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Continuing Education Course (12 Hours) for

FUNDAMENTALS

OF

INSURANCE LAW

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"F U N D A M E N T A L S O F I N S U R A N C E L A W"

SECTION I:
DEFINITIONS AND TYPES OF LAW

The most common definition of law, or the legal system, includes the idea of a system of rules which are definite and enforceable as they pertain to types of human conduct. Main ideas of law include basic philosophies of human rights, criminal codes and actions of individuals against other individuals. Also, included under the broad heading of law are treaties. Treaties are binding agreements between nations such as those prescribed by the United States Congress. From the rules of law which are written there are dozens of Federal and state courts which interpret and apply the law according to the custom and public policy of society.

COMMON LAW

The common law, which is very popular in American today, **embodies principles of conduct involving customs, ideas of justice and concepts of public policy** which are followed by court systems throughout the United States (both federal and state). The main characteristic of the common law is **unwritten** general legal principle which is enforced through the courts. The common law has its basis in Old English Law and the vast majority of states in America today.

are still **"common law jurisdictions."** When a case is brought up for review to a court, previous cases are consulted to determine whether or not the current issue at hand has its resolution based in past court holdings. In this sense these principles are written down but there is no specific and regimented organization behind the idea of common law.

CIVIL LAW

Civil law, on the other hand, unites all the principles of law and organizes these principles into a complete and sometimes complex written code. Court decisions which are made in civil law jurisdiction are always referenced according to the legal principles found in the written code. The most pronounced example of civil law in America is probably the law of the state of Louisiana which follows the idea of French Civil Law.

CONSTITUTIONAL LAW

Constitutional law seeks to embody principles which are the basis of the legal foundation of an entire government or nation. The law set forth in a constitution is considered more permanent than statutory law. For example, **the purpose of the United States constitution is to describe the government's structure and define operating principles of the nation as a whole as well as the extent of the powers of the people who operate the government.** Guarantees of basic human conduct such as freedom of worship, freedom of

speech, the rights of the people to peaceable assemble etc., are set forth in the document.

In America there is the **Federal Constitution** which sets forth the **power of the federal government**. It says the powers of authority not held by individual states are areas in which the federal government has direct authority over the people. The United States Supreme Court is the court of highest recourse and it has the final decision when issues of constitutional authority of any party have been raised. Federal or state laws running contrary to the federal U.S. Constitution can be struck down as an **"unconstitutional"** act.

In addition to the U.S. Constitution, each state outlines its own structure through what is known as a **state constitution.** Many of the same fundamental human rights found in the U.S. Constitution are also contained in state constitutions. The power of a state is limited because of the existence of a federal government in operation. The state constitution is considered to be the highest law of a particular state but, if a state law runs counter to U.S. Constitutional concepts, state law can be held unconstitutional and stuck down by the United State Supreme Court.

STATUTORY LAW

The **legislative branch** of government (i.e., congress and/or state legislative bodies) **enacts** written law which tells the citizens about something, tells them how to do something or prohibits them from doing something. From time to time,

statutes are changed, modified or eliminated. The collections of all statutory changes are contained in a state's **"revised statute book."** A **State Code,** on the other hand, is **book or set of books which collects all the statutes and arranges them according to some logical fashion**. A good example is the "insurance code" which specifically relates to the business of insurance in a state and how it is to be regulated.

When comparing a statute to constitutional provisions, statutes are less permanent than their constitutional counterparts but are expressed in much more specific terms. Constitutional provisions are set forth in more general language.

ADMINISTRATIVE AND REGULATORY

The United States has three branches of government including: the **legislative** which makes the laws, **the executive** which carries out the law, and the judicial which interpret the laws. The **executive branch contains a wide array of people called administrative officers** who carry out the details of statutes using written administrative rules and regulations as their guide. In this sense, the **Director or Commissioner of Insurance in a state is an administrative officer** and, in most cases, is appointed by the governor of a state. The **Director of Insurance has the role of utilizing and enforcing rules and regulations in order to carry out the provisions of state insurance statutes.** Generally, administrative officers perform duties including holding hearings, imposing penalties and making decisions.

CRIMINAL LAW

There are many federal and state statutes governing the **conduct** of one person toward another person. Laws also regulate individual conduct toward property by making it a crime to behave or act outside of a prescribed manner. In the event an individual disobeys a criminal statute and imposed behavior, the state and/or the federal government can choose to flex its enforcement muscle in attempting to bring a person to justice. **A crime can be a felony or misdemeanor.** A felony is a serious crime such as murder, treason, or robbery. A misdemeanor is a less serious crime which is usually punished only by short imprisonment time or a fine of money (a parking or traffic violation is an example).

Although the enforcement of insurance law does not generally intrude upon the area of criminal law, there are certain actions which an insurance agent or producer can take which are deemed to be a violation of criminal law statutes. Such an offender can receive prison time and/or be assessed fines. **Since the Insurance Commissioner of a state belongs to the executive branch of government, he is generally unable to imprison an individual** because it is not within his statutory authority. The Director can seek the cooperation of the state's judicial governmental branch and have an offending party placed in jail.

COURT SYSTEMS

Although a description and detailed analysis of the workings of court systems are beyond the scope of this course, it is necessary to review in broad terms the various component parts which represent the chronological activity of court systems. The first step would be to make a **"plead," a written statement by a party or parties of claims brought against an individual or company for which redress is sought** (these are the allegations found in a written law suit) A **"summons" (a written notification)** is delivered by a court officer to the party considered to be the offender (the "defendant").

If the defendant fails to answer the summons within a prescribed time frame, then a **"default,"** or automatic judgment, may be awarded by the court. When the defendant chooses to file a formal written response to the complaint this is called an **"answer"** and all alleged facts are explained according to the defendant's viewpoint. It is from the complaint and answers that the **"issues"** of the case are derived. An issue is the material/important point asserted by one party and defended by the other. Issues of fact are asserted by a plaintiff in a complaint are denied by a defendant. **In a jury trial all issues of fact are decided by a jury.** When there is no jury, a judge determines issues of fact in what is called a **"bench trial."**

Another other type of issue is the **"issue of law":** the plaintiff and defendant agree on facts but cannot agree as to how the law should be applied in a specific case. **It is a judge who always decides an issue of law.**

Discovery is an important device used by defendants and plaintiffs in a court proceeding before an actual trial. Discovery is designed to allow each party to get information necessary from all witnesses and parties involved in the case. This activity clarifies issues of fact and law. **Depositions,** or oral testimony, of witnesses are taken under an oath. **Interrogatories,** a set of written questions sent by one party to the other to answer, are also part of the discovery process. Finally there are the **"subpoena duces tecum"** which requires a witness to appear at a certain time in a certain place and bring documents which are considered material to a case. As long as the witness produces the required documents, a personal appearance is not required.

In attempting to establish facts in a case there are three concepts involved:

1) **Presumptions** are conclusions which can be made from a given set of facts.

2) **Conclusions** are presumed to be valid unless there is adequate evidence given to the contrary.

3) **Prima facie case** is a set of facts which entitles relief in the absence of disputing evidence.

In order for a case to continue a plaintiff must present what is considered to be a prima facie case. Then the defendant attempts to show why the facts alleged do not entitle the plaintiff to relief. The burden of proof falls on one party to prove claims. If the burden of proof is not met, the other party need not prove anything.

Courts in common law states use previous written court decisions to apply the same law to the same legal questions involving the same general facts. "Precedents" are normally followed unless there is strong reason to overturn previous decisions. This practice of following previous decisions made on similar questions of fact and law is called **"stare decisis."** A primary concern of courts is to remain consistent in the application of law in similar circumstances. In the absence of constitutional, statutory law and precedents, common law is interjected by courts in deciding the question at hand.

Courts are also divided as to **"legal"** versus **"equitable"** matters. When you want a defendant to act or perform in a certain way it is normally an equitable manner. When monetary damages are sought, it is normally a legal matter. Both legal and equitable matters can be brought to the same jurisdictional court.

INSURANCE REGULATIONS

In the United States Constitution there is a **"commerce clause"** which gives the United State congress the power (or right) to regulate interstate commerce. Only congress has the sole power to regulate commerce among and between states. Before the year 1944, insurance was not considered commerce and was regulated on a state by state basis. In the famous 1944 **"Southeastern Underwriters"** court case the U. S. Supreme Court held that insurance is commerce.

The logic of the decision said since insurance is conducted across state lines it is therefore subject to federal regulations according to the powers stated in the commerce clause of the federal Constitution. As a result of this Supreme Court holding, the **McCarran-Ferguson Act** was passed by congress stating that the **regulation and taxation of insurance by states (**and not the federal government) **is "in the public interest."** The McCarran- Ferguson act held that acts of congress do not supersede state laws and make them invalid concerning the regulation of insurance unless the Acts of congress specifically relate or govern specific areas of the business of insurance (examples: antitrust laws and anti-discrimination laws are still within the federal domain and will supersede state insurance laws in these activities).

Other federal laws which apply to insurance activities include those concerning interstate advertising, variable annuities and variable life insurance. The Supreme Court said the Federal Trade Commission can regulate the interstate mailing of unfair or deceptive advertising by an insurance company except in a state where sufficient law exists to control such deceptive materials. When it comes to **variable annuities the SEC** (Securities Exchange Commission) **says that variable annuities must be registered with the SEC since these are securities which are subject to federal regulation.** The Supreme Court has said that all variable annuities contain some insurance features but variable annuities should be regulated and therefore are not included in insurance policy exemption.

Variable life companies sought to have an SEC ruling exempt variable life contracts according to the Securities Exchange Act and the Investment Advisors Act. **The SEC said the public offerings of variable life insurance contracts must be registered under securities acts and anybody selling variable life insurance contracts must register as a broker/dealer under the Securities Exchange Act.** This is an example where federal law governs insurance companies in an area not deemed related to the business of insurance.

Insurance companies are also subject to federal regulation as it pertains to federal employment laws and the conduct and treatment of the insurance company employee. On the other hand, the regulation of the insurance industry itself has typically remained a state matter and is enforced according to state statutes.

State regulation of insurance is a necessary component due to the size and relative economic importance of the insurance industry in American society. If an insurance company fails financially due to gross mismanagement by insurance company officials, there will be important social and economic ramifications to the public. The main reasons for state regulation include making sure that insurance companies are:

1) solvent according state monitored formulas;

2) keeping funds in safe places as defined by state regulatory agencies;

3) making certain that the public is protected from unqualified or unethical agents through licensing laws; and

4) making certain that policyholders and beneficiary rights are enforced.

Because of the above concerns, the regulation of the insurance industry by a state falls under the general category of **"police power."** Police power deals with the sovereign right of a government to make certain that the general welfare of its citizens including health, safety and morals are protected.

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SECTION I STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section).

1) Briefly explain how common law differs from statutory law.

2) What is an "issue of law" versus "issue of fact?"

3) In a court proceeding, what is the purpose of Discovery?

4) Explain the significance of "stare decisis."

5) What does the "Commerce Clause" of the U.S. Constitution have to do with the regulation of the insurance business?

6) What does the McCarren-Furguson Act say?

7) Why does the SEC regulate variable life insurance contracts?

8) List four reasons for State regulation of the insurance business?

SECTION II: BASICS OF CONTRACT LAW

DEFINITIONS

"Contract" has been defined as both a binding promise and as an agreement enforceable at law. **Williston on Contracts,** an important and respected commentator on contract law says a contract is: **"a promise or set of promises for the breech of which the law gives a remedy or the performance of which the law in some way recognizes as a duty and that makes it a binding promise."** Therefore, there must be a promise or several promises in order to create a legal duty of performance. In the insurance contract, the typical pattern is for the life insurance company to use language that says it agrees to pay according to promissory words. This language creates a legal duty by the insurance company. There are various types of contracts including the following:

1) BILATERAL is a contract in which promises are made by two parties to a contract and one promise is considered to be consideration for the other. Most contracts are of the bilateral nature.

2) UNILATERAL is a contract in which the promise or promises are made by one party only. One example is the life insurance contract. The life insurance company must agree to perform as long as the insured party continues to pay premiums promptly. However, the insured can walk away from the contract any time by simply withholding or not paying premiums. The insurance company cannot enforce payment in court.

3) FORMAL promises are binding on a contractual basis when specified forms have been complying with, such as are found in deeds and negotiable instruments.

4) INFORMAL contracts create duties which are legally binding because the parties meet requirements that relate not to form but to types of transactions, such as life insurance. Most contracts are considered to be both bilateral and informal.

5) ALEATORY is a contract of unequal consideration. It is a contract in which one of the parties can get a lot more in value then has been exchanged on their behalf. An example is paying the first premium of $300.00 for a $100,000.00 life insurance policy and then dying. $100,000.00 goes to the beneficiary although only $300.00 was exchanged on the part of the insured.

6) VOIDABLE is a contract which could be set aside or avoided by action of one of the parties due to imperfections in the agreement.

7) **VOID** means a contract never had any legal effect to begin with, such as a contract to kill an individual for money.

8) ADHESION contracts are offered on a "take it or leave it" basis. When an insurance company writes and tries to market a policy with unclear language to prospective policyholders, courts will always interpret the terminology in favor of the insured or beneficiary against the insurance company. Since the insurance company was deemed to be in a superior position to create the contract to begin with, any ambiguous and unclear language is automatically construed against them. Therefore the life insurance contract is unilateral, informal and aleatory, as well as a contract of adhesion.

ESSENTIAL ELEMENTS OF THE CONTRACT

The first main ingredient to the formation of any contract is **the offer.** An offer **is a proposal which will create a binding contract if it is accepted according to its specified terms.** In order **for an offer to be valid, it must be definite**. Before a court will validate the existence of an offer, it must be communicated to the attention of the party to whom it is offered. The party to whom an offer is communicated is called the offeree.

There are **five ways to terminate an offer** and among them the most basic is for the offeror to withdraw the offer. However, once an offer has been accepted, it cannot be withdrawn. Therefore, withdrawal must occur prior to any acceptance by an offeree. An offer can be terminated by the **rejection of the offeree** who either rejects the offer outright or makes a counteroffer. The counteroffer immediately terminates the original offer. In addition to the counteroffer, **an offer may be terminated automatically at a predetermined point in time,** such as an expiration date. **Insanity of either the offeror or offeree** will end an offer **and the death of a party making an offer prior to the acceptance** terminate that offer as well. Technically, an offer is accepted by an offeree with any actions or words which indicate consent to that offer.

Mutuality of assent, meaning one party made an offer and the other party accepted it, is an essential ingredient in formulating a contract. Acceptance by an offeree must be unconditional and no counteroffer is allowed. Acceptance must be positive and intentional. This means it is clearly indicative of consent to the exact action and/or terms proposed by the person making the offer. Only the person to whom an offer has been made can accept that offer and the acceptance must be communicated by the offeree.

In the case of a bilateral contract, acceptance does not, in fact, have to be communicated if the offeree uses the means of communication that the offeror has specified. In a unilateral contract the performance of an action completes a binding agreement. Silence is generally not considered to be an acceptance. Example: If I do not hear from you in ten days you have bought my car for $2000.00. The fact that the offeree remains silent does not force him to accept the contract at the end of ten days.

Beside mutuality of assent, another major aspect to contract formation is **legal consideration.** Consideration is an **exchange of value** or quid pro quo (literally translated from Latin means "something for something"). Consideration is what is being requested and paid in exchange for a promise. **Mutual promises,** in which one promise supports another, **can be consideration.** When it comes to whether or not consideration is adequate or enough, the **law does not look into the actual adequacy** of consideration. This means if a specific act or consideration was requested and subsequently given, this can be adequate consideration.

A conditional promise is adequate consideration for another promise. For an example, the promise to pay an insurance benefit is conditional on an actual loss occurring. In the life insurance contract, consideration (premium) is the value or the benefit requested which is given in return for the promise of death benefit payment. All promises are made by **the insurance company because the life insurance contract is unilateral.**

In a **valid contract all parties** to the contract must be **competent. A corporation (insurance companies), has the capacity to contract** as determined by the state incorporation charter and laws of the corporation's domestic state (the state in which the corporation is organized and filed). Before an insurance company can be competent, it must get official licenses from each state in which it intends to be business.

Individuals must be sane and generally of legal age in order to be competent. If an insane individual has an appointed guardian then contracts made by the insane person are not enforceable. However, when there is no guardian, an insane person can either accept the contact upon regaining sanity or disaffirm it.

Minors rights depend entirely on the laws of a particular state. The vast majority of states consider anyone **over the age of eighteen** as possessing the capacity to contract. A minor can decide whether or not a contract is beneficial to them personally, and this determines whether the contract is binding. This means that **the minor has the right to void a contract. Contracts for necessaries are binding and state** laws usually hold that a **minor is liable for the reasonable value of "necessaries" including** things such as shelter, clothing and food. Minors cannot disaffirm contracts involving real estate until the age of majority is reached and then the minor must void such a contract within a reasonable time frame. **When the issue is minors and contracts and life insurance, the minor can disaffirm a contract and recover all premiums paid.**

Parties deemed not competent to contract include intoxicated persons: individuals so heavily under the influence of drugs or alcohol that they could not understand the nature of the contract. Such agreements are voidable and intoxicated persons can affirm or disaffirm contracts when they recover.

Special rules apply to competency of convicts and aliens to contract and this varies on a state by state basis. While convicts may or may not have such capacity, the contracts of aliens are normally valid and enforceable except that contracts between citizens of two countries at war are void.

Finally, in order for **contracts** to be enforceable in a court of law they **must have a legal purpose.** A contract involving wagering or gambling would not be enforceable in a court of law, although such a situation may indeed have its own, and perhaps even more enforceable, method of collection.

Contracts can either be expressed (in writing) or implied (other than in writing), which means that an informal contract does not have to be in writing to be valid. Insurance contracts do not necessarily have to be in written form but, due to their complexity, they are written.

DURESS

In contract formulation it is essential that the parties to the contract exhibit freedom of will or choice. **Duress** or, as it is sometimes imprecisely called, **"undue influence"** of one party over another party can make a contract unenforceable in a court of law. **Duress occurs when** one person makes a contract against his or her will due to the intimidating or wrongful acts of another. **Undue influence**, on the other hand, involves misusing a position of domination or confidence by one person to overcome the will of another person. In the formation of the life insurance contract the situation sometimes arises when undue influence is exerted over a policy owner to make a change of the beneficiary. If the insurance company then unknowingly pays the new beneficiary without knowing that there was duress or possible undue influence, then the insurance company ordinarily will not be liable to the original beneficiary. The exception is when the company pays benefits to this new beneficiary even though the original beneficiary made a claim of duress or undue influence **before the insurance proceeds were paid.**

CONSTRUCTION OF THE CONTRACT

Our court system has evolved a defined set of general rules which are applied by the court in deciding the meaning of a contract. **These generally defined principles are called rules of contract construction** and these rules help the court to interpret the meaning of the words in a contract. The court's

primary objective, when utilizing contract construction is to discover the most likely intent of the parties and to enforce the contract in that manner.

When the language of a written contract is clear and unambiguous, the court does not engage in construction. Courts are not permitted to rewrite contracts in the name of interpretation and unambiguous and clearly written agreements will be given complete and full effect. **The court tries to decide what the contract meaning is with respect to the entire agreement.** The court interprets meaning from the entire agreement, and not just from bits, pieces, or sections of the contract. The **court will give language and words their ordinary common use meaning** but if words are meant to be used in some technical framework then, of course, those words would be given their technical interpretation.

Whenever they can do so, **courts will provide an interpretation holding that a contract is valid** rather than interpreting means which would make a contract invalid. The rationale for this is the presumption that the parties to the contract intended to make it valid. The court then views its job as finding meaning in the contract according to the wishes or intentions of the parties since they wanted to be bound by an enforceable contract.

When language in a contract is ambiguous, courts will generally **interpret the terminology against the party** or individual **who wrote the contract.** In other words, ambiguous language is interpreted against the maker to the benefit of the other party in the contract. This application of contract construction is used frequently when insurance company policies are involved. **Courts have consistently held in favor of insureds and policy owners against insurance companies when unclear or ambiguous language has been used in the contract itself**. The feeling is that the insurance company, since it created and wrote the contract, was in a favorable position to decide what words it wished to use in the contract. If the insurance company chose language poorly then interpretations will be held against them.

When printing, typing and handwriting is present in a contract it is generally held that **typed and handwritten material is more important** than general printed matter. The rule of construction applied: typed or handwritten terms were utilized by the parties themselves and while printed matter is normally couched in more common usage. Typed and handwritten matter indicates the actual intent of the parties. When typed writing and hand writing are inconsistent, hand writing is dominant and will control in matters of contract construction.

PAROL EVIDENCE RULE

The word **"parol" is French for speech.** Parol evidence is oral in nature and is usually testimony provided by witnesses in a court of law. **The parol evidence rule is used when parties to a contract use unambiguous or clear writing. Any and all oral agreements made prior to the written agreement are merged into the written contract and become part of it.** It is not permissible for the parties to use oral evidence in order to take away from or add to, or alter a contract once it has been clearly written.

Since life insurance polices are usually written agreements, they are subject to the parol evidence rule and oral evidence cannot be used to contradict the written provisions of the life insurance policy. There are several exceptions to the parol evidence rule and the following are the most common:

FORMATION DEFECTS - If it can be **shown no contract was formed in the first place,** the parol evidence rule will not stop the use and consideration of oral testimony. Because there was no legally binding contract to begin with, oral evidence can be used to demonstrate the lack of formation.

OTHER DEFECTS - Such as fraud, duress, no consideration, illegality, and mistake can also be demonstrated by oral evidence. In court cases involving life insurance contracts, the courts always point out the parol evidence rule prohibits the introduction of oral evidence for the purpose of contradicting, changing or adding to the terms incorporated into, and made part of, a written contract. However, in a fraud case for example, no contract existed in the first place and the use of oral evidence is permitted.

INCOMPLETE FORMATION - When it can be shown that a contract, as written, is incomplete and additional provisions were to be made part of the agreement, parol evidence can be used to establish the inclusion of provisions which were agreed to but failed to be incorporated into the written contract.

LACK OF CLARITY - ambiguity in a written contract invites the use of oral evidence to properly interpret the contract. Sometimes a contract is so poorly written that is does not express the original intent of the parties. Under such circumstances, **"reformation"** can be used and the court actually rewrites the contract to reflect the original intent of the parties. Oral evidence can be used in **an attempt to reform the contract** to the original intent of the parties.

LIFE AND HEALTH INSURANCE CONTRACT LAW

When applying contract law to life and health insurance contracts, the general principles outlined above are valid. However, there are some special rules in addition to the general contract rules which also apply. A large body of special insurance contract law has developed and it is important to analyze some of the distinctions and differences that have evolved in our society. **A later section in this course deals comprehensively with life and health insurance contracts and specific provisions.** There are numerous differences between life and health insurance contracts as opposed to other contracts not dealing with insurance. Because of these contractual differences, it has been important to lay a foundation of general contract law for the express purpose of more easily understanding the distinctions specific to the uniqueness of life and health insurance contracts.

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SECTION II STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) Discuss the reasons why a life insurance contract is referred to as "unilateral."

2) List fives ways in which an offer can be terminated.

3) Name some of the conditions under which a party to a contract may be deemed incompetent.

4) Explain the difference between "duress" and "undue influence."

5) What is the general purpose of contract construction when engaged in by a court?

6) Why is handwriting more important to a court than printed material in a contract when interpretation is necessary?

7) What is the significance of the Parol Evidence Rule?

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SECTION III: THE ELEMENTS OF AGENCY

Agency centers around the concept that a person ("agent") who acts under the direction or authority of another (a "principal"), can legally bind the principal to actions taken by the agent. When an agent is appointed to act or perform on behalf of a principal a specific legal relationship is created. This special relationship needs to be explored within the context of insurance law. Corporations **(life and health insurance companies) must appoint individuals to perform virtually every task** in order to maintain day to day operations. These corporations, by their very nature, transact business through agents.

Within the context of insurance sales the word "agent," has the fairly narrow definition of "a person who acts for another person" in contractual matters with third parties. It is in this sense the agent creates, modifies, performs, and terminates contracts for the principal. **The agent who is soliciting business for an insurance company,** or helping to create contracts of insurance coverage, **is distinctly different from the agent whose job functions within an insurance company are the receptionist, computer programmers, secretaries, etc.**

Since this course is concerned with the application of contract law and how it applies to insurance contracts, the concept of an agent will be narrowly defined to mean the creation, modification and termination of contracts on behalf of a principal.

POWER AND AUTHORITY

At the heart of the concept of **agency** is the idea **power is created.** The agent operating on behalf of a principal can create, for the principal, contractual liabilities and, therefore, create rights of contract for which the principal is bound. **Power should not be confused with "actual authority"** because power is a far broader term. Sometimes it appears an agent has the power to bind a principal to a contract but in actuality the agent has no such actual authority to create as binding situation. This is an example of **"apparent authority."**

KNOWLEDGE AND DUTIES OF AGENTS

When an agent takes action within the scope of his or her powers, such action is considered to be the acts of the principal. This is agency law at its most basic and literal translation from Latin phraseology which states it as **"He who acts through another acts himself."** One key area concerning the action of agents includes **payments of funds made to an agent** when that agent has either **expressed** or **implied authority** to take the payments. **This is the same as paying the principal. "Express authority" usually means** authority which is granted in writing by a principal to an agent. **"Implied authority" is** authority to act which can be interpreted or reasonably believed to be proper due to the actions of a particular principal and agent. Even when an agent may be authorized to sell on behalf of a principal, there may be no implied authority for that agent to actually collect payment for anything sold on behalf of the principal.

Agents with apparent authority may have the power to collect payment because apparent authority indicates the existence of an agency where the authority of a principal has created the appearance of payment collection authority to an independent or third party. **When a third party makes a payment to an agent who has either implied, expressed, or apparent authority to receive that payment, this third person will in no way become liable a second time if the agent does not, in fact, provide the payment to the principal**. The principal cannot bring a law suit to force the third party to pay a second time since the action of the agent precludes such a possibility for the principal.

Agency law also mandates that the knowledge of an agent is imputed to the principal, meaning where the agent knows something about a business transaction, it is automatic that the principal is also aware of conditions between the parties. **Whether or not the principal actually knows is immaterial.**

As part of life and health insurance contract formation agents complete the application on behalf of the individual (applicant) applying for the insurance coverage. If required, a doctor, paramedic or medical examiner completes and signs certification about the proposed insured's health condition. **The personnel included above are agents of the insured** and they sometimes make mistakes or record incorrect statements. The courts of **most jurisdictions hold that any mistake made**

by an agent is within the realm of knowledge of the insurance company (principal) and the company is bound even if the policy issued would not otherwise normally be issued in the absence of the mistake. This type of contract will be considered valid even when incorrect statements are made in the application (does not include the concept of fraud or innocent mistakes).

On the other hand, it is also a rule of contract law that **the person accepting a written contract knows what is contained in the writing** and agrees to the conditions therein. Most jurisdictions in America charge the applicant, upon receiving a policy and the attached application, with the duty to review the application and give notice to the insurance company of any incorrect statements. **If incorrect statements made by the applicant are material** (of such great importance that the prior knowledge of the incorrect statements would have precluded the company from even issuing a policy in the first place) the insurance company can rescind the contract.

LEGAL CAPACITY OF AGENTS AND PRINCIPALS

Legal capacity of an individual to be a principal includes the notion that **an individual or a corporation can be a principal** and appoint agents to act on its behalf as long **as the principal has the capacity to engage in formulating a contract. Partnerships cannot be principals** since they are not legal

entities. Anyone who acts on behalf of a partnership is construed to be actually acting on behalf of individual partners. **Individuals or entities that do not have the capacity to contract cannot be principals.** A person who is incompetent or mentally infirmed cannot cure this incompetence by appointing an agent to engage in contractual capacity on their behalf.

Minors can contract with agents for goods and services which are "**necessaries"** and **will be bound** to such contracts. Contracts entered into by minors for **other than the necessaries will be voidable** by the minor. In this same vein, individuals who are mentally incapacitated have no capacity to engage in a contract and cannot appoint agents. **A person who is intoxicated** by alcohol or drugs to such an extent that the ability to reason does not exist, **cannot appoint an agent** although that same person may be able to appoint an agent when not severely intoxicated.

Virtually any person can be an agent. Agents do not posses contractual capacity since the contract which is formed by the agent is actually the principal's contract. Using this logic, a **mentally incapacitated person, a minor, or person under the influence of drugs or alcohol cannot act as principal but can act as an agent** if they can conceive and convey ideas. The principal cannot avoid a contract completed by an agent who happens to be a minor and who acted on behalf of the principal by using the argument that the agent is a minor.

Corporations, partnerships and individuals can also act as an agent. General **rules of the law of agency govern no matter if the agent is a corporation, a partnership or a natural person. If jurisdictions** such as state or federal requirements **mandate that agents must be licensed,** an **agent cannot act without one.** Individuals such as insurance agents, real estate agents, insurance and real estate brokers, attorneys, doctors, etc., must be state licensed before they can act on behalf of others.

THE PRINCIPAL-AGENT RELATIONSHIP

There are several ways in which an agency relationship can be created. A central doctrine of the agency relationship occurs with actual authority. **Actual authority means that the agent can act on behalf of the principal when the agent reasonably has a belief that he or she has been given the authority to act by the principal.** It **is the "reasonable belief" that is important** and **not in fact what the principal actually would have intended or wanted.** Courts will examine the intent of the parties to determine whether or not an agency relationship was created.

Actual authority can be broken down into the two further prongs of express authority and implied authority. When appointment is communicated to an agent and that agent accepts or consents to that agency, the agent has expressed actual authority (consideration is not always required). Because of this, an agent can act even though they may not be paid. Implied actual authority is created when there is no express agreement to create a relationship of agency but the agency relationship can be reasonably interpreted from the acts of the parties. Again, the **agent must reasonably believe he or she has agency authority to act on behalf of the principal.**

Authority of the agent can be implied when the principal fails to object or correct a series of unauthorized acts by the agent leading that agent to believe reasonably that they can repeat these acts in the future. Implied authority can also be considered coincidental to expressed authority because the grant of authority ordinarily cannot meticulously detail every possible action of an agent's authority. **The authority of an agent to use all reasonable means necessary to carry out the agency is implied** and unless a principal otherwise directs an agent, he or she has the implied authority to act within the general customs of the business in which the principal is engaged.

Apparent authority rules dictate that a principal is not responsible for the actions of another when that person claims to represent him or her unless the principal has consented to the actual agency relationship. **When a third person witnesses conduct which leads him to believe that an individual is acting on behalf of a principal as an agent then an agency situation may be created.** However, **third persons cannot say that they relied on an apparent agent's authority if they knew in fact that individual had no authorization from the principal to act.** When an apparent agent's actions are so irregular or unusual that they should have created suspicion in the mind of a reasonable person, this can stop a third person from attempting to establish apparent authority. Such irregular conduct implies the third person in fact knew, or should have known, that the agent did not have the requisite authority to act on behalf of a principal.

Agents who have authority but engage in actions that go beyond the scope of the authority granted may bind the principal if the principal allows the agent to act in this manner. Any future actions by the agent in this same regard would fall under apparent authority because third parties would have reasonable belief that the agent had the authority to act as he or she did. Apparent authority is created when agents engage in a customary business manner and a third person reasonably believes the agent acted with actual implied authority. For example, in a life insurance contract an agent customarily collects the first premium with an initial application. The insured could be led to believe that premiums subsequently collected could also be given to the agent.

Under normal insurance agency rules, agents are forbidden from accepting premiums after the initial premium. If an insured does give renewal premiums to the agent and the agent personally uses or misappropriates the funds, an insured is not required to pay the premium a second time to the insurance company. Since the insured witnessed that the agent had collected money previously, the insured (third party) reasonably believed the agent had apparent authority to collect future premiums.

RATIFICATION

When there is validation of an action because someone is a purported agent and their act is unauthorized but could be construed, due to previous relationships between the principal and agent to be a valid situation, there is "ratification." Actions can be ratified before or after they are taken to establish an agency situation. There are **five basic requirements** for an unauthorized act to become effective through **ratification:**

1) The person performing an act must have purported to have acted for the benefit or on behalf of the principal. This agent must have represented themselves as an agent and the third person must have thought that they were dealing with an authorized agent.

2) No one except the principal or the person in whose name a contract is made has the power to ratify an act.

3) For ratification to be valid, the person making the ratification has to know all the important facts about the action at the time of the ratification. This means that if the person ratifying is not aware of material facts they may avoid ratification.

4) In order to be valid an entire action or transaction must be ratified. A principal cannot agree to ratify only part of an action.

5) There can be events which occur that can take away the power of ratification such as a third party withdrawing from a transaction prior to actual ratification. Loss of capacity or death of a third party is considered withdrawal from a transaction and will also eliminate a principal's ability to achieve ratification.

When ratification is effective, it binds the principal in the same manner as if the agent has acted in accordance with the expressed desires or wishes of the principal. Ratification becomes effective as of the date of the action because it relates directly to the time an act was accomplished. Ratification of unauthorized actions removes the agent from being liable to the principal for acting without authority. When ratification takes place, the agent is deemed to have acted within the full authority of the principal.

LIMITATIONS OF THE AUTHORITY OF AN AGENT

A principal has the right to define and limit the authority given to an agent. Limitations are binding upon any parties with whom the agent would deal as long as the limitations are properly established. Limitations which are deemed proper include those which are reasonable, not against public policy and legal in the jurisdiction in which they are made. A common limitation is the insurance principal-agent relationship. Many states acknowledge that the knowledge of an agent is not imputed to the insurer and this goes against the general law stating that the agent's knowledge is the knowledge of the principal. However, most jurisdictions do hold that the actions of an insurance agent are imputed to the principal. Another common limitation of an insurance agency is the agent cannot utilize any authority or powers except those spelled out in a policy. Such a limitation is effective as it pertains to insurance agents because of the contractual powers they do have when representing the principal.

Another issue at stake is the degree of control the principal may exert over an agent. This control depends on the legal relationship between the parties: is it an employee-agent relationship or an independent contractor-agent relationship? A **principal has control over the manner and the method of how a job is done when an employee is an agent.** However when the agent is an independent contractor the agent may perform the job duties using their own discretion.

Agent duty is directly related to the concept that an agent acts in a **"fiduciary capacity"** since agents are in a **position of trust relating to the principal.** When handling the affairs of the principal, agents owe a strict duty of loyalty to the principal. Agents cannot take advantage in the marketplace and benefit personally and at the expense of the principal. Agents have a legal duty to follow a principal's instructions as long as they are reasonable and lawful in nature. **Agents must act within the limitations of the authority having been bestowed upon them.**

Even when a principal terminates an agent's authority breaching their own contract, the agent still must obey the principal. **An agent has the duty to perform the agency relationship with "reasonable care" and must exercise skill which is "ordinarily possessed by persons in the same business."** The agent also bears a duty of not performing business activity in which the agent lacks competence.

When an agent goes astray and performs poorly or improperly, the principal has at his disposal a wide array of legal and equitable remedies to use against the agent. If a third party sues a principal because an agent engaged in a wrongful act and the principal is held liable, the principal may be able to recover from the agent any money paid to the third party plus any reasonable attorney's fee incurred. Finally, if an agent steals from a principal, the principal also can hold the agent liable.

The principal owes certain responsibilities to agents. A principal must provide agents with the necessary goods for sale. The principal must compensate the agent for amounts earned in the execution of the agency relationship but agents guilty of illegal actions may lose their right to compensation. It is the duty of the principal to keep accurate records and accounts of what the principal owes to the agent and a principal may deduct various expenses as provided by law, like tax payments.

Agents also may take advantage of legal and equitable remedies on their behalf in principal-agent relationship **with the exception of "specific performance."** Specific performance would require a contract to be carried out by the principal against his will and this is not a logical possibility of the agency relationship. Likewise, the United States Constitution prohibits slavery and involuntary servitude, agency contracts are not subject to specific performance and the principal could not specifically enforce a contract against the will of an agent.

When a principal is bound by an agent to a third party, the third party can hold the principal liable on the contract as if the principal had personally entered into the agreement. Third parties have all remedies available which are available to a contracting party, but if the agent acted with improper motive or intent and the third party knew of this, then the principal will not be bound. Principals can enforce contracts made by agents against third parties and they will be

as enforceable as if the principal personally had negotiated the contract. Principals have the right to seek legal redress against third parties who knowingly commit a fraudulent or wrongful act or who encourage the agent to engage in actions counter to fiduciary duties owed to the principal. For instance, any third party who bribes an agent to act against the principal's interest can be liable to the principal for the harm which would result.

An agent who makes a promise to a third party indicating they do in fact have the authority to act for the principal is demonstrating purported authority. However, if the agent has no authority to act then a principal cannot be legally held to any contract which is formed. Furthermore, the purported agent can be liable for the harm caused to the third party. Likewise, agents can be held liable due the misrepresentations they make to the third party since the agent owes a duty to the third party not to injure them, not withstanding the agency status.

There are many classifications of agents including general agents and special agents. Such terms have no precise definition under law because the language regarding general agent and special agent is so vague that courts find it difficult to apply remedies. Terminologies such as "general" and "special" agent are not consistently used even within the insurance industry itself! The terms can mean one thing or another depending upon how they are applied. Some definitions include a general agent is the agent who is

employed to conduct a series of transactions and to keep service continuous. A special agent is authorized to act or conduct one or a few types of transactions but without service continuity.

Most commonly in the insurance industry, general agents are held to be persons who have a franchise on behalf of the insurance company to try to develop business within a certain territorial boundary. General agents seek to hire agents and staff in the hopes of growing and building a successful general agency. Policy issuance, on the other hand, is specifically within the domain of the life insurance company at the home office. **Neither life insurance agents nor general agents have the ability to complete a contract of insurance.**

Another main concern in the agency-principal relationship is the manner in which an agent's power can be terminated. It is generally held that when an agent's apparent and actual authority terminates, the agent's power also ends. Actual authority ends by agreement or operation of law while apparent authority terminates when third parties no longer have any reason to believe that an agent has the authority to act for a given principal. When the principal and agent mutually agree, an agency relationship can terminate.

An agency can also terminate due to the actions of either the principal or agent, such as the breach of agency contracts. The law can automatically end an agency relationship, such as with the death of a principal, even if the agent and third people are unaware of the death. The death of an agent also ends an agency contract. If a principal or agent experiences loss of contractual capacity (as in the case of insanity) an agent's authority terminates. An agent who no longer possesses authority cannot bind the principal in any dealing with a third party. However, if a third party is not aware of a prior agency termination, the agent may still have apparent authority and may bind the principal.

MASTER AND SERVANT

Going back to old English law, the terminology of **master and servant** was used to designate the principal-agent relationship. Today the labels of "employer-employee" are used in law rather than master-servant. An important test as to whether an individual is a servant is "physical control." When the master has the right to control the physical conduct of individuals, those people are servants when they work as full time employees, are paid on a time basis and are supervised by an employer who directs the details of carrying out jobs.

The Latin phrase **"Respondeat superior"** literally means **"let the master answer."** The impact of this legal principle means both the master and servant are responsible for injuries committed against third parties by the servant or master. The standard of care of negligence is applied to the actions of servants. Breach of this standard will bind a principal to answer for the servant's actions. Exceptions to holding a principal liable are the intentional acts of a servant which are outside the normal course of a servant's employment.

Employers are not usually liable to third parties due to the negligent acts of independent contractors. It is sometimes very difficult to define or separate the "independent contractor" from the "employee" as each has similarities of the other. For example, a person with distinct business skills hired to do a particular job and who is paid for that job rather than on a salary basis is considered an independent contractor. Contractors also use their own tools and follow their own discretion in carrying out the specifics of the job. Hiring a CPA or an attorney to act on behalf of a corporation is an independent contractor situation. One **important difference between employees and independent contractors is that an employer do not control the way in which in an independent contractor performs a job.** The employee, on the other hand, is directed specifically about the how, when and where of task completion

LIFE AND HEALTH INSURANCE AGENCY

In discussing the elements of agency and their relationship to insurance, it is important to define the legal capacities of certain types of people who act on behalf of insurance companies. **The distinction between "agent" and "broker" must be drawn.** Insurance **agents are entities or individuals who are appointed** by an insurance company **to solicit applications** for insurance **on behalf of the insurance company.** The insurance company and the agent normally have signed a written agency agreement and the agent must be licensed is the state in which applications are solicited. It is common for the agent to sell insurance for more than one insurance company. Sometimes the term "broker" is applied to such a person in this situation, however, most of the time this individual is an agent of each insurance company and is not in fact a broker. **A broker is distinguished as a person or entity whose business it is to bring buyers and sellers together** for the purpose of affecting an insurance contract. The **broker is the person who obtains insurance for people** requesting such a service **and is deemed to be the agent of the applicant** for insurance rather than to be acting on the behalf of the insurance company. This is true even though the broker could be the agent of the insurance company for other purposes, such as collecting premiums and delivering policies.

Another distinction is the **"insurance consultant,"** a person who **is paid a fee from a client for providing advice** regarding holding or purchasing insurance contracts. Such consultants are required to be licensed as such in some states. Determining which activities require specific licenses is within the domain of an individual state. **The National Association of Insurance Commissioners (NAIC)** developed the "Agents and Brokers Licensing Model Act," which requires that consultants should be licensed. Under this model act, parties such as agents, attorneys, bank trust officers, brokers, public accountants and actuaries, who act within professional capacities, do not have to be licensed as consultants. It says that licensed insurance consultants cannot be agents or brokers or receive money from agents, brokers or insurance companies. A written exam is normally required before a person can be licensed as an insurance consultant.

Finally, there is the "financial planner." There are several educational programs available including The American College which offers the Chartered Life Underwriter (CLU) and Chartered Financial Consultant (ChFC) designation. In addition, there is also a self study program available from another source leading to the Certified Financial Planner (CFP) designation. Financial planning is an area where individuals give advice to people regarding how they can manage their financial resources based on a thorough analysis of client needs. The planner studies information received from the client, directs and implements a comprehensive financial plan and then periodically reviews the program to urge the client to make changes where necessary and appropriate.

Any **insurance agents or brokers who do financial planning usually must register** with the federal government **under the Investment Advisors Act of 1940.** An individual must register if they:

1) provide advice, issue reports or analyzes securities or

2) are in the business of providing such services or

3) provide such service for compensation.

The Securities and Exchange Commission (SEC) says that a financial planner who provides advice which is not specific in nature, but which concerns securities is still acting within the legal definition of an investment advisor. The financial planner must register under the act even if they merely discuss the basic advantages and disadvantages of investing in securities as compared to other methods of investment. This broadened definition of the SEC is interpreted by many to include even a life insurance agent or broker who describes the difference between a variable and a fixed annuity. However, caution must be exercised concerning compliance because this is such a grey and undefined area. The best advice: when in doubt, comply!

AGENT AND BROKER LICENSING

Anyone who solicits a sale of an insurance contract has to be licensed in some capacity in any state where they do business. Consultants who merely advise on insurance purchases instead of selling policies, need to be licensed in some states as consultants while other states exempt certain classes or occupations of people. An individual who sells variable insurance contracts needs both a state insurance license and securities license (Series 6 or 7).

Individuals must be licensed in each and every state where they do business. **Sometimes it is not easy to determine exactly where the individual is doing business.** If there is any doubt as to where business is actually being transacted, alert agents and brokers obtain **"nonresident licenses"** in any states where the question may arise as to whether or not a license is necessary. General requirements for licensing individuals, corporations, associations, or partnerships include a minimum age requirement for a person of at least eighteen years. Many states also require prospective agents to participate in a minimum number of classroom hours in the instruction of insurance. Applicants for the insurance license must be of good character and deemed to be trustworthy, competent, and financially responsible with a good business reputation.

Some states even require that applicants for licenses must be actively engaged in the insurance business. The State of Illinois, for example, mandates that an agent can lose their insurance license if, in a previous year of business, the total of premiums collected on controlled business is more than the total amount of premiums collected for all other insurance business of the licensee applicant. **Controlled business** is defined as writing business on your own life, property or risks, or those of your spouse, employer or your own business. In Illinois, the licensee must intend to sell more insurance to the public then to others in the controlled business category.

Other states offer a temporary license and no examination is required. The temporary license allows applicants to sell insurance while training to obtain a permanent license. There is normally a 90 day specified time period under which the temporary license is effective. Also, "limited" licenses may be available involving selling insurance for limited and specific purposes such as burial, travel, credit life, and credit disability.

Recently a majority of states have adopted legislation requiring licensees to complete **continuing education** in an effort to keep them informed of changes in the field. While some states have no continuing education requirement, others limit the number of years a licensee is obligated to perform continuing education and some require continuing education be performed on an annual or biannual basis for as long as the licensee holds a license. The vast majority of individuals reading this book are undoubtedly aware of the continuing education concept.

Reasons for which an agent can lose a license or have it suspended, revoked, or denied include: felony conviction which results in prison time or fines for such things as conspiracy, embezzlement, theft, forgery, fraud and larceny. Specific **insurance code violations** which will result in revocation, denial or suspension of license include unauthorized solicitation, delinquency in remitting premiums, rebating, twisting, soliciting for an unauthorized insurance company, and misrepresenting information on applications. Twisting involves convincing an applicant to replace an existing policy and the agent uses misrepresentation as a sales technique to effect the sale of a new policy while canceling an older one. **Rebating** is giving part of a commission or offering other incentive as an inducement for the applicant to purchase insurance and it **is forbidden by law in most jurisdictions.**

A **Florida Supreme Court decision held that rebating is unconstitutional,** stating in its decision that prohibiting rebating limits the bargaining power of the consuming public. The defense from the insurance industry for not allowing rebating is based upon two central arguments: first the need to guarantee insurance company solvency from inadequate premium collection, secondly, the need to stop consumer price variations. Because of rebating, it was argued, there would be discrimination to insureds who presented the same risk to the insurance company but who would be paying different premiums. Whether or not the Florida Supreme Court decision will become a trend adopted by other jurisdictions remains to be seen.

EMPLOYMENT CONTRACT AGENCY AGREEMENTS

When an individual is appointed by an insurance company to solicit business, a written or oral contract will legally bind the parties. This creates an agency relationship. **It is the agency contract, not the state license, which gives an agent the authority to act on behalf of the insurance company.** Such agreements contain specific methods for terminating the agency contract. In almost all circumstances, agents can only solicit insurance applications for admitted (approved/licensed) insurers. Any policy form which is marketed in a state must be approved by that state's department of insurance before the policy can be legally sold. Agents must truthfully represent the coverage which is provided in a policy and full policy disclosure has to be provided by an insurance company, through an agent, to the insured. Documents such as a policy summary and buyer's guide are often required in compliance with NAIC life insurance solicitation model regulation.

Authorized premium collections, on behalf of insurance companies **by the agent, are limited to collecting only the initial premium** paid on the policy. Agents are duty bound to account to the insurance company for any premiums collected for the insurance company. Premiums must be held in trust and, in some cases, an agent's own funds may pay the premium. Where an agent lends money to the client to pay a premium, the agent is entitled to be repaid and can sue on a promissory note.

Commissions are normally calculated as a percentage of the premiums paid to the insurance company. Only licensed agents can receive a payment of commission. The person who receives such a commission is considered to be the agent or broker of record to the company. Any renewal or repeated commission payments due in the future is determined by the agency contract. Some states legally allow sharing commission between agents, especially if a subagent of an agent places a contract. This is the case with legal commission overrides in which layers of commission are paid to two or more agents. Agents who breach the duties of the agency contract can lose their right to commissions.

Record keeping procedures are specified by state law and insurance regulations. **It is specifically prohibited in most jurisdictions to commingle premiums with personal funds in bank accounts which are specifically set up for premium collection.** Failure on the part of the agent to comply with proper record keeping will usually result in the termination of the state license.

Since insurance companies are large employers of personnel throughout the United States, federal statutes which protect employees apply. Actions by an employer including discrimination based on disability, age, sex and others are prohibited by the insurance company as an employer. Insurance companies are legally bound to federal/state regulations governing employers including rights held by individuals relating to affirmative action, sexual harassment, pregnancy discrimination, immigration reforms, wrongful discharge, job performance evaluation, etc.

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SECTION III STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) Provide reasons why an insurance company appoints agents.

2) What are the basic duties owed by a principal to an agent and vice versa?

3) What is the main difference between a broker and an agent?

4) Compare and contrast actual and apparent authority.
5) Name the name requirements for ratification.

6) How would you determine whether or not an individual is working for a principal as an employee or independent contractor?

7) List at least three ways in which Agency can terminate.

8) When does an insurance agent come within the jurisdiction of the SEC?

SECTION IV: WAIVER AND ESTOPPEL

Waiver and estoppels are important legal doctrines relating to the legal formation, enforcement and effect of contracts in a state jurisdiction. First, it is necessary to define these terms.

Waiver is generally regarded as the voluntary relinquishment of a known right. Express waiver can be made orally or in writing, while an **implied waiver results from conduct.** A person who supposedly waived something must have had that intention and must have demonstrated it either expressly or implicitly.

Estoppel is defined as losing the ability to defend yourself in a court action due to inconsistent conduct. Unauthorized acts of agents cannot create a waiver situation but may, in the same instance, create an estoppel. **Legal estoppel** occurs when an individual has executed a formal legal document and has made certain statements of fact which cannot later be denied in an evidentiary proceeding. **Equitable estoppel** is where one party is mislead to enter a contract and were not negligent or careless in the fact that they were mislead. The misled party can recover damages because of being mislead.

The effect of the actual knowledge of the insurance company is important regarding waiver and estoppel. **A party to a written contract is presumed to have knowledge of the contents** of a contract. However, an insurance company may not always have particular information which would allow them to avoid a contract. **Neither estoppel nor waiver exists when an insurance company does not posses pertinent and material facts.** In a significant number of jurisdictions an insurance company is bound by the knowledge of an agent after a policy was issued, including knowledge of soliciting agents and medical examiners. The company cannot automatically relieve itself of liability because of false information found in the application.

Courts have held that the applicant for insurance is accountable for the truth of statements in the application and has the duty to read the application before signing it. The applicant is charged with the knowledge of any false or fraudulent statements inserted by the agent, even if the applicant did not make them. If both the applicant and the agent agreed to present false information in an application in order to defraud an insurance company, then it is called collusion. **In collusion,** the **agency rule that the knowledge of the agent is imputed to the principal does not apply.** Courts consistently rule that applicants and beneficiaries will not be entitled to benefit from the effects of collusion.

FORBIDDEN CONDITION

Some waivers are forbidden such as waiving any right for which the government has enacted statutes or rules deemed to be in the interest of the public. A fact cannot be waived. An **insurance contract that is unsupported by an insurable interest cannot be made enforceable by waiver or estoppel.** In the event that an insurance company is not liable for a given type of loss, it is generally held that coverage will not be created by waiver or estoppel (example: the insured ages beyond the specified age for coverage for a specified benefit, like accidental death which stops at age 60, but continues to pay of premiums for that benefit. Such an error will not create coverage). An insurance company waiving the right to defend against payment of benefits because of breach of a contract, or to rescind a contract, cannot cancel this waiver. Finally, the **"doctrine of election"** is applied by courts when an **individual has two or more remedies which are not inconsistent,** but both are available to enforce a single right. In this situation an individual **must elect only one of the remedies.**

COMMON WAIVER AND ESTOPPEL SITUATIONS

In the insurance industry the most common waiver and estoppel situations include the following:

1) repeated acceptance of overdue premiums

2) delay in adjusting a claim

3) inaccurate or incomplete application information, with the exception of collusion, and

4) the invocation of the parol evidence rule which precludes the admission of oral evidence which could tend to vary or contradict the written terms in a life insurance policy.

Under the application of modern legal principles there is a basic conflict between the parole evidence rule and estoppel. The parole evidence rule forbids introducing oral testimony into court proceedings relating to the actions of parties before the contract was signed if that testimony would contradict the written contract. As long as lawsuits were brought in which possible estoppel was based on words or actions of the parties after the contract became effective, there was no conflict with parole evidence. However, when law suits involved possible estoppel based on words or actions of a party before a policy was enforced, this did conflict with the parole evidence rule. **The rule which has been followed by most state courts is that the oral testimony is admissible to establish an estoppel.** The reason there is no conflict is because oral testimony is not being admitted which would vary or contradict the written element.

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SECTION IV STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) Define waiver. Define estoppel.

2) What is presumed about applicants once they sign applications?

3) List four common waiver and estoppel situations.

4) What is the conflict between estoppel and parol evidence?

SECTION V: LIFE INSURANCE CONTRACT FORMATION

The application of state statutes, insurance regulations and generally held contract law directly impacts on the insurance contract. This course now focuses on the legal principles already discussed and how they specifically relate to the life insurance contract. It is of critical importance for the insurance professional to understand these applications and how they apply specifically to the life insurance contract.

OFFER AND ACCEPTANCE

One of the essential elements for contract formation is **"mutual assent."** Since a court cannot presume to know the actual state of mind of the parties to a contract, the words and actions of the contracting parties will be the controlling factor in any interpretation. Mutual assent is evidenced by one party making an offer and another party accepting the offer. The person who makes the offer is called the "offeror" while the person to whom the offer made is the "offeree." **An "offer" is simply a proposal which creates a binding contract if accepted.**

Before contract formation there must be intent by the parties to enter into a contract. An applicant for insurance is merely inviting an offer of coverage from an insurance company when the applicant does not pay a first premium but does select a

policy, completes the application, determines a method of premium payment and designates a beneficiary. Such an invitation itself is pointless, for example, if an applicant does not have insurable interest with reference to the proposed insured.

When insurability of the applicant exists and a policy is issued, **the company is making an offer when the policy is issued for delivery by the agent** "during the lifetime and continued insurability" of the proposed insured. The offeror (insurance company) owns the privilege of withdrawing the offer at anytime before the offer has been accepted by the offeree. **Once an offer is accepted, it cannot be withdrawn.** If an offeree rejects the original offer outright, the offer terminates. In any contractual situation it is common for the offeree to perhaps suggest a counteroffer. **A counteroffer to an original offer immediately terminates the original offer.**

At the offer and acceptance phase of insurance contract formation, signatures of the parties are necessary for a contract to be binding. The signature of the applicant must be personal unless the applicant specifically directs somebody else to sign on their behalf and the insurance agent knows of this signature designation. **When an insurance company receives an application for insurance, it is duty bound to act on that application within a reasonable time frame.** When there is delay in acting on an application, there may be contractual liability to the company.

For example, if a doctor causes a delay in returning an Attending Physician's Statement is a company bound to coverage? The **majority view** in the United States is inaction or silence on the part of insurance company does not automatically constitute the acceptance of an applicant's offer for insurance. Some minority rulings extend this to mean such delay is an inference to the applicant of rejection and to act accordingly. Several other jurisdictions hold that when a company retains the money it is inconsistent with rejection. Other jurisdictions extend this idea by saying **"reasonable promptness" is expected** and failure to reject an applicant within a reasonable time implies acceptance. This example in the diversity of jurisdictional interpretations serves to illustrate the same set of facts can lead to coverage or no coverage depending upon which state is involved. In the final analysis the life insurance company has a duty to act on an application with reasonable speed and there is usually a possibility for civil or tort liability when a company moves too slowly.

RECEIPT OF PREMIUM

The manner in which an insurance company receives the premium can vary. The "**conditional receipt" says insurance takes effect** on a date which is before the delivery of a policy. It is stipulated within the receipt that the application will be approved if the applicant is deemed to be an insurable risk on the date the application was signed. **The "approval receipt" says that insurance is effective**

immediately on the condition the application is subsequently approved (makes the insurance effective on the date the applicant is found to be an acceptable risk for the plan, an amount and a premium rate indicated). No insurance is effective, under the terms of an approval receipt, until the insured is found to be insurable. Insurability based conditional receipts are the most frequently used receipts. Another type of receipt is the **"binder"** which establishes coverage on the date of receipt subject to the right of the company to terminate coverage if the proposed insured is not found to be insurable.

Events which decide whether or not a life insurance company is bound to a promise are predicated on many conditions. The **"condition precedent"** of a conditional receipt means a condition must happen or be performed before the life insurance company is obligated to perform a promise. When a conditional receipt creates a condition precedent then the applicant for insurance must be found to be insurable and the application has to be approved before coverage is provided. A majority of insurance contracts fall into this condition.

On the other hand, **a "condition subsequent"** states that the rights already vested or established are taken away. In a binding receipt, insurance is effective immediately but if the applicant is found uninsurable, policy termination can result and the application is not approved. Because binding receipts can make insurance coverage effective immediately upon

paying the first premium, they have not created as many legal problems as have conditional receipts. **There has been a recent tendency of courts to treat conditional receipts as binding receipts.** The overall concern in the selection process centers on the idea that life insurance risks must be undertaken with deliberate and great care. Since insurance companies do not usually have the right to cancel a policy, avoiding adverse selection (great numbers of insureds who are poor risks) demands people being offered policies must meet some standard of insurability.

CLASSIFYING RISK

Risk classification allows the insurance company to identify people who have the potential for similar loss to be placed in the same risk group for the purpose of setting the rate of premiums to be paid. Common underwriting considerations such as health condition, occupation, age, sex, hobbies, etc., are used in the risk classification process. The selection of risk means the insurance company makes choices from between proposed insureds and decides upon the individuals it is willing to insure.

Selection of risk is done by underwriters at an insurance company's home office. An **agent** who solicits business **does not have the authority to determine** the **insurability** of the proposed insured. The company reserves for itself this crucial

right to select risk because the policy cannot ordinarily be canceled by an insurance company and, therefore, risks must be selected with great care. Risk classification involves discrimination in the literal sense of the word. Younger people are charged less premium than older people, healthy people pay premiums which are lower than sickly people, people working in more hazardous occupations pay more than those employed safer occupations and, since women live longer than men, females generally pay less for life insurance but more for annuities.

The main ingredient in determining whether or not a policy will be offered is the health condition of the proposed insured. Questions eliciting information from the purposed insured about cancer, hypertension, diabetes, heart disease, strokes and family health history are crucial to the underwriting decision. **The insurance company can send an Attending Physician's Statement to the proposed insured's doctor, solicit hospital records, send the proposed insured through physical exams, perform blood and urine tests or even undergo electrocardiograms.**

AIDS (Auto Immune Deficiency Syndrome) has created an entire uninsurable class of people because of the high risk, sickness and early death that the AIDS virus represents. **In most states, tests for AIDS or AIDS antibodies are permitted but some jurisdictions do restrict or even prohibit AIDS testing.** Legislation which limits such medical testing severely diminishes the ability of the insurance company to selectively underwrite risks. The consequence of such legislation is likely to be a dramatic future rise in premiums for all insureds.

Whether a proposed insured uses tobacco has a dramatic impact on the premium charged by an insurance company. Actuarial studies indicate cigarette smoking dramatically increases the risk of early death by as much as eight years or more for young people who smoke two packs of cigarettes a day. For many years insurance companies have been offering nonsmoker premium discounts for people who have not smoked for some period of time, usually one year or longer. Since the nonsmoker discount gives a lower premium, many insurance companies test urine for by-products of smoking, such as measuring nicotine, in addition to asking about smoking on the application.

An interesting issue arises when an applicant for life insurance represents the fact that they are not a smoker on an application when in fact they do smoke. **Is this a material misrepresentation such that it would allow an insurance company to rescind (void) the policy?** One recent leading case has found that misrepresenting smoker status is indeed a material misrepresentation of fact which will allow an insurance company to rescind coverage. If the smoker's systematically and routinely receive nonsmoker rates, the main party hurt will be the nonsmoker who will have to subsidize the premium rates of smokers by paying higher costs in the future.

THE STANDARD OF INSURABLE INTEREST

The idea that an **individual must have "insurable interest"** in order to own a life insurance policy dates back hundreds of years. When somebody other than the actual insured is applying for policy ownership, insurable interest must exist. It is critical in understanding the inherent nature of insurance that ownership must be placed outside of a wagering possibility. It is unacceptable, from the viewpoint of society, for one individual to own a life insurance policy on another when there is no real reason for such ownership other than for the person buying insurance wishing to profit from the death of the insured.

Generally, each individual has unlimited insurable interest in his or her own life and can buy as much insurance as an insurance company will allow them to own and can name anyone they like as a beneficiary. In most cases the beneficiary of a policy does not need any type of insurable interest to qualify in collecting the proceeds. It is assumed the insured names as beneficiary somebody whom they feel should benefit from the proceeds of the policy and nobody has the right to contradict this intent of the insured.

People who apply for insurance on their own life do not have to worry about the question of insurable interest. Cloudy areas come into play when another person wants to be the owner of an insurance policy on your life.

Insurable interest is normally defined as "any reasonable expectation of benefit or advantage from the continued life of another person." This advantage can be monetary but it is not a requirement and it can arise from natural affection or dependent status. It is not simple to identify the relationships that create insurable interest and such a listing is, at best, a grey area. Usually, one person has insurable interest in the life of another when they are closely related by blood or marriage or if they have a business relationship which would cause the beneficiary to suffer adverse financial hardship due to the death of the insured.

According the **majority court rule in America,** a **parent has an insurable interest in the life of their child and the child has an insurable interest in the life of the parent.** This also extends in most jurisdictions to that of a grandchild having insurable interest in the life of a grandparent. However, the reverse is probably not true. **Most modern cases support the position that sisters and brothers have insurable interest in each other because of the close blood relationship. However uncles, aunts, nieces and nephews do not necessarily have insurable interest in each other solely due to their blood relationship.** This lack of interest also extends to cousins. These more distant blood relations can have insurable interest when there is a financial dependency or business relationship.

Courts have long held that husbands and wives have insurable interest in each other. Some courts even extend this to people who are engaged to marry. Relatives by marriage, other than spouses, usually do not have any insurable interest just because of the marriage relationship. An example is the stepchild, stepparent relationship.

There are many business relationships possible in which the premature death of one of the key parties could result in serious financial hardship to a survivor. In such a situation insurable interest exists. It extends both to owners of a company and key employees in a company when a key

employee's or owner's death would result the termination of the business. Creditors have insurable interest in the life of debtors but the amount of insurance and the premium paid has to be reasonable in relationship to the amount of debt. If a creditor takes out too much insurance relative to actual debt, the contract could be considered a gambling device and is therefore void according to law.

Generally, **if a policy is taken on the life of another, it is void if the insured does not give ownership consent to the third party, even if an insurable interest is present.** In other words, if somebody is going to buy insurance on your life, they must have your permission even when there is an insurable interest. If premiums are paid with the insured's money and without knowledge of the policy, the insured can recover those premiums from the insurance company.

POLICY DELIVERY AND POLICY DATING

The insurance application states, in writing, a policy cannot become effective until the application is approved, a policy is issued, the policy is delivered and the initial premium is paid during the continued good health of the purposed insured. **Each one of these conditions must be met unless there is some agreement to the contrary.** The aforementioned are conditions precedent.

Policies do not actually have to be placed in the hands of an applicant in order to be considered delivered. There are situations where courts have said delivery exists even though the applicant did not actually get the policy handed to them. This is constructive **delivery.** A policy is constructively delivered when the insurance company has parted with control with the intent to be bound as a completed contract. Delivery to the agent of the applicant is ordinarily constructive delivery. Policies are sometimes delivered to the applicant for inspection and the applicant can keep the policy for a number of days and inspect it without the insurance being in force. In such an event there is no intention by either party to be bound and the applicant must sign an inspection agreement (This instance is different from, and should not be confused with, "free examination" where a premium has been paid prior to policy delivery).

The point at which policies become effective can take several forms, including,

1) an effective date agreed upon by the insurance company and the policyholder,

2) one which incorporates backdating to save an earlier age,

3) date that the payment of the initial premium was made,

4) agreement providing coverage at an earlier date than the date stipulated in the policy and

5) the delivery date.

Generally, when the effective date of policy is agreed upon between the insurance company and the policy owner, it will be binding even if an initial premium was paid on a different date. The policy effective date is the direct result of the written agreement between the parties and it is expressly stated in the insuring agreement. The receipt issued at the time application was taken, if money was provided with the application, spells out the conditions precedent to actual policy issuance. If money was not provided at the time of the application, then the general rule is the policy must be delivered during the continued good health of the insured and a premium collected before coverage is effective.

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SECTION V STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) Compare a conditional receipt with a binding receipt.

2) Once an insurance company receives an application, how quickly must it act in reviewing the application?

3) Why is conditions precedent crucial to insurance contract formation?

4) Why are insurance companies allowed to blatantly discriminate as part of the risk classification process?

5) Why is misrepresenting yourself as a nonsmoker construed as a material misrepresentation for purposes of an insurance company being able to void a policy?

6) What is the purpose of requiring a policy owner to posses insurable interest before a life insurance contract can be considered as a valid and enforceable contract?

7) List five points in time at which a policy can become effective.

SECTION VI: THE LIFE INSURANCE POLICY - AN ANALYSIS

CONTENTS OF POLICY AND CRITICAL PORTIONS

The **modern life insurance policy reflects,** to some degree, the **consumerism movement** of the last part of this century which resulted in laws requiring **contractual language to be simpler and easier to read** for the buying public. Most states in America do have laws which require life and health insurance contracts to consist of simplified language in their writing. Some of the laws are patterned after the National Association of Insurance Commissioners Life and Health Insurance Policy Language Simplification Model Act of 1977. This movement started because contracts were written for a lawyer's benefit and consumers had difficulty understanding many of the technical legal words appearing in the contracts. In an effort to make language simpler for people so they can understand policies, states have been moving in this direction of simplifying policy language.

A **typical life insurance policy** contains the agreement between the parties, including a "face" page, followed by various contract provisions which are either mandatory or optional according to state law. There is normally a reference page for contents as well as a glossary of specific technical terms which are used in the policy. A section indicating

beneficiary, if one is named, and settlement options revealing various rights afforded the party entitled to the policy proceeds can also be found in the policy. **Policies with cash value also have what is known as a "nonforfeiture" clause** which gives the options to a policy owner in the event it is decided they no longer wish to continue paying premiums before the policy is fully paid. Other **provisions,** usually **required** from state to state, are a **grace period, an incontestable clause, a free examination or free look period, misstatement of age, a policy loan provision, a reinstatement clause, and,** in participating policies, a **divisible surplus division**. **Various optional provisions would include an assignment clause, contract change, suicide and ownership.** All pertinent policy provisions will be discussed in greater detail later in this section.

In addition to provisions which are required or optional, there are various concepts which are **prohibited from being included in life insurance policies**. Prohibited provision rules vary from state to state but generally **include the following:**

1) predating a policy before the actual date (backdating) for more than some reasonably specified period of time is prohibited,

2) a clause limiting the time in which a lawsuit could be brought is sometimes prohibited,

3) forfeiting a policy because you do not repay a policy loan cannot be included in life policy

4) statements that indicate the insurance company's agent is the agent of the applicant or policyholder rather than of the insurance company.

Other benefits or exclusions which may be in a policy can be added by rider including things such as disability, guaranteed insurability, war and aviation exclusions and the accidental death benefit. These rider possibilities will be discussed in detail in this section.

The **policy face page is one of the main components** of a life insurance policy because it contains the basic promises made by the insurance company. Typically the language on the face page states that when the insured party dies, as long as the policy is in full force and in effect, the proceeds (face amount) will be paid to the beneficiary who is named as soon as the home office of the insurance company receives proof that the insured has died.

Assuming the policy owner provided accurate information in the application and has paid the premiums on time, the insurance company will meet its end of the obligation which is to pay the face amount of the policy to the beneficiary once the company has received proper notification or proof that the insured has died.

The company, once it accepts an application and premium, is bound but thereafter the insurance company must receive renewal premiums as they become due. On the policy face page, beneath the promises of the parties, is a space for signatures of company officers. Usually the Secretary and President have their personal signatures rubber stamped on the face page, although actual personal written signatures could be placed there. These company official signatures are critical to completing the formulation of the insurance contract.

Appearing at the bottom of a **face page is a brief description of the coverage offered in the contract.** This is designed to allow the policy owner to be able to understand the coverage provided in the policy by stating, in a few simple words, the nature of the coverage being provided. Also printed on the face page is the **"free look"** or free examination period. Most states have a regulation which requires insurance companies to allow the policy owner, **once the policy has been delivered,** a period of time (usually 10 days) in which the policy owner can decide to return the policy and receive a full refund of premiums paid. Technically this voids the policy from its inception. After the face, page the rest of the contract includes a copy of the original application and all required and optional policy provisions.

REQUIRED POLICY PROVISIONS

About one hundred years ago, the first insurance laws requiring ordinary life policies, limited pay, endowment and term policies to have specified required policy provisions were enacted by the State of New York. Although specified provisions had to be included in policies, it was left up to insurance companies to decide which words would be used. The language had to **essentially meet the intent** of information required through the statute as prescribed by law.

Settlement option tables are a required provision and set forth certain options, available upon receiving the proceeds of a policy to whoever is entitled to the proceeds. Another required section deals with **"nonforfeiture"** and it basically applies to policies offering level premiums and cash value because in such policies, the policy owner contributes more premiums in the early years of a policy than is needed to meet the fair share of current mortality costs. When a whole life policy, which has been in effect for some minimum period of time (normally three years or more), has lapsed, the insurance company has to offer a table of **cash surrender value.** Alternatively, two other options are for the policy owner to take a paid up policy for a reduced amount or the full face amount of coverage could continue through extended term insurance. The nonforfeiture provision will be discussed in detail later in this section.

The **grace period** provision is required and it states that after the first premium on a policy has been received the policyholder has a **31 day period** of grace following the due date of any future premium in which **to make the premium payment and still have the policy** continue to exist in full force and effect. The grace period provision also provides coverage if the insured dies while the policy is on the grace period. The insurance company merely deducts, from the proceeds, any unpaid premium which is due up through the last day of the policy month in which the death occurred. Conversely, if the insured died in a period for which payment had already been made but was unused, the insurance company must add that amount as a refund to the policy proceeds.

The grace period concept began as a voluntary provision added by some insurance companies to their contract and was later found, upon investigation, to be widely used throughout the industry. Although the grace period is 31 days, **if the last grace period day is on a non-business day then the premium is payable on the following business day.** When premiums are paid at the end of a grace period rather than the beginning of a grace period the insurance company loses the investment opportunity of that premium for one month. Statutes in most states permit the insurance company to deduct from the death benefit paid any overdue premiums plus interest which could have been earned by the company had the policy premium been paid on time.

Another standard policy provision is the **incontestable clause.** This **unusual contract clause prevents a life insurance policy from being be contested once it has been in force for two years.** Without an incontestable clause a life insurance company could, at any time in the future, try to void a policy (get out of paying the death benefit) if the policy had been issued based on a misrepresentation of a material fact by the applicant at application time. A much more detailed explanation of the incontestable clause as well as its interesting history and variations is included later in this section.

The **entire contract provision states** that the life insurance policy plus the attached copy of the application constitutes the entire agreement between the parties and no statements outside the agreement can be used later to vary or contradict the terms within (The parole evidence rule). The **entire contract provision is designed to prevent the abuse in the past of insurance companies who incorporated the application by reference into the contract rather than making a copy and attaching it to the policy at delivery.** In the past, the insurance company would refer to the application as part of the contract but did not provide a copy of the application to the policy owner with the contract when it was delivered. This provision makes it clear that a copy of the application must be attached to the policy and be provided to the policy owner thereby eliminating uncertainties to the policy owner about whether the contents of the application were the same as those

provided at application time. It also enabled the agent, upon policy delivery, to have the policy owner examine the application for any misstatements or mistakes which could be corrected at the time of delivery. This makes it impossible for a company to say there was a misstatement, of which the applicant was unaware, which would result in voiding coverage. **The entire contract provision refers to the contract at the point at which the contract was entered into** but does not prevent later agreements, which relate to the contract, from being made between the parties as long as those parties agree in writing to subsequent changes.

The misstatement of age provision is required in insurance contracts and addresses the problem of when the age of the insured is misstated. In the history of life insurance going back a century or so, it was a very common mistake for a person not to know their exact or true age and to unintentionally misstate it. Since something had to be done about this problem, the misstatement of age provision was enacted. It said if the age of an insured had been misstated, any amount that was paid or any benefit that was accrued under the policy will be paid as if the premium had been purchased at the correct age. Essentially, this meant **if the insured's age had been overstated** (as in a case where the insured said were 40 years old when and was really 37) the **death benefit would have been increased** to match the amount actually paid. If this age overstatement were discovered during the lifetime of the

insured, most insurance companies would refund the extra premium which was paid unnecessarily. On the other hand, **if an insured understated age** (the insured claimed to be 37 but was really 40 years old) **the death benefit would have been reduced** to what the premium that had actually been paid would have bought for a person at the proper age. Furthermore, the policy would have been adjusted to reflect the proper payment if discovered when the insured was still alive. The misstatement of age provision stipulates that **when age is misstated it cannot void a contract except in the case of fraud or collusion.** An example of collusion is one insurance case dating back to the 1930's in which an insurance agent and the beneficiary of a policy got together and misrepresented the insured's age to be 30 years younger than it actually was. In this instance the court allowed the insurance company to deny paying the death benefit. The idea of misstatement of age also extends to incorrect sex either by clerical error or by misstatement.

The divisible surplus provision was added early in the 20th century as a policy provision to the life insurance contract and it **applies to participating policies issued by mutual insurance companies.** Many years ago, mutual insurance companies would credit policy owner dividends each year but would accumulate these funds for long periods of time, usually 20 years or longer, and only long time policy owners who still had policies enforced at the end of this period of time were

entitled to share in the funds that were accumulated. Other shorter term policy owners forfeited their shares and these forfeited amounts were added to the shares of those who had stuck in there for a long period of time. The divisible surplus provision in a life insurance policy requires that insurance companies must determine and apportion the divisible surplus to policy owners at very frequent intervals, thereby not rewarding long term policyholders and punishing shorter term policy owners. It is designed to make dividend dispersal more equal between policy owners regardless of the amount of time they have actually owned the contract.

The **policy loan provision** is a derivative of level premium cash building life insurance policies which allows the policy owner who didn't want to lapse a policy, yet had a need for cash, to utilize the cash value available within a life insurance policy. The **policy loan provision was at first a voluntary clause** added by some insurance companies and later it became a legal statutory requirement. It must be understood that **a life insurance policy loan is not technically a loan** and no debtor-creditor relationship exists. **The policy owner does not have to repay either principal or interest.** Policy loans are considered advances paid to a policy owner against either cash surrender or death benefit payment. Any policy loans which are not repaid are deducted from cash surrender or from a death benefit if the loan is not repaid at the death of the insured. This policy provision will be discussed later in this section.

The final required life insurance policy provision is the **reinstatement clause** and it came into general use in life insurance policies about 100 years ago. Until 1905 there were no laws that required a reinstatement provision but today more than half of the states have a law requiring this provision. It says that a policy owner who lapses a policy has a certain period of time in which to seek to have the policy reinstated. The provision usually **says the application for reinstatement must be made from within three years of the date of a policy lapse. The policy owner has to provide the insurance company with satisfactory evidence of insurability of the insured and unpaid premiums must be repaid with interest. Any outstanding policy loans must be paid with interest** and the policy neither may be surrendered for cash nor taken as a reduced paid policy before reinstatement can be an option for the policy owner. Since reinstatement is such an important contractual right to a life insurance policy owner, it will also be discussed in greater later.

OPTIONAL POLICY PROVISIONS

Beside provisions required by various state laws, there are also provisions which may be placed in a life insurance policy but are not required by law. **The more common provisions which fall into this optional category include assignment, suicide, ownership and change of plan provisions.** Assignment means the policy owner of a life insurance policy can transfer some or all of the rights held under ownership to

another party unless the contract says assignment is restricted or prohibited. The policy owner can assign the policy as a simple matter of law and there is no requirement that the policy provide a provision permitting assignment. Although assignment provisions do not legally grant the right to assign a policy, they may state that the policy owner does have this right. Assignment provisions define the insurance company's duties in the event the policy owner does elect to assign a policy to another party. The provision can stop or restrict a policy from being assigned and the insurance company would not be bound if the policy does not permit assignment. If the right to assign is merely restricted, the terms of the assignment must be complied with, but the insurance company would not be bound.

The suicide provision basically follows the logic that suicide (taking ones own life) is not a risk assumed by an insurance company, for a limited period of time. If there is no provision declaring this in the policy then courts will generally hold suicide must be covered. Most policies must contain a suicide clause which excludes proceed payments to a beneficiary or an estate if the cause of death of the insured was suicide within one or two years from the date of policy issuance. A two year period of time is typical but some states have a shorter suicide clause or even none at all. Suicide clauses are limited in time because suicide is not normally an activity planned well in advance.

Another optional provision allows the parties to the life insurance contract to change their agreement as long as they do so by mutual consent. New terms can be incorporated into the existing policy but must be agreed to by both parties.

The final important optional provision is **the ownership clause.** Most policies are issued to an insured who completes an application, names a revocable beneficiary and has full ownership and control over the policy. Insurance companies also sell policies which are applied for and issued to people who are not the actual insured. In this instance **the insured has no ownership rights under the policy when a third party applicant owns the contract.** Most of these policies are utilized for business purposes as opposed to most personal insurance which is issued to the proposed insured.

Rights of ownership include the following:

1) naming a new owner or a secondary owner at anytime while the insured is still living by filing a written request,

2) the owner is entitled to take policy loans,

3) taking policy dividends in cash or any other manner allowed by contract,

4) exercising any of the nonforfeiture options including surrendering the policy for cash, taking a reduced paid up face amount or placing the policy on extended term coverage,

5) the owner may name or change a beneficiary at any time in writing as long as the beneficiary is revocable and not irrevocable.

POLICY PROVISIONS PROHIBITED BY LAW

As outlined in the introduction to this section, there are several policy provisions which are limited or prohibited from being implemented in the insurance contract. **Dating back a policy in order to save an earlier age** (the applicant wants a policy dated back in time to when they were younger so they have the benefit of paying a lower premium) within certain time limits is not a problem. However, when a policy is dated back the premium payment starts from when the policy is dated back even though no insurance was provided from this point in time.

Incontestable and suicide clauses are shorter once a policy has been back dated because of the earlier policy effective date. To prevent back dating for unreasonable periods of time, states which permit back dating have regulated the maximum period of time a policy can be back dated to six months prior to the date of the actual application.

Also **prohibited is placing a time limit on legal or equitable action.** This prevents insurance companies from providing a policy owner or beneficiary with an unreasonable

short period of time in which to initiate legal or equitable action against the insurance company in a court of law. Laws do not prohibit a clause providing a time limitation; they merely provide a frame work not allowing the insurance companies to put in time limitations which are too restrictive. A common period of time in which legal action must be initiated would be from one to six years depending on the particular state statute. Periods of from three to five years are the most common. A few states do not allow any such limiting provision.

Less value statutes prevent insurance companies from promising benefits based on the face of a policy while subsequently eliminating or reducing value based upon the contract language contained in the policy. Contracts excluding such hazards as war, aviation, suicide and adjusting benefits as in misstatement of age are in direct opposition to less value statutes. Some states specifically exclude war and aviation and suicide as reducing a policy's value while other states don't make any provision and it is fought on a case by case basis throughout the court systems of the various states.

Many states prohibit insurance companies from forcing the policy owner to forfeit the policy for failing to repay any loan or interest on a policy loan when the total indebtedness is less than the cash value of the policy. The final prohibition is against allowing the insurance company to name the insurance agent as an agent of the applicant rather than of the insurance company.

POLICY APPROVAL PROCEDURES

Before an insurance company can market a new insurance policy, it must get permission from the state insurance commissioner or director of insurance. **Once approval for a policy form is sought, a state will not find either fault with it within a period of time, usually 30 days, or it will issue approval.** In either case, the insurance company is able to begin marketing that particular policy type. If a policy will be issued prior to statutory approval by an insurance commissioner, then the contract would be valid and enforceable for all beneficiaries. If an insurance company does issue a policy without approval, some type of penalty can be imposed upon that insurance company by the state department of insurance. Penalties can range anywhere from a simple monetary fine to the harshest punishment of all, revocation of the insurance company's license allowing them to do business in a particular state.

SUPPLEMENTARY BENEFITS AND EXCLUSIONS

Since a life insurance contract offers the single benefit of paying proceeds at the death of the insured, any other benefits which a consumer would like must be added to the basic life insurance contract as a rider. There are many types of additional benefits available in the marketplace today which

may be added as riders to the life insurance contract. Allowing riders to be added to an insurance policy provides flexibility to consumers by taking basic plans and suiting them to individual needs. Since these supplementary benefit forms carry specific rights, there are clauses in the contract which are different, under certain circumstances, compared with just the death benefit policy. Some very common types of supplementary benefits and exclusions which will be examined in this section include the accidental death benefit, guaranteed insurability, disability benefit, war exclusion and aviation exclusion.

ACCIDENTAL DEATH BENEFIT

For an extra premium an insured can elect to add the accidental death benefit by rider to the application for life insurance. The **accidental death benefit typically will match or equal the amount paid on the base policy if the cause of death results from an accident.** This is from where the term **"double indemnity"** originates. For example, if a $100,000.00 death benefit is purchased with the accidental death rider and the cause of the death is an accident, the policy will pay $100,000.00 on the base policy and match it with

another $100,000.00 for a total of $200,000.00. On the other hand, if the death is not by accident then only $100,000.00 will be paid. In certain types of accidents (death as a result of using the services of a common carrier, i.e., as a passenger on a train, plane, bus or other public conveyance) sometimes the accidental death benefit will triple or even quadruple the original face amount.

There is a long historical evolution of accidental death occurring as either a result of **"accidental means"** or an **"accidental result."** When accidental death is defined in terms of accidental means, both the cause and effect of the death must be unexpected and unforeseeable. Accidental result language means only looking at the cause of death as having been an accident. An accidental result dismisses the idea that both cause and effect must be involved in the accident. An accidental result is a much broader and more generous term to the insured than is accidental means. Courts throughout the 20th century have, for the most part, defined accidental death in terms of accidental result even if there is accidental means language used in the contract.

Courts generally interpret "accident" and "accidental" according to their ordinary definitions in society, unless a state statute or a contract provision requires some other interpretation. Customarily, an accident is an unusual event which is not foreseen by an insured whereas accidental events happen suddenly, all at once, unexpectedly. Elements of violence, force or attack may be involved in an accident. The word accidental simply means death occurs by accident. An accident must be the proximate cause of a death in order for an accidental death benefit to be paid. In legal terminology, **proximate cause simply means that a cause is either directly responsible for the death or that the death began as a result of an unbroken chain of events which brought about the death.**

Also important in the accidental death benefit provision is certain risks or causes of death are not covered by exclusions specifically incorporated into the provision itself. It is possible for the insurance company to exclude up to about 100 risks which may not be covered. However, most insurance companies limit risks not covered to only a handful, usually a dozen or less.

The most common risks which are not covered by accidental death provision include:

1) suicide of the insured whether they were sane or insane,

2) intentional or self-inflicted injury whether sane or insane,

3) participating in a felony or an assault which leads to the insured's death,

4) flight on an aircraft other than as a fare paying passenger on a regularly scheduled airline flight or if the insured is a pilot, officer or member of a crew or has duties aboard a plane,

5) any infection or disease existing before or after the accident,

6) any drug or medication taken voluntarily which was not administered by a licensed physician or taken as prescription medicine,

7) the use of alcohol in combination with any drug, medication or sedative,

8) any poison or gas fumes voluntarily taken in, absorbed or inhaled, and

9) by war or any act of war declared or undeclared.

It is also **critical,** according to the accidental death benefit, **for death to occur within 90 days of an injury** otherwise payment will not be made. Ninety days from the date of the accident is the deadline by which the insured must die to qualify the death as a result of an accident.

If a policy owner or beneficiary must sue an insurance company when there is a discrepancy or dispute involving payment of the accidental death benefit, the burden of proof is on the plaintiff (a policy owner). The burden on the insurance company is to prove that the loss or death resulted from a risk which was not covered or specifically excluded in the accidental death benefit provision.

APPLYING YOUR KNOWLEDGE OR "1, 2, -SHOOT! ... HELLO? ARE YOU STILL THERE?"

During a seminar class, one of our clients who was an owner in company which supplied accidental death benefits for debtor/creditor situations to various lending institutions, related the following true story:

It seems this distraught young man, who happened to be covered by our client's company for accidental death, had dialed his former girlfriend from a remote telephone booth, threatening to take his life by gunshot if she refused to keep dating him. The young man indicated that he had a loaded handgun held to his head and that she must agree to see him again or he would pull the trigger.

The former girlfriend, being none too thrilled with the call or the prospect of reuniting with her former beau, refused to be cajoled into a second try of the relationship and simply said "No!"

Then the ultimatum: "If you don't agree to see me again, I will blow my head off on the count of three!"

Silence on the other end.

"One," the shaken voice resolved, waiting to hear her capitulation. But there was only silence. "Two," he intoned then pausing when, suddenly, a single loud gunshot rang through the phone line. The young man was dead.

How do you analyze this particular situation? Does the beneficiary collect, or is the benefit denied due to the suicide clause?

<u>*THE ANSWER:*</u> The court ruled the young man's death was accidental and that the insurance benefit must be paid. The deciding judge noted that either the man possessed poor math skills or the gun went off before he was ready to kill himself.
If he had waited until after the count of three to pull the trigger, the benefit would have been denied.

DISABILITY BENEFIT

Although today agents are familiar with the disability income benefit as a stand alone health policy, the concept dates back almost 100 years when disability was offered as a rider to a life insurance policy. **If the insured became disabled and could not work, the company waived the premiums,** which would have to otherwise be paid, to continue the life insurance policy. The disability rider on the life insurance policy states that if the insured becomes disabled, according to the life insurance policy definition of disability, the insurance company waives the premiums due during and for as long as the disability will continue. Disability which begins after a specified age of 60 or 65 would not be covered. There is **a waiting period of six months** prior to the time disability benefit waiver will kick in thus relieving the insured from having the burden of paying premiums. **This 6-month threshold is included so the insurance company does not have to be bothered with premature claims** or short term disabilities or disabilities which would not continue for at least six months. The insurance company is concerned only with very serious and long term disabilities. Causes of disability which would not be included for a payment waiver include war, declared or undeclared, and intentional and self inflicted injuries.

Definitions are crucial to the application of the disability benefit being activated for the benefit of the policy owner. The term **"total disability" means a disability which prevents the insured from working at a customary occupation or at any other occupation for which the insured is suited by training and education.** "Permanent disability" means the disability will last for an indefinite and continuous period of time. Before the benefit will be paid, most policy riders stipulate an insured must be totally and permanently disabled in order to receive the disability benefit. Although most policy riders for disability define disability with respect to the inability to engage in any occupation or business for which the insured is trained by education or experience, there are some more generous policies offering an occupational disability clause (meaning the disability would stop the insured from working at their own specific occupation rather then the more general total disability definition). The insured needs to check their policy to see which language is used within the contract.

GUARANTEED INSURABILITY OPTION

This rider offers an insured the future ability to buy insurance even if they become uninsurable. **The GIO offers the insured the ability to purchase insurance at specified future dates without providing evidence of insurability.** The maximum amount of insurance which can be purchased in this manner is stated in the guaranteed option provision. The

standard industry GIO typically allows the insured to buy additional amounts of coverage every three years up to the age of 40. Besides age triggers, these options can also be used when certain specified occurrences happen in an insured's life such as getting married or having or adopting children. The New York Rule as it pertains to the general guaranteed insurability option is important. **The New York Rule stipulates every new policy issued under this option automatically provides an incontestable and suicide period which runs from the date of the original policy which was issued with the rider.** Under the New York Rule the insured could buy the original life insurance policy in 1980, **pick up an option in 1990 and the incontestable and suicide period runs from 1980.**

WAR AND AVIATION EXCLUSIONS

The course material has been focusing on extra types of coverage which could be added to the life insurance policy. Now the focus shifts to the two most common exclusions in the life insurance policy. **Exclusions limit the scope of coverage offered by an insurance company** in the event the insured dies in a prescribed manner as outlined in the exclusion. The two most common exclusions are **the aviation and war exclusions.** The aviation exclusion primarily states an insured will only be covered as the result of an aviation accident if they

died as a fare paying passenger on a regularly scheduled airline flight. Today this limitation is rarely used except in individual cases. The aviation exclusion always applies to military flying.

The war rider, on the other hand, limits liability of an insurance company in the event an insured dies as a result of war. There are two types of war clauses; there is the "result clause" which says death occurring as a result of military activities will not be covered. The other is the **status clause** and it excludes coverage while the insured is in military service. Clearly the more generous of the two is the result clause since the status clause would exclude coverage for an insured, while in the military, even if the insured died of a natural cause while sleeping.

LEGAL RIGHTS TO CASH VALUE AND DEATH BENEFITS

Before explaining the various legal rights of a party to an insurance contract, it is first important to discuss basic legal rights as they pertain to property law.

LAW OF PROPERTY

Under the law of property, a person possessing ownership rights has the power to use, control or dispose of anything which is owned by that individual. When referring to the law of property, the **two main classes of property include personal property and real property. Real property is land and anything affixed or attached to the land.** For instance a piece of land is real property as well as the house which is attached to that piece of real property. But a mobile home resting on blocks would be considered personal property. A tree growing on land is real property but when it is cut down and stored as firewood it becomes personal property.

Personal property is anything which is not land or something attached to the land. The **French word "chose" which literally means "thing" is a tangible item** over which a person has actual possession, normally falling within the realm of personal property. **A contract right is considered a "chose in action."**

A chose in action can be enforced by legal action and it deals with the right to recover money based on an intangible right to property. A **"chose in possession,"** on the other hand, deals with actual physical items.

RIGHTS AND DIVORCE

It is the law in most states that divorce between a policyholder and a beneficiary does not affect respective rights held under the life insurance policy unless there is a policy provision, property settlement agreement or divorce decree to the contrary. Only a few states make beneficiary designations, including those which are irrevocable, to become void upon divorce. It is customary, upon divorce, for the policy owner to be required to maintain the insurance policy and to make the first spouse and children of the marriage the beneficiaries. Such an arrangement is typically part of a divorce settlement. Many problems can arise from forcing a policy owner to maintain an insurance contract against their free will. For instance, naming a second spouse as a beneficiary, contrary to the divorce settlement, can force an insurance company to place policy proceeds with the court in an interpleader action. If the insurance company pays the proceeds to the wrong party before learning of a divorce decree, most jurisdictions will not make the company pay the proceeds a second time. Another common restriction of policy owners, who must maintain a life contract for a first spouse and/or children, is to them deny the ability to borrow against existing cash values which would reduce the insurance amount.

RIGHTS OF CREDITORS

A creditor is a party to whom money is owed by a debtor. Creditors normally assert their rights in life insurance policies in one of two ways: directly with either the creditor as both the policy owner and beneficiary or the creditor have rights in the contract values but no rights in the policy ownership. **Under a life insurance policy there are four basic rights** including:

1) a creditor who has insured a debtor's life in the creditor's own favor and has the right to repayment of the debt plus recovering any premiums paid;

2) collateral assignment in which the debtor's right to transfer a policy goes to a creditor as security for a loan. The creditor in this instance is usually a bank. The collateral assignee has the right to share in the insurance proceeds but only to the extent of the unpaid indebtedness at the insured debtor's time of death. Debtors who own policies on their own life sometimes name a creditor or bank as a beneficiary as a security for a loan but this is not as common as a collateral assignment because the creditor cannot reach prematurity value such as cash value prior to the insured's death;

3) the creditor has the right to apply for and own the life insurance policy on a debtor's life and

4) a creditor has the right to ask for an existing policy which is already on the debtor's life to be assigned to the creditor collaterally or that the creditor be made the beneficiary of the existing policy. Of course the rights of creditors vary from state to state. When considering a life insurance policy as property, from a legal standpoint, the general rule in most states is to exempt life insurance values from the claims of a creditor.

Exemption statutes protect debtors and their families by giving debtors the right to keep certain property free from the collection of creditors. **Insurance exemptions protect** the insurance proceeds, cash values, dividends and interest, health benefits, disability income benefits and annuity contract payments according to particular state law. State laws and the manner in which insurance exemptions are handled can be broken into three main categories:

1) states which allow a liberal exemption of life insurance but limit the exemption to the amount of insurance that can be purchased to a maximum amount of premiums paid annually; and

2) states which allow married women to apply for and own insurance on a husband's life and therefore the insurance is exempt from claims of a husband's creditor; and

3) states which allow broad exemption in favor of policies on a debtor's life or life policies owned by the debtor insuring another person's life. This third category includes the state of New York.

The issue of whether or not a policy owner, who is the insured, will have his creditor's obtain policy values is contingent upon four criteria: 1) the named beneficiary, 2) state laws, 3) creditor identity and 4) whether or not the creditor is seeking cash value or death benefit proceeds. **Cash values cannot be seized** when state law protects the proceeds but the exception to this rule is some states allow cash value to be seized when statutes exempt only proceeds. When the federal government is the creditor, **a federal lien can be attached** to the policy loan value and this lien **is valid regardless of any state exemption law.** Policy owners owing federal income taxes must normally pay within 90 days of the establishment of the lien or the insurance company will pay the loan value to the government! The policy remains in force when the insurance company receives no notice of a federal tax lien and the insurance company can make policy loans to the policyholder in such an instance. **Policy proceeds are typically protected by state exemption statutes.** When the creditor is the federal government, the state exemption laws do apply to the proceeds payable after the death of the insured with the exception of when a federal tax lien was attached to the policy cash value before the insured dies.

Under the Bankruptcy Reform Act of 1978, debtors have a choice of using either state or federal exemptions unless state law prohibits an individual from selecting the federal exemptions. The previous Bankruptcy Act of 1893 specifically prescribed that state exemption laws governed in bankruptcy cases.

The modern Act of 1978 allows choice and the federal statutes are the more beneficial selection when state law does not prohibit federal exemption use. Under the federal exemption a debtor may keep unmatured life insurance policies and the bankruptcy trustee cannot surrender these policies for cash value. **Loan values and accumulated dividends and interest are exempt up to four thousand dollars.**

Under state exemption law there are variations among states. Unmatured policies with no cash value are first ruled out and then those with cash value are evaluated according to state law and may also be exempt from creditors. Insolvent policy owners who pay insurance premiums do not lose the exemption if there is no attempt to defraud creditors. However, when creditor funds were wrongfully taken and used to pay insurance premiums, creditors have a legal right to at least part of the proceeds.

Another issue centers on whether the creditors of a beneficiary can reach the insurance proceeds upon the death of an insured. It depends upon three main points including

1) how state exemption statutes are worded,

2) whether the proceeds are paid in a lump sum or the insurance company will be paying on a deferred settlement basis and

3) whether or not there is a policy clause protecting the proceeds from a beneficiary's creditors.

COMMUNITY PROPERTY

Although **the laws of most states,** as well as the modern American life insurance contract, **are based on English common law** there are pockets of the country where the **French and Spanish** settled and **left a legacy of community property.** There are eight community property states including Louisiana (the French influence), Arizona, New Mexico, Nevada, Idaho, California, Texas, Washington and Wisconsin. Under community property concepts property owned by a husband and wife is owned or shared equally and each party has a one half undivided community property

interest. **Community property includes any property acquired by spouses during their actual marriage. Exceptions to what are considered community property include property acquired by one spouse through a gift, will or inheritance.** Such property acquisition is considered **"separate property."**

When one spouse dies the community becomes dissolved and the remaining spouse has a right to one half of the community property while the other half goes to the decedent's estate. Property owned before a marriage (creation of the community) is considered separate property and is specifically not part of community property. When property is acquired with community funds, it is community property even if the property is held in only one spouse's name. Property acquired after a marriage through the use of separate funds is still considered separate property.

Management of community property is deemed to be shared by spouses rather than, as in the past, considered held by husbands. Life insurance policies, or proceeds on life insurance policies, may be community property or they might be separate property depending on the varying community property laws from state to state. **When a policy is applied for and issued before marriage it is considered separate property.** If the insured dies and the spouse is not the named beneficiary, some states say the spouse is entitled to part of the

proceeds if community funds were used to pay premiums during the actual marriage. **When a policy is applied for and issued during a marriage, premiums are considered paid with community funds and the policy is community property.**

If the estate of the insured is the beneficiary then proceeds are community property. On the other hand, if the spouse is the beneficiary then proceeds are separate property and become a gift to the beneficiary-spouse who receives all of the money. A third party beneficiary could be named in a community property state instead of the spouse but there are problems associated with this scenario. One interpretation is the proceeds to the third party are considered to be a gift with no consideration and, if the policy owner's spouse did not consent to the gift, the surviving spouse can get up to one half of all the proceeds.

A community can be ended in three basic ways: divorce, death or annulment. Property division at divorce can be decided either upon by the parties involved or by the courts. Several community property states view the cash value of life insurance as community property if community funds were used to pay premiums. In one **famous 1960 Supreme Court case regarding settlement options in community property states a spouse can set aside a settlement option chosen by**

the other spouse in favor of one half of the proceeds. For example, suppose the insured dies and had previously arranged for the beneficiary, who is the surviving spouse, to receive an income for a period of time rather than the full death benefit. The surviving spouse, upon the death of the insured, could take up to half of the proceeds in a lump sum and would only have to take the remaining half through the prearranged settlement option.

INSUREDS KILLED BY BENEFICIARIES

When an insured is killed by the beneficiary listed in the policy there is law applicable as to whether or not the beneficiary can receive the proceeds from the policy. It is normally held that, when **a beneficiary applies for the insurance** on the insured **and then purposely murders the insured** in order to collect the death benefit, **the policy can be declared void** and the beneficiary will not collect the proceeds. When **the insured applies for the coverage, and the beneficiary later kills the insured, the proceeds will be payable to the beneficiary as long as the killing was not "wrongful."** A wrongful killing means the beneficiary will not collect and the proceeds will be paid to either the contingent beneficiary or the estate of the insured. **An example of a killing which is not wrongful includes self defense.**

THE BENEFICIARY: RIGHT OF SELECTION

The person named in an insurance policy to receive proceeds from the policy upon the insured's death is the beneficiary.

The right of a person applying for insurance on his or her own life, to name a beneficiary, is basic and undisputed. Clearly understand the person who owns a life insurance policy does not own the death benefit. The death benefit belongs to the beneficiary when the insured dies. The policy owner insuring his own life possesses has an unlimited insurable interest and can name anybody they wish to be the beneficiary of the policy. Defining insurable interest is not an exact science but centers around the concept that a person who is going to collect the proceeds of a life insurance policy must be doing so out of protecting an existing relationship; a relationship in which the beneficiary receives advantage from the continued life of the insured. Hoping the insured will die in order to be enriched would place the arrangement more in the category of gambling rather than risk transfer.

When a policy owner is not the insured, the choice of a beneficiary must be restricted to people who have an insurable interest. An insurance company has the right to question why a beneficiary, who has little or no insurable

interest, is being named. Two other points addressing this right of beneficiary selection include minor policy owners and rights held under group life contracts. Minors have limited contractual capacity and there is some minimum binding age for minors in most states.

An insurance company will not enter into a contract with a minor unless a state law makes the contract binding. In a group life situation policy owners have the same basic right to select the beneficiary as held under an individual policy but the policy owner cannot name the group policyholder as a beneficiary.

RIGHTS OF BENEFICIARIES

There are **eight basic types of beneficiaries.** The first two are **"revocable" and "irrevocable."** The revocable beneficiary has no rights under the policy which cannot be terminated by the policy owner. **The revocable beneficiary can be changed at anytime by the policy owner who simply makes such a request in writing to the company.** The policy proceeds are paid to the revocable beneficiary when the insured dies but the right to collect the proceeds are lost if the beneficiary dies before the insured. **The irrevocable beneficiary has a vested right to the death benefit when**

named as beneficiary and the policy owner cannot change an irrevocable beneficiary without the beneficiary's consent. The rights of the irrevocable beneficiary end if the policy is not in force when the insured dies and if the irrevocable beneficiary dies before the policy owner, the policy owner would have the right to name a new beneficiary. The new beneficiary designation could be either revocable or irrevocable.

Two other types of beneficiaries include the **"primary"** and the **"contingent"** beneficiary. The **primary is first in line** to the throne and receives the entire death benefit and the only requirement is for the primary to outlive the policy owner. More than one party can be named as a primary beneficiary and the benefit would be shared equally or as specified by the policy owner. The **contingent beneficiary is a second choice** and will receive nothing as long as the primary beneficiary outlives the insured. Contingent beneficiaries can be named according to order of preference and no contingent beneficiary would receive any benefit if the primary beneficiary is alive at the time of the insured's death. The second contingent beneficiary, called a "tertiary," would be the second contingent choice of the insured.

A **fifth type** of right is the **"donee" beneficiary**. The donee is a person who is named a beneficiary but who gives no consideration to the policy owner for being named. **This is the most common type of beneficiary.** A **"creditor"** beneficiary **is the sixth type** of possible beneficiary and is named sometimes when the policy owner owes money to a creditor. The benefit from the policy is paid to end a debt and is limited to only the amount necessary to satisfy the debt which remains at the death of the insured.

The **seventh right is that of an "intended"** beneficiary, a person who is intended by the parties of a contract to benefit from the performance of a contract. This beneficiary may have to sue to enforce the rights they feel they have. Both donee and creditor beneficiaries are intended. **The last type** of beneficiary **is the "incidental"** beneficiary. An incidental beneficiary is a party who benefits from the life insurance policy but who originally has no rights under that contract. This means the parties to the contract did not procure the contract initially to benefit the incidental beneficiary.

DESIGNATIONS

After the purchase of a life insurance policy is made, the **policy owner should review the designation of a beneficiary on a regular, periodic basis** to make sure the designation coincides with current circumstances and intentions. It is always wise to name a contingent beneficiary in addition to a primary. An insurance company must honor the designation and fulfill it according to the intent or direction of the policy owner. The policy owner should describe the beneficiary who will receive the benefits in a manner which enables the insurance company to easily identify the intended party. When designating a spouse, the **proper given name** of that person should be used. The name will be the controlling factor in the designation and wording like "wife of the insured" or "husband of the insured" is merely descriptive and should be avoided.

Children can be listed as beneficiaries and can be designated **by "name" or as a "class."** The **advantage of using the actual names of the children who are beneficiaries is the actual identity of the beneficiary is clear and easy for the company to identify.** The disadvantage is any children born after this designation would not be included unless the policyholder remembered to name them after they were born. When a class designation for children is used, a group is named without individual listing. Language such as "all the children

of the insured" is an example of class designation. **Problems usually associated with class designation include finding all the members who belong to the class after the insured dies.** Furthermore, since the legal definition of the word "children" differs from state to state, it can include illegitimate children, grandchildren and even step-children. It is **the burden of the policy owner to make sure that the designation is clear.**

CHANGES

Policy owners can change beneficiaries as long as they are revocable but this power to change can be limited by incompetency due to legal age and advanced stage illness. **Mentally incompetent policyholders do not have the power to change beneficiaries and guardians of an incompetent or a minor policy owner cannot make a change in beneficiaries on a ward's behalf.** When a policy owner is considered incompetent from a legal standpoint, the insurance agent appointed by the policy owner cannot change the beneficiary, even if the agent was told to do so before the policyholder became incompetent. Because of the legal principle that agency ends when a policyholder becomes incompetent, divorce decrees and property settlements can limit the rights of a policyholder to change beneficiaries if the settlement agreement or divorce decree affects this property right. If the spouse is an irrevocable beneficiary, they may lose the beneficiary status as part of the divorce decree or property settlement. As a general rule, however, divorce between a policy owner and beneficiary will not necessarily change the right to designate a new beneficiary.

Under community property states change of beneficiary rights for policies which are purchased in community property states, with community funds, can vary. In some states the consent of the beneficiary is required, while in others, beneficiary designation can be changed but the spouse-beneficiary will share in the proceeds.

There are normally **three ways that an insurance policy specifies how changing a beneficiary can be valid** including

1) endorsement where the insurance company must endorse the new beneficiary on the policy before the designation can become effective. The policy needs to be submitted to the insurance company; or

2) the policy owner files a written request to change with the insurance company. The policy does not have to be submitted to the insurance company; or

3) substantial compliance where the change of beneficiaries is effective if the policy owner has done everything possible to comply with the insurance contract's procedure but has failed only due to circumstances beyond his control. An example could be where a third party has physical possession of the policy and does not give the policy to the owner as a method of trying to prevent a change.

It should be noted that a policy owner's oral statement of intent to change a beneficiary is not sufficient. **Changes of a beneficiary made by a legal will are only effective if the language in the insurance contract allows this type of change.**

METHOD OF PROCEEDS DISTRIBUTION: SETTLEMENT AGREEMENTS

Life insurance contracts offer the ability of either the policy owner to designate, or the beneficiary to select, receipt of proceeds from the policy in some method other than a lump sum. Under the **settlement option** the person or persons who are going to receive the funds can receive income benefits according to a method of payment as agreed upon between the parties. **Beneficiaries can select a payment under a settlement agreement** if there was none placed in effect prior to the insured's death. The **"payee"** is the person who **receives life insurance proceeds under a settlement agreement.** It is especially useful when the recipient has inexperience in handling large sums of money.

Partial payment of proceeds to a contingent payee can also be provided. This should not be confused with a contingent beneficiary. A **"contingent payee" is a party named in a settlement agreement to receive unpaid**

amounts which are still due after a primary payee's death. When the primary beneficiary becomes the primary payee a contingent payee can be named to receive any amounts not collected by the primary. Allowing the beneficiary to choose from among settlement options, when a policy owner dies, is available because circumstances of change such as births, death, marriages, divorces and economic factors, like inflation, are not predictable.

Basic settlement options include:

1) interest income only - the proceeds are left with the insurance company but the primary payee can be given the right to withdraw some or all of the principal.

2) income for a fixed period - equal amounts of money are paid out for a period of time decided by the owner.

3) income of a fixed amount - the insurance company keeps and invests the proceeds and makes payment of a specified fixed amount until there is no money remaining.

4) income for life - the insurance company keeps the proceeds and makes payments of income on a guaranteed amount for a payee's life time. The four types of income for life include

a) straight life income - pays as long as the payee is alive,

b) life income with a period certain,

c) refund life annuity - pays to a contingent payee until all the proceeds have been exhausted, and

d) the joint survivor annuity - makes payments based on the lives of two people. As long as at least one party lives, the survivor gets income.

There are only two limitations of settlement. First, the amount being paid over a period of time must meet some minimum time frame so the company does not have to pay tiny amounts. Second, payment to a beneficiary who is not human can be accomplished only with the consent of the insurance company (all proceeds to your pet dog, "Woofie," are frowned upon).

Settlement options are also useful in preventing problems caused when the insured and the primary beneficiary die at the same time due to some common disaster. **"Common disaster"** is any occurrence where two or more people die as a result of the same incident. The existence of state laws called **"simultaneous death acts" automatically presume the insured lives longer then the beneficiary when the actual point of death cannot be determined.** Simultaneous death acts are designed to carry out the wishes of the policyholder. **"Survivor clauses" (**also known as delay or time clauses) in an insurance contract require that a beneficiary must survive the insured, in a common disaster, for a specified length of time before receiving the proceeds from an insurance policy.

TRUSTS

A trust is a fiduciary relationship under which a trustee holds the legal title to property subject to an obligation to manage the property for the benefit of another person, called the beneficiary. **Life insurance trusts are a type of "inter vivos" or living trust.** The three basic types of insurance trusts include

1) revocable life insurance trusts - the policy owner deposits the policy with a trustee, the trustee is made the beneficiary but the policy owner retains rights of ownership and can revoke the beneficiary at any time,

2) An irrevocable life trust - the trustee is named as beneficiary and cannot be changed by the policy owner without the consent of the beneficiary and

3) contingent life trust - is used to provide protection for minor children should both parents die.

The insurance company is not a party to a life insurance trust but it will verify the existence of such a trust. Life insurance proceeds **may be held in a "testamentary trust" which** is more likely to be proved invalid then one which is inter vivos because validity depends on successfully probating a will in a testamentary trust.

When drafting a trust there are two basic rules to consider. First, the **"rule against perpetuity"** demands that **an interest created by a trust must vest no later then 21 years following the lifetime of a person living when the trust is created.** This prevents tying up property, from beyond the grave, for unacceptably long periods of time. Second, the **"rule against accumulations" prohibits** one person from leaving property to another person for the purpose of accumulating income too far into the future.

There are major differences between a settlement agreement as provided in an insurance policy, as an option, versus a life insurance trust. Although both are held and invested by a insurance company (or a trustee) and paid out to a payee (or a beneficiary) according to policy owner or beneficiary direction, some sizable differences exist including the fact that **a trust is more flexible then a settlement agreement.** For example, in a life income arrangement there is a guarantee of proceeds which are left with the insurance company as well as return on investment but a trust will eliminate many investment restrictions which would otherwise be imposed on an insurance company. A trustee is considered to be more discreet than an insurance company in carrying out the terms of a trust but a settlement agreement is usually considered safer than a trust. Furthermore, the insurance company provides services free of charge. A trustee is a personal counselor to a trust beneficiary but the insurance company would not offer such a personal

relationship. The **trustee has "legal" title** to proceeds but the **beneficiary has "equitable" (real) title**. Finally, property in an individual trust can be separated from the property of other trusts.

WILLS

Wills are legal documents which outline the intent of the person making them for the disposition of property. A will can be revoked at any time by the person who makes it (known as the "testator"). Furthermore, the testator can change the document in any way, shape or form desired and they retain complete control over all the property in the will. The **will is a high secret and confidential instrument** and it will not become effective until the testator dies.

Property can be transferred, after the death of an individual, **without a will through the use of "joint tenancy."** In a joint tenancy two or more people hold property rights equally and share in the enjoyment of the property during their lives and each party has the "right of survivorship". Under survivorship when one joint tenant dies, all ownership held automatically passes to the survivors.

Another method of transferring property without a will is through **a gift "causa mortis".** These are gifts which depend on a death which is anticipated in the short term. If the death does not occur then the gift giver has ownership returned.

A third method is through a contract which creates "present interest" in the parties. These contracts are not void for lack of formality (such as the will as a legal document) even though contractual obligation is due at the death of one party. **The two types of contracts which are called "will substitutes" include life insurance contracts and optional settlement agreements.** Technically, the life insurance contract can be looked upon as a substitute to a will which allows the beneficiary more freedom in timeliness of using the proceeds from the estate.

PREMIUMS: CONDITIONAL AND RENEWAL PAYMENTS

An insurance premium is money paid to an insurance company in exchange for carrying a risk. The insurance company will invest the premium money and use it later to pay claims. The insured is provided a **conditional promise from the insurance company** that the face amount of a life contract will be paid if the premiums are paid on time. However, the insured does not promise to pay the premiums and unpaid insurance premiums are not construed as a debt. If unpaid premiums were a debt, the insurance company could sue the insured to recover unpaid premiums. This is the deciding factor of why life insurance is a unilateral contract binding only one party, the insurance company.

Initial, or first, premium is consideration for the promise of the insurance company to pay a death benefit and it will put a life insurance contract into full force and effect once the payment is made. When a beneficiary possesses a policy at the point the insured dies, this has legal significance indicating evidence of legal delivery of the policy. This constitutes a case that consideration was paid. The company or the agent can waive payment of the first premium. **Renewal premiums are a completely different matter and the company has the right to dictate how, where and to whom renewal premiums will be paid.** The life insurance **agent has no authority to collect renewal life insurance premiums.**

A life insurance contract is not separated into yearly promises with yearly premiums but is instead a continuing promise. **Payment of renewal premiums is considered a condition precedent to continuing coverage.** When the premium is not paid, the insured will lose the right to have the insurance company pay the face amount of the policy upon the insured's death. Renewal premiums can be made by beneficiaries or collateral assignees in addition to being made by the policy owner. Unless the insurance company provides an extension of time, renewal premiums have to be paid on or before a date specified in the contract. **When delivery of a policy is not a requirement** to putting a policy into effect (in other words, the first premium is paid at the time of application) **the policy effective date will control** as to when renewal premiums are due.

When a contract takes effect upon delivery but there is a date expressly stated for premium payment, even though the policy is not effective until a later date, the date specified in the policy will control. A minority of states views this the other way and considers the date of contract delivery as controlling regardless of a stated policy date. **The vast majority of states require a grace period in an insurance contract of one month before the policy goes into default.** There is no grace period for the initial premium or extensions of time. Premiums can be paid after the death of an insured, but prior to the end of a grace period.

METHODS OF PAYMENT

When an applicant makes premium payment by check, coverage is conditional upon the check clearing through the bank upon which it was drawn. **The insurance company can lapse a policy if a check is dishonored and can proceed to collect on that check.** If a check is dishonored but the agent has given a premium receipt, the company must act quickly, otherwise a waiver situation may result in which the company may still be bound to coverage. When a **postdated check** is used and honored by the bank it is considered effective payment and the policy is paid as of the date shown on the check. Very common today is the use of the "preauthorized check" plan where the insurance company automatically draws the money for the premium from the policy owners bank, according to the policy owner's prior written permission.

A "promissory note" or the unconditional acceptance of a promissory note by an insurance company is the equivalent of payment. If an insured defaults on the note it is not the same as defaulting on the premium because both the policy and note must clarify any forfeiture procedures. **Insurance companies have the right to limit or refuse the use of promissory notes as a method of payment.**

Also permitted in most states is the **automatic premium loan** of a policy which builds cash value. The insurance company will automatically take a loan, in the amount of unpaid premium due, against existing cash surrender values when the premium is not paid by the end of a grace period. Policy owners can select this benefit at application time and the company would notify the policy owner when an automatic premium loan had been charged. **The automatic premium loan is effective in avoiding a policy lapse** and keeping the entire policy in full force and effect.

Another possibility of payment is **payment by allotment plans** through which the amount of a premium is automatically deducted and forwarded from the salary of an insured to an insurance company. **All premiums made after the first premium must be payable to the company, not to the agent.**

A premium can be paid by anybody who wants to pay the premium for somebody else. If a revocable beneficiary makes payment this does not change or enlarge the expectation of the death benefit. However, if a collateral assignee pays premiums then they have the right to recover any paid premiums plus the original debt. This is different from the absolute assignee that has no duty to pay a premium and doing so will only keep the policy in force. Two other possible methods of payment are credit cards or by use of dividends, if a policy owner has selected such a dividend option.

NOTICES TO PAY PREMIUM

Insurance companies must only send a notice to pay the premium when state statutes or the policy provision requires it, otherwise there is no legal responsibility to do so. Of course it is a good idea as a business practice to send notices and most companies do send them even if they are not required to do so.

When a policy is issued by a mutual company and dividends are applied to reduce premiums then an insurance company must send a premium notice. Insurance companies may not waive sending premium notices in states requiring notices to be sent. Insurance companies who regularly send premium notice, even though not required to do so, can only discontinue the practice by notifying the policyholder.

NONPAYMENT

There is no reason a policyholder should not pay a premium on time. Payment of premiums in a timely fashion is a condition precedent to coverage and, if payment remains unpaid, the company does not have a duty to pay the claim. In this regard, **the duty of the policyholder to pay is absolute.** Exceptions exist only when the act or agreement of the insurer is involved. Common excuses include when an insurance company extends the time for the payment of a premium or waives it according to the terms of the disability rider. **Estoppel by course of conduct** such as when the insurance company accepts late payment of premiums as a matter of habit, without objecting to the late payments, can create the situation where the insurance company has waived the time of payment requirement. If an insurance company refuses to accept an offered premium then it is an excused nonpayment. For instance if a collecting agent refuses payment prior to a lapse and the insured dies after the grace period, the benefit would be payable. General failure of an agent to collect a premium may also be excused as well as the failure of the company to send premium notice when required. Failure of the post office to deliver the premium is an excusable reason for nonpayment if the insurance company allows the use of the mail in sending premiums.

DIVIDENDS

There are two types of dividends in the financial world: those paid by corporations to stockholders on profits earned and the other is to policy owners of life insurance contracts issued by mutual insurance companies. **Corporate dividends to shareholders** represent a distribution of profits which **are taxable** to people owning the stock. **Policy owner dividends from mutual life insurance** companies are considered, by the Internal Revenue Service, to be the return of an overcharge of a premium to the policyholder and **are not subject to taxation.** The insurance policy dividend is simply a refund and is not subject to income taxation.

Insurance companies are either stock (issue "nonparticipating" policies) or mutual (issue "participating" policies). Nonparticipating policies do not offer policy dividends to policy owners and they pay dividends, which are taxable, to stockholders just like any other corporation. The premiums charged by nonparticipating policies are, in theory, supposed to be lower than those charged by mutual companies and therefore dividends are not paid. Premiums for nonpar policies are based on realistic assumptions instead of the mutual concept of relying upon estimates of mortality, interest and expense.

In a participating policy, premiums are based on conservative assumptions which use higher mortality than anticipated. These **assumptions provide a margin of safety** for the mutual insurance company and overcharging is normal when it comes to a participating policy. Because of this margin of safety approach, if more people die then expected resulting in higher cost then expected and interest earnings are less than anticipated, **financial problems can be avoided before they occur.** When a mutual company does not have to pay out as much as it expects and mortality experience is better then expected there could be a surplus of funds which can then be paid out as dividends to owners of mutual policies.

Dividends are usually paid on an annual basis and, in those states which set forth by statute, the frequencies of dividends payments, also stipulate an annual payment. The manner in which the policy owner will receive the **dividend is selected by the policy owner.** When the policyholder applies for life insurance, it is at that point that a dividend option would be selected. **If none is selected** one would **automatically** become effective, usually **a "paid up addition"** option. Dividend options can be changed at any point in time by the policy owner who must notify the insurance company of the intention and desire to make a change.

Common dividend options include taking the payment in cash, taking a term insurance option to have the dividend buy as much extra term insurance as possible, using the dividend to reduce the premium which will be charged in the future,

investing the dividend with the insurance company so that it accumulates interest on an annual basis (Note: although the dividend itself is not income or taxable, interest earned on invested dividends is taxable income to the policyholder) and the common dividend option of the paid up addition which uses the dividend to purchase, in a single amount, completely paid up coverage in whatever amount of protection can be purchased at the given age of the policy owner relative to the amount of dividends. A **key advantage to the paid up addition option is** the **insurance** is **bought at "net rate," meaning** there is no provision for an agent commission. These paid up additions will increase the death benefit and the cash value of the policy. Other common uses today are to use the dividend to pay up the policy sooner or to create an earlier endowment date (the point at which the cash value equals the face amount of insurance originally purchased).

In addition to the dividends paid on an annual basis, there may be provision for an extra dividend if there is a requirement to distribute additional surpluses. **Extra dividends can take one of two forms:** it can be made in a single payment after the policy has been enforced for a specified number of years or it can be used as a settlement dividend which would be paid in the event that a policy terminates due to death, surrender or maturity of the policy.

PREMIUM RETURN

The general rule regarding return of the premium is **once the insurance company has assumed the risk and accepted the premium** it has earned the premium for the risk it has accepted. There are some basic exceptions to this rule and the most common is a minor who buys a life insurance policy and then disaffirms the contract at a later date is entitled to receive a refund of all premiums paid.

NONFORFEITURE PROVISION

Owners of permanent life insurance purchase a plan in which they pay more money into the policy during the early years and in return they benefit by receiving a level premium throughout their lifetime. Because of this extra amount being paid in the early years, a policy owner of permanent whole life insurance is entitled to a **"nonforfeiture"** provision in their contract. The risk to the insurance company diminishes each year the owner continues to pay premiums because the cash surrender value increases in the policy.

Many years ago, when a whole life contract of life insurance was lapsed, the difference between how much was paid and the actual cost of the death benefit was forfeited to the insurance company. Under modern contracts of life insurance there are several options available to the policyholder of permanent life insurance who no longer wishes to maintain the original contract.

The first option is the owner may trade the policy in for cash surrender value and end the contract. Insurance companies, upon being served notice that cash surrender request has been tendered, must pay this value but laws in most states can allow deferral of payment for up to a six-month period of time. **This is known as the delay clause. Another standard option** is to put the contract on **extended term insurance** meaning that the face amount of the policy, less any unpaid loan amounts, continues in force for as long as the cash value will purchase insurance at a term cost basis. **Any accidental death benefit rider would be excluded under this nonforfeiture provision.** The **third option is to take a reduced paid up policy**. This means the insurance will be the same type (i.e. 20 pay life is still 20 pay life) and existing cash values are used to purchase a reduced but fully paid policy based on the insured's attained age.

When a policy owner fails to pay premiums and a policy lapses but the owner does not indicate any particular nonforfeiture option, the extended term insurance option is automatically enacted, although some states require by law that the owner be given a reduced paid up policy. One interesting twist in the nonforfeiture situation is when the insured dies before the option selected is completed. In other words, **if a policy owner indicated** to the insurance company **that they wish to surrender the cash value and fills out the paperwork but the insurance company has not yet paid the**

cash surrender value, if the insured dies the **insurance company is only bound to pay the cash surrender value and not the death benefit.**

The **nonforfeiture option** from the insurance company to the policy owner **is considered to be a continuing and irrevocable offer** and acceptance of the terms of this offer binds both parties to the contract. Any riders or additional benefits placed on the contract such as disability, guaranteed insurability, or accidental death cannot be expressly excluded as stated in a policy once the nonforfeiture provision takes effect. Beneficiary rights under nonforfeiture do not exist and a **revocable beneficiary has no rights** and the policy owner can cash in a policy without the knowledge or consent of the revocable beneficiary. **Irrevocable beneficiaries must give their consent before cash surrender value can be selected by the policy owner.** The selection of either the extended term or reduced paid up option does not affect an irrevocable beneficiary designation.

POLICY LOANS

In cash value building whole life insurance policies the owner has the right to borrow against existing cash surrender values. The act of borrowing is not considered to be a loan and no creditor and debtor relationship is constructed. Policy loans do not have to be repaid because the **policy loan is an advance against the future death benefit** which will be paid anyway.

Policy loans cannot be repaid by the policy owner unless the policy is still in force. Interest does not have to be repaid since it can be added to any outstanding principal balance owed on the policy loan. Finally, when the amount of the loan plus the accumulated interest equals the maximum cash surrender or loan value, the policy owner will be notified that within 31 days the policy will terminate.

At the request of the owner, regardless of reason, a loan may be made up to existing cash values. A common reason is to borrow against cash values to pay the premium and some companies offer the automatic premium loan provision. The maximum loan value is specified in the contract and loans of from 90% to 95% of cash value are normally allowed. Interest rate charges are also specified and older contracts fixed the rate at from 4% to 6% or 7%. Since the high inflation of the late 1970's, insurance companies use a floating rate with a cap, usually around 12% to 14%.

A **common misconception of the public** is voiced as follows: **"Why do I have to pay interest to use my own money?"** Such a comment indicates a fundamental ignorance about the workings of the cash value life insurance policy. **Interest is charged because the company will invest premiums to earn income and this income is calculated in the level guaranteed cost given to the policy owner for a lifetime.** If the owner is using some of this premium and it would otherwise be invested by the company, the company must earn income from some source (in this case the policy owner).

Owners of policies on extended term insurance may not borrow against cash values but owners of reduced paid up policies may, as long as the interest plus the loan is not greater than the cash value. If the insured dies with an outstanding policy loan, the insurance company pays the entire face amount minus the policy loan and any accrued interest due on the policy.

TRANSFER OF RIGHTS: ABSOLUTE AND COLLATERAL ASSIGNMENTS

As defined earlier, assignment is a voluntary transfer of some or all rights of ownership by one person in favor of another person. **The person making the assignment is the assignor and the person receiving the assignment is the assignee.** "Absolute assignment" creates an irrevocable transfer of all ownership benefits and it can be accomplished either through a gift or a sale. A property owner can gift the property to another person or sell it to them. A "collateral assignment" is a temporary and revocable transfer of some or all of the ownership rights subject to the condition that these rights will go back to the assignor under some specified condition or at some specified point in time. **One important concept of assignment is that no one can assign away any more rights then they actually hold under a contract.**

The collateral assignment is interesting because it is normally used to secure a debt and there are special rules associated with the collateral assignment of a life insurance policy. **The transfer of collateral assignment does not designate the right to change the beneficiary and that right remains with the original owner.** The assignee under a collateral assignment has rights that are superior to the rights of a revocable beneficiary even though the beneficiary does not consent to the assignment. The irrevocable beneficiary who does not provide consent to an assignment has rights superior to those of the assignee.

An insurance policy owner engaging in collateral assignment with a bank will be asked to complete and sign the **"American Bankers Association Standard Assignment Form"** used to transfer or assign the collateral rights of a life insurance policy to a bank. **This form specifically says the bank holds the following rights; to surrender the policy if necessary, to collect proceeds not to exceed indebtedness, the right to make a loan, the right to exercise nonforfeiture options and to collect dividends, if necessary. The policy owner reserves the right to change the beneficiary, to collect disability benefits in cash and to elect settlement options.** In an absolute assignment the assignee has the right to collect disability benefits in cash, elect a settlement option change and designate beneficiaries, take policy loans, receive dividends, rights to all nonforfeiture rights including cash surrender value and to collect proceeds at maturity of a contract or at an insured's death.

MAKING AN ASSIGNMENT VALID AND RIGHTS OF AN INSURANCE COMPANY

All conditions or clauses pertaining to assignments in the life insurance contract must be met unless the insurance company waives such provisions. The assignor must have the legal capacity to make the assignment and assignments usually are in writing, although this is not absolutely necessary. The delivery of the policy or, of the written assignment, must be made to the assignee or to the assignee's agent. Notice of an assignment to an insurance company and company consent are not usually a prerequisite for receiving a copy of the assignment. The law **in most states is the assignee does not have to have an insurable interest** in the life of the insured but several states do make this a requirement. When an insurance company is aware of an assignment but pays benefits as if assignment had not been made the insurance company will be held liable for a second benefit payment to the assignee.

The general responsibility of an insurance company in an assignment situation is the company will assume no responsibility for the validity or effect of an assignment of the policy and written notice of the assignment to the home office is usually required to validate an assignment. When an assignment is intended to be absolute, the owner can assign the policy to whomever the owner wishes. **The only circumstances which can limit or stop a policy owner from assigning a policy is if:** a property settlement prohibiting an

assignment has been made, there is an irrevocable beneficiary, there is lack of insurable interest on the part on an assignee in those states requiring insurable interest, there is an outstanding collateral assignment already in existence or there is a purchase of a policy with the intent to assign the policy to a person who does not have an insurable interest thus putting the insurance policy in a gambling or wagering situation which is illegal under the laws of all states.

MULTIPLE ASSIGNMENTS

In a situation where one assignee after another is created using the same policy, there are two basic rules. First is the **English Rule** which states that the **first assignee must give notice to the insurance company and those rights are superior and they would be entitled to death benefits.** The **American Rule says the rights of the first assignee are superior to any subsequent assignee.** Assignments by the beneficiary before the insured's death are permitted unless there is a clause prohibiting such action. After the insured dies, the rights to death benefits become vested and are freely assignable by the beneficiary of the policy.

REINSTATEMENT CONCEPTS: **LAPSE**

When an insurance policy has not been paid in a timely fashion by the policy owner (within the grace period) the policy then lapses. This can mean that the contract has terminated without any further benefit passing. A lapse may also automatically trigger one of the nonforfeiture benefits such as extended term insurance or reduced paid up insurance. The **policy is said to "expire"** at the point at which nonforfeiture benefits are entirely exhausted or when cash value has been fully surrendered.

Most states in the United States require a reinstatement provision be included in a life insurance policy. The majority view of state courts assert that a new contestable period starts when the reinstatement begins and applies only to statements made in a reinstatement application. Reinstatement carries with it the possibility the insurance company can turn down the owner's request to reinstate because of the changed insurability of the insured. **Once a policy lapses, it places the owner in reinstatement territory and the policy owner has given up many essential rights.** Reinstatement provisions are usually more liberally enforced by insurance companies than an actual state statute would require. Policy provisions allow possible reinstatement usually from three to five years from the time a policy has lapsed. Any outstanding loans plus interest must be repaid plus unpaid back premiums plus any interest must also be forwarded to the insurance company. Policies that have been surrendered for cash value may not be reinstated.

The most critical loss of rights to the policy owner is **evidence of insurability which can be required by the insurance company before reinstatement will be allowed.** For reinstatement purposes, **insurability carries the same requirement** as it would for any applicant **except that the age of the insured** on the original application is still used for rate calculation. In the event an insured dies before the reinstatement procedure has been completed, most states hold that the company need not approve the reinstatement unless all conditions were met before the applicant's death. **Once a policy is reinstated it is not a new contract, therefore the company cannot impose new conditions. The contestability of a reinstated policy has been interpreted in three different ways by courts in America:**

1) reinstatement is a separate agreement which could be contested for fraud at any time,

2) once the original contestable period has expired the policy remains incontestable for any reason even after reinstatement and

3) a new contestable period runs for the same period after reinstatement on the original application but this new contestable period applies only to the statements made in the reinstatement application itself.

A final note: **reinstatement has no effect on the suicide clause once the suicide clause has expired.** Suicide is a risk assumed by the insurance company regardless of reinstatement and a suicide period does not run again after reinstatement.

LEGAL REMEDIES

"Remedies" are necessary when a policy interpretation is disputed in a court of equity. The four normal remedies associated with the life insurance contract include:

1) an **interpleader suit** in which the insurance company places the property (proceeds) with an equity court and says "we're out of this. You, the court, decide what to do with the benefit";

2) **recision** - where each party goes back in time and gives back what it had taken and no contract exists;

3) **reformation** - the court will take an agreement and interpret it to the best of their ability to enforce the original intent of the parties. The contract is essentially rewritten; and

4) **declaratory judgement -** the court makes a declaration and it is binding on the parties.

CONTESTABILITY

The **incontestable clause found in the life insurance policy is intended to limit the time that an insurance**

company can point to the misrepresentation, fraud, or concealment of an applicant to contest the policy and refuse to pay proceeds of the policy. In an incontestable clause the life insurance company essentially waives the right to contest the policy after some point in time, usually two years, from the date of the policy issue. A "contest" is deemed to be a lawsuit, or challenge, against the validity of the contract based on general contract law as enforced through a court of law. **The insurance company can initiate a lawsuit against the policy owner to cancel or rescind the policy.**

The incontestable clause, as written, sometimes includes exceptions stating that the policy will be incontestable for two years **except for non payment of premiums.** Some courts have held that if the insurance company excluded specific exceptions, other similar terms not specifically listed are presumed to be excluded. In other words, the insurance company must include all limited provisions in an incontestable clause.

The effect of the incontestable clause is the insurance **becomes effective at the date of issue** and the contestable period starts on the date of issue. When the insurance becomes effective before the issue date on the policy, the contestable period starts on the earlier date. The court interprets policy terms in favor of the insured. All statements made by the applicant in the application process can result in the attachment of corresponding legal consequences.

Warranties and representations are possible statements that could be made by an applicant. A **warranty is considered to be part of a contract and it is a very strong statement relating to fact or action taken.** Warranties are considered to be material and important statements to a contract. **Warranties** are guaranteed statements which are true and are strictly interpreted. A **representation, on the other hand, is a statement made by an applicant which is, to the best of his or her knowledge, believed to be a true and accurate statement. Therefore representations are considered to be substantially true but are not guaranteed statements.** In **modern life insurance contracts statements made to obtain insurance are considered to be representations and not warranties.** The majority legal view holds that an innocent misrepresentation which affects the acceptance of a risk gives the insurance company the right to avoid the policy (to set it aside). The majority of courts hold that the incontestable clause neither conflicts with the suicide clause nor the misstatement of age clause.

The general rule of contestability: **after a contestable period has ended, all defenses relating to whether or not a contract is valid are barred to the insurance company, even most fraud!** There are three exceptions, based on the theory that the incontestable clause would not be applicable at all because there was never a contract formed. In this scenario the three exceptions are:

1) **lack of insurable interest** - a person cannot take out a valid and enforceable policy insuring the life of another when there is no insurable interest. Such a contract is void as a matter of the public policy against wagering;

2) **fraudulent impersonation** - an application is completed but another person takes the medical exam. Incontestability does not apply because there was never a contract in the first place. Insurance companies do not insure names, they insure unique and individual lives; and

3) **procuring a policy with the intent to murder** - makes a policy void from its inception.

Contesting disability and accidental death riders, under most state laws, allows benefits to be excepted from the operation of the incontestable clause. Even after the contestable period has expired, the company still can test the validity of the disability provision.

Past incontestable clauses used the phrase "during the lifetime of the insured" as the time frame from which contestability ran. The **famous Monahan case** forced insurance companies to change this wording used in the incontestable clause. **In the Monahan case the insured died during the contestable period and because of a**

misrepresentation in the application the company denied the claim. The beneficiary was Mrs. Monahan and she waited until the expiration of the two-year contestable period from policy issue before she sued the insurance company to recover the policy proceeds. At that time, the incontestable clause read "after two years this policy shall be incontestable except for non payment of premium."

Because Mrs. Monahan waited until the contestable period expired, this was not within the lifetime of the insured and she recovered. After that, insurance companies amended incontestable clauses to read "for two years during the lifetime of the insured." Mrs. Monahan won because the clause said in two years this policy shall not be contestable but during the lifetime of the insured was not mentioned. Today the application of the rule applies when death occurs before the end of the contestable period and the policy was not enforced for two years during the life of the insured. Then the company policy can contest the death claim.

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SECTION VI STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) Explain the difference between required, optional and prohibited provisions in a life contract?

2) What information appears on the face page of a policy?

3) What is the importance of the entire contract provision?

4) Why did the divisible surplus provision become required?

5) How come policy loans do not have to be repaid?

6) Explain the advantages and disadvantages to the policy owner of the reinstatement provision?

7) List the rights of policy ownership.

8) Discuss the three prohibited policy provisions.

9) Compare and contrast the definition of "accidental means" with "accidental result."

10) Name six risks not covered by the accidental death rider.

11) Why does a disabled insured have to wait six months for a waiver of premium to become applicable?

12) Explain the significance of the New York Rule as it pertains to the Guaranteed Insurability option.

13) Compare a result versus a status clause in a war rider.

14) Is a life policy a chose in action or a chose in possession?

15) When an insured and beneficiary get divorced, what usually happens to the life policy in the settlement?

16) List four ways a creditor can protect rights regarding a debtor using a life insurance contract.

17) What do exemption statutes protect and from whom?

18) What rights are offered to insolvent insured's under the Bankruptcy Act of 1978?

19) Define community property. Define separate property.

20) In a community property state, what rights does the beneficiary spouse have if the deceased spouse leaves a life policy proceeds entirely as a settlement option?

21) A beneficiary kills the insured. Under what circumstances can the beneficiary collect the policy proceeds?

22) What limitation does the policy owner, who is also the insured, have in naming a party as a beneficiary in the policy?

23) Why does a policy owner who is not the insured have to have insurable interest in the insured?

24) What is the main distinction between beneficiaries who are revocable from those who are irrevocable?

25) Explain the rights of proceed collection of primary and contingent beneficiaries.

26) What is a donee beneficiary?

27) Why is wise for a policy owner to review beneficiary designation on a regular periodic basis?

28) What is the difference between name and class beneficiary designation?

29) What happens to the ability of the policy owner to make a beneficiary change if they become incompetent?

30) Describe three ways a beneficiary change can become valid.

31) Under a settlement agreement of life insurance proceeds, what is the role of the contingent payee?

32) List the four basic options under a settlement agreement.

33) What are the two limits imposed by insurance companies regarding settlement agreements?

34) What is the purpose of the Simultaneous Death Act?

35) Describe the three basic life insurance trusts.

36) Discuss the relative strengths and weaknesses of life insurance trusts versus utilizing settlement agreements offered under the life policy.

37) Why is a life policy a will substitute?

38) List the various ways a premium can be paid.

39) When can nonpayment of a premium be excused?

40) List dividend options available to a policy owner.

41) Describe the nonforfeiture options and tell why they exist.

42) Explain why policy loans are not "borrowing your own money."

43) What rights does a collateral assignee possess?

44) What restrictions can an insurance company impose regarding policy owner assignment?

45) How have reinstatement clauses been interpreted by courts with respect to contestability?

46) List four remedies available when a life contract is disputed.

47) What was the significance of the Monahan case?

SECTION VII: PROCEEDS AND ENTITLEMENT

ESTABLISHING THE BENEFICIARY

When a competent beneficiary is specifically named there is no problem with proceeds distribution on a life insurance policy. In the event no party has been named as a beneficiary and the insured dies, all the benefits go to the estate of the policy owner. The executor or administrator of a deceased is named the beneficiary when all named beneficiaries have died before the insured. In a **trustee beneficiary situation** the insurance company needs evidence of the trustee's power to act before the insurance company will pay the trustee. **When a beneficiary is incompetent,** (a minor or a person who is mentally incompetent) **the insurance company cannot pay proceeds to this party** because the written binding release required for the payment of the proceeds would not be valid. A guardian for the incompetent may receive the proceeds or they can be held with interest until a minor can sign a valid release form. If the insurance company pays a minor and the minor signs the release, it can be disaffirmed by the minor upon reaching the age of majority and the company could be liable a second time.

A beneficiary who kills the insured will endure obstacles when trying to collect the proceeds from a life insurance contract. "Justifiable homicide" by the beneficiary may not necessarily disqualify him if self defense was used, the killing

was accidental or the insured went insane at the time of the killing. Homicides of a lesser degree than first degree are handled differently from state to state. Acquitted beneficiaries may still have to be judged qualified or disqualified in a civil court even though a criminal court acquitted them of the murder. Proceeds of polices obtained in good faith, without any intent to murder, are paid to somebody, whether or not it is the disqualified beneficiary becomes a secondary issue. However, policies which are, from the inception, purchased with the intent to murder are void automatically and no benefits are payable to anyone.

Should the insured and beneficiary die in the same accident the simultaneous death act creates the presumption that the beneficiary died before the insured. If the beneficiary does survive the insured, the survivorship clause can require the beneficiary to live longer by a specified period of time.

DISAPPEARANCE

When an insured person disappears without explanation, death will be presumed if the following four conditions are met; there must an unexplained absence, the person must be missing for a certain period of time (usually seven years), the beneficiary must diligently search for the insured and it must be discovered that the people most likely to have heard something from the insured have not heard anything from the missing person.

In the event a death benefit has been paid and the insured reappears, the insurance company has the right to recover benefits if there was a mistake of fact. In a case of disappearance, the beneficiaries of the policy should continue paying the premiums to prevent the policy from expiring before the death can be presumed legally. By paying continued premiums, if the insured does, in fact die, during the time premiums were paid, the death benefit is payable and overpayment of premiums can be recovered from the insurance company. However, if the premiums were not paid when they should have been, a settlement may be automatically precluded.

SETTLEMENTS AND LITIGATION

Arriving at the settlement amount owed on the proceeds of a policy involves adding together many items including the face amount of the policy (unless it was otherwise reduced because of a reduced paid up policy), any paid up additions purchased through dividends, any accidental death benefit that may be payable, any premiums that were paid in advance beyond the month in which the death occurred, any post mortem dividends earned by the company for long held policies and any interest required according to state law because of delay in paying the death benefit. The insurance company has the right to deduct from this settlement any unpaid policy loans owed plus interest accrued and any

premium that was payable but was not paid at the date of death (income due to the company during the grace period provision). **The final amount, after these described additions and deductions, is then the full amount due to the beneficiary or parties entitled to receive the benefit.**

When a beneficiary must sue the insurance company to attempt recovery, claims litigation it can be very expensive and time consuming and the damages might extend beyond the policy benefits. Money could be awarded to compensate for a wrong done to a beneficiary plaintiff. A company may also be liable for extra contract damages such as attorneys' fees. When it comes to punitive, or punishment damages, the insurance company can only be held liable if it can be proven they maliciously denied claims or otherwise displayed reprehensible behavior. Punitive damages are tort actions, not contract law suits, and usually concern actions engaged in by insurance companies which do not meet the requirements of coverage and the conduct of business was not up to the policy owner's expectation. **In the event punitive damages are won they can be assessed as a percentage of the net worth of the insurance company.** The recent trend in the punitive damages area has been for the courts to hold plaintiffs to a higher and higher standard of proof. It is becoming increasingly difficult for a plaintiff to recover punitive damages.

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SECTION VII STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) What happens when a beneficiary is judged to be incompetent?

2) What are the four conditions to establishing the death of a missing insured?

3) If an insured is missing, why should a beneficiary make certain that policy premiums should be continued to be paid until death can be established?

4) What are the factors used to establish the actual proceeds payment amount under a life insurance contract?

5) Why would a life insurance company live in fear of having punitive damages awarded against it?

SECTION VIII:
GROUP LIFEINSURANCE CONCEPTS

HISTORICAL SIGNIFICANCE

Group life insurance dates back hundreds of years when slave traders insured ship loads of slaves being transported from Africa to America with slave traders as contract beneficiaries. Later contracts would involve insuring the lives of Chinese laborers who were being transported from China to North, South and Central America to work on various projects such as railroads and the Panama Canal. **The first group life insurance plans, as we know them, were established around 1911** and today's group life contracts bear a strong resemblance to this ancestor. There are more than one half million master policies now in force in the United States.

Modern group life insurance began with the efforts of Montgomery Ward and Company in negotiating with the Equitable Life Insurance Society of the United States to issue a group policy to nearly three thousand employees of Montgomery Wards. Just a few years later other major life insurance companies also began to issue group life insurance. **In 1917 the National Association of Insurance Commissioners (NAIC) developed standards by which group life insurance could be purchased and sold.** This NAIC model has been changed and amended several times

since 1970 leading to the current Act which was adopted in 1986. The earliest 1917 NAIC model group life insurance was a policy that covered not less then fifty employees, with or without medical examination. It defined contributory plans where the employer and employee split the cost of the coverage and that 75% of all eligible employees must participate in the coverage. It also described a non contributory plan in which the employer paid all the premiums and each eligible employee had to participate. The law was later revised to lower the group number to 25 and again, later, to 10. The modern 1986 version specifies no minimum number to constitute a group. Current group life insurance policies recognize the following basic categories as eligible groups; employees and employers, debtors or creditors, members of labor unions, members of associations, members of credit unions and groups which are deemed to be discretionary.

Almost all group life insurance master policies issued in America are the employer-employee group type. Under the modern version there is no requirement that the employer contribute part of the premium or that at least only 75% of eligible employees are covered in a contributory policy. However the rules on 100% participation in a noncontributory plan are still followed and only those employees who reject the coverage in writing are not covered, since the employer pays the entire cost.

STANDARD GROUP POLICY PROVISIONS

There are twelve standard provisions in the model group life insurance act of 1986. These include the following:

1) Grace period provision - there must be a grace period of 31 days for payment of premiums from the time it is due, except for the first premium.

2) The incontestable clause - makes a master policy incontestable, except for non payment of premiums, after the policy has been in force for at least two years.

3) Application provision - closely related to the incontestable clause, it has three parts:

a) the group life policy must provide a copy of the application to the policyholder and attach it to the master policy when issued,

b) the group life policy has to provide all statements made by the policyholder or people insured and all statements are representations and not warranties and

c) the group life policy has to provide that

no statement made by an insured will be used in a contest of the policy unless a copy of the instrument containing the statement is or has been furnished to the insured or to the beneficiary or administrator of the insured's estate.

4) Evidence of insurability provision - group life policies are required to have a provision setting forth the conditions under which the insurance company has the right to require an eligible person to furnish evidence of individual insurability.

5) Misstatement of age - an equitable adjustment of premiums or benefits, or both, will be made in the event the age of a person insured has been misstated and such provision must contain a clear statement of a method of adjustment.

6) Settlement provision - requires group life policies to include a provision that death benefits are payable to the person the insured has designated as a beneficiary. The insured under the group master policy has the right to name the beneficiary, not the master contract holder or employer.

7) Certificate provision - the group life master policy has to be provided by the insurance company with certificates to the policyholder for delivery to each of the insured persons.

8) Conversion privileges - employees must have a certain amount of time to convert their group coverage to individual policies without being required to prove evidence of insurability if their employment is terminated. The conversion period begins at termination of employment and lasts 31 days.

9) Extension of death benefit - the highest coverage amount for which the employee was eligible under the group life contract must be paid under an individual contract if the insured dies during the 31-day conversion period, even if the employee did not apply for individual coverage.

10) Continuation of coverage during disability - this late addition to the model act requires a continuation of coverage under group policies during periods of total disability only under an employer - employee contracts. The continuation is to be for six months unless the insurance company approves continuation under another policy provision or the policy terminates. Coverage continues as long as the employee pays the premium cost for his share of cost for coverage as if no disability existed

11) Creditor group life insurance certificates - insurance companies issuing creditor group life are required to issue certificates of insurance to creditor policyholders.

12) Nonforfeiture provisions - although most group life is usually yearly renewable term without cash valves, some group life does build cash values. Where there is cash value the policy must contain nonforfeiture options.

MASTER POLICY

When an insurance company provides group insurance, it must issue a master policy to the policyholder (normally an employer, union, association, etc.). The master policy, together with the applications of the policyholder and all insureds, constitutes the basic contract of insurance. The insurance company then issues certificates to the policyholder for distribution to insured individuals and these certificates explain the insurance to the people receiving the coverage. Although certificates contain all of the provisions found in the master policy, it is not the actual contract of insurance but, together with the master policy, constitutes the provisions of the entire agreement. Any ambiguities or conflicts between the master policy and certificates are interpreted to give the insured the best coverage possible.

REQUIREMENT FOR COVERAGE

Group polices usually stipulate that employees must be actively at working otherwise the employees will not be covered. This **"actively at work requirement"** prevents people who are too sickly or ill from being insured and receiving coverage under the group policy. The policy seeks to insure people who are reasonably able bodied. This is an important underwriting concern from the insurance company's point of view. Some group policies require the employee be a **full time worker which customarily means 30 or more hours per week.**

CONTRACT TERMINATION

Since individuals can only be insured by group policies if they are a member of a group, insurance coverage ends when the employee ceases to be a member of that group. **If an insured employee dies before the date employment terminates, the employee is considered to be insured and the death benefit will be payable.** What constitutes termination can sometimes be unclear, but when employees resign, retire or are fired by employers they are regarded as having been terminated from employment. **Mere absence** from work or a leave of absence **does not terminate employment** as a general rule. Although the date of an employee termination may sometimes not be easy to determine, many group policies contain a provision stating that when temporary leaves or layoffs continue for a period of two, or sometimes three months, the employee's employment will be considered terminated unless the employer elects to consider it as otherwise.

PREMIUMS AND DIVIDENDS

Typically premiums are paid to the insurance company by the policyholder and the premium is payable before the period of coverage will begin. Under non contributory plans, **enrollment cards are completed by each eligible employee** and this serves as a record of coverage and indicates a

beneficiary designation. Under group insurance contributory plans employees must sign an application authorizing deduction of premium contribution from salary. **Legal problems stemming from premium payment are more apt to occur when plans are contributory rather then non contributory.** Sometimes group policies provide for dividends or return of part of premiums. Premium refunds in a group situation are usually paid to the policyholder and not to insured individuals.

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SECTION VIII STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) What are a couple of trends, from the present to the future, in NAIC model regulation of group life contracts?

2) List the 12 standard provisions of the group policy and briefly describe the requirement.

3) Define actively at work and why is it a requirement for inclusion for coverage in a group contract?

4) How is termination distinguished from absence?

5) How are possible dividends distributed under a group contract?

SECTION IX: HEALTH INSURANCE CONTRACTS

UNIFORM POLICY PROVISIONS LAW

(In 1950 the National Association of Insurance Commissioners (NAIC) adopted the Uniform Individual Accident and Sickness Policy Provisions Law. This law has been accepted in all states).

"Accident and sickness insurance" is an old term for health insurance and is defined in the uniform law as "insurance against loss resulting from sickness or from bodily injury or death by accident or both." One person or more than one person can be covered. Additional people can be insured under a policy including a spouse, other dependents and dependent children less than 19 years of age. Sometimes children who are still full time students are covered up until age 23. Most states have a law requiring that newborn children be included under parent's policies but insurers may require an additional premium. **In 1979 the NAIC simplified the uniform law** and it is supposed to serve as a model for readability. There are seven required or mandatory provisions under this act.

1) The entire contract provision - the policy is the entire contract between the insurance company and the insured and no policy change is valid unless the approval of the change is made by an executive officer of the insurance company and is endorsed on the policy.

2) Time limit on certain defenses - designed to limit the period of time which an insurance company can rescind a policy or to defend a claim denial due to material misrepresentation in the policy. There are **significant differences between this and the life insurance incontestable clause.** The incontestable clause, as you will recall, in the life insurance contract runs for a two year period of time from policy issue. Health insurance contracts cannot exceed three years and when fraud is involved, health insurance contracts hold **policy is possible at any time in the future.**

3) Grace period - policies in which premiums are paid other then weekly or monthly must be at least 31 days. It can be as short as seven days when weekly premiums are collected. Policies are renewable at insurance company option and there will be no grace period when the insurance company gives timely notice of intent not to renew.

4) Reinstatement provision - if a policy lapses, the company can ask for a new application, require a premium be paid and will issue a conditional receipt. Reinstatement will be effective as of the date of the insurance company approval. If an application is not required and the premium is accepted after the lapse this results in automatic reinstatement. When an insurance company fails to act on a reinstatement application within 45 days a policy is automatically reinstated. Furthermore there is a 10-day waiting period after reinstatement concerning sickness. During the first 10 days from reinstatement the policy will not cover any sickness for the insured, but it will cover accidents.

5) Claims provision - The insured has to provide a notice of claim within 20 days, the insurance company must issue claim forms within 15 days of receiving a notice of claim and the insured must submit a written proof of loss on a claim within 90 days of the loss. An insurance company must pay claims immediately and no legal action can be taken against an insurance company for at least 60 days after written proof of loss has been furnished.

6) Misstatement of age - an equitable adjustment of premiums or benefits, or both, will be made in the event the age of a person insured has been misstated and such provision must contain a clear statement of a method of adjustment.

7) Beneficiary change provision - required in policies paying death benefits and the policy owner can change the beneficiary at any time unless the beneficiary is irrevocable. In addition to the seven mandatory provisions there are five optional provisions that the company can use (they are not required to use them).

1) Payment of claims provision - The company must pay claims and the insurance company can be allowed to pay benefits directly to a hospital, physician or other providers.

2) Change of occupation provision - Benefit or premium is adjusted according to whether a new occupation is more or less hazardous. If the insured switches to a more hazardous job they adjust the benefit down, if they switch to a less hazardous occupation the premium is reduced and any excess unearned premium that was collected is returned to the insured.

3) Over insurance provision - Benefit is reduced proportionally for extra coverage of which the insurance company was not informed. The insurance company must return premiums for excess insurance. This generally applies to companies that are on expense-based systems, like major medical plans.

4) Illegal occupation provision - There can be no coverage if loss results from the insured committing or attempting to commit a felony or engaging in illegal occupations.

5) Intoxicate/Narcotics provision - The company does not have to pay for losses resulting from the insured's getting injured as a result of the use of intoxicants or drugs which were not issued by a licensed physician.

TERMINOLOGY

"Sickness" is defined as the sickness or disease first manifested while a policy is in force. **"Injury"** includes accidental bodily injury sustained while a policy is in force. **"Hospital"** is an institution that provides service 24 hours a day and is primarily involved in the medical care and treatment and diagnosis of injured and sick individuals. **Excluded from the hospital definition are** rest homes, homes for drug addicts or alcoholics, nursing homes and homes for the aged. "Physician" is defined as a licensed person or licensed practitioner of the healing arts who performs services within the scope of the license as provided by the laws of the jurisdiction in which the practitioner resides.

KEY POLICY PROVISIONS

LIMITATIONS AND EXCLUSIONS

A **"preexisting condition"** is defined as a mental or physical condition that the insured had prior to receiving an effective policy date on a health insurance contract. Most policies limit coverage to conditions which show after a policy became effective.

Although preexisting condition is usually defined as a condition that the insured had before a policy was issued, where an insured has symptoms of such a nature that the insured should have sought medical care **before the effective date of policy but did not,** this can be construed as a preexisting condition as well.

BENEFITS

There are four major health insurance coverages including hospital expense coverage, surgical expense coverage, medical expense and disability income coverage. There are also Medicare supplement policies to provide coverage for areas not covered by Medicare program, as well as coverage for specific diseases such as cancer, leukemia, etc. Health insurance laws prescribe coverage must be available for new born and disabled children of the insured, maternity, outpatient treatment, alcoholism and drug addiction, treatment of mental illness and home health care. These laws apply to group health and individual policies.

The five areas of individual policy minimum standards apply to hospital policies, medical policies, surgical, major medical policies and disability income policies. Laws regarding minimum standards can differ from state to state these benefits can vary. There are **seven basic hospital surgical exclusions allowed including injuries and sickness already covered by Medicare, workers compensation or**

occupational disease, dental care, suicide, care treatment covered by veterans administration, pregnancy, childbirth, abortion, miscarriage, sickness contracted or injuries sustained as a result of war and injury or sickness of the insured while in the military.

RENEWAL AND CANCELLATION

Renewal and cancellation provisions are usually required to be put on the face or front page of a health policy. **Optional cancellation provisions** state the insurance company can cancel a policy anytime they choose while **optionally renewable policies** are policies which the insurance company can refuse to renew. Policies which continue at the option of the policyholder include noncancellable policies (all the insured has to do to continue coverage is to pay premiums on time) and guaranteed renewable contracts (the insured can continue coverage by paying premium but the insurance company could change the premium rate).

MEDICARE AND SUPPLEMENTAL POLICIES

Medicare is part of the United States Government Social Security program and provides health insurance benefits for people 65 and older and for certain disabled persons without regard to their age. **The two parts of Medicare consist of part A which is the basic plan covering room and board and related expenses including home health services,**

inpatient care and post hospital extended care and part B, the supplementary medical plan. Part A coverage is automatic but the insured has to pay a premium for coverage to enjoy Part B. Part B covers physicians and surgeons care, splints, casts, braces, physical therapy, artificial body parts, rental of hospital beds, ambulance and diagnostic tests. Although Medicare provides substantial benefits, there are gaps in coverage which must be bridged by purchasing Medicare supplement insurance from private insurance companies.

The NAIC Medicare Supplement Insurance Minimum Standards Model Act and regulation say that certain terms (mental and nervous disorders, physicians, doctors, nurses, sickness and accidental means) must be defined, and certain policy provisions are prohibited. Minimum supplemental benefits standards are provided, loss ratio standards are established and there are required provisions disclosing policy terms. The NAIC model also governs policy replacement.

NURSING HOME (LONG TERM CARE) POLICIES

The Long Term Care Model Act of 1987 from the NAIC has the purpose of promoting availability of long term insurance, protecting applicants from deceptive sales, creating standards for long term coverage, aiding the public in

understanding long term care policies and it increases the flexibility and innovation in developing long term insurance. This model act applies to both individual and group policies that offer at least 12 months of coverage in a setting other then the acute care unit of a hospital (in other words, nursing homes and places providing custodial care). Under the model act policies cannot be ended on the grounds of age and the policies must apply to lower levels of care. Policies cannot use overly restricted preexisting condition definitions since most people, when they get older, have some type of preexisting condition.

GROUP HEALTH INSURANCE CONTRACTS

Group health insurance faces one major problem that it must contend with: possible "over insurance." Since it is difficult to gauge whether or not a party has multiple policies and seeks to be paid on more than one, the coordination of benefits provision specifies that reimbursement will not be made for amounts covered by other group insurance policies. The insured can only collect no more then 100% of expenses covered. The main purpose is to prevent an insured from being paid more then once on the expenses actually incurred thereby reducing the possibility for over insurance. If a party has more than one policy, the coordination of benefits provision applies and coverage will be paid once to pay all claims and any excess (unnecessary) premiums paid by the insured will be refunded. The insured cannot benefit or gain economically from the health insurance policy.

Group health policies can be issued to associations, employers, trusts, credit unions, creditors and labor unions. One important change in the law in 1986 was the Consolidated Omnibus Budget Reconciliation Act, or COBRA. **COBRA forces employers to offer continued group health coverage to employees, spouses and dependents who lose coverage due to certain qualifying events.** Insurance can continue for 18 months when the qualifying event is either a reduction in employee work hours or termination for reasons other than gross misconduct. If the employee dies, is divorced or legally separated from an employed spouse, the employee is entitled to Medicare or a child's qualification as dependent ends, insurance must be continued for 36 months. Bankruptcy can also qualify for continuing coverage. The former employee must pay for the continued coverage unless the employer pays and the coverage will terminate if the employer ceases to offer group insurance, if the premium is not paid on time or if the person becomes covered under another group health plan.

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SECTION IX STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) What is the difference between "incontestable" and "time limit on certain defenses?"

2) List the five optional provisions of the NAIC model health contract.

3) How does the definition of "hospital" differ from "nursing home?"

4) What coverage does Part B offer that Part A does not under Medicare?

5) What is COBRA and who does it benefit?

SECTION X:
ADVERTISING LAWS PERTAINING TO INSURANCE

STATE LAWS

Virtually every state has laws governing the spreading of deceptive or false advertising as illegal, with punishment as a misdemeanor. Another common prohibition stops insurance companies from using a person's name or likeness for advertising without consent.

There are **three main state laws that regulate insurance** advertising and they include the **Model Unfair Trade Practices Act, Model Rules Governing Advertisements of Accident and Sickness Insurance, and Model Rules Governing the Advertisement of Life Insurance.** Under the Unfair Trade Practices Act there are **five prohibited trade practices** which are considered to be unfair and they include discrimination, rebating, defamation, false advertising and unfair claims settlement procedures. False advertising specifically includes misrepresenting a policy benefit, advantage, etc., also misrepresenting dividends, an insurance company's financial condition and the insurance policy's true nature by stating an insurance policy is a share of stock.

Under the Model Rules Governing Advertisements of Accident and Sickness Insurance every state except three including Alaska, Montana and Hawaii has adopted this rule. Model rules are designed to make certain that **truthful disclosures** of all important and relevant information regarding accident and sickness insurance are being advertised. These rules apply to any sickness, accident, medical, surgical or hospital expense policies intended for distribution or sale within a state. The important terms defined by the model rules include; a policy meaning any accident or sickness policy plan, contract agreement certificate and statement of covered rider or endorsement. It also defines exception, eliminates specific hazards from coverage, defines reduction provision which reduces the amount of the benefit and also limits any provision which restricts coverage as not an exception or reduction.

There are three types of advertisements defined by the model rules they include an institutional advertisement which just promotes viewers or readers interested in the concept of accident and health insurance or the promotion of the insurance company, an invitation to inquire further about a product and an invitation to contact. Included is the cost of the insurance which is being advertised. Exaggeration of benefits beyond the policy terms is prohibited. **Words that are exceptionally objectionable** in such advertising include "all comprehensive," "up to", "as high as" and "complete". Preexisting conditions must be expressly defined and must not appear to be a benefit

in the advertising. A paid third party endorsement must be genuine and must also be the endorser's current and actual opinion. An insurance company's identity must be clearly disclosed and no statements discrediting other insurance can be used.

In the Model Rules Governing Advertisement of Life Insurance, words like "profit," "savings" and "investment" must be used in conjunction with life insurance contracts carefully. Disclosure requirements must include that policies cannot be issued upon a guaranteed basis upon application and it will depend on answers to health questions. Advertisements must clearly indicate the policy to be life insurance and the advertisement has to disclose any changing benefit features, for example increasing or decreasing premiums as an insured gets older. Guaranteed dividends may not be implied and interest rates must be disclosed. Finally, the ad must state deferred annuities or deposit funds do not give a cash surrender value before a benefit payment begins.

FEDERAL REGULATIONS

The Federal Trade Commission Act made the business of insurance applicable to FTC control according to the McCarran-Ferguson Act only to the extent state law did not regulate the insurance business. The **FTC tried to assert its jurisdiction over insurance advertising,** especially interstate

advertising which is direct response in nature, **but was barred from doing so** when states passed laws that regulated deceptive, misleading and false advertising. **The United States Postal Service** has been involved in regulating direct response advertising if advertising which is fraudulent or misleading is sent through the mail. The **mail fraud statute sets fines and imprisonment when mail is used for fraudulent purposes.** The Federal Communications Commission has rules and regulations governing the use of radio and television advertising. The **FCC has the power to revoke or refuse a license if broadcasters air false or misleading advertising.**

The **Internal Revenue Service has a lot to say about advertising in the area of deferred annuities.** A deferred annuity is one in which a policy owner pays premiums to the insurance company and interest accumulates over time. Eventually, payments are made by the insurance company, at some later date, to the owner of a policy. The **Internal Revenue Service strictly prohibits advertising deferred annuities as a tax shelter device.** Tax shelters allow some or all of the taxpayers income to escape taxation completely, whereas deferred annuities do not avoid any tax but rather defers them to some future point when they are eventually paid. The IRS is not at all fond of advertisements for deferred annuities which are considered derogatory toward the taxing authority. An example is "don't let the government steal your interest." The IRS is also against emphasizing tax saving as an aspect of purchasing a deferred annuity.

The Securities and Exchange Commission, or **SEC, is specifically concerned about annuity products that are different** from traditional annuities because they involve the **sale or offer of securities.** To avoid compliance with federal securities laws sellers of deferred annuities must bear significant mortality and investment risk. SEC rules say that variable annuity features cannot be placed in fine print.

MODEL LAWS

Model laws are passed by the National Association of Insurance Commissioners NAIC and they seek to make the administration and regulation of the insurance business more uniform from state to state. In referring back to the section on state laws, three model laws were described. These model laws all set forth some uniformity in the application of state attitudes and regulation of the life and health insurance contract business.

DIRECT RESPONSE ADVERTISEMENTS

When an insurance company does not use an actual soliciting agent but rather solicits the inquiry about the sale of an insurance product to consumers through direct mail, mail order and mass merchandising it is a direct response advertisement. Direct mail and media advertisements include television, radio and print which are used to sell life and health insurance products supplementing basic individual life and

health policies sold through traditional sales channels. **The problem with direct response solicitation is the applicant for insurance does not have the ability to discuss the terms of the contract with an agent.** Therefore, this applicant has to rely heavily on the advertisement to understand the nature of the contract. Some court jurisdictions have held the advertisement is binding on the insurance company. In the event there is a claim settlement action brought by an applicant, the NAIC Model Unfair Claim Settlement Practices Act, which is part of the Model Unfair Trade Practices Act, states a claim cannot be settled for less than the amount which a reasonable person would have believed an applicant was entitled to because of the reference to written and printed advertising which accompanied and was made part of the application itself.

Another main concern is direct response advertising is often done on an interstate, rather then just intrastate, basis. Unless an insurance company is licensed in a state it is considered to be an unauthorized insurance company and is not legally allowed to transact direct response business in that state. **Insurance companies must make certain that direct mail advertising is not sent into a state where the insurance company is not licensed to conduct insurance business.** It is difficult to have this control since newspapers, radio and television often cross state lines. If companies print a disclaimer that a policy will not be sold a specific state, it usually offers protection for the insurance company against violating this model law.

AGENT AND GROUP INSURANCE ADVERTISING

Insurance advertising is any oral or written material whose purpose is to invite public interest or to influence the purchase of life or health insurance policies. An advertisement includes promotional literature, actual sales presentations, direct mail and use of media including radio, television and print. Since each state has advertising laws and advertising is done across state lines, complex situations are created. Rules governing advertising apply to both agents and contracts offered for group coverage purposes. One standard question which often arises about the sales presentation of an agent is whether an illustration is considered as part of the contract or simply as promotional literature. The **most often followed rule is illustrations are estimates and are not intended to be part of the insurance contract.** The Parol Evidence Rule stops the admission of evidence outside of a written contract if it would alter, contradict or vary the terms of the contract. Since illustrations are not written statements attached to the contract, they are not part of that contract. Any agent that provides intentionally false statements in trying to effect a sale allows the person who is harmed to sue on the basis of fraud in order to rescind, void or even reform the contract.

The concepts of waiver and estoppel are available to insureds to broaden their coverage under group life and health insurance policies. The rationale is an individual covered under group insurance probably did not have the

opportunity to read the master policy. If an insured depends on promotional and advertising literature and the group certificate for policy information, any information in those documents can be held to be used in favor of the insured in a court action. If the literature of advertising contained terms which are more favorable to the insured than the actual master policy, the insurance company will be forced to waive the terms of the master policy and be estopped from denying and providing the more favorable terms listed in the promotional literature.

The main purpose of these federal and state advertising rules is to protect the public from possible wrongs done, either intentionally or unintentionally, by insurance companies, their agents and independent contractors. Insurance law and regulation is a dynamic field which is constantly changing and the struggle between where state law ends and federal law picks up is constantly changing. In today's modern legal environment, consumers have more protection then ever have before and the trend continues to broaden public protection as much as possible.

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SECTION X STUDY GUIDE QUESTIONS

(It is suggested you answer the following questions pertaining to this section on a separate sheet of paper and then refer to your answers when completing your multiple choice exam. Doing this will help you focus on the important concepts of this section.)

1) List the three model state laws and briefly describe what protection to the public is being offered under each.

2) Discuss the federal government's role in the regulation of insurance concerning where it has influence and where it does not.

3) What is the purpose of model state insurance laws?

4) What is a direct response ad and common concerns about them?

5) How can an insured, under a group contract, receive broader coverage than offered in a policy due to advertising?

SEE NEXT PAGE >>>>

To complete this course

FIRST, REFER TO THE NONSUPERVISED "OPEN BOOK" EXAM FOR COMPLETION OF THIS CONTINUING EDUCATION COURSE.

SECONDLY, SUBMIT THE EXAM ANSWER SHEET, THE PROPER REGISTRATION FORM AND REQUEST FOR GRADING AND CERTIFICATION TO DOHRN INSURANCE TRAINING AS REQUIRED.