (spouses, children, parents and in-laws of the employee or retiree).

Substitute House Bill 2186 passed by the 1996 Legislature directs the PEBB to make this voluntary long-term care insurance plan available to eligible public employees, retired school district employees and their dependents (including parents, in-laws, children or spouses).

The bill establishes a Technical Advisory Committee (TAC) to advise the HCA and the PEBB on benefit design, eligibility, underwriting rules, marketing and consumer education. The product was developed jointly by HCA staff and the PEBB in accordance with their statutory authority.

The TAC had representation from the Office of the Insurance Commissioner as well as long-term care service providers, licensed insurance agents with LTC expertise, employees, retired employees, retired school employees and others.

Parents and other dependents may sign up independently of the employee, and may pay premiums independently. If interested, the employee or retiree may make arrangements to pay the premiums for their parents or other dependents.

D. The Washington Health Care Authority (HCA) & Public Employee Benefit Board (PEBB)

The PEBB made available fully insured long-term care insurance plans that comply with the requirements of chapter 48.84 RCW.

- The voluntary group long-term care insurance program became available 1/1/1998.
- Benefits are available to state employees, retirees and their eligible family members.
- Premiums will be paid by the subscribers (insureds).
- Plan must include an alternative plan of care benefit, including adult day services.
- Provides for consumer education to be undertaken by the HCA and OIC jointly.
- Special six hours of continuing education required every two years for agents who wish to sell the PEBB Long-Term Care plan.

Who Is Eligible To Apply?

- Actively at work employees of the State. However, if you retire or leave your employer, your coverage may continue at the same premium rate as that paid by active State employees.
- Retired employees of the State.
- Parents and parents-in-law (issue age under 80) of eligible employees and retirees.
- Spouses (issue age 18 or older) of eligible employees or retirees.
- Eligible subscribers must provide proof of insurability. Relaxed underwriting and no physical examination.

Call PEBB Customer Service, 1-800-399-7271, for more information.

Federal Changes Affecting Long-Term Care Insurance In Washington State

On January 1, 1997, HR 3103, the Health Insurance Portability and Accountability Act went into effect. This act covers a range of health insurance issues, but for our purposes in LTC training, we must understand the part of the legislation that affects long-term care.

The tax-exempt status of certain elements of long-term care expenses made possible by this legislation (often called the Kassebaum-Kennedy bill), stipulates the following:

- **Premiums** for qualified insurance **will be deductible** as medical expenses (for those who qualify for medical deductions)
- LTC **benefits** received from qualified insurance will be received by the insured on a **tax-free basis**
- LTC expenses not covered by insurance will be deductible as medical expenses (up to certain limits) by the insured
- Employer-paid premiums of LTC insurance will **not** be treated as income to the insured
- Tax-qualified policies must coordinate with Medicare
- A nonforfeiture benefits option must be available in all policies (i.e., it is mandatory that the option is offered; this does not mean the benefit will be standard in all policies)
- Policies sold from August 1996-January 1997 that meet state standards will be grandfathered (considered qualified).

It is important to note that this is a Federal act and as of this writing we don't have the final word on how this will look; states are waiting to hear from the Treasury.

A. Tax Incentives…Two major tax questions arise with regard to long-term care insurance.

- Are the premiums deductible?
- Are the benefits taxable?

B. Deductibility of Premiums… Qualified policies…You may be able to deduct all or part of LTC premiums you pay for yourself, your spouse, or a dependent, but only if the policy meets the IRS criteria for a "qualified" policy. If you bought the policy before January 1, 1997, and it met the requirements of the state in which it was issued, it is automatically considered a qualified policy. Otherwise, the policy must meet the following qualifications:

1. It must provide coverage for only qualified long-term care services. You are considered chronically ill if a licensed health-care practitioner has certified that you meet either of these conditions:

- you are unable (without substantial help)to perform at least two of the activities of daily living (ADLS)—bathing, dressing, toileting, transferring (from bed to chair), eating and continence—for at least 90 days, or
- you need substantial supervision to protect your health and safety because of a severe mental impairment (such as Alzheimer's disease).

2. It must be guaranteed renewable, meaning that you will be able to renew your coverage as needed without undergoing additional medical exams.

3. It must not have a cash surrender value or any provision that allows you to cash in, pledge, assign, or borrow against the policy, or receive anything more than a refund of premiums on cancellation of the contract.

4. It must provide that any refunds and dividends (other than refunds upon termination of the policy) can be used only to reduce future premiums or increase future benefits.

5. It must not pay or reimburse expenses that are reimbursable under Medicare, unless Medicare is a secondary payer, or the contract makes per diem payments regardless of expense.

6. It must meet certain consumer protection requirements set out in the Internal Revenue Code, or if it meets the preceding qualifications, at least part of the premium may be tax deductible as a medical expense. Individuals buying policies on their own will be able to deduct part of the premiums from federal taxes annually, if the total costs of medical and long-term care exceed 7.5 percent of income. Qualified long-term care insurance premiums will be treated as medical expenses for the purpose of itemized deductions.

C. Taxation of Benefits...Benefits received from a nonqualified Long-Term Care insurance policy may be subject to income tax. However, a certain portion of the benefits received from a qualified LTC policy can be excluded from your taxable income. In 2012, unreimbursed LTC benefits of up to $310 per day are considered as reimbursement of expenses actually incurred for medical care, and as such are excluded from taxable income. Benefits that exceed this amount are excludable only to the extent of actual costs for long-term care services. The extra benefits are considered taxable income.

D. Tax Breaks For Employers… Employers can deduct from their taxes the cost of providing qualified long-term care insurance to employees, just as they already do if they provide medical benefits. Employers paying qualified LTC premiums for employees can deduct premiums as a business expense. Qualified LTC premiums paid by the employer on behalf of an employee are not treated as income to the employee.

E. Qualified Services… Qualified long-term care services under the Kassebaum-Kennedy law include necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, and maintenance services or personal care. Under the new law, LTC insurance plans must coordinate benefits with Medicare in those limited instances in which Medicare covers LTC). In such cases, Medicare would be primary and insurance would be secondary.

F. Effective Dates… The Health Insurance Portability and Accountability Act (HIPAA, a.k.a. Kassebaum-Kennedy law) affects qualified contracts issued beginning January 1, 1997. Contracts that were issued before January 1, 1997 may also qualify if they meet state requirements.

Policies sold between August 1996 and January 1, 1997 that meet the standards will be grandfathered (be considered qualified), meaning insureds will not have to exchange their recently purchased policies for new ones to get the tax relief. These older policies will retain their benefits and features (even if their benefit triggers differ from those required for new plans to qualify). At the option of the policyholder, non-tax qualified policies issued between January 1, 1997 and December 31, 1997 may be exchanged for tax-qualified policies.

G. The Effect Of Kassebaum-Kennedy (HIPAA) On LTC Insurance...Within the state, LTC policies will be made available that meet the minimum standards written into the federal law. Existing policies that do not qualify for tax-preferred treatment can be kept by policyholders, and new policies will probably continue to be written that do not qualify for tax-preferred treatment (but which are more potentially usable due to less strict benefit triggers).

The insurance industry believes that the new law will create strong growth in the sale of LTC contracts. This theoretically would reduce costs to government for Medicaid. Other experts and analysts point out that the tax benefits will largely go to an upper-income group, and that older people who can afford LTC insurance are unlikely to end up on Medicaid anyway.

WAC 284-23-650
Disclosure statement

(1) The words "accelerated benefit" must be included in the required title of every life insurance policy or rider that includes a provision for accelerated benefits. Accelerated benefits shall not be described, advertised, marketed, or sold as either long-term care insurance or as providing long-term care benefits.

(2) Possible tax consequences and possible consequences on eligibility for receipt of medicare, medicaid, Social Security, Supplemental Security Income (SSI), or other sources of public funding shall be included in every disclosure statement.

(a) The disclosure form shall include a disclosure statement. The disclosure statement shall be prominently displayed on the first page of the policy, rider, or certificate. The disclosure statement shall contain substantially the following: "If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as medicare, medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy."

(b) The disclosure statement must begin with the following statement: "This accelerated life benefit does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

(c) The disclosure form must be provided (i) to the applicant for an individual or group life insurance policy at the time application is made for the policy or rider; and (ii)(A) to the individual insured at the time the owner of an individual life insurance policy submits a request for payment of the accelerated benefit, and before the accelerated benefit is paid, or (B) to the individual certificate holder at the time an individual certificate holder of a group life insurance policy submits a request for payment of the accelerated benefit, and before the accelerated benefit is paid. It is not sufficient to provide this required disclosure statement only to the holder of a group policy.

(3) The disclosure form shall give a brief and clear description of the accelerated benefit. It shall define all qualifying events which can trigger payment of the accelerated benefit. It shall also describe any effect of payment of accelerated benefits upon the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens.

(a) In the case of insurance solicited by an insurance producer, the insurance producer shall provide the disclosure form to the applicant before or at the time the application is signed. Written acknowledgement of receipt of the disclosure statement shall be signed by the applicant and the insurance producer.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the disclosure form to the applicant at the time the policy is delivered, with a written notice that a full premium refund shall be made if the policy is returned to the insurer within the free look period.

(c) In the case of group life insurance policies, the disclosure form shall be contained in the certificate of coverage, and may be contained in any other related document furnished by the insurer to the certificate holder.

(4) If there is a premium or cost of insurance charge for the accelerated benefit, the insurer shall give the applicant a generic illustration numerically demonstrating any effect of the payment of an accelerated benefit upon the policy's cash value, accumulation account, death benefit, premium, policy loans, or policy liens.

(a) In the case of agent solicited insurance, the agent shall provide the illustration to the applicant either before or at the time the application is signed.

(b) In the case of a solicitation by direct response methods, the insurer shall provide the illustration to the applicant concurrently with delivery of the policy to the applicant.

(c) In the case of group life insurance policies, the disclosure form shall be included in the certificate of insurance or any related document furnished by the insurer to the certificate holder.

(5)(a) Insurers with financing options other than as described in WAC 284-23-690 (1)(b) and (c) of this regulation, shall disclose to the policyowner any premium or cost of insurance charge for the accelerated benefit. Insurers shall make a reasonable effort to assure that the certificate holder on a group policy is made aware of any premium or cost of insurance charge for the accelerated benefits, if he or she is required to pay all or any part of such a premium or cost of insurance charge.

(b) Insurers shall furnish an actuarial demonstration to the Insurance Commissioner when filing an individual or group life insurance policy or rider form that provides accelerated benefits, showing the method used to calculate the cost for the accelerated benefit.

(6) Insurers shall disclose to the policyholder any administrative expense charge. The insurer shall make a reasonable effort to assure that the certificate holder on a group policy is made aware of any administrative expense charge if he or she is required to pay all or any part of any such charge.

(7) When the owner of an individual policy or the certificate holder of a group policy requests payment of an accelerated benefit, within twenty days of receiving the request the insurer shall send a statement to that person, and to any irrevocable beneficiary, showing any effect that payment of an accelerated benefit will have on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. This statement shall disclose that receipt of accelerated benefit payments may adversely affect the recipient's eligibility for medicaid or other government benefits or entitlements. When the insurer pays the accelerated benefit, it shall issue an amended schedule page to the owner of an individual policy, or to the certificate holder of a group policy, showing any new, reduced in-force amount of the policy. When more than one payment of accelerated benefit is permitted under the policy or rider, the insurer shall send a revised statement to the owner of an individual policy, or to the certificate holder of a group policy, when a previous statement has become invalid due to payment of accelerated benefits.

WAC 284-83-170
Form of personal worksheet
The following form of personal worksheet must be used by issuers in the sale of long-term care insurance policies.

Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$_____per month, or $_____per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable or guaranteed renewable): _____.

The Company's Right to Increase Premiums: _____.

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Issuers must use appropriate bracketed statement. Rate guarantees must not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last ten years.] [The company has raised its premium rates on this policy form or similar policy forms in the last ten years. Following is a summary of the rate increases.]

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) ☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000] ☐ $[30-50,000] ☐ Over $50,000

Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.
How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____Approximate cost $_____for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐ The answers to the questions above describe my financial situation.

OR

☐ I choose not to complete this information.

(Check one.)

☐ I acknowledge that the issuer and/or its [agent] [insurance producer] (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked).

Signed:

(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed:

[(Agent)] [(Insurance Producer)] (Date)

[Agent's] [Insurance Producer's] Printed Name:_____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My [agent] [insurance producer] has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____]

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or [agent] [insurance producer] sale.

The company may contact you to verify your answers.

Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Format of Long-Term Care Contracts

No long-term care contract shall be delivered or issued to any person in this state if it fails to comply with the following:

1) The style, arrangement, and over-all appearance of the policy shall give no undue prominence to any portion of the text (except as required by this chapter). Every printed portion of the text of the contract and of any amendment or attached papers shall be plainly printed in easily read type.

2) Limitations, exclusions, exceptions, and reductions of coverage or benefits shall be set forth in the policy and shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "LIMITATIONS and EXCEPTIONS," or "EXCLUSIONS and REDUCTIONS," except that if a limitation, exclusion, exception, or reduction specifically applies only to a particular benefit of the policy, a statement of such limitation, exclusion, exception, or reduction shall be included with the benefit provision to which it applies.

3) Each contract delivered or issued for delivery to any person in this state shall clearly indicate on its first page that it is a "LONG-TERM CARE INSURANCE" contract. In addition, the contract shall contain a table of contents which shall clearly identify the location within the contract of each of the provisions of the contract with particular attention to the location of contract provisions for (a) limitations, exclusions, exceptions or reductions of coverage, (b) renewability, (c) definitions, (d) gatekeeping provisions, and (e) any unique provisions or circumstances such as elimination periods, or minimum or maximum limits. The term "contract" or "certificate" may be substituted on the first page of the contract for the word "insurance" where appropriate.

Rate Stability

A. Loss ratio requirements…

1) The provisions of chapter 284-60 WAC shall apply to every contract of long-term care issued by a disability insurer and fraternal benefit society. This shall apply to every long-term care contract issued by a health care service contractor or health maintenance organization.

2) ***Benefits for all long-term care contracts shall be reasonable in relation to the premium or price charged***.

B. Loss ratio definitions…

1) "Loss ratio" means the claims incurred plus or minus the increase or decrease in reserves as a percentage of the earned premiums, or the projected incurred claims plus or minus the increase or decrease in projected reserves as a percentage of projected earned premiums, as defined by the commissioner.

2) "Claims" shall mean the cost of health care services paid to or provided on behalf of covered individuals in accordance with the terms of contracts issued by health care service contractors or health maintenance organizations or capitation payments made to providers of long-term care.

3) The "expected loss ratio" is a prospective calculation and shall be calculated as the projected "benefits incurred" divided by the projected "premiums earned" and shall be based on the pricing actuary's best projections of the future experience within the "calculating period."

4) The "actual loss ratio" is a retrospective calculation and shall be calculated as the "benefits incurred" divided by the "premiums earned," both measured from the beginning of the "calculating period" to the date of the loss ratio calculations.

5) The "overall loss ratio" shall be calculated as the "benefits incurred" divided by the "premiums earned" over the entire "calculating period" and may involve both retrospective and prospective data.

6) The "calculating period" shall be the time span over which the pricing actuary expects the premium rates whether level or increasing, to remain adequate in accordance with his best estimate of future experience and during which the pricing actuary does not expect to request a rate increase.

7) The "benefits incurred" shall be the "claims incurred" plus any increase (or less any decrease) in the "reserves."

8) The "claims incurred" means: Claims paid during the accounting period; plus the change in the liability for claims which have been reported but not paid; plus the change in the liability for claims which have not been reported but which may reasonably be expected. The "claims incurred" shall not include expenses incurred in processing the claims, home office or field overhead, acquisition and selling costs, taxes, contributions to surplus, or profit.

9) The "premiums earned" shall mean the premiums, less experience credits, refunds or dividends, applicable to an accounting period whether received before, during or after such period.

C**. Loss Ratio-Grouping of Contract Forms**…For purposes of rate making and requests for rate increase.

1) The actuary responsible for setting premium rates shall group similar contract forms, including forms no longer being marketed if issued on or after January 1, 1988, in the pricing calculations. Such grouping shall rely on the judgment of the pricing actuary and be satisfactory to the commissioner. Among the factors which shall be considered are similar claims experience, types of benefits, reserves, margins for contingencies, expenses and profit, and equity between contract holders. Such grouping shall enhance statistical reliability and improve the likelihood of premium adequacy without introducing elements of discrimination.

2) The insureds under similar contract forms are grouped at the time of rate making in accord with RCW 48.44.220 or 48.46.370 because they are expected to have substantially like insuring, risk and exposure factors and expense elements. The morbidity and mortality experience of these insureds will, as a group, deteriorate over time. It is hereby defined to be an unfair discriminatory practice and therefore prohibited pursuant to RCW 48.44.220 or 48.46.370 and 48.84.040(3) to withdraw a form from its assigned grouping by reason of the deteriorating health of the insureds covered there under.

3) One or more of the contract forms grouped for rate making purposes may, by random chance, experience significantly higher or more frequent claims than the other forms. It is hereby defined to be an unfair discriminatory practice and therefore prohibited to deviate from the assigned grouping of contract forms for pricing purposes at the time of requesting a rate increase unless the pricing actuary can justify to the satisfaction of the commissioner that a different grouping is more equitable because of some previously unrecognized and nonrandom distinction between forms or between groups of insureds.

4) Successive contract forms of similar benefits are sometimes introduced by health care service contractors and health maintenance organizations for the purpose of keeping up with trends in hospital costs, new developments in

medical practice, additional supplemental benefits offered by competitors, and other reasons. While this is commendable, contract holders who cannot qualify for the new improved contracts, or to whom the new benefits are not offered, are left isolated as a high risk group under the prior form and soon become subject to massive rate increases. It is hereby defined to be an unfair discriminatory practice and therefore prohibited pursuant to RCW 48.44.220 or 48.46.370 and 48.84.040(3), to fail to combine successive generic contract forms and to fail to combine contract forms of similar benefits covering generations of contract holders in the calculation of premium rate and loss ratios.

D. **Loss ratio requirements-Individual contract forms**… The following standards apply to individual contract forms:

1) Benefits shall be deemed reasonable in relation to the premiums if the overall loss ratio is at least sixty percent over a calculating period chosen by the health care service contractor or health maintenance organization which calculating period is satisfactory to the commissioner.

2) The calculating period may vary with the benefit and renewal provisions. The health care service contractor or health maintenance organization may be required to demonstrate the reasonableness of the calculating period chosen by the actuary responsible for the premium calculations. A brief explanation of the selected calculating period shall accompany the filing.

3) Contract forms, the benefits of which are particularly exposed to the effects of inflation and whose premium income may be particularly vulnerable to an eroding persistency and other similar forces, shall use a relatively short calculating period reflecting the uncertainties of estimating the risks involved. Contract forms based on more dependable statistics may employ a longer calculating period.

4) A request for a rate increase to be effective at the end of the calculating period shall include a comparison of the actual to the expected loss ratios, shall employ any accumulation of reserves in the determination of rates for the new calculating period, and shall account for the maintenance of such reserves for future needs. The request for the rate increase shall be further documented by the expected loss ratio for the new calculating period.

5) A request for a rate increase submitted during the calculation period shall include a comparison of the actual to the expected loss ratios, a demonstration of any contributions to and support from the reserves, and shall account for the maintenance of such reserves for future needs. If the experience justifies a premium increase it shall be deemed that the calculating period has prematurely been brought to an end. The rate increase shall further be documented by the expected loss ratio for the next calculating period.

6) The commissioner may accept a series of two or three smaller rate increases in lieu of one large increase. These should be calculated to reduce lapses and antiselection that often result from large rate increases. A demonstration of such calculations, whether for a single rate increase or for a series of smaller rate increases, satisfactory to the commissioner, shall be attached to the filing.

7) Health care service contractors and health maintenance organizations shall review their experience periodically and file appropriate rate revisions in a timely manner to reduce the necessity of later filing of exceptionally large rate increases.

E. Loss ratio experience records… Health care service contractors and health maintenance organizations shall maintain records of earned premiums and incurred benefits for each contract year for each contract, rider, endorsement, amendment and similar form which were combined for purposes of premium calculations, including the reserves. Records shall also be maintained of the experience expected in the premium calculations.

F. Evaluating loss ratio experience data… In determining the credibility and appropriateness of experience data, due consideration shall be given to all relevant factors including:

1) Statistical credibility of premiums and benefits such as low exposure or low loss frequency;

2) Past and projected trends relative to the kind of coverage, such as inflation in medical expenses, inflation in expense charges and others;

3) The concentration of experience at early contract durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially higher or lower than in later contract durations;
4) The mix of business by risk classification;
5) The expected lapses and anti selection at the time of rate increases.

III. Laws and Rules Relating to LTCI

48.83.130 Selling, soliciting, or negotiating coverage — Licensed insurance producers — Training — Rules.

A person may not sell, solicit, or negotiate long-term care insurance unless he or she is appropriately licensed as an insurance producer and has successfully completed long-term care coverage education that meets the requirements of this section.

1) All long-term care education required by this chapter must meet the requirements of chapter 48.17 RCW and rules adopted by the commissioner.

2) Prior to soliciting, selling, or negotiating long-term care insurance coverage, an insurance producer must successfully complete a one-time education course consisting of no fewer than eight hours on long-term care coverage, long-term care services, state and federal regulations and requirements for long-term care and qualified long-term care insurance coverage, changes or improvements in long-term care services or providers, alternatives to the purchase of long-term care insurance coverage, the effect of inflation on benefits and the importance of inflation protection, and consumer suitability standards and guidelines.

3) In addition to the one-time education and training requirement, insurance producers who engage in the solicitation, sale, or negotiation of long- term care insurance coverage must successfully complete no fewer than *four hours every twenty-four months* of continuing education specific to long-term care insurance coverage and issues. Long-term care insurance coverage continuing education shall consist of topics related to long-term care insurance, state long-term care insurance partnership programs.

4) The producer must be aware of state and federal regulations and the relationship between qualified state long-term care partnership programs and public and private coverage of LTC services, Medicaid and:

- ✓ Available long-term care services and providers;
- ✓ Changes or improvements in long-term care services or providers;
- ✓ Alternatives to the purchase of private long-term care insurance;
- ✓ The effect of inflation on benefits and the importance of inflation protection;
- ✓ This chapter and chapters 48.84 and 48.85 RCW; and
- ✓ Consumer suitability standards and guidelines.

5) The insurance producer education required by this section shall not include training that is issuer or company product-specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

6) Issuers shall obtain verification that an insurance producer receives training required by this section before that producer is permitted to sell, solicit, or otherwise negotiate the issuer's long-term care insurance products.

7) Issuers shall maintain records subject to the state's record retention requirements and shall make evidence of that verification available to the commissioner upon request.

8) Issuers shall maintain records with respect to the training of its producers concerning the distribution of its long-term care partnership policies that will allow the commissioner to provide assurance to the state department of social and health services, Medicaid division, that insurance producers engaged in the sale of long-term care insurance contracts have received the training required by this section and any rules adopted by the commissioner, and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this state.

- ✓ These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the commissioner upon request.

- ✓ The satisfaction of these training requirements for any state shall be deemed to satisfy the training requirements of this state.

48.18.230 Binders

1) A "binder" is used to bind insurance temporarily pending the issuance of the policy. No binder shall be valid beyond the issuance of the policy as to which it was given, or beyond ninety days from its effective date, whichever period is the shorter.

2) If the policy has not been issued a binder may be extended or renewed beyond such ninety days upon the commissioner's written approval, or in accordance with such rules and regulations relative thereto as the commissioner may promulgate.

3) Where the premium used in the binder differs from the actual policy premium by less than ten dollars, the insurer shall not be required to notify the insured and may use the actual policy premium.

48.30.010 RCW - Unfair Practices in General - Remedies and Penalties.

1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business.

2) In addition to such unfair methods and unfair or deceptive acts or practices as are expressly defined and prohibited by this code, the commissioner may from time to time by regulation promulgated pursuant to chapter 34.05 RCW, define other methods of competition and other acts and practices in the conduct of such business reasonably found by the commissioner to be unfair or deceptive after a review of all comments received during the notice and comment rule-making period.

3) In defining other methods of competition and other acts and practices in the conduct of such business to be unfair or deceptive, and after reviewing all comments and documents received during the notice and comment rule-making period, the commissioner shall identify his or her reasons for defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive and shall include a statement outlining these reasons as part of the adopted rule.

- ✓ The commissioner shall include a detailed description of facts upon which he or she relied and of facts upon which he failed to rely, in defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive, in the concise explanatory statement prepared under RCW 34.05.325(6).

- ✓ Upon appeal the superior court shall review the findings of fact upon which the regulation is based de novo on the record.

4) No such regulation shall be made effective prior to the expiration of thirty days after the date of the order by which it is promulgated.

5) If the commissioner has cause to believe that any person is violating any such regulation, the commissioner may order such person to cease and desist order. The commissioner shall deliver such order to such person direct or mail it to the person by registered mail with return receipt requested. If the person violates the order after expiration of ten days after the cease and desist order has been received by him or her, he or she may be fined by the commissioner a sum not to exceed two hundred and fifty dollars for each violation committed thereafter.

6) If any such regulation is violated, the commissioner may take such other or additional action as is permitted under the insurance code for violation of a regulation.

7) An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant. "First party claimant" has the same meaning as in RCW 48.30.015.

48.30.015 Unreasonable denial of a claim for coverage or payment of benefits.

1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs.

2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in this Code, increase the total award of damages to an amount not to exceed three times the actual damages.

3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

5) A violation of any of the following is a violation for the purposes of subsections (2) and (3) of this section:
(a) WAC 284-30-330, captioned "specific unfair claims settlement practices defined";
(b) WAC 284-30-350, captioned "misrepresentation of policy provisions";
(c) WAC 284-30-360, captioned "failure to acknowledge pertinent communications";
(d) WAC 284-30-370, captioned "standards for prompt investigation of claims";
(e) WAC 284-30-380, captioned "standards for prompt, fair and equitable settlements applicable to all insurers"; or
(f) An unfair claims settlement practice rule adopted under RCW 48.30.010 and codified in chapter 284-30 of the WAC.

6) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

7) Twenty days prior to filing an action based on this section, a first party claimant must provide written notice of the basis for the cause of action to the insurer and office of the insurance commissioner. Notice may be provided by regular mail, registered mail, or certified mail with return receipt requested. Proof of notice by mail may be made in the same manner as prescribed by court rule or statute for proof of service by mail. The insurer and insurance commissioner are deemed to have received notice three business days after the notice is mailed.

- ✓ If the insurer fails to resolve the basis for the action within the twenty-day period after the written notice by the first party claimant, the first party claimant may bring the action without any further notice.
- ✓ The first party claimant may bring an action after the required period of time in (a) of this subsection has elapsed.
- ✓ If a written notice of claim is served under (a) of this subsection within the time prescribed for the filing of an action under this section, the statute of limitations for the action is tolled during the twenty-day period of time in (a) of this subsection.

48.30.020 Anticompact law…
1) No person shall either within or outside of this state enter into any contract, understanding or combination with any other person to do jointly or severally any act or engage in any practice for the purpose of
   a) controlling the rates to be charged for insuring any risk or any class of risks in this state; or
   b) unfairly discriminating against any person in this state by reason of his plan or method of transacting insurance, or by reason of his affiliation or nonaffiliation with any insurance organization; or
   c) establishing or perpetuating any condition in this state detrimental to free competition in the business of insurance or injurious to the insuring public.
2) This section shall not apply relative to ocean marine and foreign trade insurances.
3) Whenever the commissioner has knowledge of any violation he shall forthwith order the offending person to discontinue such practice immediately or show cause to the satisfaction of the commissioner why such order should not be complied with. If the offender is an insurer or a licensee under this code and fails to comply with such order within thirty days after receipt thereof, the commissioner may forthwith revoke the offender's certificate of authority or licenses.

48.30.030 False financial statements. No person shall knowingly make, publish, or disseminate any financial statement of an insurer which does not accurately state the insurer's financial condition.

48.30.040 False information and advertising. No person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein.

48.30.050 Advertising must show name and domicile. Every advertisement of, by, or on behalf of an insurer shall set forth the name in full of the insurer and the location of its home office or principal office, if any, in the United States.

48.30.060 Insurer name — Deceptive use prohibited. No person who is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer.

48.30.070 Advertising of financial condition… Every advertisement by or on behalf of any insurer purporting to show its financial condition may be in a condensed form but shall in substance correspond with the insurer's last verified statement filed with the commissioner. No insurer or person in its behalf shall advertise assets except those actually owned and possessed by the insurer.

48.30.075 Using existence of insurance guaranty associations in advertising to sell insurance… No person shall make, publish, disseminate, circulate, or place before the public, or in any other way, any advertisement, announcement, or statement which uses the existence of the Washington Insurance Guaranty Association or the Washington Life and Disability Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Washington Insurance Guaranty Association Act or the Washington Life and Disability Insurance Guaranty Association Act.

48.30.080 Defamation of insurer… No person shall make, publish, or disseminate, or aid, abet or encourage the making, publishing, or dissemination of any information or statement which is false or maliciously critical and which is designed to injure in its reputation or business any authorized insurer or any domestic corporation or reciprocal being formed pursuant to this code for the purpose of becoming an insurer.

48.30.090 Misrepresentation of policies… No person shall make, issue or circulate, or cause to be made, issued or circulated any misrepresentation of the terms of any policy or the benefits or advantages promised thereby, or the dividends or share of surplus to be received thereon, or use any name or title of any policy or class of policies misrepresenting the nature thereof.

48.30.100 Dividends not to be guaranteed… No insurer, producer or other person, shall guarantee or agree to the payment of future dividends or future refunds of unused premiums or savings in any specific or approximate amounts or percentages on account of any insurance contract.

48.30.110 Contributions to candidates for insurance commissioner… No insurer or fraternal benefit society doing business in this state shall directly or indirectly pay or use, or offer, consent, or agree to pay or use any money or thing of value for any candidate for the office of insurance commissioner.

48.30.120 Misconduct of officers, employees… No director, officer, producer, or employee of an insurer shall:

- ✓ Knowingly receive or possess himself of any of its property, otherwise than in payment for a just demand, and with intent to defraud, omit to make or to cause or direct to be made, a full and true entry thereof in its books and accounts; nor
- ✓ Make or concur in making any false entry, or concur in omitting to make any material entry, in its books or accounts; nor
- ✓ Knowingly concur in making or publishing any written report, exhibit or statement of its affairs or pecuniary condition containing any material statement which is false, or omit or concur in omitting any statement required by law to be contained therein; nor
- ✓ Having the custody or control of its books, willfully fail to make any proper entry in the books of the insurer as required by law, or to exhibit or allow the same to be inspected and extracts to be taken therefrom by any person entitled by law to inspect the same, or take extracts therefrom; nor
- ✓ If a notice of an application for an injunction or other legal process affecting or involving the property or business of the insurer is served upon him, fail to disclose the fact of such service and the time and place of such application to the other directors, officers, and managers thereof; nor

48.30.130 Presumption of knowledge of director… A director of an insurer is deemed to have such knowledge of its affairs as to enable him to determine whether any act, proceeding, or omission of its directors is a violation of any provision of this chapter. If present at a meeting of directors at which any act, proceeding, or omission of its directors which is a violation of any such provision occurs, he must be deemed to have concurred therein unless at the time he causes or in writing requires his dissent therefrom to be entered on the minutes of the directors.

48.30.140 Rebating… Except to the extent provided for in an applicable filing with the commissioner then in effect, no insurer, insurance producer, or title insurance agent shall, as an inducement to insurance, or after insurance has been effected, directly or indirectly, offer, promise, allow, give, set off, or pay to the insured or to any employee of the insured, any rebate, discount, abatement, or reduction of premium or any part thereof named in any insurance contract, or any commission thereon, or earnings, profits, dividends, or other benefit, or any other valuable consideration or inducement whatsoever which is not expressly provided for in the policy.

- ✓ This section shall not apply to advertising or promotional programs conducted by insurers, insurance producers, or title insurance agents whereby prizes, goods, wares, or merchandise, *not exceeding twenty-five dollars in value per person in the aggregate in any twelve month period*, are given to all insureds or prospective insureds under similar qualifying circumstances.

48.30.150 Illegal inducements… No insurer, insurance producer, title insurance agent, or other person shall, as an inducement to insurance, or in connection with any insurance transaction, provide in any policy for, or offer, or sell, buy, or offer or promise to buy or give, or promise, or allow to, or on behalf of, the insured or prospective insured in any manner whatsoever:

- ✓ Any shares of stock or securities issued or at any time to be issued on any interest therein or rights thereto; or
- ✓ Any special advisory board contract, or other contract, agreement, or understanding of any kind, offering, providing for, or promising any profits or special returns or special dividends; or
- ✓ Any prizes, goods, wares, or merchandise of an aggregate value in excess of twenty-five dollars.

48.30.155 Life or disability insurers — Insurance as inducement to purchase of goods, etc… No life or disability insurer shall directly or indirectly participate in any plan to offer or effect any kind or kinds of insurance in this state as an inducement to the purchase by the public of any goods, securities, commodities, services or subscriptions to publications. This section shall not apply to group or blanket insurance issued pursuant to this code.

48.30.157 Charges for extra services…The commissioner may permit an insurance producer to enter into reasonable arrangements with insureds and prospective insureds to charge a reduced fee in situations where services that are charged for are provided beyond the scope of services customarily provided in connection with the solicitation and procurement of insurance, so that an overall charge to an insured or prospective insured is reasonable taking into account receipt of commissions and fees and their relation, proportionally, to the value of the total work performed.

48.30.170 Rebate — Acceptance prohibited…

- ✓ No insured person shall receive or accept, directly or indirectly, any rebate of premium or part thereof, or any favor, advantage, share in dividends, or other benefits, or any valuable consideration or inducement not specified or provided for in the policy, or any commission on any insurance policy to which he or she is not lawfully entitled as a licensed insurance producer or title insurance agent.
- ✓ The amount of insurance whereon the insured has so received or accepted any such rebate or any such commission, other than as to life or disability insurances, shall be reduced in the proportion that the amount or value of the rebate or commission bears to the premium for such insurance. In addition to such reduction of insurance, if any, any such insured shall be liable to a fine of not more than two hundred dollars.

48.30.180 "Twisting" prohibited…No person shall by misrepresentations or by misleading comparisons, induce or tend to induce any insured to lapse, terminate, forfeit, surrender, retain, or convert any insurance policy.

48.30.190 Illegal dealing in premiums…

- ✓ No person shall willfully collect any sum as premium for insurance, which insurance is not then provided or is not in due course to be provided by an insurance policy issued by an insurer as authorized by this code.
- ✓ No person shall willfully collect as premium for insurance any sum in excess of the amount required to effectuate and insurance contract.

- ✓ No person shall willfully or knowingly fail to return to the person entitled thereto within a reasonable length of time any sum collected as premium for insurance in excess of the amount actually expended for insurance applicable to the subject on account of which the premium was collected.
- ✓ Each violation of this section which does not amount to a felony shall constitute a misdemeanor.

48.30.200 Hypothecation of premium notes… It shall be unlawful for any insurer, its representative or any producer to hypothecate, sell, or dispose of any promissory note, received in payment for any premium or part thereof on any contract of life insurance or of disability insurance applied for, prior to delivery of the policy to the applicant.

48.30.210 Misrepresentation in application for insurance… A person who knowingly makes a false or misleading statement or impersonation, or who willfully fails to reveal a material fact, in or relative to an application for insurance to an insurer, is guilty of a gross misdemeanor, and the license of any such person may be revoked.

48.30.220 Destruction, injury, secretion, etc., of property… Any person, who, with intent to defraud or prejudice the insurer thereof, burns or in any manner injures, destroys, secretes, abandons, or disposes of any property which is insured at the time against loss or damage by fire, theft, embezzlement, or any other casualty, whether the same be the property of or in the possession of such person or any other person, under circumstances not making the offense arson in the first degree, is guilty of a class C felony.

48.30.230 False claims or proof — Penalty… It is unlawful for any person, knowing it to be such, to:

- ✓ Present, or cause to be presented, a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under a contract of insurance; or
- ✓ Prepare, make, or subscribe any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with intent that it be presented or used in support of such a claim.
- ✓ Except as provided in (b) of this subsection, a violation of this section is a gross misdemeanor.
- ✓ If the claim is in excess of one thousand five hundred dollars, the violation is a class C felony punishable according to chapter 9A.20 RCW.

48.30.240 Rate wars prohibited… Any insurer which precipitates, or aids in precipitating or conducting a rate war and by so doing writes or issues a policy of insurance at a less rate than permitted under its schedules filed with the commissioner, or below the rate deemed by him or her to be proper and adequate to cover the class of risk insured, shall have its certificate of authority to do business in this state suspended until such time as the commissioner is satisfied that it is charging a proper rate of premium.

48.30.250 Interlocking ownership, management…

- ✓ Any insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition or common management is inconsistent with any other provision of this title, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.
- ✓ Any person otherwise qualified may be a director of two or more insurers which are competitors, unless the effect thereof is to substantially lessen competition between insurers generally or tends to create a monopoly.
- ✓ If the commissioner finds, after a hearing thereon, that there is violation of this section he shall order all such persons and insurers to cease and desist from such violation within such time, or extension thereof, as may be specified in such order.

48.30.260 Right of debtor or borrower to select insurance producer or insurer…

- ✓ Every debtor or borrower, when property insurance of any kind is required in connection with the debt or loan, shall have reasonable opportunity and choice in the selection of the insurance producer and insurer through whom such insurance is to be placed; but only if the insurance is properly provided for the protection of the creditor or lender.

- ✓ Every person who lends money or extends credit and who solicits insurance on real and personal property must explain to the borrower in prominently displayed writing that the insurance related to such loan or credit extension may be purchased from an insurer or insurance producer of the borrower's choice.

- ✓ Nothing contained in this section shall prevent a person who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower, or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

48.30.300 Unfair discrimination, generally… A person or entity engaged in the business of insurance in this state may not refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex, marital status, or sexual orientation, or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage may not be restricted, modified, excluded, increased, or reduced on the basis of the sex, marital status, or sexual orientation, or be restricted, modified, excluded, or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured. This subsection does not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any sensory, mental, or physical handicap *when bona fide statistical differences in risk or exposure have been substantiated.*

48.30.320 Notice of reason for cancellation, restrictions based on handicaps… Every authorized insurer, upon canceling, denying, or refusing to renew any individual life, individual disability, homeowner, dwelling fire, or private passenger automobile insurance policy, shall, upon written request, directly notify in writing the applicant or insured, as the case may be, of the reasons for the action by the insurer. Any benefits, terms, rates, or conditions of such an insurance contract which are restricted, excluded, modified, increased, or reduced because of the presence of a sensory, mental, or physical handicap shall, upon written request, be set forth in writing and supplied to the insured. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.

48.30.330 Immunity from libel or slander… With respect to contracts of insurance as defined in RCW 48.30.320, there shall be no liability on the part of, and no cause of action of any nature shall arise against, the insurance commissioner, the commissioner's agents, or members of the commissioner's staff, or against any insurer, its authorized representative, its agents, its employees, furnishing to the insurer information as to reasons for cancellation or refusal to issue or renew, for libel or slander on the basis of any statement made by any of them in any written notice of cancellation or refusal to issue or renew, or in any other communications, oral or written, specifying the reasons for cancellation or refusal to issue or renew or the providing of information.

Chapter 48.84 RCW - LONG-TERM CARE INSURANCE ACT

48.84.010 General provisions, intent. This chapter may be known and cited as the "long-term care insurance act" and is intended to govern the content and sale of long-term care insurance and long-term care benefit contracts issued before January 1, 2009, as defined in this chapter. This chapter shall be liberally construed to promote the public interest in protecting purchasers of long-term care insurance from unfair or deceptive sales, marketing, and advertising practices. The provisions of this chapter shall apply in addition to other requirements of Title 48 RCW.

48.84.020 Definitions… Unless the context requires otherwise, the definitions in this section apply throughout this chapter.
1) "Long-term care insurance" or "long-term care benefit contract" means any insurance policy or benefit contract primarily advertised, marketed, offered, or designed to provide coverage or services for either institutional or community-based convalescent, custodial, chronic, or terminally ill care. Such terms do not include and this chapter shall not apply to policies or contracts governed by chapter 48.66 RCW and continuing care retirement communities.
2) "Loss ratio" means the incurred claims plus or minus the increase or decrease in reserves as a percentage of the earned premiums, or the projected incurred claims plus or minus the increase or decrease in projected reserves as a percentage of projected earned premiums, as defined by the commissioner.
3) "Preexisting condition" means a covered person's medical condition that caused that person to have received medical advice or treatment during the specified time period before the effective date of coverage.
4) "Medicare" means Title XVIII of the United States social security act, or its successor program.
5) "Medicaid" means Title XIX of the United States social security act, or its successor program.
6) "Nursing home" means a nursing home as defined in RCW 18.51.010.

48.84.030 Rules — Benefits-premiums ratio, coverage limitations…

- ✓ The commissioner shall adopt rules requiring reasonable benefits in relation to the premium or price charged for long-term care policies and contracts which rules may include but are not limited to the establishment of minimum loss ratios.
- ✓ In addition, the commissioner may adopt rules establishing standards for long-term care coverage benefit limitations, exclusions, exceptions, and reductions and for policy or contract renewability.

48.84.040 Prohibited provisions…*No long-term care insurance policy or benefit contract may:*
1) Use riders, waivers, or any similar method to limit or reduce coverage or benefits;
2) Indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;
3) Be canceled, nonrenewed, or segregated at the time of rerating solely on the grounds of the age or the deterioration of the mental or physical health of the covered person;
4) Exclude or limit coverage for preexisting conditions for a period of more than one year prior to the effective date of the policy or contract or more than six months after the effective date of the policy or contract;
5) Differentiate benefit amounts on the basis of the type or level of nursing home care provided;
6) Contain a provision establishing any new waiting period in the event an existing policy or contract is converted to a new or other form within the same company.

48.84.050 Disclosure rules — Required provisions in policy or contract…

- ✓ The commissioner shall adopt rules requiring disclosure to consumers of the level, type, and amount of benefits provided and the limitations, exclusions, and exceptions contained in a long-term care insurance policy or contract. In adopting such rules the commissioner shall require an understandable disclosure to consumers of any cost for services that the consumer will be responsible for in utilizing benefits covered under the policy or contract.
- ✓ Each long-term care insurance policy or contract shall include a provision, prominently displayed on the first page of the policy or contract, stating in substance that the person to whom the policy or contract is sold shall be permitted to return the policy or contract within thirty days of its delivery. In the case of policies or contracts solicited and sold by mail, the person may return the policy or contract within sixty days. Once the policy or contract has been returned, the person may have the premium refunded if, after examination of the policy or contract, the person is not satisfied with it for any reason. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy or contract to the insurer or insurance producer.

48.84.060 Prohibited practices… No insurance producer or other representative of an insurer, contractor, or other organization selling or offering long-term care insurance policies or benefit contracts may:

- ✓ Complete the medical history portion of any form or application for the purchase of such policy or contract;
- ✓ knowingly sell a long-term care policy or contract to any person who is receiving Medicaid; or
- ✓ use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of long-term care policies or contracts.

48.84.070 Separation of data regarding certain policies… Commencing with reports for accounting periods beginning on or after January 1, 1988, all insurers, fraternal benefit societies, health care services contractors, and health maintenance organizations shall, for reporting and record keeping purposes, separate data concerning long-term care insurance policies and contracts from data concerning other insurance policies and contracts.

48.84.910 Effective date, application …The commissioner shall adopt all rules necessary to implement RCW 48.84.060 by its effective date including rules prohibiting particular unfair or deceptive acts and practices in the advertising, sale, and marketing of long-term care policies and contracts. The commissioner shall adopt all rules necessary to implement the remaining sections of this chapter and the remaining sections of this chapter shall apply to policies and contracts issued on or after January 1, 1988.

284.83.020 Standards for policy provisions…The following standards for policy provisions apply to all long-term care insurance policies delivered or issued for delivery in this state.

1) Renewability. The terms "guaranteed renewable" and "noncancelable" must not be used in any individual long-term care insurance policy or certificate without further explanatory language in accordance with the disclosure requirements.

- ✓ A policy or certificate issued to an individual must not contain renewal provisions other than "guaranteed renewable" or "noncancelable."
- ✓ The term "guaranteed renewable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums, if the issuer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and the issuer cannot decline to renew, except that rates may be revised by the issuer on a class basis.
- ✓ The term "noncancelable" may be used only if the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the issuer has no right to unilaterally make any change in any provision of the insurance and has no right to unilaterally make any change in the premium rate.
- ✓ The term "level premium" may be used only if the issuer does not have the right to change the premium.
- ✓ In addition to the other requirements of this subsection, a qualified long-term care insurance policy or certificate must be guaranteed renewable.
- ✓

2) **Limitations and exclusions**. A long-term care policy or certificate shall not be delivered or issued for delivery in this state as long-term care insurance if it limits or excludes coverage by type of illness, treatment, medical condition or accident, except for the following permitted exclusions:

a) Preexisting conditions or diseases;

b) Alcoholism and drug addiction;

c) Illness, treatment or medical condition arising out of:

- ✓ War (whether declared or undeclared);
- ✓ Participation in a felony, riot or insurrection;
- ✓ Service in the armed forces or units auxiliary thereto;
- ✓ Suicide, attempted suicide, or intentionally self-inflicted injury; or

- ✓ Aviation (this exclusion applies only to nonfare-paying passengers);

d) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, and services provided by a member of the covered person's immediate family;

e) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

f) In the case of a qualified long-term care insurance policy only, expenses for services or items to the extent that the expenses are reimbursable.

g) Issuers may not prohibit, exclude or limit services based on type of provider or limit a coverage if services are provided in a state other than the state where the policy was originally issued.

3) Extension of benefits. Termination of long-term care insurance must be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

4) **Continuation or conversion**. Group long-term care insurance issued in this state on or after January 1, 2009, must provide covered individuals with a basis for continuation or conversion of coverage.

a) A ***basis for continuation of coverage*** means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

- ✓ Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially 'equivalent to the, benefits of the existing group policy.
- ✓ The commissioner will make a determination as to the substantial equivalency of benefits, and in doing so," will take into consideration the differences between managed care and nonmanaged care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

b) Written application for the converted policy must be made and the first premium due, if any, must be paid as directed by the issuer not later than thirty-one days after termination of coverage under the group policy. The converted policy must be issued effective on the day following the termination of coverage under the group policy, and must be renewable annually.

c) Except where the group policy from which conversion is made replaces previous group coverage, the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. If the group policy from which conversion is made replaces previous group coverage," the premium for the converted policy must be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

d) Continuation of coverage or issuance of a converted policy is mandatory, except where: the termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or the terminating coverage is replaced not later than thirty-one days after termination by group coverage effective on the day following the termination of coverage and the replacement coverage provides benefits identical to or substantially equivalent to or in excess of those provided by the terminating coverage.

e) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, do not exceed those that would have been payable had the individual's coverage under the group policy remained in full force and effect.

5) Discontinuance and replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding issuer must offer coverage to all insured persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals, by the issuer and premiums charged to persons under the new group policy:

6) The premium charged to the insured must not increase due to either the increasing age of the insured at ages beyond sixty-five or the duration the insured has been covered under the policy. The purchase of additional coverage shall not be considered a premium rate increase; but for purposes of the calculation required under WAC 284-83-090, the portion of the premium attributable to the additional coverage must be added to and considered part of the initial annual premium.

7) Electronic enrollment for group policies. In the case of a group any requirement that a signature of the insured be obtained by an insurance producer or issuer will be deemed satisfied only if the consent is obtained by telephonic or electronic enrollment by the group policyholder or issuer and verification of enrollment information is provided to the insured; or the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and the telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information is maintained.

8) Each long-term care policy delivered or issued for delivery to any person in this state must clearly indicate on its first page that it is a "long-term care insurance" policy.

HR 3103: Veteran's Choice in Nursing Home Care Act

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to provide partial payment for nursing home care to eligible veterans at a non-Department of Veterans Affairs nursing home of the veteran's choice, and for other purposes. Be it enacted by the Senate and House of Representatives of the United States of America.

SECTION 1. SHORT TITLE. This Act may be cited as the `Veteran's Choice in Nursing Home Care Act'.

SECTION 2. CONTRACTS FOR PARTIAL PAYMENT FOR SERVICES AT CERTAIN NON-DEPARTMENT OF VETERANS AFFAIRS NURSING HOMES.

1) The Secretary shall, with respect to a veteran eligible for nursing home care under section 1710A of this title, and may, with respect to a veteran eligible for nursing home care under section 1710 of this title, provide such care by entering into an agreement with a non-Department nursing home of the veteran's choice upon the application of the veteran. Under such an agreement, the Secretary shall agree to pay the non-Department nursing home for the provision of such care an amount not to exceed the lesser of the amount that is equal to the average rate paid by the Secretary to non-Department nursing homes pursuant to contracts under this section or the amount actually charged for such care by the nursing home with which the Secretary enters into an agreement under this paragraph.

2) An application submitted by a veteran to receive nursing home care in a non-Department nursing home of the veteran's choice under this subsection shall include assurances by the veteran that the veteran shall assume responsibility for any amount owed such nursing home for such care that exceeds the amount required to be paid by the Secretary under paragraph (1), and that the veteran is aware of the amount to be owed to the nursing home by the veteran.

3) If a veteran does not submit an application to receive nursing home care in a non-Department nursing home of the veteran's choice under this subsection, the Secretary shall provide nursing home care to the veteran in such manner and to such extent as would otherwise be provided under this chapter.

IV. The Washington Long-Term Care Partnership

The department of social and health services, in conjunction with the office of the insurance commissioner, coordinate a long-term care insurance program entitled the Washington Long-Term Care Partnership, whereby private insurance and

Medicaid funds shall be used to finance long-term care. For individuals purchasing a long-term care insurance policy or contract governed by chapter 48.84 or 48.83 RCW and meeting the criteria prescribed in this chapter, and any other terms as specified by the office of the insurance commissioner and the department of social and health services, this program shall allow for the exclusion of some or all of the individual's assets in determination of medicaid eligibility as approved by the federal health care financing administration.

The Partnership Long-Term Care Insurance Model offers consumers a way to prepare for their long-term care needs, while still having the assurance that the safety net will be there for them if necessary. The risk of impoverishment is greatly reduced because consumers can have confidence that their assets will not need to be totally depleted before that assistance is available. The Long-Term Care Partnership Act establishes minimum standards and disclosure requirements to be met by insurers, health care service contractors, health maintenance organizations, and fraternal benefit societies with respect to long-term care partnership insurance policies to include: contracts, certificates, riders, and endorsements. Every long-term care partnership policy must meet the standards for long-term care policies or contracts.

Important Consumer Information Regarding Washington Long-Term Care Insurance

Some long-term care insurance policies [certificates] sold in Washington may qualify for the Washington Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may protect the policyholder's assets through a feature known as "Asset Disregard" under Washington's Medicaid program.

Asset Disregard means that an amount of the policyholder's assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Assets that can't be protected under the LTC partnership provisions are described in WAC 388-518-1415. Asset Disregard is not available under a long-term care insurance policy [certificate] that is not a Partnership Policy [Certificate]. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs. **The purchase of a Partnership Policy does not automatically qualify you for Medicaid.**

What are the Requirements for a Partnership Policy [Certificate]?

In order for a policy [certificate] to qualify as a Partnership Policy [Certificate], it must, among other requirements:

- ✓ be issued or exchanged to an individual after January 1, 2012;
- ✓ be a tax-qualified policy under Section 7702(B)(b) of the Internal Revenue Code of 1986;
- ✓ meet stringent consumer protection standards; and
- ✓ meet the following inflation protection requirements.

For ages 60 or younger provides automatic annual compounded inflation increases at a rate not less than three percent or automatic annual compounded inflation increases at a rate based on changes in the consumer price index, not to be less than zero percent;

For ages 61 to 76 provides automatic simple inflation increases at a rate not less than three percent or automatic inflation increases at a rate based on changes in the consumer price index, not to be less than zero percent;

For ages 76 and older the policy may, but is not required to, provide automatic inflation increases at a rate based on changes in the consumer price index, not to be less than zero percent.

If you apply and are approved for long-term care insurance coverage, [issuer name] will provide you with written documentation as to whether or not your policy [certificate] qualifies as a Partnership Policy [Certificate].

What Could Disqualify a Policy [Certificate] as a Partnership Policy. Certain types of changes to a Partnership Policy [Certificate] could affect whether or not such policy [certificate] continues to be a Partnership Policy [Certificate]. If you purchase a Partnership Policy [Certificate] and later decide to make any changes, you should first consult with [issuer name] to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you would not receive beneficial treatment of your policy [certificate] under the Medicaid program of that state. The information contained in this disclosure is based on current Washington and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy [certificate] under Washington's Medicaid program.

Additional Information. If you have questions regarding long-term care insurance policies [certificates] please contact [issuer name.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Washington Health Care Authority http://hca.wa.gov/contact.html.

Definitions related to long-term care services. This section defines the meaning of certain terms used in chapters 388-513 and 388-515 WAC. Within these chapters, institutional, waiver, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used. Definitions of terms used in certain rules that regulate LTC programs are as follows:

Add-on hours means additional hours the department purchases from providers to perform medically oriented tasks for clients who require extra help because of a handicapping condition.

Alternate living facility (ALF) means one of the following community residential facilities that are contracted with the department to provide certain services:

Adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care.

Adult residential care facility (ARC) (formerly known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision.

Adult residential rehabilitation center (ARRC) or adult residential treatment facility (ARTF), a licensed facility that provides its residents with twenty-four hour residential care for impairments related to mental illness.

Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living.

Division of developmental disabilities (DDD) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision.

Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs.

Clothing and personal incidentals (CPI) means the same as personal needs allowance (PNA) which is defined later in this section.

Community options program entry system (COPES) means a medicaid waiver program that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility.

Community spouse (CS) means a person who does not live in a medical institution or nursing facility, and who is legally married to an institutionalized client or to a person receiving services from home and community-based waiver programs.

Comprehensive assessment (CA) means the evaluation process used by a department designated social services worker to determine the client's need for long-term care services.

DDD waiver means medicaid waiver programs that provide home and community-based services as an alternative to an intermediate care facility for the mentally retarded (ICF-MR) to persons determined eligible for services from DDD. There are four waivers administered by DDD: Basic, Basic Plus, Core and Community Protection.

Fair market value (FMV) means the price an asset may reasonably be expected to sell for on the local market at the time of transfer or assignment. A transfer of assets for love and affection is not considered a transfer for FMV.

Federal benefit rate (FBR) means the basic benefit amount the Social Security administration (SSA) pays to clients who are eligible for the Supplemental Security Income (SSI) program.

Home and Community Based Services" (HCBS) means services provided in the home or a residential setting to individuals assessed by the department.

"Home and Community Based (HCB) Waiver Programs" means Section 1915 (c) of the Social Security Act enables states to request a waiver of applicable federal Medicaid requirements to provide enhanced community support services to those Medicaid beneficiaries who would otherwise require institutional care.

Institutional services means services paid for by medicaid or state payment and provided in a nursing facility or equivalent care provided in a medical facility.

"Institutional status" means what is described in WAC 388-513-1320.

"Institutionalized client" means a client who has attained institutional status as described in WAC 388-513-1320.

"**Institutional services"** means services paid for by Medicaid or state funds and provided in a medical institution, through a Home and Community Based (HCB) Waiver ,or Program of All-Inclusive Care for the Elderly (PACE).

"Institutionalized spouse" means a client who has attained institutional status as described in WAC 388-513-1320 and is legally married to a person who is not an institutionalized client.

"Legally married" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"Likely to reside" means a determination by the department that a client is reasonably expected to remain in a medical facility for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"Look-back period" means the number of months prior to the month of application for LTC services that the department will consider for transfer of assets.

"Maintenance needs amount" means a monthly income amount a client keeps or that is allocated to a spouse or dependent family member who lives in the client's home.

"Medically intensive children (MIC)" program means a medicaid waiver program that enables medically fragile children under age eighteen to live in the community. The program allows them to obtain medical and support services necessary for them to remain at home or in a home setting instead of in a hospital. Eligibility is included in the OBRA program described in WAC 388-515-1510.

"Noninstitutional medical assistance" means medical benefits provided by medicaid or state-funded programs that do not include LTC services.

"Nursing facility turnaround document (TAD)" means the billing document nursing facilities use to request payment for institutionalized clients.

"Outward bound residential alternative (OBRA)" means a medicaid waiver program that provides a person approved for services from DDD with the option to remain at home or in an alternate living facility.

"Participation" means the amount a client is responsible to pay each month toward the total cost of care they receive each month. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income.

"Penalty period" means a period of time for which a client is not eligible to receive LTC services.

"Personal needs allowance (PNA)" means a standard allowance for clothing and other personal needs for clients who live in a medical or alternate living facility. This allowance is sometimes referred to as "CPI."

"Prouty benefits" means special "age seventy-two" Social Security benefits available to persons born before 1896 who are not otherwise eligible for Social Security.

"Short stay" means a person who has entered a medical facility but is not likely to remain institutionalized for thirty consecutive days.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI federal benefit rate (FBR).

"Swing bed" means a bed in a medical facility that is contracted as both a hospital and a nursing facility bed.

"Transfer of a resource or asset" means any act or failure to act, by a person or a nonapplying joint tenant, whereby title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means the person is not able to meet shelter, food, clothing, or health needs.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and
2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

1) Aid and attendance for an individual needing regular help from another person with activities of daily living;
2) "Housebound" for an individual who, when without assistance from another person, is confined to the home;
3) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount; or
4) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both.

"Waiver programs/services" means programs for which the federal government authorizes exceptions to federal medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under medicaid. In Washington state, waiver programs are DDD waivers, COPES, MIC, and OBRA.

For the purposes of Medicaid eligibility, long-term care is for individuals residing in a medical institution (primarily nursing homes) for 30 days or more or on a Home and Community Based Waiver.

1) Institutional status is an eligibility requirement for long-term care services (LTC) and institutional medical programs. To attain institutional status, you must: be approved for and receiving home and community based waiver services or hospice services; reside or be likely to reside in a medical institution, institution for medical diseases (IMD) or inpatient psychiatric facility for a continuous period of:

a)Thirty days if you are an adult eighteen and older;
b) Thirty days if you are a child seventeen years of age or younger admitted to a medical institution; or
c) Ninety days if you are a child seventeen years of age or younger receiving inpatient chemical dependency or inpatient psychiatric treatment.

2) Once the department has determined that you meet institutional status, your status is not affected by: transfers between medical facilities; or changes from one kind of long-term care services (waiver, hospice or medical institutional services) to another.

3) If you are absent from the medical institution or you do not receive waiver or hospice services for at least thirty consecutive days, you lose institutional status.

Eligibility Requirements:
Some of the key requirements are:
Identity and citizenship requirements
Furnish a valid social security number
Be a Washington resident
Meet aged, blind or disabled criteria
Income and resource guidelines
Institutional Medicaid is subject to penalties for resource transfers
Home equity cannot exceed $506,000
Declaration of interest in an annuity and naming the State of Washington as a remainder beneficiary

Resource standards for long-term care
$2,000 applicant
$3,000 couple both applying in the same month
$48,639 State spousal resource standard
$109,560 Federal spousal resource standard maximum

Income
Countable income is compared to 300% of the Federal Benefit Rate (FBR). The 2011 rate is around $2,000 and may also be called the SIL (Special Income Level).
Individuals with income at or below are eligible for categorically needy (CN) medical coverage.
Individuals with countable income over 300% of the FBR may be eligible for medically needy (MN) coverage based on the projected monthly cost of care in the facility or at home.
Clients must contribute income after allowable deductions towards the costs of their care.

LTC Partnership – Background

- ✓ Section 6021 of the 2005 Deficit Reduction Act expands LTC Partnership opportunities for States by effectively lifting the moratorium on expansion imposed by the Omnibus Budget Reconciliation Act (OBRA) 1993.
- ✓ DRA provides for a unique Medicaid/private insurance model designed to attract consumers who might not otherwise purchase LTC insurance by allowing them to protect a specified level of assets.
- ✓ Considered by many States as a critical link in helping citizens plan for their own future.
- ✓ Help States offset rising Medicaid costs for LTC by shifting costs to private insurance.
- ✓ Discourage impermissible transfers of assets to qualify for Medicaid.
- ✓ Consumers can protect assets for estate planning and inheritance purposes.

LTC Partnership in Washington

- ✓ Washington State uses the dollar for dollar resource protection model. An individual can protect $1 in resource for every $1 paid out by the LTC partnership policy.
- ✓ Individuals would need to meet all other Medicaid eligibility rules, but will be able to bank additional resources based on the amount the LTC policy has paid.
- ✓ Resources banked due to a Partnership policy are protected from Estate Recovery.
- ✓ Individuals with a LTC Partnership Policy must submit a DSHS XXXX LTCP Asset Designation form to Washington State Medicaid at the time of application and at each annual review in order to designate assets as protected based on the dollar amount paid for services by the LTC Partnership Policy.

LTC Partnership - Reciprocity

HHS published the reciprocity standards in the Federal Register and are effective 1/1/09. Provisions require:

Benefits paid under a LTCP policy will be treated the same by all States.

- all States will be subject to the standards unless the State notifies the Secretary of the desire to opt out
- all States will implement a $ for $ disregard.
- policies will be treated uniformly regardless of where purchased.
- exempt assets from Estate Recovery.

- ✓ Washington accepts approved LTC partnership policies purchased in other states.

Resources and LTC Partnership - Example

Individual with a LTC partnership has $50,000 in liquid resources and an excluded home.
The LTC partnership insurance has paid $48,000 in benefits. Total policy pays $150,000 in benefits.
Individual meets general Medicaid requirements and is allowed to keep $2,000 in resources for medicaid plus $48,000 based on the amount the LTC partnership has paid.
As the partnership pays, the individual is allowed to save additional resources dollar for dollar.

Resources and LTC Partnership

- ✓ Resources banked due to a LTC partnership are not subject to Estate Recovery.
- ✓ This would include part of all value of a home that is excluded for Medicaid eligibility but not excluded from Estate Recovery at death.
- ✓ Based on the previous example, if the individual's excluded home is worth $100,000 and the partnership pays out a total of the $150,000 benefit during the lifetime, the value of the home may be banked and would not be subject to Estate Recovery.

Eligibility for long-term care (institutional, waiver, and hospice) services… This section describes how the department determines a client's eligibility for medical for clients residing in a medical institution, on a waiver, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs.

1) To be eligible for long-term care (LTC) services described in this section, a client must:
   a) Meet the general eligibility requirements for medical programs
   b) Attain institutional status
   c) Meet functional eligibility
   d) Not have a penalty period of ineligibility
   e) Not have equity interest greater than five hundred thousand dollars in their primary residence
   f) Must disclose any interest the applicant or spouse has in an annuity and meet annuity requirements
2) To be eligible for institutional, waiver, or hospice services under the CN program, a client must either:
   a) Be related to the Supplemental Security Income (SSI) program
   b) Be approved and receiving the general assistance expedited medicaid disability (GA-X) or general assistance aged (GA-A) or general assistance disabled
3) The department allows a client to reduce countable resources in excess of the standard.
4) To be eligible for waiver services, a client must meet the program requirements described in:
   a) WAC 388-515-1505 through 388-515-1509 for COPES, New Freedom, PACE, and WMIP services; or
   b) WAC 388-515-1510 through 388-515-1514 for DDD waivers; or
   c) WAC 388-515-1540 for the medically needy residential waiver (MNRW); or
   d) WAC 388-515-1550 for the medically needy in-home waiver (MNIW).
5) To be eligible for hospice services under the CN program, a client must:
   a) Meet the program requirements described in chapter 388-551 WAC; and

b) Be eligible for a non institutional categorically needy program (CN-P) if not residing in a medical institution thirty days or more; or
c) Reside at home and benefit by using home and community based waiver rules described in WAC 388-515-1505 through 1509 (SSI related clients with income over the MNIL and at or below the 300 percent of the FBR); or
d) Receive home and community waiver (HCS) or DDD waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or
e) Be eligible for institutional CN if residing in a medical institution thirty days or more.

6) To be eligible for institutional or hospice services under the MN program, a client must be:
a) Eligible for MN children's medical program described in WAC 388-505-0210, -0255, or -0260; or
b) Related to the SSI program as described in WAC 388-475-0050 and in WAC 388-513-1395; or
c) Eligible for the MN SSI related program described in WAC 388-475-0150 for hospice clients residing in a home setting; or
d) Eligible for the MN SSI related program described in WAC 388-513-1305 for hospice clients not on a medically needy waiver and residing in an alternate living facility.
e) Be eligible for institutional MN if residing in a medical institution thirty days or more.

7) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:
a) Considers resource eligibility and standards described in WAC 388-513-1350; and
b) Evaluates the transfer of assets as described in WAC 388-513-1363, -1364, -1365 or -1366.

8) To determine income eligibility for an SSI-related client under the CN or MN program, the department:
a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;
b) Excludes income for CN and MN programs as described in WAC 388-513-1340;
c) Disregards income for the MN program as described in WAC 388-513-1345; and
d) Follows program rules for the MN program as described in WAC 388-513-1395.

9) A client who meets the requirements of the CN program is approved for a period of up to 12 months.

10) **A client who meets the requirements of the MN program is approved for a period of months** described in WAC 388-513-1395(6) for: institutional services in a medical institution; or hospice services in a medical institution.

11) The department determines eligibility for the state funded nursing facility program described in WAC 388-438-0110 and 388-438-0125. Nursing facility services under the state funded nursing facility program must be preapproved by aging and disability services administration (ADSA).

12) The department determines eligibility for institutional services under the GA program described in WAC 388-448-0001 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (9) through (11).

13) A client is eligible for medicaid as a resident in a psychiatric facility, if the client:
a) Has attained institutional status as described in WAC 388-513-1320; and
b) Is under the age of twenty-one at the time of application; or
c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or
d) Is at least sixty-five years old.

14) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

15) If an individual under age twenty one is not eligible for medicaid under SSI related in WAC 388-475-0050 or general assistance (GA) described in WAC 388-448-0001 and 388-505-0110 -0255 or -0260.

16) Noncitizen individuals under age nineteen can be considered for the apple health for kids program described in WAC 388-505-0210 if they are admitted to a medical institution for less than thirty days. Once an individual resides or is likely to reside in a medical institution for thirty days or more, the department determines eligibility under WAC 388-505-0260.

17) The department determines a client's total responsibility to pay toward the cost of care for LTC services as follows:

a) For SSI-related clients residing in a medical institution see WAC 388-513-1380;
b) For clients receiving HCS CN waiver services see WAC 388-515-1509;
c) For clients receiving DDD CN waiver services see WAC 388-515-1514;
d) For clients receiving HCS MN waiver services see WAC 388-515-1540, -1550 or WAC 388-505-0265.

18) Clients not living in a medical institution who are considered to be receiving SSI benefits for the purposes of medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505 through -1509 or 388-515-1514. Groups deemed to be receiving SSI and for medicaid purposes are eligible to receive CN-P medicaid. These groups are described in WAC 388-475-0880.

WAC 388-513-1350..... Resource standard and resource eligibility for long-term care (LTC) services.

This section describes how the department defines the resource standard and countable or excluded resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and still be resource eligible for program benefits.

1) The resource standard used to determine eligibility for LTC services equals:

a) Two thousand dollars for: a single client; or a legally married client with a community spouse, subject to the provisions described in subsections (8) through (11) of this section; or
b) Three thousand dollars for a legally married couple, unless subsection (3) of this section applies.

2) When both spouses apply for LTC services the department considers the resources of both spouses as available to each other through the month in which the spouses stopped living together.

3) When both spouses are institutionalized, the department will determine the eligibility of each spouse as a single client the month following the month of separation.

4) If the department has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, (but after eligibility has been established and services authorized for the institutional spouse), then the department applies the standard described in subsection (1)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, the department applies (1)(b) of this section for a couple.

5) When a single institutionalized individual marries, the department will redetermine eligibility applying the rules for a legally married couple.

6) The department applies the following rules when determining available resources for LTC services:

a) WAC 388-475-0300, Resource eligibility;
b) WAC 388-475-0250, How to determine who owns a resource; and
c) WAC 388-470-0060(6), Resources of an alien's sponsor.

7) For LTC services the department determines a client's countable resources as follows:

a) The department determines countable resources for SSI-related clients as described in WAC 388-475-0350 through-0550 and resources excluded by federal law with the exception of:
i) WAC 388-475-0550(16);

ii) WAC 388-475-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006 and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver described in WAC 388-513-1367.

b) For an SSI-related client one automobile per household is excluded regardless of value if it is used for transportation of the eligible individual/couple. For an SSI-related client with a community spouse, the value of one automobile is excluded regardless of its use or value.

c) For an SSI-related client, the department adds together the countable resources of both spouses if subsections (2), (5) and (8)(a) or (b) apply, but not if subsection (3) or (4) apply.

d) For an SSI-related client, excess resources are reduced:
i) In an amount equal to incurred medical expenses such as:
(a) Premiums, deductibles, and coinsurance/copayment charges for health insurance and Medicare;
(b) Necessary medical care recognized under state law, but not covered under medicaid;
(c) Necessary medical care covered under the state's medicaid plan incurred prior to medicaid eligibility.

e) Expenses not allowed to reduce excess resources or participation in personal care: Unpaid expense(s) prior to waiver eligibility to an adult family home (AFH) is not a medical expense. Personal care cost in excess of approved hours determined by the CARE assessment is not a medical expense.

f) The amount of excess resources is limited to the following amounts:
i) For LTC services provided under the categorically needy (CN) program:
(a) Gross income must be at or below the special income level (SIL), 300% of the federal benefit rate.
(b) In a medical institution, excess resources and income must be under the state medicaid rate.
(c) For CN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for CN-waiver eligibility.
ii) For LTC services provided under the medically needy (MN) program when excess resources are added to non excluded income, the combined total is less than the: Private medical institution rate plus the amount of recurring medical expenses for institutional services; or Private hospice rate plus the amount of recurring medical expenses, for hospice services in a medical institution. For MN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for MN-waiver eligibility.

g) For a client not related to SSI, the department applies the resource rules of the program used to relate the client to medical eligibility.

8) For legally married clients when only one spouse meets institutional status, the following rules apply. If the client's current period of institutional status began on or after October 1, 1989, the department adds together the total amount of nonexcluded resources held in the name of: either spouse; or both spouses.

9) If subsection (8)(b) of this section applies, the department determines the amount of resources that are allocated to the community spouse before determining countable resources used to establish eligibility for the institutionalized spouse, as follows:

a) If the client's current period of institutional status began on or after October 1, 1989 and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law. Effective January 1, 2009, the maximum allocation is one hundred and nine thousand five hundred and sixty dollars. This standard increases annually on January 1st based on the consumer price index. (For the current standard starting January 2009 and each year thereafter, see LTC standards at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml); or

b) If the client's current period of institutional status began on or after August 1, 2003, the department allocates the greater of:
i) A spousal share equal to one-half of the couple's combined countable resources as of the beginning of the current period of institutional status, up to the amount described in subsection (9)(a) of this section; or
ii) The state spousal resource standard of forty-five thousand one hundred four dollars effective July 1, 2007 through June 30, 2009. Effective July 1, 2009 this standard increases to forty-eight thousand six hundred thirty-nine dollars (this standard increases every odd year on July 1st). This increase is based on the CPI published by the federal bureau of labor statistics.

10) The amount of the spousal share described in (9)(b)(i) can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTC services is determined. The following rules apply to the determination of the spousal share:

a) Prior to an application for LTC services, the couple's combined countable resources are evaluated from the date of the current period of institutional status at the request of either member of the couple. The determination of the spousal share is completed when documentation and/or verification is provided; or

b) The determination of the spousal share is completed as part of the application for LTC services if the client was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.

11) The amount of allocated resources described in subsection (9) of this section can be increased, only if:
A court transfers additional resources to the community spouse; or an administrative law judge establishes in a fair hearing that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

12) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (5) or (13)(a), (b), or (c) of this section applies.

13) A redetermination of the couple's resources as described in subsection (7) is required, if:

a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;
b) The institutionalized spouse's countable resources exceed the standard described in subsection (1)(a), if subsection (8)(b) applies; or
c) The institutionalized spouse does not transfer the amount described in subsections (9) or (11) to the community spouse or to another person for the sole benefit of the community spouse either: the first regularly scheduled eligibility review; or the reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.

WAC 388-513-1315.....Eligibility for long-term care (institutional, waiver, and hospice) services.
This section describes how the department determines a client's eligibility for medical for clients residing in a medical institution, on a waiver, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under the general assistance (GA) program and the state funded nursing facility program.

1) To be eligible for long-term care (LTC) services described in this section, a client must:

a) Meet the general eligibility requirements for medical programs
b) Attain institutional status
c) Meet functional eligibility
d) Not have a penalty period of ineligibility
e) Not have equity interest greater than five hundred thousand dollars in their primary residence
f) Must disclose to the state any interest the applicant or spouse has in an annuity and meet requirements

2) To be eligible for institutional, waiver, or hospice services under the CN program, a client must either:

a) Be related to the Supplemental Security Income (SSI) program by having:

i) Gross non excluded income described in subsection (8)(a) that does not exceed the special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); and
ii) Countable resources described in subsection (7) that do not exceed the resource standard
b) Be approved and receiving the general assistance expedited medicaid disability (GA-X) or general assistance aged (GA-A) or general assistance disabled (GA-D) or
c) Be eligible for CN apple health for kids

3) The department allows a client to reduce countable resources in excess of the standard

4) To be eligible for waiver services, a client must meet the program requirements described in:
a) WAC 388-515-1505 through 388-515-1509 for COPES, New Freedom, PACE, and WMIP services; or
b) WAC 388-515-1510 through 388-515-1514 for DDD waivers; or
c) WAC 388-515-1540 for the medically needy residential waiver (MNRW); or
d) WAC 388-515-1550 for the medically needy in-home waiver (MNIW).

5) To be eligible for hospice services under the CN program, a client must:
a) Meet the program requirements
b) Be eligible for a non institutional categorically needy program (CN-P) if not residing in a medical institution thirty days or more; or
c) Reside at home and benefit by using home and community based waiver rules
d) Receive home and community waiver (HCS) or DDD waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or
e) Be eligible for institutional CN if residing in a medical institution thirty days or more.

6) To be eligible for institutional or hospice services under the MN program, a client must be:
a) Eligible for MN children's medical program
b) Related to the SSI program as described in WAC 388-475-0050 and meet all requirements described in WAC 388-513-1395; or
c) Eligible for the MN SSI related program described in WAC 388-475-0150 for hospice clients residing in a home setting; or
d) Eligible for the MN SSI related program described in WAC 388-513-1305 for hospice clients not on a medically needy waiver and residing in an alternate living facility.
e) Be eligible for institutional MN if residing in a medical institution thirty days or more.

7) To determine resource eligibility for an SSI-related client under the CN or MN program, the department: Considers resource eligibility and standards described in WAC 388-513-1350; and evaluates the transfer of assets as described in WAC 388-513-1363, -1364, -1365 or -1366.

8) To determine income eligibility for an SSI-related client under the CN or MN program, the department:
a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;
b) Excludes income for CN and MN programs as described in WAC 388-513-1340;
c) Disregards income for the MN program as described in WAC 388-513-1345; and
d) Follows program rules for the MN program as described in WAC 388-513-1395.

9) A client who meets the requirements of the CN program is approved for a period of up to 12 months.

10) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395(6) for: Institutional services or Hospice services in a medical institution.

11) The department determines eligibility for the state funded nursing facility. Nursing facility services under the state funded nursing facility program must be preapproved by aging and disability services administration (ADSA).

12) The department determines eligibility for institutional services under the GA program described in WAC 388-448-0001 for a client who meets all other requirements for such services but is not eligible for programs described in subsections (9) through (11).

13) A client is eligible for medicaid as a resident in a psychiatric facility, if the client:
- a) Has attained institutional status
- b) Is under the age of twenty-one at the time of application; or
- c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or
- d) Is at least sixty-five years old.

14) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

15) If an individual under age twenty one is not eligible for medicaid under SSI related in WAC 388-475-0050 or general assistance (GA) described in WAC 388-448-0001 and 388-505-0110(6).

16) Noncitizen individuals under age nineteen can be considered for the apple health for kids program described in WAC 388-505-0210 if they are admitted to a medical institution for less than thirty days. Once an individual resides or is likely to reside in a medical institution for thirty days or more, the department determines eligibility under WAC 388-505-0260 and must be preapproved for coverage by ADSA.

17) The department determines a client's total responsibility to pay toward the cost of care for LTC services as follows:
- a) For SSI-related clients residing in a medical institution see WAC 388-513-1380;
- b) For clients receiving HCS CN waiver services see WAC 388-515-1509;
- c) For clients receiving DDD CN waiver services see WAC 388-515-1514;
- d) For clients receiving HCS MN waiver services see WAC 388-515-1540 or 388-515-1550; or
- e) For TANF related clients residing in a medical institution see WAC 388-505-0265.

18) Clients not living in a medical institution who are considered to be receiving SSI benefits for the purposes of medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505 through -1509 or -1514. Groups deemed to be receiving SSI and medicaid are eligible to receive CN-P medicaid. These groups are described in WAC 388-475-0880.

WAC 388-513-1363….. Evaluating the transfer of assets on or after May 1, 2006 for persons applying for or receiving long-term care (LTC) services.

This section describes how the department evaluates asset transfers made on or after May 1, 2006 and their affect on LTC services. This applies to transfers by the client, spouse, a guardian or through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.

1) When evaluating the effect of the transfer of asset made on or after May 1, 2006 on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look-back" period.

2) The department does not apply a penalty period to transfers meeting the following conditions:
- a) The total of all gifts or donations transferred do not exceed the average daily private nursing facility rate in any month;
- b) The transfer is an excluded resource described in WAC 388-513-1350 with the exception of the client's home, unless the transfer of the home meets the conditions described in subsection (2)(d);
- c) The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:
- i) An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.

ii) The transfer is not made to qualify for LTC services, continue to qualify, or avoid Estate Recovery. Convincing evidence must be presented regarding the specific purpose of the transfer.
iii) All assets transferred for less than fair market value have been returned to the client.
iv) The denial of eligibility would result in an undue hardship as described in WAC 388-513-1367.
d) The transfer of ownership of the client's home, if it is transferred to the client's:
i) Spouse; or
ii) Child, who: meets the disability criteria or is less than twenty-one years old; or lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the individual to remain in the home; or
iii) Brother or sister, who has: equity in the home, and lived in the home for at least one year immediately before the client's current period of institutional status.
e) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria
f) The transfer meets the conditions described in subsection (3), and the asset is transferred:
i) To another person for the sole benefit of the spouse;
ii) From the client's spouse to another person for the sole benefit of the spouse;
iii) To trust established for the sole benefit of the individual's child who meets the disability criteria (iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria

3) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (1)(f), if the transfer or trust:
a) Is established by a legal document that makes the transfer irrevocable;
b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and
c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term of the trust, whichever is less.

4) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:
a) The transfer is in exchange for care services the family member provided the client;
b) The client has a documented need for the care services provided by the family member;
c) The care services provided by the family member are allowed under the medicaid state plan or the department's waiver services;
d) The care services provided by the family member do not duplicate those that another party is being paid to provide;
e) The FMV of the asset transferred is comparable to the FMV of the care services provided;
f) The time for which care services are claimed is reasonable based on the kind of services provided; and
g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

5) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (4) as the transfer of an asset without adequate consideration.

6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the individual is not eligible for LTC services.

7) If a client or the client's spouse transfers an asset after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:
a) For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or
b) For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and

c) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later.

8) If an asset is sold, transferred, or exchanged, the portion of the proceeds: that is used within the same month to acquire an excluded resource does not affect the client's eligibility; that remains after an acquisition becomes an available resource as of the first day of the following month.

9) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules.

10) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;
b) The amount described in subsection (10)(a) is divided by the statewide average daily private cost for nursing facilities at the time of application; and
c) A penalty period equal to the number of whole days found by subsections (7)(a), (b), and (c).

11) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services; we divide the penalty between the two spouses; if one spouse is no longer subject to a penalty (e.g. the spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.

12) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing.

13) Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

a) RCW 74.08.331 Unlawful practices — Obtaining assistance — Disposal of realty;
b) RCW 74.08.338 Real property transfers for inadequate consideration;
c) RCW 74.08.335 Transfers of property to qualify for assistance; and
d) RCW 74.39A.160 Transfer of assets—Penalties.

WAC 388-561-0201..... Annuities established on or after April 1, 2009.

1) The department determines how annuities affect eligibility for medical programs. Applicants and recipients of Medicaid must disclose to the state any interest the applicant or spouse has in an annuity.

2) A revocable annuity is considered an available resource.

3) The following annuities are not considered an available resource or a transfer of a resource as described in WAC 388-513-1363, if the annuity meets the requirements described in (4)(d), (e) and (f) of this subsection:

a) An annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986;
b) Purchased with proceeds from an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code of 1986;
c) Purchased with proceeds from a simplified employee pension (within the meaning of section 408 of the Internal Revenue Code of 1986); or
d) Purchased with proceeds from a Roth IRA described in section 408A of the I.R.C. 1986.

4) The purchase of an annuity not described in subsection (3) established on or after April 1, 2009, will be considered as an available resource unless it: is immediate, irrevocable, non assignable; and is paid out in equal monthly amounts with no deferral and no balloon payments:

a) Over a term equal to the actuarial life expectancy of the annuitant; or

b) Over a term that is not less than five years if the actuarial life expectancy of the annuitant is at least five years;
c) Over a term not less than the actuarial life expectancy of the annuitant, if the actuarial life expectancy of the annuitant is less than five years.
d) Actuarial life expectancy shall be determined by tables that are published by the office of the chief actuary of the social security administration

e) Names the state as the remainder beneficiary when the purchaser of the annuity is the annuitant and is an applicant for or recipient of medicaid, or a community spouse of an applicant for or recipient of long-term care or waiver services:
i) In the first position for the total amount of medical assistance paid for the individual, including both long-term care services and waiver services; or
ii) In the second position for the total amount of medical assistance paid for the individual, including both long-term care services and waiver services, if there is a community spouse, or a minor or disabled child who is named as the beneficiary in the first position.

f) Names the state as the beneficiary upon the death of the community spouse for the total amount of medical assistance paid on behalf of the individual at any time of any payment from the annuity if a community spouse is the annuitant;

g) Names the state as the beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual at the time of any payment from the annuity, including both long-term care services and waiver services, unless the annuitant has a community spouse or minor or disabled child. If the annuitant has a community spouse or minor or disabled child, such spouse or child may be named as beneficiary in the first position, and the state shall be named as beneficiary in the second position:
i) If the community spouse, minor or disabled child, or representative for a child named as beneficiary is in the first position and transfers his or her right to receive payments from the annuity for less than fair market value, then the state shall become the beneficiary in the first position.

5) If the annuity is not considered a resource, the stream of income produced by the annuity is considered available income.

6) An irrevocable annuity established on or after April 1, 2009 that meets all of the requirements of subsection (4) except that it is not immediate or scheduled to be paid out in equal monthly amounts will not be treated as a resource if: the full pay out is within the actuarial life expectancy of the annuitant.

7) An irrevocable annuity, established on or after April 1, 2009 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource.

8) An irrevocable annuity established on or after April 1, 2009 that meets all of the requirements of subsection (4) or (5) is considered unearned income when the annuitant is:
a) The client;
b) The spouse of the client;
c) The blind or disabled child of the client; or
d) A person designated to use the annuity for the sole benefit of the client, client's spouse, or a blind or disabled child of the client.

9) An annuity is not considered an available resource when there is a joint owner, co-annuitant or an irrevocable beneficiary who will not agree to allow the annuity to be cashed, unless the joint owner or irrevocable beneficiary is the community spouse. In the case of a community spouse, the cash surrender value of the annuity is considered an available resource and counts toward the maximum community spouse resource allowance.

10) Nothing in this section shall be construed as preventing the department from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity.

WAC 284-83-055.....Requirement to Offer Inflation Protection

No issuer may offer a long-term care insurance policy in this state unless the issuer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Issuers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than five percent.

2) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit must be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit.

3) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

4) If the policy is issued to a group, the required offer must be made to the group policyholder.

5) Disclosure of any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

6) Inflation protection must be included in any long-term care insurance policy unless the issuer obtains a rejection of inflation protection signed by the policyholder. The rejection may be either part of the application or on a separate form. The rejection is considered a part of the application.

WAC 284-83-110.....Suitability - Disclosure

1) Every issuer or other entity marketing long-term care insurance must:

a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

b. Train its insurance producers in the use of its suitability standards; and

c. Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

2) To determine whether the applicant meets the standards developed by the issuer, the insurance producer and the issuer must develop procedures that take the following into consideration:

a. The ability to pay for the proposed coverage and other financial information related to the coverage;

b. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

c. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

3) The issuer, and if an insurance producer is involved, the insurance producer must make reasonable efforts to obtain the information of this section. The efforts must include presentation to the applicant, at or prior to application, the "long-term care insurance personal worksheet." The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the form of the issuer's personal worksheet must be filed with the commissioner.

4) Except for sales of employer-group long-term care insurance to employees and their spouses, a completed personal worksheet must be returned to the issuer prior to the issuer's consideration of the applicant for coverage.

5) The issuer must use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to the applicant is appropriate.

6) Insurance producers must use the suitability standards developed by the issuer in all marketing or solicitation of long-term care insurance.

7) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "***things you should know before you buy long-term care insurance***" must be provided.

8) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. If the applicant declines to provide financial information, the issuer may use another method to verify the applicant's intent. The applicant's returned letter or a record of the alternative method of verification must be made part of the applicant's file.

9) The issuer must report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

WAC 284-83-140..... Qualified long-term care insurance policies—Additional standards for benefit triggers.

1) For purposes of this section the following definitions apply:

a) "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

b) "Chronically ill individual" means any individual who has been certified by a licensed health care practitioner as: Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least ninety days due to a loss of functional capacity; or requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(c) "Licensed health care practitioner" means a physician, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the federal Secretary of the Treasury.

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

2) A qualified long-term care insurance policy must pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

3) A qualified long-term care insurance policy must condition the payment of benefits on a determination that the insured is a chronically ill individual as defined in subsection (1)(b)(i) of this section.

4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (3) of this section must be performed by a licensed or certified physician, registered professional nurse, or licensed social worker.

5) Certifications required pursuant to subsection (3) of this section may be performed by a licensed health care professional at the direction of the issuer as is reasonably necessary with respect to a specific claim; except that when a licensed health care practitioner has certified that the insured is unable to perform activities of daily living for an expected period of at least ninety days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(6) Qualified long-term care insurance policies must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

WAC 284-83-400.....**Purpose and authority.** The purpose of these sections is to effectuate chapter 48.85 RCW, the Washington Long-Term Care Partnership Act. Pursuant to RCW 48.85.030, these sections establish minimum standards

and disclosure requirements to be met by insurers, health care service contractors, health maintenance organizations, and fraternal benefit societies with respect to long-term care partnership insurance policies to include: Contracts, certificates, riders, and endorsements.

WAC 284-83-405.....Applicability and scope. WAC 284-83-400 through 284-83-420 applies to any qualified long-term care insurance partnership policy, as defined by federal law and this chapter. These sections do not apply to Medicare supplement policies regulated under chapters 48.66 RCW and 284-55 or 284-66 WAC; or to long-term care insurance policies that are not intended to provide asset protection under chapter 48.85 RCW.

- ✓ Policies that do not meet the requirements of the Washington Long-Term Care Partnership Act and the requirements of this chapter may not be advertised, issued or delivered in this state as partnership policies.

WAC 284-83-410 ....**Minimum standards for long-term care partnership policies.** Every long-term care partnership policy must meet the standards for long-term care policies or contracts in chapters 48.83 and 48.85 RCW and this chapter, unless specifically provided otherwise.

1) As used in WAC 284-83-400 through 284-83-420, "qualified long-term care partnership policy" or "partnership policy" means a long-term care policy that meets all of the following additional requirements:

a) The policy was issued on or after January 1, 2012, or exchanged as provided in WAC 284-83-415 on or after January 1, 2012, and covers an insured who was a resident of this state or of another state that has entered into a reciprocal agreement with this state when coverage first became effective under the policy.
b) The policy is a tax qualified policy as defined in Section 7702B(b) of the IRC.
c) The policy provides minimum levels of inflation protection.

2) Issuers must file a long-term care insurance policy for approval for use as a partnership policy. The long-term care Partnership Policy Certification Form must be completed and accompany the request for approval. The form is available on the commissioner's web site: www.insurance.wa.gov.

3) Issuers requesting to make use of a previously approved policy form as a qualified state long-term care partnership policy must: submit to the commissioner a Partnership Policy Certification Form signed by an officer of the company; and file for approval an amendatory rider or endorsement indicating the policy is partnership qualified.

4) An issuer or its agent, soliciting or offering to sell a policy that is intended to qualify as a partnership policy, must provide to each prospective applicant a Partnership Program Notice found on the commissioner's web site: www.insurance.wa.gov, outlining the requirements and benefits of a partnership policy. The Partnership Program Notice must be provided with the required outline of coverage.

5) A partnership policy issued for delivery in Washington must be accompanied by a Partnership Status Disclosure Notice found on the commissioner's web site: www.insurance.wa.gov, explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified Washington state long-term care insurance partnership policy. The Partnership Disclosure Notice must also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for medicaid.

WAC 284-83-415... If a long-term care policy or certificate replaces another long-term care policy or certificate, the replacing issuer must waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

WAC 284-83-415 ....**Long-term care partnership policy exchange or replacement.**
1) Within one year of the date that an issuer begins to advertise, market, offer, or sell policies that qualify under the Washington state long-term care partnership program, the issuer must offer to all of its current policyholders and certificate holders the opportunity to exchange their existing long-term policy for a policy that is intended to qualify under the state's long-term care partnership program; provided that the existing long-term care policy was issued on or after February 8, 2006, and the existing long-term care policy is the type certified by the issuer for purposes of the state long-term care partnership program.

2) In making an offer to exchange, an issuer must offer must be made on a nondiscriminatory basis without regard to the age or health status of the insured and the offer must remain open for a minimum of ninety days from the date of mailing by the issuer.

3) An exchange occurs when an issuer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care policy with a policy that qualifies as a LTC partnership policy, and the insured accepts the offer to terminate the existing policy and accepts the new policy.

4) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and an offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care partnership program and the insured is not eligible to purchase the additional benefits under the issuer's LTC underwriting guidelines.
5) If the partnership policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then the following requirements apply: the partnership policy must not be underwritten; and the rate charged for the partnership policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

6) If the partnership policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then the following requirements apply: the issuer must apply its LTC underwriting guidelines to the increased benefits only; and the rate charged for the partnership policy must be determined using the method set forth in subsection (5)(b) of this section for the existing benefits, increased by the rate for the increased benefits using the then current attained age and risk class.

7) The partnership policy offered in an exchange must be on a form that is currently offered for sale by the issuer in the general market.

8) In the event of an exchange, the insured must not lose any rights, benefits, or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy including, but not limited to, rights established because of the lapse of time related to preexisting condition exclusions, elimination periods, or incontestability clauses.

9) Issuers may complete an exchange by either issuing a new policy or by amending an existing policy.

10) For those insureds with long-term care policies issued before February 8, 2006, an issuer may offer an insured the option to exchange an existing policy for a policy that qualifies as a Washington state long-term partnership policy.

WAC 284-83-420...Reporting. All issuers of qualified long-term care partnership policies must provide regular reports to the United States Secretary of Health and Human Services in accordance with regulations of the secretary. These reports include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the secretary determines may be appropriate to the administration of partnership policies.

WAC 284-83-425...Producer education. Prior to selling, soliciting, or negotiating, or continuing to sell, solicit, or negotiate long-term care partnership policies in this state, all licensed producers must meet the education requirements.

RCW 48.85.010....Washington long-term care partnership program. The department of social and health services shall, in conjunction with the office of the insurance commissioner, coordinate a long-term care insurance program entitled the Washington long-term care partnership, whereby private insurance and medicaid funds shall be used to finance long-term care.

48.85.020...Protection of assets — Federal approval — Rules. The department of social and health services shall seek approval from the federal health care financing administration to allow the protection of an individual's assets as provided in this chapter. The department shall adopt all rules necessary to implement the Washington long-term care partnership program, which rules shall permit the exclusion of all or some of an individual's assets in a manner specified

by the department in a determination of medicaid eligibility to the extent that private long-term care insurance provides payment or benefits for services.

48.85.030....Insurance policy criteria — Rules.
1) The insurance commissioner shall adopt rules defining the criteria that qualified long-term care partnership insurance policies must meet to satisfy the requirements of this chapter.

2) Insurers offering long-term care policies for the purposes of this chapter shall demonstrate to the satisfaction of the insurance commissioner that they:

a) Have procedures to provide notice to each purchaser of the LTC consumer education program;

b) Have procedures that provide for the keeping of individual policy records and procedures for the explanation of coverage and benefits identifying those payments or services available under the policy;

c) Agree to provide the insurance commissioner any required annual report containing information derived from the long-term care partnership long-term care insurance uniform data.

48.85.040...Consumer education program. The insurance commissioner shall, with the cooperation of the department of social and health services and members of the long-term care insurance industry, develop a consumer education program designed to educate consumers as to the need for long-term care, methods for financing long-term care, the availability of long-term care insurance, and the availability and eligibility requirements of the asset protection program provided under this chapter.

Medicaid Eligibility Issues for Long-Term Care Insurance Partnership Programs

1. Asset Protection.... The asset protection feature of the Partnership program is an incentive to potential buyers because it allows consumers to retain a pre-specified amount of assets and still be eligible for Medicaid benefits if and when additional long-term care coverage (beyond what the policies provide) is needed. Without the asset protection provision of the Partnership, a person of limited means may not opt to purchase long-term care coverage at all.

Under the asset protection program, a policyholder is allowed to keep an amount of assets equal to the amount the insurance pays out for their long-term care. The assets protected are over and above any other asset that would normally be exempt or non-countable in the Medicaid eligibility determination process.

2. Asset Transfers.... Through the DRA, the penalty for transferring assets to gain Medicaid eligibility was increased by extending the look back period from three to five years, and adjusting the start date for the penalty period to the date of Medicaid application. As a result, it becomes more difficult and costly for a consumer to give away assets to gain Medicaid eligibility. If a person transfers assets, then he or she must pay out of pocket an amount equal to the amount they had transferred, thus defeating the purpose of the transfer.

3. Home Equity..... The DRA designates anyone with home equity above $500,000 ineligible for Medicaid benefits. States have the option of increasing this limit to $750,000. The goal of this provision is to encourage the use of home equity to pay for needed care. It is also intended to get people with significant home equity to think about purchasing insurance against the risk of long-term care so their home is not at risk if care is needed.

The home equity limit is new to Medicaid and has prompted questions from both the original Partnership states and those who are looking to become Partnership states. The Centers for Medicare and Medicaid Services (CMS) has been asked if the asset protection can be used to increase the home equity value provision. For example, could someone with a Partnership policy providing $100,000 in asset protection use that to increase the protected value of their home to $600,000 and still qualify for Medicaid?

For technical reasons, the CMS response was negative. The home equity value language falls under the Medicaid payments law provision, while the Partnership language of the DRA falls under Medicaid eligibility law provisions. As such, the home equity value provision creates a new test for Medicaid eligibility. The person must qualify regarding income, then assets, then the home equity value before being eligible for Medicaid long-term care payments.

For the original Partnership states and insurers this policy is problematic because grandfathering exemptions on this Medicaid Eligibility Issues for Long-Term Care Insurance Partnership Programs 2 provision have not been offered for Partnership policies purchased before the home equity restriction was in place.

4. The following individuals may be eligible to receive Medicaid payment for long-term care services, notwithstanding possessing home equity in excess of $750,000:

- ✓ individuals who demonstrate, to the satisfaction of the Department, that they cannot obtain a reverse mortgage, home equity loan or similar instrument; and

- ✓ individuals eligible for Long-Term Care Insurance in an amount greater than or equal to the amount of home equity in excess of $750,000, plus the amount of any other counted assets.

These provisions will likely give policy holders the original expectation of asset protection that existed prior to the DRA provision. It remains to be determined if similar provisions could be implemented in new Partnership states to meet the special individual circumstances.

5. Exhaustion of Benefits Requirements
One issue that has sparked early controversy is whether or not the insured person could be eligible for Medicaid before exhausting his or her insurance benefits. Under certain circumstances, it is possible for a person to need to spend protected assets before exhausting his or her private Partnership policy benefits. In such a situation, beneficiaries were allowed to protect assets equal to what their policy had paid out to-date. A person would then be able to have Medicaid pay along with the remaining insurance instead of using the protected assets to fill in remaining gaps in coverage. Over time, the asset protection amount would actually increase as the insurance continued to pay benefits. The continued accumulation of asset protection could serve to protect earnings on existing protected assets, an inheritance, or home equity that might otherwise be subject to recovery.

"The DRA does not require that benefits available under a Partnership policy be fully exhausted before the disregard of resources can be applied. Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the individual as of the month of application, even if additional benefits remain available under the terms of the policy."

6. Services Qualified for Asset Disregard
Another issue raised and resolved in the original Partnership states relates to whether there would be any special limits placed on the types of services paid for by the private long-term care insurance. For example, if the policy paid for assisted living and a state did not cover assisted living as a Medicaid benefit, was it acceptable for the insured to gain asset protection by using such a benefit? Though there was some early resistance to this, the original Partnership states decided that this situation was no different than if the person had used his or her own money in paying for such care, which could impoverish them and qualify them for Medicaid. However, it must be noted that the insured person, upon applying for Medicaid, would not be eligible for assisted living if assisted living was not a Medicaid-covered benefit in that state. If the person wanted to continue in assisted living, he or she might have to use some protected assets to secure the necessary mix of housing along with Medicaid home care support.

7. Tracking Protected Assets
Tracking protected assets is an additional consideration in the Medicaid eligibility process for Partnership states. One option states may use to track protected assets is to require that beneficiaries designate assets to be protected. The rational for tracking protected assets is to avoid double counting, i.e., allowing policyholders to spend protected assets, and then also claim exemption from estate recovery for the original protected amount.

With any Medicaid applicant, asset identification is part of the normal eligibility process. Total assets remaining that need to be spent before Medicaid eligibility must be compared to the amount of protected assets per the dollar-for-dollar Partnership insurance payout rules in the state. The only assets protected (over and above those protected under the regular Medicaid rules in the state, e.g., burial plots and spousal protection benefits) are those that are equal to or less than the amount of asset protection earned with the Partnership insurance.

With the amount of protected assets identified and eligibility established, states can use periodic eligibility redetermination checks to review the client's financial transactions over the most recent period. In Connecticut, one of the original Partnership states, if a protected asset is sold or transferred, then the original amount is reduced for both asset disregard and estate recovery. When assets grow in value, the extra money must be spent on the cost of care. However, if an asset had lost value, earnings are allowed to increase to the most recent protected amount.

8. Eligibility Reciprocity Among Partnership States
It is still not clear how important reciprocity of Medicaid eligibility will be to widespread multi-state replication of the Partnership. With reciprocity, a state may worry that it will end up having to provide Medicaid benefits to insured persons who exhaust their private Partnership policy benefits but who were not originally tax-paying residents. Conversely, a state may see the benefit of having new incoming residents who already have long-term care insurance.

The marketing message to consumers is simpler and cleaner if both the basic benefits of the insurance and the Medicaid eligibility rules regarding asset protection are portable. However, without special provisions only the insurance benefits themselves (not the asset protection provisions) can be accessed in a state other than the state where the Partnership policy was purchased. To remedy this, Congress required the development of reciprocity standards under the DRA Section 6021(b). It states in its entirety:

9. Standards For Reciprocal Recognition Among Partnership States..... In order to permit portability in long-term care insurance policies purchased under State long-term care insurance partnerships, the Secretary of Health and Human Services shall develop, in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care partnership plans, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among States with qualified State LTC insurance partnerships under which—

1) benefits paid under such policies will be treated the same by all such States; and
2) States with such partnerships shall be subject to such standards unless the State notifies the Secretary in writing of the State's election to be exempt from such standards.

In response, the Department of Health and Human Services (HHS) drafted reciprocity standards. All states with approved Partnership program State Plan Amendments are required to accept those standards unless they explicitly opt out by notifying the Secretary of HHS. States can choose to opt in or out of the reciprocity agreement at any time. Policyholders, however, are subject to the reciprocity policy in the state of current residence. If that state has opted out of the reciprocity agreement, these policyholders may not be entitled to the asset protection that would be due to them in their original state of purchase.

10. Income Eligibility and Qualified Income Trusts
One final topic that is related to the Partnership has to do with Medicaid income eligibility. The Partnership incentive relates to the protection of assets, not Medicaid Eligibility Issues for Long-Term Care Insurance Partnership Programs. If the insured person's income is above the state's income eligibility limits, the income will have to be spent on the cost of care down to the income limit allowed in the state. But not all states allow spending down income in order to qualify for Medicaid. In some states there is a strict limit on the level of income a person can have to be eligible for Medicaid. In these states, where income spend down is not allowed, a person could need care that costs more than they had to spend while at the same time they could have more income than was allowed for Medicaid eligibility. This poses a special problem for Partnership programs, because consumers may fear that even though they have asset protection, they may never qualify for Medicaid due to income that exceeds eligibility limits.

Congress addressed this problem that allows for Qualified Income Trusts (QIT). This option permits a person to legally divert their excess income into a trust, after which the income is not counted toward the Medicaid eligibility income cap. Income paid to the trust can be used to purchase institutional services, home and community-based waiver services, or medical services for the beneficiary and not be countable for income eligibility purposes.

Conclusion

Medicaid is not uniform across states and it is not possible to predict what the program will look like in the future. It does, however, represent a safety net needed by those who are low income, and increasingly by a broader constituency

— those who are unable to cover the costs of long-term care services. This broader constituency includes many people who could shoulder some of their own long-term care costs, but do not have enough resources to guarantee never needing the safety net.

The Partnership long-term care insurance model offers consumers a way to prepare for their long-term care needs, while still having the assurance that the safety net will be there for them if necessary. The risk of impoverishment is greatly reduced because consumers can have confidence that their assets will not need to be totally depleted before that assistance is available. The Medicaid eligibility policies discussed are likely to influence how long-term care planning, including decisions about purchasing a Partnership-qualified insurance policy, are made.

ETHICS IN THE INSURANCE INDUSTRY

The word "ethics" is a derivative of two Greek words meaning "moral" and "character." Ethics represents a branch of study concerned with rules of conduct, morality, and duties which govern human behavior.

The insurance agent has many responsibilities, among them a responsibility to the insurance company, responsibility to the insurance professionals, responsibility to the client and responsibility to the public. In other words, the agent is obligated to act for the benefit of society at large.

Since insurance sales people are professional advisors, they need to be aware of their increased legal responsibility and increased legal risk. Ethics involves good business practices. The person who provides insurance coverage to a person becomes the person responsible for ascertaining the needs of clients and matching those needs with the technical aspects of a complex product. The aim is to be sure that the client's goals are met. Society as a whole also benefits by protecting individuals and families with life, health, auto, homeowners and business insurance.

This course is intended to use for the mandatory three hour ethics requirement by covering the RCWs and WACs that relate to insurance matters. Regulation of the insurance industry is shared by the individual states and the federal government. The following pages include some of the ideas of ethical business practices which are regulated by Washington State Government.

RCW 48.30.010…Unfair practices in general — Remedies and penalties.

(1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business as such methods, acts, or practices are defined pursuant to subsection (2) of this section.

(2) In addition to such unfair methods and unfair or deceptive acts or practices as are expressly defined and prohibited by this code, the commissioner may from time to time by regulation promulgated pursuant to chapter 34.05 RCW, define other methods of competition and other acts and practices in the conduct of such business reasonably found by the commissioner to be unfair or deceptive after a review of all comments received during the notice and comment rule-making period.

(3) In defining other methods of competition and other acts and practices in the conduct of such business to be unfair or deceptive, and after reviewing all comments and documents received during the notice and comment rule-making period, the commissioner shall identify his or her reasons for defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive and shall include a statement outlining these reasons as part of the adopted rule.

The commissioner shall include a detailed description of facts upon which he or she relied and of facts upon which he or she failed to rely, in defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive, in the concise explanatory statement prepared under RCW 34.05.325(6).

Upon appeal the superior court shall review the findings of fact upon which the regulation is based de novo on the record.

(4) No such regulation shall be made effective prior to the expiration of thirty days after the date of the order by which it is promulgated.

(5) If the commissioner has cause to believe that any person is violating any such regulation, the commissioner may order such person to cease and desist therefrom. The commissioner shall deliver such order to such person direct or mail it to the person by registered mail with return receipt requested. If the person violates the order after expiration of ten days after the cease and desist order has been received by him or her, he or she may be fined by the commissioner a sum not to exceed two hundred and fifty dollars for each violation committed thereafter.

(6) If any such regulation is violated, the commissioner may take such other or additional action as is permitted under the insurance code for violation of a regulation.

RCW 48.30.020…Anticompact law.

(1) ***No person shall either within or outside of this state enter into any contract, understanding or combination with any other person to do jointly or severally any act or engage in any practice for the purpose of:***

> (a) controlling the rates to be charged for insuring any risk or any class of risks in this state; or
>
> (b) unfairly discriminating against any person in this state by reason of his plan or method of transacting insurance, or by reason of his affiliation or nonaffiliation with any insurance organization; or
>
> (c) establishing or perpetuating any condition in this state detrimental to free competition in the business of insurance or injurious to the insuring public.

(2) This section shall not apply relative to ocean marine and foreign trade insurances.

(3) This section shall not be deemed to prohibit the doing of things permitted to be done in accordance with the provisions of chapter 48.19 RCW of this code.

(4) Whenever the commissioner has knowledge of any violation of this section he shall forthwith order the offending person to discontinue such practice immediately or show cause to the satisfaction of the commissioner why such order should not be complied with. If the offender is an insurer or a licensee under this code and fails to comply with such order within thirty days after receipt thereof, the commissioner may forthwith revoke the offender's certificate of authority or licenses.

RCW 48.30.030…False financial statements. No person shall knowingly file with any public official nor knowingly make, publish, or disseminate any financial statement of an insurer which does not accurately state the insurer's financial condition.

RCW 48.30.040…False information and advertising. No person shall knowingly make, publish, or disseminate any false, deceptive or misleading representation or advertising in the conduct of the business of insurance, or relative to the business of insurance or relative to any person engaged therein.

RCW 48.30.050…Advertising must show name and domicile. Every advertisement of, by, or on behalf of an insurer shall set forth the name in full of the insurer and the location of its home office or principal office, if any, in the United States (if an alien insurer).

RCW 48.30.060…Insurer name — Deceptive use prohibited. No person who is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer.

RCW 48.30.070…Advertising of financial condition.

(1) Every advertisement by or on behalf of any insurer purporting to show its financial condition may be in a condensed form but shall in substance correspond with the insurer's last verified statement filed with the commissioner.

(2) No insurer or person on its behalf shall advertise assets except those actually owned and possessed by the insurer in its own exclusive right, available for the payment of losses and claims, and held for the protection of its policyholders and creditors.

RCW 48.30.075…Using existence of insurance guaranty associations in advertising, etc., to sell insurance. No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement which uses the existence of the Washington Insurance Guaranty Association or the Washington Life and Disability Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Washington Insurance Guaranty Association Act or the Washington Life and Disability Insurance Guaranty Association Act.

RCW 48.30.080…Defamation of insurer. No person shall make, publish, or disseminate, or aid, abet or encourage the making, publishing, or dissemination of any information or statement which is false or maliciously critical and which is designed to injure in its reputation or business any authorized insurer or any domestic corporation or reciprocal being formed pursuant to this code for the purpose of becoming an insurer.

RCW 48.30.090…Misrepresentation of policies. No person shall make, issue or circulate, or cause to be made, issued or circulated any misrepresentation of the terms of any policy or the benefits or advantages promised thereby, or the dividends or share of surplus to be received thereon, or use any name or title of any policy or class of policies misrepresenting the nature thereof.

RCW 48.30.100…Dividends not to be guaranteed. No insurer, agent, broker, solicitor, or other person, shall guarantee or agree to the payment of future dividends or future refunds of unused premiums or savings in any specific or approximate amounts or percentages on account of any insurance contract. Violation of this law is considered "***illegal inducement***."

RCW 48.30.110…Contributions to candidates for insurance commissioner.

(1) No insurer or fraternal benefit society doing business in this state shall directly or indirectly pay or use, or offer, consent, or agree to pay or use any money or thing of value for or in aid of any candidate for the office of insurance commissioner; nor for reimbursement or indemnification of any person for money or property so used.

(2) Any individual who violates any provision of this section, or who participates in, aids, abets, advises, or consents to any such violation, or who solicits or knowingly receives any money or thing of value in violation of this section, shall be guilty of a gross misdemeanor and shall be liable to the insurer or society for the amount so contributed or received.

RCW 48.30.120…Misconduct of officers, employees.

No director, officer, agent, attorney in fact, or employee of an insurer shall:

(1) Knowingly receive or possess himself of any of its property, otherwise than in payment for a just demand, and with intent to defraud, omit to make or to cause or direct to be made, a full and true entry thereof in its books and accounts; nor

(2) Make or concur in making any false entry, or concur in omitting to make any material entry, in its books or accounts.

(3) Knowingly concur in making or publishing any written report, exhibit or statement of its affairs or pecuniary condition containing any material statement which is false, or omit or concur in omitting any statement required by law to be contained therein.

(4) Having the custody or control of its books, wilfully fail to make any proper entry in the books of the insurer as required by law, or to exhibit or allow the same to be inspected and extracts to be taken therefrom by any person entitled by law to inspect the same, or take extracts therefrom.

(5) If a notice of an application for an injunction or other legal process affecting or involving the property or business of the insurer is served upon him, fail to disclose the fact of such service and the time and place of such application to the other directors, officers, and managers thereof.

(6) Fail to make any report or statement lawfully required by a public officer.

RCW 48.30.130…Presumption of knowledge of director. A director of an insurer is deemed to have such knowledge of its affairs as to enable him to determine whether any act, proceeding, or omission of its directors is a violation of any provision of this chapter. If present at a meeting of directors at which any act, proceeding, or omission of its directors which is a violation of any such provision occurs, he must be deemed to have concurred therein unless at the time he causes or in writing requires his dissent therefrom to be entered on the minutes of the directors.

If absent from such meeting, he must be deemed to have concurred in any such violation if the facts constituting such violation appear on the records or minutes of the proceedings of the board of directors, and he remains a director of the insurer for six months thereafter without causing or in writing requiring his dissent from such violation to be entered upon such record or minutes.

RCW 48.30.140…Rebating.

(1) Except to the extent provided for in an applicable filing with the commissioner then in effect, no insurer, general agent, agent, broker, or solicitor shall, as an inducement to insurance, or after insurance has been effected, directly or indirectly, offer, promise, allow, give, set off, or pay to the insured or to any employee of the insured, any rebate, discount, abatement, or reduction of premium or any part thereof named in any insurance contract, or any commission thereon, or earnings, profits, dividends, or other benefit, or any other valuable consideration or inducement whatsoever which is not expressly provided for in the policy.

(2) Subsection (1) of this section shall not apply as to commissions paid to a licensed agent, general agent, broker, or solicitor for insurance placed on that person's own property or risks.

(3) This section shall not apply to the allowance by any marine insurer, or marine insurance agent, general agent, broker, or solicitor, to any insured, in connection with marine insurance, of such discount as is sanctioned by custom among marine insurers as being additional to the agent's or broker's commission.

(4) This section shall not apply to advertising or promotional programs conducted by insurers, agents, or brokers whereby prizes, goods, wares, or merchandise, not exceeding$100 in value per person in the aggregate in any twelve month period, are given to all insureds or prospective insureds under similar qualifying circumstances.

(5) This section does not apply to an offset or reimbursement of all or part of a fee paid to a broker as provided in RCW 48.17.270.

RCW 48.30.150…Illegal inducements.

No insurer, general agent, agent, broker, solicitor, or other person shall, as an inducement to insurance, or in connection with any insurance transaction, provide in any policy for, or offer, or sell, buy, or offer or promise to buy or give, or promise, or allow to, or on behalf of, the insured or prospective insured in any manner whatsoever:

(1) Any shares of stock or other securities issued or at any time to be issued on any interest therein or rights thereto; or

(2) Any special advisory board contract, or other contract, agreement, or understanding of any kind, offering, providing for, or promising any profits or special returns or special dividends; or

(3) Any prizes, goods, wares, or merchandise of an aggregate value in excess of $100 dollars.

This section shall not be deemed to prohibit the sale or purchase of securities as a condition to or in connection with surety insurance insuring the performance of an obligation as part of a plan of financing found by the commissioner to be designed and operated in good faith primarily for the purpose of such financing, nor shall it be deemed to prohibit

the sale of redeemable securities of a registered investment company in the same transaction in which life insurance is sold.

RCW 48.30.155…Life or disability insurers — Insurance as inducement to purchase of goods, etc. No life or disability insurer shall directly or indirectly participate in any plan to offer or effect any kind or kinds of insurance in this state as an inducement to the purchase by the public of any goods, securities, commodities, services or subscriptions to publications. This section shall not apply to group or blanket insurance issued pursuant to this code.

RCW 48.30.157…Charges for extra services. Notwithstanding the provisions of RCW 48.30.140, 48.30.150, and 48.30.155, the commissioner may permit an agent or broker to enter into reasonable arrangements with insureds and prospective insureds to charge a reduced fee in situations where services that are charged for are provided beyond the scope of services customarily provided in connection with the solicitation and procurement of insurance, so that an overall charge to an insured or prospective insured is reasonable, taking into account receipt of commissions and fees and their relation, proportionally, to the value of the total work performed.

RCW 48.30.170…Rebate — Acceptance prohibited. (1) No insured person shall receive or accept, directly or indirectly, any rebate of premium or part thereof, or any favor, advantage, share in dividends, or other benefits, or any valuable consideration or inducement not specified or provided for in the policy, or any commission on any insurance policy to which he or she is not lawfully entitled as a licensed agent, broker, or solicitor. The retention by the nominal policyholder in any group life insurance contract of any part of any dividend or reduction of premium thereon contrary to the provisions of RCW 48.24.260, shall be deemed the acceptance and receipt of a rebate and shall be punishable as provided by this code.

(2) The amount of insurance whereon the insured has so received or accepted any such rebate or any such commission, other than as to life or disability insurances, shall be reduced in the proportion that the amount or value of the rebate or commission bears to the premium for such insurance. In addition to such reduction of insurance, if any, such insured shall be liable to a fine of not more than two hundred dollars.

(3) This section shall not apply to an offset or reimbursement of all or part of a fee paid to a broker as provided in RCW 48.17.270.

RCW 48.30.180…"Twisting" prohibited. No person shall by misrepresentations or by misleading comparisons, induce or tend to induce any insured to lapse, terminate, forfeit, surrender, retain, or convert any insurance policy.

RCW 48.30.190…Illegal dealing in premiums. (1) No person shall wilfully collect any sum as premium for insurance, which insurance is not then provided or is not in due course to be provided by an insurance policy issued by an insurer as authorized by this code.

(2) No person shall wilfully collect as premium for insurance any sum in excess of the amount actually expended or in due course is to be expended for insurance applicable to the subject on account of which the premium was collected.

(3) No person shall wilfully or knowingly fail to return to the person entitled thereto within a reasonable length of time any sum collected as premium for insurance in excess of the amount actually expended for insurance applicable to the subject on account of which the premium was collected.

(4) Each violation of this section which does not amount to a felony shall constitute a misdemeanor.

RCW 48.30.200…Hypothecation of premium notes. It shall be unlawful for any insurer or its representative, or any agent or broker, to hypothecate, sell, or dispose of any promissory note, received in payment for any premium or part thereof on any contract of life insurance or of disability insurance applied for, prior to delivery of the policy to the applicant.

RCW 48.30.210…Misrepresentation in application for insurance. A person who knowingly makes a false or misleading statement or impersonation, or who willfully fails to reveal a material fact, in or relative to an application for insurance to an insurer, is guilty of a gross misdemeanor, and the license of any such person may be revoked.

RCW 48.30.220…Destruction, injury, secretion, etc., of property. Any person, who, with intent to defraud or prejudice the insurer thereof, burns or in any manner injures, destroys, secretes, abandons, or disposes of any property which is insured at the time against loss or damage by fire, theft, embezzlement, or any other casualty, whether the same be the property of or in the possession of such person or any other person, under circumstances not making the offense arson in the first degree, is guilty of a class C felony.

RCW 48.30.230…False claims or proof — Penalty.

(1) It is unlawful for any person, knowing it to be such, to:

(a) Present, or cause to be presented, a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under a contract of insurance; or

(b) Prepare, make, or subscribe any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with intent that it be presented or used in support of such a claim.

(2) A violation of this section is a gross misdemeanor. If the claim is in excess of one thousand five hundred dollars, the violation is a class C felony punishable according to chapter 9A.20 RCW.

RCW 48.30.240…Rate wars prohibited.

(1) Any insurer which precipitates, or aids in precipitating or conducting a rate war and by so doing writes or issues a policy of insurance at a less rate than permitted under its schedules filed with the commissioner, or below the rate deemed by him to be proper and adequate to cover the class of risk insured, shall have its certificate of authority to do business in this state suspended until such time as the commissioner is satisfied that it is charging a proper rate of premium.

(2) Any insurer which has precipitated, or aided in precipitating or conducting a rate war for the purpose of punishing or eliminating competitors or stifling competition, or demoralizing the business, or for any other purpose, and has ordered the cancellation or rewriting of policies at a rate lower than that provided by its rating schedules where such rate war is not in operation, and has paid or attempted to pay to the insured any return premiums, on any risk so to be rewritten, on which its agent has received or is entitled to receive his regular commission, such insurer shall not be allowed to charge back to such agent any portion of his commission on the grounds that the same has not been earned.

RCW 48.30.260…Right of debtor or borrower to select agent, broker, insurer.

(1) Every debtor or borrower, when property insurance of any kind is required in connection with the debt or loan, shall have reasonable opportunity and choice in the selection of the agent, broker, and insurer through whom such insurance is to be placed; but only if the insurance is properly provided for the protection of the creditor or lender, whether by policy or binder, not later than at commencement of risk as to such property as respects such creditor or lender, and in the case of renewal of insurance, only if the renewal policy, or a proper binder therefore containing a brief description of the coverage bound and the identity of the insurer in which the coverage is bound, is delivered to the creditor or lender not later than thirty days prior to the renewal date.

(2) Every person who lends money or extends credit and who solicits insurance on real and personal property must explain to the borrower in prominently displayed writing that the insurance related to such loan or credit extension may be purchased from an insurer or agent of the borrower's choice, subject only to the lender's right to reject a given insurer or agent as provided in subsection (3)(b) of this section.

(3) No person who lends money or extends credit may:

(a) Solicit insurance for the protection of property, after a person indicates interest in securing a loan or credit extension, until such person has received a commitment from the lender as to a loan or credit extension;

(b) Unreasonably reject a contract of insurance furnished by the borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards,

uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for rejection of an insurance contract because the contract contains coverage in addition to that required in the credit transaction;

(c) Require that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge, in connection with the handling of any contract of insurance required as security for a loan, or pay a separate charge to substitute the insurance policy of one insurer for that of another. This subsection does not include the interest which may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document;

(d) Use or disclose, without the prior written consent of the borrower, mortgagor, or purchaser taken at a time other than the making of the loan or extension of credit, information relative to a contract of insurance which is required by the credit transaction, for the purpose of replacing such insurance;

(e) Require any procedures or conditions of duly licensed agents, brokers, or insurers not customarily required of those agents, brokers, or insurers affiliated or in any way connected with the person who lends money or extends credit; or

(f) Require property insurance in an amount in excess of the amount which could reasonably be expected to be paid under the policy, or combination of policies, in the event of a loss.

(4) Nothing contained in this section shall prevent a person who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower, or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

(5) Nothing contained in this section shall apply to credit life or credit disability insurance.

RCW 48.30.300…Unfair discrimination, generally — Disability policies, specifically.

Notwithstanding any provision contained in Title 48 RCW to the contrary:

(1) No person or entity engaged in the business of insurance in this state shall refuse to issue any contract of insurance or cancel or decline to renew such contract because of the sex or marital status, or the presence of any sensory, mental, or physical handicap of the insured or prospective insured. The amount of benefits payable, or any term, rate, condition, or type of coverage shall not be restricted, modified, excluded, increased or reduced on the basis of the sex or marital status, or be restricted, modified, excluded or reduced on the basis of the presence of any sensory, mental, or physical handicap of the insured or prospective insured. Subject to the provisions of subsection (2) of this section, these provisions shall not prohibit fair discrimination on the basis of sex, or marital status, or the presence of any sensory, mental, or physical handicap when bona fide statistical differences in risk or exposure have been substantiated.

(2) With respect to disability policies issued or renewed on and after July 1, 1994, that provide coverage against loss arising from medical, surgical, hospital, or emergency care services:

(a) Policies shall guarantee continuity of coverage. Such provision, which shall be included in every policy, shall provide that: (i) The policy may be canceled or nonrenewed without the prior written approval of the commissioner only for nonpayment of premium or as permitted under RCW 48.18.090; and

(ii) The policy may be canceled or nonrenewed because of a change in the physical or mental condition or health of a covered person only with the prior written approval of the commissioner. Such approval shall be granted only when the insurer has discharged its obligation to continue coverage for such person by obtaining coverage with another insurer, health care service contractor, or health maintenance organization, which coverage is comparable in terms of premiums and benefits as defined by rule of the commissioner.

(b) It is an unfair practice for a disability insurer to modify the coverage provided or rates applying to an in-force disability insurance policy and to fail to make such modifications in all such issued and outstanding policies.

(c) Subject to rules adopted by the commissioner, it is an unfair practice for a disability insurer to:

(i) Cease the sale of a policy form unless it has received prior written authorization from the commissioner and has offered all policyholders covered under such discontinued policy the opportunity to purchase comparable coverage without health screening; or

(ii) Engage in a practice that subjects policyholders to rate increases on discontinued policy forms unless such policyholders are offered the opportunity to purchase comparable coverage without health screening.

The insurer may limit an offer of comparable coverage without health screening to a period not less than thirty days from the date the offer is first made.

RCW 48.30.310…Commercial motor vehicle employment driving record not to be considered. When an individual applies for a policy of casualty insurance providing either automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage, or automobile physical damage coverage on an individually owned passenger vehicle or a renewal of such policy, an insurer shall not consider the applicant's commercial motor vehicle employment driving record in determining whether the policy will be issued or renewed or in determining the rates for the policy. An insurer shall not cancel such policy or discriminate in regard to other terms or conditions of the policy based upon the applicant's commercial motor vehicle employment driving record.

"Employment driving record" means that record maintained by the director pertaining to motor vehicle accidents or convictions for violation of motor vehicle laws while the applicant is driving a commercial motor vehicle as an employee of another.

RCW 48.30.320…Notice of reason for cancellation, restrictions based on handicaps. Every authorized insurer, upon canceling, denying, or refusing to renew any individual life, individual disability, homeowner, dwelling fire, or private passenger automobile insurance policy, shall, upon written request, directly notify in writing the applicant or insured, as the case may be, of the reasons for the action by the insurer. ***The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability.***

RCW 48.30.330…Immunity from libel or slander. With respect to contracts of insurance as defined in RCW 48.30.320, there shall be no liability on the part of, and no cause of action of any nature shall arise against, the insurance commissioner, the commissioner's agents, or members of the commissioner's staff, or against any insurer, its authorized representative, its agents, its employees, furnishing to the insurer information as to reasons for cancellation or refusal to issue or renew, for libel or slander on the basis of any statement made by any of them in any written notice of cancellation or refusal to issue or renew, or in any other communications, oral or written, specifying the reasons for cancellation or refusal to issue or renew or the providing of information pertaining thereto, or for statements made or evidence submitted in any hearing conducted in connection therewith.

RCW 48.30A.005…Findings — Intent. The legislature finds that the business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. The payment of kickbacks, bribes, or rebates for referrals to service providers, as has been occurring with increasing regularity in this state, results in inflated or fraudulent insurance claims, results in greater insurance costs for all citizens, and is contrary to the public interest. The legislature finds that combating these practices requires laws carefully fashioned to identify practices that mimic customary business practices.

RCW 48.30A.015…Unlawful acts — Penalties.

(1) It is unlawful for a person:

(a) Knowing that the payment is for the referral of a claimant to a service provider, either to accept payment from a service provider or, being a service provider, to pay another; or

(b) To provide or claim or represent to have provided services to a claimant, knowing the claimant was referred in violation of (a) of this subsection.

(2) It is unlawful for a service provider to engage in a regular practice of waiving, rebating, giving, paying, or offering to waive, rebate, give, or pay all or any part of a claimant's casualty or property insurance deductible.

(3) A violation of this section constitutes trafficking in insurance claims.

(4)(a) Trafficking in insurance claims is a gross misdemeanor for a single violation.

(b) Each subsequent violation, whether alleged in the same or in subsequent prosecutions, is a class C felony.

RCW 48.30A.020…Defenses to proceedings under this chapter. In a proceeding under this chapter, it is a defense if proven by the defendant by a preponderance of the evidence that, at the time of the offense:

(1) The conduct alleged was authorized by the rules of professional conduct or the admission to practice rules for lawyers as adopted by the state supreme court, Washington business and professions licensing statutes, or rules adopted by the secretary of health or the director of licensing;

(2) The payment was an incidental nonmonetary gift or gratuity, or was purely social in nature;

(3) The conduct alleged was an exercise of a group-buying arrangement;

(4) The conduct alleged was a legal provider paying a service provider's bills from the proceeds of an insurance claim that included the bills;

(5) The conduct alleged was a legal provider paying for services of an expert witness, including reports, consultation, and testimony; or

(6) The conduct alleged was a service provider's purchase of advertising from an unrelated business that provides referrals from advertising for groups of ten or more service providers that are not related to the advertising business and not related to each other.

RCW 48.30A.030…Injunction available — Remedies — Costs — Attorneys' fees — Degree of proof — Time limit. Independent of authority granted to the attorney general, the prosecuting attorney may petition the superior court for an injunction against a person who has violated this chapter. Remedies in an injunctive action brought by a prosecuting attorney are limited to an order enjoining, restraining, or preventing the doing of any act or practice that constitutes a violation of this chapter and imposing a civil penalty of up to five thousand dollars for each violation. The prevailing party in the action may, in the discretion of the court, recover its reasonable investigative costs and the costs of the action including a reasonable attorney's fee. The degree of proof required in an action brought under this section is a preponderance of the evidence. An action under this section must be brought within three years after the violation of this chapter occurred.

RCW 48.30A.035…Detrimental judgment — Written notification to appropriate regulatory or disciplinary body or agency. Whenever a service provider or a person licensed by the state in a business or profession is convicted, enjoined, or found liable for damages or a civil penalty or other equitable relief under RCW 48.30A.030, the attorney general or the prosecuting attorney shall provide written notification of the judgment to the appropriate regulatory or disciplinary body or agency.

RCW 48.30A.040…Violation — Cause for discipline — Unprofessional conduct — Regulatory penalty. A violation of this chapter is cause for discipline and constitutes unprofessional conduct that could result in any regulatory penalty provided by law, including refusal, revocation, or suspension of a business or professional license, or right or admission to practice. Conduct that constitutes a violation of this chapter is unprofessional conduct in violation of RCW 18.130.180.

RCW 48.30A.045…Insurance antifraud plan — File plan and changes with commissioner — Exemptions.

(1) Each insurer licensed to write direct insurance in this state, except those exempted in subsection (2) of this section, shall institute and maintain an insurance antifraud plan. An insurer licensed on July 1, 1995, shall file its antifraud plan

with the insurance commissioner no later than December 31, 1995. An insurer licensed after July 1, 1995, shall file its antifraud plan within six months of licensure. An insurer shall file any change to the antifraud plan with the insurance commissioner within thirty days after the plan has been modified.

(2) This section does not apply to health carriers, as defined in RCW 48.43.005, life insurers, or title insurers; or property or casualty insurers with annual gross written medical malpractice insurance premiums in this state that exceed fifty percent of their total annual gross written premiums in this state; or all credit-related insurance written in connection with a credit transaction in which the creditor is named as a beneficiary or loss payee under the policy except vendor single-interest or collateral protection coverage as defined in RCW 48.22.110(4).

RCW 48.30A.050…Insurance antifraud plan — Specific procedures. An insurer's antifraud plan must establish specific procedures to:

(1) Prevent insurance fraud, including internal fraud involving employees or company representatives, fraud resulting from misrepresentation on applications for insurance coverage, and claims fraud;

(2) Review claims in order to detect evidence of possible insurance fraud and to investigate claims where fraud is suspected;

(3) Report fraud to appropriate law enforcement agencies and cooperate with those agencies in their prosecution of fraud cases;

(4) Undertake civil actions against persons who have engaged in fraudulent activities;

(5) Train company employees and agents in the detection and prevention of fraud.

RCW 48.30A.055…Insurance antifraud plan — Review — Disapproval — Notice — Audit to ensure compliance. If after review of an insurer's antifraud plan, the commissioner finds that the plan does not comply with RCW 48.30A.050, the commissioner may disapprove the antifraud plan. Notice of disapproval must include a statement of the specific reasons for disapproval. The insurer shall refile a plan disapproved by the commissioner within sixty days of the date of the notice of disapproval. The commissioner may audit insurers to ensure compliance with antifraud plans.

RCW 48.30A.060…Insurance antifraud plan — Actions taken by insurer — Report — Not public records. Each insurer shall annually provide to the insurance commissioner a summary report on actions taken under its antifraud plan to prevent and combat insurance fraud. The report must also include, but not be limited to, measures taken to protect and ensure the integrity of electronic data processing-generated data and manually compiled data, statistical data on the amount of resources committed to combating fraud, and the amount of fraud identified and recovered during the reporting period. The antifraud plans and summary of the insurer's antifraud activities are not public records and are exempt from chapter 42.17 RCW, are proprietary, are not subject to public examination, and are not discoverable or admissible in civil litigation.

RCW 48.30A.065…Insurance antifraud plan — Failure to file or exercise good faith — Penalty — Failure to follow plan — Civil penalty. An insurer that fails to file a timely antifraud plan or who does not make a good faith attempt to file an antifraud plan that complies with RCW 48.30A.050, is subject to the penalty provisions of RCW 48.01.080, but no penalty may be imposed for the first filing made by an insurer under this chapter. An insurer that fails to follow the antifraud plan is subject to a civil penalty not to exceed ten thousand dollars for each violation, at the discretion of the commissioner after consideration of all relevant factors, including the willfulness of the violation.

RCW 48.30A.070…Duty to investigate, enforce, and prosecute violations. It is the duty of all peace officers, law enforcement officers, and law enforcement agencies within this state to investigate, enforce, and prosecute all violations of this chapter.

RCW 48.17.450…Place of business.

(1) Every licensed agent, broker, and adjuster, other than an agent licensed for life or disability insurances only, shall have and maintain in this state, or, if a nonresident agent or nonresident broker, in this state or in the state of the

licensee's domicile, a place of business accessible to the public. Such place of business shall be that wherein the agent or broker principally conducts transactions under that person's licenses. The address of the licensee's place of business shall appear on all of that person's licenses, and the licensee shall promptly notify the commissioner of any change thereof. A licensee maintaining more than one place of business in this state shall obtain a duplicate license or licenses for each additional such place, and shall pay the full fee therefore.

(2) Any notice, order, or written communication from the commissioner to a person licensed under this chapter which directly affects the person's license shall be sent by mail to the person's last residential address, if an individual, and to the person's last business address, if licensed as a firm or corporation, as such address is shown in the commissioner's licensing records. A licensee shall promptly notify the commissioner of any change of residential or business address.

RCW 48.17.460…Display of license.

(1) The license or licenses of each agent, other than licenses as to life or disability insurances only, or of each broker or adjuster shall be displayed in a conspicuous place in that part of his place of business which is customarily open to the public.

(2) The license of a solicitor shall be so displayed in the place of business of the agent or broker by whom he is employed.

RCW 48.17.480…Reporting and accounting for premiums.

(1) An agent or any other representative of an insurer involved in the procuring or issuance of an insurance contract shall report to the insurer the exact amount of consideration charged as premium for such contract, and such amount shall likewise be shown in the contract and in the records of the agent. Each willful violation of this provision is a misdemeanor.

(2) All funds representing premiums or return premiums received by an agent, solicitor or broker, shall be so received in his or her fiduciary capacity, and shall be promptly accounted for and paid to the insured, insurer, or agent as entitled thereto.

(3) Any person licensed under this chapter who receives funds which belong to or should be paid to another person as a result of or in connection with an insurance transaction is deemed to have received the funds in a fiduciary capacity. The licensee shall promptly account for and pay the funds to the person entitled to the funds.

(4) Any agent, solicitor, broker, adjuster or other person licensed under this chapter who, not being lawfully entitled thereto, diverts or appropriates funds received in a fiduciary capacity or any portion thereof to his or her own use, is guilty of theft under chapter 9A.56 RCW.

RCW 48.17.490…Sharing commissions.

(1) No agent, general agent, solicitor, or broker shall compensate or offer to compensate in any manner any person other than an agent, general agent, solicitor, or broker, licensed in this or any other state or province, for procuring or in any manner helping to procure applications for or to place insurance in this state. This provision shall not prohibit the payment of compensation not contingent upon volume of business transacted, in the form of salaries to the regular employees of such agent, general agent, solicitor or broker, or the payment for services furnished by an unlicensed person who does not participate in the transaction of insurance in any way requiring licensing as an agent, solicitor, broker, or adjuster and who is not compensated on any basis dependent upon a sale of insurance being made.

(2) No such licensee shall be promised or allowed any compensation on account of the procuring of applications for or the placing of kinds of insurance which he himself is not then licensed to procure or place.

(3) The commissioner shall suspend or revoke the licenses of all licensees participating in any violation of this section.

Personal Insurance Based on Credit History

WAC 284-24A-001…What is the purpose of these rules? These rules describe the standards that apply to insurers that use underwriting criteria or rating plans for personal insurance based on credit history.

WAC 284-24A-005…What definitions are important to these rules? "Demographic factors" means the factors listed below if they are used in an insurer's rates, rating tiers, rating factors, rating rules or risk classification plan:

- Age of the insured;
- Sex of the insured;
- The rating territory assigned to the property location for residential property insurance and to the vehicle's garage location for personal auto insurance.

"Premium" means the same as RCW 48.18.170.

"Rate" means the cost of insurance per exposure unit.

"Rating factor" means a number used to calculate premium.

"Risk classification plan" means a plan to formulate different premiums for the same coverage based on group characteristics.

"Significant factor" means an important element of a consumer's credit history or insurance score. Examples of significant factors include:

- Bankruptcies, judgments, and liens;
- Delinquent accounts;
- Accounts in collection;
- Payment history;
- Outstanding debt;
- Length of credit history; and
- Number of credit accounts.

"Substantive underwriting factor" means a factor that is very important to an underwriting decision. Examples of substantive underwriting factors include:

- History of filing claims;
- History of moving violations or accidents;
- History of driving uninsured;
- Type of performance for which a vehicle is designed; and
- Maintenance of a structure to be insured.

"Vehicle" means any motorized vehicle that can be insured under a private passenger auto insurance policy.

WAC 284-24A-010…What must an insurer tell a consumer when it takes an adverse action?

(1) An insurer must tell a consumer about significant factors that adversely affect the consumer's credit history or insurance score. As many as four factors may be needed to explain the adverse action.
(2) An insurer must explain what significant factors led to an adverse action as defined in RCW 48.18.545 (1)(a). The insurer is responsible for making sure that the reason(s) an adverse action occurred is written in reasonably clear and simple language, even if the reason(s) is provided to the insurer by a vendor.

WAC 284-24A-012…What types of reasons do not provide enough information to adequately explain an adverse action? An insurer must explain any adverse action in reasonably clear and simple language. Insurers must not use phrases that do not explain why the consumer was charged a higher premium or determined to be ineligible for coverage by the insurer.

(1) Explanations of adverse actions that do not meet this standard include, but are not limited to:

(a) Unfavorable length of credit history.
(b) Absence of revolving credit account.
(c) Age of oldest account or revolving credit account.
(d) Age that consumer first opened a credit account.
(e) Unfavorable number of bank or revolving accounts.
(f) Unfavorable debt ratio.
(g) Unfavorable number of accounts opened in past year.

(2) Insurers must not use the term "unfavorable" to describe an attribute of credit history because it does not provide clear information to the consumer about their credit history.

WAC 284-24A-032…Under RCW 48.19.035 (2)(b) what does "eligibility rules or guidelines" mean? "Eligibility rules or guidelines" mean rules that determine whether a consumer is eligible for insurance from a single insurer or a group of affiliated companies. Eligibility rules or guidelines do not include rules that determine which company within an affiliated group of companies a consumer will be placed based on their insurance score or other underwriting criteria.

WAC 284-24A-033…How will an insurer or a group of affiliated insurers know its eligibility rules or guidelines will be withheld from public inspection? Eligibility guidelines will be kept as confidential records if they:

(1) Conform to the definition in WAC 284-24A-032; and

(2) Are clearly identified.

To ensure confidentiality, insurers should submit eligibility guidelines in a separate and distinct part of the related rate filing so they may be separated from other documents in the filing that are public records under RCW 48.19.040(5).

WAC 284-24A-040…What action will the commissioner take if a model does not comply with Washington law? The commissioner will:

(1) Notify the insurer or vendor that the model does not comply with Washington law;

(2) State the reasons why the model does not comply with Washington law;

(3) Offer the insurer or vendor sixty days to revise the model to resolve the issue(s) outlined in subsection (2) of this section; and

(4) Provide a specific date when the model may no longer be used in Washington if the model has not been revised to resolve the issue(s).

WAC 284-24A-045…If an insurer uses credit history or insurance scores to segment personal insurance business for rating purposes, how can the insurer show that its rating plan results in premium rates that are not excessive, inadequate, or unfairly discriminatory? If an insurer uses credit history or insurance scores to segment personal insurance business for rating purposes, the insurer must:

(1) Submit a multivariate analysis with the first rate and rule filing the insurer makes to comply with this law.

(2) Submit a multivariate analysis any time the insurer uses credit history to revise a risk classification plan, rating factor, rating plan, rating tier, or base rates.

WAC 284-24A-055…Should an insurer submit actuarial data based on demographic factors with an insurance scoring model or with a rate filing?

(1) Insurers should not submit actuarial data based on demographic factors with their insurance scoring model.

(2) Insurers must submit actuarial data based on demographic factors to support any difference in rates or premiums based on:

(a) **"No hit,"** which means the absence of credit history; or
(b) **"No score,"** which means the inability to determine the consumer's credit history.

(3) The actuarial data must include:

(a) Loss history for an experience period acceptable to the commissioner.
The length of the experience period will be determined by the amount of data available to the insurer.
(b) Earned exposures.
(c) Earned premiums.
(d) An analysis of the credibility of the data.

(4) The actuarial data must be segmented by:

(a) Demographic factors, which may be grouped in broader categories in a manner acceptable to the commissioner;
(b) "No hit"; and
(c) "No score."

(5) The actuarial data must show that the proposed rates, rating factors, rating rules, or risk classification plans relating to "no hit" and "no score" comply with RCW 48.19.020.

(6) These filings are subject to prior approval by the commissioner under the provisions of RCW 48.19.040.

WAC 284-24A-065…Questions and answers.

(1) **Our insurance company uses insurance scoring bands (a range of scores) to determine what to charge a consumer based on their personal insurance score. Does an insurer have to file its insurance scoring bands?** Yes. If an insurer uses insurance scoring bands for rating purposes, the insurer must file them (and any future changes to those bands). The bands are part of the rating plan and must be supported by actuarial analysis.

(2) **What types of data can an insurer use to support a credit-based rating plan?** A credit-based rating plan must be based on the experience of the insurer, an affiliated insurer under the same management, or a licensed rating organization. The commissioner will accept data from other states where comparable credit-based rating plans are in effect.

(3) **The law says an insurer cannot use the number of credit inquiries to set rates or to deny insurance. Can an insurer consider the amount of time since the most recent inquiry?** Yes. The law prohibits an insurer from considering the number of credit-seeking or promotional inquiries. It does not prohibit an insurer from considering the length of time since the most recent inquiry about a consumer's credit rating.

(4) **The law says an insurer cannot use collections identified with a medical industry code to set rates or to deny insurance. Not all credit vendors provide industry codes for collection accounts. If a vendor searches for medical references in a text field, would that action comply with the law?** Yes. Collections identified with a medical industry code cannot be used. If medical history is not coded or identified, insurers and vendors are not required to perform additional research.

(5) **The law says an insurer cannot use the initial purchase or finance of a vehicle or house that adds a new loan to the consumer's existing credit history to set rates or to deny insurance. Can my company use the number of such loans and/or the outstanding balance of such loans?**

- An insurer may not use the initial purchase of a home or vehicle to affect eligibility for insurance or insurance premiums. The initial purchase is the first loan taken out to buy a home or vehicle.

• An insurer may evaluate any subsequent borrowing by a consumer.

• A method an insurer or vendor can use to comply with the law is to eliminate vehicle and home loans from the consumer's debt load calculation.

(6) **The law says an insurer cannot use the total available line of credit to set rates or to deny insurance**. **Can my company use number of credit lines with limits over a set amount?**

• The law prohibits use of data related to the consumer's total available line of credit. Any attribute that evaluates the total amount of credit available to a consumer is prohibited.

• Your insurer may use the debt/credit ratio or other ratios that consider the actual debt load.

WAC 284-30-500…Unfair practices with respect to vehicle insurance.

(1) The following practices by any insurer with respect to every vehicle liability insurance policy applicable to private passenger automobiles registered or principally garaged in this state are unfair and prohibited:

(a) Failing to provide, to any insured under such policy, liability limits at least as great as those required by RCW 46.29.090, as measured at the effective date of the pertinent policy or its renewal;

(b) Denying or limiting liability coverage in such policy to less than the limits required by RCW 46.29.090, solely because the injured person is related to the insured by blood or marriage, as, for example, through use of so-called "family" or "household" exclusions;

(c) Denying or limiting liability coverage in such policy, with respect to injuries sustained by motorcycle passengers, to an amount below the bodily injury liability limits required by RCW 46.29.090, if the policy provides liability

coverage for an insured's ownership, operation, or use of a motorcycle.

(2) The following practices by any insurer, with respect to vehicle insurance policies applicable to private passenger vehicles registered or principally garaged in this state, are unfair and prohibited:

(a) Failing to provide a named insured under such policy an itemization of the premium costs for the coverages under the policy as to which there are identifiable separate premium charges. Such itemization shall be given no later than the time of delivery of a policy and with each offer to renew thereafter;

(b) Failing, except with respect to a motorcycle policy, to provide, to any named insured who so requests and pays the premium therefore, first party automobile benefits such as those in medical payments coverage or personal injury protection, on approved forms commonly used by the insurer in the state of Washington, with maximum benefit limits, as appropriate to the particular form, of at least:

(i) $35,000 for medical and hospital benefits incurred within three years of the accident;

(ii) $35,000 for one year's income continuation benefits, subject to a limit of the lesser of $700 per week or eighty-five percent of the weekly income; and (iii) $40 per day for loss of services benefits, for at least a year.

(3) It shall be an unfair practice for any insurer to consider traffic violations or accidents which occurred more than three years in the past, with respect to the acceptance, rejection, cancellation or nonrenewal of any insured under a private passenger automobile insurance policy, unless, because of the individual's violations, accidents or driving record during the three years immediately past, the earlier violations or accidents are significantly relevant to the individual's qualifications for insurance.

(4) For purposes of this section, the definition of a "private passenger automobile" is that set forth in RCW 48.18.297, and includes a motorcycle except as otherwise specifically provided in this section.

WAC 284-30-550…Receipts to be given.

(1) To effectuate RCW 48.17.470 and 48.17.480 and to eliminate unfair practices in accord with RCW 48.30.010, any agent, solicitor or other representative of an insurer who receives a contract payment or premium from or on behalf of an insured or applicant for homeowners', dwelling fire, private passenger automobile, motorcycle, individual life, or individual disability insurance shall deliver or mail a signed receipt therefore as promptly as possible, which should generally be no later than the next business day. Such receipt must be dated, identify the agent and the agent's address, identify the person by or for whom payment is made, state the amount received, identify the applicable insurer by its full legal name (or the premium finance company or Washington automobile insurance plan if payment is intended therefore), and identify the contract or policy including a brief description of the coverage for which payment is received.

(2) The receipt need not be an independent document but may be incorporated in an application or binder, if appropriate.

(3) For purposes of this section "life insurance" includes annuities.

(4) For purposes of this section "insurer" includes a health care service contractor and a health maintenance organization, and "disability insurance" includes their contracts and agreements.

(5) This section shall not apply to the receipt of checks or other instruments payable on their face to the insurer, premium finance company or the Washington Automobile Insurance Plan. It also shall not apply to payments (other than by cash) received by an agent after delivery of the policy for which payment is made, when the payment is pursuant to a premium financing arrangement with the agent or in response to a billing by the agent.

(6) A failure to comply with this section shall be an unfair practice pursuant to RCW 48.30.010, and a violation of a regulation pursuant to RCW 48.17.530.

(7) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

WAC 284-30-560…Applications and binders.

(1) Every application form used in connection with homeowners', dwelling fire and vehicle insurance, shall contain a clear and conspicuous statement setting forth whether or not coverage has commenced.

(a) If coverage has commenced, the effective date shall be stated.

(b) If coverage has not commenced, there shall be an explanation as to the circumstances which will cause coverage to commence and the time when coverage will become effective.

(c) The statement concerning commencement of coverage shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the other contents of the application so as to be confusing, misleading or not readily evident.

(d) A copy of such application shall be delivered or mailed to the applicant promptly following its execution.

(2) Every binder used pending the issuance of a policy of property, marine and transportation, vehicle and general casualty insurance, as those kinds of insurance are defined in chapter 48.11 RCW, shall be reduced to writing or printed form and delivered or mailed to the insured as promptly as possible, which should generally be no later than the next business day.

(a) Such binder must be dated, identify the insurer in which coverage is bound, briefly describe the coverage bound,

state the date and time coverage is effective, and acknowledge receipt of the amount of any premium money received.

(b) Such binder may be incorporated in or be attached to the application for the insurance but must be clear and conspicuous.

(3) Binders should be replaced promptly with insurance policies. With few exceptions and then only in compliance with RCW 48.18.230(2), insurers must replace binders within ninety days of their effective date.

(4) It shall be an unfair practice and unfair competition for an insurer or agent to engage in acts or practices which are contrary to or not in conformity with the requirements of this section, and a violation of this section is prohibited and shall subject an insurer and agent to the penalties or procedures set forth in RCW 48.05.140, 48.17.530, or 48.30.010.

(5) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

WAC 284-30-570…Actual reason for canceling, denying or refusing to renew insurance to be disclosed. Whenever an insurer is required by law to give the reason for its canceling, denying, or refusing to renew insurance, as, for example, pursuant to RCW 48.18.291, 48.18.292, or 48.30.320, it shall give the true and actual reason for its action in clear and simple language, so that the insured or applicant will not need to resort to additional research to understand the real reason for the action. It is not sufficient, for example, to state that an insured "does not meet the company's underwriting standards." The reason why the individual does not meet such underwriting standards is what must be given. If the actual reason relates to medical information, the insurer may make a broad reference thereto and limit specific disclosure of details to the applicant's or insured's physician.

WAC 284-30-572…Discrimination prohibited.

(1) It shall be an unfair practice for any insurer to decline, cancel, or refuse to renew any homeowners, dwelling fire or vehicle insurance policy, or to vary its terms, rates, conditions or benefits, because of an insured's or applicant's race, creed, color, national origin, religion, or ability to read, write, or speak the English language.

(2) It is an unfair practice for any insurer, and a prohibited practice for any health care service contractor or health maintenance organization, to discourage a claimant or an insured from contacting the insurance commissioner, or to unfairly discriminate against such person because of such contact.

WAC 284-30-574…Insurer must make independent evaluation. It shall be an unfair practice for any insurer to rely solely on another insurer's denial, cancellation, or nonrenewal of insurance to support a denial or termination of coverage. In every case, an insurer must go behind another insurer's action and make its own independent decision on the merits. This section does not prohibit an insurer from denying a binder pending its evaluation of another insurer's action, and does not apply to an insurer-reinsurer relationship.

WAC 284-30-580…Policies to be delivered, not held by agents.

(1) RCW 48.18.260 requires that policies be delivered within a reasonable period of time after issuance. If an insurer relies upon its agents to make deliveries of its policies, the insurer, as well as the agent, is responsible for any delay resulting from the failure of the agent to act diligently.

(2) Insurance agents delivering insurance policies to insureds must make an actual physical delivery. It is not acceptable for an agent to merely obtain a receipt indicating a delivery and then to retain the policy, for safekeeping or otherwise, in the agent's possession.

(3) Agents may obtain policies from owners or insureds and hold such policies briefly for analysis or servicing, giving a receipt therefore in every instance, but shall promptly return any such policies to their owners or insureds. Agents shall not otherwise take custody of, or hold, insurance policies, whether for fee or at no charge, unless a family or legal relationship clearly justifies such conduct, as, for example, where a policy belonging to a minor child of the agent is held, or where the agent is acting as a legal guardian or a court appointed representative and holds a policy of a ward or of an estate.

(4) It shall be an unfair practice and unfair competition for an insurer or agent to engage in acts or practices which are contrary to or not in conformity with the requirements of this section, and a violation of this section is prohibited and shall subject an insurer and agent to the penalties or procedures set forth in RCW 48.05.140, 48.17.530, or 48.30.010.

(5) Each insurer shall inform its agents and appropriate representatives of the requirements of this section.

WAC 284-30-590…Unfair practices with respect to policy cancellations, renewals, and changes.

(1) It is unfair practice to utilize a twenty-day notice to increase premiums by a change of rates or to change the terms of a policy to the adverse interest of the insured there under, except on a one time basis in connection with the renewal of a policy as permitted by RCW 48.18.2901(2), or to utilize such notice if it is not, by its contents, made clearly and specifically applicable to the particular policy and to the insured there under or does not provide sufficient information to enable the insured to understand the basic nature of any change in terms or to calculate any premium resulting from a change of rates.

(2) In the unusual situation where a contract permits a midterm change of rates or terms, other than in connection with a renewal, it is an unfair practice to effectuate such change with less than forty-five days advance written notice to the named insured, or to utilize a contract provision which is not set forth conspicuously in the contract under an appropriate caption of sufficient prominence that it will not be minimized or rendered obscure.

(3) It is an unfair practice to effectuate a change of rates or terms other than prospectively. Such changes may be effective no sooner than the first day following the expiration of the required notice.

(4) If an insured elects to not continue coverage beyond the effective date of any change of rates or terms, it is an unfair practice to refund any premium on less than a pro rata basis.

(5) The cancellation and renewal provisions set forth in chapter 48.18 RCW do not apply to surplus line policies. To avoid unfair competition and to prevent unfair practices with respect to consumers, it is an unfair practice for any surplus line broker to procure any policy of insurance pursuant to chapter 48.15 RCW that is cancelable by less than ten days advance notice for nonpayment of premium and twenty days for any other reason, except as to a policy of insurance of a kind exempted by RCW 48.15.160. This rule shall not prevent the cancellation of a fire insurance policy on shorter notice in accord with chapter 48.53 RCW.

(6) Except where the insurance policy is providing excess liability or excess property insurance including so-called umbrella coverage, it is an unfair practice for an insurer to make a common practice of giving a notice of nonrenewal of an insurance policy followed by its offer to rewrite the insurance, unless the proposed renewal insurance is substantially different from that under the expiring policy.

(7) Where the rate has not changed but an incorrect premium has been charged, if the insurer elects to make a midterm premium revision, it is an unfair practice to treat the insured less favorably than as follows:

(a) If the premium revision is necessary because of an error made by the insurer or its agent, the insurer shall:

(i) Notify the applicant or insured of the nature of the error and the amount of additional premium required;

(ii) Offer to cancel the policy or binder pro rata based on the original (incorrect) premium for the period for which coverage was provided; or

(iii) Offer to continue the policy for its full term with the correct premium applying no earlier than twenty days after the notice of additional premium is mailed to the insured.

(b) If the premium revision results from erroneous or incomplete information supplied by the applicant or insured, the insurer shall:

(i) Correct the premium or rate retroactive to the effective date of the policy; and

(ii) Notify the applicant or insured of the reason for the amount of the change. If the insured is not willing to pay the additional premium billed, the insurer shall cancel the policy, with appropriate statutory notice for nonpayment of premium, and compute any return premium based on the correct premium.

(c) This subsection recognizes that an insurer may elect to allow an incorrect premium to remain in effect to the end of the policy term because the insured is legally or equitably entitled to the benefit of a bargain made.

WAC 284-30-620…Permissible time limit for benefits payable because of accidental injury or death. It shall be an unfair practice for any insurer to deliver a policy of insurance in this state which provides for benefits in case of accidental death or accidental injury, if it limits the benefits payable there under to losses occurring within a stated period of time after the accident, unless such period of time extends for at least one year from the time of the accident. In other words, benefits for accidental death or for covered expenses incurred because of an accidental injury shall be paid if the covered death occurs, or the covered services are incurred, ***within one year of the accident***.

WAC 284-30-630…Health questions in applications to be clear and precise. If an insurer, including a health care service contractor or a health maintenance organization, intends to rely on an applicant's or enrollee's answers to health questions in an application to determine eligibility for coverage or the existence of a preexisting condition, such questions must be clear and precise. Simply asking whether the applicant has been under the care of a physician during the preceding year, for example, is not sufficient to require a "yes" answer where the applicant has been using medications that were prescribed prior to the start of the preceding year and the applicant has not seen a physician for more than a year.

WAC 284-30-650...Prompt responses required. It is an unfair practice for an insurer, and a prohibited practice for a health care service contractor or a health maintenance organization, to fail to respond promptly to any inquiry from the insurance commissioner relative to the business of insurance. A lack of response within fifteen business days from receipt of an inquiry will be considered untimely. A response must be in writing, unless otherwise indicated in the inquiry.

WAC 284-30-660…Deceptive use of quotations or evaluations prohibited.

(1) It is an unfair or deceptive practice and an unfair method of competition pursuant to RCW 48.30.010 for any insurance company, broker, agent, or solicitor in connection with the business of insurance, to utilize quotations or evaluations from rating or advisory services or other independent sources, in a manner likely to deceive the persons to whom the information is directed.

(2) Acts which are prohibited by this section include the following examples:

(a) If an insurer represents in its advertising that it has received an "A+" rating from an advisory service, such representation is deceptive unless it includes a clear explanation that such advisory service's practice is to rate insurance companies on the basis of "AAA," "AA," and declining to "A," if such is the case. The absence of such explanation would reasonably cause the ordinary person to believe falsely that the insurer had received the highest rating available from the service.

(b) Similarly, quoting figures or comments from a report, such as those representing claims paid or the capital or reserves or the quality of an insurer, in a manner to suggest that such figures or comments are impressive or that the report demonstrates the company to be particularly strong financially or of high quality relative to other companies, when such is not the case, creates a false impression and is deceptive.

WAC 284-30-700…Restrictions as to denial and termination of homeowners insurance affected by day-care operations. (1) It shall be an unfair practice for any insurer transacting homeowners insurance to deny homeowners insurance to an applicant therefore, or to terminate any homeowners insurance policy covering a dwelling located in this state, whether by cancellation or nonrenewal, for the principal reason that an insured under such policy is engaged in the operation of a day care facility, pursuant to chapter 74.15 RCW, at the insured location.

(2) This rule does not prevent an insurer from excluding or limiting coverage with respect to liability or property losses arising out of business pursuits of an insured, specifically including those related to the operation of day care facilities.

WAC 284-30-750…Brokers' fees to be disclosed. It shall be an unfair practice for any broker providing services in connection with the procurement of insurance to charge a fee in excess of the usual commission which would be paid to an agent without having advised the insured or prospective insured, in writing, in advance of the rendering of services, that there will be a charge and its amount or the basis on which such charge will be determined.

WAC 284-30-800…Unfair practices applicable to title insurers and their agents.

(1) RCW 48.30.140 and 48.30.150, pertaining to "rebating" and "illegal inducements," are applicable to title insurers and their agents. Because those statutes primarily affect inducements or gifts to an insured and an insured's employee or representative, they do not directly prevent similar conduct with respect to others who have considerable control or influence over the selection of the title insurer to be used in real estate transactions. As a result, insureds do not always have free choice or unbiased recommendations as to the title insurer selected. To prevent unfair methods of competition and unfair or deceptive acts or practices, this rule is adopted.

(2) It is an unfair method of competition and an unfair and deceptive act or practice for a title insurer or its agent, directly or indirectly, to offer, promise, allow, give, set off, or pay anything of value exceeding twenty-five dollars, calculated in the aggregate over a twelve-month period on a per person basis in the manner specified in RCW 48.30.140(4), to any person as an inducement, payment, or reward for placing or causing title insurance business to be given to the title insurer.

(3) Subsection (2) of this section specifically applies to and prohibits inducements, payments, and rewards to real estate agents and brokers, lawyers, mortgagees, mortgage loan brokers, financial institutions, escrow agents, persons who lend money for the purchase of real estate or interests therein, building contractors, real estate developers and subdividers, and any other person who is or may be in a position to influence the selection of a title insurer, except advertising agencies, broadcasters, or publishers, and their agents and distributors, and bona fide employees and agents of title insurers, for routine advertising or other legitimate services.

(4) This section does not affect the relationship of a title insurer and its agent with insureds, prospective insureds, their employees or others acting on their behalf. That relationship continues to be subject to the limitations and restrictions set forth in the rebating and illegal inducement statutes, RCW 48.30.140 and 48.30.150.

WAC 284-12-080…Requirements for separate accounts.

(1) The purpose of this section is to effectuate RCW 48.17.600 and 48.17.480 with respect to the separation and accounting of premium funds by agents, brokers, solicitors, general agents and surplus line brokers, hereinafter called "producers." Pursuant to RCW 48.30.010, the commissioner has found and hereby defines it to be an unfair practice for any producer, except as allowed by statute, to conduct insurance business without complying with the requirements of RCW 48.17.600 and this section. As provided in RCW 48.17.600, agents for title insurance companies or insurance brokers whose average daily balance for premiums received on behalf of insureds in the state of Washington equals or exceeds one million dollars, are exempt from subsections (1) through (6) of this section, except with respect to premiums and return premiums received in another licensing capacity.

(2) All funds representing premiums and return premiums received on Washington business by a producer in his or her fiduciary capacity on or after January 1, 1987, shall be deposited in one or more identifiable separate accounts which may be interest bearing.

(a) A producer may deposit no funds other than premiums and return premiums to the separate account except as follows:

(i) Funds reasonably sufficient to pay bank charges;

(ii) Funds a producer may deem prudent for advancing premiums, or establishing reserves for the paying of return premiums; and

(iii) Funds for contingencies as may arise in the business of receiving and transmitting premiums or return premiums.

(b) A producer may commingle Washington premiums and return premiums with those produced in other states, but there shall be no commingling of any funds which would not be permitted by this section.

(3)(a) The separate account funds may be:

(i) Deposited in a checking account, demand account, or a savings account in a bank, national banking association, savings and loan association, mutual savings bank, stock savings bank, credit union, or trust company located in the state of Washington. Such an account must be insured by an entity of the federal government; or

(ii) Invested in United States government bonds and treasury certificates or other obligations for which the full faith and credit of the United States government is pledged for payment of principal and interest, repurchase agreements collateralized by securities issued by the United States government, and bankers acceptances. Insurers may, of course, restrict investments of separate account funds by their agent.

(b) A nonresident licensee, or a resident producer with affiliated operations under common ownership in two or more states, may utilize comparable accounts in another state provided such accounts otherwise meet the requirements this rule, and are accessible to the commissioner for purposes of examination or audit at the expense of the producer.

(4) Disbursements or withdrawals from a separate account shall be made for the following purposes only, and in the manner stated:

(a) For charges imposed by a bank or other financial institution for operation of the separate account;

(b) For payments of premiums, directly to insurers or other producers entitled thereto;

(c) For payments of return premiums, directly to the insureds or other persons entitled thereto;

(d) For payments of commissions and other funds belonging to the separate account's producer, directly to another account maintained by such producer as an operating or business account; and

(e) For transfer of fiduciary funds, directly to another separate premium account which meets the requirements of this section.

(5)(a) The entire premium received (including a surplus lines premium tax if paid by the insured) must be deposited into the separate account. Such funds shall be paid promptly to the insurer or to another producer entitled thereto, in accordance with the terms of any applicable agreement between the parties.

(b) Return premiums received by a producer and the producer's share of any premiums required to be refunded, must be deposited promptly to the separate account. Such funds shall be paid promptly to the insured or person entitled thereto.

(6)(a) Where a producer receives a premium payment in the form of an instrument, such as a check, which is made payable to an insurer, general agent or surplus line broker, the producer may forward such instrument directly to the payee if that can be done without endorsement or alteration. In such a case, the producer's separate account is not involved because the producer has not "received" any funds.

(b) If the producer receives a premium payment in the form of cash or an instrument requiring endorsement by the producer, such premium must be deposited into the producer's separate account, unless the insurer entitled to such funds has established other procedures by written direction to a producer who is its appointed agent, which procedures:

(i) Recognize that such agent is receiving premiums directly on behalf of the insurer; and

(ii) Direct the producer to give adequate receipts on behalf of the insurer; and

(iii) Require deposit of the proceeds into the insurer's own account or elsewhere as permitted by the insurer's direction.

Thus, for example, an insurer may utilize the services of a licensed agent, known in the industry as a "captive agent," in the sale of its insurance and in the operation of its places of business, and directly receive payments intended for it without such payments being deposited into and accounted for through the licensed agent's separate account. In such cases, for purposes of this rule, the insurer, as distinguished from the agent, is actually "receiving" the funds and is immediately responsible therefore.

(c) When a producer receives premiums in the capacity of a surplus line broker, licensed pursuant to chapter 48.15 RCW, after a binder or other written evidence of insurance has been issued to the insured, subject to the express written direction of the insurer involved, such premiums may be removed from the separate account.

(7) The commissioner recognizes the practical problems of accounting for the small amounts of interest involved spread over a large number of insurers and insureds. Therefore, absent any agreement between the producer and the insured or insurer to the contrary, interest earned on the deposits held in the separate account may be retained by the producer and used to offset bank charges, establish reserves, pay return premiums, or for any of the purposes listed in subsection (2) of this section, or the interest may be removed to the operating account.

(8) A producer shall establish and maintain records and an appropriate accounting system for all premiums and return premiums received by the producer, and shall make such records available for inspection by the commissioner during regular business hours upon demand during the five years immediately after the date of the transaction.

(9) The accounting system used must effectively isolate the separate account from any operating accounts. All recordkeeping systems, whether manual or electronic must provide an audit trail so that details underlying the summary data, such as invoices, checks, and statements, may be identified and made available on request. Such a system must provide the means to trace any transaction back to its original source or forward to final entry, such as is accomplished by a conventional double-entry bookkeeping system. When automatic data processing systems are used, a description of the system must be available for review by the commissioner. A balance forward system (as in an ordinary checking account) is not acceptable.

(10)(a) A producer that is a firm or corporation may utilize one separate account for the funds received by its affiliated persons operating under its license, and such affiliated persons may deposit the funds they receive in such capacity directly into the separate account of their firm or corporation.

(b) Funds received by a solicitor may be deposited into and accounted for through the separate account of the agent or broker represented by the solicitor.

(c) Funds received by an agent who is employed by and offices with another agent may be deposited into and accounted for through the separate account of the employing agent. This provision does not, however, authorize the agent-employee to represent an insurer as to which he or she has no appointment.

WAC 284-12-095…Unfair practice with respect to use of general agent defined. It is an unfair or deceptive practice and an unfair method of competition pursuant to RCW 48.30.010 for an authorized insurer to cancel or refuse to renew any insurance policy because its contract or arrangement with a general agent or a nonappointed agent through whom such policy was written has been terminated.

WAC 284-12-110…Identification of agent or solicitor to prospective insured. It shall be an unfair practice for an agent or solicitor initiating a sales presentation away from his or her office to fail to inform the prospective purchaser, prior to commencing the sales presentation, that the agent or solicitor is acting as an insurance agent or solicitor, and to fail thereafter to inform the prospective purchaser of the full name of the insurance company whose product the agent or solicitor offers to the buyer. This rule shall apply to all lines of insurance and to all coverage solicited in this state including coverage under a group policy delivered in another state, whether or not membership in the group is also being solicited.

RCW 48.17.067…The **burden of determining** whether ***authorization*** exists with the entity issuing the coverage ***is with the solicitor, agent or broker who is soliciting, negotiating or procuring an application for the insurance or health care services in this state***. The person selling the insurance must make a good faith effort to determine whether the entity that is issuing the coverage is authorized, or is conducting business through a surplus lines broker.

RCW 48.17.063…Unlicensed Activities …*"A person may not **act** as or hold himself or herself out to be an agent, broker, solicitor, or adjuster in this state unless licensed by the Commissioner. An agent, solicitor or broker may not solicit or take applications for, procure or place for others, any kind of insurance for which he or she is not then licensed."*

For the purpose of this section, an "***act*** " is committed in this state if it is committed, in whole or in part, in the state of Washington, or affects persons or property within the state and relates to or involves an insurance contract, health care services contract or health maintenance agreement.

Any person who knowingly violates this section is ***guilty of a class B felony.***

- **The Commissioner may** issue and enforce a cease and desist order, suspend or revoke a license and/or ***assess a civil penalty*** of not more than ***$25,000*** for each violation.

- Upon failure to pay a civil penalty when due, the attorney general may bring a civil action on behalf of the commissioner to recover the unpaid penalty. Any amounts collected by the Commissioner must be paid to the state treasurer for the account of the general fund.

Privacy of Consumer Health Information

WAC 284-04-500…Health information privacy policies and procedures.

All licensees shall develop and implement written policies, standards and procedures for the management of health information, including policies, standards and procedures to guard against the unauthorized collection, use or disclosure of nonpublic personal health information by the licensee consistent with regulations adopted by the U.S. Department of Health and Human Services governing health information privacy (45 CFR 160 through 164) which shall include:

(1) Limitation on access to health information by only those persons who need to use the health information in order to perform their jobs;

(2) Appropriate training for all employees;

(3) Disciplinary measures for violations of the health information policies, standards and procedures;

(4) Identification of the job titles and job descriptions of persons that are authorized to disclose nonpublic personal health information;

(5) Procedures for authorizing and restricting the collection, use or disclosure of nonpublic personal health information;

(6) Methods for exercising the right to access and amend incorrect nonpublic personal health information;

(7) Methods for handling, disclosing, storing and disposing of health information;

(8) Periodic monitoring of the employee's compliance with the licensee's policies, standards and procedures in a manner sufficient for the licensee to determine compliance and to enforce its policies, standards and procedures; and

(9) Methods for informing and allowing an individual who is the subject of nonpublic personal health information to request specialized disclosure or nondisclosure of nonpublic personal health information as required in this chapter.

(10) A licensee shall make the health information policies, standards and procedures developed pursuant to this section available for review by the commissioner.

WAC 284-04-505…Nonpublic personal health information - When authorization is required.

(1) A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

(2) Except as provided in WAC 284-04-510, nothing in this section shall prohibit, restrict or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of insurance functions by or on behalf of the licensee, for activities permitted under RCW 70.02.050, and for activities permitted under health privacy regulations adopted by the U.S. Department of Health and Human Services governing health information privacy.

WAC 284-04-510…Right to limit disclosure of health information.

(1) Notwithstanding other provisions of this chapter, a licensee shall limit disclosure of any information, including health information, about an individual who is the subject of the information if the individual clearly states in writing that disclosure to specified individuals of all or part of that information could jeopardize the safety of the individual. Disclosure of information under this subsection shall be limited consistent with the individual's request, such as a request for the licensee to not release any information to a spouse to prevent domestic violence.

(2) Notwithstanding any insurance law requiring the disclosure of information, a licensee shall not disclose nonpublic personal health information concerning health services related to reproductive health, sexually transmitted diseases, chemical dependency and mental health, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or certificateholder, if the individual who is the subject of the information makes a written request. In addition, a licensee shall not require an adult individual to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim.

(3)(a) A licensee shall recognize the right of any minor who may obtain health care without the consent of a parent or legal guardian pursuant to state or federal law, to exclusively exercise rights granted under this section regarding health information; and (b) Shall not disclose any nonpublic personal health information related to any health care service to which the minor has lawfully consented, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or other covered person, without the express authorization of the minor. In addition, a licensee shall not require the minor to obtain the policyholder's or other covered person's authorization to receive health care services or to submit a claim as to health care which the minor may obtain without parental consent under state or federal law.

(4) When requesting nondisclosure, the individual shall include in the request:

(a) Their name and address;

(b) Description of the type of information that should not be disclosed;

(c) In the case of reproductive health information, the type of services subject to nondisclosure;

(d) The identity or description of the types of persons from whom information should be withheld;

(e) Information as to how payment will be made for any benefit cost sharing;

(f) A phone number or e-mail address where the individual may be reached if additional information or clarification is necessary to satisfy the request.

WAC 284-04-515…Authorizations.

(1) A valid authorization to disclose nonpublic personal health information pursuant to this Article V shall be in written or electronic form and shall contain all of the following:

(a) The identity of the consumer or customer who is the subject of the nonpublic personal health information;

(b) A general description of the types of nonpublic personal health information to be disclosed;

(c) General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure and how the information will be used;

(d) The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed;

(e) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making such a revocation.

(2) An authorization for the purposes of this Article V shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four months.

(3) A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to this Article V at any time, subject to the rights of any individual who acted in reliance on the authorization prior to notice of the revocation.

(4) A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

(5) Notwithstanding the provisions of this section, a licensee complying with regulations adopted by the U.S. Department of Health and Human Services governing authorization for the release of health information satisfies the provisions of this section.

WAC 284-04-520…Authorization request delivery. A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt-out notice pursuant to WAC 284-04-225, provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information pursuant to WAC 284-04-500(1).

WAC 284-04-525…Relationship to State and Federal Laws. In the event of a conflict between this chapter and the state or federal laws, licensees shall comply with the state and federal laws governing privacy, as such laws relate to the business of insurance, except as expressly required by this chapter.

WAC 284-04-600…Protection of Fair Credit Reporting Act. Nothing in this regulation shall be construed to modify, limit or supersede the operation of the Federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this regulation regarding whether information is transaction or experience information under section 603 of that act.

WAC 284-04-605…Nondiscrimination.
(1) A licensee shall not discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this regulation.

(2) A licensee shall not discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal health information pursuant to the provisions of this regulation.

WAC 284-04-610…Violation. A violation of this regulation shall be deemed to be an unfair method of competition or an unfair or deceptive act and practice in this state.

WAC 284-04-615…Severability. If any section or portion of a section of this regulation or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

WAC 284-04-620…Effective date; transition rule.

(1) Effective date. These rules are effective July 1, 2001.

(2)(a) Notice requirement for consumers who are the licensee's customers on the compliance date. By July 1, 2001, a licensee shall provide an initial notice, as required by WAC 284-04-200, to consumers who are the licensee's customers on July 1, 2001.

(b) Example: A licensee provides an initial notice to consumers who are its customers on July 1, 2001, if, by that date, the licensee has established a system for providing an initial notice to all new customers and has mailed the initial notice to all the licensee's existing customers.

(3) Two-year grandfathering of service agreements…Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of WAC 284-04-400 (1)(a)(ii), even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before January 9, 2001.

(4) With respect to nonpublic personal health information under WAC 284-04-510, these rules are effective 2002.

WAC 284-04-900…Sample clauses. Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the Federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1 — Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(a) to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

A-2 — Categories of information a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of WAC 284-04-210 (1)(b) to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

- Information we receive from you on applications or other forms, such as "your name, address, Social Security number, assets, income, and beneficiaries";
- Information about your transactions with us, our affiliates or others, such as "your policy coverage, premiums, and payment history"; and
- Information we receive from a consumer reporting agency, such as "your creditworthiness and credit history".

Sample Clause A-2, Alternative 2:

We may disclose all of the information that we collect as described in the notice, such as "above" or "below".

A-3 — Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirements of WAC 284-04-210 (1)(b), (c), and (d) to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in WAC 284-04-405 and 284-04-410.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4 — Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause to meet the requirement of WAC 284-04-210 (1)(c) to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410, as well as when permitted by the exceptions in WAC 284-04-405 and 284-04-410.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

- Financial service providers, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents";
- Nonfinancial companies, such as "retailers, direct marketers, airlines, and publishers"; and
- Others, such as "nonprofit organizations".

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5 — Service provider/joint marketing exception.

A licensee may use one of these clauses, as applicable, to meet the requirements of WAC 284-04-210 (1)(e) related to the exception for service providers and joint marketers in WAC 284-04-400. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with whom the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements:

- Information we receive from you on applications or other forms, such as "your name, address, Social Security number, assets, income, and beneficiaries";

- Information about your transactions with us, our affiliates or others, such as "your policy coverage, premium, and payment history"; and

• Information we receive from a consumer reporting agency, such as "your creditworthiness and credit history".

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described "above" or "below" to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6 — Explanation of opt out right (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(f) to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in WAC 284-04-400, 284-04-405, and 284-04-410.

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may "call the following toll-free number: (insert number)".

A-7 — Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of WAC 284-04-210 (1)(h) to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to "those employees who need to know that information to provide products or services to you". We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.