

Part III

Underwriting, Completing the Application & Policy Delivery

The Underwriting Process

As we have learned, underwriting is the process of selecting and classifying risks. Underwriting identifies who is eligible to be insured, what the criteria will be for their selection, how similar risks will be grouped together and what rates will be charged. The underwriting process depends on a particular insurer's underwriting philosophy as well as the specifics of the insurance policy under consideration. Underwriting begins when the producing agent completes the application and the producer report which is usually a part of the application. This is known as "field underwriting." This process begins with you, the agent/producer through the submission of an accurate, fully completed application. The following are considered your responsibilities as the agent regarding the underwriting process:

- The honest, complete and accurate completion of the application for insurance as well as any relative comments concerning the applicant
- Administration of any necessary Fair Credit Reporting Act forms or inspection report requests
- Issuance of a conditional receipt upon the applicant's payment of premium
- Submission of the completed application and any other pertinent information to the insurer for its underwriting evaluation
- Delivery of the policy (once issued by the insurer) to the insured, complete with an explanation of coverage and the collection of any additional premium not collected at time of application
- Sign policy delivery receipt, leaving a copy with the insured and submitting original to insurer
- Prompt submission to the insurer of any premiums received
- On-going contact with the insured

Completing the Application

The life insurance policy has a provision that addresses the "entire contract." This provision means that the policy with all of its provisions, riders, exclusions and a photo copy of the original, completed and signed application constitute the entire contract of life insurance. A typical life insurance application includes:

- The name, address, age, sex and occupation of the insured
- The type of insurance desired
- The mode of premium payment

Part III – Underwriting, Completing the Application & Policy Delivery - I

Life and Health Insurance License Preparation Course

- Information concerning beneficiaries (primary and contingent)
- Information concerning other life insurance in force
- A health questionnaire and examining physician's statement if required

A life insurance application must be signed by the insured and the agent: The insured's signature attests to the accuracy of the statements made in the application; the agent's signature acts as witness to the transaction. In addition, if the insured is not the applicant for the policy, the applicant (policyowner) must sign as well. Finally, if an examining physician's statement is required, the physician must sign the application to attest to the accuracy of his/her remarks.

Since a copy of the application becomes part of the "entire contract" along with the life policy itself, any changes in the application must be signed by the insured and agent. In addition, the agent must remind the insured of the importance of completing the application fully and accurately. The consequence of incomplete applications is rejection by the company's underwriters.

As previously noted, *representations are statement of fact. Warranties are guarantees that a condition exists.* Warranties become part of an insurance contract; representations do not. *With life insurance, statements made in the application are considered representations, not warranties.*

Finally, once the application has been completed by the applicant, the agent usually collects the initial premium and issues a "conditional receipt." The initial premium payment demonstrates the applicant's seriousness in purchasing insurance. The use of a conditional receipt demonstrates the ability of life insurance agents to make coverage effective on one of the following dates:

- Date of application, or
- Date of the medical examination.

A properly completed application is obviously important to the insurer, applicant and the agent. Some possible consequences of an incomplete application are:

- Possible inaccurate decisions may be made by the underwriter.
- Policy issue delays due to a return of the application to the agent for proper completion in the presence of the applicant.
- Possible loss of trust and credibility of the agent by applicant.
- Delays may occur with the request of an attending physician statement (APS) and initiation of investigation reports.
- Claim processing and payment of claims could be delayed.
- Possible contestability of a claim.

Please review the sample application that follows.

Part III – Underwriting, Completing the Application & Policy Delivery - 2

As referred to earlier, the underwriting process begins with you and the information recorded in the completed application and submitted to your company. The process moves forward to a conclusion as a result of the underwriting factors that follow.

Medical Information/Medical Examination – If required, a medical examination may range from a minimal exam to a very extensive exam depending on the amount of insurance applied for and the age of the applicant. In today's marketplace, the medical information/medical exam required could fall into one of the following categories:

- **Non-medical Application** – Required in cases where a medical examination is not required. Consists of a health statement completed by the agent and the applicant.
- **Laboratory Screen** – Blood and urine samples are collected from the proposed insured and sent to a medical lab. The blood screen is primarily concerned with HIV, cholesterol levels, and liver and renal functions. The urinalysis can show a variety of medical conditions as well as screen for nicotine and illegal drug use. The laboratory screen is used for individual insureds in situations where the company needs some medical information but the amount of insurance does not merit a full physical exam. Lab screens are also commonly used in group insurance.
- **Paramedical Exam** – Some of the essential facts about a proposed insured's health (height, weight, pulse rate, blood pressure) can be obtained much more economically by using a paramedic rather than a doctor. For certain cases, this may be all the company needs to make an underwriting decision.
- **Medical Exam** – Here, as in a laboratory screen and a paramedical exam, the insurance company conducts a physical exam and takes blood and urine tests. However, it is done by a *medical doctor or a registered nurse*, so a great deal more credibility is given the information. Depending on the amount of insurance requested, the exam could be more extensive and include X-rays, a complete blood profile and medical tests such as an EKG.

Attending Physician's Statement – This is used if information collected on an application requires follow-up. For example, if an applicant indicates that he saw a doctor 12 weeks ago for chest pains but the doctor said it was gas and prescribed an antacid, the company might want to write to that doctor (the attending physician) just to verify that there was no evidence of a heart condition. This would be considerably cheaper than conducting a full-blown medical exam. This device is also frequently used in health insurance to determine the likelihood of future claims for a condition that has been treated in the past.

The Medical Information Bureau (MIB) - Insurance companies share medical data through an organization called the Medical Information Bureau (MIB). The MIB is a not-for-profit association designed to allow member companies to share data on health risks and to uncover misrepresentation and prevent concealment. Since insurance companies will sell small amounts of insurance on a non-medical basis, they can be easily victimized by an unscrupulous client. For example, suppose that an unethical person applies for \$50,000 of life insurance from Company A. The medical exam reveals that this person is dying from an incurable disease, so Company A rejects him. He then finds out that most companies would issue him \$10,000 of life insurance on a non-medical basis so he then applies for five \$10,000 policies at five different companies. To protect against such abuse, the insurance companies started the MIB. Referred to as inter-company data, information on applicants is pooled by computer and made available to any of the

Part III – Underwriting, Completing the Application & Policy Delivery - 3

subscribing companies. Member companies are required to report any specific impairments they might find. Claim information or the amount of insurance applied for is not reported to the MIB. In addition to medical information, other relevant underwriting data from the application is also reported such as reckless driving habits, aviation or hazardous sports activities. Therefore, the five companies from which the unethical individual selected to buy smaller policies would be protected by getting the information from the MIB without ever conducting a medical exam.

Obviously, this system could misfire and cause a perfectly insurable person to be denied insurance. Therefore, many safeguards are built in to protect the consumer. First of all, we should point out that all of this information comes from a physical exam that the company pays for. Your doctor does not sell your file to the MIB. In a very real sense, the information belongs to the insurance company as they paid to collect it. However, the company must advise the client of several facts:

- The company will check the information held by the MIB.
- Information collected by the company will be shared with other companies through the MIB.
- Most information held by the MIB can be checked by the individual. However, sensitive medical information will only be released to the individual through his or her family physician.

Inspection (Consumer Investigative) Report – Although most insurance companies routinely get the applicant's permission to investigate his or her credit report, they rarely utilize this source of information. For the most part, a credit report is only used in business insurance situations where the business is insuring a key employee or the insurance is funding a buy-sell agreement. The insurance company is primarily concerned with the value of the business purchasing the insurance and if the amounts of insurance are in line with the value of the business.

In order to get a customer's credit report, the insurance company must comply with the federal *Fair Credit Reporting Act*. This law requires that any applicant for insurance be notified in writing that an investigative consumer report (credit report) is being made. This notification is frequently a part of the application form itself. This law also gives every consumer in the United States the right to question the validity and source of any credit information collected and retained on file. If the consumer questions such information, the credit bureau must reinvestigate the case. If the consumer believes the credit bureau has sent any inaccurate information to an insurance company within the past six months, the credit bureau must check the accuracy of the information and forward the corrected data to the receiving company. If the data was not truly incorrect but somewhat one-sided, the bureau must include the consumer's side of the story in the file.

While the Act provides the consumer with many additional rights concerning credit information, the thrust of the law is to give insurance applicants the right to review their credit report, to know who has the data, and to have incorrect data updated and corrected. The Act also limits the retention of data to 7 years (10 years on bankruptcy information).

Selection and Classification Criteria

In order to treat all policyowners equitably and to maintain the financial well being of the insurance company, companies give careful consideration to a number of significant factors for each application for

Part III – Underwriting, Completing the Application & Policy Delivery - 4

insurance. The information the companies obtain relating to these factors aids the underwriters in determining the extent of the risks involved. In other words, the company will discriminate in favor of good risks and to the disfavor of poor risks. Obviously, we cannot unfairly discriminate by using factors such as race or national origin. The key factors we can use are:

Age - The probability of death or disability increases as a person grows older. Surprisingly enough, an applicant is not required to furnish proof of age at the time of application.

Sex - Statistically, women outlive men by three to five years. However, women submit 40% more health claims. Therefore, women's premiums for life insurance are less than men's, but their health premiums are higher than those charged to men. Interestingly enough, some states view sex in rating to be unfairly discriminatory and have forced unisex rating in their jurisdictions.

Tobacco Usage - Today this is as big of a factor as sex in rate determination. A 40-year-old male who smokes a pack a day will pay about 20% - 50% more for insurance than he would if he were a non-smoker.

Build - Build includes height, weight, and distribution of weight. Experience has shown that being overweight significantly increases the life and health risk at all ages.

Physical Condition - The physical condition of a proposed insured's cardiovascular, nervous, digestive, and glandular systems is obviously very important. The insurance company will screen out pre-existing conditions (physical defects that already exist) such as a heart condition, nervous disorders, ulcers, hernia, and chronic illnesses. This information can be obtained through a medical exam.

Personal & Family Health History - An individual's past health experiences are a very good predictor of that individual's future health. Since some diseases are hereditary, the family health history and cause of death of family members is also helpful.

Occupation - Hazardous occupations obviously increase the risk. Coal miners or race car drivers are exposed to much more risk than schoolteachers or office workers. Less obvious is the danger of working in dusty or poorly ventilated spaces, or being exposed to poisonous air or fumes.

Personal Living Habits - The concern here is with the use of drugs and alcohol. If the applicant drinks heavily or takes illicit drugs, then the company may rate the applicant as substandard or decline the risk altogether.

Moral Hazard - An applicant's character, personal reputation, living habits, and financial status are of prime importance to the insurance company. Information concerning the applicant's character includes business as well as personal activities. The applicant's reputation for meeting obligations and fairness in business and personal dealings indicates the type of moral risk involved. Also of interest is the total amount of insurance in force because overinsurance can increase the risk.

Aviation - It is customary to ask about participation in either private or military aviation, which, not surprisingly, increases the risk. If so, the company can either charge an extra premium to compensate for the aviation risk or exclude it entirely from coverage. If the risk is excluded and if death occurs from an aviation accident, then the company is liable only for the return of premiums paid. Flying on regularly

scheduled commercial flights as a fare-paying passenger does not significantly increase an individual's risk and, therefore, is usually not excluded from coverage or cause an increase in premium.

Military Service - Military service also increases the insurance company's risk. In the past, the military service problem was usually handled by a military service clause, or war clause. This clause limited the company's liability to the return of premium plus interest if the insured died while on active duty. Today, in the absence of major hostilities, most life policies are issued with no military service exclusions or limitations. However, in the presence of potential hostilities, underwriters would probably either: (a) reintroduce the military service clause in future policies, (b) place a limit on the amount of insurance each individual could buy or, (c) waive this clause in exchange for increased premium. Most health policies contain a clause stating that the policy will not pay benefits if the loss is covered by a federal or state government medical plan (such as is provided by the military).

Other Factors - Other important factors to underwriters include residence outside the U.S. or Canada (due to increased mortality rates as the result of disease and lack of quality health care providers), and hobbies or avocations. Activities such as sky-diving, scuba diving, skiing, snowmobiling, mountain climbing, and competitive automobile racing are normally handled either by charging a flat extra premium or by attaching a rider to the policy excluding death or disability as the result of participation in such activities.

AIDS, HIV and Underwriting

Obviously, the disease known as Acquired Immune Deficiency Syndrome, or AIDS, has and will continue to have a huge impact on the underwriting of life and health insurance. Blood tests to detect the presence of HIV (Human Immunodeficiency Virus) are becoming commonplace. However, laws have been passed in most states to protect the privacy of the applicants, to prohibit unfair discrimination and to provide full disclosure of the purpose and use of these test results. Though some variation exists from state to state, most laws regarding AIDS testing include the following:

- While questions on the application can seek *medically specific* information regarding AIDS and HIV, no information can be sought directly or indirectly concerning an applicant's sexual orientation.
- Companies may not use the fact that an individual has previously sought AIDS testing or counseling to trigger an AIDS test to obtain insurance.
- The companies at their own expense can require AIDS testing.
- Applicants must be informed as to the testing methodology to be used and must give written permission for such testing.
- The test results must be kept strictly confidential.
- The company may only report to the MIB that the individual has *abnormal blood test results*, but not the presence of AIDS antibodies.
- A company may choose to deny coverage to an individual with AIDS. However, if a policy is issued, it cannot contain exclusions for AIDS-HIV losses, nor shall it contain any specific benefit limits for AIDS-related claims.

Part III – Underwriting, Completing the Application & Policy Delivery - 6

Delivering the Policy

As noted, if the initial premium is paid at the time of application, the applicant is issued a conditional receipt. This conditional receipt makes coverage effective on one of the following dates:

- Date of application, or
- Date of the medical examination if required by the insurer.

If the initial premium is not paid at the time of the application, the policy goes into effect when it is delivered to the applicant (who must be in good health at the time) and premium is paid.

Finally, if the premium had been paid at the time of application, but no conditional receipt had been issued, the policy would become effective upon the delivery of the policy.

Remember, coverage does not begin until the policy is delivered to the insured by the agent unless conditional receipts are used. When a conditional receipt is used, coverage begins either on the date of the application or the date of a medical examination (if required), depending on the particular receipt.

When the agent delivers the policy to the insured, he/she must explain the policy and its provisions, riders, exclusions and ratings to the client. When the insurer mails the policy to the agent, this is considered “constructive delivery.”

Summary

As you anticipate taking the following review quiz, several points of study emphasis are important because of their inclusion on the state licensing examination. You must be familiar with the signing parties on an application for life insurance. You must also be able to distinguish between representations and warranties and know that statements given on an application for life insurance are representations. You should review the significance of the conditional receipt and remember that this receipt is given only when premium is collected with the completion of the application. The acronym “CLOC” that was introduced earlier in this course plays a vital role in your study of the conditional receipt and effective date of coverage. You may be helped by the expression, “follow the money.” Read and study the conditional receipt that is part of the sample application. Note the conditions that must be met for coverage to become effective.

The underwriting section has several vital points that you should focus on. Pay particular attention to the section regarding insurable interest and the Medical Information Bureau (MIB). Be aware of what the MIB is and its role in the underwriting process.

The state examination may ask questions regarding the Fair Credit Reporting Act which is a federal law defined in this section. Bear in mind that this law extends to the information provided to the insurer from the MIB.

Part III – Underwriting, Completing the Application & Policy Delivery - 7

Review Quiz

1. _____ are guarantees that certain conditions exist.
 - A. Representations
 - B. Concealment
 - C. Misrepresentations
 - D. Warranties

2. _____ are statements of fact believed to be true.
 - A. Representations
 - B. Concealment
 - C. Misrepresentations
 - D. Warranties

3. Statements made in an application are:
 - A. Representations
 - B. Concealment
 - C. Misrepresentations
 - D. Warranties

4. Who must sign an application for insurance?
 - A. Insured/Owner
 - B. The insurance agent
 - C. Both A and B
 - D. Only the policyowner

5. All of the following are factors in underwriting a life insurance policy except:
 - A. Insurable Interest
 - B. Risk Classification
 - C. MIB/Consumer Reports
 - D. Premium

6. Life insurance rate making is based on three major factors: mortality tables, interest income and:
 - A. The applicant's marital status
 - B. The applicant's state of residence
 - C. The applicant's warranty of answers on the application
 - D. Loading factors

Part III – Underwriting, Completing the Application & Policy Delivery - 8

7. Agent Jones submitted an application for life insurance on John L. Smith. Agent Jones did not get any money from Mr. Smith. When will this policy become effective?
- A. When the underwriting process is complete.
 - B. On the date the policy issued.
 - C. When the 10 day free look has ended.
 - D. When the policy has been delivered to the client and the premium paid.
8. If a premium has been paid with an application and the agent failed to give a conditional receipt, when will the policy become effective?
- A. When the underwriting process is complete.
 - B. On the date the policy issued.
 - C. Upon delivery of the policy to the insured.
 - D. When the 10 day free look expires.
9. If the initial premium is paid at the time of application and the applicant is issued a conditional receipt, coverage will become effective:
- A. On the date the policy is issued.
 - B. Date of application or date of medical exam.
 - C. When the policy is delivered to the insured
 - D. When the 10 day free look expires.
10. Reinstatement of a life insurance policy requires an insured to take all of the following actions except:
- A. Provide evidence of insurability
 - B. Make collateral assignment to the insurance company
 - C. Repay any outstanding policy loans plus interest
 - D. Repay all past due premiums
11. Bill Insured is the supervising computer programmer for I.M. Big Client. The president of I.M. Big Client wants to insure Bill as a key person in the business. Who is required to sign the application?
- A. Bill Insured
 - B. Bill Insured and the agent
 - C. Bill Insured, the agent and the president of I.M. Big Client
 - D. None of the above need to sign

12. John Agent did not receive a premium at the time of application on Bill Insured. After the underwriting process, but prior to policy issue, Bill had a very slight heart attack. John Agent learns of this episode when he delivers the policy to Bill Insured who just happens to be working in his garden. What should John Agent do?
- A. Collect the premium due and give Bill the policy.
 - B. Keep the policy, take the premium and get a current medical report from Bill's physician for the company.
 - C. Keep the policy, take the premium and notify his company about what he learned about Bill.
 - D. Keep the policy and notify his company.
13. If, in question 12 above, John Agent had collected the first premium at the time of application and learned of Bill's very slight heart attack at the time of policy placement, what should John Agent do?
- A. Keep the policy and notify his company.
 - B. Give Bill the policy and notify his company
 - C. Notify his company and then give the policy to Bill.
 - D. Any of the above are acceptable answers.
14. John Agent is completing an application on Bill Insured and Bill lights a cigarette as John asks Bill to sign the application. Bill told John that he didn't smoke when asked if he smoked. At this moment, John Agent refers back to the smoking section of the application and is told by Bill that he does not want to pay a higher rate because he smokes and that he will not sign the application if the answer is changed. What should John do?
- A. Leave the answer as is and have Bill sign the application because Bill is responsible for his answers.
 - B. Have Bill sign the application and change the answer at the office.
 - C. Ask his company to issue two policies; one at smoker rates and the other with non-smoker rates.
 - D. Try and explain to Bill his responsibility to his company and if Bill holds fast to his position, terminate the interview.
15. Your client tells you that earlier in the year he had been significantly overweight and had elevated blood pressure. He has now lost most of the excess weight and now has normal blood pressure and does not take any medication. How should you handle this situation when taking an application?
- A. Record the facts as they exist today and submit the application to your company.
 - B. Defer taking the application for at least one year.
 - C. Record the facts as they exist today and arrange for a medical exam.
 - D. Record the facts as they exist today and give a report of the history to your company's underwriting department and await direction from the underwriter.

16. If a client admits to having a blood pressure problem controllable with medication, you should:
- A. Consider the client uninsurable and forget taking an application.
 - B. Submit a “trial application” and let your underwriter access the risk.
 - C. Take the application and premium so your client will be “bound.”
 - D. Have your client examined and then take the application.
17. Your client had been treated for alcoholism two years ago and has not had a drink of alcohol for two years. You should:
- A. Record all facts and let your underwriter access the risk.
 - B. Have your client examined so you can prove your client does not drink alcohol.
 - C. Record the facts as they are today and ignore the past alcohol problem.
 - D. Decline the risk until the client has been “dry” for five years.
18. Although your client does not tell you, you are aware that eight years ago your client served a jail sentence for a felony conviction. You should:
- A. Openly discuss this situation with your client.
 - B. Tell the consumer reporting agent to focus on this matter.
 - C. Record the answers given by the client and when submitting the application to the company, attach a confidential memo to the underwriter.
 - D. Ignore what happened eight years ago and record only what the client tells you.
19. Your client has been declined coverage due to confidential information contained in a consumer report. Under the Fair Credit Reporting act, your client has the right to:
- A. Obtain a summary of the substance of the information from the insurance company and the consumer reporting agency.
 - B. Secure the names of other individuals and/or companies who have obtained consumer reports on the applicant within the previous six months from that consumer reporting agency.
 - C. Obtain a summary of the substance of the information from the consumer reporting agency.
 - D. Both B and C.
20. If a client filed bankruptcy, information regarding his bankruptcy can be included in the consumer reporting agency report for a period of:
- A. Seven (7) years.
 - B. Five (5) years.
 - C. Ten (10) years.
 - D. Twenty (20) years.

Part III – Underwriting, Completing the Application & Policy Delivery - I I

Answer Key

- | | |
|-------|-------|
| 1. D | 11. C |
| 2. A | 12. D |
| 3. A | 13. B |
| 4. C | 14. D |
| 5. D | 15. D |
| 6. D | 16. B |
| 7. D | 17. A |
| 8. C | 18. C |
| 9. B | 19. D |
| 10. B | 20. C |