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COMBINED INSURANCE COMPANY OF AMERICA

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UNDERWRITING – ISSUES AND CLAIMS

PART II

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DEALING WITH AN APPLICATION

What the Underwriter does with an Application

It is the underwriter's responsibility to decide whether or not an applicant is an acceptable risk for the company to insure. After reviewing all of the information on an application and after obtaining additional information, if needed, the underwriter approves or denies the application for life insurance.

Medical Underwriting

An underwriter may decide to obtain more information on the life insured's health background, if the information submitted on the application dictates.

Example: An applicant may indicate that she experienced high blood pressure in 1999, saw Dr. Prescription who prescribed medication to lower her blood pressure and cited that her blood pressure is currently normal.

The underwriter can obtain additional information regarding the life insured's condition in four ways:

A. REQUEST AN *ATTENDING PHYSICIAN'S STATEMENT (APS)* FROM THE APPLICANT'S DOCTOR

In the application papers, the applicant signed a statement indicating authorization for the insurance company to contact his or her regular physician (or any other doctor by whom he or she had been treated). The underwriter includes that authorization form with the APS form that is sent to the doctor, along with a cheque for payment for a report on the applicant's medical background.

An attending physician's statement may contain information regarding the patient's medical history (including previous illnesses, injuries, operations and treatments) as well as details on any current conditions, treatments and tests or medications, along with a prognosis for the outcome of the condition.

The physician provides the information directly to the insurance company. After receiving the APS, the underwriter might be satisfied that the applicant's health background warrants a policy contract to be issued or may require additional information.

B. REQUEST THE APPLICANT TO OBTAIN A MEDICAL EXAMINATION

Sometimes, due to the amount of life insurance being purchased or the age or the medical history of the life insured (or a combination of these factors), an underwriter may request that the life insured have a partial examination by a paramedic or a full medical examination by a physician. The physician may have a relationship with the insurance company or be the applicant's own personal physician. The insurance company pays for the cost for such an examination and the results are sent to the underwriter for consideration.

C. REQUEST THE APPLICANT TO UNDERGO SPECIAL TESTS

In certain circumstances, the underwriter may request the applicant to take special tests, such as a stress test or electrocardiogram (ECG), which the insurance company will pay for, if the underwriter decides that some information received indicates that additional tests should be completed. The results of the tests are sent to the insurance company's underwriter for review.

D. OBTAIN INFORMATION FROM THE MEDICAL INFORMATION BUREAU (MIB)

Again, in the application papers, the applicant has given his or her authorization for the insurance company to obtain health information from the MIB. As part of the application, the proposed life insured acknowledges receiving a disclosure notice concerning the MIB and authorizes the insurance company to obtain information from the MIB.

E. OBTAIN AN INSPECTION REPORT

An underwriter may request an inspection report on the life insured for additional information on the applicant's lifestyle, hobbies, job, finances and so on. The applicant provides authorization for such a report on the application papers, although not all situations require such a report. There are inspection companies that carry out background checks on applicants specifically for this purpose. They contact the applicant's employer, neighbours and/or bank to obtain more information about the applicant's:

- employment duties (e.g., is there heavy lifting or work with volatile chemicals);
- hobbies and recreational activities (e.g., scuba diving, parachuting or dangerous sports or activities); and
- solvency (e.g., bankruptcy, credit ratings).

The insurance company pays for the cost of an inspection report.

F. REQUEST A HAZARDOUS SPORT OR OCCUPATION QUESTIONNAIRE

An inspection report does not have to be carried out in all cases. Rather, an applicant can complete an additional form describing his or her hazardous sport or occupation. The form has specific questions on it that have to be answered. For example, if an applicant flies airplanes for recreation, the underwriter will want to know information such as how often he or she flies and how often in the future he or she plans to fly. It is important for agents to have available all forms in case they come across an applicant who participates in hazardous activities. Otherwise, a delay in the underwriting process could occur until the form is obtained and an interview is rescheduled to complete it.

G. PERFORM FINANCIAL UNDERWRITING

Financial underwriting is needed when the amount of life insurance being applied for, in collaboration with the amount of life insurance already owned, is not in alignment with the annual income of the applicant.

Example: An application has been completed on Joe Black for \$1,250,000 of life insurance coverage, but the 24-year-old applicant's salary is \$32,000. Joe is single with no dependants. That could indicate a situation of being "over insured" and the underwriter would want to receive additional information to learn why the particular amount of coverage is being applied for.

Affordability is a criterion an underwriter is always looking for; the ability of the applicant to meet his or her premium obligations under the policy, in the long run.

The concept of *indemnification* is also an important consideration. "Indemnification", in this instance, means making certain that the amount of death benefit is reasonable in relation to the amount of financial loss that the policy beneficiary would suffer as a result of the death of the life insured. Life insurance companies do not want to over-insure" an applicant, such that he or she is "worth more dead than alive."

After being satisfied that all relevant information has been provided, the underwriter can approve or decline an application for life insurance. Sometimes an underwriter will approve the application but at a higher than standard premium. This is a *rated* policy, which means that the proposed life insured poses a higher than normal risk. The higher premium charged compensates the insurance company for the greater risk it is assuming by insuring the life insured. In this way, the insurance company is protected from excessive risks while still allowing the applicant to be insured.

If the underwriting decision is to issue a rated policy, the underwriter may want confirmation from the applicant that he or she will accept such a policy prior to having it issued. Once the confirmation is provided, the underwriter will request that a policy be issued. The applicant is not obligated to accept the policy contract on delivery.

Factors Affecting Premiums

The two sources of income for a life insurance company are: premiums and investment earnings. The income must be sufficient to pay all benefits promised by the company, to pay the company's operating expenses and to earn a profit. The *premium* is the amount of money paid by policyowners that is required on the basis of the assumed mortality experience, together with assumed investment earnings, to pay the benefits promised on death and maturity and to pay that share of the company's operating expenses that should be charged to the policy. It should be noted that guaranteed cash values do not enter into the premium calculation because they are a normal by-product of the level premium system and not a benefit that is charged for separately.

There are several factors that affect the magnitude of premium rates for a specific life to be insured:

AGE OF THE LIFE INSURED

In simple terms, the older the life insured, the higher the premium for life insurance will be. That is because, according to mortality tables, older people will die within a shorter number of years than younger people. Of course, this is not guaranteed because one does not know when one will die. Since older people will, on average, die sooner, they can be expected to pay fewer premiums and the insurance company can expect to have to pay out the death benefit sooner. Consequently, higher premiums must be charged to older lives insured as a compensating factor.

SEX OF THE LIFE INSURED

The mortality (death rate) of males is higher than that for females. That is, according to mortality tables, males in general will die before females. The result of this is that a male will pay a higher premium for life insurance than a female of the same age. The logic is the same as for older lives insured (above).

The gap between the life expectancy for males and females has been getting smaller over the past few years, as females become more affected by stress in their working and personal lives. That is not to say that females did not experience stress and related health impairments (such as heart disease) before, only that the incidence of these factors is becoming more common for females.

SMOKING STATUS OF THE LIFE INSURED

It used to be that a premium for life insurance was the same for a smoker and a non-smoker. However, in more recent years, life insurance companies have made available a premium discount for those lives insured that do not use tobacco products. A life insured that does not use tobacco products may qualify for a reduced *non-smoker* premium rate.

Life insurance companies offer non-smoker premium rates for all adult ages and usually will quote them if the applicant has not used any tobacco products during the previous 12 months. The assumption is that non-smokers (statistically) will live much longer than smokers.

If a life insured smoked at the time the application was completed, but subsequently quit smoking, he or she can apply to have the premium changed to “non-smoker rates” once the life insured has not used any tobacco products during, at least, the previous 12 months. To apply, the policyowner makes a declaration on a change form provided by the life insurance company. Should the change be approved and the life insured resume smoking sometime in the future, he or she will continue to pay non-smoker rates. The belief is that once one quits smoking, the chances are small that he or she will return to smoking. At this time, other tobacco products are also included in the definition of “non-smoker” used by most life insurance companies.

HAZARDOUS OCCUPATION

If the life insured has a hazardous occupation, such as that of a coal miner, this factor might cause a policy premium to be rated. This is because there is a greater chance of premature death occurring to the miner than to someone in a less hazardous occupation, like an accountant. The miner works underground and coal dust could cause respiratory problems, leading to a premature death.

PARTICIPATING IN HAZARDOUS ACTIVITIES

If the life insured engages in a hazardous hobby, such as parachuting, this might also cause a policy to be rated. Once again, this is because there is a greater risk of dying prematurely from a parachuting accident as compared to a person who does not parachute.

Now a coal miner or a person who parachutes might argue that his or her job or hobby is perfectly safe. Indeed, the coal miner likely will never be involved in a cave-in and the person who parachutes might make all of his or her jumps safely. But compared to those who do not work in mines or do not parachute, the chances of an increased risk of premature death are significant. Life insurance premiums take into account the increase in risk.

Rating for Substandard Risks

Most people who apply for life insurance products qualify at standard rates. A *substandard risk* (rated) experiences a higher than normal mortality rate and therefore is charged a higher premium. Every effort is made to insure, on some basis, those who cannot qualify for standard insurance. Only about two per cent of insurance applications are declined.

Substandard risks are those classified as expected to produce a mortality rate higher than the standard group on which the company regular premium rates are based. When a policy is issued at standard rates, the company cannot later add a rating because the insured has subsequently become a substandard risk. However, if a policy was issued on substandard basis, but the cause for the rating no longer exists, the insured can request the rating be removed or decreased, with an appropriate declaration and/or medical evidence if required.

Example: Sam, a coal miner, was rated because of working in a hazardous occupation, but if he quits that job to work in a retail store, he might then qualify for standard rates.

TYPES OF RATING

Ratings are usually applied through the employment of either a dollar amount or a percentage system.

In the case of a dollar amount rating, the premium rate charged to a “standard” risk individual of the same general underwriting class (e.g., male, 45, non-smoker) as the rated applicant is increased by a flat dollar amount per \$1,000 of face amount of coverage applied for. In this way, an adjusted insurance rate is obtained for the rated applicant.

Example: Floyd was rated \$10 per \$1,000 on his life insurance policy, such that the standard premium of \$15 per \$1,000 of life insurance coverage was increased to \$25 per \$1,000 in his case.

In the case of a percentage rating, the standard premium rate is merely increased by a prescribed percentage, to compensate the insurer for the “extra” risk that it is assuming by issuing a policy on a person who is a substandard risk.

Example: Alternatively, the insurance company could have imposed a percentage rating on Floyd (above) of 67%, such that the standard premium of \$15 per \$1,000 would likewise have been increased to \$25 per \$1,000.

In some cases, both rating methods may be imposed. A percentage rating might be used as a permanent rating; while a dollar amount rating might also be imposed as a temporary rating.

Example: If the condition causing Floyd's rating was severe, but was expected to modify if he were to live for at least five more years, a permanent rating might be based on a 50% increase in the standard premium for life, plus a \$10 per \$1,000 rating imposed for only the first five policy years.

A life insurance policy may be "rated" in a different way than by increasing the premium payable. A standard premium could be charged, but an exclusion could be added to the policy. For example, a parachuting exclusion might be added, which provides that no death benefit will be paid if the life insured were to die as a consequence of a parachute jump. Of course, if the life insured died as the result of an illness or injury unrelated to parachuting, the policy death benefit would be paid to the beneficiary.

A combination of both forms of rating is also possible. If a coal miner's hobby is parachuting (for example), his life insurance policy could be issued with an exclusion for parachute jumping *and* a higher than standard premium rate because of his hazardous occupation.

DELIVERING THE INSURANCE CONTRACT

The Agent's Responsibilities when Delivering a Policy

The agent helped the applicant complete an application for life insurance and send it to the underwriting department. The underwriter completed the underwriting process and a policy contract was issued. The policy has now been sent to the agent. What does the agent do now?

The agent's initial responsibility is to check the policy contract to ensure it has been issued as it was applied for:

- Are the names of the life insured, policyowner and beneficiary spelled correctly?
- Are the face amount, dividend option and premium correct?
- Is the type of plan correct?
- Are the benefits listed correctly?
- Is the correct age and sex of the life insured cited?
- Are the policy date and date of issue correct?

The agent can verify all this information with that recorded on the application. If something is not accurate, the agent should send the policy back to the insurance company's head office to be reissued. (it is far more professional looking for errors to be caught and corrected at the agent level than for a faulty policy to be delivered to the policyowner.)

If the policy is correct, the agent will contact the policyowner to arrange a date and time to deliver the policy contract.

WHAT THE AGENT DOES AT POLICY DELIVERY

After congratulating the policyowner on his or her purchase of life insurance, the agent's responsibility is to review all features and provisions of the policy contract with the policyowner. This provides the agent with the opportunity to highlight how the policyowner can benefit from the policy. Helping the policyowner understand his or her policy will help the customer to appreciate the significance of the purchase, and reduce the risk that the policyowner might cancel the contract or allow it to lapse at a later date.

REQUIREMENTS TO PUT THE POLICY INTO FORCE

The Uniform Life Insurance Act provides that a policy will be deemed to be delivered (and in force) only when:

- it has been issued as applied for;
- at least one month's premium on the policy has been paid;
- it has been delivered to the agent for delivery to the policyowner; and
- delivery to the agent has been for "unconditional" delivery to the policyowner.

Some insurers may also require proof of physical delivery of the contract to the policyowner and written verification that there has been no change in the physical health of the life insured since the date of application, before they will consider that the policy has been delivered. These would constitute "conditions" that must be fulfilled before the policy can be considered to have been delivered "unconditionally." Other such conditions might involve the completion of additional underwriting questionnaires or acceptance of a rated policy by the applicant, for example.

Failure to fulfil such conditions would void the coverage under the policy, even if a temporary insurance agreement (TIA) were in force.

PROOF OF DELIVERY

At time of delivery, it is important that the agent establish proof that the policy was actually physically delivered to the applicant and the date upon which delivery took place. This is necessary for a number of reasons:

- the "10-day free look" (right of rescission – see below) does not start until the policy is actually delivered to the applicant;
- some contracts may stipulate that the policy is not in force until it is actually delivered to the applicant. In such cases, the effective date of the insurance coverage could not be confirmed unless the actual policy delivery date could be confirmed; and,
- the Uniform Life Insurance Act required that a policy cannot take effect if there has been a change in the applicant's health between the date of application and the date of delivery. Delivery must have been affected and the date of delivery must be proven for this provision to be effective.

The date of policy delivery is usually established in one of two ways:

THE POLICY RECEIPT

A Policy receipt is a form that the policyowner dates and signs, and the agent witnesses, stating that the policy contract has been received. It is important to obtain a policy receipt as proof that the policy contract was delivered to as accepted by the policyowner. The form can be simple in nature, but it should include the policy number and the date of delivery.

Example: Policy A-7563 was delivered to George Bellevue on May 24, 2001, but the agent did not have George sign a policy receipt. Three years later, George wanted to rescind the contract and receive all his money back, claiming that he never received a policy. Since there was no proof of policy delivery available, the insurance company complied with George's request. Had a policy receipt been completed and George announced that he had not received the policy, the receipt could have been obtained from the agent's file and proof of delivery of the policy and George would not have been permitted to rescind the contract at such a late date.

THE ACME INSURANCE COMPANY

Policyowner's Name: _____

Policy Number: _____

This statement confirms that I:

1. have received a contract form the Acme Insurance Company

yes

no

2. have received and reviewed a Security Needs Analysis.
(Answer only if you are 21 years of age or older)

yes

no

If you have not received one or more of the above items, please explain:

3. has there been any change in your health, occupation or lifestyle since you applied for this insurance coverage?

yes

no

If yes, please explain:

Owner's or insured's Signature _____

Date: _____

Witness: _____

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REGISTERED MAIL

If it is not possible, or practical, to physically deliver the policy contract to the policyowner in a timely fashion, the most appropriate alternative would be to send the contract to the policyowner's home address by courier or by registered mail. In either case, the delivery method should specify that the recipient has to sign for the policy, verifying the date upon which it was received. As a further verification, it is prudent to also send the policy receipt to the applicant along with the policy, asking that he or she sign and date the receipt on the date of delivery and send it back to the agent or the insurance company.

Example: In the case above, had the agent been unable to deliver the policy to George Bellevue in person, she could have sent it to him by "double-registered" mail (or similar method), requiring that he sign for the receipt of the package. In such case, if George were to try to rescind the policy long into the future, claiming that he never received the contract, his assertion could be refuted by obtaining a copy of the signed and dated delivery receipt from the post or courier service.

C.O.D. (CASH-ON-DELIVERY) POLICIES

If at least one month's premium was not paid at time of application, the policy may not go into force until such time as a suitable initial premium payment has been received by the insurance company. In the case of such C.O.D. policies, the agent should not deliver the policy to the applicant until and unless the first premium has been paid. The same holds true if there is an increase in premium required in relation to the premium tendered at the time of application (perhaps the agent miscalculated the premium or the premium was "rated" in the underwriting process) – the policy should not be delivered until the premium difference has been paid.

Example: Mario applied for a policy for \$200,000 of term to 100 insurance, for a premium of \$120 a month. He gave his agent a cheque for \$120 at the time of application, to place the Temporary Insurance Agreement (TIA) in force. When the policy was delivered to Mario three weeks later, the agent advised him that the premium had been increased from \$120 to \$175 a month because of Mario's obesity. The agent also advised Mario that the policy could not be delivered and put into force until the \$55 premium difference was paid. Mario refused to pay the difference and the agent returned the contract to the life insurance company.

If the agent should deliver a C.O.D. policy and not advise the applicant that the coverage is not in force, the policy would still be void and the insurance company would not have to pay a death claim in the event of the death of the life insured, but the agent could be held personally responsible for the death claim.

If the applicant insists on receiving the contract for review prior to making a premium payment, the agent can accede to the request, but should obtain a signed and dated receipt from the applicant stating that the policy has been received “for inspection purposes only” and that he or she understands that the coverage is not in force until the premium has been paid.

Example: Agent Alfie Britton approached his neighbour Ralph regarding a life insurance review. Ralph didn't think that he needed any insurance, but he agreed to talk with Alfie. By the end of the interview Ralph agreed that he “might” need coverage and agreed to a “trial” application, just to see if he could be insured at standard rates (he had a history of moderately high blood pressure). Ralph agreed to the application only on a C.O.D. basis – he did not tender any premium with the application.

Two weeks later, Alfie delivered the policy to Ralph, with a 100% rating for high blood pressure. Alfie explained how important the coverage was to Ralph, given that he had health issues. Again, Ralph tended to agree, but wanted to look at the policy for a few days before making any financial commitment to it. Alfie decided to leave the policy with Ralph and had him sign a letter acknowledging that he understood that the policy was not yet in force. They agreed to meet again soon to discuss the matter.

WHY THE AGENT NEEDS TO CONFIRM THE LIFE INSURED'S STATE OF HEALTH

The *Uniform Life Insurance Act* stipulates that a policy cannot take effect if there has been a change in the applicant's state of health between the date of application and the date of policy delivery. This interval may involve a time frame of several weeks (or months), depending on how much secondary information was needed by the underwriter and how long it took to obtain that information. While the date of the policy may have been made to coincide with the date on the application, it is the agent's responsibility to ensure that there has not been a change in the health of the life insured in the interim. If there has been a change, the policy is void. Verification that there has been no change can be done by observation and discussion with the policyowner at the time of delivery of the policy.

In instances where there has been a change in health, the agent should not deliver the contract, but should gather all relevant data from the life insured regarding the change and submit both the policy and the data to the insurance company's underwriting department for reassessment.

Example: Four weeks had passed since Linda Fairchild applied for her life insurance policy. When Diane Agent arrived at Linda's home to deliver the contract, Linda's husband informed her that Linda was in the hospital experiencing chest pains. Clearly, Diane knew that there had been a change in Linda's health and that she should not deliver the contract until the underwriter could assess the situation. It turned out that Linda's chest pains were stress-related, rather than heart-related, and she fully recovered and the policy was delivered at a later date.

THE RIGHT OF RESCISSION

Included with virtually every life and health insurance policy contract is a right of rescission, also known as the 10-day free look. This is an administrative or a contractual right on behalf of the applicant/policyowner. It is not legislated under the Uniform Life Insurance Act. The "right of rescission" means that a policyowner can keep the policy for up to 10 days after delivery before accepting it as it has been issued ("deemed delivery" of the policy under the insurance company's administrative rules does not constitute actual delivery of the contract for purpose of the start date of the 10-day free look period). Should the policyowner decide that he or she does not want the policy, it can be returned to the insurance company within the 10-day period for a full refund of any premiums that have been paid to date.

Example: Bernice applied for a life insurance policy on February 12, 2004. She gave a cheque for the first month's premium at time of application and was given a receipt and a conditional insurance agreement. The policy was approved as applied for by the insurance company on February 20, 2004, and the policy was actually issued three days later. The policy was delivered to Bernice's agent on February 27, 2004, for unconditional delivery to Bernice. After a couple of unsuccessful attempts to get together, Bernice and her agent finally met on March 15, 2004, at which time the policy was physically delivered to her. If Bernice should have decided not to accept the policy, she has until March 25, 2004, to exercise her 10-day right of rescission and cancel the contract and obtain a refund of all of the premiums she paid.

WHY THE AGENT NEEDS TO SOLIDIFY THE INSURANCE PURCHASE

Delivering a policy is a special time for the agent and policyowner. It is a time when the policyowner can feel good about the purchase and the agent can review all aspects of the policy and reaffirm how well it will serve the policyowner. This process will "cement the sale" and the value of the contract in the mind of the policyowner.

Example: Louise has owned a \$100,000 whole life participating insurance policy for five years now. She had not had occasion to meet with the agent who sold her the policy since the policy delivery appointment. She was recently contacted by another agent who recommended that she cancel the whole life policy, buy cheaper term insurance, and invests the premium difference in mutual funds. Louise remembered her original agent's affirmation at the policy delivery interview that the whole life policy would grow in death benefits (as dividends were invested in PUAs) and the cash values could be used to pay policy premiums in the future, if needed. She decided to keep the whole life policy.

CLAIMS SETTLEMENT ADMINISTRATION

How the Agent is Notified of a Claim

Very likely the agent has established a business and/or personal relationship with the policyowner. After all, when an application for insurance was completed, the agent may have already known the policyowner and life insured well, or they may have been acquaintances. Notwithstanding their relationship at the time of their first appointment, throughout several years of their business development, the agent and policyowner would normally establish and maintain a good rapport. Several years, indeed decades, could have passed since the completion of the initial application. Of course, there are instances where the time elapsed may be only a few days or weeks.

An agent may learn of the death of a life insured in one of many ways:

- if the life insured is a relative, personal friend or business associate, the agent will likely learn about the death because he or she is “in the loop”,
- the notification of the death could be read in a newspaper obituary column, or
- the beneficiary, executor or a family member may contact the agent or the life insurance company announcing the death of the life insured.

How the Agent begins the Claims Settlement

Quite simply, the agent begins the claims settlement process by supplying the claimant (beneficiary), with the necessary forms required. The agent may assist the claimant with completing the forms and submits them to the claims settlement process.

The Claimant

A claimant is the person or organization that is claiming the life insurance proceeds. For a life insurance policy, the claimant is the beneficiary named under the policy contract. If a life insurance policy includes a total disability waiver of premium, the claimant for the waiver benefit is the contract's policyowner. Similarly, the claimant for an accident and sickness policy is the policyowner, who usually would also be the life insured. In group disability insurance policies, the claimant is the group life insured.

The Forms that a Claims Examiner Requires

A claim for benefits can be generally classified as simple or complex depending on the cause of the event (death, disability, etc.) and how long the policy has been in force.

- a *claimant's statement* completed by the person making the request for benefits;
- an Attending Physician's Statement (APS) completed by the insured's doctor who confirms the date, cause of death (and any treatment of the event causing the claim). Any cost associated with this form is the responsibility of the claimant. Some insurance claims will require a provincial death certificate instead of an APS; and
- return of the policy contract, if it is available, so the insurance company can remove it from circulation. Otherwise, the policy may be found several years later and a subsequent request for benefits could be made. If the policy is not available, the claimant confirming that the policy is not available may complete a Loss of Policy form.

If the beneficiary of a life insurance policy is the "estate of the Life Insured" rather than a named beneficiary, the claims examiner may require a certified copy of the deceased's probated will (or letters of administration, if the deceased died without a valid will (in testate)). In some instances, the claims examiner may accept a provincial death certificate, funeral director's certificate or a coroner's report. In extreme cases, several months could go by before the executor receives the necessary documents, although a funeral director's certificate is normally readily available.

Example: Bob Gibson died and the beneficiary on his life insurance policy was his estate. The claims examiner required a copy of Bob's will for two reasons: to confirm which person, persons or organization was to receive the insurance benefits and to ensure that the executor(s) of the estate was legally authorized to request the claim proceeds. Before releasing the proceeds, the claims examiner has to be satisfied that the will in question was Bob's valid and final will. It could take several months for the executor to obtain probate – before the policy proceeds could be made payable.

What the Claims Examiner does when Notified of a Claim

Upon receipt of claims forms, the claims examiner needs to:

- confirm that the policy contract is in force (if it is not in force, a claim will not be paid because there is no contractual obligation to do so);
- confirm that the claimant on the form is the same person on the insurance company records;
- be satisfied that there was a loss and the loss is covered by the policy contract;
- confirm that the life insured under the policy contract is the person who has died; and
- determine and confirm the amount to be paid under the claim.

Why a Policy might not be in Force at the Time of a Death Claim

A policy may not be in force at the time of the claim for a number of reasons:

- the policy lapsed because premiums had not been paid;
- the policy was no longer in force because the policyowner surrendered it prior to the claim; or
- the policy may have contractually expired (for example, a 20-year non-renewable term policy bought 21 years ago).

From the records the insurance company has (usually the original application); the claims examiner confirms that the name, age and sex of the life insured is the same as on the claim form. If there is a discrepancy, the claims examiner will require additional documentation, such as the insured's birth certificate. Incidentally, some life insurance companies may require the life insured to provide proof of age when the application is completed. The file would then state that *age was admitted*.

Example: A life insurance policy was issued to Gavin Stevens who said he was 35 years old when the application was completed. Six years after buying the policy, Gavin died. The beneficiary, Gavin's wife, Molly, completed a claimant's statement but stated Gavin's date of birth was such that at the time of application, he was actually 36 years old. The claims examiner required Molly to submit a copy of Gavin's birth certificate or other paperwork documenting proof of age. She did and it revealed that Gavin really was 36 years old when he applied for the life insurance.

In this example, it is said that Gavin made "misstatement of age." The life insurance company would not decline to pay the death benefit under Gavin's policy. Rather, it would adjust the amount of the death benefit payable by determining how much life insurance would have been purchased at age 36 for the same premium that Gavin paid. If Gavin had paid \$50 per month for a \$50,000 policy based on age 35, that same \$50 may have purchased only \$47,363 of life insurance for an applicant age 36. It is that latter, lesser amount that would be paid to Molly.

The claims examiner checks files to determine if the insured was covered under the policy contract at the time of the death. If not, no claim will be incurred. Remember our parachute enthusiast mentioned earlier? In his application he mentioned his hobby was parachuting. The insurance company could have issued him a policy that contained a "parachuting exclusion." Had the policy been so issued and our enthusiast died in a parachuting accident, a claim would not be paid because a death resulting from parachuting was "excluded from coverage under the contract."

The claims examiner reviews the policy records to confirm the amount of the claim and that the loss happened. In a death claim, the claims examiner takes into account:

- the face amount of the policy,
- dividends credited to the policy under the paid-up insurance or accumulated dividend option,
- any outstanding policy loan and interest to the date of death and any outstanding policy loan and interest to the date of death and any outstanding premiums owing.

Dividend amounts on policies are added to the death claim while outstanding policy loans; interest and outstanding premiums are deducted from it. It is the net amount that is paid to the claimant.

Example: When Joseph Mountbatten died, his \$75,000 whole life participating policy had accumulated dividends of \$896.42 and a policy loan (including interest) of \$1,828.69 was outstanding. His annual premium of \$700 was due on March 1, but he died on March 16 having not yet paid it. Therefore, the net amount payable to Joseph's beneficiary was:

	Face amount	\$75,000.00
Plus:	Accumulated dividends	896.42
Minus:	Policy loan and interest	1,828.69
Minus:	Annual premium owing	700.00
	Net death benefit	\$73,367.73

The Disability Claims Settlement Process

In broad terms, there are two distinct types of disability claims: total *disability of premium waiver* (TDW) and *income replacement* due to accident or sickness.

DISABILITY WAIVER OF PREMIUM

This is a rider that is purchased on a life insurance policy contract where the life insurance company waives future premiums while the insured is totally disabled. Generally, when an insured becomes disabled, a claim is not approved until six months of total disability has passed.

NOTE: Disability waiver of premium is underwritten separately from the underwriting of the base policy to which it is attached. If the waiver protection is placed on the life of someone other than the basic life insured (as in the case of *applicant's waiver of premium*) (such as when a parent insures a minor child), the underwriting of the waiver is based upon the applicant (the parent), not upon the life insured under the base policy (the child).

The six-month Elimination Period

Many disabilities will not last longer than several weeks. A broken bone is an example in which full recovery may take only two months to heal. By maintaining a six-month waiting period from the onset of the disability, short duration disabilities are alleviated and the cost of the rider remains reasonably priced.

What Happens During the Six-month Period

After a disabling event, the insured may inform the insurance company that a total disability has occurred. If so, the insured will be informed to keep paying premiums on the policy and to complete a *claimant's statement for total disability* after six months have passed.

What Happens After the Six-month Period

After the six months have passed, the life insured files a claim for waiver of premium benefits. When the claim is approved, the insurance company will pay future premiums and reimburse the insured for the premiums he or she paid during the previous six months since the onset of the disability. Proof of continuing total disability will be required periodically by the claims examiner to ensure that premiums should continue to be waived. If and when the disability is cured and the insured is no longer disabled, he or she simply resumes premium payment. The premiums waived by the company do not then have to be paid back by the insured.

THE REQUIREMENTS TO MAKE A CLAIM

The insured notifies the insurance company that he or she has experienced a disability and will receive a claimant's statement on which details are to be provided:

- the cause of disability;
- the nature of the disability,
- the date the disability began;
- the treatment for the disability; and
- the identity of the insured's physician.

The attending physician will also complete an APS, providing details of the disability including an estimate of the duration of the disability. Upon approval of the claim, the claims examiner will arrange for the reimbursement of premiums paid since the date of the disability and the waiving of future premiums. The case is placed on a follow-up system for the claims examiner to contact the insured to confirm that the disability is over or it is continuing. It may be necessary for the insured to provide additional proof of continuing disability in the future. This may include, but is not restricted to, having a medical examination by a physician. Once (and if) the disability ends, the claims examiner removes the case from the follow-up system and the insured resumes the payment of the premiums.

INCOME REPLACEMENT CLAIMS

Income replacement policies are also known as:

- disability income policies;
- accident and sickness policies;
- long-term disability policies; and
- short-term disability policies.

Applicants can buy insurance to replace their income while they are disabled and cannot make money by working, as a consequence of the disability. There are many permutations one can have on one's policy that are beyond the scope of this module. Suffice it to say that disability policies can have one of several waiting periods (such as 1st, 30th, 60th day), which is when the benefit period begins. Disability policies can also have different benefit periods (such as two years, five years or to age 65), which is how long the benefit is payable while the insured is disabled. Once the benefit period expires, the benefits cease too. The shorter the waiting period, the more expensive the disability insurance is and, also, the longer the benefit period, the more expensive the coverage is.

HOW A CLAIMANT FILES A CLAIM FOR AN INCOME REPLACEMENT POLICY

Filing a claim for a disability income replacement policy is similar to filing a claim for a total disability of waiver rider on a life insurance policy...That is, the claimant (the insured) completes a form for benefits and an APS is generally required to provide the medical information concerning the disability. Subsequent forms for proof of continuing disability will be required at certain times throughout the claim period, as determined by the claims examiner.

The claim ends when:

- the insured returns to work; or
- the benefit period expires, whichever comes first.

GROUP INSURANCE CLAIMS

Group insurance provides insurance coverage to a number of people insured under a master contract. Normally, the *group* lives insured have a common characteristic; such as they all work for the same company or attended the same university. The employer, in the case of the former, holds the master contract and the lives insured receive a certificate, or summary, of the policy. The group insurance premiums can be paid for entirely by the employer or be split between the employer and the employee through payroll deduction. Types of loss insured against include:

- group life insurance – provides a death benefit to the life insured and sometimes to a spouse and dependent children;
- group dental benefits – provides benefits for dental care for the life insured, spouse and dependent children, including check-ups, hygiene, orthodontics and repairs; and
- group health benefits – provides benefits for specific health care costs, including prescription drugs, wheel chairs, chiropractic services for the life insured, spouse and dependent children.

Often there is a waiting period of three to six months, before a new employee is insured under the master contract. Coverage usually ceases when employee is terminated.

HOW GROUP BENEFIT CLAIMS ARE SETTLED

You guessed it! With forms!

The first thing a group life insured does after incurring a loss is to complete a claims form for benefits. The claims form is generally submitted directly to the insurance company, although sometimes it can be submitted to the employer who will forward it to the insurance company. The claim form requires invoices for the treatment to be sent along with it so the company can approve the claim. Reimbursement from the insurance company is sent directly to the group life insured.

Some dentists will send the form directly to the insurance company for reimbursement rather than having the insurance company forward a cheque for work completed to the group life insured, who would in turn pay (or have already paid) the dentist directly.

Some group health plans allow a pharmacy to bill for prescriptions directly to the insurance company, and the group life insured pays the co-insurance factor. This is beneficial to a group life insured because he or she does not have the initial outlay for health care to be subsequently reimbursed.

THE AGENT'S ROLE IN RELATION TO AN ESTATE

If a policyowner named a beneficiary on his or her life insurance policy, the proceeds of the policy will be paid to that person or organization upon the approval of the death claim. Naming a beneficiary keeps the life insurance proceeds out of the deceased's estate and exempts them from probate fees.

However, a person's "estate" can be named as the beneficiary, meaning that he or she wishes the life insurance proceeds to become part of his or her entire estate and distributed according to the terms of his or her will. It is the responsibility of the executor of the estate to administer the wishes of the deceased through the last will and testament. The executor may seek the assistance of an attorney and accountant to carry out this responsibility.

The agent may be called upon to provide information about, and claimant forms for, settlement options associated with death benefits, annuities and group policies with which the deceased was associated. Indeed, the agent can provide quotations for settlement options that may be very beneficial for the beneficiary (or beneficiaries) of the estate. After all, an executor may not be aware that there are other options available, rather than taking a lump sum payment from the insurer.

Settlement options can include, for example, taking a monthly life income guaranteed for a certain number of years rather than a lump sum payment. The payment of a large lump sum may not be in the best interests of the estate's beneficiary if that person is a spendthrift. Receiving a monthly income that cannot be outlived by the estate's beneficiary may be a more appropriate way to receive the funds. The agent can provide such quotations on settlement options, so that the claimant can make an educated decision concerning the disbursement of the life insurance proceeds.

An agent *should not* become personally involved in settling an estate of a policyowner because it could be construed as a *conflict of interest*. Nor should the agent be named as a beneficiary of a life insurance policy other than those he or she is personally involved with, such as being the beneficiary under a spouse's policy. The agent can provide information about life insurance settlements, but should leave the settling of an estate to the executors, attorneys and accountants.