

**DOHRN INSURANCE TRAINING, INC.
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PRELICENSING:

ACCIDENT & HEALTH

INSURANCE

This course is valid only for the individual in whose name it is registered. It must be completed within three years from date of purchase to be valid. This course may not be sold, transferred or given to any other individual for completion and certification.

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ILLINOIS INSURANCE LAW

**THIS SECTION IMMEDIATELY FOLLOWS THE
ACCIDENT AND HEALTH MULTI-STATE
PART ONE TEST MATERIALS, ABOVE
THIS IS PART II OF YOUR STATE EXAM**

EXAMINATIONS

**THIS SECTION IMMEDIATELY FOLLOWS THE ILLINOIS LAW SECTION AND
CONSISTS OF THREE EXAMS. THE FIRST ONE IS THE NONSUPERVISED EXAM
AND IT MUST BE COMPLETED AND RETURNED TO Dohrn Insurance Training TO
RECEIVE CREDIT. THE OTHER TWO PRACTICE EXAMS ARE SELF SCORING
AND MUST BE COMPLETED TO ASSURE PASSING THE PROMISSOR STATE
INSURANCE EXAM.**

READ THIS PAGE FIRST

WHETHER YOU ARE ATTENDING THE ONE DAY SEMINAR OR COMPLETING THE COURSE VIA SELF STUDY:

Read through all materials pertaining to the license you wish to obtain (life, accident & health, property, casualty or personal lines).

Complete the "NONSUPERVISED" exam in an open book fashion. THIS EXAM WILL BE GRADED BY DOHRN INSURANCE TRAINING. The "NONSUPERVISED" exam is the first exam in the EXAM SECTION located in the read of your text (immediately following the gold sheet in this manual). You must score 70% or better on any life, accident & health, property or casualty NONSUPERVISED exam in order to pass your prelicensing course! If you fail this exam you will be sent a make-up exam. If you fail the make-up exam you must take a prelicensing course from a different provider and attempt to pass their course. **THIS IS AN OPEN BOOK EXAM! LOOK UP THE ANSWER IF UNCERTAIN – DO NOT GUESS!**

YOU MUST PASS YOUR PRELICENSING COURSE before your license can be issued. Upon passing this prelicensing course, Dohrn Insurance Training will report your course completion date via the Internet to the Illinois Department of Insurance. **We report course completions to the Division of Insurance every weekday.** Upon successful course completion **we will send you a confirmation letter** showing your completion date plus a list of incorrectly answered questions. **Once the Department of Insurance receives our report IT WILL TAKE THEM ONE OR TWO DAYS TO DOWNLOAD THE REPORT AND KNOW THAT YOU HAVE PASSED A PRELICENSING COURSE.**

ALL NONSUPERVISED EXAM ANSWER SHEETS must contain your name AND signature or your request for course completion cannot be honored. You also need to complete the reverse side of the exam answer sheet so that DOHRN knows how to contact you with NONSUPERVISED exam results in a timely fashion.

If you provide us with the proper information we will grade your exam, contact you and provide you with a list of all incorrectly answered NONSUPERVISED exam questions. Please review all missed questions, since these will probably indicate any weakness you may have.

AFTER COURSE COMPLETION, BUT BEFORE TAKING THE STATE EXAM:

- 1) AFTER YOU RECEIVE YOUR NONSUPERVISED EXAM RESULTS FROM DOHRN, REVIEW ALL STUDY MATERIALS AND NOTES AGAIN.
- 2) **The final practice tests for you to complete are the ones marked "SIMULATED".** The answers are provided and these exams should be completed and scored by you about one or two days before you sit for the state exam. Take this exam in "closed book" fashion. By reviewing all missed questions and analyzing the reason you selected an incorrect answer, you will learn from mistakes before they actually count.

ABOUT SCHEDULING FOR THE STATE EXAM:

*** YOU SHOULD PASS THIS PRELICENSING COURSE BEFORE YOU TAKE THE STATE TEST.

*** DON'T FORGET: IF YOU SCHEDULE YOURSELF AND DO NOT SHOW FOR THE PROMISSOR EXAM, YOU WILL PAY THE FEE ANYWAY UNLESS YOU CANCEL OR RESCHEDULE AT LEAST 4 BUSINESS DAYS IN ADVANCE.

PROMISSOR test centers are located throughout the state (as well as in Schererville, IN and St. Louis, Mo) but the main locations are

•Downtown Chicago • Schaumburg, • Oakbrook • Springfield.

**TO REGISTER FOR YOUR STATE EXAM WITH PROMISSOR CALL
800-274-0402**

FOR OTHER INFORMATION CALL 800-274-1257.

You can access all test information, including online registration information by going to the PROMISSOR website at:

<http://www.promissor.com/>

For the latest course information from DOHRN INSURANCE TRAINING, INC, as well as the most current issue of our client newsletter, **TRAINING TIMES**, please visit our Web Site:

www.dohrnit.com

Remember...Don't say "Darn it!"

...GO TO DOHRNIT!

STRUCTURE OF THE PROMISSOR INSURANCE EXAMINATIONS

This page illustrates how the PROMISSOR, the testing company THE STATE OF ILLIOIS has contracted with, formats insurance exams. Use the handy reference chart, below, to identify the actual number of questions for which you will be held responsible for each exam and part.

Each of the five insurance exams (Life, Accident & Health, Property, Casualty or Personal Lines) **are divided into two parts** called PART I and PART II. **PART I is referred to as the “multi-state”** section of the course and the questions pertain to generic insurance concepts relating to the particular testing subject (i.e. Life, Accident & Health, Property or Casualty). The material upon which the questions are based would be similar from state to state. **PART II, however, is state specific law** and question here pertain only to the insurance law of your particular testing state (i.e. Illinois).

YOU MUST PASS BOTH PART I AND PART II OF A PARTICULAR INSURANCE EXAM IN ORDER TO BE ENTITLED TO APPLY FOR THE LICENSE. Should you fail one part but pass another, you may return within 90 days and retake only the part you failed without being required to retake the part you originally passed. However, a full test fee will be charged for any exam retake.

NUMBER OF TEST QUESTIONS, PER PART AND PER EXAM ARE AS FOLLOWS:

PART I (MULTISTATE)	LIFE	ACC&Health	PROPERTY	CASUALTY	PERS LN
Total Number of Questions that COUNT in your score	50	50	50	50	75
Total “PRETEST” Questions (Do not count in your score)	10	10	10	10	11
PART II (STATE LAW)					
QUESTION WHICH COUNT	31	39	30	37	36
PRETEST QUESTIONS	8	8	7	7	

Of the law questions cited above as “questions that count,” **22 are common to all lines of insurance** while **the remainder are specific to the line of insurance.**

PROMISSOR uses a method called “scaled scoring” to determine whether or not a candidate has passed an exam. These means tests are statistically analyzed based on the weight given individual questions in the scoring process. Therefore, **straight percentage scoring is not used** (i.e. 70%, 75%, etc.)

“PRETEST” questions, although they do not count in your score, **will not be identified as such** and the test candidate is advised to approach answering all questions with equal intensity.

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SECTION I) TYPES OF POLICIES AND COVERAGE

(28% of content -14 QUESTIONS)

A) Disability Income

Disability Income (DI) is probably the single most important policy type emphasized on the exam. The **need** this policy addresses is **related to becoming sick or injured** and subsequently not being able to work and earn a living. The "**living death**" as disability has been called, puts an individual in the position of **having financial needs without the ability to satisfy them** through earned income.

■ **Individual Disability Income** - Although a person might qualify for the meager benefits offered by social insurance or have generous family or friends, the **best way to transfer the risk of disability is through insurance**. The greater a person's income, the more likely it is that the individual has purchased (or should purchase) the DI policy. For the average person **in the twenty to early thirty-year-old range**, statistics indicate the **likelihood of suffering from a disability 90 days or longer is seven times more likely than death**.

The **typical policy** provides periodic payments for a specified length of time to an insured for the inability to work and earn income due to injury and/or sickness. **Benefits received under DI are usually 1/2 to 2/3 of the gross income** of the insured (but never more than 80%) salary because:

- The insured would have little incentive to return to work if the benefit was too high, and
- The **income received** as a benefit is **free from federal income tax** (as long as the insured has paid their own premiums as an individual) and therefore insurance for the full amount is unnecessary.

Benefits are usually paid monthly after an **elimination period**, ranging from a few days to a year (up to two years is the normal maximum), has expired. This elimination period is a **deductible of time** that can keep the cost of coverage lower if a longer (i.e. 90 days, six months or one year) waiting period is selected. ? **The longer the insured is willing to wait to start the benefit, the cheaper the premium will be.**

The **indemnity period (IP)** is the **total time a contract will cover** any **single accident or illness**. The IP can be one, two, five years or longer with even lifetime coverage available to certain qualified occupations. Typically, white collar professionals (doctors, lawyers, CPA's, etc.) will select coverage to age 65 while benefits to age 100 are optionally available if the insured continues to actively work in their profession.

⊛ **Underwriting DI:** age, health, occupation, income level and personal background information are main information sources. Age and health condition have a great impact on premium cost, but occupation is a critical underwriting factor as well. White collar professionals will enjoy the best contracts and coverage at the lowest rates, while blue collar workers are limited as to indemnity period selected and premium cost is higher for benefits, all factors like age and health being equals.

■ **Business Overhead Expense (BOE)** is **designed to help business owners** meet regular periodic and relatively stable business expenses for which the owner is responsible during a period of total disability to the owner(s). **Expenses such as rent, utilities, employee salaries, etc., can continue to be paid even when the owner temporarily cannot help bring in as much revenue to the company because of a total disability.** The BOE is usually added as a rider to the individual DI policy of a business owner, but it is also offered as a stand alone policy.

■ **Business Disability Buyout** - This is a concept similar to the buy-sell agreement concept most commonly associated with life insurance. It is a **business continuation approach** in which the owners of a business agree to buy a disability contract on each other (called a “**cross purchase**”) with the further agreement that should any owner become disabled, the receipt of benefits from the DI contract entitles the non-disabled owners to have the disabled owner’s share of the business transferred to them. Sometimes the business itself will purchase and own the policies on the insured (this is called an “**entity purchase**”).

■ **Group Disability Income Policy** - is a situation where employees of a company receive coverage for disability **income as a result of their employment**. The benefit can be paid either entirely by the employer or partially by the employee. In the event any or the entire premium is paid by the employer and deducted as a business expense, then the benefit paid to the employee is taxable. This group plan is also referred to as “**salary continuation**.”

■ **Key Employee/ Partner Policies** - If a partner or other key employee of a firm becomes disabled this can result in the disruption of the business revenue which normally flows to the company as a result of the efforts of that key employee. A company can protect against this disruption of revenue with DI coverage specifically designed to reimburse the firm for this lost revenue. Insurance Carriers typically base a key person's benefit amount on the person's salary or the documented amount of revenue the person directly generates. The benefit generally equals one times the key person's annual salary or the amount of documented revenue the employee generates. It is paid monthly over 12 months after one of the short elimination periods (30, 60 or 90 days) has run. A common alternative benefit is up to three times salary paid in a lump sum after a one-year elimination period.

B) Accidental Death and Dismemberment (AD&D)

This benefit is only payable when either death or dismemberment is the result of an accident. **The key word is accident**. Without the root cause of loss being related to an accident, there is no benefit payment. AD&D can be written as an individual (stand alone) health insurance contract but is also available as a rider to most life insurance contracts.

■ Possible **exclusions to AD&D** can number upwards of 100, but the most common includes:

- Illegal activities of the insured resulting in loss
- Involvement of illness or disease (these are never accidents! Therefore if the root cause of loss is diabetes or cancer, for example, neither loss of life nor any resulting amputations will be covered under AD&D).
- WAR
- Aviation other than as a fare paying passenger on a regularly scheduled airline flight
- Doubtful accidental cause (i.e. an accident which masks a suicide)
- Suicide (always excluded)
- Intentional injury
- Death by voluntary inhalation of poisonous fumes

➔ **Accidental Death** pays a "**principal**" sum in the event of accidental death.

➔ **Dismemberment** pays a lump or "**capital**" sum for certain losses or dismemberments as shown in the following combinations; typical of most AD&D contracts (**each contract clearly states the particular dismemberment and corresponding payment amount**):

Loss of both hands, feet, sight in both eyes.....	Full lump sum
Loss of one hand, foot or sight in one eye.....	50% of lump sum.
Loss of one hand or foot and sight in one eye. . .	Full lump sum
Loss of speech or hearing.	50% of lump sum

Other accident coverage available includes for losses sustained due to accidental injury, surgery, hospital and medical expenses due to accidental injury. The **typical definition of “Accidental Bodily Injury”** is "any injury resulting from accidents, with the limitation of self-inflicted injury and any stated exclusion."

◆ **Death must occur within 90 days from an injury** otherwise, contractually, the death is not considered to be an accident or as the result of the initial injury sustained from the accident.

◆ Double dismemberments (loss of any two limbs) leads to an automatic contractual “**presumptive disability**” - premium payments are waived by the company.

C) Medical Expense Insurance

This is a broad category of possible methods by which a person can receive benefits for required medical care.

There are four basic approaches to insuring medical expenses:

- **Indemnity-based products** is the payment of a specified benefit according to the health contract regardless of actual charges (i.e., “Basic” hospital, medical and surgical policies)
- **Reimbursement (expense incurred) based products** are payment for all expenses or a fixed percentage of incurred expenses according to costs which are actually incurred (i.e., major med., comprehensive major med. and long term care)
- **Prepaid plans** – insured’s benefit is paid whether they access the health care or not (i.e., blues plans, HMO’s, PPO’s). This is also referred to as the “Managed Care” approach.
- **Consumer Driven Health Care** which combines tax favored accounts used in conjunction with high deductible plans designed to give health care consumers more control over choice and cost (i.e. FSAs, MSAs, HRAs and CDHPs).

Indemnity Approach

■ **Basic plans** cover for a limited amount and specified time for hospital, medical or surgical expense. They typically provide *great first dollar coverage* but *have very low maximum benefit amounts*. (COMPARE WITH MAJOR MEDICAL)

- **Hospital** – a basic plan that pays either a daily rate or a percentage (a small one) of cost incurred. For example, if a contract agrees to pay \$100 per day for a hospital room but the hospital charges \$500 per day, the benefit paid is \$100 per day! That’s right, only \$100 because that is the benefit purchased and the maximum amount that the company is contractually obligated to pay or “indemnify” to the insured.
- **Medical Miscellaneous Expense** – under this basic plan benefit a specified benefit is paid for scheduled (specifically stated) expenses, (i.e., X-rays, lab fees, drugs, dressings, operating room, anesthesia and supplies). An overall Limit may be \$1,000 with lower item limits on specific scheduled items (i.e., \$150 for anesthesia, \$200 for an operating room, \$10 per aspirin, etc.).
- **Surgical** – this basic plan benefit *pays according to an established schedule of various surgical procedure types* up to stated amounts or for a percentage of the fee. For example, gall bladder removal might only pay \$1,000 while the brain surgeon gets the maximum benefit of \$4,000. There is a maximum dollar amount this basic plan pays, per surgery, regardless of actual fees charged by the surgeon. Therefore is the surgeon charges \$10,000 but the schedule only pays \$2,000, the insured must pay the difference out of pocket.

Reimbursement Approach

■ **Major Medical** deals with coverage for prolonged or serious illness and is a prime example of the reimbursement (“expense-based”) plan. **Unlike the basic plan, major medical policies provide for high maximum coverage and have deductibles and coinsurance.** (THE INSURED PAYS FIRST DOLLARS, BUT ENJOYS HIGH MAXIMUM LIMITS)

- The **insured pays the deductible (the first dollars paid on any claim)** amount which can range from \$100 to \$5,000 or more.
- **Coinsurance (shared expenses) exceeding the deductible amount**, are normally split on an 80% - 20% basis between the company and insured (other splits are possible such as 75% -25%, 60% -40% and even 50% -50%).

The example on the next page demonstrates the method of solving an exam question which poses a major medical problem. The problem will provide information on the plan amounts and hospital charges, leaving it to the test candidate to figure the result. Use the example below as a guide for any such problem.

MATHEMATICAL EXAMPLE: Suppose a major medical plan has a \$100 deductible and a coinsurance clause of 80%-20% on the next \$5,000 (**AFTER** the deductible has been satisfied). The insured suffers a \$10,000 loss. A **typical exam question** will ask one of two possible questions: 1) how much does the insured pay? or 2) how much will the insurance company pay?

STEP 1

LOSS = \$10,000
 $\frac{- 100}{\$ 9,900}$ (DEDUCTIBLE IS REMOVED FIRST)
(DUE AFTER DEDUCTIBLE)

STEP 2

COINSURANCE CALCULATED AS FOLLOWS:
 \$5,000 (TOTAL MAXIMUM
 CO-INSUR. $\frac{X .20}{\$1,000}$ (INSURED'S SHARE)
(PAID BY INSURED IN ADDITION TO DEDUCTIBLE)

STEP 3

APPLYING THE COINSURANCE

\$9,900 (DUE ON BILL AFTER DEDUCTIBLE)
 $\frac{- 1,000}{\$8,900}$ (INSURED'S SHARE OF COINSURANCE)
(AMOUNT PAID BY INSURANCE COMPANY)

STEP 4

\$ 10,000 (TOTAL LOSS)
 $\frac{8,900}{\$ 1,100}$ (PAID BY COMPANY)
(AMOUNT PAID BY INSURED)

.....

NOTE: The example above also raises two other critical concepts. They are

- **STOP LOSS LIMIT** or a **maximum** amount the insured will have to pay **out-of-pocket on ANY claim**. In the math example, above, since the deductible is \$100 and the coinsurance is 80% -20% on the next \$5,000, the **STOP LOSS LIMIT** for this policy to the insured is \$1,100. **\$1,100 is the most the insured would take out-of-pocket** regardless of the loss, up the policy maximum coverage amount which is typically \$1,000,000 or higher.

> Secondly, when calculating the amounts of responsibility between the insured and the company, make certain the coinsurance percentage is applied **after** the deductible has been subtracted. In other words, in the example above (SEE STEP 2), it **WOULD BE INCORRECT TO TAKE 20% OF \$4,900!** **Watch out for this common error.**

•• **Other Major Medical policy factors:**

- **Effect of deductible** on cost: **the higher the deductible** selected, **the lower the premium** cost.
- **Benefit period** - (1) Calendar Year: once the deductible and coinsurance have been satisfied within a year, all other expenses incurred in that same year are picked up 100% by the policy. (2) Per Cause: the insured pays out-of-pocket **based on the cause of loss** - a different cause each month would mean deductibles and coinsurance must be paid each month, for each and every separate cause.
- **Comprehensive Major Medical** - this health insurance is *a combination of the basic plan and major medical*. The initial charges are usually covered, and then a small deductible (a single deductible per person, per family) is paid followed by a coinsurance applied. The comprehensive plan has made a comeback recently and there are numerous variations which can be adapted to meet the specific needs of a group.

Since low end charges (like those found in “basic” plans) **AND** high end charges (like those found in Major Medical Plans) are covered, **this plan tends to be more expensive medical coverage than any other plan available**. It offers the broadest possible coverage of all medical plans. Its use is not common today but many people utilize the concept by supplementing Major Medical coverage or a PPO with Basic Plan coverage, especially a daily hospital benefit rider, and use the basic plan benefits to help offset the major medical deductible and coinsurance requirements.

Managed Care Approach

■ **HMO or Health Maintenance Organizations** - provide prepaid, prenegotiated comprehensive health care. HMO's **stress preventive** health care **as a strategy** to keep people healthier and to lower health care costs. The HMO typically provides more care in an outpatient environment rather than the more expensive inpatient method, thus reducing the net cost of the HMO system. The growth of HMO's has been explosive since 1973 when the federal government began requiring employers with 25 or more employees, who offer health care benefits, to offer enrollment in an HMO if membership in a federally qualified HMO served the nearby area. **HMO's service is usually contracted for on a "local geographic area" basis** and the nature of their **structure has** prevented them from successfully expanding regionally or nationally in scope.

In an HMO the Doctor is paid on a system of "**Capitation**" rather than upon the familiar fee for service basis. From the "*subscriber's*" (*the person receiving benefits under and HMO agreement is called a subscriber or an enrollee, BUT NEVER AN INSURED*) perspective **a regular fee is paid in exchange for virtual 100% medical care required throughout the year. The four basic models of HMO's include :**

- **The Staff Model**- a group of doctors with various specialties, who are **salaried employees** of the HMO, provide physician services to the HMO (Rare to the point of extinction).
- **The Group Model**- a group of doctors with various specialties are part of an independent group and the group of doctors **contract** with the HMO to provide **service on a "per head" cost basis**. They are not employees of the HMO and can serve other (non-HMO) patients as well.
- **Individual Practice Associations (IPA)** - Doctor's in this model agree to **treat HMO patients at their own office** and to provide medical services to the HMO. The **Doctor bills the HMO** (not the patient) for services rendered **on a fee for service basis** within an agreed upon payment range. The doctor has the risk of earning reduced fees if the revenue of the HMO is not sufficient to provide full payment.
- **Network Model**- is very similar to the Group Model except that **the HMO signs many contracts with several physician groups** who offer multi-specialty doctors. The **Group receives a monthly "perenrollee fee"** and then the group decides the amount to pay each doctor.

> In the HMO concept, the "**primary care physician**" is given the responsibility for deciding what care is given and when a specialist referral must be provided.

■ **Preferred Provider Organization (PPO)** - this is a network in which an **employer or insurance company contracts with** a medical group of health care providers (**i.e., hospitals and doctors**). The **insured will receive a discount** in the form of lower deductibles or copays **when utilizing the PPO providers** rather than going out of the network for care (which is a choice the insured can make, but one for which the discounts of the PPO will not apply). **This system allows the covered party to seek treatment outside of the network (greater choice) than would be the typical case in an HMO but it will be at a significantly higher cost than staying within the provider network.**

■ **Service Organizations (i.e. Blues Plans)** are **nonprofit associations like Blue Cross (hospital coverage) and Blue Shield (physician coverage)**. They provide group medical expense plans on a "**prepaid**" basis. These groups offer the same or similar benefits provided by commercial carriers. The favorable tax treatment they have been afforded (although some states have eliminated these tax breaks) enables them to compete in the health insurance marketplace often at lower cost than commercial carriers. They are **not insurance companies** but they are regulated by the state department of insurance. The unique feature of BC/BS plans is that it uses a **service approach** instead of a reimbursement. Rarely does the "**Blues,**" or "**Subscriber**" (cannot refer to a covered person as an insured), receive direct payment of any kind.

■ **Point of Service - POS plans** - is a *managed healthcare system* that **combines** characteristics of the **HMO and the PPO**. Like an HMO, you pay no deductible and usually only a minimal co-payment when you use a healthcare provider within your network. You also must choose a primary care physician who is responsible for all referrals within the POS network. However, **a POS plan offers a choice to go outside the network for healthcare** (at higher costs including deductibles and higher percentage copays). When choosing to go outside the network the POS coverage functions more like a PPO.

If you use your freedom of choice you will pay more than if you stayed in network and used your POS like an HMO plan. By using your POS like an HMO you are still subject to a primary care physician acting as your gatekeeper to broader services but your out of pocket expenses will be minimal. Therefore *the POS plan is really a hybrid between the best features of an HMO (no deductible and small copays) and a PPO (freedom of choice but at a higher cost).*

Consumer Driven Health Care Approach

■ **Medical Savings Accounts (MSA's)** were created by Congress as a result of the 1996 HIPPA enactment. The MSA has effectively been replaced by the HSA (Health Savings Account) which took effect on January 1, 2004. **The MSA was available only to small employers** (50 or fewer employees) and **operated very much like an IRA account**. It also **required the purchase a High Deductible Health Plan** in order to take advantage of the program. Contributions could be made by either the employer or the employee and were deductible in either case and excluded from the employees income. Any distribution from the account used other than to pay for qualified medical expenses was includable in income plus the assessment of a 15% tax penalty. Exemptions from this 15% tax penalty were death, disability and reaching the Medicare eligibility age. Rollovers from one account to another were permitted one time per year (similar to the IRA rule).

■ **Flexible Spending Account (FSA)** - also called a flex plan or reimbursement account, **it is an employersponsored benefit** that allows an employee to pay for eligible medical expenses on a pre-tax basis (similar arrangements are available for dependent and child-care expenses). Employees expecting to incur medical expenses that won't be reimbursed by the regular health insurance plan can take advantage of an employer sponsored FSA if one is offered. **An FSA saves individuals money by reducing their income taxes**. The contributions you made to a Flexible Spending Account are deducted from pay BEFORE Federal, State, or Social Security Taxes are calculated and are never reported to the IRS. Taxable income is decreased and spendable income is increased.

At the beginning of the plan year (which usually starts January 1st), your *employer asks you how much money you want to contribute for the year (there are limits)*. You have *only one opportunity a year to enroll*, unless you have a qualified "family status change," such as marriage, birth, divorce, or loss of a spouse's insurance coverage. The *amount you designate for the year is taken out of your paycheck in equal installments each pay period and placed in a special account by your employer*.

As you incur medical expenses that are not fully covered by your insurance, you submit a copy of the Explanation of Benefits or the provider's invoice and proof of payment to the plan administrator, who will then issue a reimbursement check. Any expense that is considered a deductible medical expense by the Internal Revenue Service and is not reimbursed through your insurance plan can be reimbursed through the Flexible Spending Account.

■ **Health Reimbursement Arrangements (HRAs)**- are a tax-favored benefit allowing employers to help employees with the increasing cost of healthcare. **An HRA is an employer owned account that allows a participant (employee) to be reimbursed for eligible out of pocket expenses like copays, deductibles and coinsurance**. Usually an **HRA is connected with a Consumer Driven Health Plan (CDHP** – see discussion in section below, which follows) or a High Deductible Health Plan (HDHP) and this allows an environment for both the employer and employee to lower health insurance premiums.

The HRA works this way: the employer will contribute a predetermined dollar amount for each employee into an account and the employee will have a specific amount of time to claim the funds. When an employee claims reimbursement a claim form must be completed and supplied with supporting documentation. The required supporting is the Explanation of Benefit statement provided by the health insurance provider.

HRAs permit employees to be reimbursed for these eligible expenses from a pool of funds set aside by the employer. Usually the employee must meet a deductible threshold before the HRA will start a reimbursement pay out.

An example: The HRA is established by the employer to reimburse after an employee has paid the first \$600 of deductible but the employee has a \$2,000 health plan deductible. The employee must submit a claim and required documentation showing expense of at least \$600.01 have been met before any reimbursement payment can be made. Eligible claims may be submitted at any time by the employee and reimbursement should occur within a few business days of proper submission.

■ High Deductible Health Plan (HDHP) and related Health Savings Accounts (HSA's)

Health Savings Accounts (HSAs) effectively replace medical savings account (MSA) plans that were authorized by the federal government. HSAs can be used with health plans with decreased minimum deductibles, and *a much higher percentage of the population is eligible to enroll in them* compared to with the earlier MSAs. The changes were made in legislation signed by President Bush that went into effect on January 1, 2004.

HSAs differ in several ways from MSAs. Perhaps the most significant difference is that **employers of all sizes can offer an HSA account and insurance plan to employees**. MSAs were limited to employers who employed 50 or fewer people. That change is important, because employers are the sponsor of health insurance for most people in the US.

The concept is that *a tax-favored savings account is combined with a qualifying high-deductible health insurance plan* (HDHP). This concept allows the deposit of tax-deductible funds into a health savings account that can then be used to cover medical costs. HSAs enable small employers and self-employed individuals and their families to take control of your own health care decisions. *One of the key aspects to HSAs is a system that is responsive primarily to individual consumers, rather than to third-party payers*. There is a requirement that the consumer must first have a high-deductible health insurance plan that qualifies to be partnered with a Health Savings Account. These plans are available through various insurance companies, depending upon geographic area.

Currently (2006) the plans are all similar in the fact that HDHPs have deductibles that range from between **\$1,050** and **\$5,250** for singles, and between from **\$2,100** and **\$10,500** for families. Once an HDHP insurance policy has become effective, the funding of the Health Savings Account may commence. Annual Contribution Levels for HSAs: For 2006 the maximum annual HSA contribution for an eligible individual with self-only coverage is \$2,700 and for family coverage the maximum HSA contribution is \$5,450. These range of limits for deductibles and contribution levels can change from year to year so consult your carrier or account for specific details for any given tax year).

Health Savings Accounts allows the legal avoidance of federal income tax by depositing 100% of the health plan's deductible into the Health Savings Account. Whatever is deposited into an HSA up to April 15 allows a federal income tax deduction for money put in even if the taxpayer takes the standard deduction and does not itemize deductions. If your employer makes a Health Savings Account contribution for you, it is "excluded" from income, and not subject to any income tax or FICA. Therefore **whether the contribution is made by an employer or by the employee it still results in a reduction of federal income tax due for the year**. Most states also allow you to take a state income tax deduction for HSA contributions.

■ **Consumer Driven Health Care (CDHC)** - are health insurance plans that allow members to use personal Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products to pay medical expenses directly, while enjoying the protection of a high-deductible health insurance policy. *High-deductible policies cost less per month than low-deductible policies, but the user needs to pay more upfront for medical procedures*. This system of healthcare is also often referred to as "consumer directed health care" because proponents believe it gives patients greater control over their health. Supporters feel that most Americans will pay less money for healthcare in the long haul under CDHC not only because their monthly premiums will be lower, but the use of HSAs and similar products will bring back free-market variables into the healthcare system that will encourage competition, lower prices and improve service.

D) Medicare Supplement Policies

Medicare offers medical care for almost everyone who is age 65 or older. Medicare also provides coverage to some classes of people under age 65. **The Medicare program pays only necessary and reasonable medical cost, determined yearly by tracking usual and customary costs and fees in a given geographical area.** This means if Doctor X charges \$5,000 for heart surgery but Medicare says only \$3,000 is necessary or reasonable, the insured must pay the total difference plus meet the deductible and coinsurance on the covered expense amount. Since such a large out-of-pocket expense may be attributable to the insured, supplemental coverage (sometimes referred to as a “Medigap” policy) is virtually a necessity in some form.

There are FOUR PARTS to Medicare, the first two are dealt with below and the other two (Parts C and D) are discussed in Section III, Social Insurance, a later section:

- **Part A - Hospital Insurance** covers, with deductible, the following: (please note the daily deductible amounts shown are as of 2006 and they can change annually. The amount is not important but rather understanding the concept that significant amounts of money can be owed by insureds is the main point)

- +**Hospital Care** - all covered services for 60 days except in hospital deductible charge (\$952). After 60 through 90 days the daily deductible amount is \$238 and for the 91st day and thereafter it is \$476 daily charged to the insured.

- +**Inpatient skilled nursing** facility care as medically necessary; all covered expenses first 20 days, then next 80 days with a \$119 daily deductible.

- +**Home health visits** (medically necessary) entire cost covered.

- **Part B - Supplementary Medical Insurance.** Part B helps to pay the doctor bill, home health service, psychiatric care and other medical and health services. A deductible (currently \$124) is paid and then cost is split 80% - 20%, and that 20% does not end. Unlike Part A, Part B coverage is not mandatory although most people covered under Plan A also have Part B coverage (an additional premium is charged by the government).

Medicare supplements are policies offered by private insurance companies designed to pay some or all the charges not covered by the Medicare program. **These supplements pay the deductibles of Parts A & B and the daily copay amounts. Supplements must meet one of 10 forms** approved by the NAIC, labeled **Plan A through Plan J**, from least expensive and least coverage to most costly and comprehensive.

- **Plan A (most basic)** covers the following: (1) Insured gets reimbursed for his share of hospital charges (coinsurance) under Part A (**BUT not for the inpatient deductible**, which does get paid under Plans B-J) as well as the costs for days 61-90 and days 91 -150. (2) All charges for an additional 365 days in the hospital are covered. (3) 3 pints of blood (Hospital Insurance) deductible is reimbursed. (4) Medical Insurance (Part B) 3 pint blood deductible and (5) reimbursement for the 20% of expenses covered under Part B.

- Plan B through Plan J - covers more and more expenses that the insured would otherwise be responsible for.

E) Group Insurance

- **Group Conversion** - If an individual covered under a group policy leaves the group (either voluntarily, by termination or the plan is discontinued and not replaced), then the individual has the **right of conversion**. The individual without regard to insurability, may apply for coverage offered by the same company under an individual policy (at the rate charged for individuals). There is a **31 DAY window** to convert.

It should be noted that such a conversion, although granted at standard individual rates, is inevitably going to cost more than the same group plan rate due to the concept of “**adverse selection**.” Adverse selection results in the insurance company attracting many risks that have little or no choice but to convert. The resulting pool of insureds possesses a much higher loss ratio than would be the case if underwriting techniques could be used.

(Group conversion should **not be confused with options available under COBRA, which is described below**).

■ **Differences Between Individual and Group Contracts - The vast majority of health insurance in America is written on a group basis** (as opposed to disability income contracts which are mostly individually owned). Basic characteristics of group health insurance include :

- **Many people are covered by ONE (Master) POLICY** - employees are "enrolled" into the plan.
- Greater variety of health insurance benefits are available than is the case for individuals.
- Groups consist of some minimum number of individuals.
- **The purchase of group insurance must be incidental to the purpose for which the group was formed.** (You cannot just form a company with the basic intent of being eligible to buy a group health policy).
- It can be issued without evidence of insurability but preexisting conditions may be excluded in some cases. (In the current era, the minimum number for guaranteed issue contracts has risen by most major insurers to 50+, and to even 100 or more employee groups). State laws have been enacted since the mid 1990's that require group insurers to take "small groups" defined as a minimum number as low as two individuals comprising the employment group. In these small group plans, underwriting can be used and extra premiums assessed for greater risks along with limited periods of excluding pre-existing conditions. But generally insurance cannot be refused.
- If an **employer pays all of the cost**, then **100%** of the **employees are covered**. This is a **non-contributory** plan.
- If the **employer pays a percentage but not the full premium**, then **75%** of all eligible employees must agree to participation in the plan or it cannot be written. This is a **contributory** plan, because the employees are contributing toward some of the cost, they therefore have a voice in the actual plan selected.

> **General Concepts.** Standard policy provisions for individual health policies do not apply to groups and insurance companies allow greater contractual rights and coverage under the group contract.

Group health coverage is designed to **cover accident and illness incurred while away from the job** since, in most states, work related accident or illness is covered under workers compensation laws. (Refer to occupational vs. nonoccupational in Section IV, below)

■ **COBRA** - Federal legislation enacted in 1986 **applies to employers with 20 or more employees**. It specifies continuation of health benefits when an employee, quits, gets fired, becomes divorced, qualifies for Medicare, employer files bankruptcy, a covered child becomes too old or the employee dies. The **continuation rights** also apply to any spouses and dependent children who were covered. **Employees who were fired** or given reduced hours must get continuation for up to **18 months** (29 months if they meet the Social Security definition of disabled). All **other circumstances** as coverage relates to spouses and children continues **coverage for up to 36 months** (coverage must be identical but premium can be charged to the individual at individual cost. There is a **per day penalty for noncompliance**. The participant usually pays a premium amount based on the existing group rate.

■ **The Health Insurance Portability and Accountability Act (HIPAA)** was enacted by the U.S. Congress in 1996. Title I of HIPAA *protects health insurance coverage for workers and their families when they change or lose their jobs* and it requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The *Act's provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the US health care system.*

Title I *prohibits any group health plan from creating eligibility rules or assessing premiums for individuals in the plan based on health status, medical history, genetic information, or disability.* This **does not apply to private individual insurance (ONLY GROUP COVERAGE)**. Title I *also limits restrictions that a group health plan can place on benefits for preexisting conditions.* Group health plans may refuse to provide benefits relating to preexisting conditions for a period of 12 months after enrollment in the plan or 18 months in the case of late enrollment Individuals may reduce this exclusion period if they had health insurance prior to enrolling in the plan. Title I allows individuals to reduce the exclusion period by the amount of time that they had "creditable coverage" prior to enrolling in the plan and after any "significant breaks" in coverage. "Creditable coverage" is defined quite broadly and includes nearly all group and individual health plans, Medicare, and Medicaid. A *"significant break" in coverage is defined as any 63 day period without any creditable coverage*

F) Long Term Care

This is a policy that provides coverage for varieties of related care offered in the areas of health, personal care and social needs of **individuals who are chronically ill or who require 24 hours -a-day, medical care.**

Although long term care requirements are normally attributed to the aged, individuals of a young age can require such care (i.e., the victim of a motorcycle accident). Insurance industry studies show that **more than 40% of all persons age 65 and over will enter a nursing home in the future.** Recently, less than **4% of long term care (nursing home expenses) costs were paid for by privately owned insurance contracts.** Medicaid (a federal and state plan) and private individuals just about equally split the remaining 96% of all cost for long term care. Under the current tax code premiums are tax deductible based on age, for those taxpayers who itemize their deductions.

THE PROBLEM: a person works hard and accumulates **assets** during their lifetime only to have most of it spent for long term care costs during old age. With the typical long term care facility charging between \$30,000 and \$60,000 per year, the need for proper planning in this area is obvious.

THE SOLUTION: Long Term Care insurance policies. LTC policies are available through group plans offered by employers and are also **individually** purchased. A main **difference between individual versus group LTC can be that the group policy may not “guaranteed renewable,”** meaning the insurer can increase the premium on a class basis or even cancel the master (group) policy!

• **ABOUT THE LTC CONTRACT:** There are three basic recognized levels of care:

- **SKILLED - daily nursing and rehabilitation provided by skilled medical personnel** A registered nurse acts upon the orders of a licensed physician. (THE MOST EXPENSIVE LEVEL OF CARE).
- **INTERMEDIATE** - the same care level as offered in SKILLED, except that the **care is intermittent or occasional and is not provided on a daily basis.**
- **CUSTODIAL - help provided in performing “activities of daily living” (ADL);** eating, help in getting in or out of bed, bathing, dressing, toileting, etc. The **care givers are not medically skilled** although care is based on a physician's certification that care is needed. (LEAST EXPENSIVE LEVEL).

The typical coverage and **pertinent contract protection** offered in a LTC contract includes:

- **BENEFIT AMOUNT** - A fixed number of dollars will be paid daily as specified in the agreement for the length of a stipulated indemnity period (i.e., one yr, two yrs. etc.). Daily benefits can range from \$30 for home health care and up to \$150 or more for skilled nursing care. Home health care benefits are being increasingly offered by insurers and the benefit is usually 60% of the ADL benefit amount. Benefit amounts are selected by the insured and premiums due are based in part on the amounts selected.
- **INFLATION PROTECTION** - the benefit amount can be optionally increased by the insured (usually at a minimum rate of 5 % **compounded annually**) without requiring proof of insurability.
- **ELIMINATION PERIOD** - a **time deductible** whereby the longer the insured will pay out-of-pocket once a claim begins (but before the policy takes over and provides benefits), the less the premium cost
- **Group Conversion of Long Term Care Insurance** – If an insured is covered under a group LTC contract and leaves the group for any reason they will have to right to covert the group plan to an individual policy as long as the conversion takes place within 31 days of leaving the group. Also, depending upon state law, the conversion to an individual plan may require the carrier to provide a guaranteed renewable plan even if the group coverage was not guaranteed renewable.
- **Group/Voluntary LTC Contracts** – More *employers are adding the availability of Long Term Coverage on a voluntary basis through a group plan.* In a group plan the cost can be less and insurability may not be required. Additionally, group plans often allow the inclusion of spouses and other family members (parents and perhaps even aunts and uncles) into coverage

■ **Service Days vs. Calendar Days** – refers to *the crediting of benefits under a long term care insurance policy*. If a benefit is paid on *a calendar day basis it means that specified benefits will be paid for a set number of days* (i.e. this plan will pay \$100 per day for 365 days total). If a benefit is paid on *a service day basis it means that a benefit will be paid for a set number of days for any day upon which the covered service* was actually rendered up to a maximum number of days (i.e. home health visits are paid for a total of 90 service days. If covered home health visits take place only one time per week then this particular benefit will be covered for 90 weeks).

G) Cancer (for specified diseases) Plans

Cancer insurance provides benefits only if you get cancer. No policy will cover you for cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. *A specified disease plan, like Cancer coverage, is not a substitute for comprehensive coverage like that found in an HMO or a PPO*. Since cancer treatment accounts for about 10% of U.S. health expenses an additional and specified form of coverage will interest some consumers. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why *it is essential to have insurance coverage for all conditions, not just cancer*. Cancer plans *are normally for a fixed dollar amount and pay the insured the full amount upon the confirmed diagnosis of cancer* As defined in the contract.

H) Critical Illness Plans

Critical illness insurance is a medical related policy that pays a lump-sum benefit upon diagnosis of a critical illness or condition as defined in the policy. A critical illness insurance lump sum payout helps the insured avoid the financial strain a major illness can create. Such coverage offers the freedom to obtain the treatment you want, spend time with your family and friends and to ultimately increase the chance of keeping your home and other assets. Critical illness insurance could be a strong supplement to other health insurance. *The benefit is paid directly to the insured*.

Some of the conditions that may trigger the full lump-sum payment include heart Attack, life-threatening cancer, stroke, Alzheimer's disease, major organ transplant, multiple sclerosis paralysis, kidney failure, blindness and deafness (and perhaps others that may vary from company to company).

I) Worksite (employer sponsored) Plans

Worksite Insurance Plans (WIPs) *are made available on a group and individual platform basis, and plans can include one, some or all of these insurance products*: Dental, Vision, Term, Universal Life, Accident-Disability, Short-Term Disability, Long-Term Disability Insurance, Critical Illness, Long Term Care Insurance and Retirement plans and more. *Individual participants can pick and choose only the particular insurance product desired*. WIPs *are voluntary and are offered to interested employees thru salary reduction*. There are also *flexible payments funding options*: Employer only, Employee only, or cost shared program designed by the employer, and a Section 125 Cafeteria Plan option. *WIPs can be offered at no cost to the employer while also providing maximum portability to the employee*.

SECTION II) POLICY PROVISIONS, CLAUSES AND RIDERS **(40% of content - 20 QUESTIONS)**

The National Association of Insurance Commissioners in 1950 developed the "Uniform Individual Accident and Sickness Policy Provisions Law" which requires **12 Mandatory Provisions to appear** in all individual health insurance contracts. (NAIC wording). Additionally, there are 11 optional provisions which can appear, if a company so chooses (only three are included because that is all the Promissor outline makes a test candidate responsible for).

IT IS HIGHLY RECOMMENDED THAT YOU MEMORIZE THE NAMES OF THE NAIC PROVISIONS WHICH FOLLOW SINCE YOU CAN EXPECT AT LEAST 5 QUESTIONS (OUT OF 50) ON YOUR STATE EXAM FROM THESE PROVISIONS. UNDERSTAND EXACTLY TO WHAT EACH PARTY IS BOUND BY THE CONTRACT.

A) Mandatory Provisions (NAIC)

① **Entire Contract** - the **policy** and any **endorsements**, including the **application** for insurance (**a copy of which is attached to the policy and therefore becomes part of the contract**) **comprise the entire** contract for insurance. All endorsements (*ENDORSEMENTS are changes made to the contract after it has been issued*) have to be signed by an officer of the insurance company in order to be valid.

② **Time Limit on Certain Defenses:**

- **Paragraph A** states that **EXCEPT FOR FRAUDULENT MISSTATEMENTS** made by the applicant in the application, **after** a specified number of years (the model law says three but most states mandate the use of **two years**) **from date of issue, no misstatements can** be used to **void the policy or deny a claim** for loss incurred after the expiration of the two-year period.

>>**Be careful!** Do not confuse this with a life incontestable clause because "**fraudulent misstatements**" **CAN BE used** → **at ANY TIME** in the future **to void** most Accident & Health policies. The **exception to this rule** is the "**Guaranteed Renewable**" health contract which is **incontestable after two years EVEN FOR MOST FRAUD.**

- **Paragraph B** states there can be **no denial of coverage** due to any **preexisting condition that was not specifically excluded** in the contract by name or description. **In other words**, if the company failed to name or describe a preexisting condition it wished to limit or exclude when it had the chance, after a certain period of time has elapsed since the issue date of the contract (again two or three years depending upon the state) it must cover such conditions.

③ **Grace Period** - **allows** the insured extra time to pay the premium while still keeping the policy in force even though the premium is unpaid. The insured has **a specified number of days, usually 31**, after the premium due date in which to pay and still have coverage. The **actual length of the grace period is contingent upon the mode of premium payment.** A 31 day grace period is required if the premium mode is monthly, quarterly, semiannual or annual. A 10-day grace is sometimes used when premium is paid on a monthly basis, as in the case of an "Industrial Accident & Health Contract."

- If the policy type is one in which the company can refuse renewal; **notice of at least 30 days** must be sent prior to the normal renewal date advising the insured of **the decision of the company not to renew.**

④ **Reinstatement** – this provision allows a policy to be put back into effect, without requiring a new application, **WHEN DELINQUENT PREMIUM IS PAID** after lapse which was due to nonpayment of premium.

- However, if a new application is required (WHICH IS PROBABLY A 99% BET), a **conditional receipt is given** for premium received and reinstatement occurs upon approval of the application. **If the application is not approved**, the insurance company must **notify the prospective insured** within **45 days** that the application was not approved **OTHERWISE reinstatement automatically takes place.**

● The reinstated **policy covers only losses DUE TO ILLNESSES which begin more than 10 days after the reinstatement date** (*this is an example of a "probationary waiting period"*) ? **NOTE: injuries** (which are caused by accidents and are therefore not foreseen) are **covered immediately** upon reinstatement.

● Any premium accepted by the insurer for reinstatement purposes is applied to the regular premium period but can not be retroactively applied for 60 days or more prior to the reinstatement date.

[The following three provisions, #5, #6 and # 7, should be taken together in order to understand the time sequence of notifying the company of a claim (20 days), the number of days a company has to provide a claim form (45 days) and the proof of loss form completed in writing (90 days) and presented to the company] :

⑤ **Notice of Claim** - The company requires within **20 days**, written **notice of any loss** covered or as soon as reasonably possible thereafter. Notice to the company or to any authorized agent of the company with information identifying the insured is deemed notice to the company.

⑥ **Claim Forms** - Once the insured provides notice to the company of a claim and the company is in receipt of that notice, the **company must furnish** the claimant with the **necessary forms, within 15 days**, for filing proof of loss. Otherwise the insured shall be deemed to have completed and submitted proof of loss.

⑦ **Proof of Loss - Written proof of loss** must be given to the company **within 90 days after the date of loss** unless it was not reasonably possible to do so. The time proof is furnished must be reasonable, but in no event shall it be more than one year after the required time. The only exception allowing for more time is if a claimant is legally incapacitated.

⑧ **Time of Payment of Claims** - Claims will be **paid immediately upon proof of loss**.

>**THE EXCEPTION:** contracts with periodic payment benefits that are made at least monthly or as otherwise specified in the policy. (i.e. LIKE THOSE FOUND IN A DISABILITY INCOME or LTC POLICY). Periodic payments for loss of time coverage shall commence not later than 30 days after receipt of proof (i.e., DI policy)

After policy termination, claims must be paid when proof of loss is submitted for any loss which was incurred during the time period coverage existed.

⑨ **Payment of Claims** - including any death benefit, will be paid to the named beneficiary, or to the estate of the insured in the absence of a named beneficiary. All other benefits are payable to the insured, or under optional provision, the company may make payment to a person, hospitals, etc. rendering medical services.

⑩ **Physical Examination and Autopsy** - The **company** may, at its own **expense**, examine the physical remains of a person (the insured) while a claim is pending. An autopsy may be performed, again at company expense, where it is not forbidden by law. **NOTE:** ANYTIME a contract provision contradicts a state law, the **STATE LAW HAS PRIORITY** and the contract provision is not enforceable.

①① **Legal Actions** - **No legal action** against the company may be taken **before 60 days after proof of loss is filed**. No legal action may be taken **after three years from the time proof of loss is required to be filed**. (Therefore, the maximum time frame here is three years and 90 days from date of loss because proof of loss is required to be filed no later than 90 days for the time of loss).

①② **Change of Beneficiary** - *Unless there is an irrevocable beneficiary designation, the right to change the beneficiary is reserved to the owner of the contract.* The consent of the beneficiary therefore is not needed to surrender, assign or make any other policy change.

● **Primary & Contingent Beneficiaries** - In the event proceeds are payable to a party named by the owner, one or two designations are possible: 1) **Primary Beneficiary** - **is** the first in line to receive the entire benefit payable. 2) **Contingent Beneficiary** - *is a second choice and will receive nothing as long as there is a primary beneficiary* who has received the benefits. In the event the primary beneficiary dies before the insured and no change to the beneficiary designation is made by the owner, the contingent beneficiary collects benefits payable under the policy.

B) Optional Provisions (NAIC)

1) **Change of Occupation** - If a loss arises after the insured has changed to a **more hazardous job**, or while engaged for pay for doing a more hazardous job, **benefits will be reduced** to the amount that premium paid would have purchased for the insured while working in that occupation. **Conversely, switching to less hazardous work entitles the insured to apply for a rate reduction.** If this language makes it sound as if the policyowner is getting the short end of the stick, you are analyzing it correctly. Consider the following **EXAMPLE:**

- **Mr. Smith**, a high school **teacher**, owns a **DI policy** under which he pays a **\$500 annual premium** for a benefit which will pay **\$1,000** monthly in the event of total disability. **Mr. Smith** grows weary of teaching and **buys a small farm** in Iowa. He fails to inform the company and is subsequently severely injured while being jarred out of bed by the alarm clock at four in the morning. His accident leaves him totally disabled. **Smith makes a DI claim** and is informed that his monthly **benefit will be only \$250** monthly instead of \$1,000. ? **THE REASON: A \$250 monthly benefit is what a \$500 annual premium buys for a farmer** (which is ranked as a **more hazardous occupation**).

- **Conversely**, if Mr. Smith **switches from farming to teaching** without telling the company and subsequently becomes disabled his, benefit is **still \$250** and the company will **refund any excess premium** he had paid.

> **THE BOTTOM LINE: if you switch occupations - inform the insurance company.**

NOTE: When applying this change of occupation rule for the test, simply **use this rule of thumb** to determine which occupation is more hazardous: **look at the COLOR OF THE COLLAR of the workers.** Teaching is a white collar occupation while farming is **blue**. **Blue collar jobs** are always considered **more hazardous than white collar** occupations.

2) **Misstatement of Age** - The benefit the insured would have received if the correct age had been given at application time is the amount to which the **BENEFIT IS ADJUSTED**. **Therefore the benefit** is either increased (if the insured was really younger than they said on the application) or decreased (if the insured was really older than than they said on the application) by the company to provide the proper coverage based upon the correct age.

>THE KEY TEST IDEA – providing the wrong age on the application is not a material misrepresentation and will not lead to voiding an insurance contract.

3) **Illegal Occupation** - This provision allows the company to deny benefits if loss resulted from the insured's attempting to commit or actually committing a felony, or from the insured's participation in an illegal occupation.

C) Other Provisions and Clauses

- **Insuring Clause** - This section contains a general definition of the coverage offered in the policy. **The parties to the contract are named;** the type of loss covered as well as the dollar amount of the loss is stated. It clearly sets forth that the obligation of the insurance carrier to pay benefits is subject to all provisions, conditions and exclusions of the policy.

- **Free Look/Free Examination (10, 20 or 30 days)** clause says that once a policy has been **delivered (delivery date is key as the test concept) to an owner**, the owner has a specified period of time to decide whether or not to keep the insurance. At any time during "Free Look" the **owner may return the policy** to the company for a **full refund** of premium paid.

- **Consideration Clause** states that the life insurance coverage is in effect upon payment of the premium which is due in a timely fashion. The **only duty** placed on the **policy owner** is to **pay the premium** on time. **The first premium** due, when **submitted with the application, constitutes "initial premium."**

>Initial consideration therefore equals two factors:

- ① the **statements made** in the application (representations must not be material misrepresentations) and
- ② the **money collected** at the time of application (payment must be good. i.e. no bounced checks).

■ **Probationary (waiting) Period** – is a specific **number of days** during which **specified illnesses are not covered** after the **policy effective** date begins. It stops claims from being filed which relate to illnesses actually begun prior to the application for insurance. This clause does not affect accidents which are covered from date of policy issuance because they are not foreseeable.

■ **Waiver of Premiums** – occurs if the **insured suffers total disability** for a time specified in the contract (usually 90 days but this can vary in conjunction with a policy elimination period). If waiver is granted **premium does not have to be paid** and the policy continues in effect as if premium was paid. The **company has the right to periodically request a medical exam** of an insured whose policy is under waiver to determine if the waiver is still applicable.

>**NOTE: there is no waiver of premium associated with medical expense plans:** become disabled and your major medical or indemnity plan still requires premium payment for potential benefits no matter how long you remain disabled.

■ **Exclusions** - Some **exclusion conditions commonly found in A & H policies** include:

● **Preexisting conditions**, war injuries received while in the armed service, injury sustained in aircraft accidents (except fare paying passengers who received injuries on regularly scheduled airline flights), self-inflicted injury, mental conditions, pregnancy and many others that may be specifically stated in the policy.

● **Exclusions common to a MAJOR MEDICAL POLICY are limited** (broad coverage here) and usually include war related injuries, dental & eye exams, cosmetic surgeries, workers compensation injuries, aviation.

The most interesting exclusion common to major medical is the worker's compensation exclusion because the **major medical** contract **ONLY covers loss AWAY FROM THE WORKPLACE**. Therefore, **major medical is "nonoccupational" coverage**. Any injury or illness sustained as a direct result of a job is covered under the employer's Worker's Compensation Policy (which is a casualty coverage form).

■ **Recurrent Disability** - Under the terms of disability income contracts, *disability which occurs and then appears to have passed but then recurs because of the same or a related cause, is called a recurrent disability*. If a contract stipulates that if a specific period of time passes between the original and subsequent bouts of a related disability, then it can be treated as a new illness subject again to the applicable elimination period. **This provision defines whether a loss will be treated as an ongoing cause (and therefore no new elimination period is required) or a new claim (which requires the passing of the elimination period again before benefits will be paid on a claim.**

■ **Deductibles** are dollar amounts under an insurance policy that are **the first dollars which are required to be paid when a loss occurs. They are payable by the insured** before the company starts to reimburse or pay a covered loss. Deductibles paid by the insured are not reimbursed by the Company. (See the mathematical example provided in Section I regarding Major Medical)

In the **math example back in Section I, above, a "FLAT" deductible was used**. The **other two deductibles** you need to understand are called **"CORRIDOR" AND "INTEGRATED."** The corridor and integrated deductibles are **ideas associated with major medical and comprehensive plans**. This is supplemented coverage because *a basic plan is used to help pay the "first" dollars* (deductible and copays the insured must pay out-of-pocket). The *basic plan dollars are used to pay the "corridor" of cost owed by the insured* (the deductible and coinsurance) under the major medical coverage and are therefore "integrated" into the fully paid area of major medical (the 100% coverage which is achieved once the stop loss limit has been met by an insured). **Any unpaid corridor cost is owed by the insured** when the basic coverage is insufficient to eliminate completely the cost corridor.

■ **Eligible Expenses** – A **reimbursement requirement** of any Health Reimbursement Account (HRA), Medical Savings Account (MSA) or Flexible Savings Account (FSA) is that **the expense or expenses for which the insured seeks reimbursement must be deemed "eligible" expenses**. Each plan will provide a detailed listing of which expenses are, and are not, eligible. An **expense must be "medically necessary"** in order to be eligible. One test to determine eligibility is for a health provider to offer a specific diagnosis, the specific treatment needed and a description of how the treatment will alleviate the medical condition. For instance, eligible expenses for reimbursement would include ambulance service, band-aids and even bus fare to receive treatment while expenses not eligible would be COBRA payments (premiums, prescriptions) cold cream and cosmetic surgery.

■ **Pre-authorization and Prior Approval Requirements** – are contract conditions which required the insured to get permission before certain medical services are rendered in order for them to be covered under the terms of the health insurance contract. **Preauthorization** means **notifying the provider** (insurance carrier) prior to receiving specified services. If the insured fails to obtain preauthorization when required then the benefits may be reduced or denied. **Prior Approval** refers to a process under which the member **or insured must provide information substantiating the necessity** of specified services to the carrier prior to receiving care. The carrier reserves the right to deny benefits if the member or insured does not obtain prior approval. **Preauthorization and prior approval is usually associated with managed health care plans like HMOs, PPOs and POSs.**

■ **Usual, Customary and Reasonable Charges (UCR)** - Defined Usual, Customary and Reasonable Charges (UCR) are **a calculation by a managed care plan of what it believes is the appropriate fee to pay for a specific health care product or service in the geographic area in which the plan operates.** When an insurance carrier has a UCR Charge (Allowable Charge) that is below that of a provider of care's UCR Charge (Actual Charge), then the patient may be responsible for the difference. This is called **Balance Billing.**

The type of plan that the patient has selected (PPO, POS, EPO, PHO, IPA, Managed Indemnity Program, and HMO), determines Balance Billing amounts and the financial responsibility of the patient. Patients should know what type of plan they have and what their financial responsibility will be with regard to Balance Billing. This information should be addressed in the Summary Plan Description (SPD). ***When care is to be rendered outside of an insurance carrier's network of providers, the patient should always approach their insurance carrier to request that they contact the provider of care to arrange for a reduction in the UCR.*** If a provider of care agrees to accept the UCR Charge (Allowable Charge) of the insurance carrier as a payment in full, which is called accepting assignment, then the patient should not be responsible for Balance Billing. Providers of care can accept assignment (Allowable Charges) on a case-by-case basis.

■ **Lifetime, Annual or Per Cause Maximum Benefit Limits**– refer to the limits of coverage in a health insurance contract. Usually a health contract contains one of these limits for the coverage provided.

A **Lifetime Limit** offers a specific **amount that is provided to an insured for their lifetime** under that contract. All benefits that have been provided is added together and coverage will continue as long as the total of benefits does not exceed the lifetime policy limit.

An **Annual Limit** is the total specified **benefit amount the insurance carrier will provide during a twelve month or on a calendar year basis.** If the benefit total exceeds the limit during the annual time period then coverage stops until a new annual period begins.

A **Per Cause Limit** refers to a policy **which pays a specified dollar limit based on the actual illness that is being treated.** As long as treatment is continuous for a particular ailment, the policy limit is in effect for the treatment of that specific ailment. If a new and unrelated ailment pops up then the full per cause limit will now apply to this new ailment. Per cause limits follow the course of the treatment of a particular illness and this treatment can continue for years if continuous. Therefore **per cause is concerned about the illness and not about time duration.**

■ **Elimination (waiting) Period** - This is a contractually specified period of time which runs from the beginning of a disability or illness to the date upon which benefits are to be paid by the insurance company. **It is a deductible of time.** The longer the insured is willing to wait to begin receiving the first benefit check (as well as monthly checks thereafter) the less expensive will be the premium for the plan charged by the company.

■ **Coinsurance** is the term used in health insurance contracts for the respective **percentages paid by the company and the insured** (who participates in payment), **after the deductible** has been satisfied **but before 100%** coverage begins. A common coinsurance base is 80% paid by the company and 20% by the insured for losses sustained and covered by the policy. (See the mathematical example provided in Section I under Major Medical, above).

D) Riders

Riders are optional benefits that can be added to the basic protection offered by the DI contract. An additional premium is charged for a rider. The most common riders available (normally associated with Disability Income and Long Term Care policies) include:

- **Impairment Rider** is a rider that is attached to a health insurance policy excluding loss arising from certain preexisting causes. For example, a heart attack might result in exclusion for subsequent heart attacks.
- **Guaranteed Insurability Rider** allows the insured the right to purchase specified amounts of additional coverage at precise future points in time, without regard to insurability. In a disability income policy it offers the right to purchase future higher amounts of coverage, regardless of health at the time of increase in coverage amount. Since white collar professionals enjoy higher income levels during the middle and later career stages, this is an important option.
- **Multiple Indemnity Rider** is a provision that a benefit, which is specified in a contract, will be increased by a multiple amount (i.e., double or triple) in the event a described loss occurs in a prescribed manner.
- **COLA (Cost of Living Adjustment)** will adjust benefits each year during long term claims **which are in effect** to reflect increases in the cost of living as recorded and published by the U.S. Department of Labor. Under the terms of a Disability Income Policy, **the insured must be disabled and collecting benefits before this rider will trigger benefit increases.** Under the terms of a Long Term Care policy, COLA is purchased and premiums are paid prior to policy benefit claims. The increased benefit is paid later according to the LTC agreement.

■ **Rights of Renewability** (*ALERT: very important test area, 3-4 questions on state exam*)

These are contractual definitions that describe which party has the right to renew a contract under specified conditions for precise periods of time. A general **rule of thumb** for **premium cost** is: **the more favorable the rights are to the insured the more expensive the cost.** Therefore, the most costly to least expensive options are:

- **Noncancelable (Noncan)** is a health insurance contract under which the **premium is always level(guaranteed)** and, as long as the owner pays premium in a timely manner, the **company has no right to change any stated contract provision or cancel the contract. Only the insured has the right to end coverage** as long as they pay the premium on time. This provision is normally available with DI and LTC policies. While this provision is preferred to any other, past losses to insurance carriers from noncancelable contracts have made their availability scarce in the marketplace today. Usually only very low risk occupation groups have access to this type of renewability.
- **Cancelable** - The insurer or the insured can end the contract at any time, even during coverage, as long as a specified number of days notice is provided
- **Guaranteed Renewable** means the policy cannot be canceled by the company once it has been put into force and so long as all premiums due are paid in a timely manner. **The premium rate is not guaranteed** and may change with claims experience as to same "class" of insureds at their original insuring ages. Rates charged cannot be increased to a single individual.

NOTE: A "**class**" of insureds means all policyholders owning the exact same policy type, within an entire state. Guaranteed renewable is used for DI, LTC and sometimes medical expense insurance.

- **Conditionally Renewable** provides that the owner of the insurance contract may renew the contract to a specified date or age, **subject to the right of the insurance company to decline** renewal only under conditions as defined in the contract. The **company may not refuse to renew solely because of changes in the insured's health condition** after issuance of the policy. Refusal may be applied to an entire class within a state or because of a switch to a more hazardous occupation or if the economic need for the product has ended.

- **Optionally Renewable** or renewable at company option provides the company with the right to renew the contract on a year-by-year basis. Such a policy can only be terminated at the completion of, and not during, the coverage period. There are options to the owner either for renewal or for level of premium.

- **Period of Time for Renewal** provides coverage for a limited period as agreed to and set forth in the contract. Coverage is for a term of time that is normally very restricted in nature when compared to the other renewability rights listed above. There may also be a set number of days allowing the insured to renew the contract for a period of time equal to the coverage time that has just ended, often subject to insurability.

SECTION III) SOCIAL INSURANCE

(6% of content -3 QUESTIONS)

A) Medicare

Has two parts of coverage called **PART A (hospital care) and PART B (physician and supplemental coverage)** {SEE MEDICARE SUPPLEMENTS, SECTION II, ABOVE}.

- **Primary Payor** applies to individuals between the ages of 65-70 **who work at a company with fewer than twenty employees where health insurance coverage (group basis) is provided**. In this situation the company group plan is the Medicare supplement (or secondary payor) and **Medicare is the primary payor**. The cost to the employer drops significantly for the insured that becomes primarily covered by Medicare upon reaching age 65, but remains working.

- **Secondary Payor** - When individuals between the ages of 65-70 **work at a company with twenty or more employees, where health insurance coverage (group basis) is provided**, the company **group plan is the primary payor** and Medicare is the secondary payor.

- **Medicare Part C** - **If** a Senior has (or has just become eligible to enroll in Medicare) Medicare Parts A and/or B, they can join a Medicare Advantage (formerly Medicare + Choice) plan. With one of these plans they do not need a Medigap policy, because **Medicare Advantage plans generally cover many of the same benefits that a Medigap policy would cover**, such as extra days in the hospital after a Senior has used the number of days that Medicare covers. Medicare Advantage plans include:

- Medicare managed care plans;
- Medicare preferred provider organization (PPO) plans;
- Medicare private fee-for-service plans; and
- Medicare specialty plans.

If a Senior decides to join a Medicare Advantage plan, they will use the health card that they get from their Medicare Advantage plan provider for their health care. The Senior may also have to pay a monthly premium for their Medicare Advantage plan because of the extra benefits it offers.

- **Medicare Part D**- effective January 1, 2006 this is the **federal government's plan to provide prescription drug benefits** for the first time to people ages 65 and older who currently have Medicare Part A (hospital expenses) and/or Part B (medical and related expenses). ***Every eligible Senior citizen must choose from privately run drug plans designed to fit individual budgets and prescription drug needs.***

Every Medicare-approved provider must offer at least a standard plan option. Participants pay an average premium of \$32 per month and an **annual \$250 deductible**. *Medicare will cover 75 percent of drug costs between the deductible and \$2,250 during the calendar year.* Participants are responsible for the other 25 percent. (Please note that deductible numbers and copays and coverage levels are subject to change from time to time and the numbers provided in this section are effective as of 2006).

Participants are required to pay all drug costs between \$2,250 and \$5,100. This is known as the coverage gap. *Once drug costs exceed \$5,100, Medicare will cover 95 percent of costs for the remainder of the calendar year. This is known as reaching the catastrophic threshold.* In addition to the standard plan, most insurers are offering plans with enhanced benefits. These plans must be studied carefully because each has different levels of premiums, deductibles or co-payments based on the type of coverage. An enhanced plan will likely cost more than a standard version.

B) Medicaid is a federal Social Security program developed to help those who cannot afford to pay the deductibles or co-payments required under Medicare. The administration and funding of the plan is done by the states and then partially reimbursed by the federal government. The federal government establishes the regulations, eligibility requirements, provider participation, reimbursement and benefit coverage.

C) Social Security Benefits

(Known as OASDHI: “Old Age, Survivorship, Disability and Health Insurance)

■ **Old Age** benefits refer to the monthly income amount paid to the recipient upon attaining retirement age. Age 65 is the standard age for full benefits while a reduced benefit can be taken by age 62 for those who qualify.

■ A worker must normally have 40 quarters or **ten years of participation** under social security to be entitled to OASDHI benefits under the definition of "**fully insured,**" otherwise an individual is called "currently insured" and receives a correspondingly lower benefit amount in the various benefit categories. Each working American has a social security tax amount deducted from wages and the actual amount paid varies according to wages earned. There are several

Survivorship Benefits :

- Lump Sum death benefit of \$255
- Widows or widowers age 62 or over.
- Widows or widowers disabled age 50 - 59.
- Widows or widowers any age if caring for deceased worker's child (up to age 18 {age 19 if completing last year of high school, regardless of education) are entitled to survivorship benefits.
- Dependent parents age 62 or older.

■ For the Accident and Health exam, the **Disability income benefit** is important: DI is available to qualifying participants under the system. The earliest a benefit will be paid is at the end of **5 completed months** (under age 65) of disability. However, most applications are denied. An appeal process can usually take up to a year or longer and again, the majority is upheld in favor of the SS administration. Also, **to qualify for benefit**, an insured **must have a disability** which is **expected to last at least 12 months** (or longer) or result in death (sooner, before the 12 month period is completed). Blindness is automatic qualification.

■ **Health Insurance benefits** are Medicare benefits (see the full discussion of Medicare under Medicare supplement policies in Section I, D) above).

SECTION IV) OTHER INSURANCE CONCEPTS

(8% of content -4 QUESTIONS)

A) Total, Partial and Residual Disability

● **Total Disability** is defined by contract to mean that more than 50% of job duties are incapable of performance. Traditionally, there have been two definitions of total disability according to whether the contract is covering the insured for “any” occupation or their “own” occupation, as follows:

- + Insured's inability to perform the duties of **any occupation** for which he is suited or trained, or
- + Insured's inability to perform any of the duties of his **own occupation** or profession.

In the marketplace, the availability of the “own” occupation definition has become scarce since its introduction in the early 1980's. This definition became far more costly to insurers in terms of paying benefits than was originally anticipated. **The “any” occupation standard is the one in prevalent use today.**

❖ **Both the concepts of partial and residual disability**, below, mean the inability of the insured to perform **one or more important duties** of his profession or occupation. The benefit payable and the coverage time are reduced or limited compared with total disability. **Usually the breakpoint is 50%.** This means more than 50% disability translates into "total" disability while **at least 50% and no less than 20% inability to work is defined as "partial."** Less than 20% inability to work does not trigger any payable benefit.

● **Partial Disability** means that the duty or duties which can no longer be performed are analyzed with respect to their relative dollar worth. **The amount of benefit paid is based on the value of the duties no longer performed.** (This is the old-fashioned way of providing less than a total benefit).

● **Residual Disability** is the modern approach used in contracts and it differs from loss of time as outlined above in "partial" disability because the **main function of “residual” contracts are to protect income rather than occupational duties.** Benefits are paid to the insured when they return to work but are unable to perform one or more important duties of the job. Since less than a full percentage of income is earned, **this residual benefit will pick up the difference between full wages and the reduced amount paid by the employer due to the remaining disability.**

B) Owner's Rights

As long as premiums are paid on time, here is a listing contract rights belonging to the policyholder:

- Can pay up to **31 days** after the premium due date as specified in the **Grace Period.**
- **Right to renew** the contract as specified
- **Right to walk away** from the contract by ceasing to pay the premium
- Right to **request Reinstatement** as provided
- Right to **change a revocable beneficiary**
- **Incontestability** of a policy **EXCEPT for fraudulent** misstatements
- The right to name a new owner

C) Dependent Children Benefits

These are offered under most group health plans. The **cost of coverage is much lower** than under individual plans because group plans charge the same rate no matter the number of children, while individual policies charge on a per child basis. Whether the employee or employer pays for the dependent children is determined by the employer. (See section F) Nonduplication and Coordination of Benefits, below, for details about dependent children’s coverage when both parents work and have coverage under a group health plan with dependent children benefits).

D) Beneficiary Designations

The decision as to who will be a beneficiary under an Accident and Health contract is made by the applicant (who will be the owner of the policy). The beneficiary will receive the insurance proceeds (proceeds are what the death benefit is called technically upon the death of the insured) in the event of the insured's death. Many group health plans also offer an amount of death benefit coverage to all persons enrolled under the master contract.

● **Primary versus Contingent:** the primary beneficiary is first named to receive ALL proceeds as the **first claim holder** of the insured. The **contingent** beneficiary is a **second choice** and **only collects in the event the primary beneficiary dies before the insured. Other beneficiary concepts include:**

● **"Revocable" or "Irrevocable"** - Most beneficiary designations are **"revocable"** meaning the **owner may change the beneficiary at any time** by properly notifying the insurance company. However, if the owner chooses to name an **"irrevocable"** beneficiary (or is forced to by a judge as is the case commonly with divorce settlements), the **owner** of the policy **has waived** (given up) any **right to change the beneficiary** without first getting the approval of the named irrevocable beneficiary. Other rights in the policy which are also affected are the ability of the policyowner to borrow against cash value or to cash surrender a policy. Both actions require the permission of the irrevocable beneficiary.

● **Change of Beneficiary language in the policy** entitles the policy owner to change a revocable beneficiary at any time. **Changes must be** requested by the owner (must be authenticated in writing) and the insurance company must acknowledge any change in writing by **"endorsement"** (**an endorsement means a change was made to an insurance policy after the original point of policy issuance**). Furthermore, the policyowner has no obligation to inform a revocable beneficiary that he or she is no longer a beneficiary.

E) Modes of Premium Payment

This refers to the **frequency of payment** which is chosen by the owner. The modes available include:

- ◆ ANNUAL (1 payment a year), ◆ SEMIANNUAL (2 payments a year),
- ◆ QUARTERLY (4 payments a year) and ◆ MONTHLY (12 payments a year).

Since overhead to an insurance company is lower for less frequent premium payment modes, the annual mode (which is the least expensive of the four modes available) provides a discount versus semiannual and semiannual is less than quarterly and quarterly is less than monthly (although because of modern computerized banking and automatic monthly debiting, the monthly payment selection is often just slightly more than the annual mode selection).

NOTE: The **owner** of the policy has the **right to select a new payment mode AT ANY TIME** after policy issuance, (i. e., there is NO restriction that the owner must wait for a policy anniversary date to effect a mode change). A change can be made effective with a **simple request** by the owner for the **change** made to the company.

F) Nonduplication and Coordination of Benefits (i.e., primary vs. excess benefits)

If the insured has **coverage with more than one company who is on an expense-based system** (for example, an insured owns more than one major medical policy), the **claim is settled on a pro rata basis** between companies (the claim of the insured will not be paid fully more than one time). Any premium for excess amounts will be returned.

● **Duplicate coverage through a working spouse – EXAMPLE:** if a wife is **covered through her own** employer plan and is also a recipient of coverage **as a dependent under her husband's plan**, then **her claims would be paid by her employer plan (Primary coverage)** before her husband's coverage would apply (his would be excess coverage for his wife in the event she exhausted the benefits of her own plan). ? **In the case of dependent children, coverage would be under the policy of the parent whose BIRTHDAY occurs first** during the calendar year.

NOTE: This provision is related to the basic insurance concept that **owning insurance is for risk transfer purposes (PRINCIPLE OF INDEMNIFICATION)**. An **insured is only paid for actual loss** thus putting the insured in the same position he was in prior to the loss. The insured is **never in a position to receive economic gain under insurance coverage for having suffered a loss**.

G) Occupational vs. Non-occupational Coverage

Most **occupational (work related)** injury or illness is covered by workers compensation policies or by state and federal statute. **Group** Accident and Health Insurance is **designed** to pay benefits for losses suffered on a **non-occupational (unrelated to the work place)** basis. If a business owner is not covered by a workers compensation policy (which is allowed in many states including Illinois) he or she must make certain that their individual or group health insurance contract offer what is known as “24-hour coverage.” **Twenty-four hour coverage means that the insured is covered whether the sickness or illness happens at or away from the workplace.** Without such coverage the business owner without workers compensation coverage is vulnerable to vast amounts of personal economic loss in they event they suffer a health loss due to the workplace.

H) Tax Treatment of Premiums and Proceeds of Insurance Contracts

(i. e., medical expense and disability income, etc)

- **Employers (corporations)** who pay all or part of their employee’s health premium **can deduct their cost for tax purposes.** **Employees** who pay some or all health premiums may deduct the premium to the extent that they itemize their federal taxes and the amount they pay is in excess of a 7.5% of their adjusted gross income (individuals will not get dollar for dollar deduction as will the corporate employer). **NOTE: Medical expenses that are reimbursed are not considered income** to the insured and therefore are not income taxable.

- **Disability premiums** (corporations) are tax **deductible to employers** who pay the premium for the employee if the employee receives the benefits, otherwise the premium is not deductible (in the event the employer receives the benefits).

- **Proceeds that are paid to the employee are taxable income if the employer paid** the premium of the policy (and therefore deducted the premium as an expense). When the **individual** pays his own premium for disability insurance, the **premium is not tax deductible** but the benefits are **exempt from federal income tax.** It is for this reason that the purchase of a 100% benefit based on gross income is not allowed by insurance companies. To allow otherwise would violate the principle of indemnification and would enrich the insured.

NOTE: There is **no option for the individual to take a deduction** for premium paid in exchange for a taxable benefit -- it simply is not allowed by the Internal Revenue Code.

PREMIUMS	
EMPLOYER PAID – DEDUCTIBLE	INDIVIDUAL PAID – NOT DEDUCTIBLE
EMPLOYER RECEIVES – TAXABLE	INDIVIDUAL RECEIVES – TAX FREE

PROCEEDS

I) Managed Care

These are health care coverage programs which emphasize stronger relationships between the actual health care providers (i.e., doctors and hospitals) and the insurance carrier (PPO’s, HMO’s). **This concept was the emerging alternative beginning in earnest by the mid 1980’s to traditional fee-for-service-based indemnity and reimbursement plans** (i.e., Major Medical forms of coverage) and has taken a market share equal to reimbursement plans

J) Workers Compensation - People who are: ●injured ● become disabled or ● die from injuries or illness arising out of and occurring in their course of employment have a right to hold employers liable for economic or financial damages under workers compensation laws. These are state laws that require an employer to provide coverage (this is actually a casualty policy) to all employees who suffer injury or illness as a result of the employment function.

The workers comp policy pays **benefits restricted to the following four categories:**

- **Medical benefits** are provided to an injured worker in limited amounts as to medical, surgical, nursing care, and hospital. Payment is included for medical specialist, x-rays, drugs and artificial limbs.
- **Disability Income benefits** are stipulated by state law and benefits are normally based on earned wages and the duration and severity of the injury which has occurred. The rate of wages provided under workers compensation laws differ from state to state but the benefit is usually set at some percentage of the employees weekly wage.
- **Survivor (Death) benefits** made are generally lump sum payments which are payable to an employee's dependents.
- **Rehabilitation Benefit** the costs associated with physical therapy to regain the use of damaged part areas.

The *Workers Compensation coverage has unlimited dollar coverage and there is no deductible or copay to the employee.* Other forms of health insurance (all those discussed under policy types like major medical or managed care) DO NOT COVER a person when they are injured or become ill due to employment as the cause. However, an individually owned indemnity policy usually will pay stated benefits, according to the terms of the policy. **Workers Compensation insurance is occupational coverage.**

K) Subrogation - (also called Transfer of Recovery Rights)

The insurance company, by assignment from the insured as stipulated in the insurance contract, has the **right to recover from third parties** any recoverable loss which was reimbursed by the insurance company to the insured during the settlement of the claim. If third party liability was involved (i.e. due to the negligence of another party the insured is injured and incurs medical expenses) the insurance carrier is entitled to be reimbursed for any benefits paid to the insured as a result of the third party liability.

Example: Bob is injured in an auto accident that is not his fault. Bob has medical payments coverage under his auto coverage. If Bob's health insurer pays benefits for injury resulting for the accident, the health insurer would be entitled to reimbursement (subrogation) from Bob's auto coverage AND from the negligent party (or THEIR CARRIERS) insured by American Insurance for property coverage

Subrogation allows the company to step into the shoes of the insured for purposes of recovering losses which have been paid to the insured by the company due to the liability of the third party. *Subrogation is a concept related to indemnity*, or the prevention of the insured to profit, in this case, from collecting for sustained damages twice. In the example, above, once Bob has settled with the insurance company, he cannot then go after Sally to also pay.

SECTION V) FIELD UNDERWRITING PROCEDURES

(18% of content - 9 EXAM QUESTIONS)

A) Completing the application

■ **Required Signatures - The application must be signed by two, perhaps three parties:**

① **the authorized producer (agent) who is taking the application on behalf of an insurance company**

② **by the applicant - this is the party who will own the policy** . For instance, in the case of a minor, the applicant is a parent or legal guardian.

③ **When the Insured is Not the Applicant** - Sometimes the insured will not be the owner of the contract, even though the policy is written on his or her life. However, *when the insured is not the applicant, the insured's signature is still required in the application*. This requirement is designed to protect the insured and it lets the insurance company know that the insured not only recognizes a third party owns a policy on their life but that he also approves of the transaction (this helps establish insurable interest for policy ownership in a third party to exist).

■ **Changes in the Application** - The application should always be completed in the presence of the applicant and the applicant should review all recorded information prior to signing the document. Occasionally mistakes are made in completing the application and an earlier response must be corrected. Any **later changes** (i.e., deletions, additions or corrections) **must be initialed by all parties who originally signed the application**

■ **Consequences of Incomplete Applications** - Completing the application for insurance in a full and accurate manner is essential. It is the duty of the insurance producer to take great care in completing the application because it is the main information the company uses in the determination of whether or not to offer coverage. **The most serious aspect of submitting an incomplete application is the potential delay involved in issuance of the life contract.** Covering the lives of people is an enormous responsibility and delays due to incomplete applications can put the company (and producer) in a difficult position with respect to potential liability if the insured's health condition substantially changes during the delayed period.

■ **Warranties and Representations**

• **Warranties** are statements or conditions that the applicant for insurance represents to be **absolutely true**. The application becomes a part of the policy when attached thereto and any material misrepresentation, concealment or fraud can lead to voiding the insurance contract. False warranties, therefore, would preclude recovery of benefits in the event of loss. However, **under modern insurance law, statements made by applicants in the negotiation process are deemed to be representations and are NOT considered to be warranties.**

• **Representations** are written or oral statements made by the applicant during negotiation for an insurance policy. The maker of a representation is saying "my statement is true to the best of my knowledge and belief." When a statement is false, it is a "**misrepresentation**" and it may lead to voiding coverage **ONLY IF the misrepresentation deals with a MATERIAL FACT** (a fact so crucial that had the company known it originally, the application would have either been rejected or offered in a substantially different manner. Consequently, minor facts and information, if misrepresented, will not allow the insurance company the ability to void or rescind the contract.

■ Collecting the Initial Premium and Issuing the Receipt

At the conclusion of completing the application, it is customary for the initial (first) premium to be paid. **Initial payment is necessary before coverage can go into effect.** It is the responsibility of the agent to issue a receipt to the applicant upon receiving initial premium. *There are three possible application and/or receipt scenarios:*

- **The Effect of the Application with Money** - It is common practice in the insurance industry to take an initial payment at the time of application. The key question when money is taken with an application is: "**When does coverage begin?**" Since policy issuance is strictly within the control of an insurance company, the most generic answer is "**When the company says so!**"

The receipt most commonly issued in this circumstance is called a "**Conditional Receipt**". *This means if the applicant has complied with all that was requested of him and has not supplied any material misrepresentations, then coverage may become effective at the point the application is signed and the initial premium tendered.*

- **Unconditional Receipt ("Binder")** - this is a much **stronger receipt and indication that coverage goes into effect immediately.** The practice of issuing binders is not common among life companies, but many courts favor interpreting conditional receipts as binders in disputes brought before it as to when coverage actually begins.

- **The Effect of the Application Without Money** - When **no initial payment is made at the time of application,** there can be no insurance coverage at that point. Coverage only goes into **effect when the policy is then**

- ◆ **Delivered AND**

- ◆ **The first premium payment is made AND**

- ◆ **The applicant has signed a statement** attesting to the fact that **their health has not changed** since the time at which the original application was completed.

> The **MAIN CONCEPT:** since **no money was taken** with an application, both elements of initial consideration (signed statements in the application and the first premium) are not present, therefore **no contract yet exists.**

- **Replacement** – all applications ask whether or not the policy being applied for is intended to replace an already existing, individual life contract on the insured. *If replacement is involved then the producer has a legal duty to inform the applicant that the proposed replacement may or may not be in the best interests of the customer and that they should check out all the facts before deciding.* There is further requirement for the producer to complete an **appropriate form** regarding replacement which identifies policies being replaced that is **signed by the producer and the insured.** This **form must be forwarded with the application** to the insurance company. The insurance company must by law then notify the other company(s) of the possible replacement.

■ Disclosures at point of Sale (i.e. HIPPA and HIV)

Increased confidentiality concerns have led to federal **regulation designed to protect the privacy of individuals concerning their personal medical information and records.** As part of the life insurance application process the producer has additional forms to be signed by the applicant relating to their medical privacy rights. These forms limit the use to which an insurance carrier can put an applicant's personal medical information as well as to whom such medical information may or may not be shared (with other parties).

- **HIPPA** - under the **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996,** insurance carriers must disclose to applicants that that all personal medicals are available to the carrier with the written permission of the insured. **This notification from allows the release of private medical information between health providers and the insurance company to assist in the underwriting process.** The authorization for medical records remains in force for 36 months unless revoked in writing sooner by the applicant. The sign permission form also defines and limits the use of the personal medical information of the applicant to the insurance underwriting function with that particular company.

• **HIV** - a **notice and consent form** relating to AIDS testing and the AIDS virus must also be provided to and signed by the insurance applicant as part of the life application process. The form lets the applicant know that any blood or urine sample collected by the insurer may be checked for HIV and that any evidence of HIV can be used adversely (against) to the pending application. The form further **allows the company to inform the MIB** (Medical Information Bureau) **and the personal physician of the applicant** about the positive presence of HIV in the collected and tested samples. **Positive results cannot be disclosed to agents or brokers** (insurance producers).

B) Underwriting

This is the process by which the insurance company, by reviewing background information of the applicant and medical history (and even medical exams), decides whether or not to offer a policy and if a policy is offered the underwriter decides the rating classification used for premium cost. **Underwriting is the right of the company and is usually conducted at the home office of the company.** Agents have no authority to issue coverage while in the field.

■ **Insurable Interest** - Each person has an "**unlimited**" insurable interest **in their own life** and may apply for and own coverage on their own life. However, **when the applicant is someone other than the insured** (third party ownership is involved), that applicant must have a direct and identifiable interest in the insured. Reason for third party ownership may include an immediate blood relationship (i.e., husband/wife, parent/child) or an economic dependence (financial loss potential due to the insured's death (i.e. co-ownership of a business or the insured owed the applicant money). Underwriters will also look for a relationship to exist between the insured and the beneficiary.

The core of the concept is that insurable interest exists if you are protected by the insurance but would not enjoy a windfall as the result of the death of the insured. Gambling, or **hoping the insured dies so you can** experience gain or **profit, mean you do not have insurable interest.** If policies could be owned by third parties who had no financial stake in the life of the insured the potential for murder or foul play for profit would be greatly increased.

■ **Medical Information and Consumer Reports** - **The most common third party sources (a party other than the applicant or insurance company)** include using **Attending Physician Statement (APS)** (a short set of questions is sent to the insured's personal physician for the doctor's opinion regarding overall insurability) and the **Medical Information Bureau (MIB)**. The MIB is a central database supported by member insurance companies through which information about previous insurance applications are stored and checked against current application information. A third source of collaborative medical information would be original and copied medical or hospital reports from previously treated conditions. In some cases (usually larger face or premium amount cases) an insurance carrier may order an "**inspection report**" which is a consumer report relating a proposed insured's lifestyle, occupation, and economic standing. An inspection report is considered an investigative consumer report, as defined by the Fair Credit Reporting Act.

KEY POINT > In the event **information from a third party source adversely affects** the applicant's ability to secure a **standard insurance** contract, the law says **the applicant is entitled to discover the source of the adverse information.** Applicants may then dispute incorrect data and ask that appropriate corrections be made and new reports issued or, in the alternative, a written response may state an opposing position in writing for the record.

■ **Fair Credit Reporting Act** - This federal **regulation is designed to protect credit and insurance applicants** with respect to information obtained about the applicant **from third-party sources.** Since the applicant gives written authorization in the application for the insurance company to corroborate statements made, credit reports are often requested by insurance companies. The main reason is the company does not want to go through the expense of issuing coverage if someone is not likely to keep the coverage or be able to make payments.

If information on a credit report adversely affects the applicant's chances of being offered a contract, then the applicant is entitled to a free copy of the credit report used and > the ORIGINAL CREDIT REPORTING AGENCY must supply the free copy.

■ **Risk Classification** - If issued by an insurance company, a policy will have premium cost based on one of the following classifications:

- **“Standard Issue ”** means a policy is issued at normal rates for the applicant's attained age and without any restrictions. This person is expected to live a normal lifespan according to current mortality tables
 - **“Preferred-Risk”** means having a mortality experience which is expected to be lower than average and to whom the company will offer a cost which is lower than the standard charge. Eligibility is usually based on the fact the applicant is in excellent health, is within normal height and weight requirements and does not smoke or use tobacco products. An acceptable family health history is usually also required to qualify for this lower rate. If an applicant has had either parent or a sibling die before age 60 due to cancer, stroke or coronary causes, then the applicant will not qualify for a preferred rate
 - **"Substandard Risk"** means the applicant will be charged an additional premium (a surcharge over the standard issue rate) because he is in a higher risk category (can be based on health and/or occupational factors) Substandard rating can be as minimal as 20% greater than standard or as high as 500% (five times) the normal standard rate. Anytime an applicant is quoted a rate lower than the one actually offered by the company after underwriting it is the duty of the producer to notify the applicant of this higher offer (actually a counteroffer by the insurance company rate no later than policy delivery.
- > **"Uninsurable"** - is the label given to people who are such poor risks that they can not obtain any coverage at any cost. Normally individuals considered uninsurable are terminally ill.

■ Do Not Call List

The **Federal Trade Commission (FTC)** launched the National Do Not Call Registry **to give Americans a choice about getting telemarketing calls at home.** Producers must not contact by phone any number that is listed on this registry. The registry applies also to cell phones but not businesses. Political and charitable organizations and those conducting legitimate phone surveying are exempt from the requirements of the Do Not Call List. Also exempt are companies with which you have an existing business relationship, or those to whom you've provided express agreement in writing to receive their calls. If you are an existing customer you may be contacted up to 18 months from your last purchase with them unless you ask the company not to call again.

An established business relationship with a company also will be created if you make an inquiry to the company, or submit an application to it. This kind of established business relationship exists for three months after the inquiry or application. During this time, the company can call you. If you make a specific request to that company not to call you, however, then the company may not call you, even if you have an established business relationship with that company. A phone *number stays registered for five years and anyone violating this registry will pay hefty fines* (thousands of dollars) for each violation. More importantly (at least to the life insurance company you may be working with) your life carrier may also be subject to fines when you call on their behalf.

C) Delivering and Explaining the Policy

■ Explaining The Policy (provisions, riders, exclusions and ratings)

It is good business practice for the policy, upon issuance, to be personally delivered to the insured by the producer who took the application. The policy delivery session should include a basic review of the coverage purchased, options and contract provisions that will be useful to the insured and an explanation of exclusions or any surcharges which might apply to the applicant. Any questions can be answered, errors corrected and minor changes made without major inconveniences.

Personal delivery (also called **"Actual Delivery"**) is the perfect opportunity to see if the client has additional insurance needs which may require satisfaction and to procure referrals. The opposite of personal delivery is called **“Constructive Delivery”** (the policy is delivered via mail, UPS, messenger, etc.).

■ **When Coverage Begins** -At delivery the producer should inform the owner as to when coverage begins. *If money was accepted with the original application then it is likely coverage started prior to the delivery* of the policy to the owner and the **date on which coverage began**, called the “**issue date**” will be listed in the policy. *If any other requirements need to be met such as collecting the first premium, the producer should instruct the policy owner that coverage is not effective until the first premium is paid* and the applicant would have to sign a statement that the insured’s health had not changed since the date the original application had been taken.

The coverage begins according to the contract or whenever the conditional receipt, which may have been taken originally with the application, indicates. It is generally considered the right of the company to decide when coverage begins but carriers are of course bound to the principals of contract law as to when an agreement is formed and effective on both parties.

If an initial premium was collected with the application but, after underwriting, a higher (rated) premium was assessed then the insurance company is making a **counteroffer** to the applicant and there is no coverage until or unless the applicant pays the higher premium amount offered by the company.

D) Contract Law – There are some aspects of contract law that apply uniquely to the health insurance contract . The following three contract concepts are defined on the first page of your Illinois Insurance Law manual but are repeated below for your convenience:

- **CONDITIONAL** - performance by one party is predicated upon the satisfaction of certain conditions first being met by the other party. **e.g. The insurance company will perform if the insured has met the condition of premium payment.**
- **UNILATERAL** - only one of the parties to the contract is bound. **E.g. If the insured continues to pay the premium, the company is always bound, or must give some required notice to cancel or not renew. In the case of a “Guaranteed” renewable health contract the carrier is bound and cannot end the contract unless the insured fails to pay timely premiums as required**
- **ADHESION** - The insured cannot negotiate cost or terms but instead is bound to the contract language as written by the carrier. In this "**take it or leave it**" concept of an insurance contract; there is no give and take, therefore any contractual ambiguities are resolved in favor of the insured in a court of law.

Accident & Health Exam Prep Power Points

Checklist of concepts you must master to easily pass the State Accident & Health Exam.

- DI coverage pertains to **both sickness AND injury**.
- Distinguish easily between **Elimination Period** and **Indemnity Period**.
- **AD&D** coverage **only applies** if the root **cause of the loss** was an **ACCIDENT**.
- **Principal Sum** = payment for **accidental DEATH** while **Capital Sum** = payment for **dismemberment**.
- *Under Accidental death policy, death must occur within 90 DAYS from an injury* or NO benefit.
- Know difference between Basic Plan, Reimbursement Plans and Prepaid Plans.
- Definitions of **“Deductible”** and **“Co-Insurance.”** Be able to work math for major medical problem.
- Definition of **“Stop Loss Limit”** and the *effect of deductibles* on Health Insurance *cost*.
- Learn to recognize the **three** levels of Long Term Care... **skilled, intermediate and custodial**.
- The **four models** of HMO and the *role of the “primary care physician”*; also **definition of PPO**.
- Know how a *Service Organization differs* from an HMO and the traditional insurance company plans.
- Understanding the different **Consumer Driven Health Plans** and the needs they serve
- **Part A versus Part B of MEDICARE program**; differences of Plans A through J.
- Understand the **principle of adverse selection** and how it impacts insurance rates to a group.
- **Group Conversion Option** = 31 days from date of leaving group coverage, no proof of good health needed.
- Contributory = 75% and NON Contributory = 100% (totally employer paid).
- **MEMORIZE** the main elements of all **twelve NAIC Mandatory Provisions** for individual A&H policies.
- Unless policy is Guaranteed Renewable, it can be voided after 2 years for fraud, material misrepresentations.
- Grace period number of days is contingent upon premium payment mode.
- Reinstatement automatic after **45 days** if not previously denied; **10 day** probationary waiting period for illness.
- **Notice of claim** = **20** days; **Claim forms** = **15** days and **Proof of loss** = **90** days from date of loss.
- **Legal actions** against company: none for first 60 days and none past 3 years & 90 days from actual loss.
- *The Insuring clause names the parties to the contract.*
- **Free Look** **BEGINS ONCE THE policy has ACTUALLY BEEN DELIVERED**.
- **Initial Premium** = **TWO** ELEMENTS: 1) **first premium** **AND** 2) **Statements** sworn to **in application**.
- *Occupational versus nonoccupational.*
- Be familiar with **all RENEWABILITY PROVISIONS**, especially **Noncan** and **guaranteed renewable**,
- **Noncan** = level and **GUARANTEED premium cost...it can NEVER BE increased**.
- **Guaranteed Renewable** = **company can never cancel the policy** **BUT** they can raise premium.
- **Primary Payor (under 20 employees) = Medicare** ; **Primary Payor (20 or more employees) = group plan**.
- The **Four Parts of MEDICARE** (A, B, C, D) and what they do.
- **Social Security DI Qualification**: 5 completed months must pass **BEFORE the 1st benefit check** is possible **AND** disability **MUST** be expected to last **AT LEAST 12 months OR LONGER** or result in death sooner.
- **Total Disability** (**more than 50%**) versus **Partial/Residual** (**at least 20% BUT no more than 50%**).
- Learn the **RIGHTS OF policy ownership** under the contract. Owner can change “mode” at ANYTIME.
- **Beneficiary ideas**: Primary versus contingent **AND** revocable versus irrevocable.
 - **Nonduplication/coordination** of benefits: **Claims are only paid ONCE fully**, even with more than one plan.
 - DI Premiums are only deductible to an Corporation (employer) and not to an individual (purchaser of policy).
 - **When an employer pays** for DI premiums, **benefits are all INCOME TAXABLE** to the employee.
 - **When an individual pays** their own premium on DI, the **benefits collected are all INCOME TAX FREE**.
 - **Application Concepts**: two or three parties who **MUST sign an APPLICATION**.
 - **Any APP changes** **MUST BE initialed by all parties** that originally signed the APP.

- **Money PLUS APP = “Conditional Receipt”** means coverage **BEGINS BEFORE** policy delivery usually.
- **NO \$\$ with APP = No coverage** until three conditions met: 1) **delivery**, 2) **1st payment** & 3) **good health**.

- **Insurable Interest** must be present to OWN a life policy on any life; this removes gambling element from insurance; **everyone has UNLIMITED insurable interest in THEIR OWN LIFE.**
- **Third party information** is allowed (APA, MIB); any mistakes can be changed on medical/credit records
- **Fair Credit Reporting Act** means reporting agency must give free credit report when there is a problem.
- Understand difference between **Actual and Constructive delivery** of policy.



All of the concepts listed above with a “●” indicate a key probable state licensing exam question area. If you understand the power point shown then move to the next one and mentally review the next and then the next and so on. If you reach a power point about which you are uncertain or not confident then you should locate that topic area in the materials and study it more thoroughly. Once you are able to go through all power points with a clear understanding of the material included you are ready to easily pass the PART 1 portion of your state licensing exam.

You should use the power points list both before and after you take your REQUIRED open book “NONSUPERVISED” exam.

NOTE > ALL EXAMS IN YOUR BOOK HAVE AN ANSWER KEY FOR SELF-GRADING EXCEPT THE NONSUPERVISED EXAM. ALL NONSUPERVISED EXAMS ARE GRADED BY DOHRN INSURANCE TRAINING ONLY: THIS IS A STATE REQUIREMENT. YOU MUST PASS THE NONSUPERVISED EXAM WITH 70% OR GREATER ACCURACY AND THEN DOHRN WILL REPORT YOUR SUCCESSFUL COURSE COMPLETION TO THE ILLINOIS DEPARTMENT OF INSURANCE.

STUDY LAW CAREFULLY...YOU MUST PASS IT OR NO LICENSE!!!

Be sure to go through Law nonsupervised exam and look up any answer you are not certain of. **DO NOT GUESS!!!!** This must be learned properly. The answers to law are supplied at the end of this helpful open book test.

OTHER KEYS TO PASSING:

- **Do your course exams in their proper sequence (Nonsupervised/Diagnostic/Simulated)**
- Do not skip any exam in your book. If you do not know the answer on a nonsupervised LIFE question...then, **LOOK IT UP, NEVER GUESS!**
- You must complete and return the Nonsupervised (open book) Life test for grading and course certification.
- **The state exams will challenge those that are not unprepared. You have a time proven method to pass the first time in your hands right now, use it wisely and properly.**
- If you vary from this format, expect your chances of passing to diminish with each shortcut.
It costs \$106 to take the Promissor exam each time....resolve to pay this fee only one time and prepare the right way.

>> RECOMMENDED STRATEGY FOR STATE EXAM

- Use the “know it or skip it” test method. If you are not certain, skip a question and return to it later.
- Go through all skipped questions and answer if you are fairly certain of the answer or skip again
- Review all unanswered questions and give it your best shot
- Once you are done, **GET OUT** and do not review questions already answered and change them!

GOOD LUCK AND MUCH SUCCESS TO YOU!