Prelicensing

Life, Accident & Sickness STUDY MANUAL

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Eddie K. Emmett / FYI Express

200 Russell Court, Canton, GA 30115

eddie@FYIExpress.com www.FYIExpress.com

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To earn your certificate of completion:

- Read every chapter and take the end-of-chapter quiz.
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Your exam will be based on the Georgia exam outline, which can be found on pages S4 – S5 in PearsonVUE's Candidate Handbook.

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It is not mandatory to take the quizzes but it sure is fun (especially if you turn on the music, memes & sound effects.

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Take it when you are ready at https://www.classmarker.com/online-test/start/?quiz=4tc67756c7b0241f

You will need to correctly answer at least 70% of the questions in order to earn the GA Life, Accident & Sickness Insurance Agent Certificate to use to get your LAS license as soon as you pass the State Exam.

I. LIFE: TYPES OF POLICIES

A. Traditional Whole Life Products

1. Ordinary Whole Life

Summation: Ordinary whole life insurance provides coverage for the insured's entire life with fixed premiums and a guaranteed death benefit. It also includes a cash value component that grows over time and can be borrowed against.

Example: John purchases an ordinary whole life policy with a death benefit of $100,000 and annual premiums of $1,200. Over the years, the cash value of his policy grows to $20,000, which he can borrow against if needed.

2. Limited-Pay and Single-Premium Life

Summation: Limited-pay life insurance policies require premiums to be paid for a specified period (e.g., 10 years), after which no further premiums are due. Single-premium life insurance involves a one-time lump-sum payment.

Example: Sarah buys a limited-pay whole life policy with a 10-year premium payment period and a death benefit of $200,000. She pays $10,000 annually for 10 years, after which her policy remains in force without further premiums.

B. Interest/Market Sensitive/Adjustable Life Products

1. Universal Life

Summation: Universal life insurance offers flexible premiums and an adjustable death benefit. It includes a cash value component that earns interest based on current market rates.

Example: Mike has a universal life policy with a death benefit of $150,000. He can adjust his premium payments and death benefit as needed, and the cash value of his policy grows based on market interest rates.

2. Variable Whole Life

Summation: Variable whole life insurance combines life insurance with investment options, allowing the cash value to be invested in various securities. The death benefit and cash value can fluctuate based on the performance of the investments.

Example: Emily invests in a variable whole life policy with a death benefit of $250,000. She chooses to invest the cash value in mutual funds, and the value of her policy grows or declines based on the performance of those funds.

3. Variable Universal Life

Summation: Variable universal life insurance offers the flexibility of universal life with the investment options of variable life. The policyholder can adjust premiums, death benefits, and investment choices.

Example: David has a variable universal life policy with a death benefit of $300,000. He can change his premium payments, investment options, and death benefit as needed, with the cash value tied to the performance of his chosen investments.

4. Interest-Sensitive Whole Life

Summation: Interest-sensitive whole life insurance provides lifelong coverage with a cash value component that earns interest based on market rates. Premiums and cash value growth can fluctuate with interest rate changes.

Example: Lisa buys an interest-sensitive whole life policy with a death benefit of $180,000. The cash value of her policy grows faster when interest rates are high and slower when rates are low3.

5. Indexed Life

Summation: Indexed life insurance combines life insurance with an investment component tied to a market index, such as the S&P 500. The cash value can earn interest based on the performance of the index, with a guaranteed minimum interest rate.

Example: Tom purchases an indexed life policy with a death benefit of $220,000. The cash value of his policy grows based on the performance of the S&P 500, with a guaranteed minimum interest rate to protect against market downturns.

C. Term Life

1. Types

a. Level Term Life

Summation: Level term life insurance provides coverage for a specified period (e.g., 10, 20, 30 years) with a fixed death benefit and fixed premiums throughout the policy term.

Example: Jane purchases a 20-year level term policy with a $500,000 death benefit. Her premiums remain the same for the entire 20-year period, and her beneficiaries receive $500,000 if she passes away within that time.

b. Decreasing Term Life

Summation: Decreasing term life insurance provides coverage for a specified period, but the death benefit decreases over time while premiums remain constant. It’s often used to cover decreasing financial obligations, like a mortgage.

Example: Tom buys a 15-year decreasing term policy with an initial death benefit of $300,000. The benefit decreases each year until it reaches zero at the end of the term, aligning with his mortgage balance reduction.

c. Return of Premium Term Life

Summation: Return of premium (ROP) term life insurance refunds the premiums paid if the policyholder outlives the policy term. Premiums are higher than those of standard term policies.

Example: Emily buys a 20-year ROP term policy with a $250,000 death benefit. If she survives the 20 years, she receives a refund of all premiums paid.

d. Annually Renewable Term Life

Summation: Annually renewable term life insurance provides coverage for one year at a time, with the option to renew annually. Premiums increase each year based on the insured's age.

Example: David purchases an annually renewable term policy with a $100,000 death benefit. His premium is $200 in the first year, and it increases each year as he renews the policy.

2. Special Features

a. Renewable Term Life

Summation: Renewable term life insurance allows the policyholder to renew the policy at the end of the term without undergoing a medical exam. Renewal premiums are based on the insured's age at renewal.

Example: Sarah has a 10-year renewable term policy. When it expires, she renews it for another 10 years without a medical exam, but her premiums increase based on her current age.

b. Convertible Term Life

Summation: Convertible term life insurance allows the policyholder to convert the term policy into a permanent life insurance policy (e.g., whole life or universal life) without a medical exam. **Example:** Mark has a 15-year term policy. After 10 years, he decides to convert it to a whole life policy to ensure lifelong coverage, locking in premiums based on his age at conversion.

D. Annuities

1. Single, Level, and Flexible Premium

- **Single Premium:** A single lump-sum payment made to purchase the annuity.

Example: John invests $100,000 in a single premium annuity, providing him with future income.

- **Level Premium:** Regular, fixed payments made over time to purchase the annuity.

Example: Sarah pays $500 monthly into her level premium annuity for 20 years.

- **Flexible Premium:** Payments made at irregular intervals and amounts, allowing flexibility.

Example: Mike makes contributions to his flexible premium annuity whenever he has extra funds.

2. Immediate and Deferred

- **Immediate Annuity:** Begins paying out income shortly after the initial premium is paid.

Example: Emily invests $200,000 in an immediate annuity and starts receiving monthly payments immediately.

- **Deferred Annuity:** Accumulates value over time, with payouts starting at a future date.

Example: David invests in a deferred annuity at age 40, planning to receive income starting at age 65.

3. Fixed and Variable

- **Fixed Annuity:** Provides guaranteed, fixed payments based on a set interest rate.

Example: Tom purchases a fixed annuity, receiving $1,000 per month for life.

- **Variable Annuity:** Payments vary based on the performance of invested subaccounts.

Example: Lisa invests in a variable annuity with subaccounts in mutual funds, resulting in fluctuating payments based on market performance.

4. Indexed

Summation: Indexed annuities earn interest based on the performance of a market index, like the S&P 500, with a guaranteed minimum interest rate to protect against market downturns.

Example: John invests in an indexed annuity tied to the S&P 500. He benefits from index gains while being protected by a minimum interest rate.

5. Accumulation and Annuity Periods

- **Accumulation Period:** The phase during which the annuity grows through contributions and interest.

Example: Sarah's annuity accumulates value over 20 years as she makes regular contributions.

- **Annuity Period:** The phase during which the annuity pays out income to the annuitant.

Example: Mike begins receiving monthly income from his annuity after the accumulation period ends.

6. Payout Options

- **Life Annuity:** Provides payments for the annuitant's lifetime.

Example: Emily receives monthly payments for life, regardless of how long she lives.

- **Joint and Survivor Annuity:** Provides payments for the lifetimes of two individuals, continuing to the survivor.

Example: David and his spouse receive payments, with payments continuing to the surviving spouse.

- **Period Certain Annuity:** Provides payments for a fixed period, regardless of the annuitant's life span.

Example: Tom's annuity pays monthly income for 20 years, even if he passes away before the term ends.

E. Combination Plans and Variations

1. Joint Life (First to Die)

Summation: Joint life insurance covers two individuals and pays out upon the death of the first insured person.

Example: Mark and his spouse purchase a joint life policy with a $500,000 death benefit. When Mark passes away, the policy pays the death benefit to his spouse.

2. Survivorship Life

Summation: Survivorship life insurance, also known as second-to-die insurance, covers two individuals and pays out only after both insured persons have passed away.

Example: Jane and her husband buy a survivorship life policy with a $1,000,000 death benefit. The policy pays the benefit to their beneficiaries after both Jane and her husband have passed away.

II. LIFE: POLICY RIDERS, PROVISIONS, OPTIONS, AND EXCLUSIONS

A. Policy Riders

1. Waiver of Premium and Waiver of Monthly Deduction

Summation: These riders allow the policyholder to waive premium payments or monthly deductions if they become disabled and are unable to work, ensuring the policy remains in force.

Example: John has a waiver of premium rider on his life insurance policy. After an accident leaves him disabled, he doesn't have to pay premiums, but his coverage continues.

2. Guaranteed Insurability

Summation: This rider allows the policyholder to purchase additional insurance coverage at specified intervals or life events without undergoing a medical exam.

Example: Sarah adds a guaranteed insurability rider to her policy. She later buys more coverage after having a child without needing a medical exam.

3. Payor Benefit

Summation: This rider waives premium payments on a juvenile life insurance policy if the payor (usually a parent or guardian) becomes disabled or dies.

Example: Emily buys a life insurance policy for her child with a payor benefit rider. If she becomes disabled, the premiums are waived, and the policy remains active.

4. Accidental Death and/or Accidental Death and Dismemberment (AD&D)

Summation: This rider provides additional benefits if the insured dies or suffers dismemberment due to an accident.

Example: David's life insurance policy includes an AD&D rider. If he dies in a car accident, his beneficiaries receive an additional death benefit.

5. Term Riders

Summation: Term riders add temporary additional coverage to a permanent life insurance policy for a specified period.

Example: Mike adds a 20-year term rider to his whole life policy, increasing his coverage during his mortgage years.

6. Other Insureds

Summation: This rider provides coverage for additional individuals, such as a spouse or child, under the primary insured's policy.

Example: Jane adds a rider to her policy to cover her spouse for $50,000.

7. Long Term Care (LTC)

Summation: This rider provides coverage for long-term care expenses, such as nursing home or in-home care, reducing the death benefit by the amount used.

Example: Tom's policy includes an LTC rider. If he needs nursing home care, the rider covers the costs, reducing his policy's death benefit.

8. Return of Premium

Summation: This rider refunds the premiums paid if the insured outlives the policy term.

Example: Lisa's term life policy includes a return of premium rider. If she survives the policy term, she receives a refund of all premiums paid.

9. Disability

Summation: This rider provides a monthly income benefit if the policyholder becomes totally disabled and unable to work.

Example: Mark's life insurance policy includes a disability rider. After becoming disabled, he receives a monthly benefit to replace his lost income.

10. Cost of Living

Summation: This rider adjusts the death benefit to keep pace with inflation, ensuring the coverage amount retains its value over time.

Example: Emily's policy includes a cost-of-living rider. Each year, the death benefit increases based on the inflation rate, maintaining its purchasing power.

B. Policy Provisions and Options

1. Entire Contract

Summation: The entire contract provision states that the life insurance policy, along with the application and any attached riders or endorsements, constitutes the entire agreement between the insurer and the policyholder. No external documents or statements are included.

Example: If John has a dispute with his insurer, they will refer only to the policy document, the application, and any attached riders to resolve the issue, as these documents make up the entire contract.

2. Insuring Clause

Summation: The insuring clause is a provision in the policy that outlines the insurer's promise to pay a specified benefit upon the occurrence of the insured event, such as the death of the insured, in exchange for the payment of premiums.

Example: Sarah’s life insurance policy includes an insuring clause stating that the insurer will pay a $200,000 death benefit to her beneficiaries if she passes away while the policy is in force.

3. Free Look

Summation: The free look provision allows the policyholder a specified period (usually 10-30 days) to review the policy after receipt. If the policyholder is not satisfied, they can return the policy for a full refund of premiums paid.

Example: Emily receives her new life insurance policy and has 15 days to review it. If she decides the policy doesn't meet her needs, she can return it within this period for a full refund.

4. Consideration

Summation: The consideration clause specifies the exchange of value between the parties involved in the contract. For life insurance, the policyholder’s consideration is the payment of premiums, and the insurer’s consideration is the promise to pay the death benefit.

Example: David pays his monthly premiums to the insurance company (consideration), and in return, the insurer agrees to provide a $300,000 death benefit (consideration).

5. Owner’s Rights

Summation: The owner's rights provision outlines the rights and privileges of the policy owner, including the right to change beneficiaries, borrow against the policy, and transfer ownership.

Example: Mike is the owner of his life insurance policy. He decides to change the beneficiary from his spouse to his child, exercising his owner's rights.

6. Beneficiary Designations

a. **Primary and Contingent**

The primary beneficiary is the first person or entity designated to receive the death benefit. The contingent beneficiary receives the benefit if the primary beneficiary predeceases the insured.

Example: Sarah names her spouse as the primary beneficiary and her sibling as the contingent beneficiary. If her spouse predeceases her, the death benefit goes to her sibling.

b. **Revocable and Irrevocable**

A revocable beneficiary can be changed by the policyholder at any time without the beneficiary's consent. An irrevocable beneficiary cannot be changed without the beneficiary's consent.

Example: Mark names his child as a revocable beneficiary and later decides to change the beneficiary to his spouse. He can do so without the child's consent. If he had named an irrevocable beneficiary, he would need the child's consent to make the change.

c. **Common Disaster**

The common disaster provision outlines what happens if both the insured and the primary beneficiary die in a common disaster. It typically assumes that the primary beneficiary predeceased the insured, allowing the death benefit to be paid to the contingent beneficiary.

Example: Jane and her spouse die in a car accident (a common disaster). According to the common disaster provision, the policy assumes the spouse died first, so the death benefit is paid to the contingent beneficiary.

d. Minor Beneficiaries

Summation: A minor beneficiary is a person under the legal age of majority (usually 18 or 21) designated to receive the death benefit. Since minors cannot legally control the proceeds, the insurance company may hold the funds until the minor reaches the age of majority, or a guardian or trustee can be appointed to manage the funds.

Example: John names his 10-year-old son as the beneficiary of his life insurance policy. If John passes away, the death benefit is held in a trust managed by a trustee until his son reaches 18.

e. Designation by Class

Summation: Designation by class refers to naming a group of beneficiaries without specifying individuals. Common class designations include "all my children" or "my grandchildren."

Example: Sarah designates "all my children" as beneficiaries. If she has three children at the time of her death, the death benefit is divided equally among them. If another child is born later, they are also included automatically.

7. Premium Payment

a. Modes

Summation: Premium payment modes refer to the frequency with which premiums are paid. Common modes include annual, semi-annual, quarterly, and monthly.

Example: Emily opts to pay her life insurance premiums monthly instead of annually, making smaller, more manageable payments each month.

b. Grace Period

Summation: The grace period is a specified time (usually 30 or 31 days) after a premium payment is due during which the policyholder can make the payment without losing coverage.

Example: David's premium is due on the first of the month, but he has a 30-day grace period. If he pays by the 30th, his coverage remains in force without interruption.

c. Automatic Premium Loan

Summation: This provision allows the insurer to automatically borrow from the policy's cash value to pay any overdue premiums, preventing the policy from lapsing.

Example: Mike has an automatic premium loan provision in his whole life policy. When he misses a premium payment, the insurer uses part of the policy's cash value to cover it, keeping the policy active.

d. Level or Flexible

Summation: Level premium policies have fixed premium amounts throughout the policy term. Flexible premium policies allow the policyholder to adjust the premium payments within certain limits.

Example: Lisa's whole life policy has level premiums of $1,000 per year. In contrast, her universal life policy allows her to vary her payments based on her financial situation.

8. Reinstatement

Summation: The reinstatement provision allows the policyholder to restore a lapsed policy within a certain period (typically up to 3-5 years) by meeting specific requirements, such as paying past-due premiums and providing evidence of insurability.

Example: Jane's policy lapsed due to non-payment, but she reinstates it within two years by paying the overdue premiums and proving she is still insurable.

9. Policy Loans, Withdrawals, Partial Surrenders

Summation: Policy loans allow the policyholder to borrow against the cash value of a permanent life insurance policy. Withdrawals and partial surrenders involve taking money directly from the cash value, potentially reducing the death benefit.

Example: Tom borrows $10,000 against his whole life policy's cash value to cover a medical expense. Alternatively, he could withdraw $10,000, reducing his policy's death benefit by that amount.

10. Nonforfeiture Options

Summation: Nonforfeiture options protect the policyholder from losing their cash value if they stop paying premiums. Options typically include cash surrender value, reduced paid-up insurance, and extended term insurance.

Example: If Mark can no longer pay premiums, he can choose to surrender his policy for its cash value, convert it to a reduced paid-up policy with a lower death benefit, or use the cash value to buy term insurance for a limited time.

11. Dividends and Dividend Options (e.g. participating, non-participating

Summation: Participating policies pay dividends to policyholders based on the insurer's financial performance. Dividend options include taking cash, reducing premiums, purchasing additional insurance, and leaving them to accumulate with interest.

Example: Emily's participating whole life policy pays her annual dividends. She can choose to take the dividends as cash, use them to reduce her premium payments, buy additional paid-up insurance, or leave them with the insurer to accumulate interest.

12. Incontestability

Summation: The incontestability clause states that after a certain period (usually two years), the insurer cannot contest or void the policy based on misstatements or omissions made by the insured in the application, except for fraud.

Example: John's life insurance policy has been in force for over two years. The insurer discovers an error in his application but cannot contest or void the policy because the incontestability period has passed.

13. Assignments

Summation: The assignment provision allows the policyholder to transfer ownership rights or the death benefit of the policy to another person or entity. This can be absolute (permanent) or collateral (temporary, usually to secure a loan).

Example: Sarah assigns her life insurance policy to her bank as collateral for a loan. Once the loan is repaid, the assignment is terminated.

14. Suicide

Summation: The suicide clause typically states that if the insured commits suicide within a specified period (usually two years) after the policy is issued, the insurer will not pay the death benefit, but will refund the premiums paid.

Example: If David commits suicide within one year of purchasing his policy, his beneficiaries receive a refund of the premiums paid, but not the death benefit. After two years, the full death benefit is payable regardless of suicide.

15. Misstatement of Age and Gender

Summation: This provision addresses the situation where the insured's age or gender is misstated on the application. The insurer will adjust the death benefit or premiums to reflect the correct age or gender.

Example: Jane's age was misstated on her policy application. Upon her death, the insurer discovers the error and adjusts the death benefit to the amount that the correct premium would have purchased for her true age.

16. Settlement Options

Summation: Settlement options refer to the various ways the death benefit can be paid to the beneficiaries, including lump-sum payments, interest-only payments, fixed period payments, fixed amount payments, and life income.

Example: Emily's policy offers several settlement options. Her beneficiaries choose to receive the death benefit in fixed monthly payments over 10 years instead of a lump sum.

17. Accelerated Death Benefits

Summation: This rider allows the policyholder to receive a portion of the death benefit early if they are diagnosed with a terminal illness or have a specified critical illness, reducing the amount payable to beneficiaries upon death.

Example: Tom is diagnosed with a terminal illness and opts to receive 50% of his $200,000 death benefit early to cover medical expenses. The remaining $100,000 is paid to his beneficiaries upon his death.

C. Policy Exclusions

1. War

Summation: The war exclusion specifies that the policy will not pay a death benefit if the insured dies as a result of war or military action.

Example: If John, a soldier, dies in combat, his beneficiaries will not receive the death benefit due to the war exclusion clause in his policy.

2. Aviation

Summation: The aviation exclusion states that the policy will not pay a death benefit if the insured dies while participating in certain types of aviation activities, often excluding commercial flights.

Example: Sarah, an amateur pilot, dies in a private plane crash. Her beneficiaries do not receive the death benefit because the policy excludes deaths resulting from private aviation activities.

3. Dangerous Occupation

Summation: The dangerous occupation exclusion denies coverage if the insured dies while engaged in a high-risk job or activity, such as mining or scuba diving.

Example: David, a commercial diver, dies during an underwater operation. His policy includes a dangerous occupation exclusion, so his beneficiaries do not receive the death benefit.

III. LIFE: COMPLETING THE APPLICATION, UNDERWRITING, AND DELIVERING THE POLICY

A. Completing the Application

1. Required Signatures

Summation: The application for life insurance requires the signatures of the applicant, the insured (if different from the applicant), and the agent. These signatures confirm that all parties have reviewed the application and agree to its terms.

Example: John applies for life insurance for his wife, Sarah. Both John (applicant) and Sarah (insured) sign the application, along with the insurance agent.

2. Changes in the Application

Summation: Any changes or corrections made to the application after it has been completed must be initialed by the applicant to confirm their agreement with the modifications.

Example: Sarah notices a mistake in her date of birth on the application. The agent corrects it, and Sarah initials the change to acknowledge the correction.

3. Consequences of Incomplete Applications

Summation: Incomplete applications can delay the underwriting process, result in additional questions, or even lead to the application being declined or returned.

Example: John submits an application without providing his medical history. The insurance company returns the application, requesting the missing information, which delays the approval process.

4. Warranties and Representations

Summation: Warranties are statements guaranteed to be true and, if found false, can void the policy. Representations are statements believed to be true to the best of the applicant's knowledge and, if found false, may lead to denial of a claim but not necessarily void the policy.

Example: Sarah represents her smoking status as non-smoker. If it is later discovered that she smokes, the insurer may deny a claim based on this misrepresentation.

5. Collecting the Initial Premium and Issuing the Receipt

Summation: The agent typically collects the initial premium payment at the time of application and issues a receipt (conditional receipt) confirming payment. This initiates temporary coverage until the application is approved or declined.

Example: John pays the initial premium when he submits his application, and the agent gives him a conditional receipt, indicating that temporary coverage is in effect.

6. Replacement

Summation: Replacement involves purchasing a new life insurance policy to replace an existing one. Agents must follow specific protocols, including providing a comparison of the old and new policies and obtaining necessary disclosures and acknowledgments.

Example: Sarah replaces her old life insurance policy with a new one that offers better benefits. The agent provides a side-by-side comparison and ensures all replacement forms are signed.

7. Disclosures at Point of Sale (e.g., HIPAA, HIV Consent)

Summation: Agents must provide various disclosures to applicants at the point of sale, including privacy notices under the Health Insurance Portability and Accountability Act (HIPAA) and, where applicable, consent forms for HIV testing.

Example: John signs a HIPAA privacy notice, ensuring his medical information is protected, and an HIV consent form if the insurer requires HIV testing as part of the underwriting process.

8. USA PATRIOT Act/Anti-Money Laundering

Summation: Life insurance companies must comply with the USA PATRIOT Act and anti-money laundering (AML) regulations. This includes verifying the identity of applicants and reporting suspicious activities.

Example: Sarah provides identification documents, and the agent verifies her identity to comply with AML regulations and prevent potential money laundering activities.

9. Gramm-Leach-Bliley Act (GLBA) Privacy

Summation: The GLBA requires financial institutions, including life insurance companies, to protect consumers' private information. This includes providing privacy notices and allowing consumers to opt out of certain information sharing.

Example: John receives a privacy notice from the insurer, explaining how his information will be used and shared. He has the option to opt out of sharing his information with non-affiliated third parties.

B. Underwriting

1. Insurable Interest

Summation: Insurable interest refers to the financial or emotional stake that the policyholder has in the insured's life. To purchase life insurance, the policyholder must demonstrate that they would suffer a financial loss or hardship if the insured were to die.

Example: John buys a life insurance policy on his business partner, David. Since John relies on David for the business's success, he has an insurable interest in David's life.

2. Medical Information and Consumer Reports

Summation: Underwriting involves evaluating the applicant's medical history and other relevant information. Insurers may request medical exams, access medical records, and obtain consumer reports to assess the applicant's health and lifestyle risks.

Example: Sarah applies for life insurance. The insurer requests her medical records, asks her to undergo a medical exam, and obtains a consumer report to determine her insurability and premium rates.

3. Fair Credit Reporting Act (FCRA)

Summation: The FCRA regulates the collection, dissemination, and use of consumer information, including credit reports. Insurers must inform applicants if their credit information is used in the underwriting process and provide them with the details of the reporting agency.

Example: David's life insurance application is partly based on his credit report. The insurer informs him of this and provides the name of the credit reporting agency that supplied the information.

4. Risk Classification

Summation: Insurers classify applicants into different risk categories based on their health, lifestyle, and other factors. Common classifications include preferred, standard, and substandard. These classifications determine the premium rates.

Example: Tom, a non-smoker with no medical issues, is classified as a preferred risk and receives lower premium rates. John, a smoker with a history of heart disease, is classified as substandard and pays higher premiums.

5. Stranger/Investor Owned Life Insurance (STOLI, IOLI)

Summation: STOLI and IOLI refer to life insurance policies taken out by third-party investors, who do not have an insurable interest in the insured's life, for speculative purposes. These arrangements are often considered illegal and unethical.

Example: Jane is approached by an investor to purchase a life insurance policy, with the investor as the beneficiary. This STOLI arrangement is not allowed, as the investor has no insurable interest in Jane's life.

C. Delivering the Policy

1. When Coverage Begins

Summation: Coverage typically begins when the policy is delivered, the initial premium is paid, and any required delivery requirements (e.g., a signed delivery receipt) are completed. Conditional coverage may begin earlier if a conditional receipt was issued.

Example: Sarah's life insurance coverage begins when she receives the policy, pays the initial premium, and signs the delivery receipt. If she had a conditional receipt, temporary coverage would have started when she paid the premium.

2. Explaining the Policy and Its Provisions, Riders, Exclusions, and Ratings to the Client

Summation: It is important for the agent to thoroughly explain the policy's details, including the death benefit, premiums, policy provisions, riders, exclusions, and any ratings that affect the premium. This ensures the client understands their coverage and how it works.

Example: When delivering the policy to Tom, the agent reviews the death benefit, premium amounts, grace period, waiver of premium rider, suicide clause, and the impact of his substandard rating on his premiums. Tom leaves with a clear understanding of his policy.

D. Contract Law

1. Elements of a Contract

a. Consideration

Summation: Consideration is the value exchanged between the parties in a contract. In an insurance contract, the policyholder's consideration is the premium payment, and the insurer's consideration is the promise to pay the death benefit or provide coverage.

Example: John pays monthly premiums (consideration) for his life insurance policy, and the insurer promises to pay a $250,000 death benefit (consideration) to his beneficiaries.

b. Offer and Acceptance

Summation: Offer and acceptance are critical components of forming a contract. The applicant makes an offer by submitting an application and paying the initial premium. The insurer accepts the offer by issuing the policy.

Example: Sarah submits an application for life insurance and pays the initial premium (offer). The insurer reviews the application, approves it, and issues the policy (acceptance).

c. Competent Parties

Summation: Competent parties mean that both parties entering the contract must have the legal capacity to do so. This typically means they must be of legal age, mentally sound, and not under duress or influence.

Example: David, who is 30 years old and of sound mind, applies for a life insurance policy. Both David and the insurance company are considered competent parties, making the contract valid.

d. Legal Purpose

Summation: The contract must have a legal purpose, meaning it must be for a lawful reason and not against public policy. In insurance, this means the policy must be for legitimate coverage and not for illegal activities.

Example: Mark purchases a life insurance policy to provide financial security for his family, which is a legal purpose. A policy intended to support illegal activities would not be valid.

2. Unique Aspects of the Insurance Contract

a. Conditional

Summation: An insurance contract is conditional because the insurer's obligation to pay is contingent upon the occurrence of a specified event (e.g., the death of the insured) and the policyholder's compliance with the contract terms.

Example: Jane's life insurance policy will pay out the death benefit if she dies while the policy is active and all premium payments have been made.

b. Unilateral

Summation: An insurance contract is unilateral, meaning only one party (the insurer) makes a legally enforceable promise. The policyholder is not obligated to pay premiums but loses coverage if they don't.

Example: Tom's insurer is obligated to pay the death benefit upon his death, provided he has paid his premiums. Tom, however, can stop paying premiums at any time, which will result in the loss of coverage.

c. Adhesion

Summation: An insurance contract is a contract of adhesion, meaning it is drafted by one party (the insurer) and presented on a "take-it-or-leave-it" basis to the other party (the policyholder), who has little to no ability to negotiate terms.

Example: When Sarah applies for life insurance, she must accept the terms and conditions set by the insurer. She cannot negotiate the policy terms but can choose whether to accept or reject the offer.

d. Aleatory

Summation: An insurance contract is aleatory, meaning the performance of one party depends on the occurrence of an uncertain event. The value exchanged may not be equal, as one party may receive significantly more than they paid in premiums.

Example: John pays $500 annually for his life insurance policy. If he dies after paying only one year's premium, his beneficiaries receive the full $200,000 death benefit, which is much more than the premiums paid.

IV. LIFE: RETIREMENT AND OTHER INSURANCE CONCEPTS

A. Third-Party Ownership

Summation: Third-party ownership refers to a life insurance policy where the owner is someone other than the insured. This is common in business and estate planning.

Example: John buys a life insurance policy on his business partner, David. John is the owner and beneficiary, while David is the insured.

B. Life Settlements

Summation: A life settlement involves selling an existing life insurance policy to a third party for a lump sum that is more than the cash surrender value but less than the death benefit.

Example: Sarah, an elderly policyholder, sells her $500,000 life insurance policy to an investor for $150,000. The investor becomes the new owner and beneficiary and will receive the death benefit upon Sarah's death.

C. Group Life Insurance

1. Conversion Privilege

Summation: The conversion privilege allows an insured person to convert their group life insurance coverage to an individual policy without providing evidence of insurability, usually within a specified period after leaving the group.

Example: Emily leaves her job where she had group life insurance. She converts her group coverage to an individual policy within 30 days, ensuring continued protection.

2. Contributory vs. Noncontributory

Summation: Contributory plans require employees to pay a portion of the premium, while noncontributory plans are fully paid by the employer.

Example: In a contributory plan, Sarah pays part of her group life insurance premium through payroll deductions. In a noncontributory plan, her employer covers the entire premium cost.

D. Retirement Plans

1. Qualified Plans

Summation: Qualified retirement plans meet IRS requirements and offer tax advantages, such as tax-deferred growth. Examples include 401(k) and pension plans.

Example: John contributes to his company's 401(k) plan, receiving tax benefits and employer matching contributions.

2. Nonqualified Plans

Summation: Nonqualified retirement plans do not meet IRS requirements for tax advantages and are typically used to provide additional benefits to key employees. Examples include deferred compensation plans.

Example: Sarah has a nonqualified deferred compensation plan, allowing her to defer part of her salary until retirement, without immediate tax advantages.

E. Life Insurance Needs Analysis/Suitability

1. Personal Insurance Needs

Summation: Personal insurance needs analysis evaluates an individual's life insurance needs based on factors such as income, debts, and family obligations to determine the appropriate coverage amount.

Example: Tom assesses his income, mortgage, and children's future education costs to determine he needs a $500,000 life insurance policy.

2. Business Insurance Needs

Summation: Business insurance needs analysis evaluates a company's insurance requirements to protect against financial loss due to the death of key personnel or other risks.
Example:

a. Key Person

Summation: Key person insurance provides coverage for a company against the financial loss that may occur due to the death of a key employee whose skills and knowledge are vital to the business.

Example: Jane's company purchases a key person insurance policy on her, ensuring the business receives funds to cover losses and find a replacement if she were to pass away.

b. Buy-Sell

Summation: A buy-sell agreement funded by life insurance ensures that the surviving owners can buy out the deceased owner's share of the business, providing liquidity and business continuity.

Example: Mark and his partner have a buy-sell agreement, each owning life insurance on the other. If one dies, the policy proceeds are used to buy out the deceased's share.

F. Social Security Benefits

Summation: Social Security provides retirement, disability, and survivor benefits to eligible individuals based on their earnings history and contributions to the Social Security system.

Example: Emily receives Social Security retirement benefits based on her work history after reaching the eligible retirement age.

G. Tax Treatment of Insurance Premiums, Proceeds, Dividends

1. Individual Life

Summation: Premiums for individual life insurance are generally not tax-deductible. The death benefit is usually received tax-free by beneficiaries, and dividends (if any) are not taxable but can be used to reduce premiums or purchase additional coverage.

Example: Tom's beneficiaries receive his $250,000 death benefit tax-free, and he uses dividends to buy additional paid-up insurance.

2. Group Life

Summation: Premiums paid by an employer for group life insurance are tax-deductible for the employer. Coverage up to $50,000 is tax-free for the employee, but any excess coverage is considered taxable income.

Example: Sarah’s employer pays for her $100,000 group life coverage. The first $50,000 is tax-free, but the remaining $50,000 is reported as taxable income.

3. Modified Endowment Contracts (MECs)

Summation: MECs are life insurance contracts that fail to meet the IRS's 7-pay test, losing some tax advantages. Withdrawals and loans are taxed as income first (LIFO) and may incur penalties if taken before age 59½.

Example: David withdraws funds from his MEC policy. The withdrawals are taxed as ordinary income up to the amount that exceeds his basis, and he incurs a 10% penalty because he is under 59½.

V. ACCIDENT & SICKNESS: TYPES OF POLICIES

A. Disability Income

1. Individual Disability Income Policy

Description: Provides income replacement if the insured becomes unable to work due to a disability.

Example: A policy that pays 60% of your salary if you are unable to work due to an illness or injury.

2. Business Overhead Expense Policy

Description: Covers business expenses such as rent, utilities, and employee salaries if the business owner becomes disabled.

Example: A policy that pays $5,000 per month to cover office rent and utilities while the owner is recovering from surgery.

3. Business Disability Buyout Policy

Description: Provides funds to buy out a disabled partner's share of the business.

Example: A policy that pays $500,000 to buy out a partner who can no longer work due to a severe accident.

4. Group Disability Income Policy

Description: Offered by employers, this policy provides disability income benefits to employees.

Example: An employer-provided policy that pays 50% of an employee's salary if they are unable to work due to a long-term illness.

5. Key Employee Policy

Description: Provides benefits to a business if a key employee becomes disabled.

Example: A policy that pays $100,000 to a company if their top sales executive is unable to work for six months due to a disability.

B. Accidental Death and Dismemberment

Description: Provides benefits if the insured dies or loses a limb due to an accident.

Example: A policy that pays $200,000 for accidental death and $100,000 for the loss of a limb.

C. Medical Expense Insurance

1. Basic Hospital, Medical, and Surgical Policies

Description: Covers basic hospital, medical, and surgical expenses.

Example: A policy that covers hospital stays, surgeries, and doctor visits

2. Major Medical Policies

Description: Provides comprehensive coverage for major medical expenses.

Example: A policy that covers extensive medical treatments, including surgeries and hospital stays.

3. Health Maintenance Organizations (HMOs)

Description: Provides health services through a network of providers for a fixed annual fee.

Example: An HMO plan that requires members to choose a primary care physician and get referrals for specialists.

4. Preferred Provider Organizations (PPOs)

Description: Offers more flexibility in choosing healthcare providers and does not require referrals.

Example: A PPO plan that allows members to see any doctor without a referral but offers lower costs for in-network providers.

5. Point of Service (POS) Plans

Description: Combines features of HMOs and PPOs, requiring a primary care physician but allowing out-of-network care at a higher cost.

Example: A POS plan that covers out-of-network visits but at a higher copayment.

6. Flexible Spending Accounts (FSAs)

Description: Allows employees to set aside pre-tax dollars for medical expenses.

Example: An FSA that lets employees use pre-tax dollars for prescriptions and doctor visits.

7. High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)

Description: HDHPs have higher deductibles but lower premiums, and HSAs allow pre-tax savings for medical expenses.

Example: An HDHP paired with an HSA that lets employees save pre-tax dollars for future medical expenses.

8. Health Reimbursement Accounts (HRAs)

Description: Employer-funded accounts that reimburse employees for medical expenses.

Example: An HRA that reimburses employees for out-of-pocket medical costs.

D. Medicare Supplement Policies

Description: Also known as Medigap, these policies cover costs not covered by Original Medicare.

Example: A Medigap Plan G that covers Medicare Part A and B coinsurance and deductibles.

Open Enrollment

Insurers may not deny the issuance of any Medicare supplement policy or discriminate in the pricing of a policy because of the health status, claims experience, or receipt of health care, if an application for a policy has been submitted prior to or within 6 months beginning with the first day of the first month in which the applicant is both: age 65 or older, and is enrolled for benefits under Medicare Part B.

Free Look

Medicare supplement policies must have a notice prominently printed on the first page stating that the policyholder are entitled for a 30-day free-look period, during which the policy can be return with a full refund of premium, if the policyholder is not satisfied with the policy for any reason.

Standards for Marketing

Medicare Supplement policies that are advertised or marketed in this state may not contain limitations or exclusions of coverage, except those permitted by pre-existing condition clauses, that are more restrictive than Medicare. Policies may not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or conditions.

No supplement policy or certificate in force may contain benefits that duplicate benefits provided by Medicare.

Twisting, high-pressure tactics, and cold lead advertising are prohibited. The terms Medicare Supplement, Medigap, Medicare Wrap-Around, and similar words may not be used unless the policy is in full compliance of the law.

Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

A Medicare supplement policy or certificate may NOT be issued to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

On or before March 1 of each year, issuers must report the policy number and date of issuance for every individual resident of this state for which the issuer has more than one Medicare supplement policy or certificate in force.

Permitted Compensation

Insurers may provide commissions to insurance producers for the sale of Medicare supplement policies only if the first-year commission does not exceed 200% of the commission or other compensation paid for the sale or servicing of policy in the second year. Commissions provided in subsequent (renewal) years must be the same as that in the second year and must be provided for no fewer than 5 renewal years.

Replacement

Application forms for Medicare supplement insurance policies must include a question to determine if the applicant intends to replace any existing accident and sickness policy with the Medicare supplement policy. If that is so, the insurer or its agent must furnish the applicant with a Notice Regarding Replacement prior to issuing or delivering the Medicare supplement policy.

Replacement notices must be signed by the applicant and the agent. Each party must retain a signed copy.

E. Group Insurance

1. Differences Between Individual and Group Contracts

Description: Group insurance is provided to a group of people under a single contract, usually through an employer.

Example: An employer-provided health insurance plan versus an individually purchased plan.

2. General Characteristics

Description: Group insurance typically offers lower premiums and simplified underwriting.
Example: A group life insurance policy that does not require medical exams for coverage.

3. COBRA

Description: Allows employees to continue their group health insurance coverage after leaving employment.
Example: An employee who continues their health insurance coverage for 18 months after leaving a job.

F. Individual/Group Long Term Care (LTC)

1. Eligibility

Description: Typically requires the inability to perform at least two activities of daily living (ADLs).

Example: A policyholder who needs help with bathing and dressing qualifies for benefits.

2. Levels of Care

Description: Includes home care, assisted living, and nursing home care.
Example: A policy that covers in-home care services and nursing home stays.

G. Other Policies

1. Dental

Description: Covers dental care expenses such as cleanings, fillings, and orthodontics.

Example: A policy that covers 80% of the cost of dental cleanings and fillings.

2. Vision

Description: Vision insurance covers routine eye care, including eye exams, glasses, and contact lenses.

Example: A policy that covers an annual eye exam and provides a $150 allowance for glasses or contact lenses.

3. Cancer Insurance

Description: Cancer insurance provides a lump-sum benefit upon diagnosis of cancer, helping to cover treatment costs and other expenses.

Example: A policy that pays $50,000 upon diagnosis of cancer, which can be used for medical bills, travel, or household expenses.

4. Critical Illness or Specified Disease Insurance

Description: This insurance provides a lump-sum payment if the insured is diagnosed with a specified critical illness, such as heart attack, stroke, or cancer.

Example: A policy that pays $25,000 upon diagnosis of a heart attack, which can be used for medical and non-medical expenses.

5. Worksite (Employer-Sponsored) Insurance

Description: These are voluntary benefits offered by employers, including health, dental, vision, and life insurance, often at reduced rates.

Example: An employer-sponsored plan that includes health, dental, and vision insurance, with premiums partially paid by the employer.

6. Hospital Indemnity Insurance

Description: Provides a fixed daily, weekly, or monthly benefit if the insured is hospitalized, helping to cover out-of-pocket expenses.

Example: A policy that pays $200 per day for each day the insured is hospitalized.

7. Short-Term Medical Insurance

Description: Provides temporary health coverage for a limited period, typically up to 12 months, for individuals between jobs or waiting for other coverage.

Example: A policy that covers emergency room visits and hospital stays for up to six months.

8. Accident Insurance

Description: Provides a lump-sum benefit for injuries resulting from accidents, covering medical and non-medical expenses.

Example: A policy that pays $5,000 for a broken leg resulting from a car accident.

VI. ACCIDENT AND SICKNESS: POLICY PROVISIONS, CLAUSES, AND RIDERS

A. Mandatory and Optional Provisions

1. Entire Contract

Description: The policy and the application constitute the entire contract between the insurer and the insured.

Example: Ensures that no external documents can alter the terms of the policy.

2. Time Limit on Certain Defenses (Incontestable)

Description: Limits the time during which the insurer can contest the policy based on misstatements in the application.

Example: Typically, after two years, the insurer cannot contest the policy except for fraud.

3. **Grace Period**

Description: A period after the premium due date during which the policy remains in force without penalty.

Example: A 30-day grace period for premium payments.

4. **Reinstatement**

Description: Allows a lapsed policy to be reinstated within a certain period, usually with proof of insurability and payment of back premiums.

Example: A policy that can be reinstated within five years of lapse.

5. **Notice of Claim**

Description: The insured must notify the insurer of a claim within a specified time period.

Example: A requirement to notify the insurer within 20 days of a loss.

6. **Claim Forms**

Description: The insurer must provide claim forms to the insured within a specified time period after receiving notice of a claim.

Example: Insurer must send claim forms within 15 days of notification.

7. **Proof of Loss**

Description: The insured must provide proof of loss within a specified time period.

Example: Proof of loss must be submitted within 90 days of the loss.

8. **Time of Payment of Claims**

Description: Specifies the time period within which the insurer must pay claims after receiving proof of loss.

Example: Claims must be paid within 60 days of receiving proof of loss.

9. **Payment of Claims**

Description: Specifies to whom the claims are payable.

Example: Claims are payable to the insured or the beneficiary.

10. **Physical Examination and Autopsy**

Description: Allows the insurer to require a physical examination or autopsy to determine the cause of death.

Example: Insurer may require an autopsy in case of accidental death.

11. Legal Actions

Description: Limits the time period within which the insured can bring legal action against the insurer.

Example: Legal action must be brought within three years of the claim denial.

12. Change of Beneficiary

Description: Allows the policyholder to change the beneficiary designation.

Example: Policyholder can change the beneficiary by submitting a written request to the insurer.

13. Misstatement of Age or Gender

Description: Adjusts the benefits if the insured's age or gender was misstated on the application.

Example: Benefits are adjusted to what the premiums would have purchased at the correct age or gender.

14. Change of Occupation

Description: Adjusts the premium or benefits if the insured changes to a more hazardous occupation.

Example: Premiums are increased if the insured changes from an office job to a construction job.

15. Illegal Occupation

Description: Excludes coverage if the insured is injured or dies while committing an illegal act.

Example: No benefits

16. Relation of Earnings to Insurance

Description: This provision allows the insurer to limit the insured's benefits based on their average monthly earnings for the previous two years[1].

Example: If an insured person has a disability policy that pays $5,000 per month but their average monthly earnings were only $3,000, the insurer may reduce the benefit to $3,000.

B. Other Provisions and Clauses

1. Insuring Clause

Description: The insuring clause is the part of the insurance policy that outlines the insurer's promise to pay benefits upon the occurrence of a specified event, such as the death of the insured[2].

Example: In a life insurance policy, the insuring clause states that the insurer will pay a death benefit to the beneficiary upon the death of the insured.

2. Free Look

Description: The free look provision allows the policyholder to review the policy for a specified period (usually 10 days) and return it for a full refund if they are not satisfied[1].

Example: A policyholder receives their new life insurance policy and decides within 10 days that it does not meet their needs. They return the policy and receive a full refund of the premium paid.

3. Consideration Clause

Description: The consideration clause specifies the amount and frequency of premium payments that the policyholder must make to keep the insurance policy in force[3].

Example: A life insurance policy might require monthly premium payments of $100 to maintain coverage.

4. Probationary Period

Description: The probationary period is the time period that must pass before coverage for certain conditions begins[4].

Example: A health insurance policy might have a 30-day probationary period for coverage of preexisting conditions.

5. Elimination Period

Description: The elimination period is the waiting period between the onset of a disability and the time benefits begin to be paid[5].

Example: A disability insurance policy might have a 90-day elimination period, meaning benefits start 90 days after the insured becomes disabled.

6. Waiver of Premium

Description: The waiver of premium rider allows the policyholder to stop paying premiums if they become disabled and are unable to work[6].

Example: If a policyholder becomes permanently disabled, the waiver of premium rider would allow them to maintain their life insurance coverage without paying premiums.

7. Exclusions and Limitations

Description: Exclusions and limitations are specific conditions or circumstances for which the policy will not provide benefits[7].

Example: A life insurance policy might exclude coverage for death resulting from suicide within the first two years of the policy.

8. Preexisting Conditions

Description: A preexisting condition is any health issue or condition that existed before the insurance coverage began[8].

Example: If an individual has diabetes before applying for health insurance, it is considered a preexisting condition.

9. Coinsurance

Description: Coinsurance is the percentage of costs that the insured must pay after the deductible has been met[3].

Example: If a health insurance policy has an 80/20 coinsurance clause, the insurer pays 80% of covered expenses, and the insured pays 20%.

10. Deductibles

Description: A deductible is the amount the insured must pay out-of-pocket before the insurance company begins to pay for covered expenses[3].

Example: A health insurance policy might have a $1,000 deductible, meaning the insured pays the first $1,000 of covered expenses each year.

11. Eligible Expenses

Description: Eligible expenses are medical costs that are covered by the insurance policy[3].

Example: Eligible expenses under a health insurance policy might include hospital stays, surgeries, and prescription medications.

12. Copayments

Description: A copayment is a fixed amount the insured must pay for a covered service at the time of service[3].

Example: A health insurance policy might require a $20 copayment for each doctor's visit.

13. Pre-authorizations and Prior Approval Requirements

Description: Pre-authorizations and prior approval requirements are processes that require the insured to obtain approval from the insurer before receiving certain services[3].

Example: A health insurance policy might require pre-authorization for elective surgeries.

14. Usual, Reasonable, and Customary (URC) Charges

Description: URC charges are the amounts typically charged for a particular service in a specific geographic area[3].

Example: If a doctor charges $200 for a service, but the URC charge is $150, the insurance company may only pay $150.

15. Lifetime, Annual, or Per Cause Maximum Benefit Limits

Description: These limits cap the amount the insurer will pay over the lifetime of the policy, annually, or per cause[3].

Example: A health insurance policy might have a $1 million lifetime maximum benefit limit, meaning the insurer will not pay more than $1 million over the life of the policy.

D. Riders

1. Impairment/Exclusions

Description: Impairment or exclusion riders are provisions in an insurance policy that exclude coverage for certain conditions or activities that pose a higher risk[1].

Example: If an individual has a preexisting heart condition, an impairment rider might exclude coverage for any medical expenses related to heart issues.

2. Guaranteed Insurability

Description: The guaranteed insurability rider allows the policyholder to purchase additional insurance coverage at specified times without undergoing a new medical examination[2].

Example: A policyholder can increase their life insurance coverage when they reach certain ages or life events, such as marriage or the birth of a child, without proving insurability.

3. Future Increase Option

Description: The future increase option rider allows the policyholder to increase their coverage amount at future dates without providing evidence of insurability[1].

Example: A policyholder can opt to increase their disability insurance coverage every few years to keep up with inflation or salary increases.

E. Rights of Renewability

1. Noncancelable

Description: A noncancelable policy guarantees that the insurer cannot cancel the policy or increase the premiums as long as the policyholder continues to pay the premiums[1].

Example: A noncancelable disability insurance policy ensures that the policyholder's coverage and premium rates remain unchanged until the policy expires.

2. Cancelable

Description: A cancelable policy allows the insurer to cancel the policy at any time, usually with a notice period[1].

Example: A health insurance policy that can be canceled by the insurer with a 30-day notice period.

3. Guaranteed Renewable

Description: A guaranteed renewable policy ensures that the policyholder can renew the policy without providing evidence of insurability, although the insurer can increase the premiums[1].

Example: A health insurance policy that the policyholder can renew each year regardless of their health status, but the insurer may adjust the premium rates.

VII. SOCIAL INSURANCE

A. Medicare (Parts A, B, C, D)

Description: Medicare is a federal health insurance program primarily for individuals aged 65 and older, but also for some younger people with disabilities. It has four parts:

- **Part A**: Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care[1].
- **Part B**: Covers certain doctors' services, outpatient care, medical supplies, and preventive services[1].
- **Part C (Medicare Advantage)**: An alternative to Original Medicare that includes Parts A and B and often Part D, offered by private companies approved by Medicare[2].
- **Part D**: Provides prescription drug coverage[2].

- **Example**: An individual turning 65 enrolls in Medicare Part A and Part B, and then chooses a Medicare Advantage plan (Part C) that includes prescription drug coverage (Part D).
- **More Information**: Medicare Parts A, B, C, and D - Medicare.org

B. Medicaid

Description: Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. It also offers benefits not normally covered by Medicare, like nursing home care and personal care services[3].

Example: A low-income family with children may qualify for Medicaid to cover their healthcare costs.

More Information: Medicaid - Medicaid.gov

C. Social Security Benefits

Description: Social Security provides financial assistance to retirees, disabled individuals, and survivors of deceased workers. Benefits include retirement income, disability income, and survivor benefits[4].

Example: A retired worker who has paid into Social Security for at least 10 years receives monthly retirement benefits starting at age 62 or later.

More Information: Social Security Benefits - SSA.gov

VIII. ACCIDENT AND SICKNESS: OTHER INSURANCE CONCEPTS

A. Total, Partial, Recurrent, and Residual Disability

Description: These terms refer to different levels and types of disability coverage:

- **Total Disability**: The inability to perform any of the duties of one's occupation[5].
- **Partial Disability**: The inability to perform some, but not all, of the duties of one's occupation[5].
- **Recurrent Disability**: A disability that recurs after the insured has returned to work[5].
- **Residual Disability**: Provides benefits if the insured can work but at a reduced capacity, resulting in a loss of income[5].
- **Example**: A surgeon who injures their hand and can no longer perform surgeries may receive total disability benefits. If they can still perform some tasks but not all, they may receive partial or residual disability benefits.
- **More Information**: Residual or Partial Disability Benefits - Maddox Firm

B. Owner's Rights

Description: The policy owner has the legal rights to make decisions about the policy, including naming beneficiaries, borrowing against the policy, and transferring ownership[6].

Example: The owner of a life insurance policy can change the beneficiary from one family member to another.

More Information: Ownership Clause in Life Insurance - LiveWell

C. Dependent Children Benefits

Description: Health insurance plans often cover dependent children up to a certain age, typically 26, under the Affordable Care Act[7].

Example: A 24-year-old college student remains covered under their parent's health insurance plan.

More Information: Dependent Child Coverage - HealthCare.gov

D. Primary and Contingent Beneficiaries

Description: A primary beneficiary is the first in line to receive the death benefit from an insurance policy. A contingent beneficiary receives the benefit if the primary beneficiary is unable to[8].

Example: A policyholder names their spouse as the primary beneficiary and their children as contingent beneficiaries.

More Information: Primary vs. Contingent Beneficiary - Cake

E. Modes of Premium Payments

Description: The frequency with which premium payments are made, such as monthly, quarterly, semi-annually, or annually[9].

Example: A policyholder chooses to pay their life insurance premium monthly instead of annually.

More Information: Mode of Premium - Investopedia

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

Description: Coordination of benefits ensures that when a person is covered by multiple insurance plans, the benefits are coordinated to avoid over-insurance or duplication of benefits[10].

Example: If a person has two health insurance plans, one plan will be designated as primary and the other as secondary to ensure the total benefits do not exceed the actual medical expenses.

More Information: Coordination of Benefits - ADA

G. Occupational vs. Nonoccupational

Description: Occupational insurance covers injuries or illnesses that occur at work, while nonoccupational insurance covers those that occur outside of work[11].

Example: Workers' compensation is an example of occupational insurance, while a standard health insurance policy may provide nonoccupational coverage.

More Information: Occupational vs. Non-Occupational Insurance - Study.com

H. Tax Treatment of Premiums and Proceeds of Insurance Contracts (e.g., disability income and medical expenses, etc.)

Description: The tax treatment of insurance premiums and proceeds varies depending on the type of insurance and the specific circumstances. Generally, life insurance death benefits are tax-free, while disability income benefits may be taxable[4].

Example: Life insurance death benefits received by beneficiaries are typically not subject to federal income tax.

More Information: Tax Treatment of Insurance - IRS.gov

I. Managed Care

Description: Managed care plans are health insurance plans that contract with healthcare providers and medical facilities to provide care for members at reduced costs. These plans include HMOs, PPOs, and POS plans.

Example: An HMO plan requires members to choose a primary care physician and get referrals to see specialists.

J. Workers Compensation

Description: Workers' compensation is a form of insurance that provides wage replacement and medical benefits to employees injured in the course of employment[4].

Example: An employee who is injured on the job receives medical treatment and a portion of their lost wages through workers' compensation insurance.

More Information: Workers Compensation - U.S. Department of Labor

K. Subrogation

Description: Subrogation is the process by which an insurance company seeks reimbursement from the responsible party for a claim it has already paid[4].

Example: If an insurance company pays for damages caused by a third party, it may seek to recover those costs from the third party.

More Information: Subrogation – Investopedia

IX. ACCIDENT AND SICKNESS: FIELD UNDERWRITING PROCEDURES

A. Completing the Application

Description: Completing a life insurance application involves gathering personal, financial, and medical information about the applicant. This information helps the insurer assess the risk and determine the premium rates.

Example: An applicant provides details about their age, occupation, health history, and lifestyle habits.

More Information: MarketWatch Guide to Filling Out a Life Insurance Application

B. Explaining Sources of Insurability and HIPAA Privacy

Description: Insurers use various sources to verify an applicant's insurability, such as the Medical Information Bureau (MIB) report and credit reports. The Health Insurance Portability and Accountability Act (HIPAA) ensures the privacy and security of health information.

Example: An insurer may request an attending physician's statement (APS) to get detailed medical history.

More Information: HIPAA Privacy Rule Summary

C. Initial Premium Payment and Receipt and Consequences of the Receipt

Description: The initial premium payment is often required when submitting the application. A receipt, such as a conditional receipt, may be issued, which can provide temporary coverage until the policy is approved or denied.

Example: An applicant pays the first premium and receives a conditional receipt, which provides coverage if they meet the underwriting requirements.

More Information: Investopedia on Conditional Binding Receipt

D. Submitting Application (and Initial Premium if Collected) to Company for Underwriting

Description: After completing the application and collecting the initial premium, the application is submitted to the insurance company for underwriting. The underwriter assesses the risk and decides whether to approve the policy.

Example: An agent submits the application and initial premium to the insurer, who then reviews the applicant's medical records and other information.

More Information: The Zebra on Life Insurance Underwriting

E. Policy Delivery

Description: Once the policy is approved, it is delivered to the policyholder. The delivery date is important as it marks the start of the coverage and the free-look period.

Example: An agent delivers the policy to the policyholder, who then has a certain period to review and return it if they are not satisfied.

More Information: Principal Financial Group on Policy Delivery

F. Explaining Policy and Its Provisions, Riders, Exclusions, and Ratings to Clients

Description: The agent explains the details of the policy, including its provisions, riders (additional benefits), exclusions (what is not covered), and ratings (premium adjustments based on risk).

Example: An agent explains to a client that their policy includes an accidental death rider but excludes coverage for certain high-risk activities.

G. Replacement

Description: Replacement involves canceling an existing policy and purchasing a new one. This process is regulated to protect consumers from unnecessary replacements that may not be in their best interest.

Example: A policyholder replaces their current policy with a new one that offers better coverage and lower premiums.

More Information: Investopedia on Life Insurance Replacement

H. Contract Law

1. Elements of a Contract

Description: A valid contract must have an offer and acceptance, consideration, competent parties, and a legal purpose.

Example: An insurance policy is a contract where the insurer promises to pay a death benefit in exchange for premium payments.

More Information: Insuranceopedia on Elements of an Insurance Contract

2. Insurable Interest

Description: Insurable interest means the policyholder must have a legitimate interest in the continued life of the insured.

Example: A spouse has an insurable interest in their partner's life.

More Information: ThinkAdvisor on Insurable Interest

3. Warranties and Representations

Description: Warranties are statements guaranteed to be true, while representations are statements believed to be true to the best of the applicant's knowledge.

Example: An applicant states they do not smoke (representation) and guarantees their age is correct (warranty).

More Information: Insuranceopedia on Warranties and Representations

4. Unique Aspects of the Insurance Contract

Description: Insurance contracts have unique characteristics such as being conditional, unilateral, contracts of adhesion, and aleatory.

Example: An insurance contract is unilateral because only the insurer makes a legally enforceable promise.

More Information: Henssler Financial on Life Insurance Contractual Obligations

Unique Aspects of the Insurance Contract

a. Conditional

Description: An insurance contract is conditional because the insurer's obligation to pay a claim is dependent on the occurrence of a specified event and the fulfillment of certain conditions by the insured.

Example: If a policyholder files a claim for a car accident, the insurer will only pay if the accident is covered under the policy and the policyholder has met all conditions, such as paying premiums and reporting the accident promptly.

b. Unilateral

Description: A unilateral contract is one in which only one party, the insurer, makes a legally enforceable promise. The insured does not make any promises but must fulfill certain conditions, such as paying premiums, to keep the policy in force.

Example: In a life insurance policy, the insurer promises to pay a death benefit if the insured dies during the policy term, provided the premiums have been paid.

More Information: Unilateral Contracts in Insurance

c. Adhesion

Description: An adhesion contract is one drafted by the insurer, where the insured has little to no ability to negotiate the terms. The insured must accept the contract as is or not at all.

Example: When purchasing a standard auto insurance policy, the policyholder must accept the terms set by the insurer without negotiation.

More Information: Adhesion Insurance Contract

d. Aleatory

Description: An aleatory contract is one where the performance of one or both parties is dependent on an uncertain event. In insurance, this means the insurer only pays out if a specified event, such as a loss or death, occurs.

Example: A homeowner's insurance policy is aleatory because the insurer only pays if there is damage to the home due to a covered peril, like a fire.

More Information: Aleatory Contract in Insurance

X. GEORGIA LAWS, RULES AND REGULATIONS PERTINENT TO LIFE, ACCIDENT & SICKNESS INSURANCE

A. Insurance Department and Commissioner

1. Broad Powers and Duties

The Georgia Insurance Commissioner has broad powers and duties, including regulating insurance companies, ensuring compliance with state laws, and protecting consumers. The Commissioner can issue rules and regulations, conduct investigations, and enforce penalties.

Example: The Commissioner can revoke an insurance company's license if it violates state laws.

More Information: Georgia Code § 33-2-1 through 6; 9 through 32

2. Examination of Records

The Commissioner has the authority to examine the records of insurance companies to ensure compliance with state laws. This includes reviewing financial statements, policyholder records, and other relevant documents.

Example: An insurance company may be required to submit its financial records for examination to verify solvency.

More Information: Georgia Code § 33-2-10 through 13

3. Investigations/Notice of Hearing

The Commissioner can conduct investigations into potential violations of insurance laws and issue notices of hearings to address these issues.

Example: If an insurance company is suspected of fraud, the Commissioner can investigate and hold a hearing to determine the appropriate action.

If, after a hearing, the Commissioner determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, the Commissioner will send to the person a written copy of the violations and a **cease and desist order** requiring the person to stop engaging in such method of competition, act, practice, or violation. The Commissioner may also impose one or more of the following penalties:

- A monetary fine up to $1,000 for each violation, or $5,000 for willful violations, where a person knew or reasonably should have known they were in violation;
- Suspension or revocation of the person's license if the person has knowingly committed the violation; or

Any other relief as is reasonable and appropriate.

More Information: Georgia Code § 33-6-6

4. Penalties

The Commissioner can impose penalties on insurance companies and agents for violations of state laws. Penalties can include fines, license suspension, or revocation.

Example: An insurance agent found guilty of fraud may face fines and have their license revoked.

More Information: Georgia Code § 33-6-9

B. General Insurance Definitions

1. Domestic, Foreign, and Alien

- **Domestic Insurer**: An insurer formed under the laws of Georgia.
- **Foreign Insurer**: An insurer formed under the laws of another state within the U.S.
- **Alien Insurer**: An insurer formed under the laws of a country other than the U.S.

Example: A Georgia-based insurance company is a domestic insurer in Georgia but a foreign insurer in Florida.

More Information: Georgia Code § 33-3-1

2. Stock and Mutual

- **Stock Insurance Company**: Owned by shareholders who may receive dividends.
- **Mutual Insurance Company**: Owned by policyholders who may receive dividends.

Example: State Farm is a mutual insurance company, while Allstate is a stock insurance company.

More Information: Georgia Code § 33-14-2

3. Authorized/Unauthorized and Certificate of Authority

- **Authorized Insurer**: An insurer with a certificate of authority to operate in Georgia.
- **Unauthorized Insurer**: An insurer without a certificate of authority.

Example: An insurer must obtain a certificate of authority from the Commissioner to legally sell insurance in Georgia.

More Information: Georgia Code § 33-3-2 through 5; 33-3-13 through 30

4. Insurance Transaction / Transacting Business

Transacting insurance includes activities such as soliciting, negotiating, and selling insurance policies.

Example: An insurance agent meeting with a client to discuss policy options is transacting insurance.

More Information: Georgia Code § 33-1-2

C. Licensing of Agents & Counselors

1. Agent Responsibility

Insurance agents must act in the best interest of their clients, provide accurate information, and comply with state laws.

Example: An agent must disclose all policy details to a client and ensure they understand the terms.

More Information: Agents & Agency Licensing

2. License Maintenance

Agents must renew their licenses periodically and complete continuing education requirements.

Example: An insurance agent must complete a certain number of continuing education hours every two years to maintain their license.

More Information: Agent Licensing & Renewals

3. License Revocation, Suspension, Denial, or Refusal to Renew

The Commissioner can revoke, suspend, deny, or refuse to renew an agent's license for violations of state laws.

Example: An agent found guilty of unethical practices may have their license revoked.

More Information: Georgia Code Title 33, Chapter 23

4. Temporary License

A temporary license may be issued to an individual under certain circumstances, such as the death of an agent.

Example: A temporary license may be granted to a spouse of a deceased agent to continue the business.

More Information: Temporary License Information

5. Nonresident License

Nonresident licenses are issued to agents who are licensed in another state but wish to operate in Georgia.

Example: An agent licensed in Florida can apply for a nonresident license to sell insurance in Georgia.

More Information: Nonresident License Information

6. Counselor License

Insurance counselors provide advice on insurance policies and must be licensed to do so.

Example: A licensed insurance counselor can help clients choose the best insurance policies for their needs.

More Information: Counselor License Information

D. Unfair Trade Practices

1. Rebating

Rebating involves returning a portion of the premium or the agent's commission to the insured or offering any other inducement not specified in the policy.

Example: An agent offers a client a portion of their commission as a rebate to encourage them to purchase a policy.

It is unlawful to pay, offer or accept any of the following as an **inducement** to buy insurance:

- Any special favor or advantage in dividends or benefits;
- Any stocks, bonds, securities, or accrued dividends or profits; or
- Anything of value not specified in the insurance contract.

In Georgia, the regulation regarding unlawful inducement does not apply to the insurer's advertising or promotional programs in which insureds or prospective insureds may be given articles of merchandise, prizes, store gift cards, gift certificates, or sporting event tickets not exceeding **$100** in value per person in any one calendar year, as long as the giving of the item of value is not contingent upon the sale or renewal of a policy.

More Information: Georgia Code § 33-6-4 and 5

2. Defamation

Defamation in insurance involves making false or maliciously critical statements about an insurer's financial condition or business practices.

Example: An agent spreads false rumors about a competitor's financial instability to gain business.

More Information: Georgia Code § 33-6-4

3. Unfair Discrimination

Unfair discrimination occurs when insurers make distinctions between individuals of the same class and risk without a valid reason.

Example: Charging different premiums to individuals of the same age and health status without a justified reason.

More Information: Georgia Code § 33-6-4

4. Misrepresentation

Misrepresentation involves providing false or misleading information about the terms, benefits, or advantages of an insurance policy.

Example: An agent exaggerates the benefits of a policy to make a sale.

More Information: Georgia Code § 33-6-4

5. Twisting and Churning

- **Twisting**: Inducing a policyholder to lapse or switch policies through misrepresentation.
- **Churning**: Replacing policies within the same company to earn additional commissions.

Example: An agent persuades a client to switch to a new policy by falsely claiming it offers better benefits.

More Information: Georgia Code § 33-6-34

6. Advertising

Insurance advertising must be truthful and not misleading. It should provide clear and accurate information about the policy.

Example: An advertisement falsely claims that a policy covers all medical expenses without any exclusions.

Advertising

Advertisements for accident or sickness insurance policies must be accurate and sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Advertisements must be **truthful and not misleading** in fact or in implication and must clearly and accurately state the dollar limits and time limits of benefits where applicable.

Advertisements for policies providing benefits only for specified illnesses or accidents must clearly and conspicuously in prominent type state the limited nature of the policy. If a policy provides different benefits for the same loss occurring under different circumstances or from different causes, the smaller benefits payable must be given the same prominence as the larger benefits.

All policies advertised must be identified by names that reasonably describe their contents; *for example*, Hospital and Surgical Expense Policy, Hospital Income Policy, or Disability Income Policy.

Any optional benefit advertised must be labeled as such and must be prominently and conspicuously displayed in conjunction with the conditions to qualify for the benefits. The advertisement must disclose that an additional premium may be charged for each optional benefit.

Advertisements must include the name, address, and phone number of the home or principal office of the nearest authorized representative of the insurer.

Any advertisement making reference to "Medicare Supplement Insurance" or to coverage designed to supplement "Medicare," must contain a clear, prominent, and conspicuous statement in language identical to or substantially the same as the following: "THIS IS A LIMITED POLICY DESIGNED TO COVER ONLY THOSE EXPENSES WHICH MEDICARE DOES NOT COVER."

Any advertisement that refers to the maximum benefits paid for any period greater than one day must disclose at the same time the daily rate of benefits, and when applicable, the fact that the benefits are payable only for the actual number of days of hospital confinement and, when applicable, the limit on the number of days for which coverage is provided.

Testimonials

Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced.

If the person making a testimonial has a financial interest in the insurer or a related entity, that must be prominently disclosed in the advertisement.

If a person is compensated for making a testimonial, that must be prominently disclosed in the advertisement by language identical or similar to the following: "THIS IS A PAID ENDORSEMENT."

More Information: Georgia Code § 33-6-35

7. Coercion

Coercion involves using force or threats to compel someone to purchase insurance.

Example: An agent threatens to cancel a client’s existing policy unless they purchase an additional policy.

It is illegal to be involved in any activity of coercion which is intended to restrict fair trade or to create a monopoly. **Coercion** is an unfair trade practice in which an agent uses physical or mental force with the intent of inducing an applicant to purchase insurance.

More Information: Georgia Code § 33-9-36

8. Controlled Business

Controlled business refers to insurance written primarily for the agent’s own interests or those of their family or employer.

Example: An agent writes most of their policies for their own family members.

Controlled business is any coverage written on a producer's own life, health or property, and/or that of the producer's immediate family or business associates. A licensee is not allowed to collect commissions on controlled business above the state-specified limit. In the state of Georgia, a license will not be issued to a person if it is determined that the primary purpose of the license is to write controlled business. **No more than 25%** of the agent's volume of insurance per calendar year can be issued on controlled business.

More Information: Georgia Code § 33-23-1

9. Unfair Claims Practices

Unfair claims practices include actions like delaying claim payments, denying claims without a valid reason, or failing to investigate claims properly.

Example: An insurer delays payment of a legitimate claim without providing a valid reason.

More Information: Georgia Code § 33-6-34

10. Fraud

Insurance fraud involves deceitful practices to gain an unfair advantage, such as filing false claims or providing false information on an application.

Example: A policyholder submits a false claim for damages that never occurred.

More Information: Georgia Code § 33-6-4

E. Reporting and Disposition of Premiums

1. Fiduciary Responsibility

Agents have a fiduciary responsibility to handle premiums and other funds in a trustworthy manner, ensuring they are used appropriately and not for personal gain.

Example: An agent must deposit client premiums into a separate trust account and not use them for personal expenses.

More Information: Georgia Code § 33-23-35

2. Commingling

Commingling occurs when an agent mixes personal funds with client premiums, which is prohibited.

Example: An agent deposits client premiums into their personal bank account.

More Information: Georgia Code § 33-23-35

F. Georgia Life and Health Insurance Guaranty Association

The Georgia Life and Health Insurance Guaranty Association protects policyholders if an insurance company becomes insolvent. It provides coverage for life, health, and annuity policies up to certain limits.

Example: If an insurance company goes bankrupt, the association ensures that policyholders still receive their benefits up to the covered limits.

More Information: Georgia Code § 33-38-1 through 10

GA CODE § 33-38-1: Purpose

Summary: This section outlines the purpose of the chapter, which is to protect policyholders against the failure of insurers to fulfill their contractual obligations due to insolvency or impairment. It establishes an association of member insurers to guarantee payment of benefits and continuation of coverage.

Example: If an insurance company providing life insurance becomes insolvent, the association steps in to ensure that policyholders still receive their benefits.

GA CODE § 33-38-2: Scope

Summary: This section defines the types of policies and contracts covered under this chapter, including direct, nongroup life insurance, health insurance, and annuities. It specifies the persons eligible for coverage.

Example: A person holding a direct, nongroup health insurance policy from a member insurer would be covered under this chapter if the insurer becomes insolvent.

GA CODE § 33-38-3: Construction

Summary: This section states that the chapter should be construed to effectuate its purpose as outlined in § 33-38-1.

Example: In legal disputes, interpretations of this chapter should favor protecting policyholders as intended by the chapter's purpose.

GA CODE § 33-38-4: Definitions

Summary: This section provides definitions for terms used in the chapter, such as "account," "affiliate," and "authorized assessment."

Example: "Account" refers to the two accounts created under § 33-38-5, which are used for administration and assessment purposes.

GA CODE § 33-38-5: Creation; Required Membership; Functions and Powers

Summary: This section establishes the Georgia Life and Health Insurance Guaranty Association, outlines its required membership, and details its functions and powers.

Example: All life and health insurers operating in Georgia must be members of this association and contribute to its funding.

GA CODE § 33-38-6: Membership of the Board of Directors; Vacancies; Compensation and Reimbursement of Expenses

Summary: This section describes the composition of the board of directors for the association, how vacancies are filled, and the rules for compensation and reimbursement of expenses.

Example: The board consists of 7 to 11 members selected by the Commissioner from a list provided by the board.

GA CODE § 33-38-7: Powers and Duties of the Association

Summary: This section outlines the powers and duties of the association, including guaranteeing benefits, providing coverage, and assisting in the detection and prevention of insurer impairments.

Example: The association may adopt alternative policies to ensure continued coverage for policyholders of an insolvent insurer.

GA CODE § 33-38-8: Submission of Plan of Operation; Contents; Compliance With Such Plan

Summary: This section requires the association to submit a plan of operation to the Commissioner for approval, detailing how the association will be administered.

Example: The plan might include procedures for assessing member insurers and handling claims.

GA CODE § 33-38-9: Delegation of Powers and Duties of the Association

Summary: This section allows the association to delegate its powers and duties to a similar organization, with the approval of the board of directors and the Commissioner.

Example: The association could delegate its responsibilities to a national guaranty association if it provides similar protections.

GA CODE § 33-38-10: Duties and Powers of the Commissioner

Summary: This section details additional duties and powers of the Commissioner, such as providing premium statements and demanding insurers to make good on impairments.

Example: If an insurer is declared impaired, the Commissioner can demand that the insurer rectify the impairment within a reasonable time.

XI. GEORGIA RULES AND CODES PERTINENT TO LIFE INSURANCE ONLY

A. Replacement of Life Insurance

Summation: Replacement involves terminating an existing life insurance policy and purchasing a new one. Georgia regulations require specific disclosures and procedures to ensure policyholders understand the implications of replacement.

Example: Jane decides to replace her old life insurance policy with a new one offering better benefits. The insurer must provide her with a detailed comparison and a notice explaining the potential consequences of replacement.

Ref: Reg. 120 2-24; 33-24-6.1

More Information: Georgia Code Title 33, Chapter 25

B. Life Insurance Advertisements and Solicitation

Summation: Advertisements and solicitation for life insurance in Georgia must comply with regulations to ensure they are not misleading and provide clear information to consumers.

Example: An insurance company runs a TV ad promoting its life insurance policies. The ad must clearly state the terms and conditions and not make any false claims about the benefits.

Ref: Reg. 120-2-11; 120-2-31; 33 25-1 through 12; 33-27-1 through 9

More Information: Georgia Code Title 33, Chapter 25

C. Insurable Interest

Summation: Insurable interest means the policyholder must have a legitimate interest in the insured person's life, such as financial dependency or close family relationship.

Example: John buys a life insurance policy on his business partner, David, because David's death would financially impact the business.

Ref: 33-24-6

More Information: Georgia Code Title 33, Chapter 25

XII. GEORGIA RULES AND CODES PERTINENT TO ACCIDENT & SICKNESS INSURANCE ONLY

A. Individual and Group Accident and Sickness Insurance

These regulations cover the requirements for individual and group accident and sickness insurance policies, including policy provisions, benefits, and exclusions.

Example: Policies must include specific benefits and cannot exclude coverage for certain pre-existing conditions.

Accident and sickness insurance is provided under a policy that insures one person and their dependents.

It is illegal for contracts to contain provisions that exclude or reduce coverage for an insurable person solely because the person is eligible for or receiving medical assistance.

Basic insurance policy forms or application forms must be filed with the Commissioner for approval at least **90 days before use**. At the end of the 90 days, the form will be considered approved, unless previously approved or disapproved. The Commissioner may extend the approval period by 90 days but must give notice before the end of the initial approval period. At the end of the extension, the form will be considered approved, unless previously approved or disapproved.

Every individual accident and sickness policy must provide for a **10-day free-look period** that allows the policyowner to return the policy if dissatisfied for any reason. Upon the return of the policy, the insurer must refund any premium paid, and the policy will be considered void from its inception.

Optional Provisions

An insurer may, at its option, include any of the following optional provisions:

- **Change of occupation** — if the insured makes a change in occupation, upon claim, the insurer will either reduce the benefits to what premiums paid would have purchased assuming the more hazardous occupation or reduce the premium and return the excess pro rate unearned premium if the change is to a less hazardous occupation.
- **Misstatement of age** — the insurer will adjust the amount payable under the policy according to what the premium paid would have bought at the correct age of the insured.
- **Other insurance in this insurer** — if a policyholder holds multiple policies with the same company and the aggregate coverage is in excess of the maximum limit of indemnity,

  The excess insurance will be void, and the insurer will return all premiums paid for the excess; or

  The insured may choose which policy will remain in effect, and the insurer will return all premiums paid for all other policies.
- **Relations of earnings to insurance** — insurer may limit the insured's benefits based on their average monthly earnings for the previous 2 years.
- **Unpaid premium** — upon the payment of a claim, any unpaid premium that is due to the insurer will be deducted from the benefit.
- **Return of premium on cancellation** — if the insured cancels a policy, the earned premium will be computed on a short-rate basis.
- **Conformity with state statutes** — any provision that is in conflict with the statutes of the state in which the insured resides will be amended to conform to the minimum requirements of the statutes.
- **Illegal occupation** — the insurer is not liable for any loss sustained as a result of the insured's commission or attempted commission of a felony, or for any loss contributed to by the insured’s engagement in an illegal occupation.
- **Intoxicants and narcotics** — the insurer is not liable for any loss sustained as a result of the insured's being intoxicated or under the influence of any non-prescribed narcotic.
- **Cancellation of travel accident policies** — the insurer reserves the right to cancel the policy for allowable reasons with a required notice, as specified in the Insurance Code.

Every authorized insurer that issues individual accident and sickness policies in the state of Georgia is required to make the following coverages available either as a part of the policy or as an optional endorsement:

- Human heart transplants, including any charge for acquisition, transportation, or donation of a human heart. The coverage should be at least as extensive as treatment of any other physical illnesses covered by the policy.
- Coverage for mammograms and PAP smears:
- One baseline mammogram for any female between the ages of 35 and 40;
- One mammogram every 2 years for any female between the ages of 40 and 50;
- Annual mammogram for any female who is at least 50 years old; and
- Whenever ordered by a physician.
- Coverage for annual prostate specific antigen tests for the covered males who are 45 years of age or older, or for covered males who are 40 years of age or older if ordered by a physician.
- Coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease.
- Basic coverage for child wellness services for an insured child from birth through the age of 5.

Group Insurance

Group accident and sickness insurance is a policy form that covers a group of employees, members of an association or another eligible group, with or without one or more members of their immediate family being covered. The following stipulations apply:

- A policy issued to an **employer** who is the policyholder insures at least two employees of such employer (not including the employer);
- A policy issued to an **association**, including a labor union, that has a constitution and bylaws and that was organized for a purpose other than obtaining insurance, insures at least 10 members;
- A policy issued to **the trustees of a fund** established by two or more employers in the same industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association, for which trustees are the policyholder, to insure not less than 10 people in their applicable group;
- A policy issued to a **creditor** where the creditor is the policyholder insures mortgagors of the creditor and must be written in connection with a credit transaction that is secured by a first mortgage or deed of trust;
- A policy issued to a **legal entity** providing a multiple employer welfare arrangement (MEWA), which means any employee benefit plan established or maintained for the purpose of offering or providing accident and sickness benefits to the employees of two or more employers; or
- A group policy at the discretion of the Commissioner.

Required Provisions

Georgia law requires group accident and sickness policies to include the following provisions:

- All statements made by the insured will be deemed representations and not warranties.

- The insurer must provide certificates to the policyholder, who is required to distribute them to each insured. Certificates must state the insurance protection to which the person is entitled and to whom the insurance benefits are payable.
- Newly eligible employees or members or dependents may be added to the group originally insured in accordance with the terms of the policy.
- Dependent children of an insured will continue to be insured up to the age of 26 as long as the coverage of the member continues in effect.
- Group policies have a grace period of 31 days for the payment of any premium due except the first.

Small Groups

Georgia law defines **"small group"** as a group of **at least 2 and no more than 50** employees, members, or enrollees. Insurers may pool the claims experiences produced by small groups they cover for rating purposes.

The initial and renewal rating of each small group may consider the following factors:

- Age;
- Sex,
- Size;
- Area;
- Industry; and
- Occupational and avocational factors.

Any newly eligible group member who has had creditable coverage under another health benefit plan within the previous 90 days is eligible for coverage immediately upon completion of any waiting period. Once the creditable coverage terminates, the insurer must offer a conversion policy to the eligible group member.

Blanket Policies

Blanket accident and sickness insurance covers special groups:

- Passengers of a common transportation carrier;
- Employees in a hazardous profession;
- Students/campers and teachers/supervisors of an educational institution or camp;
- Members of any religious, charitable, recreational, educational, or civic organization;
- Members, officials, and supervisors of a sports team; or
- Members of a group exposed to risks or classes of risks that the Superintendent approves.

More Information: Regulations 100-2-10 through 12; Georgia Code § 33-29-1 through 22; 33-30-30-1 through 15

Rule 120-2-10-.01: Profit-Sharing Policies

Summary: This rule prohibits the sale or approval of insurance policies that allow policyholders to participate in future distributions of general corporate profits unless specific conditions are met.

Example: An insurance company cannot sell a life insurance policy that promises policyholders a share of the company's future profits unless it complies with the requirements set forth in this rule.

Rule 120-2-10-.02: Coupon Policies or Policies with Annual Pure Endowment Benefits

Summary: This rule restricts the sale of policies that include pure endowment benefits during the premium-paying period unless they meet certain criteria.

Example: A policy that offers annual pure endowment benefits through coupons must comply with specific requirements to be approved for sale in Georgia.

Rule 120-2-10-.03: Medical or Surgical Policies-Outpatient Coverage

Summary: This rule mandates that medical or surgical policies must include provisions for reimbursing policyholders for covered procedures performed on an outpatient basis.

Example: A health insurance policy must cover the cost of a minor surgery performed at an outpatient clinic, as specified in the policy.

Rule 120-2-10-.04: Misleading Terms Prohibited

Summary: This rule prohibits the use of misleading terms in insurance policies or marketing materials that could deceive purchasers into thinking they are receiving something other than an insurance policy.

Example: An insurance company cannot use terms like "Founders Plan" or "Charter Policy" in a way that misleads customers into believing they are getting special benefits not available to others.

Rule 120-2-10-.05: Describing Premiums as "Deposits", "Savings", or "Investments"

Summary: This rule prohibits describing insurance premiums using terms like "deposits," "savings," or "investments" unless specific conditions are met.

Example: An insurance company cannot advertise that policy premiums are "investments" unless it clearly explains that these are actually insurance premiums.

Rule 120-2-10-.06: Filing Requirements-Life and Health Forms

Summary: This rule outlines the requirements for submitting life and health insurance forms for approval, ensuring compliance with relevant sections of the Georgia Insurance Code.

Example: An insurance company must submit its new health insurance policy forms in duplicate for approval, following the guidelines set forth in this rule.

Rule 120-2-10-.07: Agents, Payments for Furnishing Leads and Reference to Regulations

Summary: This rule regulates the payment of commissions or other valuable considerations to individuals for furnishing leads unless they are licensed to sell life insurance in Georgia.

Example: An insurance agent cannot pay someone for providing a lead on a potential life insurance customer unless that person is a licensed insurance agent.

Rule 120-2-10-.08: Participating Policies

Summary: This rule sets requirements for participating life insurance or annuity policies, ensuring policyholders are eligible to participate in future distributions of profits, savings, or unabsorbed portions of premiums.

Example: A participating life insurance policy must meet specific criteria to allow policyholders to share in the company's profits.

Rule 120-2-10-.09: Life, Annuities and Accident and Sickness Insurance Policy Language Simplification Standards

Summary: This rule establishes minimum standards for the readability of policy language to ensure that insurance policies are easy to understand.

Example: An insurance policy must be written in clear, simple language that policyholders can easily comprehend.

Rule 120-2-10-.10: Group Coverage Discontinuance and Replacement

Summary: This rule provides guidelines for the discontinuance and replacement of group insurance coverage, ensuring continuity of coverage for policyholders.

Example: If an employer switches group health insurance providers, the new policy must provide similar coverage without significant gaps.

Rule 120-2-10-.11: Group Health Insurance Conversion Privilege

Summary: This rule grants individuals the right to convert their group health insurance coverage to an individual policy under certain conditions.

Example: An employee leaving a job can convert their group health insurance to an individual policy without undergoing a new medical examination.

Rule 120-2-10-.11A: Group Health Insurance Enhanced Conversion Privilege

Summary: This rule provides additional conversion privileges for group health insurance, offering more options for individuals converting their coverage.

Example: An employee may have enhanced options for converting their group health insurance to an individual policy, such as additional plan choices.

Rule 120-2-10-.12: Small Group Health Insurance Access and Pooling

Summary: This rule facilitates access to health insurance for small groups by allowing them to pool their resources to obtain better coverage options.

Example: Small businesses can join a health insurance pool to access more affordable and comprehensive health insurance plans for their employees.

More Information:

GA CODE § 33-29-1

Summary: This section defines “accident and sickness policy” as any policy insuring against loss resulting from sickness or bodily injury or death by accident, or any contract to furnish ambulance service in the future[1].

Example: A health insurance policy that covers medical expenses due to illness or injury.

GA CODE § 33-29-2

Summary: This section outlines the general requirements for accident and sickness insurance policies, including that the entire consideration for the policy must be expressed, and the time at which the insurance takes effect and terminates must be stated[2].

Example: An insurance policy that clearly states the premium amount and the coverage period from January 1, 2024, to December 31, 2024.

GA CODE § 33-29-3

Summary: This section specifies the required provisions that must be included in accident and sickness policies, such as grace periods, reinstatement, and notice of claim[3].

Example: A policy that includes a 30-day grace period for premium payments.

GA CODE § 33-29-3.1

Summary: This section mandates that insurers must offer coverage for human heart transplants, including charges for acquisition, transportation, or donation of a human heart[4].

Example: An insurance policy that covers the costs associated with a heart transplant surgery.

GA CODE § 33-29-3.2

Summary: This section requires insurers to include coverage for mammograms, Pap smears, and prostate-specific antigen tests in their policies[5].

Example: A health insurance policy that provides annual mammogram screenings for women over 40.

GA CODE § 33-29-3.3

Summary: This section requires insurers to provide coverage for colorectal cancer screenings[6].

Example: An insurance policy that covers colonoscopy procedures for individuals over 50.

GA CODE § 33-29-3.4

Summary: This section mandates coverage for child wellness services, including immunizations and preventive care[7].

Example: A health insurance policy that includes routine check-ups and vaccinations for children.

GA CODE § 33-29-4

Summary: This section allows insurers to include optional provisions in policies, such as changes in occupation and misstatement of age[8].

Example: A policy that adjusts benefits if the insured changes to a more hazardous occupation.

GA CODE § 33-29-5

Summary: This section requires policies to include a provision for the payment of claims within a specified time frame[9].

Example: An insurance policy that stipulates claims must be paid within 30 days of submission.

GA CODE § 33-29-6

Summary: This section allows policies to limit benefits for medical or surgical services to those performed by specifically defined professions[10].

Example: A policy that only covers surgeries performed by board-certified surgeons.

GA CODE § 33-29-7

Summary: This section requires policies to include a provision for the payment of benefits to the insured or their beneficiary[10].

Example: A policy that specifies benefits will be paid directly to the insured or their designated beneficiary.

GA CODE § 33-29-8

Summary: This section mandates that policies must include a provision for the refund of premiums in case of policy cancellation[10].

Example: A policy that refunds unused premiums if the policy is canceled before the end of the coverage period.

GA CODE § 33-29-9

Summary: This section requires policies to include a provision for the adjustment of premiums based on changes in the insured's age[10].

Example: A policy that increases premiums as the insured reaches certain age milestones.

GA CODE § 33-29-10

Summary: This section mandates that policies must include a provision for the reinstatement of coverage after a lapse[10].

Example: A policy that allows reinstatement of coverage if premiums are paid within 60 days of a lapse.

GA CODE § 33-29-11

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's death[10].

Example: A policy that pays a death benefit to the insured's beneficiary.

GA CODE § 33-29-12

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's disability[10].

Example: A policy that provides monthly disability benefits if the insured is unable to work due to illness or injury.

GA CODE § 33-29-13

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's hospitalization[10].

Example: A policy that covers hospital expenses for inpatient treatment.

GA CODE § 33-29-14

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's surgery[10].

Example: A policy that covers the costs of surgical procedures.

GA CODE § 33-29-15

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's outpatient treatment[10].

Example: A policy that covers outpatient visits to a doctor's office.

GA CODE § 33-29-16

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's emergency treatment[10].

Example: A policy that covers emergency room visits.

GA CODE § 33-29-17

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's prescription medication[10].

Example: A policy that covers the cost of prescribed medications.

GA CODE § 33-29-18

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's mental health treatment[10].

Example: A policy that covers therapy sessions for mental health conditions.

GA CODE § 33-29-19

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's substance abuse treatment[10].

Example: A policy that covers rehabilitation programs for substance abuse.

GA CODE § 33-29-20

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's dental treatment[10].

Example: A policy that covers routine dental check-ups and procedures.

GA CODE § 33-29-21

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's vision treatment[10].

Example: A policy that covers eye exams and corrective lenses.

GA CODE § 33-29-21.1

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's hearing treatment[10].

Example: A policy that covers hearing aids and related services.

GA CODE § 33-29-22

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's long-term care[10].

Example: A policy that covers nursing home care or in-home care services.

GA CODE § 33-30-1

Summary: Defines "group accident and sickness insurance" as insurance issued to an employer or trustees of a fund established by an employer, insuring at least two employees for the benefit of persons other than the employer[1].

Example: A company providing health insurance coverage to its employees through a group policy.

GA CODE § 33-30-1.1

Summary: Specifies the applicability of the chapter to policies of insurance, certificates evidencing coverage, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in Georgia[2].

Example: A health insurance policy issued to a Georgia-based company for its employees.

GA CODE § 33-30-2

Summary: States that nothing in this chapter validates any charge or practice illegal under any rule of law or regulation governing usury, small loans, retail installment sales, or the like[3].

Example: An insurance policy cannot include terms that violate state usury laws.

GA CODE § 33-30-3

Summary: Defines "blanket accident and sickness insurance" as insurance covering groups of persons under a single policy issued to entities such as schools, camps, or other institutions[4].

Example: A school providing accident insurance coverage to all its students under a single policy.

GA CODE § 33-30-4

Summary: Lists required provisions for group accident and sickness policies, including the issuance of individual certificates to insured employees or members, and continuation of coverage for dependent children up to age 25[5].

Example: A group health insurance policy that provides certificates to each employee detailing their coverage.

GA CODE § 33-30-4.1

Summary: Requires insurers to make available coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease[6].

Example: A health insurance policy that includes coverage for bone marrow transplants as part of its benefits.

GA CODE § 33-30-4.2

Summary: Mandates coverage for mammograms, Pap smears, and prostate-specific antigen tests in group accident and sickness policies[7].

Example: A group health insurance policy that covers annual mammograms for women over 40.

GA CODE § 33-30-4.3

Summary: Requires health care insurers to provide an explanation of the payment or reimbursement method for mail-order pharmaceutical services compared to other providers[8].

Example: A health insurance policy that includes a detailed explanation of how mail-order prescription services are reimbursed.

GA CODE § 33-30-4.4

Summary: Requires insurers to make available coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease[9].

Example: A health insurance policy that includes an optional endorsement for bone marrow transplant coverage.

GA CODE § 33-30-4.5

Summary: Defines "child wellness services" and mandates coverage for these services in group accident and sickness policies[10].

Example: A health insurance policy that covers routine check-ups and immunizations for children.

GA CODE § 33-30-5

Summary: Requires group accident and sickness policies to include a provision for the payment of claims within a specified time frame.

Example: A policy that stipulates claims must be paid within 30 days of submission.

GA CODE § 33-30-6

Summary: Allows policies to limit benefits for medical or surgical services to those performed by specifically defined professions.

Example: A policy that only covers surgeries performed by board-certified surgeons.

GA CODE § 33-30-7

Summary: Requires policies to include a provision for the payment of benefits to the insured or their beneficiary.

Example: A policy that specifies benefits will be paid directly to the insured or their designated beneficiary.

GA CODE § 33-30-8

Summary: Mandates that policies must include a provision for the refund of premiums in case of policy cancellation.

Example: A policy that refunds unused premiums if the policy is canceled before the end of the coverage period.

GA CODE § 33-30-9

Summary: Requires policies to include a provision for the adjustment of premiums based on changes in the insured's age.

Example: A policy that increases premiums as the insured reaches certain age milestones.

GA CODE § 33-30-10

Summary: Mandates that policies must include a provision for the reinstatement of coverage after a lapse.

Example: A policy that allows reinstatement of coverage if premiums are paid within 60 days of a lapse.

GA CODE § 33-30-11

Summary: Requires policies to include a provision for the payment of benefits in the event of the insured's death.

Example: A policy that pays a death benefit to the insured's beneficiary.

GA CODE § 33-30-12

Summary: Mandates that policies must include a provision for the payment of benefits in the event of the insured's disability.

Example: A policy that provides monthly disability benefits if the insured is unable to work due to illness or injury.

GA CODE § 33-30-13

Summary: Requires policies to include a provision for the payment of benefits in the event of the insured's hospitalization.

Example: A policy that covers hospital expenses for inpatient treatment.

GA CODE § 33-30-13.1

Summary: Mandates that policies must include a provision for the payment of benefits in the event of the insured's surgery.

Example: A policy that covers the costs of surgical procedures.

GA CODE § 33-30-14

Summary: Requires policies to include a provision for the payment of benefits in the event of the insured's outpatient treatment.

Example: A policy that covers outpatient visits to a doctor's office.

GA CODE § 33-30-15

Summary: Mandates that policies must include a provision for the payment of benefits in the event of the insured's emergency treatment.

Example: A policy that covers emergency room visits.

B. Medicare Supplement

Regulations for Medicare Supplement insurance ensure that these policies provide additional coverage to Medicare beneficiaries, covering gaps in Medicare coverage.

Example: A Medicare Supplement policy may cover co-payments, deductibles, and other out-of-pocket expenses not covered by Medicare.

More Information: Georgia Code § 33-43-1 through 8

Here is a summary and example for each of the specified Georgia Insurance Rules & Regulations related to Medicare Supplement Insurance:

1. **Rule 120-2-8-.01 Purpose**

Summary: This rule aims to standardize coverage and simplify the terms and benefits of Medicare supplement policies to facilitate public understanding and comparison, and to eliminate misleading or confusing provisions.

Example: Ensuring that all Medicare supplement policies in Georgia have clear and consistent terms to help consumers make informed decisions[1].

2. **Rule 120-2-8-.02 Authority**

Summary: This rule cites the legal authority under which the regulations are issued, referencing specific sections of the Georgia Code.

Example: The Commissioner of Insurance enforces these regulations under the authority granted by O.C.G.A. Sections 33-2-9, 33-43-3 to 33-43-6[2].

3. **Rule 120-2-8-.03 Applicability and Scope**

Summary: This rule defines the scope of the regulations, specifying which types of policies and providers are subject to these rules.

Example: These regulations apply to all Medicare supplement policies delivered or issued for delivery in Georgia on or after the effective date of the regulation[3].

4. **Rule 120-2-8-.04 Definitions**

Summary: This rule provides definitions for terms used throughout the regulations to ensure clarity and consistency.

Example: Defining “applicant” as the person seeking to contract for insurance benefits in the case of an individual Medicare supplement policy[4].

5. **Rule 120-2-8-.05 Policy Definitions and Terms**

Summary: This rule specifies the required definitions and terms that must be included in Medicare supplement policies.

Example: A policy must define terms like “Medicare eligible expenses” and “physician” to ensure policyholders understand their coverage[5].

6. **Rule 120-2-8-.06 Policy Provisions**

Summary: This rule outlines the required provisions that must be included in Medicare supplement policies.

Example: Policies must include a provision for guaranteed renewability, meaning the policy cannot be canceled as long as premiums are paid[6].

7. **Rule 120-2-8-.07 Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to the Effective Date of This Regulation**

Summary: This rule sets minimum benefit standards for Medicare supplement policies issued before the effective date of the regulation.

Example: Policies must cover a specified percentage of Medicare Part B coinsurance to ensure adequate coverage for policyholders[7].

8. **Rule 120-2-8-.08 Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After September 30, 2005 and With an Effective Date for Coverage Prior to June 1, 2010**

Summary: This rule establishes benefit standards for Medicare supplement policies issued or delivered between September 30, 2005, and June 1, 2010.

Example: Policies must include benefits for Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up[8].

9. **Rule 120-2-8-.09 Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After September 8, 2005 and With an Effective Date for Coverage Prior to June 1, 2010**

Summary: This rule outlines the standard benefit plans for Medicare supplement policies issued for delivery during the specified period.

Example: Standardized plans must include core benefits such as coverage for the first three pints of blood each year[9].

10. **Rule 120-2-8-.09.1 Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020**

Summary: This rule provides standards for Medicare supplement benefit plans issued to individuals newly eligible for Medicare on or after January 1, 2020.

Example: New plans must include benefits for Medicare Part A hospice care coinsurance or copayment[10].

11. **Rule 120-2-8-.10 Medicare Select Policies and Certificates**

Summary: This rule sets standards for Medicare Select policies, which are a type of Medicare supplement policy that requires the use of specific health care providers.

Example: Medicare Select policies must provide full benefits if emergency care is needed outside the network[9].

12. **Rule 120-2-8-.11 Open Enrollment**

Summary: This rule outlines the open enrollment period during which individuals can purchase Medicare supplement policies without medical underwriting.

Example: Individuals have a six-month open enrollment period starting the first month they are 65 or older and enrolled in Medicare Part B[9].

13. **Rule 120-2-8-.12 Guaranteed Issue for Eligible Persons**

Summary: This rule ensures that certain individuals have guaranteed issue rights to purchase Medicare supplement policies without medical underwriting.

Example: Individuals losing other health coverage have a guaranteed issue right to buy a Medicare supplement policy[9].

14. **Rule 120-2-8-.13 Standards for Claims Payment**

Summary: This rule sets standards for the timely and accurate payment of claims under Medicare supplement policies.

Example: Insurers must pay claims within 30 days of receiving all necessary information[9].

15. **Rule 120-2-8-.14 Loss Ratio Standards and Refund or Credit of Premium**

Summary: This rule establishes minimum loss ratio standards to ensure that a certain percentage of premiums are used to pay claims, and outlines the process for refunding or crediting premiums if the standards are not met.

Example: Insurers must spend at least 75% of premiums on claims for individual policies[11].

16. **Rule 120-2-8-.15 Filing and Approval of Policies and Certificates and Premium Rates**

Summary: This rule specifies the filing and approval requirements for Medicare supplement policies, certificates, and premium rates.

Example: Insurers must file policy forms and premium rates with the Commissioner for approval before issuing policies[9].

17. **Rule 120-2-8-.16 Permitted Compensation Arrangements**

Summary: This rule outlines the permitted compensation arrangements for agents and brokers selling Medicare supplement policies.

Example: Compensation must not exceed a specified percentage of the premium for the first year and renewal years[9].

18. **Rule 120-2-8-.17 Required Disclosure Provisions**

Summary: This rule mandates specific disclosures that must be provided to consumers when they purchase Medicare supplement policies.

Example: Insurers must disclose the potential for premium rate increases and the policyholder's right to review the policy within a specified period[9].

19. **Rule 120-2-8-.18 Requirements for Application Forms and Replacement Coverage**

Summary: This rule outlines the requirements for application forms and the process for replacing existing coverage.

Example: Application forms must include questions about existing coverage and whether the new policy will replace it[9].

20. **Rule 120-2-8-.19 Filing Requirements for Advertising**

Summary: This rule outlines the requirements for filing advertising materials related to Medicare supplement policies.

Example: Insurers must submit all advertising materials to the Commissioner for review to ensure they are not misleading[9].

21. **Rule 120-2-8-.20 Standards for Marketing**

Summary: This rule sets standards for the marketing of Medicare supplement policies to protect consumers from deceptive practices.

Example: Marketing materials must clearly explain the benefits, limitations, and costs of the policy[9].

22. **Rule 120-2-8-.21 Appropriateness of Recommended Purchase and Excessive Insurance**

Summary: This rule requires insurers to ensure that Medicare supplement policies are suitable for the applicant's needs and financial situation.

Example: Agents must assess the applicant's financial situation and health status to recommend appropriate coverage[9].

23. **Rule 120-2-8-.22 Reporting of Multiple Policies**

Summary: This rule requires insurers to report the issuance of multiple Medicare supplement policies to the same individual.

Example: Insurers must report to the Commissioner if an individual holds more than one Medicare supplement policy[9].

24. **Rule 120-2-8-.23 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates**

Summary: This rule prohibits insurers from imposing preexisting condition exclusions or waiting periods on replacement policies.

Example: A policyholder switching to a new policy cannot be denied coverage for preexisting conditions that were covered under the previous policy[9].

25. **Appendix (120-2-8) C DISCLOSURE STATEMENTS**

Summary: This appendix provides the required disclosure statements that must be included in Medicare supplement policies.

Example: Disclosure statements must inform policyholders about their rights and the terms of their coverage[9].

C. Long Term Care

Ref: 33-42-1 through 6; 120-2-16-.01 through .33

1. **Rule 120-2-16-.01 Purpose**

Summary: This rule outlines the purpose of the regulations, which is to promote the public interest, ensure the availability of long-term care insurance, and protect applicants from unfair or deceptive sales practices.

Example: Ensuring that all long-term care insurance policies sold in Georgia meet minimum standards to protect consumers.

2. **Rule 120-2-16-.02 Authority**

Summary: This rule cites the legal authority under which the regulations are issued, typically referencing specific sections of the Georgia Code.

Example: The Commissioner of Insurance has the authority to enforce these regulations under Georgia Code Section 33-42-1.

3. **Rule 120-2-16-.03 Applicability and Scope**

Summary: This rule defines the scope of the regulations, specifying which types of insurance policies and providers are subject to these rules.

Example: These regulations apply to all long-term care insurance policies issued in Georgia, including those provided by both domestic and foreign insurers.

4. **Rule 120-2-16-.04 Definitions**

Summary: This rule provides definitions for terms used throughout the regulations, ensuring clarity and consistency.

Example: Defining “long-term care insurance” as a policy designed to provide coverage for at least 12 consecutive months for necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services.

5. **Rule 120-2-16-.05 Policy Definitions**

Summary: This rule specifies the required definitions that must be included in long-term care insurance policies.

Example: A policy must define terms like “home health care” and “assisted living facility” to ensure policyholders understand their coverage.

6. **Rule 120-2-16-.06 Policy Practices and Provisions**

Summary: This rule outlines the required practices and provisions that must be included in long-term care insurance policies.

Example: Policies must include a provision for guaranteed renewability, meaning the policy cannot be canceled as long as premiums are paid.

7. **Rule 120-2-16-.07 Unintentional Lapse**

Summary: This rule requires insurers to provide a grace period and notification process to prevent unintentional lapses in coverage.

Example: Insurers must notify policyholders and a designated third party before canceling a policy due to non-payment of premiums.

8. **Rule 120-2-16-.08 Required Disclosure Provisions**

Summary: This rule mandates specific disclosures that must be provided to consumers when they purchase long-term care insurance.

Example: Insurers must disclose the potential for premium rate increases and the policyholder's right to review the policy within a specified period.

9. **Rule 120-2-16-.09 Required Disclosure of Rating Practices to Consumers**

Summary: This rule requires insurers to disclose their rating practices to consumers, including how premiums are determined.

Example: Insurers must inform policyholders if their premiums are based on age, health status, or other factors.

10. **Rule 120-2-16-.10 Initial Filing Requirements**

Summary: This rule specifies the documentation and information that insurers must submit when filing new long-term care insurance policies for approval.

Example: Insurers must provide actuarial data supporting the proposed premium rates and policy forms.

11. **Rule 120-2-16-.11 Prohibition Against Post-Claims Underwriting**

Summary: This rule prohibits insurers from denying claims based on information that should have been obtained during the underwriting process.

Example: An insurer cannot deny a claim for a pre-existing condition if the condition was not disclosed due to the insurer's failure to ask the appropriate questions during underwriting.

12. **Rule 120-2-16-.12 Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies**

Summary: This rule sets minimum standards for home health and community care benefits that must be included in long-term care insurance policies.

Example: Policies must cover a specified percentage of home health care costs to ensure policyholders can receive care in their homes.

13. **Rule 120-2-16-.13 Requirement to Offer Inflation Protection**

Summary: This rule requires insurers to offer policyholders the option to purchase inflation protection to ensure benefits keep pace with rising costs.

Example: Offering a rider that increases the daily benefit amount by a certain percentage each year.

14. **Rule 120-2-16-.14 Requirements for Application Forms and Replacement Coverage**

Summary: This rule outlines the requirements for application forms and the process for replacing existing coverage.

Example: Application forms must include questions about existing coverage and whether the new policy will replace it.

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15. **Rule 120-2-16-.15 Reporting Requirements**

Summary: This rule specifies the reporting requirements for insurers, including data on claims, premiums, and policyholder demographics.

Example: Insurers must submit annual reports detailing the number of claims filed and paid.

16. **Rule 120-2-16-.16 Licensing**

Summary: This rule outlines the licensing requirements for agents and brokers who sell long-term care insurance.

Example: Agents must complete specific training and continuing education courses related to long-term care insurance.

17. **Rule 120-2-16-.17 Discretionary Powers of Commissioner**

Summary: This rule grants the Commissioner of Insurance discretionary powers to enforce the regulations and take action against non-compliant insurers.

Example: The Commissioner can impose fines or revoke licenses for violations of the regulations.

18. **Rule 120-2-16-.18 Reserve Standards**

Summary: This rule sets the reserve standards that insurers must maintain to ensure they can meet future policyholder obligations.

Example: Insurers must hold sufficient reserves to cover anticipated claims and expenses.

19. **Rule 120-2-16-.19 Loss Ratio**

Summary: This rule establishes the minimum loss ratio that insurers must achieve, ensuring that a certain percentage of premiums are used to pay claims.

Example: Insurers must spend at least 60% of premiums on claims and related expenses.

20. **Rule 120-2-16-.20 Premium Rate Schedule Increases**

Summary: This rule outlines the process and requirements for insurers to increase premium rates.

Example: Insurers must provide justification for rate increases and obtain approval from the Commissioner.

21. **Rule 120-2-16-.21 Filing Requirement**

Summary: This rule specifies the filing requirements for long-term care insurance policies, including forms and rates.

Example: Insurers must file policy forms and premium rates with the Commissioner for approval before issuing policies.

22. **Rule 120-2-16-.22 Filing Requirements for Advertising**

Summary: This rule outlines the requirements for filing advertising materials related to long-term care insurance.

Example: Insurers must submit all advertising materials to the Commissioner for review to ensure they are not misleading.

23. **Rule 120-2-16-.23 Standards for Marketing**

Summary: This rule sets standards for the marketing of long-term care insurance to protect consumers from deceptive practices.

Example: Marketing materials must clearly explain the benefits, limitations, and costs of the policy.

24. **Rule 120-2-16-.24 Suitability**

Summary: This rule requires insurers to ensure that long-term care insurance policies are suitable for the applicant's needs and financial situation.

Example: Agents must assess the applicant's financial situation and health status to recommend appropriate coverage.

25. **Rule 120-2-16-.25 Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates**

Summary: This rule prohibits insurers from imposing preexisting condition exclusions or probationary periods on replacement policies.

Example: A policyholder switching to a new policy cannot be denied coverage for preexisting conditions that were covered under the previous policy.

26. **Rule 120-2-16-.26 Availability of New Services or Providers**

Summary: This rule requires insurers to make new services or providers available to existing policyholders.

Example: If a new type of home health care service becomes available, existing policyholders must have access to it.

27. **Rule 120-2-16-.27 Right to Reduce Coverage and Lower Premiums**

Summary: This rule allows policyholders to reduce their coverage and lower their premiums if they can no longer afford the original policy.

Example: A policyholder can opt to reduce their daily benefit amount to lower their premium payments.

28. **Rule 120-2-16-.28 Nonforfeiture Benefit Requirement**

Summary: This rule requires insurers to offer a nonforfeiture benefit, which provides some level of continued coverage if the policy lapses.

Example: A policyholder who stops paying premiums may still receive reduced benefits based on the premiums paid.

29. **Rule 120-2-16-.29 Standards for Benefit Triggers**

Summary: This rule sets the standards for conditions that must be met to trigger benefit payments under long-term care insurance policies. It focuses on the insured's ability to perform activities of daily living (ADLs) and cognitive impairment.

Example: A policyholder becomes eligible for benefits if they are unable to perform at least two ADLs, such as bathing and dressing, or if they suffer from severe cognitive impairment like Alzheimer's disease[1].

30. **Rule 120-2-16-.30 Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts**

Summary: This rule provides additional standards for benefit triggers specifically for qualified long-term care insurance contracts, ensuring they meet federal requirements for tax-qualified plans.

Example: A qualified long-term care insurance policy must include benefit triggers that comply with Section 7702B of the Internal Revenue Code, such as requiring a licensed health care practitioner to certify that the insured needs substantial assistance with at least two ADLs for at least 90 days[2].

31. **Rule 120-2-16-.31 Standard Format Outline of Coverage**

Summary: This rule prescribes a standard format and content for the outline of coverage that must be provided to consumers. The outline helps consumers understand and compare long-term care insurance policies.

Example: The outline of coverage must be a separate document, using no smaller than ten-point type, and must include a description of the policy's benefits, limitations, and exclusions[3].

32. **Rule 120-2-16-.32 Requirements to Deliver Shopper's Guide**

Summary: This rule mandates that insurers provide a shopper's guide to consumers when they are considering the purchase of long-term care insurance. The guide helps consumers make informed decisions.

Example: Insurers must deliver the National Association of Insurance Commissioners (NAIC) Shopper's Guide to Long-Term Care Insurance to all prospective applicants at the time of solicitation[4].

33. **Rule 120-2-16-.33 Penalties**

Summary: This rule outlines the penalties for insurers, representatives, officers, or employees who fail to comply with the long-term care insurance regulations. Penalties can include fines and other enforcement actions.

Example: An insurer that fails to provide the required disclosures or misleads consumers about policy benefits may be subject to fines and could have their license to sell insurance in Georgia revoked[5].

GA CODE § 33-43-1

Summary: This section defines "Medicare supplement policy" as a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health care plans, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare[1].

Example: A health insurance policy that provides additional coverage to help pay for costs not covered by Medicare, such as copayments and deductibles.

GA CODE § 33-43-2

Summary: This section specifies the applicability of the chapter to all Medicare supplement policies delivered or issued for delivery in Georgia[2].

Example: A Medicare supplement insurance policy issued to a Georgia resident.

GA CODE § 33-43-3

Summary: This section prohibits Medicare supplement insurance policies from containing benefits that duplicate those provided by Medicare[3].

Example: A Medicare supplement policy that does not cover hospital stays already paid for by Medicare.

GA CODE § 33-43-4

Summary: This section requires that Medicare supplement policies must be guaranteed renewable and cannot be canceled or non-renewed for any reason other than non-payment of premium or material misrepresentation[4].

Example: A Medicare supplement policy that continues to provide coverage as long as premiums are paid on time.

GA CODE § 33-43-5

Summary: This section mandates that insurers provide an outline of coverage, informational brochures, and specific captions or notice requirements to ensure that policyholders are fully informed about their Medicare supplement policies[5].

Example: An insurance company providing a detailed brochure explaining the benefits and limitations of a Medicare supplement policy.

GA CODE § 33-43-6

Summary: This section requires insurers to offer Medicare supplement policyholders the option to purchase additional benefits, such as coverage for outpatient prescription drugs[6].

Example: A Medicare supplement policy that offers an optional rider for prescription drug coverage.

GA CODE § 33-43-7

Summary: This section mandates that insurers must adjust benefits and premiums to reflect changes in Medicare deductibles and copayments[7].

Example: A Medicare supplement policy that adjusts its premiums annually based on changes in Medicare's cost-sharing amounts.

GA CODE § 33-43-8

Summary: This section prohibits certain acts by adjusters, such as soliciting clients during a natural disaster[8].

Example: An adjuster refraining from soliciting business from individuals affected by a hurricane while the disaster is ongoing.

D. Long Term Care Partnership Requirements

These regulations establish the requirements for long-term care insurance policies that qualify for the Long-Term Care Partnership Program, which allows policyholders to protect more of their assets if they need to apply for Medicaid.

Example: A qualifying long-term care policy may allow a policyholder to retain more assets while still being eligible for Medicaid benefits.

More Information: Regulation 120-2-16-.01 through .33; Georgia Code § 33-42-1 through 6

Rule 120-2-16-.34 Georgia Long - Term Care Insurance Partnership Program

Regulation 120-2-16-.01

Summary: This regulation outlines the purpose of the long-term care insurance rules, which is to promote the public interest, ensure the availability of long-term care insurance, protect applicants from unfair practices, and facilitate public understanding and comparison of long-term care insurance policies[1].

Example: A regulation that ensures long-term care insurance policies are clearly explained to consumers, helping them make informed decisions.

Regulation 120-2-16-.02

Summary: This regulation specifies the scope and applicability of the long-term care insurance rules, indicating that they apply to all long-term care insurance policies delivered or issued for delivery in Georgia[2].

Example: A long-term care insurance policy issued in Georgia must comply with these regulations.

Regulation 120-2-16-.03

Summary: This regulation defines the terms used in the long-term care insurance rules, such as “long-term care insurance,” “policy,” and "certificate"[3].

Example: A policy document that includes definitions for terms like “long-term care services” and “benefit triggers.”

Regulation 120-2-16-.04

Summary: This regulation outlines the policy definitions that must be included in long-term care insurance policies, ensuring that terms are clearly defined and consistent[4].

Example: A long-term care insurance policy that defines “home health care” and “assisted living facility” in accordance with the regulation.

Regulation 120-2-16-.05

Summary: This regulation specifies the policy practices and provisions that must be included in long-term care insurance policies, such as renewability, eligibility, and benefit triggers[5].

Example: A policy that includes a provision stating it is guaranteed renewable for life, as long as premiums are paid.

Regulation 120-2-16-.06

Summary: This regulation requires policies to include certain practices and provisions, such as a 30-day free look period, incontestability after two years, and a prohibition on post-claims underwriting[6].

Example: A policy that allows the insured to cancel within 30 days for a full refund if they are not satisfied.

Regulation 120-2-16-.07

Summary: This regulation mandates that policies must include provisions to prevent unintentional lapse, such as requiring insurers to offer the option to designate a secondary addressee to receive lapse notices[7].

Example: A policy that allows the insured to designate a family member to receive notices if the policy is at risk of lapsing due to non-payment.

Regulation 120-2-16-.08

Summary: This regulation outlines the required disclosure provisions for long-term care insurance policies, including the need for clear and conspicuous statements about renewability, eligibility, and benefit triggers[8].

Example: A policy that includes a prominently displayed statement on the first page indicating it is guaranteed renewable.

Regulation 120-2-16-.09

Summary: This regulation requires insurers to disclose their rating practices to consumers, including any potential rate increases and the basis for such increases[9].

Example: A policy that includes a section explaining how and when premium rates may be increased.

Regulation 120-2-16-.10

Summary: This regulation mandates that insurers must provide a history of rate increases for the past ten years for the policy being purchased[9].

Example: A policy that includes a table showing the rate increase history for the past decade.

Regulation 120-2-16-.11

Summary: This regulation requires insurers to offer nonforfeiture benefits, which provide some level of continued coverage or benefits if the policy lapses due to non-payment[9].

Example: A policy that offers a reduced paid-up benefit if the insured stops paying premiums.

Regulation 120-2-16-.12

Summary: This regulation specifies the requirements for contingent benefit upon lapse, which provides benefits if the policy lapses after a substantial premium increase[9].

Example: A policy that offers a contingent benefit if premiums increase by more than a specified percentage.

Regulation 120-2-16-.13

Summary: This regulation outlines the requirements for the marketing of long-term care insurance policies, including prohibitions on misleading advertising and requirements for agent training[9].

Example: A policy that includes a statement ensuring all marketing materials have been reviewed for compliance with state regulations.

Regulation 120-2-16-.14

Summary: This regulation mandates that insurers must establish procedures to handle consumer complaints and grievances related to long-term care insurance policies[9].

Example: A policy that includes a section detailing the process for filing a complaint with the insurer.

Regulation 120-2-16-.15

Summary: This regulation requires insurers to provide a suitability form to help consumers determine if a long-term care insurance policy is appropriate for their needs[9].

Example: A policy that includes a suitability questionnaire to be completed by the applicant.

Regulation 120-2-16-.16

Summary: This regulation specifies the requirements for the delivery of a shopper's guide to prospective applicants of long-term care insurance[9].

Example: A policy that includes a guide explaining the basics of long-term care insurance and how to compare policies.

Regulation 120-2-16-.17

Summary: This regulation mandates that insurers must provide a policy summary to applicants, detailing the key features and benefits of the long-term care insurance policy[9].

Example: A policy that includes a summary page highlighting the main benefits and coverage limits.

Regulation 120-2-16-.18

Summary: This regulation requires insurers to provide an outline of coverage to applicants, summarizing the policy's benefits, limitations, and exclusions[9].

Example: A policy that includes an outline of coverage with a detailed list of covered services and exclusions.

Regulation 120-2-16-.19

Summary: This regulation specifies the requirements for the delivery of a policy or certificate to the insured, including the timing and method of delivery[9].

Example: A policy that is delivered to the insured within 30 days of approval.

Regulation 120-2-16-.20

Summary: This regulation mandates that insurers must provide a notice of the right to return the policy within 30 days for a full refund[9].

Example: A policy that includes a notice on the first page stating the insured can return it within 30 days for a full refund.

Regulation 120-2-16-.21

Summary: This regulation outlines the requirements for the renewal or continuation of long-term care insurance policies[9].

Example: A policy that clearly states it is guaranteed renewable for life.

Regulation 120-2-16-.22

Summary: This regulation specifies the requirements for the termination of long-term care insurance policies, including the conditions under which a policy can be canceled[9].

Example: A policy that can only be canceled for non-payment of premiums.

Regulation 120-2-16-.23

Summary: This regulation mandates that insurers must provide a notice of premium rate increases to policyholders[9].

Example: A policy that includes a provision requiring the insurer to notify the insured of any premium rate increases at least 60 days in advance.

Regulation 120-2-16-.24

Summary: This regulation outlines the requirements for the payment of claims under long-term care insurance policies[9].

Example: A policy that specifies claims must be paid within 30 days of receipt of all required documentation.

Regulation 120-2-16-.25

Summary: This regulation mandates that insurers must provide a notice of the right to appeal a denied claim[9].

Example: A policy that includes a section detailing the process for appealing a denied claim.

Regulation 120-2-16-.26

Summary: This regulation specifies the requirements for the coordination of benefits with other insurance policies[9].

Example: A policy that coordinates benefits with Medicare to avoid duplication of coverage.

Regulation 120-2-16-.27

Summary: This regulation mandates that insurers must provide a notice of the right to reduce coverage and lower premiums[9].

Example: A policy that allows the insured to reduce their coverage amount to lower their premium payments.

Regulation 120-2-16-.28

Summary: This regulation outlines the requirements for the reinstatement of long-term care insurance policies after a lapse[9].

Example: A policy that allows reinstatement within 60 days of lapse if the insured provides proof of cognitive impairment.

Regulation 120-2-16-.29

Summary: This regulation specifies the requirements for the payment of benefits in the event of the insured's death[9].

Example: A policy that pays a death benefit to the insured's beneficiary.

Regulation 120-2-16-.30

Summary: This regulation mandates that insurers must provide a notice of the right to convert a group policy to an individual policy[9].

Example: A group policy that allows the insured to convert to an individual policy upon leaving the group.

Regulation 120-2-16-.31: Standard Format Outline of Coverage

Summary: This regulation mandates that insurers provide a standardized outline of coverage for long-term care insurance policies. The outline must be a separate document, clearly formatted, and use a font size no smaller than ten points. It should include key information about the policy, such as benefits, limitations, and exclusions.

Example: An insurer issues a long-term care insurance policy and includes a separate document titled "Outline of Coverage." This document highlights the main benefits of the policy, such as daily benefit amounts, the duration of coverage, and any waiting periods before benefits begin. It also lists exclusions, like pre-existing conditions that are not covered.

Regulation 120-2-16-.32: Required Disclosure of Rating Practices to Consumers

Summary: This regulation requires insurers to disclose their rating practices to consumers. This includes providing information on how premiums are determined, any potential rate increases, and the factors that could lead to such increases. The goal is to ensure transparency and help consumers make informed decisions.

Example: When a consumer applies for a long-term care insurance policy, the insurer provides a document explaining how the premium is calculated based on the applicant's age, health status, and other factors. The document also informs the consumer that premiums may increase in the future due to changes in the insurer's claims experience or other financial factors.

Regulation 120-2-16-.33: Penalties

Summary: This regulation outlines the penalties for insurers and agents who violate the state's long-term care insurance regulations. Penalties can include fines and other disciplinary actions as provided under the Official Code of Georgia Annotated (O.C.G.A.).

Example: An insurance agent is found to have misrepresented the benefits of a long-term care insurance policy to a consumer. As a result, the Georgia Insurance Commissioner imposes a fine on the agent and requires them to undergo additional training on ethical sales practices.

Chapter 42. Long-Term Care Insurance

GA CODE § 33-42-1: Short Title

Summary: This section designates the chapter as the “Long-term Care Insurance Act.”

Example: When referring to the regulations governing long-term care insurance in Georgia, one would cite the “Long-term Care Insurance Act” as established by GA CODE § 33-42-1.

GA CODE § 33-42-2: Purpose of Chapter

Summary: This section outlines the purpose of the chapter, which is to promote the public interest, ensure the availability of long-term care insurance policies, protect applicants from unfair practices, and establish standards for these policies.

Example: An insurer must adhere to the standards set forth in this chapter to ensure that their long-term care insurance policies are fair and transparent, thereby protecting consumers from deceptive sales practices.

GA CODE § 33-42-3: Applicability of Chapter

Summary: This section specifies that the requirements of this chapter apply to all long-term care insurance policies issued, delivered, or issued for delivery in Georgia.

Example: A long-term care insurance policy issued by an insurer in Georgia must comply with all the regulations outlined in this chapter, regardless of where the policyholder resides.

GA CODE § 33-42-4: Definitions

Summary: This section provides definitions for terms used within the chapter, such as “applicant” and “group long-term care insurance policy.”

Example: In the context of this chapter, an “applicant” refers to the person seeking to contract for long-term care insurance benefits, whether for an individual or group policy.

GA CODE § 33-42-5: Group Policy Issued in Another State

Summary: This section addresses the conditions under which a group long-term care insurance policy issued in another state can be offered in Georgia.

Example: A group long-term care insurance policy issued in Florida can be offered to Georgia residents if it meets the standards and requirements set forth in this chapter.

GA CODE § 33-42-6: Disclosures; Provisions; Definition of Terms

Summary: This section allows the Commissioner to adopt regulations for full and fair disclosure in the sale of long-term care insurance policies. It includes standards for renewability, eligibility, coverage, and other key policy terms.

Example: An insurer must provide clear disclosures about the terms of renewability and any limitations or exclusions in the long-term care insurance policy, ensuring that consumers fully understand what they are purchasing.

That's It! You finished the course!

Feel free to take the Final Exam when you are ready at
https://www.classmarker.com/online-test/start/?quiz=4tc67756c7b0241f

Want to know more about Life, Accident & Sickness Insurance?

Then continue enjoy learning for a change on the following pages!

Georgia Access

Georgia Access is a state-based health insurance marketplace established to provide Georgians with a platform to shop for, compare, and enroll in health insurance coverage. This initiative aims to improve access to affordable, high-quality health insurance for residents of Georgia.

Key Features and Benefits

1. **State-Based Marketplace**:

Georgia Access allows residents to bypass the federal marketplace (Healthcare.gov) and use a state-specific platform tailored to their needs.

The platform offers a variety of health insurance plans, making it easier for Georgians to find coverage that suits their needs and budget.

Example: A Georgia resident can visit GeorgiaAccess.gov to compare different health insurance plans, check their eligibility for subsidies, and enroll in a plan directly through the state platform.

2. **Reinsurance Program**:

Georgia Access includes a reinsurance program that helps lower insurance premiums by reducing the risk for insurers. The state assumes part of the insurance claim costs, which helps stabilize the market and lower premiums for consumers.

Example: Due to the reinsurance program, a family in Georgia might see a reduction in their monthly health insurance premiums, making coverage more affordable.

3. **Enhanced Customer Service**:

Georgia Access focuses on providing superior customer service, with resources available to help residents understand their health coverage options and navigate the enrollment process.

Example: A resident can get assistance from local navigators or customer service representatives to help them choose the best health insurance plan and complete their enrollment.

4. **Employer Participation**:

The program allows employers to offset healthcare costs for their employees, making it easier for businesses to provide health benefits.

Example: A small business owner in Georgia can use Georgia Access to find affordable health insurance options for their employees, helping to attract and retain talent.

5. **Focus on Reducing Uninsured Rates**:

Georgia Access aims to reduce the number of uninsured residents by offering more plan options and making health insurance more accessible and affordable.

Example: Since the implementation of Georgia Access, the state has seen a decrease in the number of uninsured residents, providing more people with the security of health coverage.

About Georgia Access

Georgia Access is the state's program for Georgians to shop for and enroll in health insurance. With Georgia Access, Georgians will find many options to enroll in high-quality, comprehensive, and affordable health insurance.

In February 2023, Governor Brian P. Kemp designated OCI Commissioner John F. King to lead Georgia's transition from a State-based Exchange on the Federal Platform (SBE-FP) to a State-based Exchange (SBE). During Open Enrollment 2024, Georgia Access will operate as a SBE-FP, and Georgians should continue to shop for and enroll in health insurance coverage as they do today on the Federally-facilitated Exchange, also known as HealthCare.gov. During Open Enrollment 2025, Georgia Access will be a SBE, which means Georgians can visit GeorgiaAccess.gov to shop for, compare, and directly enroll in health insurance coverage.

If you want to learn about your health coverage options or just want to understand the advantages of health coverage, we can help. Georgia Access is here to connect Georgians with the resources you need to find affordable health insurance coverage. It's part of our ongoing commitment for all Georgians to get covered and get healthy.

Improving the Health Care Landscape in Georgia

According to September 2023 data from the U.S. Census Bureau, there are 1.2 million Georgians without health insurance. That's too many of our citizens left to worry about finances when they're impacted by a medical concern — and it doesn't have to be that way.

Since the passage of the Patients First Act in 2019, Georgia has worked to lower the cost of premiums and reduce the number of uninsured Georgians. Under Georgia Governor Brian Kemp and OCI Commissioner John F. King's leadership, Georgia has seen a decrease in premiums statewide and an increase in the number of plans offered across the state. A Reinsurance Program was also implemented in 2022 under a Section 1332 Waiver. Georgia Access allows Georgia to continue improving the quality and quantity of health insurance options available in the state.

Governor Kemp and **Commissioner King** have taken the following steps to establish an SBE and improve the health care landscape for Georgians:

Georgia SBE Milestones

The following outlines the key milestones in Georgia's journey to launch an SBE.

- **March 27, 2019:** Governor Kemp signs the Patients First Act authorizing the state to pursue innovative strategies for providing residents with access to high-quality, comprehensive, and affordable health insurance.
- **December 19, 2019:** Georgia submits application for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act (PPACA).
- **November 1, 2020:** Center for Medicare & Medicaid Services (CMS) grants approval of Georgia's 1332 Waiver providing authority to implement a Reinsurance Program and move its market off the federal exchange.
- **January 1, 2022:** Office of the Insurance and Safety Fire Commissioner (OCI) launches a Reinsurance Program aimed at lowering the cost of premiums and expanding coverage options for Georgians.
- **November 1, 2022:** Georgia launches a Public Awareness Campaign to encourage Georgians to enroll in health coverage during Open Enrollment 2023.
- **February 1, 2023:** Senate Bill 65 was introduced in the Georgia Legislature granting OCI authority to establish and operate an Exchange.
- **February 13, 2023:** Governor Kemp submits an SBE Letter of Intent to CMS.
- **February 14, 2023:** OCI Commissioner King submits the SBE Blueprint Application and Readiness Letter.
- **May 2, 2023:** Senate Bill 65 signed into law by Governor Kemp.
- **July 27, 2023:** CMS grants approval for the State of Georgia to operate an SBE-FP Open Enrollment 2024 and an SBE Open Enrollment 2025.
- **August 3, 2023:** OCI Commissioner King responded to the letter from CMS granting conditional approval.
- **November 1, 2023:** OCI launched Georgia Access as an SBE-FP ahead of Open Enrollment 2024.
- **July 24, 2024:** Georgia submitted its final SBE blueprint to CMS.
- **November 1, 2024:** OCI will launch Georgia Access as an SBE ahead of Open Enrollment 2025.

CMS Communications

CMS requires that states seeking to operate an SBE or SBE-FP must complete and submit an Exchange Blueprint Application:

August 24, 2023: OCI Commissioner King submits a revised SBE-FP Blueprint Application.

September 19, 2023: OCI Commissioner King submits a revised SBE Blueprint Application.

Please note the applications are living documents that are subject to change.

The State of Georgia provided comments on the Notice of Proposed Rule Making (NPRM) entitled, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025," which has far-reaching implications for states, issuers, and consumers. Georgia's full comment is posted to the federal comment website.

Georgia Access represents a significant step towards improving the health insurance landscape in Georgia, making it easier for residents to find and maintain affordable health coverage.

Kemp Announces Georgia Access Health Waiver

Atlanta, GA - Today Governor Brian P. Kemp joined members of the General Assembly and business leaders to unveil Georgia Access - a Section 1332 state relief and empowerment waiver to the Affordable Care Act. Georgia Access will help lower insurance premiums, introduce greater choice in the private health insurance market, and strengthen small businesses across Georgia.

"On the campaign trail, I promised to lead on healthcare reform in Georgia," **said Governor Kemp**. "During the 2019 legislative session, I worked with Lt. Governor Duncan, Speaker Ralston, and members of the House and Senate to champion the Patients First Act.

"Since then, we have worked with medical professionals, industry experts, state leaders, our partners in the federal government, and stakeholders to craft a Georgia-centric approach to lower healthcare costs and insurance premiums for Georgia families, enhance access to top-notch doctors and state-of-the-art services, and ultimately improve health outcomes for every Georgian in every part of our state.

"Georgia Access creates a state reinsurance program to incentivize the private sector, empower consumers, and lower insurance premiums for families. This plan shakes up the status quo as we work to enhance access to affordable, quality healthcare in Georgia.

"When combined with Georgia Pathway, our Section 1115 demonstration waiver, we will have healthcare reform in the Peach State that actually puts patients first."

"Governor Kemp‘s announcement today will do exactly what we talked about on the campaign trail - putting Georgia in the lead on the national conversation surrounding meaningful healthcare reform," **said Lt. Governor Duncan**. "Georgia Access will allow us to immediately begin tackling the top two issues that impact every single Georgian: affordability and access to quality services. Healthcare is a complicated topic, but the Georgia Access plan provides the framework to begin simplifying things through innovation and competition in order to better serve Georgia families."

“We know that access to quality healthcare is key to the health of our citizens and the economic well-being of our state,” **said Speaker David Ralston**. “I look forward to working with Governor Kemp as we review the details of the Georgia Access plan. We remain committed to Georgia-designed solutions that are fiscally-responsible and empower Georgians to care for themselves and their families.”

“I applaud Governor Kemp’s leadership on healthcare reform in Georgia," **said Insurance and Safety Fire Commissioner John King**. "Through Georgia Access, we will spur competition, enhance choice in the marketplace, and ultimately lower insurance premiums for families and hardworking Georgians.”

Georgia Access

State Relief and Empowerment 1332 Waiver

Since the inception of the Affordable Care Act, the individual insurance market in Georgia has experienced a significant level of instability. Between 2017 and 2019, the average individual insurance plan in Georgia increased between 27% and 41%. For many Georgia families, private sector health insurance coverage is the largest – and most volatile – expense in their budget.

Many are forced to compromise coverage for affordability while others seek new employment opportunities or take another job to foot the bill.

The Governor's 1332 Waiver, Georgia Access, will launch a state reinsurance program to create more choice, foster competition, and lower insurance costs for families. Like other states with similar programs, Georgia families will see a noticeable reduction in their insurance premiums – some upwards of double digits in certain parts of the state.

To generate a customer-focused and intuitive purchasing experience for Georgia families who qualify for health insurance subsidies (100% to 400% of the Federal Poverty Level), the state – if approved by the federal government – will no longer force Georgians to use Healthcare.Gov as the sole insurance enrollment portal. Instead, shoppers will use services from Direct Enrollment Brokers or purchase a plan directly from insurance providers. Through this waiver, Georgians will have access to more options which cover preexisting conditions and ensure optimal coverage at the right price.

Small businesses are the backbone of the Peach State's economy, employing millions of Georgians. Local employers have always tried to take care of their employees and their families, but with rapidly rising healthcare costs, many can no longer afford to offer full coverage to these hardworking Georgians. Under current law, employers cannot offset the cost of an employee's health insurance plan purchased through the federal exchange. Georgia Access waives that restriction and allows employers to invest in the health and well-being of their employees.

Features

• Establishes a reinsurance program where the state assumes part of the insurance claim to reduce risk, exposure
• Lowers private sector insurance rates – upwards of double digits
• Allows Georgians shopping for insurance to bypass Healthcare.gov and use industry-leading websites to find the best coverage at a lower price
• Allows employers to offset healthcare costs for their employees

Benefits

• Makes health insurance affordable for Georgia families
• Fosters competition, grows choice, lowers premiums
• Creates a customer-focused experience for shopping, enrollment
• Empowers employers to provide more benefits to their employees

What is Georgia Access, and how does it differ from the federal program on Healthcare.gov?

In May of 2023, **Georgia** Governor Brian Kemp signed legislation establishing a state-based marketplace where Georgia residents can apply, shop, and enroll in the health coverage that is right for them. While there are many similarities to the federal program, Georgia Access brings health coverage closer to home, and is focused solely on improving access to health coverage for Georgians.

Georgia Access is also driven to provide a superior customer service experience across the state. With Georgia Access, Georgians have access to a variety of resources to help them understand how to apply, shop, and enroll in coverage, including access to people who can help them right in their community.

Quizizz Questions & Answers Review

Question 1

What is a key feature of ordinary whole life insurance?

A) Premiums increase over time

B) It provides coverage for a limited period

C) It includes a cash value component that grows over time

D) The death benefit decreases over time

Correct Answer: C) It includes a cash value component that grows over time

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Question 2

Which type of life insurance policy requires a one-time lump-sum payment?

A) Ordinary Whole Life

B) Limited-Pay Life

C) Single-Premium Life

D) Universal Life

Correct Answer: C) Single-Premium Life

Question 3

What is a characteristic of universal life insurance?

A) Fixed premiums and death benefit

B) Flexible premiums and adjustable death benefit

C) Decreasing death benefit over time

D) No cash value component

Correct Answer: B) Flexible premiums and adjustable death benefit

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Question 4

In variable whole life insurance, what can cause the death benefit and cash value to fluctuate?

A) Changes in the insured's health

B) Market interest rates

C) Performance of the investments

D) Length of the policy term

Correct Answer: C) Performance of the investments

Question 5

Which type of life insurance policy combines the flexibility of universal life with investment options?

A) Indexed Life

B) Variable Universal Life

C) Interest-Sensitive Whole Life

D) Decreasing Term Life

Correct Answer: B) Variable Universal Life

Question 6

What is a feature of interest-sensitive whole life insurance?

A) Fixed premiums and cash value growth

B) Cash value growth based on market rates

C) Investment options in mutual funds

D) Decreasing death benefit over time

Correct Answer: B) Cash value growth based on market rates

Question 7

Which type of term life insurance provides a fixed death benefit and fixed premiums for a specified period?

A) Decreasing Term Life

B) Level Term Life

C) Return of Premium Term Life

D) Annually Renewable Term Life

Correct Answer: B) Level Term Life

Question 8

What happens in a return of premium (ROP) term life insurance policy if the policyholder outlives the policy term?

A) The death benefit is reduced

B) The premiums are refunded

C) The policy is automatically renewed

D) The cash value is forfeited

Correct Answer: B) The premiums are refunded

Question 9

What is a characteristic of an immediate annuity?

A) Payments start at a future date

B) Payments begin shortly after the initial premium is paid

C) Payments vary based on market performance

D) Payments are made for a fixed period only

Correct Answer: B) Payments begin shortly after the initial premium is paid

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Question 10

Which type of annuity provides guaranteed, fixed payments based on a set interest rate?

A) Variable Annuity

B) Indexed Annuity

C) Fixed Annuity

D) Deferred Annuity

Correct Answer: C) Fixed Annuity

Question 11

What is the accumulation period in an annuity?

A) The phase when the annuity pays out income

B) The phase when the annuity grows through contributions and interest

C) The phase when the annuity is converted to a life insurance policy

D) The phase when the annuity is terminated

Correct Answer: B) The phase when the annuity grows through contributions and interest

Question 12

What is a joint life (first to die) insurance policy?

A) It covers one individual and pays out upon their death

B) It covers two individuals and pays out upon the death of the first insured person

C) It covers two individuals and pays out only after both have passed away

D) It covers multiple individuals and pays out upon the death of the last insured person

Correct Answer: B) It covers two individuals and pays out upon the death of the first insured person

Question 13

What is a survivorship life insurance policy also known as?

A) First-to-die insurance

B) Second-to-die insurance

C) Convertible term insurance

D) Renewable term insurance

Correct Answer: B) Second-to-die insurance

Question 14

Which type of term life insurance allows the policyholder to renew the policy without a medical exam?

A) Convertible Term Life

B) Renewable Term Life

C) Decreasing Term Life

D) Return of Premium Term Life

Correct Answer: B) Renewable Term Life

Question 15

What is a feature of a convertible term life insurance policy?

A) It can be converted to a permanent life insurance policy without a medical exam

B) It provides a decreasing death benefit over time

C) It offers a refund of premiums if the policyholder outlives the term

D) It requires annual renewal with increasing premiums

Correct Answer: A) It can be converted to a permanent life insurance policy without a medical exam

Question 16

What is the primary benefit of a Waiver of Premium rider in a life insurance policy?

A) It allows the policyholder to purchase additional coverage without a medical exam.

B) It waives premium payments if the policyholder becomes disabled.

C) It provides additional benefits in case of accidental death.

D) It refunds premiums if the insured outlives the policy term.

Correct Answer: B) It waives premium payments if the policyholder becomes disabled.

Question 17

Which rider allows a policyholder to buy more insurance at specified intervals without a medical exam?

A) Accidental Death and Dismemberment

B) Guaranteed Insurability

C) Payor Benefit

D) Long Term Care

Correct Answer: B) Guaranteed Insurability

Question 18

What does the Payor Benefit rider do in a juvenile life insurance policy?

A) Provides additional coverage for accidental death.

B) Waives premiums if the payor becomes disabled or dies.

C) Allows the purchase of additional insurance without a medical exam.

D) Adjusts the death benefit for inflation.

Correct Answer: B) Waives premiums if the payor becomes disabled or dies.

Question 19

Which rider provides additional benefits if the insured dies in an accident?

A) Term Riders

B) Waiver of Premium

C) Accidental Death and Dismemberment

D) Return of Premium

Correct Answer: C) Accidental Death and Dismemberment

Question 20

What is the purpose of a Term Rider in a life insurance policy?

A) To provide coverage for additional individuals.

B) To add temporary additional coverage for a specified period.

C) To waive premiums if the policyholder becomes disabled.

D) To refund premiums if the insured outlives the policy term.

Correct Answer: B) To add temporary additional coverage for a specified period.

Question 21

Which rider provides coverage for additional individuals under the primary insured's policy?

A) Long Term Care

B) Other Insureds

C) Disability

D) Cost of Living

Correct Answer: B) Other Insureds

Question 22

What does the Long Term Care rider cover in a life insurance policy?

A) Nursing home or in-home care expenses.

B) Additional benefits for accidental death.

C) Waiver of premiums if the policyholder becomes disabled.

D) Refund of premiums if the insured outlives the policy term.

Correct Answer: A) Nursing home or in-home care expenses.

Question 23

What is the benefit of a Return of Premium rider?

A) It provides a monthly income if the policyholder becomes disabled.

B) It refunds premiums if the insured outlives the policy term.

C) It adjusts the death benefit for inflation.

D) It allows the purchase of additional insurance without a medical exam.

Correct Answer: B) It refunds premiums if the insured outlives the policy term.

Question 24

Which provision states that the life insurance policy and any attached riders constitute the entire agreement?

A) Insuring Clause

B) Free Look

C) Entire Contract

D) Consideration

Correct Answer: C) Entire Contract

Question 25

What does the Insuring Clause in a life insurance policy outline?

A) The rights and privileges of the policy owner.

B) The insurer's promise to pay a specified benefit upon the insured event.

C) The exchange of value between the policyholder and insurer.

D) The frequency of premium payments.

Correct Answer: B) The insurer's promise to pay a specified benefit upon the insured event.

Question 26

What is the purpose of the Free Look provision in a life insurance policy?

A) To allow the policyholder to review the policy and return it for a full refund if unsatisfied.

B) To specify the exchange of value between the policyholder and insurer.

C) To outline the rights and privileges of the policy owner.

D) To adjust the death benefit for inflation.

Correct Answer: A) To allow the policyholder to review the policy and return it for a full refund if unsatisfied.

Question 27

What does the Consideration clause specify in a life insurance policy?

A) The rights and privileges of the policy owner.

B) The exchange of value between the policyholder and insurer.

C) The frequency of premium payments.

D) The insurer's promise to pay a specified benefit upon the insured event.

Correct Answer: B) The exchange of value between the policyholder and insurer.

Question 28

What is the primary beneficiary in a life insurance policy?

A) The person who receives the death benefit if the primary beneficiary predeceases the insured.

B) The first person or entity designated to receive the death benefit.

C) A person under the legal age of majority designated to receive the death benefit.

D) A group of beneficiaries named without specifying individuals.

Correct Answer: B) The first person or entity designated to receive the death benefit.

Question 29

What does the Grace Period provision allow in a life insurance policy?

A) The policyholder to make premium payments after the due date without losing coverage.

B) The insurer to automatically borrow from the policy's cash value to pay overdue premiums.

C) The policyholder to adjust premium payments within certain limits.

D) The policyholder to review the policy and return it for a full refund if unsatisfied.

Correct Answer: A) The policyholder to make premium payments after the due date without losing coverage.

Question 30

What is the purpose of the Automatic Premium Loan provision?

A) To allow the policyholder to make premium payments after the due date without losing coverage.

B) To automatically borrow from the policy's cash value to pay overdue premiums.

C) To adjust the death benefit for inflation.

D) To allow the purchase of additional insurance without a medical exam.

Correct Answer: B) To automatically borrow from the policy's cash value to pay overdue premiums.

Question 31

What is the reinstatement provision in a life insurance policy?

A) It allows the policyholder to borrow against the cash value of the policy.

B) It allows the policyholder to restore a lapsed policy by meeting specific requirements.

C) It provides options for receiving dividends from the insurer.

D) It specifies exclusions for certain causes of death.

Correct Answer: B) It allows the policyholder to restore a lapsed policy by meeting specific requirements.

Question 32

Which of the following is a nonforfeiture option in a life insurance policy?

A) Policy loan

B) Dividend accumulation

C) Cash surrender value

D) Accelerated death benefit

Correct Answer: C) Cash surrender value

Question 33

What does the incontestability clause in a life insurance policy state?

A) The insurer can contest the policy at any time for any reason.

B) The insurer cannot contest the policy after a certain period, except for fraud.

C) The policyholder can change the beneficiary at any time.

D) The policyholder can borrow against the policy's cash value.

Correct Answer: B) The insurer cannot contest the policy after a certain period, except for fraud.

Question 34

What happens if the insured commits suicide within the specified period after the policy is issued?

A) The death benefit is paid in full.

B) The premiums paid are refunded, but the death benefit is not paid.

C) The policy is voided with no refund.

D) The death benefit is doubled.

Correct Answer: B) The premiums paid are refunded, but the death benefit is not paid.

Question 35

What is the purpose of the assignment provision in a life insurance policy?

A) To allow the policyholder to receive dividends.

B) To transfer ownership rights or the death benefit to another person or entity.

C) To exclude certain causes of death from coverage.

D) To provide a loan against the policy's cash value.

Correct Answer: B) To transfer ownership rights or the death benefit to another person or entity.

Question 36

Which of the following is a settlement option for a life insurance policy's death benefit?

A) Lump-sum payment

B) Policy loan

C) Dividend payment

D) Reinstatement

Correct Answer: A) Lump-sum payment

Question 37

What does the misstatement of age and gender provision in a life insurance policy address?

A) Adjusting the death benefit or premiums based on the correct age or gender.

B) Excluding coverage for certain causes of death.

C) Providing dividends to policyholders.

D) Allowing early access to the death benefit.

Correct Answer: A) Adjusting the death benefit or premiums based on the correct age or gender.

Question 38

What is the effect of a policy loan on a life insurance policy?

A) It increases the death benefit.

B) It reduces the cash value and may reduce the death benefit if not repaid.

C) It voids the policy.

D) It changes the policy's beneficiary.

Correct Answer: B) It reduces the cash value and may reduce the death benefit if not repaid.

Question 39

Which of the following is an example of a policy exclusion?

A) Dividend accumulation

B) War

C) Reinstatement

D) Settlement options

Correct Answer: B) War

Question 40

What is an accelerated death benefit in a life insurance policy?

A) A loan against the policy's cash value.

B) A provision allowing early access to a portion of the death benefit if the insured is terminally ill.

C) A dividend option.

D) A nonforfeiture option.

Correct Answer: B) A provision allowing early access to a portion of the death benefit if the insured is terminally ill.

Question 41

Who must sign the life insurance application to confirm that all parties have reviewed and agree to its terms?

A) Only the applicant

B) The applicant and the insured

C) The applicant, the insured, and the agent

D) Only the agent

Correct Answer: C) The applicant, the insured, and the agent

Question 42

What must the applicant do if there are changes or corrections made to the life insurance application after it has been completed?

A) Sign a new application

B) Initial the changes

C) Notify the insurance company

D) Do nothing

Correct Answer: B) Initial the changes

Question 43

What can result from submitting an incomplete life insurance application?

A) Immediate approval

B) Higher premium rates

C) Delays in the underwriting process

D) Automatic policy issuance

Correct Answer: C) Delays in the underwriting process

Question 444

What is the difference between warranties and representations in a life insurance application?

A) Warranties are not legally binding, representations are

B) Warranties can void the policy if false, representations may lead to claim denial

C) Representations are guaranteed to be true, warranties are not

D) There is no difference

Correct Answer: B) Warranties can void the policy if false, representations may lead to claim denial

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Question 45

What is issued to the applicant when the initial premium is collected at the time of application?

A) A final policy document

B) A conditional receipt

C) A refund receipt

D) A policy cancellation notice

Correct Answer: B) A conditional receipt

Question 46

What must agents provide when replacing an existing life insurance policy with a new one?

A) A verbal agreement

B) A side-by-side comparison and necessary disclosures

C) A refund of the old policy's premiums

D) A waiver of the new policy's premiums

Correct Answer: B) A side-by-side comparison and necessary disclosures

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Question 47

Which act requires life insurance companies to verify the identity of applicants and report suspicious activities?

A) Gramm-Leach-Bliley Act (GLBA)

B) Fair Credit Reporting Act (FCRA)

C) USA PATRIOT Act

D) Health Insurance Portability and Accountability Act (HIPAA)

Correct Answer: C) USA PATRIOT Act

Question 48

What is insurable interest in the context of life insurance?

A) The interest rate applied to the policy's cash value

B) The financial or emotional stake in the insured's life

C) The interest earned on premium payments

D) The interest charged on late premium payments

Correct Answer: B) The financial or emotional stake in the insured's life

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Question 49

Under the Fair Credit Reporting Act (FCRA), what must insurers do if they use an applicant's credit information in the underwriting process?

A) Ignore the credit information

B) Inform the applicant and provide the reporting agency's details

C) Automatically approve the application

D) Increase the premium rates

Correct Answer: B) Inform the applicant and provide the reporting agency's details

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Question 50

What is a Stranger/Investor Owned Life Insurance (STOLI) arrangement?

A) A policy taken out by the insured for their own benefit

B) A policy taken out by a third-party investor without insurable interest

C) A policy taken out by a family member

D) A policy taken out by a business partner

Correct Answer: B) A policy taken out by a third-party investor without insurable interest

Question 51

When does coverage typically begin for a life insurance policy?

A) When the policy is applied for

B) When the policy is delivered, the initial premium is paid, and any required delivery requirements are completed

C) When the policyholder signs the application

D) When the insurer approves the application

Correct Answer: B) When the policy is delivered, the initial premium is paid, and any required delivery requirements are completed

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Question 52

What is the role of a conditional receipt in life insurance coverage?

A) It guarantees coverage from the date of application

B) It provides temporary coverage if the initial premium is paid

C) It is a receipt for the policyholder's records

D) It is used to confirm the policyholder's identity

Correct Answer: B) It provides temporary coverage if the initial premium is paid

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Question 53

Which of the following is NOT typically explained to the client when delivering a life insurance policy?

A) Death benefit

B) Premium amounts

C) Policyholder's credit score

D) Exclusions and riders

Correct Answer: C) Policyholder's credit score

Question 54

In the context of contract law, what does "consideration" refer to in an insurance contract?

A) The policyholder's promise to pay premiums

B) The insurer's promise to pay the death benefit

C) The value exchanged between the parties

D) The legal capacity of the parties

Correct Answer: C) The value exchanged between the parties

Question 55

What constitutes an "offer" in the formation of an insurance contract?

A) The insurer issuing the policy

B) The applicant submitting an application and paying the initial premium

C) The policyholder signing the delivery receipt

D) The insurer reviewing the application

Correct Answer: B) The applicant submitting an application and paying the initial premium

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Question 56

Which of the following best describes a "unilateral" insurance contract?

A) Both parties have equal obligations

B) Only the insurer makes a legally enforceable promise

C) The policyholder can negotiate terms

D) The contract is voidable by either party

Correct Answer: B) Only the insurer makes a legally enforceable promise

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Question 57

What does it mean for an insurance contract to be a "contract of adhesion"?

A) It is flexible and negotiable

B) It is drafted by the policyholder

C) It is presented on a "take-it-or-leave-it" basis

D) It requires mutual agreement on all terms

Correct Answer: C) It is presented on a "take-it-or-leave-it" basis

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Question 58

Which of the following is an example of an "aleatory" contract?

A) A contract where both parties exchange equal value

B) A contract where performance depends on an uncertain event

C) A contract that is void if not signed

D) A contract that is illegal

Correct Answer: B) A contract where performance depends on an uncertain event

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Question 59

What is required for parties to be considered "competent" in forming a contract?

A) They must be of legal age and mentally sound

B) They must have a high credit score

C) They must be related by blood

D) They must have a legal representative

Correct Answer: A) They must be of legal age and mentally sound

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Question 60

What is the "legal purpose" of an insurance contract?

A) To ensure the policyholder profits from the contract

B) To provide coverage for illegal activities

C) To ensure the contract is for a lawful reason

D) To allow the insurer to avoid paying claims

Correct Answer: C) To ensure the contract is for a lawful reason

Question 61

What is third-party ownership in life insurance?

A) The insured is also the owner of the policy.

B) The owner of the policy is someone other than the insured.

C) The policy is owned by a government entity.

D) The policy is owned by a non-profit organization.

Correct Answer: B) The owner of the policy is someone other than the insured.

Question 62

Which of the following best describes a life settlement?

A) Selling a life insurance policy for its cash surrender value.

B) Selling a life insurance policy for a lump sum greater than the cash surrender value but less than the death benefit.

C) Surrendering a life insurance policy for its death benefit.

D) Converting a life insurance policy to an annuity.

Correct Answer: B) Selling a life insurance policy for a lump sum greater than the cash surrender value but less than the death benefit.

Question 63

What is the conversion privilege in group life insurance?

A) The ability to convert a group policy to an individual policy without evidence of insurability.

B) The ability to convert a group policy to a higher coverage amount.

C) The ability to convert a group policy to a different insurance company.

D) The ability to convert a group policy to a term policy.

Correct Answer: A) The ability to convert a group policy to an individual policy without evidence of insurability.

Question 64

In a contributory group life insurance plan, who pays the premiums?

A) The employer pays the entire premium.

B) The employee pays the entire premium.

C) Both the employer and employee share the premium cost.

D) The government subsidizes the premium.

Correct Answer: C) Both the employer and employee share the premium cost.

Question 65

Which of the following is a characteristic of a qualified retirement plan?

A) It does not meet IRS requirements for tax advantages.

B) It offers tax-deferred growth and meets IRS requirements.

C) It is only available to self-employed individuals.

D) It provides immediate tax benefits without IRS approval.

Correct Answer: B) It offers tax-deferred growth and meets IRS requirements.

Question 66

What is key person insurance?

A) Insurance that covers all employees equally.

B) Insurance that provides coverage for a company against the financial loss due to the death of a key employee.

C) Insurance that covers only the CEO of a company.

D) Insurance that is mandatory for all businesses.

Correct Answer: B) Insurance that provides coverage for a company against the financial loss due to the death of a key employee.

Question 67

What is the tax treatment of premiums for individual life insurance?

A) Premiums are tax-deductible.

B) Premiums are not tax-deductible.

C) Premiums are tax-deductible only if the policy is a term policy.

D) Premiums are tax-deductible only if the policy is a whole life policy.

Correct Answer: B) Premiums are not tax-deductible.

Question 68

How are Social Security benefits determined?

A) Based on the individual's age at retirement only.

B) Based on the individual's earnings history and contributions to the Social Security system.

C) Based on the individual's health status.

D) Based on the individual's family size.

Correct Answer: B) Based on the individual's earnings history and contributions to the Social Security system.

Question 69

What happens if a life insurance contract is classified as a Modified Endowment Contract (MEC)?

A) It retains all tax advantages of a regular life insurance policy.

B) Withdrawals and loans are taxed as income first and may incur penalties if taken before age 59½.

C) It becomes a tax-free investment vehicle.

D) It is automatically converted to an annuity.

Correct Answer: B) Withdrawals and loans are taxed as income first and may incur penalties if taken before age 59½.

Question 70

In a noncontributory group life insurance plan, who pays the premiums?

A) The employee pays the entire premium.

B) The employer pays the entire premium.

C) Both the employer and employee share the premium cost.

D) The premiums are paid by a third-party insurer.

Correct Answer: B) The employer pays the entire premium.

Question 71

What is required by Georgia regulations when replacing an existing life insurance policy with a new one?

A) No disclosures are necessary.

B) A detailed comparison and a notice explaining potential consequences.

C) Only verbal confirmation from the policyholder.

D) A simple form with the policyholder's signature.

Correct Answer: B) A detailed comparison and a notice explaining potential consequences.

Question 72

Which of the following is true about life insurance advertisements in Georgia?

A) They can make exaggerated claims about benefits.

B) They must comply with regulations to ensure clarity and truthfulness.

C)They do not need to state terms and conditions.

D) They can omit important information if space is limited.

Correct Answer: B) They must comply with regulations to ensure clarity and truthfulness.

Question 73

What does "insurable interest" mean in the context of life insurance?

A) The policyholder must have a legitimate interest in the insured person's life.

B) The policyholder can insure anyone without any specific reason.

C) The policyholder must be a family member of the insured.

D) The policyholder must be a business partner of the insured.

Correct Answer: A) The policyholder must have a legitimate interest in the insured person's life.

Question 74

According to Georgia regulations, what must a life insurance advertisement include?

A) Only the benefits of the policy.

B) Clear terms and conditions without misleading information.

C) The history of the insurance company.

D) Testimonials from satisfied customers.

Correct Answer: B) Clear terms and conditions without misleading information.

Question 75

In the example provided, why does John buy a life insurance policy on his business partner, David?

A) Because they are family members.

B) Because David's death would financially impact the business.

C) Because John wants to invest in life insurance.

D) Because David requested it.

Correct Answer: B) Because David's death would financially impact the business.

Question 76

What is the primary purpose of an Individual Disability Income Policy?

A) To provide funds for a business buyout

B) To cover business expenses like rent and utilities

C) To provide income replacement if the insured becomes unable to work due to a disability

D) To offer disability income benefits to employees

Correct Answer: C) To provide income replacement if the insured becomes unable to work due to a disability

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Question 77

Which type of policy is designed to cover business expenses if the business owner becomes disabled?

A) Individual Disability Income Policy

B) Business Overhead Expense Policy

C) Business Disability Buyout Policy

D) Group Disability Income Policy

Correct Answer: B) Business Overhead Expense Policy

Question 78

What does a Business Disability Buyout Policy provide?

A) Income replacement for employees

B) Funds to buy out a disabled partner’s share of the business

C) Coverage for business expenses like rent and utilities

D) Income replacement for the insured individual

Correct Answer: B) Funds to buy out a disabled partner’s share of the business

Question 79

Which policy is typically offered by employers to provide disability income benefits to employees?

A) Individual Disability Income Policy

B) Business Overhead Expense Policy

C) Business Disability Buyout Policy

D) Group Disability Income Policy

Correct Answer: D) Group Disability Income Policy

Question 80

An Individual Disability Income Policy typically pays what percentage of your salary if you are unable to work due to an illness or injury?

A) 30%

B) 40%

C) 50%

D) 60%

Correct Answer: D) 60%

Question 81

A Business Overhead Expense Policy example includes a policy that pays how much per month to cover office rent and utilities while the owner is recovering from surgery?

A) $2,000

B) $3,000

C) $5,000

D) $10,000

Correct Answer: C) $5,000

Question 82

What is the main benefit of a Group Disability Income Policy?

A) It provides funds for a business buyout

B) It covers business expenses like rent and utilities

C) It offers disability income benefits to employees

D) It provides income replacement for the insured individual

Correct Answer: C) It offers disability income benefits to employees

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Question 83

In a Business Disability Buyout Policy, what is the typical amount provided to buy out a partner who can no longer work due to a severe accident?

A) $100,000

B) $250,000

C) $500,000

D) $1,000,000

Correct Answer: C) $500,000

Question 84

Which type of policy is NOT specifically designed for business-related purposes?

A) Individual Disability Income Policy

B) Business Overhead Expense Policy

C) Business Disability Buyout Policy

D) Group Disability Income Policy

Correct Answer: A) Individual Disability Income Policy

Question 86

Which policy would be most suitable for a business owner concerned about covering employee salaries during their disability?

A) Individual Disability Income Policy

B) Business Overhead Expense Policy

C) Business Disability Buyout Policy

D) Group Disability Income Policy

Correct Answer: B) Business Overhead Expense Policy

Question 87

What does Accidental Death and Dismemberment insurance provide?

A) Benefits for natural death

B) Benefits if the insured dies or loses a limb due to an accident

C) Coverage for medical expenses

D) Coverage for routine check-ups

Correct Answer: B) Benefits if the insured dies or loses a limb due to an accident

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Question 88

Which of the following is an example of a benefit provided by Accidental Death and Dismemberment insurance?

A) 50,000/50,000 for routine dental care

B) 200,000/200,000 for accidental death

C) 100,000/100,000 for a broken arm

D) 300,000/300,000 for cancer treatment

Correct Answer: B) 200,000/200,000 for accidental death

Question 89

What type of expenses do Basic Hospital, Medical, and Surgical Policies cover?

A) Cosmetic surgery expenses

B) Basic hospital, medical, and surgical expenses

C) Alternative medicine expenses

D) Fitness and wellness programs

Correct Answer: B) Basic hospital, medical, and surgical expenses

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Question 90

Which policy provides comprehensive coverage for major medical expenses?

A) Basic Hospital, Medical, and Surgical Policies

B) Major Medical Policies

C) Accidental Death and Dismemberment

D) Health Maintenance Organizations (HMOs)

Correct Answer: B) Major Medical Policies

Question 91

What is a characteristic of Health Maintenance Organizations (HMOs)?

A) Provides unlimited choice of healthcare providers

B) Requires members to choose a primary care physician

C) Offers no coverage for hospital stays

D) Charges per service rather than a fixed annual fee

Correct Answer: B) Requires members to choose a primary care physician

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Question 92

Which of the following is true about Preferred Provider Organizations (PPOs)?

A) They require referrals for specialists

B) They offer more flexibility in choosing healthcare providers

C) They only cover emergency services

D) They have no network of providers

Correct Answer: B) They offer more flexibility in choosing healthcare providers

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Question 93

What is an example of a service covered by Basic Hospital, Medical, and Surgical Policies?

A) Gym memberships

B) Hospital stays

C) Over-the-counter medications

D) Cosmetic procedures

Correct Answer: B) Hospital stays

Question 94

Which type of insurance plan typically requires a fixed annual fee?

A) Major Medical Policies

B) Preferred Provider Organizations (PPOs)

C) Health Maintenance Organizations (HMOs)

D) Accidental Death and Dismemberment

Correct Answer: C) Health Maintenance Organizations (HMOs)

Question 95

What is a key feature of Major Medical Policies?

A) Limited coverage for minor illnesses

B) Comprehensive coverage for major medical expenses

C) Coverage only for dental procedures

D) No coverage for surgeries

Correct Answer: B) Comprehensive coverage for major medical expenses

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Question 96

Which insurance type is most likely to require choosing a primary care physician?

A) Accidental Death and Dismemberment

B) Major Medical Policies

C) Health Maintenance Organizations (HMOs)

D) Preferred Provider Organizations (PPOs)

Correct Answer: C) Health Maintenance Organizations (HMOs)

Question 97

What is another name for Medicare Supplement Policies?

A) Medigap

B) Medicaid

C) Medicare Advantage

D) Health Savings Account

Correct Answer: A) Medigap

Question 98

Which of the following is covered by a Medigap Plan G?

A) Prescription drugs

B) Medicare Part A and B coinsurance and deductibles

C) Long-term care

D) Vision and dental care

Correct Answer: B) Medicare Part A and B coinsurance and deductibles

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Question 99

During the open enrollment period, insurers may not deny a Medicare supplement policy based on which of the following?

A) Age

B) Health status

C) Employment status

D) Geographic location

Correct Answer: B) Health status

Question 100

How long is the free-look period for Medicare supplement policies?

A) 15 days

B) 30 days

C) 45 days

D) 60 days

Correct Answer: B) 30 days

Question 101

What happens if a policyholder is not satisfied with their Medicare supplement policy during the free-look period?

A) They can exchange it for another policy

B) They can return it for a full refund of the premium

C) They must keep it for one year

D) They can only cancel it after six months

Correct Answer: B) They can return it for a full refund of the premium

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Question 102

When does the open enrollment period for Medicare supplement policies begin?

A) When the applicant turns 60

B) When the applicant is enrolled in Medicare Part A

C) When the applicant is both age 65 or older and enrolled in Medicare Part B

D) When the applicant retires

Correct Answer: C) When the applicant is both age 65 or older and enrolled in Medicare Part B

Question 103

Which of the following is NOT typically covered by Medigap policies?

A) Foreign travel emergency care

B) Long-term care

C) Part A hospital coinsurance

D) Part B excess charges

Correct Answer: B) Long-term care

Question 104

What must be prominently printed on the first page of a Medicare supplement policy?

A) The policyholder's name

B) The insurer's contact information

C) A notice of the 30-day free-look period

D) The policy's effective date

Correct Answer: C) A notice of the 30-day free-look period

Question 105

Which of the following is a requirement for the issuance of a Medicare supplement policy during open enrollment?

A) The applicant must have a pre-existing condition

B) The applicant must be under 65 years old

C) The application must be submitted within 6 months of enrolling in Medicare Part B

D) The applicant must have a high income

Correct Answer: C) The application must be submitted within 6 months of enrolling in Medicare Part B

Question 106

What is the primary purpose of Medigap policies?

A) To replace Original Medicare

B) To cover costs not covered by Original Medicare

C) To provide dental and vision coverage

D) To offer prescription drug coverage

Correct Answer: B) To cover costs not covered by Original Medicare

Question 107

What is typically required for eligibility for Long Term Care (LTC) benefits?

A) The ability to perform all activities of daily living (ADLs)

B) The inability to perform at least two activities of daily living (ADLs)

C) A diagnosis of a chronic illness

D) A recommendation from a healthcare provider

Correct Answer: B) The inability to perform at least two activities of daily living (ADLs)

Question 108

Which of the following is NOT a level of care included in Long Term Care (LTC) policies?

A) Home care

B) Assisted living

C) Hospital care

D) Nursing home care

Correct Answer: C) Hospital care

Question 109

What percentage of the cost of dental cleanings and fillings is typically covered by a dental policy mentioned in the prompt?

A) 50%

B) 60%

C) 80%

D) 100%

Correct Answer: C) 80%

Question 110

Which of the following services is typically covered by vision insurance?

A) Dental cleanings

B) Routine eye care

C) Physical therapy

D) Prescription medications

Correct Answer: B) Routine eye care

Question 111

What is the primary benefit of cancer insurance as described in the prompt?

A) It provides coverage for routine check-ups.

B) It offers a lump-sum benefit upon diagnosis of cancer.

C) It covers all medical expenses related to cancer treatment.

D) It provides a monthly stipend for living expenses.

Correct Answer: B) It offers a lump-sum benefit upon diagnosis of cancer.

Question 112

Which of the following is an example of a service covered under a Long Term Care (LTC) policy?

A) Annual eye exam

B) In-home care services

C) Orthodontic treatment

D) Prescription drug coverage

Correct Answer: B) In-home care services

Question 113

What is an example of a benefit provided by vision insurance according to the prompt?

A) $150 allowance for dental procedures

B) $150 allowance for glasses or contact lenses

C) $150 allowance for physical therapy

D) $150 allowance for prescription medications

Correct Answer: B) $150 allowance for glasses or contact lenses

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Question 114

Which activity is mentioned as an example of an activity of daily living (ADL) in the context of Long Term Care (LTC) eligibility?

A) Cooking

B) Bathing

C) Driving

D) Shopping

Correct Answer: B) Bathing

Question 115

What type of insurance policy covers expenses such as cleanings, fillings, and orthodontics?

A) Vision insurance

B) Cancer insurance

C) Dental insurance

D) Long Term Care insurance

Correct Answer: C) Dental insurance

Question 116

Which of the following is NOT typically covered by a Long Term Care (LTC) policy?

A) Nursing home stays

B) Assisted living

C) Routine eye exams

D) Home care

Correct Answer: C) Routine eye exams

Question 117

What constitutes the entire contract between the insurer and the insured according to the policy provisions?

A) The policy, application, and any external documents

B) The policy and the application

C) The policy only

D) The application only

Correct Answer: B) The policy and the application

Question 118

What is the purpose of the "Time Limit on Certain Defenses" provision?

A) To allow the insurer to contest the policy indefinitely

B) To limit the time during which the insurer can contest the policy based on misstatements

C) To ensure the policy can be altered by external documents

D) To provide a grace period for premium payments

Correct Answer: B) To limit the time during which the insurer can contest the policy based on misstatements

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Question 119

After how many years can the insurer typically not contest the policy, except for fraud, according to the "Time Limit on Certain Defenses" provision?

A) One year

B) Two years

C) Three years

D) Five years

Correct Answer: B) Two years

Question 120

What does the "Grace Period" provision ensure?

A) The policy is canceled immediately after the premium due date

B) The policy remains in force without penalty after the premium due date for a certain period

C) The policy can be reinstated without proof of insurability

D) The insurer can contest the policy indefinitely

Correct Answer: B) The policy remains in force without penalty after the premium due date for a certain period

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Question 121

What is a typical duration for a grace period for premium payments?

A) 10 days

B) 20 days

C) 30 days

D) 60 days

Correct Answer: C) 30 days

Question 122

What does the "Reinstatement" provision allow?

A) A lapsed policy to be canceled permanently

B) A lapsed policy to be reinstated within a certain period with proof of insurability and payment of back premiums

C) A policy to be altered by external documents

D) A policy to be contested indefinitely

Correct Answer: B) A lapsed policy to be reinstated within a certain period with proof of insurability and payment of back premiums

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Question 123

Within how many years can a policy typically be reinstated after it has lapsed?

A) One year

B) Three years

C) Five years

D) Ten years

Correct Answer: C) Five years

Question 124

Which of the following is NOT a mandatory provision in the policy?

A) Entire Contract

B) Time Limit on Certain Defenses

C) Grace Period

D) Notice of Claim

Correct Answer: D) Notice of Claim

Question 125

What is the primary function of the "Entire Contract" provision?

A) To allow external documents to alter the policy terms

B) To ensure that no external documents can alter the terms of the policy

C) To provide a grace period for premium payments

D) To allow the policy to be contested indefinitely

Correct Answer: B) To ensure that no external documents can alter the terms of the policy

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Question 126

Which provision allows the insurer to contest the policy based on misstatements in the application?

A) Entire Contract

B) Time Limit on Certain Defenses

C) Grace Period

D) Reinstatement

Correct Answer: B) Time Limit on Certain Defenses

Question 127

What does the "Payment of Claims" clause specify in an insurance policy?

A) The method of premium payment

B) To whom the claims are payable

C) The amount of the deductible

D) The policy's expiration date

Correct Answer: B) To whom the claims are payable

Question 128

In the context of insurance, what is the purpose of a physical examination or autopsy as described in the "Physical Examination and Autopsy" clause?

A) To determine the policyholder's health status

B) To assess the value of the claim

C) To determine the cause of death

D) To verify the policyholder's identity

Correct Answer: C) To determine the cause of death

Question 129

What is the time limit within which legal action must be brought against the insurer according to the "Legal Actions" clause?

A) One year from the policy start date

B) Two years from the claim filing

C) Three years from the claim denial

D) Five years from the policy expiration

Correct Answer: C) Three years from the claim denial

Question 130

How can a policyholder change the beneficiary designation according to the "Change of Beneficiary" clause?

A) By calling the insurer

B) By submitting a written request to the insurer

C) By notifying the beneficiary

D) By updating their will

Correct Answer: B) By submitting a written request to the insurer

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Question 131

What happens if the insured's age or gender was misstated on the application, according to the "Misstatement of Age or Gender" clause?

A) The policy is voided

B) The premiums are refunded

C) The benefits are adjusted

D) The policy is transferred to another insurer

Correct Answer: C) The benefits are adjusted

Question 132

Who are the potential recipients of claims as specified in the "Payment of Claims" clause?

A) The insurer or the government

B) The insured or the beneficiary

C) The policyholder or the agent

D) The hospital or the doctor

Correct Answer: B) The insured or the beneficiary

Question 133

Under what circumstance might an insurer require an autopsy according to the "Physical Examination and Autopsy" clause?

A) In case of a natural death

B) In case of accidental death

C) When the policyholder requests it

D) When the beneficiary is unknown

Correct Answer: B) In case of accidental death

Question 134

What is the primary function of the "Legal Actions" clause in an insurance policy?

A) To extend the policy term

B) To limit the time period for legal action

C) To increase the policy coverage

D) To reduce the premium amount

Correct Answer: B) To limit the time period for legal action

Question 135

What must a policyholder do to change the beneficiary according to the "Change of Beneficiary" clause?

A) Pay an additional fee

B) Submit a written request

C) Obtain the beneficiary's consent

D) Wait for the policy renewal

Correct Answer: B) Submit a written request

Question 136

If the insured's age was misstated, how are the benefits adjusted according to the "Misstatement of Age or Gender" clause?

A) Based on the original application

B) To what the premiums would have purchased at the correct age

C) According to the current market rate

D) By reducing the coverage by 50%

Correct Answer: B) To what the premiums would have purchased at the correct age

Question 137

What is the primary purpose of the insuring clause in an insurance policy?

A) To outline the policyholder's rights

B) To specify the insurer’s promise to pay benefits upon a specified event

C) To detail the exclusions of the policy

D) To list the beneficiaries of the policy

Correct Answer: B) To specify the insurer’s promise to pay benefits upon a specified event

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Question 138

Which of the following best describes the free look provision in an insurance policy?

A) It allows the insurer to cancel the policy at any time

B) It permits the policyholder to review and return the policy for a full refund within a specified period

C) It provides a discount on the premium for the first year

D) It guarantees the policyholder a fixed interest rate

Correct Answer: B) It permits the policyholder to review and return the policy for a full refund within a specified period

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Question 139

How long is the typical free look period in an insurance policy?

A) 5 days

B) 10 days

C) 15 days

D) 30 days

Correct Answer: B) 10 days

Question 140

What does the consideration clause in an insurance policy specify?

A) The amount and frequency of premium payments

B) The conditions under which the policy can be canceled

C) The list of covered events

D) The policyholder's personal information

Correct Answer: A) The amount and frequency of premium payments

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Question 141

In a life insurance policy, what event typically triggers the payment of benefits according to the insuring clause?

A) The policyholder's retirement

B) The death of the insured

C) The policyholder's marriage

D) The birth of a child

Correct Answer: B) The death of the insured

Question 142

If a policyholder is not satisfied with their new insurance policy, what can they do during the free look period?

A) Request a partial refund

B) Return the policy for a full refund

C) Change the beneficiaries

D) Increase the coverage amount

Correct Answer: B) Return the policy for a full refund

Question 143

Which clause in an insurance policy outlines the insurer's obligation to pay benefits?

A) Exclusion Clause

B) Insuring Clause

C) Consideration Clause

D) Free Look Provision

Correct Answer: B) Insuring Clause

Question 144

What is the consequence of not adhering to the consideration clause in an insurance policy?

A) The policy may lapse due to non-payment

B) The policyholder will receive a bonus

C) The insurer will increase the coverage

D) The policyholder can change the terms of the policy

Correct Answer: A) The policy may lapse due to non-payment

Question 145

Which of the following is NOT typically included in the insuring clause?

A) The promise to pay benefits

B) The specified event triggering payment

C) The premium payment schedule

D) The identity of the insured

Correct Answer: C) The premium payment schedule

Question 146

What is the main benefit of the free look provision for policyholders?

A) It allows them to negotiate lower premiums

B) It provides an opportunity to review and cancel the policy without financial loss

C) It guarantees a fixed interest rate on the policy

D) It offers additional coverage options

Correct Answer: B) It provides an opportunity to review and cancel the policy without financial loss

Question 147

What is coinsurance in a health insurance policy?

A) A fixed amount paid for each medical service

B) The percentage of costs the insured pays after the deductible is met

C) The total amount paid by the insurer for covered expenses

D) The amount paid before the insurance company starts paying

Correct Answer: B) The percentage of costs the insured pays after the deductible is met

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Question 148

If a health insurance policy has an 80/20 coinsurance clause, what percentage of covered expenses does the insurer pay?

A) 20%

B) 50%

C) 80%

D) 100%

Correct Answer: C) 80%

Question 149

What is a deductible in a health insurance policy?

A) The percentage of costs the insured pays after the deductible is met

B) A fixed amount paid for each medical service

C) The amount the insured must pay out-of-pocket before the insurance company pays

D) The total amount paid by the insurer for covered expenses

Correct Answer: C) The amount the insured must pay out-of-pocket before the insurance company pays

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Question 150

If a health insurance policy has a $1,000 deductible, what does this mean for the insured?

A) The insured pays 20% of covered expenses

B) The insured pays the first $1,000 of covered expenses each year

C) The insurer pays the first $1,000 of covered expenses each year

D) The insured pays a fixed amount for each medical service

Correct Answer: B) The insured pays the first $1,000 of covered expenses each year

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Question 151

What are eligible expenses in a health insurance policy?

A) Medical costs not covered by the insurance policy

B) Medical costs covered by the insurance policy

C) The total amount paid by the insurer for covered expenses

D) A fixed amount paid for each medical service

Correct Answer: B) Medical costs covered by the insurance policy

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Question 152

Which of the following is an example of an eligible expense under a health insurance policy?

A) Cosmetic surgery

B) Over-the-counter medications

C) Hospital stays

D) Gym memberships

Correct Answer: C) Hospital stays

Question 153

What is a copayment in a health insurance policy?

A) A fixed amount the insured must pay for a covered service at the time of service

B) The percentage of costs the insured pays after the deductible is met

C) The amount the insured must pay out-of-pocket before the insurance company pays

D) The total amount paid by the insurer for covered expenses

Correct Answer: A) A fixed amount the insured must pay for a covered service at the time of service

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Question 154

If a health insurance policy requires a $20 copayment, what does this mean for the insured?

A) The insured pays 20% of covered expenses

B) The insured pays $20 for each covered service at the time of service

C) The insurer pays $20 for each covered service

D) The insured pays the first $20 of covered expenses each year

Correct Answer: B) The insured pays $20 for each covered service at the time of service

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Question 155

Which of the following best describes the relationship between deductibles and coinsurance?

A) Deductibles are paid after coinsurance

B) Coinsurance is paid after the deductible is met

C) Deductibles and coinsurance are the same

D) Coinsurance is a fixed amount paid for each service

Correct Answer: B) Coinsurance is paid after the deductible is met

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Question 156

Which of the following is NOT typically considered an eligible expense under a health insurance policy?

A) Prescription medications

B) Routine dental care

C) Surgeries

D) Hospital stays

Correct Answer: B) Routine dental care

Question 157

What is an impairment or exclusion rider in an insurance policy?

A) A provision that allows policyholders to increase coverage without a medical exam.

B) A provision that excludes coverage for certain high-risk conditions or activities.

C) A provision that guarantees a payout upon the policyholder's death.

D) A provision that reduces the premium for healthy individuals.

Correct Answer: B) A provision that excludes coverage for certain high-risk conditions or activities.

Question 158

Which of the following is an example of a guaranteed insurability rider?

A) Excluding coverage for preexisting conditions.

B) Allowing the purchase of additional insurance without a new medical exam.

C) Reducing premiums for non-smokers.

D) Providing a lump sum payment upon diagnosis of a critical illness.

Correct Answer: B) Allowing the purchase of additional insurance without a new medical exam.

Question 159

What does the future increase option rider allow a policyholder to do?

A) Decrease their coverage amount at future dates.

B) Increase their coverage amount at future dates without evidence of insurability.

C) Cancel their policy without penalty.

D) Transfer their policy to another person.

Correct Answer: B) Increase their coverage amount at future dates without evidence of insurability.

Question 160

Which rider would be most beneficial for someone expecting significant life changes, such as marriage or having children?

A) Impairment or exclusion rider.

B) Guaranteed insurability rider.

C) Accidental death benefit rider.

D) Waiver of premium rider.

Correct Answer: B) Guaranteed insurability rider.

Question 161

If a policyholder has a preexisting heart condition, which rider might affect their coverage?

A) Future increase option rider.

B) Impairment or exclusion rider.

C) Guaranteed insurability rider.

D) Return of premium rider.

Correct Answer: B) Impairment or exclusion rider.

Question 162

What is a key benefit of the guaranteed insurability rider?

A) It allows for premium reductions over time.

B) It provides coverage for high-risk activities.

C) It allows for additional coverage without a medical exam.

D) It guarantees a payout for accidental death.

Correct Answer: C) It allows for additional coverage without a medical exam.

Question 163

Which rider would allow a policyholder to increase their disability insurance coverage as their income grows?

A) Impairment or exclusion rider.

B) Future increase option rider.

C) Guaranteed insurability rider.

D) Critical illness rider.

Correct Answer: B) Future increase option rider.

Question 164

What is the primary purpose of an impairment or exclusion rider?

A) To provide additional benefits for critical illnesses.

B) To exclude coverage for specific high-risk conditions or activities.

C) To allow policyholders to increase coverage without a medical exam.

D) To offer a refund of premiums if no claims are made.

Correct Answer: B) To exclude coverage for specific high-risk conditions or activities.

Question 165

Which rider is specifically designed to allow policyholders to increase their coverage at specified times?

A) Impairment or exclusion rider.

B) Guaranteed insurability rider.

C) Future increase option rider.

D) Accidental death benefit rider.

Correct Answer: B) Guaranteed insurability rider.

Question 166

How does the future increase option rider benefit policyholders?

A) It allows them to decrease their premiums over time.

B) It provides a payout for accidental death.

C) It allows them to increase coverage without proving insurability.

D) It excludes coverage for certain conditions.

Correct Answer: C) It allows them to increase coverage without proving insurability.

Question 167

What is the primary purpose of Medicare?

A) To provide health insurance for individuals of all ages

B) To offer health insurance primarily for individuals aged 65 and older

C) To provide health insurance only for children

D) To offer health insurance exclusively for veterans

Correct Answer: B) To offer health insurance primarily for individuals aged 65 and older

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Question 168

Which part of Medicare covers inpatient hospital stays?

A) Part B

B) Part C

C) Part A

D) Part D

Correct Answer: C) Part A

Question 169

What does Medicare Part B cover?

A) Prescription drug coverage

B) Inpatient hospital stays

C) Outpatient care and preventive services

D) Hospice care

Correct Answer: C) Outpatient care and preventive services

Question 170

Which part of Medicare is also known as Medicare Advantage?

A) Part A

B) Part B

C) Part C

D) Part D

Correct Answer: C) Part C

Question 171

What is the role of private companies in Medicare Part C?

A) They provide prescription drug coverage only

B) They offer an alternative to Original Medicare that includes Parts A and B and often Part D

C) They manage Medicaid services

D) They provide only inpatient hospital services

Correct Answer: B) They offer an alternative to Original Medicare that includes Parts A and B and often Part D

Question 172

Which part of Medicare provides prescription drug coverage?

A) Part A

B) Part B

C) Part C

D) Part D

Correct Answer: D) Part D

Question 173

An individual turning 65 enrolls in Medicare Part A and Part B. What additional plan can they choose to include prescription drug coverage?

A) Part A

B) Part B

C) Part C

D) Part D

Correct Answer: C) Part C

Question 174

What type of care does Medicare Part A NOT cover?

A) Inpatient hospital stays

B) Skilled nursing facility care

C) Outpatient care

D) Hospice care

Correct Answer: C) Outpatient care

Question 175

Which of the following is NOT a component of Medicare?

A) Part A

B) Part B

C) Part E

D) Part D

Correct Answer: C) Part E

Question 176

What is the relationship between Medicare and Medicaid?

A) They are the same program

B) Medicare is a federal program, while Medicaid is a joint federal and state program

C) Medicaid is only for individuals over 65

D) Medicare provides more comprehensive coverage than Medicaid

Correct Answer: B) Medicare is a federal program, while Medicaid is a joint federal and state program

Question 177

What is the definition of Total Disability in insurance terms?

A) The inability to perform some, but not all, of the duties of one's occupation.

B) The inability to perform any of the duties of one's occupation.

C) A disability that recurs after the insured has returned to work.

D) Provides benefits if the insured can work but at a reduced capacity.

Correct Answer: B) The inability to perform any of the duties of one's occupation.

Question 178

Which type of disability coverage provides benefits if the insured can work but at a reduced capacity, resulting in a loss of income?

A) Total Disability

B) Partial Disability

C) Recurrent Disability

D) Residual Disability

Correct Answer: D) Residual Disability

Question 179

What does Partial Disability refer to in insurance terms?

A) The inability to perform any of the duties of one's occupation.

B) The inability to perform some, but not all, of the duties of one's occupation.

C) A disability that recurs after the insured has returned to work.

D) Provides benefits if the insured can work but at a reduced capacity.

Correct Answer: B) The inability to perform some, but not all, of the duties of one's occupation.

Question 180

Which type of disability is described as a disability that recurs after the insured has returned to work?

A) Total Disability

B) Partial Disability

C) Recurrent Disability

D) Residual Disability

Correct Answer: C) Recurrent Disability

Question 181

In the context of insurance, what rights does the policy owner have?

A) The right to receive disability benefits.

B) The right to make decisions about the policy, including naming beneficiaries.

C) The right to change the terms of the insurance contract unilaterally.

D) The right to cancel the policy at any time without penalty.

Correct Answer: B) The right to make decisions about the policy, including naming beneficiaries.

Question 182

A surgeon who injures their hand and can no longer perform surgeries may receive which type of disability benefits?

A) Total Disability

B) Partial Disability

C) Recurrent Disability

D) Residual Disability

Correct Answer: A) Total Disability

Question 183

If an insured person can perform some tasks but not all after an injury, which type of benefits might they receive?

A) Total Disability

B) Partial or Residual Disability

C) Recurrent Disability

D) None of the above

Correct Answer: B) Partial or Residual Disability

Question 184

Which of the following is NOT a type of disability coverage?

A) Total Disability

B) Partial Disability

C) Recurrent Disability

D) Accidental Disability

Correct Answer: D) Accidental Disability

Question 185

What is the primary difference between Partial and Residual Disability benefits?

A) Partial Disability is for total inability to work, while Residual is for partial inability.

B) Partial Disability provides benefits for some duties, while Residual is for reduced capacity and income loss.

C) Partial Disability is temporary, while Residual is permanent.

D) There is no difference; they are the same.

Correct Answer: B) Partial Disability provides benefits for some duties, while Residual is for reduced capacity and income loss.

Question 186

Which of the following scenarios best describes a Recurrent Disability?

A) An individual who cannot perform any job duties due to a severe injury.

B) An individual who returns to work after recovery but experiences the same disability again.

C) An individual who can perform some job duties but not all.

D) An individual who can work but at a reduced capacity, leading to income loss.

Correct Answer: B) An individual who returns to work after recovery but experiences the same disability again.

Question 187

What type of insurance covers injuries or illnesses that occur at work?

A) Nonoccupational insurance

B) Occupational insurance

C) Health insurance

D) Life insurance

Correct Answer: B) Occupational insurance

Question 188

Which of the following is an example of nonoccupational insurance?

A) Workers' compensation

B) Health insurance policy

C) Employer liability insurance

D) Disability insurance

Correct Answer: B) Health insurance policy

Question 189

What is the tax treatment of life insurance death benefits received by beneficiaries?

A) Taxable as ordinary income

B) Subject to capital gains tax

C) Tax-free

D) Subject to estate tax

Correct Answer: C) Tax-free

Question 190

Which type of insurance benefits may be taxable under certain circumstances?

A) Life insurance death benefits

B) Disability income benefits

C) Health insurance benefits

D) Workers' compensation benefits

Correct Answer: B) Disability income benefits

Question 191

What is the primary focus of managed care in the healthcare system?

A) Increasing healthcare costs

B) Providing unlimited access to specialists

C) Coordinating and managing patient care

D) Eliminating the need for primary care physicians

Correct Answer: C) Coordinating and managing patient care

Question 192

Which of the following is NOT typically covered by occupational insurance?

A) Injuries at the workplace

B) Illnesses due to workplace conditions

C) Injuries during a personal vacation

D) Accidents while performing job duties

Correct Answer: C) Injuries during a personal vacation

Question 193

What is the primary purpose of workers' compensation insurance?

A) To provide health coverage for families

B) To cover non-work-related injuries

C) To compensate employees for work-related injuries

D) To offer retirement benefits

Correct Answer: C) To compensate employees for work-related injuries

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Question 194

Which of the following statements is true regarding the tax treatment of insurance premiums?

A) All insurance premiums are tax-deductible

B) Life insurance premiums are always tax-deductible

C) Disability insurance premiums may be tax-deductible depending on the policy

D) Health insurance premiums are never tax-deductible

Correct Answer: C) Disability insurance premiums may be tax-deductible depending on the policy

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Question 195

What is a common feature of managed care plans?

A) Unlimited choice of healthcare providers

B) Emphasis on preventive care

C) No requirement for referrals

D) High out-of-pocket costs

Correct Answer: B) Emphasis on preventive care

Question 196

Which of the following is a characteristic of nonoccupational insurance?

A) Covers injuries that occur at work

B) Provides coverage for personal health issues

C) Is mandatory for all employers

D) Only covers work-related illnesses

Correct Answer: B) Provides coverage for personal health issues

Question 197

What is one of the broad powers of the Georgia Insurance Commissioner?

A) To set insurance premium rates

B) To revoke an insurance company's license if it violates state laws

C) To appoint insurance company executives

D) To provide legal advice to policyholders

Correct Answer: B) To revoke an insurance company's license if it violates state laws

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Question 198

What authority does the Georgia Insurance Commissioner have regarding the examination of insurance company records?

A) To audit only the policyholder records

B) To examine records to ensure compliance with state laws

C) To review only the marketing strategies of the company

D) To examine records only when a complaint is filed

Correct Answer: B) To examine records to ensure compliance with state laws

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Question 199

Which of the following is an example of the Commissioner's power to examine records?

A) Requiring an insurance company to submit its marketing plans

B) Requiring an insurance company to submit its financial records for examination to verify solvency

C) Requiring an insurance company to submit its employee records

D) Requiring an insurance company to submit its customer satisfaction surveys

Correct Answer: B) Requiring an insurance company to submit its financial records for examination to verify solvency

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Question 200

What is the primary purpose of the Georgia Insurance Commissioner's power to conduct investigations?

A) To increase state revenue

B) To ensure compliance with state laws and protect consumers

C) To promote insurance companies

D) To provide financial advice to insurance companies

Correct Answer: B) To ensure compliance with state laws and protect consumers

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Question 201

Which of the following is NOT a duty of the Georgia Insurance Commissioner?

A) Issuing rules and regulations

B) Conducting investigations

C) Enforcing penalties

D) Setting federal insurance policies

Correct Answer: D) Setting federal insurance policies

Question 202

What is the primary purpose of Medicare Supplement insurance?

A) To replace Medicare coverage entirely

B) To provide additional coverage to Medicare beneficiaries, covering gaps in Medicare coverage

C) To offer dental and vision insurance

D) To provide life insurance benefits

Correct Answer: B) To provide additional coverage to Medicare beneficiaries, covering gaps in Medicare coverage

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Question 203

Which of the following expenses might a Medicare Supplement policy cover?

A) Prescription drugs

B) Co-payments and deductibles

C) Gym memberships

D) Cosmetic surgery

Correct Answer: B) Co-payments and deductibles

Georgia Insurance Guaranty Association Quiz

Question 204

What is the primary purpose of the Georgia Life and Health Insurance Guaranty Association?

A) To provide new insurance policies to policyholders

B) To protect policyholders against the failure of insurers due to insolvency

C) To offer discounts on insurance premiums

D) To regulate insurance companies' pricing strategies

Correct Answer: B) To protect policyholders against the failure of insurers due to insolvency

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Question 205

Which types of policies does the Georgia Life and Health Insurance Guaranty Association cover?

A) Only life insurance policies

B) Only health insurance policies

C) Life, health, and annuity policies

D) Only annuity policies

Correct Answer: C) Life, health, and annuity policies

Question 206

What happens if an insurance company becomes insolvent according to the Georgia Life and Health Insurance Guaranty Association?

A) Policyholders lose all their benefits

B) The association ensures policyholders receive their benefits up to covered limits

C) The government takes over the insurance company

D) Policyholders must find a new insurance provider immediately

Correct Answer: B) The association ensures policyholders receive their benefits up to covered limits

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Question 207

What does the association of member insurers established by the Georgia Life and Health Insurance Guaranty Association do?

A) Provides loans to policyholders

B) Guarantees payment of benefits and continuation of coverage

C) Offers investment advice to policyholders

D) Sets insurance premium rates

Correct Answer: B) Guarantees payment of benefits and continuation of coverage

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Question 208

Which of the following is NOT a function of the Georgia Life and Health Insurance Guaranty Association?

A) Protecting policyholders from insurer insolvency

B) Offering new insurance policies

C) Ensuring continuation of coverage

D) Guaranteeing payment of benefits

Correct Answer: B) Offering new insurance policies

Question 209

If an insurance company providing life insurance becomes insolvent, what role does the Georgia Life and Health Insurance Guaranty Association play?

A) It does nothing as it only covers health insurance

B) It steps in to ensure policyholders receive their benefits

C) It cancels all existing policies

D) It increases the premiums for remaining policyholders

Correct Answer: B) It steps in to ensure policyholders receive their benefits

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Question 210

What is required for individual and group accident and sickness insurance policies in Georgia?

A) They must exclude coverage for pre-existing conditions.

B) They must include specific benefits and cannot exclude coverage for certain pre-existing conditions.

C) They can exclude coverage for individuals receiving medical assistance.

D) They do not need to be filed with the Commissioner for approval.

Correct Answer: B) They must include specific benefits and cannot exclude coverage for certain pre-existing conditions.

Question 211

Under Georgia regulations, who can be insured under an accident and sickness insurance policy?

A) Only the individual policyholder.

B) The policyholder and their dependents.

C) Only the dependents of the policyholder.

D) Any person residing in Georgia.

Correct Answer: B) The policyholder and their dependents.

Question 212

Is it legal for insurance contracts in Georgia to exclude coverage for an insurable person solely because they are receiving medical assistance?

A) Yes, it is legal.

B) No, it is illegal.

C) It depends on the insurance company.

D) Only if the person is over 65 years old.

Correct Answer: B) No, it is illegal.

Question 213

How long before use must basic insurance policy forms be filed with the Commissioner for approval in Georgia?

A) 30 days

B) 60 days

C) 90 days

D) 120 days

Correct Answer: C) 90 days

Question 214

What happens if the Commissioner does not approve or disapprove a policy form within the initial 90-day period?

A) The form is automatically disapproved.

B) The form is automatically approved.

C) The form is sent back for revision.

D) The form is considered void.

Correct Answer: B) The form is automatically approved.

Question 215

What is the primary purpose of Rule 120-2-8-.01 regarding Medicare Supplement insurance in Georgia?

A) To increase the cost of Medicare supplement policies

B) To standardize coverage and simplify terms and benefits

C) To limit the number of policies available to consumers

D) To provide exclusive benefits to certain groups

Correct Answer: B) To standardize coverage and simplify terms and benefits

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Question 216

Which of the following is an example of a benefit provided by Medicare Supplement policies?

A) Coverage for cosmetic surgery

B) Coverage for co-payments and deductibles

C) Coverage for gym memberships

D) Coverage for elective procedures

Correct Answer: B) Coverage for co-payments and deductibles

Question 217

Which of the following is NOT typically covered by Medicare Supplement policies?

A) Co-payments

B) Deductibles

C) Out-of-pocket expenses

D) Prescription drugs

Correct Answer: D) Prescription drugs

Question 218

What type of expenses do Medicare Supplement policies help cover?

A) Expenses for alternative medicine

B) Out-of-pocket expenses not covered by Medicare

C) Expenses for luxury healthcare services

D) Expenses for non-medical services

Correct Answer: B) Out-of-pocket expenses not covered by Medicare

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Question 219

What is the primary purpose of a Medicare supplement policy?

A) To provide dental insurance.

B) To supplement reimbursements under Medicare for hospital, medical, or surgical expenses.

C) To offer life insurance benefits.

D) To replace Medicare entirely.

Correct Answer: B) To supplement reimbursements under Medicare for hospital, medical, or surgical expenses.

Question 220

Which of the following is an example of a Medicare supplement policy?

A) A policy that covers only prescription drugs.

B) A health insurance policy that provides additional coverage for costs not covered by Medicare, such as copayments and deductibles.

C) A policy that offers vision and dental coverage.

D) A policy that provides travel insurance.

Correct Answer: B) A health insurance policy that provides additional coverage for costs not covered by Medicare, such as copayments and deductibles.

Question 221

What type of insurance is NOT included in the definition of a Medicare supplement policy in GA CODE § 33-43-1?

A) Accident and sickness insurance.

B) Hospital and medical service associations.

C) Health care plans.

D) Life insurance.

Correct Answer: D) Life insurance.

Question 222

Which program allows policyholders to protect more of their assets if they need to apply for Medicaid?

A) Medicare Advantage Program

B) Long-Term Care Partnership Program

C) Social Security Disability Insurance

D) Supplemental Nutrition Assistance Program

Correct Answer: B) Long-Term Care Partnership Program

Question 223

According to the Georgia regulations, what is one benefit of a qualifying long-term care policy?

A) It increases the premium costs for policyholders

B) It allows policyholders to retain more assets while being eligible for Medicaid benefits

C) It reduces the coverage period for long-term care

D) It limits the types of care covered under the policy

Correct Answer: B) It allows policyholders to retain more assets while being eligible for Medicaid benefits

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Question 224

Which of the following is NOT a goal of the long-term care insurance rules?

A) To protect applicants from unfair practices

B) To facilitate public understanding and comparison of long-term care insurance

C) To ensure the availability of long-term care insurance

D) To increase the complexity of insurance policies

Correct Answer: D) To increase the complexity of insurance policies

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Question 225

Which of the following is a key feature of the Long-Term Care Partnership Program?

A) It provides free long-term care services to all residents

B) It allows policyholders to protect more assets when applying for Medicaid

C) It mandates that all long-term care policies cover dental services

D) It requires policyholders to pay higher premiums

Correct Answer: B) It allows policyholders to protect more assets when applying for Medicaid

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Question 226

What is the main focus of the regulations under the “Long-term Care Insurance Act”?

A) Health insurance for children

B) Long-term care insurance

C) Automobile insurance

D) Home insurance

Correct Answer: B) Long-term care insurance

Question 227

What is the primary purpose of Georgia Access?

A) To provide a federal platform for health insurance

B) To offer Georgians a state-based marketplace for health insurance

C) To increase taxes for health insurance

D)To eliminate health insurance subsidies

Correct Answer: B) To offer Georgians a state-based marketplace for health insurance

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Question 228

Which program within Georgia Access helps to lower insurance premiums by reducing the risk for insurers?

A) Subsidy Program

B) Reinsurance Program

C) Premium Assistance Program

D) Deductible Reduction Program

Correct Answer: B) Reinsurance Program

Question 229

During which Open Enrollment period will Georgia Access operate as a State-based Exchange (SBE)?

A) Open Enrollment 2023

B) Open Enrollment 2024

C) Open Enrollment 2025

D) Open Enrollment 2026

Correct Answer: C) Open Enrollment 2025

Question 230

Who was designated to lead Georgia's transition to a State-based Exchange?

A) Governor Brian P. Kemp

B) OCI Commissioner John F. King

C) The U.S. Census Bureau

D) The Federal Government

Correct Answer: B) OCI Commissioner John F. King

Question 231

What significant change occurred in Georgia's health insurance landscape in 2022?

A) Implementation of a new tax on health insurance

B) Introduction of a Reinsurance Program under a Section 1332 Waiver

C) Elimination of all health insurance subsidies

D) Closure of all state-based health insurance exchanges

Correct Answer: B) Introduction of a Reinsurance Program under a Section 1332 Waiver

Disability Income (DI) Insurance: What It Is and How It Works

What Is Disability Income (DI) Insurance?

The term disability income (DI) insurance refers to an insurance policy that provides income to individuals who can no longer work because of a disability. Disability income insurance helps protect people from financial losses if an accident or illness renders them incapable of working and receiving regular income.

DI insurance is available through employers, Social Security, or insurance companies and comes in short-term and long-term disability coverage. Premiums are based on a number of factors, including a person's age and occupation. Policies pay benefits on a monthly basis.

What Is Social Security?

Social Security is the Old-Age, Survivors, and Disability Insurance (OASDI) program in the United States. It's run by the Social Security Administration (SSA), a federal agency. It's best known for retirement benefits, but it also provides survivor benefits and income for workers who become disabled.

Over 72 million Americans will collect benefits from Social Security in 2024.

Key Takeaways

- Social Security is a federal program in the U.S. that provides retirement benefits and disability income to qualified individuals and their spouses, children, and survivors.
- Workers must be at least 62 years old and have paid into the system for 10 years or more to qualify for Social Security retirement benefits.
- Workers who wait to collect Social Security until age 70 will receive higher monthly benefits.
- The amount of retirement benefits is calculated based on your average indexed monthly earnings (AIME) during your 35 highest-earning years. It varies from person to person.
- People who can’t work due to a disability and surviving spouses and children may also be eligible for benefits if they meet certain requirements.

How Social Security Works

Social Security is an insurance program. Workers pay into the program, typically through payroll withholding from their paychecks. Self-employed workers pay Social Security taxes when they file their federal tax returns.

The Basics on Payroll Tax

What Is a Payroll Tax?

A payroll tax includes the taxes employees and employers pay on wages, tips, and salaries. For employees, taxes are withheld from their paychecks and paid to the government by the employer. These taxes include federal, state, and local income taxes. It also includes the employee's share of Social Security and Medicare taxes (FICA), which are paid to the federal government.

Taxes that employers must pay include their share of FICA as well as federal and state unemployment taxes. The employer's share of payroll taxes is paid directly by the employer and not withheld from employees' paychecks.

Key Takeaways

- Payroll taxes are withheld from every employee's salary and remitted to the federal government.
- In the U.S., payroll taxes are used to fund Social Security and Medicare.
- Both employers and employees have to pay an equivalent share of Social Security and Medicare taxes.
- Payroll taxes are used to pay for government spending, including Social Security, Medicare, local infrastructure, and other designated programs.

Understanding Payroll Taxes

Federal payroll taxes include Social Security and Medicare contributions, which constitute the Federal Insurance Contributions Act (FICA) tax in the United States. These are labeled as MedFICA and FICA on pay stubs. Federal income tax, which is also withheld from employee paychecks, goes into the general fund of the U.S. Treasury.

What Is the Social Security Tax?

The Social Security program, established in 1935, provides monthly financial benefits to workers when they reach retirement age, as well as to survivors of deceased workers (e.g., a spouse or child), and disabled workers.

The Social Security tax is the tax levied on employers and employees to fund the Social Security program in the U.S. The revenue is collected in the form of a payroll tax and a self-employment tax.

Key Takeaways

- Social Security taxes fund the retirement, disability, and survivorship benefits that millions of Americans receive each year from the Social Security Administration.
- The Social Security tax rate is 12.4% and is divided evenly between employers and employees, on a maximum wage base of $168,600 in 2024 ($160,200 in 2023).
- Self-employed individuals pay the employer and employee portions of Social Security tax, but only on 92.35% of net business earnings.

- Certain groups, including some nonresident aliens and members of religious groups with specific views, are exempt from paying the Social Security tax.

The Social Security Tax for Employees

The Social Security tax is mandated by the Federal Insurance Contributions Act (FICA).1 It pays for the benefits that Americans receive under the Old-Age, Survivors, and Disability Insurance (OASDI) program—the official name for Social Security.

The Social Security tax is applied to income earned by employees and self-employed taxpayers. Employers usually withhold this tax from employees' paychecks and forward it to the government.

The funds collected for Social Security are not put into a trust for the individual employee currently paying into the fund, but are rather used to pay existing older people in a "pay-as-you-go" system.2

The Social Security tax is also collected to support individuals who are entitled to survivorship benefits—benefits paid to a surviving spouse upon the death of their spouse or to a dependent child upon the death of their parent(s).2

As of 2024, the Social Security tax rate is 12.4%. Half of the tax, or 6.2%, is paid by the employer, and the other 6.2% is paid by the employee.

The Social Security tax rate is assessed on all types of income earned by an employee, including bonuses.3

However, there is an income limit above which the tax cannot be applied. The limit for 2024 is $168,600. For 2023, it's $160,200.4

The Social Security Tax for Self-Employed People

The self-employment tax (which, for self-employed people, includes the Social Security tax) is mandated by the Self-Employed Contributions Act (SECA).

It's applied to the net earnings of the self-employed, up to an income limit: $168,600 in 2024, and $160,200 in 2023. Since the Internal Revenue Service (IRS) considers a self-employed individual to be both an employer and an employee, they have to pay the full 12.4% Social Security tax on their own.

The self-employment tax is made up of the Social Security tax and the Medicare tax. As of 2024, the self-employment tax is 15.3% (12.4% Social Security tax + 2.9% Medicare tax).5 The tax is applied to 92.35% of net business earnings.

Example

Chen, who runs a human resources consulting business, calculates his total net income for 2024 to be $200,000 after business expenses have been deducted. His self-employment tax rate will be assessed at 92.35% of $200,000, or $184,700 (.9235 x $200,000).

However, since this amount is above the $168,600 income limit, his tax bill actually will be 15.3% of $168,600, or $25,795.80 (.153 x $168,600).

Chen can claim an above-the-line deduction for half of his self-employment tax, or $12,897.90 ($25,795.80 ÷ 2). In effect, he gets a partial refund on the 7.65% employer portion of his self-employment tax (6.2% Social Security + 1.45% Medicare).

The U.S. Social Security program provides Americans with some financial protection from earnings lost due to retirement, death, or disability. Retired workers, their families, and survivors

of deceased workers receive monthly benefits payments. Social Security is funded mainly by the taxes that employees, their employers, and self-employed individuals pay throughout their working years.

Exemptions

Not every taxpayer has to pay the Social Security tax. Exemptions are available to specific groups of individuals, including:

- Members of a religious group who are opposed to receiving Social Security benefits during retirement, if disabled, or after death.
- Nonresident aliens—that is, individuals who are neither citizens nor legal residents of the United States, such as people who are in the country temporarily as students.
- Nonresident aliens working in the U.S. for a foreign government1.
- Students who are employed at the same school where they are enrolled, and where employment is contingent upon continued enrollment.

Example of Social Security Taxes

The Social Security tax is a regressive tax, meaning that a larger portion of lower-income earners' total income is withheld, compared with that of higher-income earners.12

Consider two employees, Aleksandr and Diego. Aleksandr earns $85,000 for the tax year 2024 and has the 6.2% Social Security tax withheld from his pay. The federal government collects $5,270 (.062 x $85,000) from Aleksandr to help pay for retirement, survivorship, and disability benefits.

Diego, on the other hand, earns $175,000 for the tax year 2024. The Social Security tax rate will only be applied up to the limit of $168,600.

Therefore, Diego will pay $10,453.20 (.062 x $168,600) as his contribution to the country's Social Security program for older people, survivors, and people with disabilities. But his effective Social Security tax rate is 6.0% ($10,453.20 ÷ $175,000). Diego, with a lower income, is taxed at the higher 6.2% rate ($5,270 ÷ $85,000).

What Is the Social Security Tax?

The Social Security tax is the revenue collected by the U.S. government to finance the Social Security program. The tax is automatically collected via employee payroll, and both employers and employees fund the program. Self-employed people pay it via the self-employment tax as both employees and employers along with Medicare. They pay it when they file their taxes.

What Is the Social Security Tax Income Limit?

In 2024, the income limit for Social Security tax is $168,600 (for 2023, it was $160,200). That means employees will not have to pay tax on any amount they earn above $168,600.4

How Can I Avoid Paying Taxes on Social Security?

If you earn in retirement between $25,000 and $34,000 and file as an individual, you may have to pay up to 50% in taxes on your Social Security benefits. If you earn more than $34,000, you may have to pay up to 85%. To minimize the tax, you can earn less, move income-generating assets into an individual retirement account (IRA), minimize withdrawals from retirement plans, or donate your required minimum distributions (RMDs).13

At What Age Is Social Security Not Taxable?

Social Security is always taxable, regardless of age. Your income in any given year determines whether or not your Social Security benefits are taxed.

The Bottom Line

The Social Security tax (at a rate of 12.4% as of 2024) is applied to the earned income of Americans throughout their working years. The revenue derived from the Social Security tax funds the Old-Age, Survivors, and Disability Insurance (OASDI) program, which is commonly known as Social Security.

Most states as well as some cities and counties, impose income taxes, which are also withheld as payroll taxes. In addition, employers, but not employees, also pay federal unemployment taxes for each of their employees.

Payroll taxes are collected by federal authorities and some state governments in many countries, including the U.S. These payroll tax deductions are itemized on an employee's pay stub. The itemized list notes how much is withheld for federal, state, and municipal income taxes, as well as the amounts collected for Medicare and Social Security payments.

Governments use revenues from payroll taxes to fund specific programs, including Social Security, healthcare, and workers' compensation. Local governments may collect a small payroll tax to maintain and improve local infrastructure and services, including first responders, road maintenance, and parks.

Payroll Tax Amounts

The premise of Social Security and Medicare is that you pay into them during your working years in order to qualify to withdraw these funds after retiring or under certain medical circumstances. An employee pays 7.65% of their pay for Medicare and Social Security (6.2% for Social Security and 1.45% for Medicare). An employer also pays the same tax of 7.65% for an employee, for a combined total of 15.3%.

Social Security Payroll Tax

Funds paid to Social Security taxes go into two trust funds: the Old-Age and Survivors Insurance (OASI) Trust Fund, which pays retirement and survivor benefits; and the Disability Insurance Trust Fund, for disability benefits. The Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security, and two public trustees manage these trust funds.

The Social Security tax is 6.2%, paid by both the employee and the employer, for a total of 12.4%. In 2024, income above $168,600 in 2024 is not taxed for Social Security.

President Franklin D. Roosevelt signed the Social Security Act into law on Aug. 14, 1935, to provide a safety net for the disabled and retirees. When the program was conceived, high-wage earners were exempt from paying into the fund and receiving Social Security benefits; however, the U.S. Congress replaced the exemption with a cap that usually increases at the same rate as wages.

Medicare Payroll Tax

As noted above, payroll taxes also go toward Medicare. These payroll deductions go into one of two separate trust funds: the Hospital Insurance Trust Fund. The Hospital Insurance Trust Fund pays for Medicare Part A and the associated administration fees. Part A assists in covering hospital care, skilled nursing inpatient care, and, in some cases, home care.

Most people don't pay a premium for Part A (hospital insurance) since they likely paid into the program during their working years through the payroll tax. The tax for Medicare is 1.45% for the employer and 1.45% for the employee, for a total Medicare tax of 2.9%. For individuals that earn over $200,000, an additional 0.9% is charged. This additional tax only applies to the employee, not the employer.

The other Medicare trust fund is the Supplementary Medical Insurance Trust Fund, which assists in paying for Medicare Parts B and D and other Medicare program administration costs. Part B covers laboratory tests and screenings, outpatient care, x-rays, ambulance service, and many additional costs. Part D helps with prescription drugs. This trust fund is funded through the authorization of congress that allocates funds, the premiums from people who are enrolled in Part B and D, and other sources, such as interest earned on the fund's investments.

Unemployment Taxes

Employers bear the primary responsibility for funding unemployment insurance. If they lay off employees, those employees are entitled to unemployment benefits. The rate of unemployment insurance the employer will pay varies by industry, state, and federal fees. Some states also require employees to contribute to unemployment and disability insurance.

Self-Employment Taxes

Self-employed individuals, including contractors, freelance writers, musicians, and small business owners, must remit payroll taxes as well. These are sometimes referred to as self-employment taxes.

Unlike most salaried workers, self-employed people don't have employers to remit payroll taxes on their behalf. As a result, they must cover both the employer and employee portions of the tax on their own.

The self-employment tax rate for 2024 is 15.3%, including a 12.4% contribution to Social Security—old-age, survivors, and disability insurance. The other portion of the tax is a 2.9% payment to Medicare, with another 0.9% surtax for Medicare on earnings that exceed $200,000.

If you are self-employed, you can deduct the employer portion of FICA taxes as a business expense.

Payroll Taxes vs. Income Taxes

There is a distinction between a payroll tax and an income tax, although both are deducted from paychecks. Payroll taxes are used to fund specific programs. Income taxes go into the general funds at the U.S. Treasury.1 State income tax, if the state levies any, goes into the state's treasury.

Everyone pays a flat payroll tax rate up to a yearly cap. Income tax, however, are progressive. Rates vary based on an individual's earnings.

What Makes Up Payroll Taxes?

Payroll taxes include all of the taxes on an individual's salary, wage, bonus, commission, and tips. These taxes are used to pay for Social Security, Medicare, unemployment, government programs, and local infrastructure.

What Is the FICA Tax?

The FICA tax stands for Federal Insurance Contributions Act and is used to pay for Social Security and Medicare. The total tax is 15.3%, split evenly between an employer and an

employee, meaning each pays a tax of 7.65%. This is made up of the Social Security tax (6.2%) and the Medicare tax (1.45%).

Does Everyone Pay a Payroll Tax?

Yes, for the most part, everyone pays a payroll tax, which is automatically deducted from one's paycheck. The Social Security and Medicare taxes are regressive (everyone pays the same amount), while income tax is progressive (those who make more are taxed at a higher rate). If you don't receive a paycheck, you must pay estimated taxes equivalent to what would have been withheld from your income.

The Bottom Line

Payroll taxes are the taxes employees and employers pay on wages, tips, and salaries. These taxes include federal, state, and local taxes, as well as FICA taxes, which are taxes for Social Security and Medicare. These taxes are all taken out of an employee's wages.

These taxes fund a range of programs, including Social Security, healthcare, defense spending, government salaries, and workers' compensation. Local governments may collect a small payroll tax to maintain and improve local infrastructure and services, including first responders, road maintenance, and parks.

Workers can earn up to four credits each year. One credit is granted up to $6,920 for every $1,730 earned in 2024, or up to four credits achieved.

The money goes into two Social Security trust funds: the Old-Age and Survivors Insurance (OASI) Trust Fund for retirees and the Disability Insurance (DI) Trust Fund for disability beneficiaries. These two funds are used to pay benefits to people who are currently eligible for them. The money that's not spent remains in the trust funds.6

A board of trustees oversees the financial operations of the two Social Security trust funds. Four of the six members are the secretaries of the Departments of Treasury, Labor, and Health and Human Services, and the Commissioner of Social Security. The remaining two members are public representatives appointed by the president and confirmed by the Senate.

Medicare is the federal health insurance program for Americans who are age 65 and older and some people who are receiving Medicare benefits due to disability. It's also supported through payroll withholding. This money goes into a third trust fund that's managed by the Centers for Medicare & Medicaid Services (CMS).

Social Security provides benefits to retirees, their survivors, and workers who become disabled.

Spouses and ex-spouses may be eligible for benefits based on the earnings records of their partners or former partners.

Who Can Get Retirement Benefits?

Workers who have paid into the Social Security system for at least 10 years become eligible for early retirement benefits at age 62.5 Waiting until your full retirement age (FRA) (between ages 66 and 67, depending on the year you were born) results in higher monthly benefits.12 You'll receive even more if you delay collecting retirement benefits until age 70, but benefits don’t continue to increase if you wait any longer than that.

Spouses can also claim benefits based on either their own earnings records or their spouses' records. A divorced spouse who isn't currently married can receive benefits based on an ex-spouse’s earnings record if the marriage lasted at least 10 years. Children of retirees can

also receive benefits until they turn 18 or longer if the child is disabled or a student. The cutoff is age 16 if you're caring for a child who isn't your own.

How Much Can I Get in Social Security Benefits?

The amount of your Social Security retirement benefit depends on your average indexed monthly earnings (AIME) during your 35 highest-earning years. Amounts will differ significantly among retirees. The average monthly retirement benefit was $1,869.77 as of June 2024.

Your annual amount increases by 8% for each year that you delay collecting benefits if your retirement age is 66 to 67. This starts with the year after you reach your full retirement age, and it stops at age 70. Those who begin taking Social Security when they reach the FRA of 66 would receive 100% of their primary insurance amount (PIA). They'd receive 108% of their PIA if they delayed taking benefits until the following year. They would receive 132% by delaying until age 70.

Social Security Administration. "Effect of Early or Delayed Retirement on Retirement Benefits."

The benefit varies depending upon when you begin taking it. The maximum monthly benefit for people aged 62 is $2,710 ($32,350 annually) in 2024. It's $4,873 ($58,476 annually) for those who have reached age 70.

A cost-of-living adjustment is made to Social Security benefits annually to keep pace with inflation. It was 8.7% for 2023 and it's 3.2% for 2024.

Workers can get a projection of their benefits at different retirement ages by using a calculator that's provided on the Social Security Administration website.

Social Security provides a special minimum benefit for long-term low earners that was first enacted in 1972. You must have income for at least 11 years to qualify. The special monthly minimum benefit was $50.90 ($610.80 annually) for December 2023. It increases for each additional year of low-income work, topping out at $1,066.50 or $12,798 annually for people who have worked for 30 years.

Who Can Get Disability Benefits?

People who can’t work due to a physical or mental disability that's expected to last for a year or more or result in death may be eligible for Social Security disability benefits (SSDI). You generally have to meet certain earnings tests to qualify.20 Family members of disabled workers can also be eligible.

How Much Can I Get in Disability Benefits?

About 8.3 million Americans were collecting SSDI benefits as of June 2024. The average monthly benefit was $1,398.08 ($16,776.96 annually). The monthly average for disabled workers was $1,537.70 ($18,452.40 annually). Spouses of disabled workers received an average of $420.74 monthly ($5,048.88 annually) and children of disabled workers received $493.19 monthly ($5,918.28 annually).

Who Can Get Survivor Benefits?

The spouse and children of a deceased worker may be eligible for survivor benefits based on the worker’s earnings record. This includes surviving spouses who are age 60 or older or age 50 or older and disabled. A surviving spouse who is caring for a child who is younger than 16 or disabled may be eligible for these benefits as well.

Children must generally be younger than 18 or disabled to receive benefits. A stepchild, a grandchild, a step-grandchild, or an adopted child may also qualify for benefits under certain circumstances.

Parents who are age 62 or older and who were dependent upon a deceased worker for at least half their income may also be eligible to collect benefits. Surviving spouses and minor children are also entitled to a one-time payment of $255 after an eligible worker's death under some circumstances.

How Much Can I Get in Survivor Benefits?

Approximately 5.8 million people were collecting survivor benefits as of June 2024. The average monthly benefit was $1,507.76 or $18,093.12 annually. Survivor benefits are broken down into five categories. Average payments in June 2024 were:

- Children of deceased workers: $1,105.32 monthly ($13,263.84 annually)
- Widowed mothers and fathers: $1,279.53 monthly ($15,354.36 annually)
- Nondisabled widow(er)s: $1,784.09 monthly ($21,409.08 annually)
- Disabled widow(er)s: $927.89 monthly ($11,134.68 annually)
- Parents of deceased workers: $1,618.45 monthly ($19,421.40 annually)1

The History of Social Security

The Social Security system was created on Aug. 14, 1935, when President Franklin D. Roosevelt signed the Social Security Act into law. The first monthly benefits checks became payable on Jan. 1, 1940. Ida M. Fuller, a retired legal secretary in Vermont, was the first person to collect one. Her check was for $22.54.

The system and its rules have evolved since 1935. Social Security is one of the largest government programs in the world, paying out hundreds of billions of dollars in benefits each year.

183 million

The number of people who paid Social Security taxes in 2023.

The Future of Social Security

Concerns have been raised about the aging of the U.S. population and the viability of a system in which fewer active workers will support a greater number of retirees as the cost of living continues to rise.

In its 2024 report, the Social Security Board of Trustees estimated that reserves in the retirement fund (OASI Trust Fund) will become depleted in 2033. This was unchanged from the previous year's projection. Ongoing tax revenue will be enough to pay only 79% of scheduled benefits after that time.

The report also projected that reserves of the Hospital Insurance (HI) Trust Fund that finances Medicare Part A will be depleted in 2036. This is five years later than projected in 2023. The program income will be able to cover 89% of scheduled benefits after 2036.

Congress will have to find ways to fill the gap if these predictions hold. This might mean higher taxes on workers, lower benefits, higher age requirements for retirees, or some combination of these elements.

What Benefits Does Social Security Provide?

Social Security provides monthly benefit payments for qualified retirees, disabled individuals, and for their spouses, children, and survivors. The benefit amount is based on several factors, including earnings history.

What Is the Difference Between Social Security and Supplemental Security Income (SSI)?

Supplemental Security Income (SSI) is a separate program from Social Security. It provides monthly cash distributions to elderly or disabled people with little to no income to help them meet their basic needs. You can be eligible for both Social Security benefits and SSI.

What Is Full Retirement Age (FRA)?

Full retirement age (FRA) is the age you must reach to be eligible to receive full retirement benefits from Social Security. Your FRA varies depending on when you were born. It's 66 years and two months for those born in 1955 and it gradually increases to age 67 for those born in 1960 or later.

The Bottom Line

The enactment of Social Security in 1935 was one of the signature achievements of President Franklin D. Roosevelt's administration. The program remains a cornerstone of most Americans' retirement, serving more than 72 million people.

Benefit amounts vary depending on income and years of employment. Surviving spouses, children, parents, and disabled workers and their family members may also be eligible to collect benefits in addition to retired workers.

The average retired worker's benefit amounts to about $20,000 annually so the program shouldn't be relied on as your sole source of retirement income. It's important to supplement it with other sources of retirement funding such as individual retirement accounts (IRAs), employer-sponsored plans such as a 401(k) or a 403(b), and other savings and investments.

Key Takeaways

- Disability income insurance provides insured individuals with income when they can no longer work because of an accident, injury, illness, and/or disability.
- DI insurance is available through employers, the Social Security Administration, or private insurance companies.
- Policies pay out benefits for short- or long-term disability coverage.
- Premiums are based on a number of factors, including a person's age and occupation.
- Policies pay benefits on a monthly basis, normally after the waiting period.

How Disability Income (DI) Insurance Works

Disabilities can cause a disruption in incomes and prevent people from maintaining their standards of living, paying their bills, or providing for their families. As many as 43% of individuals aged 40 will have a long-term disability by the time they turn 65. Enrolling in a disability income insurance policy can help individuals mitigate any losses that stem from an illness or accident that leads to a short- or long-term disability.

DI insurance isn't designed to guarantee 100% of your regular income. Instead, it intends to replace between 45% and 65% of your gross income. As noted above, most employers provide their employees with DI insurance benefits. This type of program is referred to as group insurance coverage. Benefits are also available to insured individuals and their families through

the Social Security Administration (SSA). Individuals may choose to purchase DI insurance to supplement existing coverage or if they don't have any insurance at all.

Premiums are based on a series of factors, including your age and occupation. If you work in a field that has a higher risk of injury, your premiums will be higher. The amount of income you receive is also factored into how much you pay for coverage—the more you earn, the higher your premiums.1 Policies pay benefits in the event that illness, accident, or injury prevents you from performing the material and substantial duties of your occupation.

Benefits are tax-free because the policyholder uses after-tax dollars to pay premiums.

You may have to pay taxes on your benefits if your employer pays for your DI insurance coverage.

After-Tax Contribution: Definition, Rules, and Limits

What Is an After-Tax Contribution?

An after-tax contribution is money paid into a retirement or investment account after income taxes on those earnings have already been deducted. When opening a tax-advantaged retirement account, an individual may choose to defer the income taxes owed until after retiring, if it is a traditional retirement account, or pay the income taxes in the year in which the payment is made, if it is a Roth retirement account.

Some savers, mostly those with higher incomes, may contribute after-tax income to a traditional account in addition to the maximum allowable pre-tax amount. They don't get any immediate tax benefit. This commingling of pre-tax and post-tax money takes some careful accounting for tax purposes.

Key Takeaways

- There are pre-tax and after-tax contributions to retirement accounts.
- Traditional accounts consist of pre-tax contributions, and Roth accounts consist of after-tax contributions.1
- If you think you will have a lower income during retirement, a traditional account may make sense. If you think you will have a higher income during retirement, a Roth may make sense.
- The 2024 annual limit on funding an IRA is $7,000 per year if under 50 years of age ($8,000 for those age 50 or older). For 2023, those numbers were $6,500 and $7,500.
- The 2024 annual limit on funding a 401(k) is $23,000 per year if under 50 years of age ($30,500 for those age 50 or older). For 2023, those numbers were $22,500 and $30,000.

Understanding After-Tax Contributions

In order to encourage Americans to save toward their retirement years, the government offers several tax-advantaged retirement plans such as the 401(k) plan, offered by many companies to their employees, and the individual retirement account (IRA), which anyone with earned income can open through a bank or a brokerage.

Most, but not all, people who open a retirement account can choose either of the two main options:

- The traditional retirement account allows its owner to put pre-tax money in an investment account. That is, the money is not subject to income tax in the year it is paid in. The saver's

gross taxable income for that year is reduced by the amount of the contribution. The IRS will get its due when the account holder withdraws the money, typically after retiring.

- The Roth account is the after-tax option. It allows the saver to pay in money after it is taxed. That is more of a hit to the person's immediate take-home income. But after retirement, no further taxes are owed on the entire balance in the account, as long as it's been five years since the first contribution was made to the account. There are Roth IRAs, Roth 457(b)s, and Roth 403(b)s. The Roth 401(k) option (referred to as a designated Roth option) is newer, and not all companies offer them to their employees. Earners above a set limit are not eligible to contribute to a Roth IRA account.

Post-Tax or Pre-Tax?

The post-tax Roth option offers the attraction of a retirement nest egg that is not subject to further taxes. It makes the most sense for those who believe they may be paying a higher tax rate in the future, either because of their expected retirement income or because they think taxes will go up.

In addition, money contributed post-tax can be withdrawn at any time without penalty. (The same is not true for the profits in the account, however; account-holders must wait until they are 59½ to withdraw profits without penalty.)3

On the downside, the post-tax option means a smaller paycheck with every contribution into the account.

The pre-tax or traditional option reduces the saver's taxes owed for the year the contributions are made, and it is a smaller hit to current income. With a traditional account that is funded with pre-tax contributions, withdrawals are considered taxable income, whether it's money that was paid in or profits from the money earned.

Contribution Limits

Both post-tax and pre-tax retirement accounts have limits on how much can be contributed each year:

- The annual contribution limit for both Roth and traditional IRAs is $7,000 for tax year 2024 ($6,500 in 2023). Those age 50 or older can deposit an additional catch-up contribution of $1,000 in both 2023 and 2024.

- The annual contribution limit for both Roth and traditional 401(k) plans is $23,000 for tax year 2024 ($22,500 in 2023), plus up to an additional $7,500 for those age 50 and older in both 2023 and 2024.

- If you have a pre-tax or traditional account, you will have to pay taxes on money withdrawn before age 59½. The funds are also subject to a 10% early withdrawal penalty.

Special Considerations

Withdrawals of after-tax contributions to a traditional IRA should not be taxed. However, the only way to make sure this doesn't happen is to file IRS Form 8606. Form 8606 must be filed for every year you make after-tax contributions to a traditional IRA and for every subsequent year until you have used up all of your after-tax balance.

Since the funds in the account are separated into taxable and non-taxable components, figuring the tax due on the required distributions is more complicated than if the account holder had made only pre-tax contributions.

What Are the IRA Limits?

The IRA contribution limits for 2023 are $7,000 ($6,500 in 2023). If you are age 50 or older, you may contribute an additional $1,000 in both 2023 and 2024. These limits are for both traditional IRAs and Roth IRAs.

Can I Contribute to Both a Traditional IRA and a Roth IRA?

Yes, you can contribute to both a traditional IRA and a Roth IRA. There are no restrictions on contributing to both; however, the total amount you contribute to both cannot be over the overall limit for IRAs set by the IRS. That limit in 2024 is $7,000. For 2023, it was $6,500. There's an additional $1,000 allowed in both years if you're 50 or older.

Is It Better to Do Pre-Tax or After-Tax Contributions?

Whether it's better to contribute on a pre-tax or after-tax basis will depend on your financial circumstances. The rule of thumb is that pre-tax contributions are better for higher-earners while after-tax contributions are better for lower-earners, particularly those who expect to be in a higher tax bracket when they retire.

The Bottom Line

After-tax contributions into retirement accounts can be beneficial if you expect to be in a higher income-tax bracket when you are retired. This may not always be the case, and everyone's situation is different. Generally, it's good to have a mix of retirement accounts that allow for tax advantages in the present and when you are retired.

Special Considerations

Disability income insurance policies contain a specific monthly benefit amount that is based on your monthly or annual income. For instance, your employer-provided benefit may pay $3,000 a month. Unless stated in the policy language, DI policies do not coordinate with Social Security benefits but pay in addition to it. Look for an indexed policy that keeps up to date with inflation, as your benefits likely won't kick in for some time.

Most insurance companies provide plans that carry a maximum benefit period of two, three, five, or 10 years. However, some companies have plans that pay up to the age of 65, 67, 70, or for the rest of your life. Once again, the price increases to purchase an extended benefit period.

Policies have waiting periods before you're able to receive any benefit payments. This refers to the amount of time or number of days that you are disabled before benefits kick in. These periods, which are also called elimination periods, vary by employer and insurer. The most common period is 90 days. The shorter the elimination period, the more expensive the premium.

Waiting Period: Definition, Types, and Examples

What Is a Waiting Period?

A waiting period is the amount of time an insured must wait before some or all of their coverage comes into effect. The insured may not receive benefits for claims filed during the waiting period. Waiting periods may also be known as elimination periods and qualifying periods.

Key Takeaways

- A waiting period, also known as a qualifying period, is the time before insurance coverage kicks in.
- Various insurance policies can have waiting periods, including homeowners' insurance, auto insurance, and short-term disability.

- Waiting periods are often used by companies that experience high turnover rates.
- Some private health insurance plans have longer wait periods, such as for cancer or maternity care.

How a Waiting Period Works

The waiting period or elimination period before the insured may make claims varies by insurer, policy, and type of insurance. For more extended waiting periods before coverage is active, the cost of a premium may reduce slightly. In health insurance, there are several types of waiting periods.

An employer waiting period requires an employee to wait a specified period, such as three months, before they may receive company-subsidized health services. Often a provision like this will be in place for a company that expects a high turnover rate in employees. Once an employee enrolls, they may have an additional waiting period before they may claim on the coverage.

Health Maintenance Organizations (HMO) have affiliation waiting periods. The Health Insurance Portability and Accountability Act (HIPAA) regulates affiliation wait periods and does not allow them to exceed two months (three months for late enrollees).

A pre-existing condition exclusion period varies from one to 18 months. These wait times refer to specific health conditions an individual may have in the six months before enrolling in a health insurance plan. Coverage may be limited or excluded for the pre-existing condition. However, if the insured can prove uninterrupted insurance previous to changing policies, that coverage can count towards the pre-existing condition exclusion. Exemptions allow those who have at least one year of group health coverage at one job and a span of no more than 63 days to avoid this provision.

Some private health insurance plans come with long mandatory waiting periods for certain types of coverage:

- Cancer and cardiovascular care may have wait periods of up to two years.
- Maternity care waits may be as long as 10 to 12 months but commonly are 30 to 90 days.
- The dental care waiting period is typically 6 to 12 months. Some insurance companies also impose restrictions, or additional waiting periods, that control how often the insured may receive specific dental treatments. For example, denture replacement may be restricted to once every five years.

Policyholders need to consider their ability to pay for expenses when choosing the length of the waiting period for a policy.

Types of Waiting Periods

Homeowner insurance wait periods will usually span 30 to 90 days before coverage is in effect. After the waiting period expires, policyholders may file claims against the policy. Wait periods will vary by the insurance provider. Also, in some regions, such as coastal zones, when a named storm is in the area, new policies will not go into effect until after the storm passes.

Some states may impose wait periods on other insurance products. As an example, Texas will place a 60-day wait on new auto insurance policies. This period gives the provider a chance to decide if the driver fits within their risk profiles. During the 60-day period, the company may cancel the auto policy if they have concerns about the risk profile or undisclosed issues.

Short-term disability coverage can have wait periods as short as a few weeks, but these policies will have higher premiums. Most short-term policies wait 30 to 90 days for coverage. Long-term disability wait periods can be between 90 days and a full year. As with other insurance products, during the probationary period, no benefits are payable. For Social Security, disability payments will also have a waiting period of five months.

Policies do not pay 100% of an employee's salary and may not guarantee job protection. But there are certain protections that come with most policies. Noncancelable policies mean insurers can't cancel the policy for any reason unless you stop paying your premiums. Guaranteed renewable policies allow individuals to renew their policies without any changes. But the insurer may increase premiums at any time.

Not all disability income insurance policies are the same. You should review any coverage offered by your employer or private insurer before you sign up.

How to Get Disability Income Insurance

You aren't required to have DI insurance unlike other forms of coverage, such as homeowners insurance. But most employers provide their employees with some type of disability insurance as part of their annual benefits packages. They may also give the option of additional coverage. Premiums are paid through regular payroll deductions.

Workers' compensation is a form of disability insurance mandated by the government. Individuals receive benefits through employers who are covered by the Workplace Safety and Insurance Act. This form of disability insurance covers injuries or illnesses as a result of employment. Compensation usually covers medical fees that are related to an employee's injuries or the equivalent of sick pay during a medical leave.

The quality and scope of the employer-provided and workers' compensation coverage may leave a disabled employee short of the protection they require. Many employer-offered plans are part of a suite of coverage and may not pay to the levels an employee needs to meet their expenses. You can choose to elect supplementary coverage on your own through a private insurance company. This is especially important for self-employed individuals and small business owners who may not claim workers' compensation for themselves.

As noted above, you may qualify for disability benefits through the Social Security Administration. Social Security Disability Insurance and Supplemental Security Insurance (SSI) provide benefits to insured individuals and their families. Being insured means you worked long (and recently) enough and contributed through Social Security taxes on your earnings. This means you don't actually purchase coverage through the SSA the same way you would through a private insurance company. You must apply online, by phone, in person, or by mail to begin receiving benefits, which are capped. Changes are made each year by the agency.

California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico require all employers to take part in disability income plans. Participation in any type of plan is completely voluntary for employers in other states.

Types of Disability Income (DI) Insurance

Disability income insurance comes in two different types: Short- and long-term disability coverage. We've noted some of the basic components of each below.

Short-Term Disability Income Insurance

Short-term disability provides employees with coverage for time spent away from work for a short period of time. Wage insurance covers events, such as an illness, accident, or injury,

where the employee intends to return to work after a few weeks, months, or a year. Most STD policies have a waiting period of zero to 14 days before benefits kick in. Benefits may only be paid for a maximum of two years.

Long-Term Disability Income Insurance

As the name implies, long-term disability insurance covers individuals who may experience more lengthy or lifelong events. Employer plans normally work in conjunction with STD plans. This means that individuals begin receiving STD benefits before any long-term benefits kick in. Put simply, long-term benefits begin after any short-term benefits are fully paid out.

The waiting period for LTD benefits can range anywhere between a few weeks to several months. The maximum benefit goes beyond STD coverage, from a few years to the rest of the insured individual's life.

The Cost of Disability Income (DI) Insurance

The final premium for disability income insurance varies and is based on a number of factors. Policy premiums generally range between 1% and 3% of your gross income.10 Insurance underwriters also consider age during the underwriting process. The minimum age for applicants is 18 while the maximum tends to be 60. Unlike life insurance, DI insurance rates for women are higher per unit of coverage than those for male applicants.

Insurers have historically paid more and higher dollar amounts for claims filed by women. This includes those filed during an earlier period of their lives. This may be attributed to pregnancy, childbirth, and higher rates of depression and autoimmune disorders. Smokers can also expect to pay as much as 25% more for the same protection as non-smokers because of the higher incidence of smoking-related illnesses.

When determining premiums, providers often place applicants into career and income classifications. The basis of these classifications is on the carrier’s claim experience for these job categories and incomes. The classification with the lowest risk pays less.

Business Overhead Expense Policy

Description: Covers business expenses such as rent, utilities, and employee salaries if the business owner becomes disabled.

Example: A policy that pays $5,000 per month to cover office rent and utilities while the owner is recovering from surgery.

What Is Disability Income Insurance?

Disability income insurance is a type of insurance policy that provides financial support to individuals who become unable to work due to a disability.

This coverage helps replace a portion of the policyholder's income, making it easier for them to maintain their financial stability and meet their expenses during their recovery period.

Disability income insurance is an essential component of financial planning because it helps protect individuals and their families from the potential financial hardships that may result from an unexpected illness or injury.

The loss of income during a disability can significantly impact a person's financial situation, making it difficult to cover essential expenses such as housing, medical care, and daily living costs.

Disability income insurance policies typically cover a wide range of disabilities, including both physical and mental health conditions that may prevent an individual from working.

Some examples include musculoskeletal disorders, cardiovascular diseases, mental health disorders, and neurological conditions.

Types of Disability Income Insurance

Short-Term Disability Insurance

Coverage Period

Short-term disability insurance provides coverage for a limited time, usually ranging from three to six months. This type of policy is designed to provide temporary financial support to individuals recovering from a brief illness or injury.

Benefit Amounts

Short-term disability insurance policies typically offer a benefit amount that replaces a percentage of the policyholder's pre-disability income, often around 60-80%. This amount is usually paid out on a weekly or monthly basis, depending on the policy terms.

Waiting Period

Short-term disability insurance policies typically have a waiting period, also known as an elimination period, which is the time between the onset of the disability and when the policyholder starts receiving benefits.

Waiting periods can range from a few days to a few weeks, depending on the policy.

Long-Term Disability Insurance

Coverage Period

Long-term disability insurance provides coverage for an extended period, which can last several years or until the policyholder reaches a specified age, such as 65.

This type of policy is designed to provide financial support to individuals who are unable to work due to a long-lasting or permanent disability.

Benefit Amounts

Long-term disability insurance policies generally offer a benefit amount that replaces a percentage of the policyholder's pre-disability income, similar to short-term disability insurance.

However, long-term policies typically have a lower percentage, ranging from 50-70%. The benefit amount is usually paid out on a monthly basis.

Waiting Period

Long-term disability insurance policies often have a longer waiting period compared to short-term policies. Waiting periods can range from 30 days to several months, depending on the policy.

Comparison of Short-Term and Long-Term Disability Insurance

Short-term and long-term disability insurance policies differ in terms of their coverage periods, benefit amounts, and waiting periods.

Short-term policies provide temporary financial support for brief periods of disability, while long-term policies offer extended coverage for longer-lasting or permanent disabilities.

Additionally, short-term policies typically have shorter waiting periods and higher benefit amounts compared to long-term policies.

Types of Disability Income Insurance

Key Features of Disability Income Insurance

Benefit Period

The benefit period refers to the length of time during which the policyholder receives disability income benefits. Depending on the policy, the benefit period can last from a few months to several years or until the policyholder reaches a specified age.

Elimination Period

The elimination period, also known as the waiting period, is the time between the onset of the disability and when the policyholder starts receiving benefits. Elimination periods can vary depending on the type of policy and the policyholder's preferences.

Definition of Disability

Disability income insurance policies use different definitions of disability to determine eligibility for benefits, which can significantly impact the scope of coverage. The two most common definitions of disability are:

Own-Occupation

Under the own-occupation definition, a policyholder is considered disabled if they are unable to perform the duties of their specific occupation due to an illness or injury.

This definition offers broader coverage, as it considers the policyholder disabled even if they can still work in a different job.

Any-Occupation

The any-occupation definition considers a policyholder disabled only if they are unable to work in any occupation for which they are reasonably suited based on their education, training, and experience. This definition offers narrower coverage and may result in fewer claims being approved.

Residual Benefits

Residual benefits are a feature of some disability income insurance policies that provide partial benefits to policyholders who experience a partial loss of income due to a disability. This feature helps support individuals as they transition back to work or adjust to a reduced work capacity.

Cost of Living Adjustments (COLA)

Cost of Living Adjustments (COLA) is an optional feature in some disability income insurance policies that increases the benefit amount to account for inflation over time. This ensures that the policyholder's benefits maintain their purchasing power throughout the benefit period.

Non-cancelable and Guaranteed Renewable

Non-cancelable and guaranteed renewable provisions ensure that the insurance company cannot cancel the policy or increase the premiums as long as the policyholder continues to pay their premiums on time. These features provide long-term stability and peace of mind for the policyholder.

Factors Affecting Disability Income Insurance Premiums

Several factors can influence the cost of disability income insurance premiums, including:

Age

Premiums typically increase with age, as older individuals have a higher likelihood of experiencing a disability.

Gender

Women often pay higher premiums than men, as they generally have a higher risk of experiencing a disability during their working years.

Occupation

High-risk occupations, such as construction or manual labor, can result in higher premiums due to the increased likelihood of work-related injuries and disabilities.

Health and Lifestyle

Individuals with pre-existing health conditions or risky lifestyle habits, such as smoking, may face higher premiums due to the increased likelihood of experiencing a disability.

Coverage and Benefit Options

The coverage and benefit options chosen by the policyholder, such as the elimination period, benefit period, and optional riders, can significantly impact the cost of premiums.

Understanding Group and Individual Disability Income Insurance

Group Disability Income Insurance

Pros and Cons

Group disability income insurance is a type of coverage that is commonly offered by employers as part of their employee benefits package. Some advantages of group coverage include lower premiums, simplified underwriting, and easy enrollment.

However, group coverage may offer limited customization options, and benefits may be taxable if the employer pays the premiums.

Commonly Offered by Employers

Many employers offer group disability income insurance to their employees as a way to attract and retain talent. Employees can often choose to enroll in the coverage during their annual benefits enrollment period.

Individual Disability Income Insurance

Pros and Cons

Individual disability income insurance policies are tailored to the specific needs and preferences of the policyholder. Advantages of individual coverage include customizable benefit options, portability, and non-taxable benefits (when premiums are paid with after-tax dollars).

However, individual policies may have higher premiums and require a more thorough underwriting process compared to group coverage.

Tailored to Individual Needs

Individual disability income insurance policies can be customized to suit the unique needs and preferences of the policyholder, including their preferred elimination period, benefit period, and optional riders.

Understanding Group and Individual Disability Income Insurance

How to Choose the Right Disability Income Insurance Policy

Assessing Your Needs and Financial Situation

Before choosing a disability income insurance policy, it's important to assess your financial situation and determine how much coverage you need.

Consider factors such as your current income, expenses, existing savings, and any other financial resources you have access to in case of a disability.

Comparing Policies and Providers

Once you have a clear understanding of your needs, compare different policies and insurance providers. Look for features that are important to you, such as the definition of disability, elimination period, benefit period, and optional riders.

Additionally, compare premium costs and the financial strength of the insurance companies.

Working With a Financial Advisor or Insurance Agent

A financial advisor or insurance agent can provide expert guidance and help you navigate the process of choosing the right disability income insurance policy. They can help you assess your needs, compare policies, and ensure you make an informed decision.

Periodically Reviewing Your Coverage

As your financial situation and needs change over time, it's important to periodically review your disability income insurance coverage to ensure it remains adequate. Consider updating your coverage if you experience significant life changes, such as a change in income, family status, or job.

Claims Process for Disability Income Insurance

Filing a Claim

If you become disabled and need to file a claim for disability income insurance benefits, you will need to follow your insurance provider's specific claims process. This typically involves submitting a claim form, along with any required documentation and medical records.

Providing Documentation and Medical Records

When filing a claim, you may need to provide documentation, such as proof of your income and employment status, as well as medical records and reports from your healthcare providers.

This information will be used by the insurance company to assess your claim and determine your eligibility for benefits.

Appeals Process for Denied Claims

If your claim is denied, you have the right to appeal the decision. The appeals process may involve submitting additional documentation or evidence to support your claim.

It's essential to follow your insurance provider's specific appeals process and timelines to ensure your appeal is properly considered.

Conclusion

In conclusion, disability income insurance is a critical component of a comprehensive financial plan, offering vital protection against the financial challenges that may arise due to an unexpected disability.

This type of insurance can help replace a portion of a person's income, enabling them and their families to maintain financial stability and cover essential expenses, such as housing, medical care, and daily living costs.

As the impact of a disability can be significant, it is crucial for individuals to carefully consider their insurance needs and options to ensure they have adequate coverage in place.

To find the most suitable disability income insurance policy, individuals should thoroughly research different policies and providers, comparing key features such as the definition of disability, elimination period, benefit period, and optional riders.

Additionally, working with a financial advisor or insurance agent can provide valuable guidance and expertise to help navigate the selection process. Periodic reviews of coverage are also essential, as financial situations and needs change over time, necessitating adjustments to insurance policies.

By taking these steps, individuals can better safeguard their financial well-being and have greater peace of mind in the face of potential disabilities.

Disability Income Insurance FAQs

What is disability income insurance?

Disability income insurance is a type of insurance policy that provides financial protection for individuals who are unable to work due to a disability or injury. It pays out a portion of your income to help you cover your living expenses while you are unable to work.

Who needs disability income insurance?

Anyone who relies on their income to cover their living expenses should consider disability income insurance. This includes people who are self-employed, freelance workers, and those who do not have access to disability benefits through their employer.

How much does disability income insurance cost?

The cost of disability income insurance varies depending on several factors, including your age, occupation, and health status. Generally, the younger and healthier you are, the lower your premiums will be. Premiums can range from a few hundred dollars to several thousand dollars per year.

What does disability income insurance cover?

Disability income insurance covers a portion of your income if you are unable to work due to a disability or injury. The amount of coverage you receive depends on the terms of your policy. Some policies may also provide additional benefits, such as coverage for medical expenses or rehabilitation.

How do I choose the right disability income insurance policy?

When choosing a disability income insurance policy, it's important to consider factors such as the amount of coverage you need, the length of the benefit period, and the waiting period before benefits begin. It's also a good idea to compare policies from multiple insurers to find the best coverage at a price you can afford. Working with an experienced insurance agent can also help you navigate the process and find the right policy for your needs.

Business Disability Buyout Policy

Description: Provides funds to buy out a disabled partner’s share of the business.

Example: A policy that pays $500,000 to buy out a partner who can no longer work due to a severe accident.

Types of disability insurance

There are two main types of personal disability insurance — short term and long term. But there are other kinds of personal disability insurance policies, along with Social Security disability and state disability insurance.

All disability insurance replaces your income while you're hurt or sick and can't work, but there are different types of policies and coverage.

The ten main types of disability insurance are:

- Personal and group disability insurance
- Long-term disability insurance
- Short-term disability insurance
- Business overhead expense insurance
- Mortgage disability insurance
- Social Security disability insurance
- State disability insurance
- Supplemental disability insurance
- Workers' compensation

If you're not sure what kind of disability insurance to get, or you want to compare quotes to make sure you get the best rates for your coverage needs, talk with an agent.

Personal and group disability insurance

A policy that you buy for yourself is called **personal** or **individual** disability insurance (also called private disability insurance), while one you get through work as an employee benefit is called group disability insurance.

The main difference between group disability insurance and a personal policy is that a group policy is controlled by your employer and tied to your job, so you don't get to keep the coverage if you leave. Since you usually pay for group disability policies with pre-tax dollars, your benefits are taxable.

Group disability insurance is also more likely to be short-term coverage, so it may be a good idea to get a personal long-term policy even if you already have group disability coverage through your job.

Long-term disability insurance

Long-term disability insurance can last anywhere from one year to through retirement age (usually 65 to 67). The longer your benefit period, the more expensive your policy will be.

Most long-term disability policies cover up to 60% of your gross income (which should come close to what you take home after taxes) and cost between 1% to 3% of your salary. So if you make $120,000 a year, you might pay between $100 and $300 a month for a policy.

Long-term disability insurance is best for high earners or people with jobs that require a lot of schooling or specialized training who want to protect their incomes.

Types of long-term disability insurance

When you buy long-term disability insurance, you can choose between own-occupation and any occupation coverage:

- **Any-occupation**: Only pays benefits if you can't work *any job* that you're reasonably suited for. Any-occupation coverage is cheaper, but it's harder to qualify for benefits.
- **Own-occupation**: Pays out when you can't work the specific job that you're trained for (like a heart surgeon or a lawyer), even if you can work in another, related role.

Types of own-occupation disability insurance

There are also multiple types of own-occupation coverage.

- **True own-occupation**: You'll still get paid out even if you can still work, as long as you're unable to do the specific job you had before your illness or injury
- **Transitional own-occupation**: If you can't work in your specialized role due to injury or illness, but you can get a new lower-paying job, you can still get benefits. You can collect your entire benefit as long as your new salary and your benefits don't add up to more than what you used to make.
- **Own-occupation, not engaged**: You'll only get paid if you can't work in your original role and you haven't yet found a new job. Once you start a new job, no matter the field, you'll stop receiving benefits.

Short-term disability insurance

Like long-term disability insurance, short-term disability insurance covers up to 60% of your pre-tax income if you can't work. The difference is that short-term disability coverage usually only lasts for up to a year.

It's worth having short-term disability insurance if you get it for free or at a discount through your job but, since it can cost as much as long-term disability insurance, it might be a smarter investment to get long-term disability insurance instead.

Business overhead expense insurance

Business overhead expense insurance is a special kind of disability insurance for small business owners. It doesn't cover your personal expenses — that's what a personal disability insurance policy does. A business overhead policy pays for your business's overhead costs while you can't work, including:

- Accounting fees
- Employee salaries
- Payroll taxes
- Postage
- Rent
- Utilities

Mortgage disability insurance

Mortgage disability insurance, which is also sometimes called mortgage payment protection insurance, is a type of limited long-term disability insurance that covers your mortgage payments while you can't work due to an illness or injury.

You can buy mortgage disability insurance through your mortgage lender, an insurance agency, or a broker.

Mortgage disability insurance doesn't require the typical underwriting process or medical exam that other long-term disability insurance policies do, so it might be worth having if you don't qualify for regular long-term disability coverage but don't want to risk defaulting on your mortgage.

Credit disability insurance

Your bank or mortgage lender may offer you credit disability insurance on top of your loan, which is a type of coverage that can help make your mortgage payments if you're sick or injured and can't work.

But credit disability insurance offers less coverage than a regular disability insurance policy. It's also more expensive, and you may have to pay interest on your premiums, so if you can qualify for a regular long-term disability option, that's probably a better option.

Social Security disability insurance

Social Security disability insurance, or SSDI, is disability coverage that you get through the federal government. While SSDI is free, it's hard to qualify for coverage and the benefits are much lower than with other types of disability insurance.

To qualify for SSDI, you have to have a condition that's expected to keep you out of work for at least a year. You must also meet work and income requirements and go through a potentially long screening process in order to qualify.

→ Read more about Social Security disability insurance

State disability insurance

Some states offer temporary disability insurance plans, which are funded by deductions from your paychecks. Most of these plans offer coverage for up to a year.

The following states (and U.S. territory) have state disability insurance programs, also known as temporary disability insurance:

- California
- Hawaii
- New Jersey
- New York
- Rhode Island
- Puerto Rico

You can't purchase state insurance through an agent or broker, and benefits don't usually pay out for more than one year.

Supplemental disability insurance

A supplemental disability insurance policy adds more coverage to any disability insurance you already have. It's a great way to get more disability benefits or extend your benefit period without paying for an entirely new policy or going through another medical exam.

Supplemental disability insurance can close the gap between an employer-sponsored disability plan (which can be taxed or capped), and the full amount of money you'll need to cover your expenses in case you can't work.

Workers' compensation

Workers' compensation, also known as workers' comp, is a type of insurance that your employer is required to provide. While workers' compensation pays out if you become injured at work, it's different from disability insurance.

Workers' comp actually offers less coverage than disability insurance does, and you can only qualify if your injury happened at work. A regular disability insurance policy doesn't have this restriction — you can get benefits no matter where your injury happened.

Hurt on the job? A state-by-state guide to workers' compensation

Updated September 18, 2020: Workers' compensation covers income and medical care if you are injured or become ill as a direct result of your job. It does not cover illness or injury incurred off the clock or unrelated to your job duties. That's because workers' compensation is insurance for **employers**. Businesses purchase a policy from private insurers or special state funds. This policy provides medical and wage benefits if a worker files and the insurer approves a claim.

For personal protection, **employees** need disability insurance, which covers your income if you can't work due to illness or injury. (We can help you compare and buy disability insurance across carriers.)

How workers' compensation works

If you have been injured on the job, it's important to know your rights — especially because they vary widely, depending on where you live. Most workers' compensation laws are set by your state. It determines which businesses must carry coverage, how much and how long they must pay an injured or ill employee, and what penalties are imposed if a company doesn't comply with the laws.

States also sets time limits for every step of the workers' comp claim process. Employees must formally report a job-related illness or injury to their employer within a certain time period, usually 10 to 90 days. They also must file a claim with their state workers' compensation agency, though those deadlines are much broader.

Employers and insurers, meanwhile, have a certain amount of time, usually 14 to 30 days, to investigate, process and approve or deny claims. Most states allow you to appeal a denial. That appeal must also be filed and processed by the state-imposed deadlines.

The types of workers' compensation benefits

Workers' compensation generally requires employers — or, by extension, their insurer — cover all reasonable **medical expenses** associated with an injury or illness occurred on the job. Often, there are restrictions regarding which health care providers you can visit or paperwork involved when switching physicians.

Wage benefits generally fall into four buckets:

- **Temporary total disability benefits (TTD)** are paid out to employees while they're unable to work and recuperating from a workplace illness or injury. There's usually a waiting period (akin to the elimination period associated with disability insurance) for TTD, meaning the injury must keep you out of work for a certain number of days before you're eligible to file a

claim. TTD typically continues until you return to work, reach maximum medical improvement or receive benefits for the maximum number of weeks allotted by the state.

- **Temporary partial disability benefits (TPD)** are paid out to employees who can return to work in a modified or "light duty" capacity. The amount is usually the difference of what you're paid under TTD and what you're making in the new position. They end when you return to work full-time or reach the maximum number of weeks allotted by state law.

- **Permanent partial disability benefits (PPD)** are paid out when an employee experiences a permanent impairment, like loss of a limb, as a result of a workplace incident. The payment correlates to the severity of the disability and is determined in a myriad of ways. Most commonly, a number of weeks is assigned to your injury and multiplied by the wages you're eligible for under TTD. PPD is generally determined and paid out after you reach maximum medical improvement. You are eligible for PPD even if you're receiving other workers' comp wage benefits.

- **Permanent total disability benefits (PTD)** are paid out to workers' who are severely disabled due to a job-related injury and cannot return to the workforce as a result. Some states cap PTD. Many reduce benefits once the employee qualifies for Social Security Disability Insurance.

Most states also stipulate employers pay death benefits and burial expenses to dependents of employees who died as a direct result of a workplace incident. Again, these benefits are no substitute for a private life insurance policy, which broadly covers the unexpected death of a loved one. (Learn how life insurance works.)

Remember, workers' compensation laws are complex. Your state's program administrator or an experienced attorney can walk your through the applicable nuances. Scroll down to see the basic workers' compensation laws in your state.

Workers' compensations laws by state

Alabama workers' compensation

Program administrator: Alabama Department of Labor, Workers' Compensation Division

Employers required to provide coverage: Any business with five or more full-time or part-time employees, excluding contractors.

Medical benefits: Employers are responsible for hospital, surgical and medical treatment during the period of disability.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, but subject to the state's maximum benefit allowance. As of July 1, 2018, the maximum benefit is $865 per week. The minimum benefit is $238 per week. The number of weeks you are eligible for temporary total benefits is unlimited.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage, minus the compensation you're receiving for light duty or modified work. TPD is capped at 300 weeks. Total and partial disability benefits don't cover the first three days of lost wages unless you are out of work for 21 days or longer (you'll receive back pay).

Permanent partial disability benefits: Varies by illness or injury, but subject to a cap of $220 per week. Benefits are limited to 300 weeks.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum. The time you can receive benefits is unlimited.

Other notable coverage: Death benefits, equal to 50% or two-thirds of the employee's average weekly wage, are available to qualified dependents for up to 500 weeks. Employers are also responsible for up to $6,500 in funeral expenses for workers killed as a direct result of their job.

Alaska workers' compensation

Program administrator: Alaska Department of Labor and Workplace Development

Employers required to provide coverage: Any employer with one or more employees, unless they've been approved to self-insure.

Medical benefits: Employers must pay at least two years' worth of qualified medical expenses.

Temporary total disability benefits: Equal to 80% of your spendable weekly wages, subject to the state maximum, which amounts to no more than 120% of the state's average weekly wage. At a minimum, insurers must pay you at least 22% of the maximum weekly rate or, if you fail to provide proof of income, at least $110 per week. Benefits are paid every two weeks until you're medically stable or can return to work (whichever comes first).

Temporary partial disability benefits: Equal to 80% of the difference between your spendable weekly wage prior to the disability and your spendable weekly wage under light duty. TPD benefits pay out until you reach medical stability or up to five years (whichever comes first).

Permanent partial disability benefits: Paid in addition to TTD. Once you're medically stable, a doctor will determine how impaired you are and you'll be compensated based on a percentage of $177,000, depending on the severity of your injury. You'll receive payment in a lump sum.

Permanent total disability benefits: Equal to 80% of your spendable weekly wages, minus the amount of any permanent partial disability award you received and adjusted for inflation. PTD benefits last until the disability ends or death.

Other notable coverage: The program provides a $5,000 death benefit, $10,000 in funeral expenses and weekly income replacement equal to TTD benefits to surviving spouses and children.

Arizona workers' compensation

Program administrator: The Industrial Commission of Arizona

Employers required to provide coverage: Any business with one or more full-time or part-time employee, with a few standard exceptions. (Standard exceptions include sole proprietors who are eligible to self-insure or absent employees, independent contractors and people who employ domestic workers in their private home.)

Medical benefits: Employers are responsible for paying medical expenses directly related to the workplace illness or injury. These expenses include emergency room charges, doctor's fees, doctor visits and prescriptions.

Temporary total disability benefits: Equal to two-thirds of of your average monthly wage, subject to the state maximum. For 2019, the maximum monthly wage for the purposes of calculating benefits is $4,741.57 per week. Wages are not paid out on the first 7 consecutive lost days of work unless your disability lasts 14 days or more (then back pay is issued). Benefits are paid every two weeks until a doctor clears you for work.

Temporary partial disability benefits: Equal to two-thirds of of your average monthly wage minus your wages for light duty. TPD gets paid out once a month until you are cleared to resume full-time work.

Permanent partial disability benefits: Compensation for “scheduled” permanent injuries, such as loss of an arm, leg or eye, ranges from 50% to 55% of the average monthly wage. Workers who suffer facial scarring or teeth loss are eligible for benefits equal to 55% of the average monthly wage for up to 18 months. Compensation for “unscheduled” injuries, including occupational diseases and injuries to the hip, shoulder, or back, is 55% of the difference between your average monthly wage and the amount ICA estimates you can earn given your injury.

Permanent total disability benefits: Equal to 75% and two-thirds of the average monthly wage for scheduled injuries and unscheduled injuries, respectively. Benefits continue until your death, unless the ICA rules otherwise or you fail to file a mandated annual report of income. PTD is paid each month, unless you are awarded a special lump sum commutation.

Other notable coverage: Surviving spouses, minor children, parents and minor siblings are eligible for death benefits of up to 66.67% of the deceased worker’s average monthly wage until death or remarriage. The program also offers a burial allowance of up to $5,000.

Arkansas workers’ compensation

Program administrator: Arkansas Workers’ Compensation Commission

Employers required to provide coverage: Businesses with three or more employees, with a few exceptions.

Medical benefits: Employer must cover all reasonably necessary medical care. However, they have the right to designate the initial provider and your claim can get denied if you seek non-emergency treatment without notice.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state’s maximum. For 2019, the TD maximum is $695. Payments are made every other week for as long as you are unable to work. Benefits are not paid out on the first seven days of disability, beginning the day after it occurs, unless you are out of work for 14 calendar days or more. In that case, back pay is issued.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage minus what you are making on light duty, subject to the state’s maximum.

Permanent partial disability benefits: Varies by amount of wages and number of weeks, depending on the severity of your injury. The PPD rate for amputation or permanent total loss of use of a member is the same as your TD rate, subject to the state maximum. For 2019, the PPD maximum is $521 per week.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state’s weekly maximum. Arkansas also caps PTD benefits. As of 2019, maximum compensation equals $225,875.

Other notable coverage: Spouses, children and other dependents are eligible to receive weekly benefits in the event an employee’s work-related death. The amount and length of payments vary, depending on their relationship to the deceased. The program pays up to $6,000 in funeral expenses.

California workers' compensation

Program administrator: California Department of Industrial Relations, Workers' Compensation Division

Employers required to provide coverage: Any business with one or more employee, excluding sole proprietors who do not have to self-insure. Temporary, part-time and even contractors may be entitled to workers' comp.

Medical benefits: Employers must pay for medical expenses "reasonably required to cure or relieve" the workplace disability. You are limited to 24 chiropractic visits, 24 physical therapy visits and 24 occupational therapy visits unless a claims administrator approves extended care. Employers can require you stay in their medical network for care.

Temporary total disability benefits: Usually equal to two-thirds of your wages prior to injury, subject to the state maximum. In 2019, if your gross wages were more than $1,877.07 per week before you were hurt, the maximum TTD payment is $1,151.38 per week. If your gross wages before the injury were less than $281.57 per week, the minimum TTD payments are $187.71 per week.

Temporary partial disability benefits: Equal to two-thirds of your wages prior to the injury, minus what you are making for light duty and subject to the state maximum. TD benefits are paid every two weeks. Benefits typically last until a doctor clears you to work or up to 104 weeks within five years from the date of injury. At that point, if you can no longer work, you might qualify for permanent disability benefits.

Permanent partial disability benefits: The length and amount of compensation varies by disability, date of injury and your wages before the disability. As an example, total loss of vision in one eye (not adjusted for age or occupation) could warrant close to $35,000 in PPD.

Permanent total disability benefits: The amount of compensation varies by disability, date of injury and your wages before the disability, but if you are deemed permanently disabled due a workplace illness or injury, you could be entitled to benefits for life.

Other notable coverage: Injured employees can receive supplemental job displacement benefits, which are vouchers that help pay for vocational rehabilitation. Spouses, children and other dependents are eligible for up to $320,000 in death benefits, depending on the number of bereaved, as well up to $10,000 for funeral expenses. The death benefit is paid out at the total temporary disability rate, subject to a minimum of $224 per week.

Colorado workers' compensation

Program administrator: Colorado Department of Labor and Employment

Employers required to provide coverage: Companies with one or more full- or part-time employers, with limited exceptions

Medical benefits: Employers must cover all reasonable and necessary medical bills for workers disabled on the job. However, they can stipulate a network of health care providers. You can switch doctors once if you are within 90 days of the incident and have not medically improved.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage as of the date of your injury, subject to a maximum of $987.84 in 2018. Benefits are not paid out if the disability causes you to miss work for three days or less. If you are out of work for longer than three days, you will receive back pay for that missed time.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage, up to a state maximum, as of the date of your injury, minus what wages you are making on a modified schedule.

Permanent partial disability benefits: Compensation varies by disability, date of injury and your wages before the disability. Scheduled impairments are payable at a weekly compensation rate of $307.26, while non-scheduled impairments are paid out at the TTD rate, subject to a $150 per week minimum and $542.78 per week maximum in 2018. Body disfigurement benefits are between $5,229.68 and $10,457.52.

Permanent total disability benefits: Equal to two-thirds of the average weekly wage in effect at the time of the injury or illness paid for the lifetime of the injured worker.

Other notable coverage: Dependents are eligible for a death benefit of between $246.96 and $987.84 per week and up to $7,000 for burial expenses. If a deceased worker has no dependents, the insurer pays out up to $20,836.09 to the Colorado Uninsured Employers Fund.

Connecticut workers' compensation

Program administrator: State of Connecticut's Workers' Compensation Commission

Employers required to provide coverage: Companies with one or more full- or part-time employers, with the exception of those that can self-insure.

Medical benefits: The employer is responsible for covering all necessary and appropriate medical treatment. They can choose the health care provider of initial treatment, but the employee has the right to choose their attending physician.

Temporary total disability benefits: Equal to 75% of the after-tax-and-Social-Security average weekly wage the injured worker was making before the incident, subject to the state maximum of $1,298 per week. TTD and TPD aren't paid out until the worker is out for three calendar days. They are paid starting on the fourth day of missed work and compensated for the first three days if they are too injured or ill to work for seven days or longer. Employers must pay a weekly minimum equal to 20% of the maximum weekly benefit ($259.60) not to exceed 75% of the employee's average weekly wage.

Temporary partial disability benefits: Equal to 75% of the after-tax-and-Social-Security average weekly wage the injured worker was making before the incident minus the wages they are making on light or modified duty. TPD is subject to a state maximum of $1,046 per week.

Permanent partial disability benefits: The length and amount of compensation varies by injury. Benefits run between $50 and $1,046 and nine to 208 weeks.

Permanent total disability benefits: Equal to 75% of the injured worker's after-tax average weekly wage, subject to the state maximum of $1,298 per week. You can potentially receive benefits for the length of your life.

Other notable coverage: Surviving spouses or eligible dependents are entitled to a death benefit equal to 75% of the deceased worker's after-tax average weekly wage, subject to the maximum, plus $4,000 for burial expenses.

Delaware workers' compensation

Program administrator: Delaware Division of Industrial Affairs

Employers required to provide coverage: Employers with one or more employees, excluding contractors. Farmers are exempt from workers' comp laws.

Medical benefits: Employers are responsible for paying for all necessary medical treatment and hospitalization services.

Temporary total disability benefits: Equal to two-thirds of the injured employee's gross weekly wages received at the time of the injury, subject to the state maximum. As of 2018, the maximum was $713.65 per week. Minimum compensation was $237.88 per week. No benefits are paid out on the first three days of missed wages, unless the injury causes the worker to miss seven days or more. At that point, back pay is issued.

Temporary partial disability benefits: Equal to two-thirds of the injured employee's gross weekly wages prior to injury minus what they are making on a modified schedule, subject to the state maximum. TPD is available for up to 300 weeks.

Permanent partial disability benefits: Equal to two-thirds of the average week wage paid out for 20 to 220 weeks, depending on the severity of your permanent injury.

Permanent total disability benefits: Equal to two-thirds of the injured employee's gross weekly wages received at the time of the injury, subject to the state maximum. Benefits are potentially payable for life.

Other notable coverage: Spouses and dependents are eligible for weekly death benefits, but they cannot exceed 80% of the state maximum. Benefits are paid out for a maximum of 400 weeks, but cease after certain life events. Say, a spouse remarries or a minor child turns 18 (or 25, if in school). They also receive up to $3,500 in funeral expenses,

Florida workers' compensation

Program administrator: Florida Division of Workers' Compensation

Employers required to provide coverage: It varies by industry. Construction companies must provide workers' comp when they have one or more employee, including the owner if they're a corporate officer or LLC. Non-construction companies must carry insurance if they have four or more employees, subject to the same parameters. Agriculture companies have a slightly higher threshold at six or more employees. There are exemptions for owners who can self-insure.

Medical benefits: Employers are responsible for all necessary medical care, treatment and prescriptions related to your injury.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, calculated using wages earned 13 weeks prior to your injury, though some severe injuries may entitle you to 80% of your regular wages for up to six months. TTD, TPD or a combination of the two are paid out for no more than a maximum of 104 weeks. You aren't paid for the first seven days of lost wages unless you are out of work for over 21 days, in which case back pay might be issued.

Temporary partial disability benefits: Up to two-thirds of your average weekly wage, calculated using wages earned 13 weeks prior to your injury, minus the income you are making on a modified schedule.

Permanent partial disability benefits: The length and amount of compensation varies, depending on your illness or injury. Maximum compensation as of 2018 was $917 per specified week.

Permanent total disability benefits: Equal to two-thirds of the average weekly wage, paid out until the injured worker reaches 75 years of age, unless the employee is not eligible for Social Security due to their inability to work.

Other notable coverage: Surviving dependents are eligible for a total of $150,000 in compensation to cover funeral expenses (up to $7,500), income replacement and educational benefits in the case of a spouse.

Georgia workers' compensation

Program administrator: Georgia's State Board of Workers' Compensation

Employers required to provide coverage: Any business with three or more workers, including part-time employees.

Medical benefits: Employers are responsible for paying authorized doctor, hospital and rehabilitation bills for up to 400 weeks after your injury. They can request you visit select health care providers outside of initial emergency care, so long as you are provided with a choice of six doctors or more.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to a maximum of $575 per week. TTD doesn't start until an employee has missed more than seven days of work. Those wages are only replaced if you injury or illness extends over 21 days. Benefits are paid out for a maximum of 400 weeks.

Temporary partial disability benefits: Equal to no more than $383 per week, paid out for up to 350 weeks.

Permanent partial disability benefits: Benefits vary by injury. As an example, if you lost an arm or leg you will receive benefits of 225 weeks.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to a maximum of $575 per week, paid potentially for life.

Other notable coverage: Dependents are eligible to receive two-thirds of your average weekly wage as a death benefit, subject to a maximum of $575 per week. Surviving spouses are eligible for up to $230,000 in death benefits. However, payments cease if they remarry or cohabit with a new partner.

Hawaii workers' compensation

Program administrator: State of Hawaii Disability Compensation Commission

Employers required to provide coverage: Companies with one or more employees whether full-time, part-time, permanent or temporary workers with a few exceptions

Medical benefits: Employers are responsible for paying for treatment, hospital charges, prescription drugs, X-rays, physical therapy and reasonable transportation expenses related directly to the injury. Employees can choose their own physician.

Temporary total disability benefits: Equal to two-thirds of your average weekly wages, subject to the state maximum of $883 (as of 2018). There is a three-day waiting period for benefits. They last until you return to work or reach maximum medical recovery. At that point, you might be eligible for PPD or PTD.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wages, subject to the state maximum minus the wages you make from your modified schedule.

Permanent partial disability benefits: The amount of compensation and length of benefits varies by injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wages, subject to the state maximum and potentially paid for life.

Other notable coverage: Hawaii also offers temporary disability insurance benefits to employees who lose wages to non-work-related illness or injury up to $620 per week. Surviving spouses and dependent minor children are eligible for death benefits equal to TTD benefits, plus funeral expenses and burial expenses up to 10 times and five times the maximum weekly benefit rate, respectively.

Idaho workers' compensation

Program administrator: The Idaho Industrial Commission

Employers required to provide coverage: Companies with one or more full-time, part-time, seasonal or occasional employees with a few exceptions

Medical benefits: Employers are reasonable for covering “reasonable” medical care to treat workplace injuries.

Temporary total disability benefits: Equal to 67% of your average weekly wage, subject to the state maximum, which is 90% of its total average weekly wage. There’s a five-day waiting period. If your injury causes you to lose work for longer than two weeks, back pay is issued. TTD benefits are paid out for up to 52 weeks.

Temporary partial disability benefits: Equal to 67% of the decrease in your wages. TPD benefits cannot exceed TTD benefits.

Permanent partial disability benefits: Equal to (55%) of the average weekly state wage and paid out for one to 350 weeks, depending on the permanent disability.

Permanent total disability benefits: Equal to 67% of the average weekly state wage, subject to the state maximum and potentially paid for life.

Other notable coverage: Dependents are eligible for death benefits between 20% to 60% of the state average weekly wage, subject to the state maximum. Surviving spouses can receive benefits for up to 500 weeks with payments ceasing upon death or remarriage. Able-bodied minor children can receive benefits up until they turn 18 (or 23, if they are in school). Some compensation is provided for funeral expenses, if the death occurs within four years of the workplace injury.

Illinois workers' compensation

Program administrator: Illinois Workers’ Compensation Commission **Employers required to provide coverage:** Every employer located in Illinois.

Medical benefits: Employers are required to cover all medical care that is reasonably necessary to cure or relieve the employee from the injury. Employees can choose their health care provider with some restrictions.

Temporary total disability benefits: Equal to two-thirds of the employee’s average weekly wage, subject to the state maximum ($1,480.12 as of 2018). TTD is not paid out for the first three days of disability, unless the disability lasts two week or more. Benefits are paid until the employee returns to work or reaches maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of the employee’s average weekly wage, subject to the state maximum, minus the *gross* wages the worker earns in their light-duty job.

Permanent partial disability benefits: Length and the amount of compensation varies, depending on the injury and whether the worker is able to secure a new job.

Permanent total disability benefits: Equal to two-thirds of your average weekly wages, subject to the state maximum and paid for life.

Other notable coverage: Death benefits, equal to two-thirds of the deceased's average weekly wages, are paid to surviving dependents for up to 25 years or $500,000, whichever is greater. They also receive up to $8,000 for funeral expenses.

Indiana workers' compensation

Program administrator: Workers' Compensation Board of Indiana

Employers required to provide coverage: Most businesses, with some exceptions, including train services.

Medical expenses: Employers must cover medical expenses related to the workplace injury. However, they can specify the health care provider.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, but not more than $780 per week as of 2018. You're not eligible for benefits until you miss more than seven days of work and you only receive back pay for those days if the disability lasts 21 days.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage prior to the injury minus your average weekly wages on light duty. TPD pays out for a maximum of 300 weeks.

Permanent partial disability benefits: Compensation varies, depending on the severity of your workplace injury. Indiana caps total compensation for TTD, TPD and PPD at $390,000 per person.

Permanent total disability benefits: Equal to two-thirds of the state's average weekly wage. Indiana caps PTD benefits at 500 weeks.

Other notable coverage: Dependents are eligible for death benefits equivalent to TTD benefits: Equal to two-thirds of the deceased average weekly wage, capped at 500 weeks. They also are eligible for up to $7,500 to cover funeral expenses.

Iowa workers' compensation

Program administrator: Iowa Division of Workers' Compensation

Employers required to provide coverage: Most businesses, excluding agriculture workers and contractors.

Medical expense: Employers must pay all reasonable and necessary medical care required to treat a workplace injury, including travel expenses for treatment.

Temporary total disability benefits: Generally equal to 80% of your spendable income, but varies by your average gross weekly earnings, number of income tax exemptions and marital status, but cannot exceed $1,765 per week. There's a three-day waiting period with back pay due for those days if you are out for longer than 14 calendar days. TTD benefits continue until you're healthy enough to return to work.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average gross weekly earnings when injured and your actual earnings while working a modified schedule.

Permanent partial disability benefits: Compensation varies by severity of your injury. Weekly PPD is capped at $1,623 and 500 weeks.

Permanent total disability benefits: Equal to your TTD benefits, but paid out until death.

Other notable coverage: Surviving dependents are eligible for death benefits, potentially equal to the deceased TTD benefits. The employer must also pay for reasonable burial expenses not to exceed 12 times the statewide average weekly wage at the time of death.

Kansas workers' compensation

Program administrator: Kansas Department of Labor

Employers required to provide coverage: All employers outside of those in certain agricultural pursuits or with a gross annual payroll of $20,000 or less.

Medical benefits: Employers must cover all medical treatment reasonably needed to cure or relieve the effects of the injury. They can choose your health care provider. If you seek health care out of network, the insurer only has to pay $500 toward bills.

Temporary total disability benefits: Equal to two-thirds of your gross average weekly wage, subject to a weekly maximum of $645 and a total maximum of $130,000. There is a one-week waiting period before you're eligible for benefits.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average gross weekly wage before the injury and your wages after the injury, subject to the $130,000 maximum.

Permanent partial disability benefits: Compensation varies based on the disability remaining after recovery and is capped at 415 weeks.

Permanent total disability benefits: Equal to two-thirds of your gross average weekly wage, subject to a weekly maximum of $645 and a total maximum of $155,000.

Other notable coverage: Surviving dependents are eligible for death benefits up to $300,000 in total compensation (at least $430 per week) and $5,000 for funeral expenses.

Kentucky workers' compensation

Program administrator: Kentucky Department of Workers' Claims

Employers required to provide coverage: Employers with one or more employees

Medical benefits: All reasonable medical care related to the injury

Temporary total disability benefits: Equal to two-thirds of your average weekly salary, subject to the state maximum ($933.25 as of August 2018). You're not eligible for benefits until you've missed eight calendar days of work, due to the disability. If you are out for longer than 15 days, back pay is issued.

Temporary partial disability benefits: N/A

Permanent partial disability benefits: Compensation varies by impairment and determined once you reach maximum medical improvement.

Permanent total disability benefits: * Equal to two-thirds of your average weekly salary, payable until you're eligible for Social Security.

Other notable coverage: Dependents are collectively eligible for death benefits up to 75% of the deceased average weekly wage, subject to the state maximum, with the exact amount varied by relationship and number of dependent children. If the worker died within four years of the injury, they can also receive a lump-sum settlement to pay for burial expenses and more. As of 2018, that lump-sum maximum is $83,336.22.

Louisiana workers' compensation

Program administrator: Louisiana Workforce Commission

Employers required to provide coverage: All companies with employees, including full-time, part-time, seasonal or minor workers and some subcontractors or independent contractors.

Medical benefits: Employers must cover all approved medical treatment and reasonable travel expenses to receive treatment. Employees can pick their own doctor.

Temporary total disability benefits: Equal to two-thirds of the employee's average weekly wage, subject to the state maximum of $655 per week in 2019. No compensation is paid for the first week, unless the disability continues for two weeks or longer, then back pay is issued. Benefits are paid out for the duration of the disability.

Temporary partial disability benefits: Equal to two-thirds of the difference between your pre-injury average monthly wages and the average monthly wage in your modified job, subject to the state maximum. Payable for up to 520 weeks.

Permanent partial disability benefits: You are eligible for a one-time payment of $50,000 if your workplace injury is deemed catastrophic.

Permanent total disability benefits: * Equal to two-thirds of the employee's average weekly wage, subject to the state maximum of $655 per week in 2019 and paid out potentially for life.

Other notable coverage: Surviving dependents are eligible for death benefits equal to the TTD benefits. If there are no other dependents, surviving parents are entitled to a one-time benefit of $75,000 each. The employer must also pay up to $8,500 in funeral expenses.

Maine workers' compensation

Program administrator: Maine Workers' Compensation Board

Employers required to provide coverage: Businesses with one or more employees, excluding sole proprietors, partners, LLC members and certain farming employers.

Medical benefits: Employers are required to cover reasonable medical care. They can stipulate your doctor. However, you can request a different health care provider after 10 days of treatment.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to a weekly maximum of $829.30 as of 2018. There's a seven-day waiting period for benefits. Back pay for those days are issued only if your disability causes you to miss 14 days or more. Payments are made as long as the disability lasts.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average weekly wage before the injury and your average weekly wages after it. Payments are made for up to 520 weeks.

Permanent partial disability benefits: Compensation varies based on the severity of your injury. Benefits are considered payable for between 11 and 269 weeks.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to a weekly maximum of $829.30 as of 2018, potentially paid out for life.

Other notable coverage: Surviving dependents are eligible for death benefits equal to two-thirds of the deceased's average weekly wage, payable for up to 500 weeks. They are also

eligible for up to $4,000 in burial expenses and up to $3,000 as incidental compensation. Benefits for surviving spouses cease if the spouse dies or remarries. Benefits for minor children cease at age 18, unless the child is otherwise physically or mentally incapacitated.

Maryland workers' compensation

Program administrator: Maryland Workers' Compensation Commission

Employers required to provide coverage: Companies with one or more employees with exceptions made for sole proprietors, farming employers and independent contractors.

Medical benefits: Employers are required to cover reasonable medical care; employees can choose their health care provider.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage not to exceed 100% of the state average weekly wage ($1,094 as of 2018). Employees are not compensated for the first three days of lost wages unless the disability lasts over 14 days. TTD continues until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to 50% of the difference between your average weekly wage and the wage you're earning after your injury, capped at 50% of the State Average Weekly Wage ($547.00 as of 2018).

Permanent partial disability benefits: Compensation varies by severity of the injury, but cannot exceed $365 per week. Benefits are awarded for up to 250 weeks.

Permanent total disability benefits: Equal to your average weekly wage not to exceed 100% of the state average weekly wage ($1,094 as of 2018) to continue indefinitely.

Other notable coverage: Surviving dependents are eligible for death benefits equal to two-thirds the deceased's average weekly wage, subject to the state maximum, and up to $7,000 in funeral expenses. Benefits are paid out potentially until the dead worker would have turned 70 with standard exceptions (a spouse remarries; a child turns 18). Non-spouse or child dependents can receive a maximum death benefit of $73,690.

Massachusetts workers' compensation

Program administrator: Massachusetts Department of Industrial Accidents

Employers required to provide coverage: Almost all employers must carry workers' comp insurance, with sole proprietors, partners, LLC members, some cab drivers and seamen subject to exemptions.

Medical benefits: Employers must cover any reasonable and necessary medical treatment related to a job-related injury or illness, including mileage reimbursement.

Temporary total disability benefits: Equal to 60% of your gross average weekly wage, subject to the state maximum ($1,383.41 as of 2018) and paid out for up to 156 weeks. There's a five-day waiting period for benefits to kick in and you're only compensated for those five days if your disability lasts 21 days or more.

Temporary partial disability benefits: Equal to 75% of what your TTD benefits would be, payable for up to 260 weeks.

Permanent partial disability benefits: Benefits are dispersed in varying amounts, depending on the severity of your disability. Disfigurement compensation may not exceed $15,000.

Permanent total disability benefits: Equal to two-thirds of your gross wages, paid weekly for the duration of the disability.

Other notable coverage: Surviving spouses are eligible for up to $4,000 in funeral expenses and death benefits equal to two-thirds of the deceased worker's average weekly wage, subject to the state maximum. Minor children are also eligible for the death benefits. Surviving spouses can be paid until they die or remarry.

Michigan workers' compensation

Program administrator: Michigan Workers' Compensation Agency

Employers required to provide coverage: Companies regularly employing one or more employees for at least 35 hours per week for 13 weeks or longer in any 52-week period or all companies with three or more employees.

Medical benefits: Employers must cover all reasonable and necessary medical care for work-related injuries or diseases. They can choose the health care provider for the first 28 days of your treatment.

Temporary total disability benefits: Equal to 80% of your after-tax average weekly wage, subject to a state maximum ($900 per week as of 2018), paid for the duration of your disability. You don't qualify for benefits until you are out for seven days and back pay for those days is only issued if the disability lasts two weeks or more.

Temporary partial disability benefits: Equal to 80% the difference between your weekly wage before the injury and your weekly wage after the injury.

Permanent partial disability benefits: Any worker that suffers a loss is eligible for 65 weeks of compensation benefits regardless of whether their disability causes them to miss work. Beyond that, compensation varies on the severity of the loss.

Permanent total disability benefits: Equal to 80% of your after-tax average weekly wage, subject to a state maximum ($900 per week as of 2018), paid for the duration of your disability. Benefits reduce by 5% each year between the ages of 65 and 75.

Other notable coverage: Dependents are eligible for death benefits equal to 80% of the worker's after-tax weekly wage and up to $6,000 for funeral expenses.

Minnesota workers' compensation

Program administrator: Minnesota Department of Labor and Industry

Employers required to provide coverage: All employers with some exceptions, including some sole proprietors, corporation officers and LLC managers.

Medical benefits: Your employer must cover all reasonable medical care associated with your workplace illness or injury.

Temporary total disability benefits: Equal to two-thirds of your gross weekly wage at the time of injury, subject to the state maximum ($1,098.54 as of 2018). There's a three-day waiting period for benefits with back pay issued if the disability last longer than 10 days. TTD caps at 130 weeks.

Temporary partial disability benefits: Equal to two-thirds of the difference between what the you earned at the time of the injury and your earnings in your modified position. TPD is capped at 225 weeks paid out within 450 weeks after the date of your injury.

Permanent partial disability benefits: The amount varies by injury; PPD is generally paid out when TTD ends and when you reach maximum medical improvement.

Permanent total disability benefits: Equal to two-thirds of your gross weekly wage at the time of injury, subject to the state maximum. Once the insurer has paid $25,000 in PTD, it can reduce benefits by the amount you're receiving in Social Security Disability Insurance (SSDI) benefits.

Other notable coverage: Dependents are eligible for death benefits, but the amount and duration varies by their relationship to the deceased. Surviving spouses, for example, are eligible for 50% of the deceased's weekly wage at the time of the injury for up to 10 years, subject to state maximums. They can also receive up to $15,000 for burial expenses.

Mississippi workers' compensation

Program administrator: Mississippi Workers' Compensation Commission

Employers required to provide coverage: Companies with five or more employees; domestic and farm employers are exempt from having to carry coverage.

Medical benefits: Employers must cover all reasonable and necessary medical care for work-related injuries or diseases, including mileage reimbursement.

Temporary total disability benefits: Equal to two-thirds of the workers' average weekly wage, subject to the state maximum ($487.04 as of 2018). There's a five-day waiting period for benefits with back pay issued if the disability extends 14 days or more.

Temporary partial disability benefits: Equal to two-thirds of the difference between the workers' average weekly wage before and after the injury, subject to the state maximums.

Permanent partial disability benefits: Two-thirds of the workers' average weekly wage, subject to the state maximum for up to 200 weeks depending on the injury.

Permanent total disability benefits: * Two-thirds of the workers' average weekly wage, subject to the state maximum ($487.04 as of 2018). All benefits are capped at 450 weeks with a lifetime pay out of $219,168 as of 2018.

Other notable coverage: Surviving spouses and other eligible dependents receive death benefits equal to a certain percentage of the workers' average weekly wage for up to 450 weeks. Spouses also receive up to $5,000 for funeral expenses and an immediate $1,000 in compensation.

Missouri workers' compensation

Program administrator: Missouri Division of Workers' Compensation

Employers required to provide coverage: Companies with five or more employees, whether full-time, part-time or seasonal; construction companies must carry coverage if they have one or more employees.

Medical benefits: The employer is responsible for covering all medical treatment related to the injury, though it can choose the health care provider.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum ($947.64 per week through June 2019). There's a three-day waiting period for which back pay is issued if you are out of work for 14 days or longer.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average earnings prior to the accident and the amount you are able to earn after the accident, subject to the state maximum ($947.64 per week through June 2019)

Permanent partial disability benefits: Compensation is equal to two-thirds of your average weekly wage, subject to the maximum ($496.38 per week), but paid out for varying number of weeks (as a lump sum) depending on the severity of your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly at the time of the injury, not to exceed the state maximum, but payable for the course of your life.

Other notable coverage: Surviving spouses and dependent children are eligible for weekly death benefits equal to two-thirds of the deceased's average weekly wage for the year prior to the accident (subject to the state maximum of $947.64 per week, and up to $5,000 in funeral expenses. Spouses are eligible for life until they remarry. Children are eligible until they turn 18 (22 if a full-time student).

Montana workers' compensation

Program administrator: Montana Department of Labor & Industry

Employers required to provide coverage: All businesses with employees

Medical benefits: Employers must cover reasonable doctor, hospital, prescription and medical care costs related to the injury. However, medical benefits cease 60 months from the date of the injury.

Temporary total disability benefits: Equal to two-thirds your gross wages, subject to the state maximum of $793 per week. Benefits begin 32 hours or four days after wage loss, whichever is less. You will receive back pay if the disability lasts 21 days or more.

Temporary partial disability benefits: Equal to the the difference between your average weekly wage at the time of injury, subject to a maximum of 40 hours a week, and the wages you earn in the modified schedule. Earnings cannot exceed your temporary total disability rate of $793 per week and is capped at 26 weeks, but the insurer can extend that period.

Permanent partial disability benefits: Compensation varies based on your injury, but is capped at $396.50 per week and a total of 400 weeks.

Permanent total disability benefits: Equal to TTD benefits, paid out until you are eligible for Social Security retirement benefits.

Other notable coverage: Surviving dependents are eligible for death benefits up to two-thirds of the deceased's gross wages, not to exceed the state maximum weekly wage, and burial expenses up to $4,000. Surviving spouses are eligible for up to 500 weeks of benefits. Payments cease upon remarriage or death.

Nebraska workers' compensation

Program administrator: Nebraska State Employees Workers' Compensation

Employers required to provide coverage: All businesses with one or more employees

Medical benefits: Employers must cover reasonable, necessary medical care and prescriptions directly related to the work injury. You can choose your physician so long as you've seen them prior to the injury.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage for 26 weeks prior to the injury, subject to a maximum of $831 per week. There's a seven-day

waiting period for benefits with back pay only issued if the disability lasts over 42 days. TTD benefits stop when you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average weekly wage and your weekly wage in the modified position. TPD is paid out for up to 300 weeks.

Permanent partial disability benefits: Paid at a rate of two-thirds of your average weekly wage times the number of weeks associated with the severity of your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage for 26 weeks prior to the injury, subject to a maximum of $831 per week, but payable for life.

Other notable coverage: Surviving spouses are eligible for weekly death benefits equal to two-thirds of the deceased's average weekly wage or 75% of their average weekly wage if they have children, subject to the state maximums. Benefits are payable for life or until the spouses remarries. They also receive up to $6,000 in burial expenses.

Nevada workers' compensation

Program administrator: Nevada Division of Industrial Relations

Employers required to provide coverage: Any company with one or more employees

Medical benefits: Employers must cover all medical expenses related to the workplace injury. However, they can choose your doctor(s).

Temporary total disability benefits: Equal to two-thirds your average weekly wage, subject to the state maximum ($897.82 per week for 2019). Benefits aren't paid out unless the disability causes you to miss five consecutive days or five cumulative days in a 20-day period. In that case, back pay is issued. TTD is paid out until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds your average weekly wage, subject to the state maximum, minus what you are making in your modified position. TPD benefits are capped at 24 months.

Permanent partial disability benefits: Benefits are paid out in varying amounts, depending on the severity of your disability and your age and wage.

Permanent total disability benefits: Equal to two-thirds your average monthly wage, subject to the state maximum ($897.82 per week for 2019). Benefits are paid out for life, but could be reduced by 10% if you receive a PPD payout.

Other notable coverage: Dependents are eligible for death benefits up to two-thirds of the deceased's salary and up to $10,000 in burial expenses.

New Hampshire workers' compensation

Program administrator: New Hampshire's Workers' Compensation Division

Employers required to provide coverage: All employers with any employees, full- or part-time

Medical benefits: The employer must cover the cost of all medical, hospital and remedial care related to the workplace injury.

Temporary total disability benefits: Equal to 60% the employee's gross average weekly wage, subject to the state maximum ($1,582.50 as of 2018). There's a three-day waiting period.

Benefits are paid out on those three days if the disability lasts 14 days or more. They last until the employee returns to work or reaches maximum medical improvement.

Temporary partial disability benefits: Equal to 60% of the difference between prior injury earnings and post-injury earnings, subject to the state maximum.TPD paid out for up to 262 weeks.

Permanent partial disability benefits: Equal to your average weekly wage, multiplied by a number of weeks correlating to the severity of your injury. Weeks are capped at 350.

Permanent total disability benefits: Equal to 60% the employee's gross average weekly wage, subject to the state maximum ($1,507.50 as of 2016), paid out for the duration of your disability.

Other notable coverage: Surviving spouses and minor children are eligible for death benefits of up to 60% the employee's gross average weekly wage, subject to the state maximum ($1,582.50 as of 2018). and burial expenses up to $10,000.

New Jersey workers' compensation

Program administrator: New Jersey Division of Workers' Compensation

Employers required to provide coverage: All businesses, outside of state and federal government employers

Medical benefits: Employers are required to cover all necessary and reasonable medical treatment, prescriptions and hospitalization services. They can designate the treating physician.

Temporary total disability benefits: Equal to 70% your average weekly wage, not to exceed 75% of the state's average weekly wage (amounts to a maximum benefit of $921 in 2019). Benefits are paid out for a maximum of 450 weeks. At that point, you become eligible for PTD.

Temporary partial disability benefits: Technically, not applicable; However, New Jersey has a Temporary Disability Income (TDI) program for anyone too ill or injured to work. These workers can receive weekly benefits, up to the state maximum ($637 per week as of 2018) and for 26 weeks, even if the illness or injury didn't occur in the workplace.

Permanent partial disability benefits: Equal to 70% your average weekly wage, multiplied by a number of weeks correlated to the severity of your injury.

Permanent total disability benefits: Equal to 70% your average weekly wage, not to exceed 75% of the state's average weekly wage ($921 in 2019). Benefits are initially paid out for 450 week, after which the recipient must demonstrate they are still unable to work.

Other notable coverage: Dependents are eligible for death benefits up 70% of the deceased's average weekly, capped at the maximum ($921) and up to $3,500 in burial expenses.

New Mexico workers' compensation

Program administrator: New Mexico Workers' Compensation Administration

Employers required to provide coverage: Businesses with three or more workers, including part-time and temporary workers. Agricultural employers are exempt, however; and all construction businesses must carry coverage.

Medical benefits: Employers must cover reasonable and necessary medical care related to the work-related injury or illness indefinitely.

Temporary total disability benefits: Equal to two-thirds your average weekly wage, based on wages for the 26 weeks prior to the accident, subject to the state maximum ($814.64 per week). There's a seven-day waiting period for benefits and back pay is only issued for those days if the disability lasts for four weeks or longer.

Temporary partial disability benefits: Equal to two-thirds the difference between the regular and wages in the modified job, subject to the state maximum.

Permanent partial disability benefits: Compensation varies. Benefits are capped at 500 to 700 weeks, depending on the severity of the injury. They're paid once an injured workers reaches maximum medical improvement.

Permanent total disability benefits: Equal to two-thirds your average weekly wage, based on wages for the 26 weeks prior to the accident, subject to the state maximum, but paid out for the workers' lifetime.

Other notable coverage: Surviving dependents are eligible for death benefits equal to the deceased's TTD benefits, subject to the state maximum and capped at 700 weeks. They also receive up to $7,500.

New York workers' compensation

Program administrator: New York State's Workers' Compensation Board

Employers required to provide coverage: All businesses with employees, including day laborers, leased employees, borrowed employees, part-time employees, unpaid volunteers (including family members) and most subcontractors.

Medical benefits: Employers are required to cover all necessary medical care related to the illness or injury for the duration of your disability. Employees must use authorized providers, however, even for emergency care.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage multiplied by the percentage of your disability, subject to the state maximum ($904.74 as of 2018). There's a seven-day waiting period for benefits. That first week is only paid out if your disability lasts longer than 14 days.

Temporary partial disability benefits: Equal to two-thirds of the difference between your wages prior and post injury, subject to the state maximum.

Permanent partial disability benefits: Compensation is equal to two-thirds your average weekly wage, subject to the state maximum, and multiplied by a number of weeks (up to 525 weeks) dictated by the severity of your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage multiplied by the percentage of your disability, subject to the state maximum, but paid out until death.

Other notable coverage: Surviving spouses and minor children are eligible for weekly death benefits equal to two-thirds of the deceased worker's average weekly wage for the year before the accident, subject to the state's maximum, and up to $12,500 in funeral expenses. Surviving parents or the worker's estate might be entitled to a $50,000 lump-sum death benefit.

North Carolina workers' compensation

Program administrator: North Carolina Industrial Commission

Employers required to provide coverage: All businesses with three or more employees with a few notable exceptions in the agriculture industry.

Medical benefits: Employers are responsible for covering medical care related to the injury, but can specify health care providers.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum ($1,028 as of 2019). There's a 7-day waiting period for benefits with pay for those days only getting issued if your disability last 21 days or more. You are eligible for benefits until you return to work.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage prior to the injury minus the wages you are making on a modified schedule. Benefits are payable for up to 500 weeks.

Permanent partial disability benefits: Compensation varies by injury, but is limited to 300 weeks of pay.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum (==), paid for life.

Other notable coverage: Surviving dependents are eligible for death benefits equal to two-thirds of the deceased average weekly wage, subject to the state maximum, and up to $10,000 in burial expenses.

North Dakota workers' compensation

Program administrator: North Dakota Workforce Safety and Insurance

Employers required to provide coverage: All employers with employees including full-time, part-time, seasonal and occasional workers.

Medical expenses: The insurer must cover all reasonable medical care related to the workplace injury.

Temporary total disability benefits: Equal to two-thirds of your pre-injury gross weekly wage, plus $15 per week for each dependent child, subject to the state maximum. There's a five-day waiting period for benefits.

Temporary partial disability benefits: * Equal to two-thirds of your pre-injury gross weekly wage minus your post-injury gross wages. TPD ends when your wages return to at least 90% of your gross weekly pre-injury wages and is capped at five years.

Permanent partial disability benefits: Amount varies by injury and is paid out once you reach maximum medical improvement.

Permanent total disability benefits: Equal to two-thirds of your pre-injury gross weekly wage, reduced by 50% once you're receiving SSDI.

Other notable coverage: Varies by relationship to the deceased. Surviving spouses receive death benefits equal to two-thirds of a deceased's weekly wage, up to 125% of the state's average weekly wage, plus up to $15 each week for each dependent child. They also receive a one-time payment of $2,500, plus $800 for each dependent child, and up to $10,000 in funeral expenses. Total death benefits are capped at $300,000.

Ohio workers' compensation

Program administrator: Ohio Bureau of Workers' Compensation

Employers required to provide coverage: All employers with one or more employees

Medical benefits: Employers must cover all authorized medical treatment related to the injury, including mileage reimbursement.

Temporary total disability benefits: For the first 12 weeks of injury, benefits are equal to 72% of the worker's full weekly wage. After that, benefits are equal to two-thirds of your average weekly wage, subject to the current state maximum of $932 per week. There's a seven-day waiting period for benefits; they last for the duration of your disability.

Temporary partial disability benefits: Known as Wage Loss (WL) benefits in Ohio, you are eligible for benefits based on the reduction in your earnings, subject to the $932 max. Working wage loss benefits, comparable to standard TTD, caps at 200 weeks. Non-working wage loss, where you're actively seeking, but haven't found suitable employment, caps at 52 weeks. If you combine the two, benefits cap at 226 weeks with a few exceptions.

Permanent partial disability benefits: Awards are calculated by multiplying two-thirds of your average weekly wage by the number of weeks correlated to the severity of your injury. The maximum number of weeks is 200.

Permanent total disability benefits: Equal to two-thirds of the average weekly wage, subject to the current max, and payable for life.

Other notable coverage: Surviving dependents are eligible for death benefits based on level of dependency and subject to the $932 max, plus funeral expenses up to $5,500. Ohio also has a Disabled Workers' Relief Fund, which offers additional benefits to disabled workers whose income falls below the current cost of living.

Oklahoma workers' compensation

Program administrator: Oklahoma Workers' Compensation Commission

Employers required to provide coverage: Most businesses, with notable exceptions made for certain agricultural employers

Medical benefits: Employers must cover reasonable and necessary medical treatment related to the injury, though they can decide the health care provider.

Temporary total disability benefits: Equal to 70% of your average weekly wage, but can't exceed 70% of the state average weekly wage, and subject to the current state maximum of $590.63 per week (as of 2018). There's a three-day waiting period for benefits. TTD can last for a maximum of 104 weeks, plus 52 weeks for any consequential injury.

Temporary partial disability benefits: Equal to 70% of the difference between the your pre-injury average weekly wage and your post-injury weekly wage, subject to the weekly cap of $320. Benefits are capped at 52 weeks.

Permanent partial disability benefits: Equal to 70% of the injured employee's average weekly wage (subject to a $323 max) multiplied by a number of weeks (up to 500) based on the severity of the injury.

Permanent total disability benefits: Equal to 70% of your average weekly wage, but capped at 100% of the state's average weekly wage, subject to the state max of $843.75 per week (as of 2018). PTD is available for 15 years or until you're eligible for maximum Social Security benefits (whichever comes first).

Other notable coverage: Surviving dependents are eligible for a lump sum death benefit based on their relationship to the deceased. A surviving spouse could receive s $100,000, plus 70% of deceased's average weekly wage or the state's average weekly wage, (subject to state maximums) whichever is the lesser amount. Death benefits also include up to $10,000 in funeral expenses.

Oregon workers' compensation

Program administrator: Oregon's Workers' Compensation Division

Employers required to provide coverage: Employers with one or more employees with few exceptions

Medical benefits: Employers will provide medical treatment, prescription drugs and most transportation, meals and lodging related to the on-the-job injury.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum of $1,339.38 per week through 2019. There's a three-day waiting period for benefits with back pay issued if you're out for 14 days in a row or hospitalized overnight within 14 days of the injury. TTD lasts indefinitely.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage before your injury minus your average weekly wage post-injury, paid for the duration of your disability.

Permanent partial disability benefits: Varies by date, severity of the injury, age of the worker, education and adaptability to perform a job post-disability. If amount awarded is greater than $6,000, it's paid monthly at 4.35 times the TTD rate or in a lump sum. If the award is under $6,000, it will be paid in a lump sum.

Permanent total disability benefits: Equal to two-thirds of the worker's average weekly wage, but subject to the state maximums. PTD could last for life. However, claims are re-evaluated every two years.

Other notable coverage: Death benefits are available to dependents, but the amount varies by their relationship to the deceased. Spouses are eligible for monthly benefits equal to 4.35 times two-thirds of the state's average weekly wage, which currently amounts to $2,920.59, plus funeral expenses up to $20,141.

Pennsylvania workers' compensation

Program administrator: Pennsylvania Department of Labor and Industry

Employers required to provide coverage: Employers with one or more employees, whether part-time or full-time, including family members.

Medical benefits: All reasonable medical care related to the injury

Temporary total disability benefits: Equal to two-thirds your gross weekly wage, subject to the state maximum ($1,025 as of 2018) with a few exceptions for low-paid employees. Capped at 104 weeks.

Temporary partial disability benefits: Equal to two-thirds of the difference between the your wages before and after the injury, capped at 500 weeks.

Permanent partial disability benefits: Equal to two-thirds your pre-injury wage, multiplied by a number of weeks, based on the loss in question.

Permanent total disability benefits: Equal to two-thirds your gross weekly wage, subject to the state maximum, with a few exceptions for low-paid employees. Once 104 weeks of TTD is paid out, you must have a medical exam to continue benefits.

Other notable coverage: Dependents are eligible for death benefits up to two-thirds of the deceased worker's average weekly wage (subject to the state maximum), though the exact

amount varies by relationship and the number of dependent children. Families are also eligible for up to $3,000 for burial expenses.

Rhode Island workers' compensation

Program administrator: Rhode Island Department of Labor and Training

Employers required to provide coverage: Employers with one or more employees, with standard exceptions

Medical benefits: The employer's insurance covers all bills related to the injury, and you can pick your first primary physician. There are limits on palliative care once you reach maximum medical improvement.

Temporary total disability benefits: Equal to 75% of your spendable wage (earnings minus withholding) and subject to the state maximum ($1,253 as of 2018) and a three-day waiting period (no retroactive pay). You also receive $15 per dependent per week.

Temporary partial disability benefits: Equal to 75% of your spendable base wage (earnings minus withholding) minus what you are making in your modified position. TTD and TPD are available until you return to work or reach maximum medical improvement.

Permanent partial disability benefits: Depends on the severity of the injury, but benefits are generally between $45 and $90 per week for a certain number of weeks, paid with TTD or as a lump sum.

Permanent total disability benefits: Equal to 75% of your spendable base wage (earnings minus withholding) and subject to the state maximum.

Other notable coverage: Surviving spouses are eligible for benefits equal to 75% of the deceased's spendable base wages, subject to the state maximum, plus $40 per week per child and up to $20,000 in burial expenses.

South Carolina workers' compensation

Program administrator: South Carolina Workers' Compensation Commission

Employers required to provide coverage: Employers with four or more employers, including part-time workers and family members.

Medical benefits: Insurance covers 100% of medical expenses related to the workplace injury, but employers can select your treating physician.

Temporary total disability benefits: Equal to two-thirds of your average weekly wages, subject to a $838.21 maximum (as of 2018) and a seven-day waiting period, with back pay only issued if you're out of work for 15 days or more.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wages minus what you're making, subject to 340-week cap.

Permanent partial disability benefits: The amount varies by severity of injury, but is subject to a 340 week-cap.

Permanent total disability benefits: Equal to two-thirds of your average weekly wages, but subject to a 500-week cap. Paraplegics, quadriplegics and employees who incur physical brain damage are eligible to receive weekly compensation benefits for life.

Other notable coverage: Dependents are eligible for death benefits up to 500 weeks and burial expenses up to $2,500.

South Dakota workers' compensation

Program administrator: South Dakota Department of Labor and Regulation

Employers required to provide coverage: None

Medical benefits: Employers must cover all medical bills related to the workplace injury. You can choose your doctor, but the employer and insurer are entitled to request a second opinion for which they must cover the cost.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to a weekly $805 maximum and a seven-day waiting period. Benefits are paid until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage, minus your pre-injury wage.

Permanent partial disability benefits: Varies by disability, with payments made weekly or bi-weekly until a lump sum is approved.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the weekly maximum and payable for life.

Other notable coverage: Varies, depending on your relationship to the deceased. Surviving spouses are eligible for death benefits up to two-thirds of the deceased's average weekly wage, subject to the state maximum, plus $50 per month per dependent child They can also receive up to $10,000 in burial expenses.

Tennessee workers' compensation

Program administrator: The Tennessee Department of Labor & Workforce

Employers required to provide coverage: Any employer with five or more employees, both full and part-time. There are some notable exceptions for construction and mining employers.

Medical benefits: The employer must cover all medical bills related to the employee's injury with some say over the treating physician, and travel expenses to and from medical treatment.

Temporary total disability benefits: Equal to two-thirds of your average weekly wages, subject to a $1,021.90 weekly maximum through June 2019 and an eight-day waiting period with back pay issued if the disability lasts 14 days.

Temporary partial disability benefits: Equal to two-thirds of the difference between your gross light duty wages and your average weekly wage.

Permanent partial disability benefits: Equal to two-thirds of your average weekly wages with the exact amount determined by the severity of the injury.

Permanent total disability benefits: Equal to two-third of your average weekly wages, subject to $929 weekly maximum through June 2019.

Other notable coverage: Equal to two-thirds of the deceased's average weekly wages, subject to the state maximum, when there is a surviving spouse and dependent; Equal to 50% of the deceased average weekly wages when there is only a surviving spouse. Dependents can also receive up to $10,000 for burial expenses.

Texas workers' compensation

Program administrator: Texas Department of Insurance

Employers required to provide coverage: None

Medical benefits: All reasonable medical care related to the injury

Texas structures benefits a bit differently. Employees are eligible for the following:

Temporary income benefits (TIB): Equal to 70% of the difference between your average weekly wage and the wages you earn after your work-related injury, subject to the state maximum ($938 as of 2018). TIB begins eight days after the injury and continues until you reach maximum medical improvement.

Impairment income benefits (IIB): If you reach maximum medical improvement, but are unable to return to work, you are eligible for IIB. Benefits are equal to 70% of your average weekly wage, subject to the state maximum ($656 as of 2018), payable for a number of weeks that correlates to the severity of your injury.

Supplemental income benefits (SIB): Severely disabled workers are eligible for SIB, once IIB payments run out. Benefits are equal to 80% of the difference between 80% of your average weekly wage and your weekly wages after your work-related injury, subject to the state maximum ($656). TIB, IIB and SIB combined are capped at 401 weeks.

Lifetime Income Benefits (LIB): Equal to up to 75% of average weekly wages, initially subject to the state maximum ($938), with a 3% increase each year.

Other notable coverage: Surviving dependents are eligible for death benefits up to 75% of the deceased's average weekly wage, subject to state maximum ($938), and possible burial expenses.

Utah workers' compensation

Program administrator: Utah Labor Commission

Employers required to provide coverage: All employers with a few standard exceptions.

Medical benefits: The employer must cover all reasonable medical expenses related to the workplace injury. They can only stipulate a health care provider on your first visit.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, plus $20 for a dependent spouse and $20 per dependent child (up to four children), not to exceed 100% of the state’s average weekly wage ($879 through June 2019).

Temporary partial disability benefits: Equal to two-thirds the the difference between your average weekly wages before the accident and your weekly wages earned after the accident, plus your dependent allowance, but subject to the state maximums. TTD and TPD are capped at 312 weeks.

Permanent partial disability benefits: Equal to two-thirds of your average weekly, plus dependent allowance, multiplied by a number of weeks correlated to the severity of your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage for the first 312 weeks of disability. After which, compensation is 36% of the current state average weekly wage, rounded to the nearest dollar.

Other notable coverage: Surviving spouses are eligible for death benefits equal to two-thirds of the deceased’s average weekly wage, plus the dependent allowance, so long as it doesn’t exceed the state maximum, for a period of 312 weeks. After 312 weeks, extended benefits are subject to review. Dependents can also receive up to $9,000 in burial expenses.

Vermont workers' compensation

Program administrator: Vermont Department of Labor

Employers required to provide coverage: Employers with one or more full-time or part-time employees

Medical benefits: Employers must cover all reasonable medical care related to the injury.

Temporary total disability benefits: Equal to two-thirds of your standard wage, plus an extra $10 per week for each dependent child, subject to a weekly maximum of $1,311 through June 2019. Benefits are subject to a four-day waiting period. They continue until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of your standard wage minus your part-time pay.

Permanent partial disability benefits: Amount varies by severity of your injury and is paid periodically unless a request for a lump sum is approved by the state's Workers' Compensation and Safety Division.

Permanent total disability benefits: Equal to two-thirds of your standard wage, paid for a minimum of 330 weeks.

Other notable coverage: Death benefits vary by relationship to the deceased: Surviving spouses are eligible for two-thirds the average weekly wage, subject to the state's max, while surviving spouses with dependents are eligible for up to 76.6% of the deceased's average weekly wage. Dependents can also receive up to $10,000 in burial expenses.

Virginia workers' compensation

Program administrator: Virginia Workers' Compensation Commission

Employers required to provide coverage: Any business with more than two employees. Policies must cover all work performed in Virginia, even temporary work.

Medical benefits: All reasonable medical care related to the injury

Temporary total disability benefits: Equal to two-thirds your regular wages, based upon earnings for the 52 weeks prior to your injury, subject to the state maximum ($1,082 as of 2018). There's a seven-day waiting period for benefits, with back pay issued, if you're out of work for over 21 days. TTD is capped at 500 weeks.

Temporary partial disability benefits: Equal to two-thirds of the difference between the worker's wages before and after his injury, also capped at 500 weeks.

Permanent partial disability Benefits: Equal to two-thirds your regular wages, multiplied by a number of weeks correlated to the severity of your injury and paid out once you reach maximum medical improvement.

Permanent total disability benefits: Equal to two-thirds of your gross average weekly wage for the duration of the disability.

Other benefits: Dependents are eligible for death benefits up to two-thirds of the deceased average weekly wages, subject to the state maximum, for a maximum 500 weeks from the date of injury. They can also receive up to $10,000 in burial expenses.

Washington workers' compensation

Program administrator: Washington State Department of Labor and Industries

Employers required to provide coverage: Employers with one or more employees with the standard exceptions.

Medical benefits: Employers must cover all reasonable medical treatment related to your workplace injury. You may choose a doctor for your first visit, but after that, your employer can ask you stay in-network.

Temporary total disability benefits: Equal to 60% to 75% of your wages, depending on how many dependents you have and the state's current average weekly wage ($1,190 as of 2018) . There's a three-day waiting period for benefits; they're paid until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to 80% of your pre-injury wages minus post-injury wages.

Permanent partial disability benefits: Varies, depending on the severity of your injury, which must be rated by a qualified doctor.

Permanent total disability benefits: Permanent and totally disabled workers are eligible for a monthly pension. The amount depends on your wages, the state's average wage at the time of your injury, your marital status, number of dependent children, health-care benefits and Social Security benefits.

Other notable coverage: Survivors are also eligible to receive this monthly pension; the maximum benefit is currently 120% of the statewide average wage for the year prior to the pension award. Domestic partners and spouses are also eligible for a one-time immediate death benefit and burial expenses.

Washington D.C. workers' compensation

Program administrator: Washington D.C. Department of Employment Services

Employers required to provide coverage: Employers with one or more employees

Medical benefits: Employers must cover all reasonable medical expenses related treatment for the workplace injury.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum ($1,491.90 as of 2018). Benefits are subject to a three-day waiting period (with back pay issued if the disability lasts longer than 14 days). They're paid until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage pre-injury, minus your average weekly wage post-injury, paid for a maximum of 5 years.

Permanent partial disability benefits: Equal to two-thirds of your average weekly wage multiplied by a number of weeks correlated to your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum and potentially available for life.

Other notable coverage: Death benefits vary by relationship to the deceased, with surviving spouses or domestic partners eligible to receive benefits totaling 50% of the average wages of the deceased, subject to the state maximum, and an additional 16.6% of the wages per dependent child. They're also eligible for up to $5,000 in funeral expenses.

West Virginia workers' compensation

Program administrator: West Virginia

Employers required to provide coverage: All employers with a few standard exceptions

Medical benefits: All reasonable medical care related to the injury

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to a state maximum of $823.14 as of 2018 and limited to 104 weeks.

Temporary partial disability benefits: Equal to 70% of the difference between your average weekly earnings before and after the injury, also limited to 104 weeks.

Permanent partial disability benefits: Varies by injury, but the weekly benefit amount is subject to the state maximum of $576.20 as of 2018.

Permanent total disability benefits: Equal to two-thirds of your weekly wage, subject to the state's maximum, paid out potentially for life.

Other notable coverage: Surviving dependents are eligible for death benefits equal to two-thirds of the deceased's average weekly wage, subject to a state maximum of $823.14 and up to $7,000 to cover burial expenses.

Wisconsin workers' compensation

Program administrator: Wisconsin Department of Workplace Development

Employers required to provide coverage: Companies employing three or more full-time or part-time employees

Medical benefits: All reasonable and necessary medical expenses related to the disability

Temporary total disability benefits: Equal to two-thirds of your average weekly earnings, subject to the 2018 state maximum of $1,491. There is a three-day waiting period of coverage, with back pay issued if the disability lasts seven days or more. TTD benefits are paid until you return to work, or your condition is no longer expected to improve — you become eligible for permanent disability benefits.

Temporary partial disability benefits: Equal to TTD benefits minus the wages you're making in your modified position, subject to the state max.

Permanent partial disability benefits: Amount and duration of benefits vary by the severity of your injury, but are subject to a weekly ($362), monthly ($1,568.67) and annual maximum ($74,550) as of 2018.

Permanent total disability benefits: Equal to two-thirds of the employee's average weekly wage subject to $1,491 maximum, payable for life.

Other notable coverage: Death benefits vary by relationship. Surviving spouses are entitled to a maximum death benefit of four times the average annual earnings ($298,200 as of 2018), paid out monthly at a corresponding maximum. Dependents can also receive up to $10,000 for burial expenses.

Wyoming workers' compensation

Program administrator: Wyoming Department of Workforce Services

Employers required to provide coverage: All of them, with a few standard exclusions; Unlike most states, Wyoming mandates employers purchase workers' compensation insurance from its state fund. They can't purchase a private plan or self-insure.

Medical expenses: All care directly related to the illness or injury.

Temporary total disability benefits: Equal to two-thirds of your monthly gross income or 30% of the statewide average monthly income ($3,779.75 in 2018), depending on how much you normally earn each month. Payments are made for up to 24 months. You are not paid for the first three days of lost wages, unless your disability lasts eight days or more.

Temporary partial disability benefits: Equal to 80% of the difference between your modified wage and your actual monthly wages prior to your workplace illness or injury.

Permanent partial disability benefits: The length and amount of compensation depends on salary, age, occupation, education and career plans.

Permanent total disability benefits: You can apply for up to 80 months' worth of income replacement. Total compensation varies by salary, age, occupation, education and career plans. Once the 80 months elapses, you must reapply annually to renew benefits.

Other notable coverage: Dependents are eligible for varying death benefits. For instance, a spouse can receive up to 100 months of benefits with total compensation based on a percentage of wages at the time of death compared to the state average. Dependents can receive up to $5,000 in burial expenses.

Types of disability insurance riders

A rider is an add-on that changes your disability insurance coverage. Some riders are free while others cost extra to add. Although riders aren't exactly types of insurance, they can affect how your policy works.

Here are a few common disability insurance riders:

- **Automatic increase rider**: Raises your benefits over a limited number of years without a medical exam.
- **Cost of living adjustment rider**: Increases your monthly benefits to keep pace with inflation.
- **Future increase option**: Allows you to increase your benefits a limited number of times without a medical exam.
- Guaranteed renewable and non-cancelable: Ensures your policy stays active and your rates stay the same as long as you keep paying your premiums.
- **Partial or residual disability rider**: You can receive some disability benefits if an injury or illness affects your income at all, even if you're not unable to work.
- **Rehabilitation waiver**: Helps pay for the cost of physical or occupational rehabilitation after a disability.
- **Retirement protection rider**: Covers the payments that you would have made to a retirement fund while you were working.
- **Student loan protection rider**: Continues your student loan payments while you're out of work.
- **Survivor or death benefit:** Pays a few months of benefits to a surviving beneficiary if you die while receiving disability payments.

What kind of policy is guaranteed-renewable?

Both short and long-term disability insurance policies can be guaranteed-renewable.

Is disability insurance always guaranteed-renewable?

Not necessarily. Although it's more common for coverage to be guaranteed-renewable than conditional, you should always make sure you know what kind of policy you're buying before finalizing your coverage.

Does everyone need to have guaranteed-renewable insurance?

Yes, your disability insurance should be guaranteed-renewable. Otherwise, you can't be certain that you'll be able to use your benefits in the future.

What does guaranteed-renewable disability insurance cost?

Most disability insurance policies are guaranteed-renewable, so you won't need to worry about paying an extra fee to add that to your policy.

Alternatives to disability insurance

Self-insuring can be an alternative to disability insurance. Self-insurance isn't a type of disability insurance; it just means using your savings to cover your expenses while you're out of work.

This is only an option if you have enough money saved up that you can rely on your savings alone while you're not working.

Disability insurance basics

Here are some important terms and phrases to know if you're shopping for disability insurance:

- **Benefit amount**: The amount you'll be paid if an injury or illness keeps you from working.
- **Benefit period**: The length of time that you'll receive payments after a disability. Your benefit period can last a few months, years, or even decades.
- **Claim**: The process of submitting proof of your disability to your insurance company so that you can start to collect your benefits.
- **Definition of disability**: Your policy's rules for what counts as a covered "disability." This can affect whether you can receive any benefits, and how much you can collect.
- **Elimination period**: Also called a "waiting period," this is the amount of time you have to wait between a disabling event or injury and when you can start receiving payments.

You usually get to pick an elimination, or waiting, period when you buy a disability insurance policy. For long-term disability insurance, you can sometimes choose a longer elimination period means cheaper rates, but don't make your elimination period too long, because it may mean going months or even years without an income. Remember that the best way to find affordable disability insurance is by comparing quotes from multiple companies.

Elimination periods for long-term disability insurance range from 30 days to two years, and seven days for a short-term policy.

Your elimination period begins on the day of your disabling event, **not** when you file a claim. So, for an illness, that would mean the first day your symptoms keep you from working. Once your elimination period is up, and as long as your condition lines up with your policy's definition of a disability and your claim is accepted, your benefits will start.

How do elimination periods work?

Elimination periods work like this: You can file a claim as soon as you have an illness or injury that keeps you out of work, but you won't start receiving payments until the elimination period is up. So if your elimination period is 6 months, you won't start getting payments until 6 months from the date of your disabling event.

But elimination periods can sometimes be tricky. Depending on how you choose to receive your benefits (meaning your payments), they might not arrive right after your elimination period ends, and you may have to live on your savings for longer than expected.

You only have one elimination period per injury or illness, so if you try to go back to work after a few weeks off but can't, your elimination period won't restart.

It's also possible to skip your elimination period altogether if you have a serious disability, are permanently disabled, or if you have to submit more than one disability claim.

How to you choose an elimination period

When you're choosing an elimination period, consider how long you can afford to live without a paycheck, and any other coverage you have that can pay out while you're waiting.

These steps can help you decide on an elimination period for your disability insurance policy:

- **Do the math**: Calculate your monthly expenses and divide the total by the money you have saved. This will tell you how many months' cushion you have to rely on your savings alone.
- **Account for other forms of income**: If you don't have much in savings, but you have a partner who earns enough money to keep you both afloat while you're out of work, or you have short-term disability insurance that will pay out right away, you may be able to opt for a longer elimination period for your long-term disability coverage.

How do different elimination periods affect disability insurance rates?

Your elimination period is just one of the factors — along with the amount of coverage you get, your benefit period, and your age — that determines your disability insurance rates. In fact, your elimination period can affect your rates by quite a bit.

We found that the average cost of disability insurance with a 30-day elimination period is almost double the cost of a policy with a 90-day waiting period. An even longer 720-day elimination period is about one third cheaper than a policy with a 90-day waiting period.

Elimination period	Average rate
30 Days	$1,667
60 Days	$1,358

90 Days	$843
180 Days	$713
365 Days	$604
720 Days	$575

Average monthly rates for own-occupation long-term disability insurance with a benefit period through age 65.

Remember that you still have to be able to cover your expenses while you're out of work and not receiving any benefits or income from another source, so don't just choose the longest elimination period you can to get affordable disability coverage**.**

Elimination period vs. probationary period

An elimination period isn't the same as a probationary period in insurance. A probationary period is a set amount of time during which you can't file a claim.

Long-term disability insurance usually doesn't have a probationary period — most disability policies don't. Other types of insurance, like health insurance, typically have probationary periods, but you could file a disability claim the day after your policy starts if you need to, as long as it's not for a pre-existing condition.

- **Rider**: A disability rider is a change or addition to your coverage. Riders can be included or optional — you may have to pay extra to add an optional rider.
- **Premium**: The regular payments you make to keep your disability insurance policy active.

Group Disability Income Policy

a. **Description**: Offered by employers, this policy provides disability income benefits to employees.

b. **Example**: An employer-provided policy that pays 50% of an employee's salary if they are unable to work due to a long-term illness.

Key Employee Policy

c. **Description**: Provides benefits to a business if a key employee becomes disabled.

d. **Example**: A policy that pays $100,000 to a company if their top sales executive is unable to work for six months due to a disability.

Group Life Insurance Policy: Defined and Explained

Roughly two-thirds of Americans rely on group life insurance from work. However, nearly half of these people either don't understand or only somewhat understand how it works, according to an Insurance Barometer Study by LIMRA and Life Happens, both industry-funded groups.

What Is Group Life Insurance?

Group life insurance is a single contract that provides coverage to a group of people, typically those who work for the same company. The employer owns the policy which covers the employees. Your beneficiaries will get a payout if you pass away while covered by group insurance.

The most common group life insurance policy is provided by employers. However, some churches, professional associations, alumni groups, unions and other affiliate organizations offer group life insurance to members.

There are many different formulas used to calculate group life insurance benefits. Some of the most common types are below.

Fixed multiple-of-earnings benefit plans

These group life insurance plans tie your death benefit amount to a multiple of your wages, such as two times your annual salary. Because the payout is linked to your salary, the level of protection rises as your income increases.

Variable multiple-of-earnings benefit plans

These group life insurance plans' benefits are based on multiples of your earnings at certain thresholds. For example, the death benefit might be equal to your salary if you make under a certain amount, or it might be two times your annual earnings if you make over a certain amount.

Flat-dollar-amount benefit plans

These group life insurance plans pay the same amount to all employees and are a fixed dollar amount. Payouts ranging from $10,000 to $25,000 tend to be the most common.

Variable-dollar-amount benefit plans

Variable-dollar-amount plan payouts can vary based on your earnings and length of service.

What Is the Purpose of Group Life Insurance?

The purpose of group life insurance is to help provide peace of mind for employees and their families, knowing they will have some financial security if the person covered by group life insurance passes away.

Businesses offer group life insurance as a way to help attract and retain talent. For businesses, offering group life insurance can be an effective way to show employees that they're valued and that their well-being is a priority.

For families struggling to make ends meet, group life insurance can be a lifeline. However, one thing you should know about group life insurance is that it often isn't enough on its own. Group life insurance is also sometimes called supplemental life insurance because it's meant to provide additional protection beyond an individual life insurance policy.

Pros and Cons of Group Life Insurance

Although group life insurance is a valuable perk, it has its pros and cons.

Advantages of group life insurance

- Group life insurance is generally less expensive than individual life insurance because your employer pays all or most of the cost.
- It's often easier to qualify for group life insurance because there's no medical exam required—unless you want to buy extra group life.
- Group life insurance is easy to get because you can sign up during employee onboarding or open enrollment.
- You may be able to add coverage for a spouse and/or dependent.

Disadvantages of group life insurance

- If you leave your job, you often lose coverage. The only exception is if your policy is "portable," which means you continue to buy the group life insurance (at your own cost) after you've left the job.
- The death benefit of a group life insurance policy is usually lower than that of an individual policy.
- Most group life insurance policies don't have cash value, which means you can't borrow against it, as you can with permanent life insurance.

Summary: Group life insurance pros and cons

Pros	Cons
Typically free or low cost	Coverage is typically tied to employment
No medical exam in most cases	Low death benefit amounts
Easy to sign up for at work	No cash value

When to Get Group Life Insurance

If your employer offers free group life insurance, it makes sense to opt into it. It usually costs you nothing and will provide a little more financial security to your beneficiaries in the event of your death. Even if you have to pay for group life, it's usually cheaper than an individual life insurance policy.

Beyond that, group life insurance can be a great way to get coverage if you have trouble qualifying for an individual policy due to health issues. This is because the underwriting standards are often more lenient for group policies.

Requirements for Group Life Insurance

To qualify for group life insurance, you must usually be an active employee of the company that offers the policy. Some policies may require that you work a certain number of hours per week to qualify, while others may be available to all employees regardless of status.

Premiums for Group Life Insurance

Premiums for group life insurance are often paid in full or partially by the employer. If you pay a portion it can be deducted from your paycheck. Your premium can depend on factors such as your age, salary and whether you smoke. Your employer may also offer different levels of coverage at different price points, so you can choose how much coverage you want based on your needs and budget.

The Cost of Group Life Insurance

Group life insurance costs vary depending on your employer, the life insurance company and the characteristics of the group, such as the average age of employees. The average cost of group life insurance purchased through an employer is usually quite low.

For example, here's a look at Walmart and Amazon's group life insurance, two of the largest companies in the U.S.

Walmart gives full-time employees company-paid life insurance equal to their annual pay, up to $50,000. Beyond this, hourly associates can pay for up to $200,000 in group life insurance, while salaried associates and drivers can pay for up to $1 million in coverage.

A 40-year-old full-time Walmart employee who does not use tobacco pays $.0295 for $1,000 or $2.95 per biweekly pay period for $100,000 in additional coverage.

These additional premiums are deducted from paychecks.

Amazon gives most part-time and full-time employees free basic life insurance equal to two times their annual salary. Employees have the option to buy additional coverage up to 10 times their base annual earnings.

For example, a 40-year-old full-time Amazon employee will pay $0.059 for every $1,000 of additional coverage. If that employee wants to purchase $100,000 of additional group life insurance, they'd have a monthly premium of $5.90.

B. Accidental Death and Dismemberment

- **Description**: Provides benefits if the insured dies or loses a limb due to an accident.
- **Example**: A policy that pays $200,000 for accidental death and $100,000 for the loss of a limb.

Understanding AD&D Insurance: Benefits & Coverage

Accidents are the fourth leading cause of death in the U.S., and the No. 1 cause of death for adults ages 25 to 44, according to the Centers for Disease Control. Only heart disease, cancer and Covid kill more Americans than accidents.

That's why there is accidental death and dismemberment (AD&D) insurance. But as with all the best life insurance products, it pays to understand what it really covers and if you need it.

What Is Accidental Death and Dismemberment Insurance?

As the name suggests, accidental death and dismemberment insurance provides coverage for a death due to an accident. It generally also pays if you lose a limb or a function such as sight, hearing or speech in an accident.

Typically, the beneficiaries you name on your policy will receive a lump-sum payment if you die in an accident. You can receive what are called living benefits if you are injured, and the amount you receive often depends on the type of injury.

For example, an AD&D policy might pay 50% of the coverage amount you purchase if you lose one thing—for example, a hand, foot or sight in one eye—and 100% if you lose two or more things. And policies might pay 50% to 100% of the benefit amount for paralysis as a result of an accident.

The amount of coverage you can get will depend on limits set by insurers or by employers that offer AD&D insurance as a workplace benefit. For example, you can purchase an AD&D policy from Farmers Insurance with a benefit ranging from $37,500 to $200,000 for an accident covered by your policy. Farmers may also pay $1 million for “certain circumstances,” such as losing your life in a plane crash on a commercial flight.

What’s Covered by AD&D Insurance?

AD&D insurance will cover only deaths and injuries from accidents—not natural causes or illnesses. Not heart attacks or strokes. Policies typically cover death or injuries from accidents at work, home and while traveling.

In addition, if your death is the result of an accident while traveling on public transportation, including a bus, train or airplane, the payout can be double or triple the amount of your base coverage. To be covered, a death from an accident doesn’t have to be instant, but it usually needs to occur within a certain time frame, such as within a few months. The policy will outline the rules.

Are There Additional AD&D Insurance Benefits?

Some insurers will pay an additional benefit if you were wearing a seatbelt during an accident that led to an injury or death. Additional benefits might also be provided to help children pay for higher education. Counseling, legal and financial advising services for beneficiaries can be added benefits for a surviving spouse, too. These options will vary by insurer.

What’s Not Covered by AD&D Insurance?

What is considered an “accident” by insurance companies isn’t as straightforward as it might seem.

“The definition of accident could be subjective,” says Jon Voegele, agency vice president of Country Financial.

Policies tend to have a long list of situations when death or injury won’t be covered. Those exclusions can vary from company to company and can depend on the state where the policy is issued. Benefits are generally not payable for:

- Injury that happened prior to coverage
- Death caused by illnesses, including mental illness
- Suicide or self-inflicted injuries
- Drug overdose
- Death or injury while driving under the influence of alcohol
- Death or injury from voluntarily inhaling gas or taking poison
- Death or injury while committing a crime
- Death or injury while participating in a riot or suffered during a war
- Injuries while serving in the armed services

- Death or injury from car racing, flying a plane, playing professional sports or participating in extreme sports such as sky diving and scuba diving

How Can You Get AD&D Insurance?

If you work for a company, there's a good chance your employer offers AD&D insurance as part of its benefits package. Some employer group plans also allow employees to insure their spouse and children.

A few insurance companies, such as AIG Direct, Farmers Insurance and Mutual of Omaha, sell individual AD&D insurance policies. You can also look for quotes online or could work with an insurance agent who can compare policies to find the best one for your needs.

Accidental death coverage can also often be purchased as a life insurance rider, or add-on, to life insurance policies. The coverage can double what your life insurance payout would be if you die as a result of an accident.

Also see: What Is Voluntary Life Insurance?

Cost of AD&D Insurance

The cost for AD&D insurance tends to be lower than rates for traditional life insurance because the coverage is limited to accidents. And if your employer offers AD&D insurance, you might be able to get a basic amount as a free benefit.

In general, AD&D insurance costs are tied to the amount of coverage you purchase. For example, monthly premiums might start at $4.50 for every $100,000 in accidental death coverage from Farmers. Rates start at about $8 a month for $100,000 of coverage from Fabric. Because rates can vary from insurer to insurer, it can pay to shop around for the best rate.

Pros and Cons of AD&D Insurance

Some people mistakenly think that having AD&D insurance is a financial safety net if someone dies unexpectedly. "It gives them a false sense of security," Voegele says. Because AD&D provides limited coverage, it isn't right for everyone.

Pros

You don't have to take a medical exam to get AD&D insurance. And you don't have to answer questions about your health, which can make this type of policy appealing to people with pre-existing conditions that make it difficult to find affordable life insurance.

You won't be denied coverage because of your health. You just have to meet the age requirements. Typically, you must be between the ages of 18 and 70 or 80.

You can get coverage quickly. Because there are no lengthy questionnaires to fill out, no medical exams to take and no waiting period, you can get approved for a policy within a matter of days or even minutes for some policies purchased online.

Cons

Coverage is limited. AD&D will only pay out if the death or injury was a result of an accident—and there are plenty of ways to die other than an accident. This limited coverage is a big drawback.

Coverage isn't as cheap as it seems. An AD&D policy will cost less than regular life insurance. But that's because the chance of an AD&D payout is relatively low. "The odds of you using it are so far down the scale that it becomes expensive for the payout," Voegele says.

You might lose your coverage if you leave your job. Most people who have AD&D insurance get it through a group plan at work, Voegele says. Often, you can't keep that coverage if you leave your job.

Who Should Get AD&D Insurance?

Because it only pays out in the event of an accident, AD&D insurance isn't ideal for everyone. But don't turn it down if it's offered as a free workplace benefit.

"If it's offered for free, absolutely take it," Voegele says. "If you have to pay for it, I would recommend that one size does not fit all."

In other words, consider the value you get for a workplace policy you'd have to pay for to determine if the coverage you'd get would be worth the cost.

Alternatives to AD&D Insurance

A term life insurance policy is usually better coverage than AD&D insurance because it provides a payout for any cause of death (except suicide, generally within the first two years of having the policy). So, accidents, heart attacks, strokes and more are all covered under a traditional term life policy.

If you're young and healthy, you might be able to get a term life policy at a rate that's not much higher than what you'd pay for AD&D insurance.

You'd also be better off signing up for disability insurance through your employer or getting a policy on your own in case you're unable to work. Disability insurance will help replace lost wages if you can't work because of illness as well as an injury.

"I would shy away from accidental death plans because there are so many things that can happen to us that aren't accidents," Voegele says. "You need to be covered for anything."

C. Medical Expense Insurance

Basic Hospital, Medical, and Surgical Policies

a. **Description**: Covers basic hospital, medical, and surgical expenses.

b. **Example**: A policy that covers hospital stays, surgeries, and doctor visits

Key takeaways:

If you itemize deductions, you can deduct unreimbursed medical and dental expenses that exceed 7.5% of your adjusted gross income (AGI).

The IRS allows you to deduct expenses for many medically necessary products and services, including surgeries, prescription medications, and dental and vision care.

You can't deduct medical expenses that are for general health purposes, like nutritional supplements and vitamins. To qualify as deductions, expenses must be for the purpose of preventing or treating a specific medical condition.

With tax-filing deadlines approaching, you might be trying to figure out the different ways you can lower your income tax bill. One often overlooked opportunity for savings is deducting medical expenses.

Although many people choose to take the standard deduction, if you itemize deductions, you may be able to lower your income tax for the year by deducting certain medical and dental expenses. If you had surgery, were diagnosed with cancer or another serious medical condition, or went through a process like IVF to get pregnant, the high out-of-pocket costs could make you

a candidate to claim a medical expense deduction. Some of the expenses that qualify as deductions, such as wigs and LASIK surgery, may even surprise you.

What are the rules for deducting medical expenses?

You must meet certain requirements to be eligible to deduct medical expenses on your tax return.

First, you must itemize your deductions on Schedule A of your tax return, instead of taking the standard deduction. Generally, you'll only itemize deductions if they total more than the standard deduction. You'll want to choose the option that allows you to pay the lowest amount in federal income tax. So if you are a single filer whose standard deduction is $13,850, you'll only want to itemize deductions if they exceed $13,850.

Unfortunately, you won't be eligible to deduct all of your medical expenses on your tax return, even if you do choose to itemize deductions. You can only deduct unreimbursed medical and dental expenses for you, your spouse, and dependents that exceed 7.5% of your adjusted gross income (AGI). It's important to keep all your receipts so you can have proof of your medical expenses if you're audited.

Let's say you have an AGI of $60,000, and your medical bills add up to $15,000 for the year. On your tax return, you can deduct qualified expenses over $4,500 (7.5% of $60,000). That's $10,500 worth of qualifying medical expenses ($15,000 minus $4,500) for the year.

According to IRS Publication 502, you can only classify services or items as medical expenses if they "alleviate or prevent a physical or mental disability or illness." Below are 99 medication expenses you may be able to deduct on your tax return in 2024, organized by category.

Vision services or products

Vision services or products that are used to treat defective vision fall under the category of qualifying medical expenses. This is also true for contact lenses and related products. Below are 11 vision expenses you may be eligible to deduct in 2024:

- Braille books and magazines used by visually impaired people
- Contact lenses
- Contact lens cases
- Enzyme cleaner
- Eye drops
- Eye exams
- Laser eye surgery
- Prescription eyeglasses
- Prescription sunglasses
- Radial keratotomy
- Saline solution

If your dental expenses are not covered by insurance, they may be tax deductible if they help prevent or alleviate dental disease. Below are 14 dental expenses that you may be able to deduct:

- Application of sealants to prevent tooth decay
- Braces
- Crowns
- Dental bridges
- Dental checkups
- Dental X-rays
- Dentures
- Extractions
- Fillings
- Fluoride treatments to prevent tooth decay
- Gum surgery
- Invisalign products
- Root canals
- Teeth cleanings to prevent tooth decay

Medications that are prescribed by a healthcare professional also count as qualifying medical expenses. This is also true for insulin that's not prescribed by a healthcare professional. Below are 13 of the most commonly prescribed medications that may be tax deductible.

- Antidepressants
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Medications for chronic weight management
- Saxenda (liraglutide)
- Wegovy (semaglutide)
- Zepbound (tirzepatide)
- Medications for erectile dysfunction
- Sildenafil (Viagra)
- Tadalafil (Cialis)
- Stendra (avanafil)
- Type 2 diabetes medications
- Mounjaro (tirzepatide)
- Ozempic (semaglutide)

- Trulicity (dulaglutide)

You may be able to deduct the following 10 expenses related to family planning and fertility treatments:

- Birth control pills prescribed by a healthcare professional
- Breast pumps
- In vitro fertilization (including temporary storage of sperm or eggs)
- Legal abortion
- Milk storage bags
- Nursing pads
- Pregnancy test kits
- Tubal ligation
- Vasectomy
- Vasectomy reversal

You may be able to claim health insurance premiums on your tax return depending on how much you spent on medical care, how you paid for premiums, and if you were self-employed. But you cannot deduct any expenses that were reimbursed by an insurance plan, flexible spending account (FSA), health savings account (HSA), or any other tax-advantaged savings account.

If you paid for any of these nine types of insurance premiums with after-tax dollars, they may be deductible:

- Dental insurance
- Long-term care insurance (up to an annual limit)
- Medical insurance through the ACA marketplace
- Medicare Part A
- Medicare Part B
- Medicare Part C
- Medicare Part D
- Medigap
- Vision insurance

If you were self-employed during the year, you may be eligible to claim the self-employed health insurance deduction for premiums you paid out of pocket, even if you claim the standard deduction on your taxes. The deduction allows you to claim up to 100% of the premiums you paid for yourself, your spouse, your dependents, or your eligible adult children.

If you have a disability and needed to make certain accommodations to your home, you qualify to deduct costs for the following six items as medical expenses:

- Grab bars in a bathroom

- Lowered kitchen cabinets
- Moved electrical outlets
- Outdoor wheelchair lifts (porch lifts)
- Ramps to get in and out of your home
- Widened doors and hallways

Here is a list of 36 additional items that you may be able to deduct as medical expenses in 2024:

- Acupuncture treatments
- Ambulance services
- Annual physical exams
- Artificial limbs
- Bandages
- Blood sugar test kits
- Breast reconstruction surgery
- Body scans
- Car modifications designed for people with disabilities
- Chiropractor services for medical care
- Copays
- Crutches
- Guide dog trained to assist visually impaired or hearing disabled people
- Hand sanitizer for preventing the spread of COVID-19
- Hearing aids
- Inpatient care at a hospital
- Lab fees
- Masks for preventing the spread of COVID-19
- Nursing home costs, including lodging and meals
- Organ transplant
- Osteopath services for medical care
- Oxygen to relieve breathing problems caused by a medical condition
- Oxygen equipment
- Medical conference attendance
- Psychiatric care
- Substance use disorder treatment

- Services from a Christian Science practitioner for medical care
- Therapy received as medical treatment
- Transportation to another city for medical services
- Treatment at a health institute, if certain requirements are met
- Visits to a psychologist for medical care
- Weight-loss programs to treat heart disease, hypertension, or certain other conditions
- Wheelchairs
- Wheelchair maintenance services, like battery or tire replacement
- Wigs that are considered medically necessary
- X-rays

What medical expenses are not tax deductible?

You are not allowed to deduct expenses that are for general health purposes, such as gym memberships, vitamins, and diet food. You also cannot deduct payments for future medical and dental services.

Below are some other services and items that are likely not tax deductible:

- Deodorant
- Diapers
- Face-lifts
- Hair transplants
- Health club dues
- Health beverages
- Herbal supplements
- Insurance premiums paid by your employer
- Liposuction
- Nicotine patches and gum that don't require a prescription
- Nonprescription medications
- Nutritional supplements
- Surrogacy expenses
- Toothpaste
- Travel to and from work

The bottom line

If you itemize deductions, you may be able to deduct medical and dental expenses that have not already been reimbursed. To qualify as deductions, expenses must be related to the prevention or treatment of a specific medical condition. The total expenses must exceed 7.5% of your AGI if you want to deduct them on your tax return.

Major Medical Insurance: What Is It?

Major medical insurance offers comprehensive coverage, which most of us have come to expect from health insurance. It covers most medical services and procedures, from doctor visits to hospital stays, surgeries and prescription drug coverage.

Most insured Americans have major medical insurance, but it's not the only type of health insurance available. If you're considering purchasing health insurance, it's important to clearly understand what major medical insurance—and its alternatives—offer to you.

What Is Major Medical Insurance?

People looking for medical coverage often want the best health insurance at the most affordable price. Major medical insurance is likely the most attractive option.

Major medical insurance is the type of coverage typically offered through a workplace and the Affordable Care Act (ACA) marketplace. This type of insurance covers the majority of health care services and procedures you might encounter in a given year, including:

- Preventive care
- Emergency room care
- Urgent care

- Outpatient care
- Mental health
- Labs and tests
- Prescription drugs
- Surgery and other procedures
- Hospital care

By contrast, other types of health care coverage usually aren't as comprehensive. For example, short-term health insurance generally provides coverage for up to a year with the chance to extend for two more years in most states. Short-term plans offer lower premiums but higher out-of-pocket costs when you need care, fewer benefits and consumer protections than major medical health insurance.

Hospital indemnity plans are another type of health coverage. Indemnity plans offer a fixed benefit paid directly to you when you require hospital care. But this type of insurance doesn't cover standard medical care and is meant to supplement—rather than replace—health insurance.

What Major Medical Insurance Covers

One of the hallmarks of major medical insurance found on the ACA marketplace is that it covers 10 essential health benefits as defined by the federal government. Private health insurance in group health insurance offered by employers also often covers these services.

The essential health benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Health plans in the ACA marketplace must also provide birth control and breastfeeding coverage, though they're not specifically listed under the essential health benefits.

Types of Major Medical Insurance

There are various ways to get major medical insurance, including:

ACA marketplace health insurance

This type of health insurance is available to individuals and families who cannot get affordable coverage through an employer. Private health insurance companies offer this type of comprehensive health coverage.

You can purchase individual and family insurance plans at the federal and state health insurance marketplaces. People who qualify for advanced premium tax credits and subsidies may pay less for an ACA plan. Only ACA plans provide those household income-related discounts.

Employer-sponsored health insurance

Most working Americans get their medical coverage through group health insurance coverage from an employer.

In many cases, employer-sponsored health insurance offers the most affordable and comprehensive health insurance option. Employers typically pay more than half of premiums costs, which makes it cheaper for employees.

Employees paid an average of $1,327 per year ($111 per month) for health insurance through an employer, while businesses paid an average of $6,584 annually, according to Kaiser Family Foundation's 2022 Employer Health Benefits Survey.

COBRA

If you have coverage in a major medical plan at work and then leave or lose your job, COBRA insurance is an option for extending your coverage for a period, usually 18 to 36 months.

COBRA provides the same coverage you had with the employer plan, but you're responsible for the full premium costs instead of splitting them with your provider. This can make COBRA coverage quite expensive.

Medicaid

Medicaid is a federal/state health insurance program primarily for low-income Americans and eligible children, pregnant women, the elderly and those with disabilities. Medicaid costs are based on your income.

Medicare

Medicare is the federal health insurance program primarily serving adults 65 and older. It also offers coverage to younger people with specific disabilities and those with end-stage renal disease.

Student health plans

This type of health insurance is typically available to college students, but many students don't need this type of coverage, as federal law lets them remain on their parent's health insurance plan until they turn 26.

Who Needs Major Medical Insurance?

Just about everybody needs major medical insurance. Perhaps those who are independently wealthy can self-insure. But if that's not you, major medical insurance is essential. It provides preventive care and can help you avoid financial ruin if you're hospitalized or develop a life-threatening or chronic health condition.

Some people skip major medical insurance and choose short-term insurance simply because it's cheaper and they only want to bridge a short coverage gap. But you never know when your health will take a turn for the worse.

If that happens, major medical insurance can offer comprehensive coverage that saves you thousands of dollars.

How Much Does Major Medical Insurance Cost?

The average health insurance cost per month is $928 for a Bronze ACA plan. The average monthly costs increase to $1,217 for a Silver plan and $1,336 for a Gold plan. Those averages don't consider premium tax credits and subsidies that can reduce costs for an ACA plan based on household income.

Health insurance companies set rates for ACA plans by age, plan type, metal tier and tobacco use. They can't use gender or where you live.

Here's the average cost by age.

Average cost of health insurance by age

A plan's benefit design dictates such things as whether you can get out-of-network care and whether you need referrals to see specialists. Health maintenance organization (HMO) and exclusive provider organization (EPO) plans are typically cheaper than preferred provider organization (PPO) plans. Here's the average cost by plan type.

How to Get Major Medical Insurance

There are many ways to get major medical insurance:

1. Through your employer. If your workplace offers group coverage, this is often the best and most affordable way to get coverage.

2. Through the ACA marketplace. Going to a federal or state health insurance marketplace is one way to get coverage if you can't get it at work. These plans offer tax credits and subsidies if your household income qualifies.

3. Directly through an insurer or a website. You also can purchase directly from a health insurer or may be able to buy through a third-party website.

4. Through Medicaid. If you qualify, you can get coverage through this program, which is a joint effort between the federal government and individual states.

5. Through Medicare. If you are 65 or meet other criteria, you can get coverage through this federal program.

6. Through a college or other institution of higher learning. Students often can get coverage this way.

Major Medical Health Insurance vs. Short-Term Health Insurance

Major medical insurance provides more comprehensive coverage and better consumer protections than short-term insurance.

Two benefits of short-term insurance are that it's much cheaper than major medical insurance, and you can buy it anytime during the year.

Major Medical Health Insurance vs. Hospital Indemnity Insurance

Hospital indemnity insurance is not a form of standard health insurance. Rather, it's intended to supplement your primary insurance policy.

While major medical insurance covers most types of health care services and procedures, hospital indemnity insurance pays you if you're in the hospital for an extended period. It doesn't offer coverage for other types of medical services.

Health Maintenance Organizations (HMOs)

c. **Description**: Provides health services through a network of providers for a fixed annual fee.

d. **Example**: An HMO plan that requires members to choose a primary care physician and get referrals for specialists.

Preferred Provider Organizations (PPOs)

e. **Description**: Offers more flexibility in choosing healthcare providers and does not require referrals.

f. **Example**: A PPO plan that allows members to see any doctor without a referral but offers lower costs for in-network providers.

Point of Service (POS) Plans

g. **Description**: Combines features of HMOs and PPOs, requiring a primary care physician but allowing out-of-network care at a higher cost.

h. **Example**: A POS plan that covers out-of-network visits but at a higher copayment.

Flexible Spending Accounts (FSAs)

i. **Description**: Allows employees to set aside pre-tax dollars for medical expenses.

j. **Example**: An FSA that lets employees use pre-tax dollars for prescriptions and doctor visits.

High Deductible Health Plans (HDHPs) and Health Savings Accounts **(HSAs)**

k. **Description**: HDHPs have higher deductibles but lower premiums, and HSAs allow pre-tax savings for medical expenses.

l. **Example**: An HDHP paired with an HSA that lets employees save pre-tax dollars for future medical expenses.

Health Reimbursement Accounts (HRAs)

m. **Description**: Employer-funded accounts that reimburse employees for medical expenses.

n. **Example**: An HRA that reimburses employees for out-of-pocket medical costs.

What is Medigap?

Your guide to Medicare supplement insurance

What Medicare supplement plans cover, when you can enroll if you're eligible, and what you can expect to pay for coverage

What is Medigap?

Medigap, also known as Medicare supplement insurance, is an insurance policy that supplements Original Medicare. It’s designed to cover some or all of the out-of-pocket costs that a beneficiary would otherwise have to pay for services covered by Original Medicare.

Original Medicare does not have a cap on out-of-pocket costs, and most people have supplemental coverage. Only 8% of Medicare beneficiaries rely solely on Original Medicare. So when you’re enrolling in Medicare, you can either choose Original Medicare plus a Medigap policy (and a Medicare Part D prescription drug plan if you don’t have other prescription coverage), or a Medicare Advantage policy. You can’t use (and don’t need) a Medigap policy in conjunction with a Medicare Advantage plan.

What is the difference between Medicare Advantage and Medicare supplement (Medigap)?		
	Medigap	**Medicare Advantage**
Is there an annual plan change opportunity?	Not without medical underwriting, unless you're in a state that requires it.	Yes, during the Annual Election Period and Medicare Advantage Open Enrollment Period.
Is coverage guaranteed-issue?	Yes, during your Medigap open enrollment period (six months, starting when you're 65 and enrolled in Medicare Part B). In most states, no, after your initial enrollment period has ended. If you're under 65, this varies by state.	Yes. (Note that you can enroll when you're first eligible or during the Annual Election Period. You can also make a plan change during the Medicare Advantage Open Enrollment Period. Outside of those windows, you generally cannot enroll in a Medicare Advantage plan without a special enrollment period.
How high are out-of-pocket costs?	This varies by plan. For new enrollees, it can be as low as just the $240 Part B deductible (with Plan G), but less comprehensive plans can result in higher out-of-pocket costs. (Note that this does not include prescription costs.)	Out-of-pocket costs can be as high as $8,850 for in-network benefits, although the average is less than $5,000. (Note that this does not include prescription costs.)
How high are premiums?	Varies by plan and location.	Varies by plan and location, but the average premium in 2023 was about $18/month (in addition to the cost of Part B). About two-thirds of enrollees are in plans that have no premium other than the cost of Part B.
What medical providers can you see?	With the exception of Medicare SELECT, Medigap plans cover any providers who accept Medicare, nationwide. Medigap plans are not managed care plans, so you will not	Plans create their own provider networks, which can be local or national. Plans can limit care to in-network providers (HMOs, for example), or give the option to see out-of-network

What is the difference between Medicare Advantage and Medicare supplement (Medigap)?		
	see them labeled as HMOs, PPOs, etc.	providers at a higher cost (PPOs, for example).
Are prescription drugs covered?	No. Medigap plans sold after 2005 do not include prescription coverage, so enrollees need separate coverage for that.	89% of all Medicare Advantage plans include prescription coverage.
Are plans available in all areas of the U.S. and its territories?	Plans are available throughout the U.S., although the number of available plans varies from one area to another. Plans are not available in the U.S. territories.	Plans are available in nearly all areas, although 68 rural counties have no Medicare Advantage plans available in 2024. There are also no Medicare Advantage plans available in Guam, the Virgin Islands, American Samoa, or the Northern Mariana Islands, although there are Medicare Advantage plans available in Puerto Rico.

What is Medigap coverage used for?

Medigap coverage will pay various medical bills that Original Medicare beneficiaries would otherwise have to pay themselves. Original Medicare includes Medicare Part A, for inpatient care, and Medicare Part B, for physician services and outpatient care. Both parts have out-of-pocket costs, and there is no limit on how high those costs can be:

- Medicare Part A has a deductible for each benefit period, plus daily charges that begin to accrue after 60 days in the hospital or after 20 days of a covered skilled nursing facility stay.
- Medicare Part B has an annual deductible, and then 20% coinsurance for all covered services. (Certain preventive care is fully covered, without a deductible or coinsurance.)

What is the difference between Original Medicare and Medicare Advantage?

Original Medicare vs. Medicare Advantage: a comparison*

	Original Medicare	Medicare Advantage (MA)
Also known as	Traditional Medicare	Medicare Part C
Enrollment through	**Federal government:** Centers for Medicare & Medicaid Services (CMS)	Private carriers
What's covered?	Medicare Part A covers inpatient hospital stays, skilled nursing facility care, hospice care and some home health care. Medicare Part B covers medically necessary services and preventative services, including doctors visits, outpatient hospital stays and medical equipment.	Combines Medicare Part A and Medicare Part B and usually also includes Medicare Part D prescription drug coverage plus additional benefits described below.
Availability	Nationwide	Sold in most but not all counties.
Outpatient prescription drug coverage	Not included. (**Exception:** When administered by injection/infusion in medical office.)	Included in most plans.
Dental & vision	Not included	Included in most plans
Monthly premium cost	No Part A premium for most enrollees Part B premium of $174.70/month in 2024 for most enrollees	Average premium projected to be $18.50/ month in 2024. You'll pay this in addition to your Original Medicare premium. **Note:** In 2023, 73% of Medicare Advantage enrollees paid no MA premium, and only paid the Medicare Part B premium.
Cap on out-of-pocket costs	No	**Yes:** In-network out-of-pocket costs can't exceed $8,850 in 2024 (not including prescription drug costs).
Nationwide access to physicians	Yes	Access varies plan to plan. Some MA plans have narrower networks – with fewer physicians in their county.
Will you need to buy additional supplemental coverage?	Probably. Most people buy supplemental insurance due to the lack of prescription drug coverage, dental, vision, and cap on out-of-pocket costs.	Probably not, because most Medicare Advantage plans include coverage for prescription drugs, dental, vision, and cap on out-of-pocket costs.

medicare resources .org

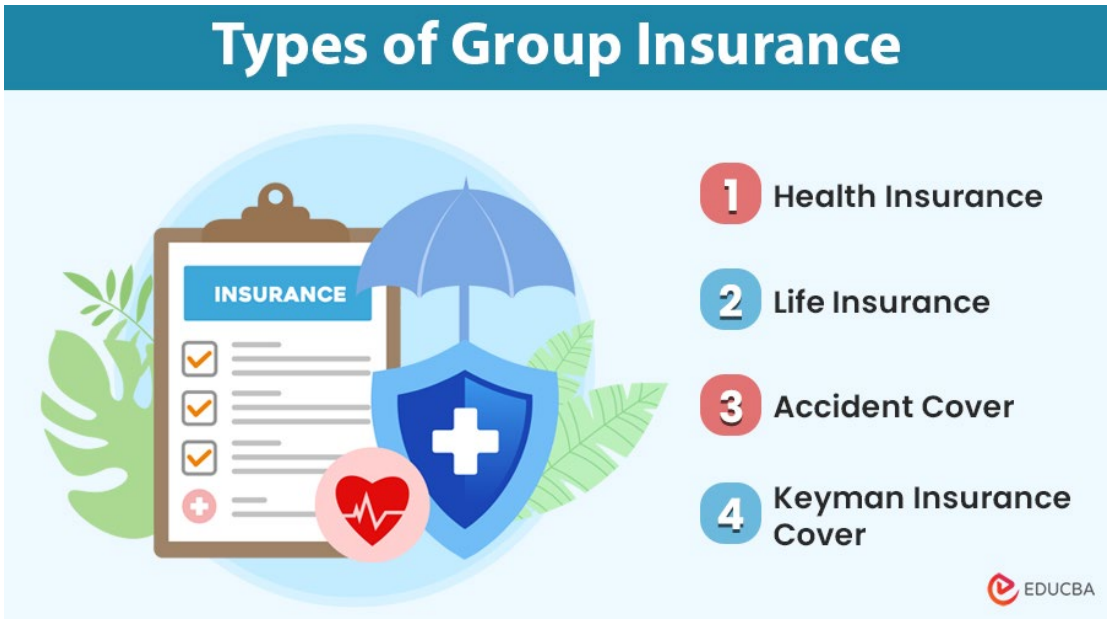
*Complete infographic information available at medicareresources.org/compare

E. Group Insurance

Differences Between Individual and Group Contracts

a. **Description**: Group insurance is provided to a group of people under a single contract, usually through an employer.

4. **Example**: An employer-provided health insurance plan versus an individually purchased plan.



5. General Characteristics

a. **Description**: Group insurance typically offers lower premiums and simplified underwriting.

b. Example: A group life insurance policy that does not require medical exams for coverage.

Definition of Group Insurance

Group Insurance refers to insurance coverage that covers an entire set of people which can be of a particular group, company, or any other associated entity which makes them a group with a common identity.

In short Group Insurance is a collective insurance coverage with a standardized product for all its group members and comprises a single policy being issued instead of a policy to each member of the group. Group Insurance is a common feature in Employer-Employee groups or the case professional groups. However, it is not confined to these groups and can be for any group with a common link between them.

Explanation

It involves multiple groups of members governed by a single policy with the premium amount either paid by the group head which in the case of employer-employee is the employer itself or may involve premium contributed by its group members. It remains valid for group members as long as they are part of the group and the benefits cease to exist if one leaves the group.

Characteristics of Group Insurance

Some of the common characteristics are enumerated below:

- Group Insurance involves the issuance of a single master policy covering all the group members with a separate Identity card issued to each group member.
- Usually, economical compared to individual policies of the same terms and conditions.
- It is standardized and non-customized and follows a one-fit approach.
- It is usually covered under Heath and Life Insurance.

How Does Group Insurance Work?

The working is quite simple and straight forward and unlike normal insurance where every individual is provided a customized policy, it involves a direct master agreement between the Insurance Company and the Employer Organization related to terms of the policy and coverage and premium amount.

In case the premium is fully payable by the Employer the whole premium amount is directly paid by the Employer to the Insurance Company and each group member is provided with a unique Health Identity Card through which the benefits can be availed. In case the premium is payable by the Employee, the amount of premium is debited by the employer and collectively paid to the Insurance Company and the remaining procedure remains the same.

Example of Group Insurance

ABC Limited provides legal consultancy to its clients on matters of Intellectual property rights. Due to the inherent scope of work leading to various contingent liabilities and suits clients can file in case of issues in the discharge of the duties, ABC limited has taken Public Liability Insurance for all its employees which safeguards them from any lawsuit filed by its clients while discharging their responsibilities and any financial claim in future.

Types of Group Insurance

There are various types that are available catering to various needs of the group which can be based on health, life cover, retirement benefits, and liability assurance as well as related to compensation liability, etc.; however, the major types are enumerated below:

- **Group Health Insurance:** The most common and prevalent Group Insurance covers the medical and health-related expenditure cost for a group with standardized features and a fixed sum assurance for group members (In some cases the sum assured varies based on the particular grade of employees, other features being equal).
- **Group Life Insurance:** Usually this is provided by the employer to its employees as a life cover under which a fixed amount is paid in case the employee dies while discharging his/her duties. The premium is either paid by the employer or collected from employees and paid collectively by the employer to the insurance company.
- **Group Accident Cover:** This type of scheme is usually provided to cover any injury and loss of life on account of an accident during employment. Normally this type of premium is payable by the employer.
- **Group Keyman Insurance Cover:** This is a late entrant, however, its importance is ever increasing. Normally the key officials in certain industries such as Banking, the Medical profession, and the legal profession take professional decisions in their day-to-day business affairs which can have serious financial implications if things went awry. As such this type of is taken by the employer to limit the financial liability of such key men while they discharge their professional responsibilities independently without the fear of financial failure.

Importance of Group Insurance

It is very important and a necessary part of the benefits offered as part of remuneration in the Service Agreement. Its relevance and utility is not just confined to Employer-Employee relation but can be observed in all types of group setups which includes Non-Employee as well

Further, it helps in providing better and customized benefits to a large group at an economical cost which leads to the better financial and economic well-being of group members.

Benefits

It offers multiple benefits. A few of them are enumerated below:

- It provides medical, and life benefits at an economical cost to group members.
- It acts as a supplement for an employer to attract the right talent. Normally it has been observed that employees prefer companies that provide group insurance.
- It helps companies to save costs as they have a larger pool and can negotiate better with Insurance companies.
- It also provides a tax benefit to employers and results in lowering the tax outflow of the company as group Insurance expenses are tax-deductible.
- In most cases, the group insurance doesn't require medical tests which are required in the case of Individual Insurance.

Limitations

Despite various advantages, there are certain disadvantages as enumerated below:

- It provides a standardized product that is based on size fit all strategy and may not be a good fit for many group members. For instance, an employer providing a health cover of $10000 for its employees may be sufficient for your employees but not much for employees in a higher age bracket.
- It ceases to exist once the group member leaves the group. In the case of the employment contract, the group insurance ceases to exist once the employee leaves the organization.

Long-Term Care Insurance: What You Need to Know

According to the Administration for Community Living, adults who are 65 years old today have nearly a 70% chance of needing some type of long-term care service and support at some point in their later years[1]. Long-term care—which can take many forms to address an individual's needs for assistance with activities of daily living (ADLs)—can be expensive, and most private health insurance plans don't cover it. For this reason, some older adults decide to enroll in a long-term care insurance plan.

Read on to learn more about what long-term care insurance is, how it works, what it covers and more.

Types of Long-Term Care Insurance Policies

There are two ways to purchase long-term care insurance, according to Georgia-based insurance broker Robyn Pate. An individual can either purchase an independent long-term care insurance policy from their preferred insurance provider, or they can purchase long-term care coverage as part of a life insurance plan.

Both plans require premium payments so long as the policy is active, and the policyholder submits a claim whenever they need to use the coverage. And in both types of plans, the policyholder chooses the amount of coverage they want, which often affects the cost of the

plan's premium. Most policies cap the amount they would pay out in benefits per day should the policyholder need to use those benefits. They also cap how much the policy can pay out in benefits during the policyholder's lifetime.

How Does Long-Term Care Insurance Work?

Regardless of the type of plan a person chooses, a health care provider must prescribe long-term care assistance in order for a long-term care insurance policy to cover its portion of the costs, says Pate. If the individual has a standalone policy, it's more likely that the insurance provider will pay a home care agency or skilled nursing facility directly on their behalf. There are some standalone policies that will pay the individual directly.

With most policies, the policyholder is required to pay for the long-term care services they need through what's called the "elimination period," which usually lasts 30, 60 or 90 days. After this period, the insurer providing the long-term care policy starts reimbursing them up to the maximum daily amount provided by their coverage until they reach the full lifespan of the policy.

What Does Long-Term Care Insurance Cover?

A long-term care policy helps cover the costs of a person's care when they need help navigating ADLs due to a chronic medical condition, disability or disorder. To receive long-term care benefits under most policies, an older adult must require help within at least two ADL areas: bathing, eating, dressing, navigating the bathroom and getting in and out of a bed or chair. A health care provider must also predict that they will require this level of help for more than 60 days.

If the long-term care plan is a part of a life insurance policy, the plan will typically pay 2% of the death benefit toward the monthly cost of long-term care for three to five years, according to Pate. For example, if someone purchased a $100,000 life insurance policy, they would receive up to $2,000 per month for three to five years for use toward the cost of their care. The amount could be applied to care provided in a skilled nursing facility, an assisted living community or their own home. The policyholder could also elect to use the money as they wish, opening the possibility of paying a family member to provide care.

While $2,000 may sound generous, extended long-term care can be expensive. Nationally, skilled nursing facilities charge over $90,000 per year for a shared room, the median cost of assisted living is around $54,000 per year, and the median cost of a full-time home health aide hired through a home health care agency exceeds $61,000 per year.

Some long-term care insurance providers deny coverage to those with preexisting chronic illnesses and conditions. However, these people shouldn't be deterred from seeking out long-term care insurance, says Pate, adding that they'll likely pay more for a plan, but the coverage would still be beneficial should they need long-term care services in the future.

How Common Is Long-Term Care Insurance?

Long-term care insurance has gained popularity since its introduction in the 1980s, due to the likelihood of needing higher levels of care at some point in one's later years and the rising costs of care. The U.S. Department of Health and Human Services states that, on average, women tend to need care longer (3.7 years) than men (2.2 years), with a combined average of three years. While 30% of older adults won't require any long-term care at all, it's estimated that 20% will have care needs that extend beyond five years.

With that said, long-term care policies aren't as widely used as one might expect. As of 2020, roughly 7.5 million U.S. adults have long-term care insurance, according to the American

Association for Long-Term Care Insurance[2]. More specifically, only 7% of U.S. adults over the age of 50 have a long-term care insurance policy[3].

How Much Does Long-Term Care Insurance Cost?

Premiums for long-term care insurance policies vary based on the person's age and health status when they apply for coverage, gender and marital status. The cost also depends on the amount of coverage the person wants to purchase and the company providing the policy.

Long-term care policies tend to be less expensive the younger and healthier the person is when they purchase the policy. However, Pate says most people don't think about adding long-term care insurance until they reach 62 years old. A long-term care insurance policy for an average 62-year-old costs approximately $300 per month, she says.

Pros and Cons of Long-Term Care Insurance

Pros	Cons
• Should you need long-term care, a policy can offset a considerable amount of the costs associated with that care, providing some protection for your financial assets as you age. • Some plans allow you to choose where you receive your care, empowering older adults who want to remain at home to continue aging in place with hired assistance. • Depending on your coverage, if you choose to receive care at home, you can choose to hire and pay family members for their assistance instead of hiring someone from a home health agency.	• The premium costs of a long-term care insurance policy may exceed the monthly (or annual) budget of some older adults. • Some plans only pay for long-term care provided in a facility rather than including at-home options. • Some providers deny coverage to those with preexisting conditions or illnesses. • Some plans have an elimination period during which the policyholder is still responsible for the total cost of their care.

What Is Vision Insurance?

Vision insurance helps pay for eye exams, glasses and contacts and may offer discounts for other types of services like LASIK surgery.

Vision insurance is typically not part of health insurance, so you have to buy separate vision insurance coverage. You can buy coverage directly from insurance companies, or vision insurance may be part of an employer's benefits package.

What Does Vision Insurance Cover?

Vision insurance typically covers an annual eye exam and may help pay for glasses once a year or every other year. Here's a list of services and products often covered by vision insurance:

- Annual eye exam
- Allowance for glasses, either annually or every other year
- Allowance for contact lenses, often annually
- Lens enhancements like anti-glare, blue light reduction coatings, scratch resistance coatings and UV protection
- Bifocals and trifocals
- Discounts for glasses and/or contact lenses over the policy allowance

What Doesn't Vision Insurance Cover?

Vision insurance doesn't cover laser surgeries to correct vision—including photorefractive keratectomy (PRK) and LASIK. Those surgeries are considered elective surgery. Vision insurance policies often provide discounts at participating locations for those services.

What to Look for in a Vision Insurance Plan

Consider the following factors when comparing vision insurance plans and looking for the option that best fits your needs.

Wide coverage

When it comes to vision insurance, it's easiest to get coverage from a plan that is offered in every state and has an extensive number of doctors within the provider network. In fact, it's more convenient and helps prevent gaps in coverage if you move or need care while traveling.

Low monthly premiums

Pricing varies based on your plan and coverage levels. It's important to consider your budget when looking for a new vision insurance plan and avoid pricier vision plans if you don't need a high level of coverage. For instance, a generous frames allowance may not be needed if you don't need glasses, but that allowance may be a vital part of a plan if you have glasses.

Full or partial coverage of annual eye examinations

Vision insurance covers annual eye examinations, but not all vision insurance companies cover these exams completely. Vision insurance policies also typically require a copay for eye exams, but our research found that EyeMed Healthy does not have a copay for exams.

Eyewear and contact lens allowances

Whether you need glasses or contacts now or in the future, understand the allowances provided by your vision insurance plan for these expenses. Vision insurance covers frames for glasses and contact lenses up to a specified dollar amount, such as $150 or $200. A plan may require that you only get one allowance per year, and you have to choose between contacts and frames. If you exceed the amount, the policy may offer a discount on the rest of the costs.

Ease of access

Accessibility is important when researching and enrolling in a vision insurance plan, as well as when you need to file a claim or reach a customer service representative. Reading reviews

can give you a helpful idea of how responsive the vision insurance company you're considering is in times of need—not just when you're trying to sign up for coverage.

Things to know about your insurance if you have cancer

If you have cancer, it's important to understand your health insurance's Summary of Plan Benefits (SPB) to understand covered and excluded services.

Many insurance companies require pre-authorization for cancer services. Here are some things you might want to check your insurance coverage for:

- Cancer tests such as PET/CT scans, blood tests, bone scans, and other procedures.
- Inpatient and outpatient care including screening, tests, and treatment.
- Cancer therapies such as chemotherapy, radiation, or outpatient infusion) and clinical trials.
- Routine cancer screening or diagnostic test coverage might be different depending on if they are considered "routine" versus "diagnostic."
- Genetic screening or testing to check your cancer risk or find the best treatment.
- Medical equipment such as a cane, walker, hospital bed, or lymphedema supplies (also called Durable Medical Equipment or DME).
- Disposable Medical Supplies like gloves, needles, saline flushes, or dressing kits. Health insurance plans might have different coverage for disposable supplies than for DME.
- Wigs may be covered if your doctor writes a prescription for a "cranial or hair prostheses."
- Nutritional supplies such as nutritional supplements or feeding supplies.

What Is Critical Illness Insurance?

Critical illness insurance is a form of supplemental health insurance that provides coverage for expenses that your health plan doesn't cover. The purpose of critical illness insurance is to provide a monetary safety net in the event of a medical diagnosis that could result in expensive treatments or other financial hardships.

You can generally get critical illness insurance through an employee benefits program at work or by buying an individual policy on your own.

How Does Critical Illness Insurance Work

Critical illness insurance kicks in after you've been diagnosed with a critical illness that the policy covers, such as cancer. You'll typically get a lump sum, such as $25,000 or $50,000, when you're diagnosed with a critical illness.

You can use the money for any reason. That may include:

- Helping pay for your care.
- Paying your health insurance deductible or copayments.
- Reducing your mortgage.
- Paying for childcare.
- Paying for living expenses.

Supplemental critical illness insurance works differently than a traditional health insurance plan. Your regular health insurance plan covers the costs of your healthcare. If you're diagnosed with a critical illness, you can also file a claim with your critical illness insurance company. Your critical illness insurance company provides a lump sum payout up to your policy's coverage limit.

Critical illness insurance can be a good investment for people with a high deductible health plan and large out-of-pocket health insurance costs. Or, if you have a family history of certain health conditions, like cancer or heart disease, critical illness insurance can provide financial peace of mind that you will get financial help if you're diagnosed with the condition.

Because critical illness insurance offers coverage for a wide range of conditions, it can also be beneficial for people who don't have an emergency fund or are concerned about the financial consequences of an unexpected medical diagnosis.

What Does Critical Illness Insurance Cover?

Critical illness insurance provides benefits if you get diagnosed with a qualifying medical condition. The illnesses covered by a policy vary depending on your plan.

Here are some of the critical illnesses that are usually covered under this type of insurance:

- Cancer, though it might get limited to a life-threatening diagnosis.
- End-stage renal failure.
- Heart attack.
- Major organ transplant.
- Multiple sclerosis.
- Parkinson's disease.
- Stroke.

Make sure to dig into the coverage for a policy. Critical illness insurance policies can vary. For instance, some plans cover Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) and hearing loss, while other policies don't cover those health issues.

Does Critical Illness Insurance Cover Pre-Existing Conditions?

Most critical illness plans don't cover pre-existing conditions that were diagnosed before the policy was purchased.

For example, your critical illness plan may not provide benefits if you were diagnosed with coronary artery disease before getting critical illness insurance and later needed bypass surgery.

What Does Critical Illness Insurance Not Cover?

Check your policy for specific exclusions, but a critical illness insurance policy generally won't cover:

- Asthma.
- Diabetes.
- Injuries sustained in an illegal act.
- Injuries sustained by substance abuse.

- Injuries sustained in war.
- Pre-existing conditions, though a critical illness insurance policy may cover the condition after a certain time period, such as one year after purchase.
- Self-inflicted injuries.

Advantages of Critical Illness Insurance

- **Provides financial help if you get sick:** A critical illness insurance plan can offer financial protection for your family. This type of insurance can also keep you financially stable while you pay for treatment.
- **Benefits can be used for anything:** The payout from a critical illness insurance plan goes directly to you and can be used for any purpose, not just medical costs. If you need to pay for childcare or catch up on mortgage payments, for example, the proceeds can cover those expenses.
- **Affordable premiums:** Most critical illness insurance plans are relatively affordable, especially compared to the cost of health insurance. Purchasing a plan can supplement your existing health insurance without raising your overall monthly health insurance premium significantly.

Drawbacks of Critical Illness Insurance

- **Low coverage limits:** Critical illness insurance plans generally offer low benefits. For example, many companies provide maximum coverage limits of $50,000. Depending on your financial situation and the cost of treatment, this may not cover most of your expenses.
- **Doesn't cover pre-existing conditions:** If you have pre-existing health conditions, your critical illness insurance policy probably won't cover them. Many plans also exclude coverage for new critical conditions that resulted from previous diagnoses.
- **Premiums increase with age:** The cost of critical illness insurance usually increases as you get older. Some policies allow you to lock in a lower rate while you're younger, while others increase rates as you age. If you're buying a policy, check with the insurer about whether the costs will increase or if you're locked in with that rate for the life of the policy.

How Much Does Critical Illness Insurance Cost?

The cost of critical illness insurance is largely dependent on the coverage amount, as well as your health, age, gender, nicotine use and how you get coverage, such as through an employer or an individual plan you buy yourself.

For instance, a 30-year-old nonsmoker may be eligible for an employer-sponsored critical illness insurance policy for $1.64 per month for every $5,000 of coverage from Protective. That would mean you would pay about $8 a month for $25,000 worth of coverage. That same $25,000 policy may cost you $12 per month for a 40-year-old and $19 for a 50-year-old.

In most cases, you can expect to pay lower rates for an individual critical illness insurance if you are young and healthy, with no pre-existing conditions.

Alternatives to Critical Illness Insurance

If you're not sure that critical illness insurance is right for you, alternatives can provide financial protection after a medical diagnosis.

Here are some other secondary health insurance policies you might consider:

- **Disability insurance:** If you become disabled and can't work, disability insurance provides income replacement during that period. Insurers may sell short-term disability insurance and long-term disability insurance, which offer benefits for varying lengths of time.
- **Hospital indemnity insurance:** Hospital indemnity insurance provides monetary benefits if you're hospitalized beyond your health insurance plan. Depending on the policy, hospital indemnity insurance may provide a fixed benefit for an entire hospital stay or it might provide coverage for each day you stay in the hospital.
- **Accident insurance:** Accident insurance provides a lump sum payout if you sustain injuries in an accident, such as a broken bone or severe burn. The money can be used for medical or non-medical expenses.
- **Flexible Spending Account (FSA):** A flexible spending account is essentially a savings account that can be used to cover out-of-pocket healthcare expenses, including copayments and coinsurance. FSAs are also beneficial because you don't pay taxes on the contributions. One drawback with an FSA is that you generally can't carry over funds to the next year unless the employer allows it.
- **Health savings account (HSA):** An HSA is another way to save money to pay for future health care costs, but those savings accounts are connected only to high-deductible health plans (HDHPs). Unlike FSAs, an HSA also lets you carry funds over into the next year and you can take it with you when you change jobs.

What Does Insuring Clause Mean?

The insuring clause is an integral part of any insurance contract and one that all insureds should pay close attention to. The insuring clause is the section of an insurance policy that outlines the risks assumed by the insurer. In other words, this clause details exactly the risks the insurer is liable for paying and defines the scope of the coverage.

Although it is called an insuring clause, it is actually more likely a collection of clauses for all the different perils, losses, and additional coverage an insurer is offering you in the insurance policy. For example, on a typical home insurance policy, your insurance clauses might state that you have coverage for:

- Dwelling Building.
- Detached Private Structures.
- Personal Property.
- 3rd Party Liability.
- Defense Costs & the Right and Duty of the Insurer (to defend you from liability claims)

When you receive a copy of your policy wordings from your insurance company, you should make sure you understand the insuring clause(s) to grasp what is and is not covered by your policy and for how much.

If you have questions about any of the terms contained within, you should contact your insurance provider for clarification. The last thing you want is to find out you do not have coverage for something when you have a claim because by then, it is too late.

Insuranceopedia Explains Insuring Clause

The insuring clause(s) are one of the most critical components of an insurance contract and forms its foundation. It outlines the major guarantees and protections offered by the insurance

company and states what is covered. That is why it is so critical for you to understand this part of the policy and to communicate with your insurance provider for clarity if there are any areas you are unsure about.

Put another way, this clause outlines the role the insurance company has agreed to perform as part of the contract. Examples include paying for certain losses arising from insured risks, providing certain agreed-upon services, providing defense for a lawsuit subject to certain conditions, and other agreements that form part of the insurance policy protections you are paying for.

For example, in a life insurance policy, the insuring clause states the main purpose of paying out a specific amount in a death benefit to the named beneficiary after the death of the insured.

In this context, it would include the insurer's name, the face value payable, and the insured's name. In more complex policies, the insuring clause(s) section might also include information on the causes of death that are accepted and any limitations (if any) that might apply under different scenarios.

Waiver of Premium in Insurance: Everything You Need to Know

A waiver of premium rider is a life insurance policy provision that eliminates the necessity for premium payments if the policyholder becomes critically ill or disabled. Your health and age may impact your eligibility.

Adding a waiver of premium rider to your life insurance policy protects you against a lapse in coverage if you can't pay your premiums because of a disability. The definition of disability triggering the waiver of premium benefit varies per insurer, so it's important to check the fine print.

Depending on the insurance provider, this rider may be included for free as a clause in your policy. However, in most cases, the policyholder will have to add a waiver of premium benefit as a rider at an additional cost.

When adding this provision, note that the waiting period on a waiver of premium rider can also differ among insurers, affecting when the benefit takes effect.

Key Takeaways

A waiver of premium is a type of life insurance policy rider that allows you to waive premium payments should you develop a qualifying disability.

While some companies offer a waiver of premium provision for free as a clause in a life insurance policy, others consider it an add-on that may increase your premiums.

Insurance providers have different qualification requirements, conditions and definitions of disability. Individuals with pre-existing conditions are usually not eligible for a waiver of premium benefit.

Waiver of Premium Benefit in Life Insurance Overview

The waiver of premium provision gets you off the hook for premium payments if you meet certain conditions. For instance, if you become disabled or ill, the insurance company may allow you to stop making premium payments and keep your coverage.

Each company has its own rules for signing up for a waiver of premium rider in life insurance. Generally, the waiver of premium provision is either included in the base policy or must be purchased as a rider.

Getting a waiver of premium as an add-on may make your rates more expensive.

Waiver of Premium in Life Insurance: Mechanisms

The waiver of premium rider can be a vital feature in life insurance policies, providing financial relief during times of disability or severe illness. It allows policyholders to maintain their coverage without financial strain while they are unable to work. Understanding the mechanics of this rider is essential for anyone considering its benefits as part of their life insurance plan.

Activation and Waiting Period

A waiver of premium rider allows an insured to waive premium payments if the insured is fully disabled, as determined by the insurer. However, this rider doesn't activate immediately after a disability or illness is reported. Even after the insurance provider deems you fully disabled, there's typically a waiting period on a waiver of premium rider. During this time, you must continue to pay premiums. If your claim is approved, many insurers will reimburse the premiums paid during this period.

Continuation of Policy Benefits

A life insurance policy waiver of premium rider has the ability to ensure that your policy's benefits continue as if you never missed a payment. If you have whole life or variable life insurance, it will continue to accumulate cash value and dividends, if applicable.

Specifics of Total Disability

The definition of total disability can vary among insurers. Some may define it as the inability to perform your regular job, while others may require that you be unable to perform any job. Understanding this definition is vital when considering the waiver of premium rider.

Choosing a life insurance policy with a waiver of premium rider can significantly impact your financial security during unexpected life events. It's advisable to carefully review the terms associated with this rider and discuss them with your insurance advisor to ensure you fully understand and can take advantage of its provisions.

Waiver of Premium in Life Insurance: Cost

The cost of adding a waiver of premium rider to your life insurance policy can vary widely based on factors like age, occupation, health and the type of policy. For instance, a young, healthy individual working in a low-risk occupation may find the cost of this rider to be relatively minimal. Conversely, someone in a high-risk job or with pre-existing health conditions might face a higher expense.

Although a waiver of premium benefit may seem like an additional expense at the outset, the protection it offers can be invaluable for certain policyholders. For example, a sole breadwinner with a family relying on their income may find this a good addition to their coverage. If an unexpected illness or accident leaves them unable to work, paying life insurance premiums may become a monetary strain. Having a disability waiver of premium rider could be a financial lifeline, ensuring that the life insurance policy continues without the need for premium payments during the period of disability.

EXPERT TIP

When purchasing a life insurance policy, make sure you check the fine print. Not all policies have a waiver of premium clause. Most insurance providers also don’t offer this benefit to anyone over 65. If you’re a senior, you're likely ineligible.

Benefits of a Waiver of Premium Provision

A waiver of premium rider in life insurance can serve as a financial safety net to help you in a time of need. But it may not be a suitable option for everyone. Understanding this provision's unique benefits can help determine if it's right for you.

It offers financial protection

Getting seriously ill or injured can leave you unable to work. A waiver of premium rider will allow you to stop making payments for your life insurance policy. Instead, this rider will cover the premiums.

It prevents a lapse in coverage

An inability to make premium payments can cause your life insurance coverage to lapse. A waiver of premium clause can prevent that from happening as it waives off your future payments until you recover.

It isn't limited to one use

Using a waiver of premium in life insurance isn’t limited to one incident. You may use it several times as long as you meet the qualifications. That’s especially helpful should your disability or illness recur.

It helps reduce stress

An illness or disability doesn’t only affect you physically but also mentally. Worrying about your finances and premium payments can add to your stress. With a waiver of premium benefit, you don’t have to figure out how to pay for your policy while recovering.

Potential Drawbacks of a Waiver of Premium Rider

While the waiver of premium rider provides valuable financial protection, it also comes with potential drawbacks. Understanding these can help you make an informed decision that aligns with your unique needs and circumstances.

There's an additional cost

Adding a waiver of premium rider isn't free and can increase the overall cost of your policy. Weigh this against the benefits it offers.

There may be a waiting period

Many policies include a waiting period for a waiver of premium rider. Also referred to as an elimination period, this time depends on the insurance provider. In most cases, it's around six months. This delay can be challenging if you're unable to work during this time.

Qualifications may vary

The definitions for qualifying disabilities or illnesses can vary, and some waiver of premium riders might not cover partial disabilities, limiting the protection.

There may be duration limits

Some riders only waive premiums up to a certain age, such as 60 or 65, potentially leaving you with out-of-pocket expenses afterward.

You may need to undergo medical examinations

Insurance companies may require policyholders with a waiver of premium rider to get periodic medical examinations to continue the benefits.

Factors to Consider When Adding a Waiver of Premium Provision to a Policy

It's wise to consider some factors before adding a waiver of premium provision to your life insurance policy. Get information from your insurance provider because conditions, rules and requirements vary per insurer. Reading the fine print can help you better understand how this benefit works.

Factor	Description
Qualifications	Eligibility requirements for a waiver of premium rider vary depending on the insurance carrier, so clarify them with the provider early on. Typically, the policyholder must be less than 60 or 65 years old. They shouldn't have a pre-existing disability or illness. The insurer may also consider overall health, lifestyle and occupation. Some provisions may only activate if the disability keeps you from working for a minimum of six months.
Waiting period	In most cases, the waiver of premium for disability only takes effect after the waiting period passes. This can be anywhere from a few months to a year, usually six months.
Duration	The waiver of premium provision takes effect after the waiting period and lasts until the policyholder recovers from the disability. In some cases, the duration may be up to a specific age. The policy contract will have the details. After the duration of the waiver, the policyholder will have to pay premiums again.
Expiration date	The waiver of premium in life insurance may expire depending on the terms and conditions stated in the policy contract. Usually, the age limit is 60 or 65. After this age, the policyholder will likely no longer qualify for the premium waiver.
Cost	Adding riders, such as a waiver of premium, may add additional cost to your life insurance rate. The amount depends on the insurer and individualized factors like your age and health. This is typically up to 25% of your policy's cost.

INTERPRETATIONS OF QUALIFYING DISABILITIES

A waiver of premium rider takes effect when the policyholder suffers from a disability. However, not all types of disabilities may qualify, and insurance companies interpret disability in various ways.

Here are some common interpretations of what can be considered a qualifying disability:

- An injury or sickness caused the disability.
- The disability causes loss of mobility, such as losing a limb.
- The disability causes sensory loss, such as hearing impairment or blindness.
- An injury or illness prevents the policyholder from performing the occupation they qualified for through education, experience or training.

Reasons to Add a Waiver of Premium Rider to a Life Insurance Policy

Although a waiver of premium rider offers multiple benefits, it's not always the best option. It can be suitable for people with only one source of income, who have high-risk professions or hobbies or who have a family history of serious illness.

You only have one source of income

A disability can prevent you from going to work, which means you may suffer from a temporary loss of income. If you only have one source of income, getting a waiver of premium rider may be wise since it lessens the possible financial burdens you may have to face if you become disabled.

You have a high-risk profession

Some jobs come with inherent risks. If there's a high chance of you getting injured on the job, consider looking for a policy with a waiver of premium provision.

Examples of high-risk professions include the following:

- Firefighters
- Police officers
- Pilots
- Construction workers
- Moving company employees
- Bus and truck drivers
- EMTs
- Nurses

You have risky hobbies

Certain hobbies and activities may increase the risk of serious injuries leading to disability. A waiver of premium benefit provides a financial safety net should unexpected incidents happen.

You're at risk of getting a serious illness based on your family history

If you think you're at risk of getting a disease based on your family health history, getting a waiver of premium benefit may be a smart move. It can be a form of preparation for unfortunate circumstances should you also suffer from a similar condition and end up with a disability.

EXPERT TIP

The Centers for Disease Control and Prevention (CDC) reported that around 27% of Americans have some type of disability. While life can be unpredictable, and there's no sure way

of knowing whether a person will eventually have a disability, certain lifestyles may increase the risk. If you know you have specific risk factors, it might be worth getting a waiver of premium.

How to File a Waiver of Premium Claim

If you're interested in getting a waiver of premium clause, you should add it to your policy when you buy your life insurance. The following steps will walk you through the process of filing a waiver of premium claim if you have a covered disability.

Get a medical statement from your doctor

Requirements for filing a waiver of premium claim depend on the insurance provider. Typically, it includes submitting a medical statement from a doctor — you can't say that you have a disability without proof.

Your insurance provider will then determine if you're qualified for a claim. Make sure the certificate provides details on your condition and that it prevents you from working.

Obtain a notice from the Social Security Administration (SSA)

In some instances, the insurance provider may require additional evidence by requesting a copy of a notice from the SSA. This document can confirm a disability or physical impairment. It will also verify your inability to work due to your disability.

You can find the nearest SSA office using the agency's field office locator.

Contact your insurer and file your claim

Let your insurance provider know about your plan to file a claim. Ask them if there are any additional requirements. They may ask you to fill out a claim form or provide additional information.

Depending on the company, you may be able to file a claim online or through mail or fax.

Navigating the process of filing a waiver of premium claim requires attention to detail and adherence to your insurer's specific procedures. By following these steps and ensuring all documentation is complete and accurate, you can facilitate the approval of your claim, allowing you to focus on your health without the financial burden of premium payments.

FAQ About Waiver of Premium in Insurance

What is an insurance waiver?

An insurance waiver is a document or provision that allows an individual to opt out of required insurance coverage or exempts them from certain conditions within an insurance policy.

What is a waiver of premium rider in life insurance?

A waiver of premium can be a clause or rider that allows the policyholder to waive their premium payments in the event of a qualifying disability or illness.

What is a disability waiver?

A disability waiver, also known as a disability waiver of premium rider, is a specific type of waiver of premium. Generally, the term "waiver of premium" broadly applies to any condition under which the insurance company allows the cessation of premium payments while the coverage continues. The "disability waiver of premium rider" specifically refers to the condition being related to the policyholder's disability.

What is the level of disability required to activate a waiver of premium provision?

The definition of a qualifying disability differs per insurer. We recommend checking with the insurance company to find out more.

What is the waiting period for a waiver of premium rider in life insurance policies?

Typically, the waiver of premium rider waiting period spans around six months, but it can vary from a few months to a year, depending on the insurer's policy.

How do you file a waiver of premium claim?

The claims process for a waiver of premium benefit may vary per insurer. Typically, it includes submitting a medical statement from a doctor, an SSA notice and a completed claim form.

Which type of life insurance rider will waive the premium?

A waiver of premium rider or a disability waiver of premium rider is designed to waive premium payments on a life insurance policy in the event of a qualifying disability.

When does a life insurance policy waiver of premium take effect?

A waiver of premium in life insurance generally takes effect after the specified waiting period, provided the policyholder meets the criteria for a qualifying disability as defined by the insurer.

What is a payor benefit rider?

A payor benefit clause or rider, also known as a juvenile waiver rider, is an addition to a life insurance policy that waives premium payments if the policy's payor, typically a parent or guardian, passes away or becomes disabled. This ensures the policy remains active for the beneficiary.

Which provision does the waiver of premium not include?

Life insurance waiver of premium does not include coverage for short-term disabilities or illnesses that do not meet the insurer's definition of total disability, as specified in the policy's terms.

What are life insurance exclusions?

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As you get older, having a life insurance policy in place may allow you to leave money to your loved ones if you pass away. However, not everyone knows that there are certain exclusions that might prevent your beneficiaries from claiming your death benefit. If you have a life insurance policy, it's important to know what those exclusions are so your loved ones can avoid any surprises following your death.

Common life insurance policy exclusions

A life insurance exclusion is a situation or circumstance that prevents your beneficiaries from receiving your death benefit. Essentially, it means that certain causes of death are not covered by the policy. Life insurance exclusions are regulated at the state level, but insurance companies can decide which of those exclusions they include in their policies. Exclusions will be listed in the policy at the time of application, so the insured will know which causes of death may not be covered by the policy before accepting a policy.

The main reason life insurance companies add exclusions is to protect them from risk — namely untimely deaths, which may cost the company more money in the form of an early death benefit. Exclusions are a way for insurers to reduce the likelihood of paying a death benefit in certain situations.

You might be surprised to learn what situations may not be covered by insurance. Some common life insurance exclusions include death caused by:

- **Suicide:** If the policyholder dies by suicide within a certain timeframe after purchasing their policy, then a life insurance suicide exclusion likely applies, and the insured's beneficiaries are not eligible for death benefits. In most cases, the suicide clause is a two-year period, but this will be defined in the policy.
- **Acts of war:** If a policyholder dies as a result of wartime activities, coverage may be denied.
- **Service in the military:** Because military service may make a policyholder a higher risk to insure, this exclusion may be present in policies.
- **Aviation accident:** Although fairly rare anymore, death caused by aviation accidents is a common life insurance exclusion.

James Miles, consulting staff fellow for the Society of Actuaries, says virtually every life insurer typically includes the same outright exclusion in its policy: a suicide clause.

"Depending on the state, it's usually a two-year suicide clause. If you die by suicide within the first two years of the contract, the beneficiary would receive the premiums back but not the death benefit," he says.

The suicide clause is in place to prevent individuals from purchasing a life insurance policy when they are struggling with mental health disorders or are planning suicide. Most life insurance companies screen applicants for mental health conditions, like depression and anxiety, before they are approved for coverage. And while you will likely pay a higher premium if you are living with a mental health condition, you will still most likely be able to get a life insurance policy.

In the case of physician-assisted suicide, the same rule applies. If you live in a state where assisted suicide is legal, you must pass the two-year period before you can claim death benefits.

Accidental death policy exclusions

Some life insurance policies, known as accidental death policies, only provide coverage for the insured if they die due to an accident. Causes of death related to illness, medical issues or chronic health conditions are not covered. These policies will define what constitutes an accident and may include exclusions due to death from:

- **Illegal activity:** When someone dies as a result of illegal activity, their beneficiaries likely cannot claim their death benefits. This includes everything from drug deals gone wrong to DUI crashes.
- **Risky activity:** Any death due to risky activities, such as skydiving or rock climbing, are usually counted as an exclusion.
- **Substance abuse:** If a policyholder's death is the result of drug or alcohol abuse, it may be excluded from their policy.

It's also worth noting that risky hobbies, substance abuse and misrepresentation (providing false information on your application) could bar you from getting coverage in the first place or subject you to a higher premium.

Additionally, life insurance policies have a contestability period, in which life insurance companies can investigate your application and deny claims. This period is typically one to two years from the effective date of the policy. If you pass during the contestability period and the insurer determines you misrepresented yourself or provided any false information to your life insurance company, it could completely void your coverage and no death benefits will be paid.

How do I know if I have life insurance exclusions on my policy?

Knowing what your life insurance covers may be vital. After all, some types of life insurance will cover you for your entire life — which means making premium payments for your entire life, too. As such, not understanding your life insurance exclusions could prove to be a costly mistake.

One way to learn more about the exclusions in your life insurance policy is to read through your contract. Although it may be dense, your contract will spell out precisely what is and isn't covered in your life insurance policy. However, life insurance is complex, and contracts may be hard to decipher. With that in mind, it may be a good idea to meet with your life insurance agent, so they can break it down for you.

Do life insurance exclusions change over time?

Over the years, life insurance companies have altered their definition of risky behavior based on global, economic and socially driven changes. For instance, some life insurance companies used to exclude private aviation from the list of covered causes of death. However, as private aircraft became safer, many life insurance companies eased up on the rules for most policyholders. Today, some life insurance companies offer an aviation rider for recreational pilots.

It's important to note that although some circumstances and health statuses may not be exclusions on your life insurance policy, they could be risk factors that may contribute to a higher premium. Additionally, every insurance company is different, so it's important to read through your contract to understand your policy limitations.

Summary of the HIPAA Privacy Rule

This is a summary of key elements of the Privacy Rule including who is covered, what information is protected, and how protected health information can be used and disclosed. Because it is an overview of the Privacy Rule, it does not address every detail of each provision.

Summary of the Privacy Rule - PDF

Introduction

- The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").[1] The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect

to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

This is a summary of key elements of the Privacy Rule and not a complete or comprehensive guide to compliance. Entities regulated by the Rule are obligated to comply with all of its applicable requirements and should not rely on this summary as a source of legal information or advice. To make it easier for entities to review the complete requirements of the Rule, provisions of the Rule referenced in this summary are cited in the end notes. Visit our Privacy Rule section to view the entire Rule, and for other additional helpful information about how the Rule applies. In the event of a conflict between this summary and the Rule, the Rule governs.

Statutory and Regulatory Background

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. Collectively these are known as the *Administrative Simplification* provisions.

HIPAA required the Secretary to issue privacy regulations governing individually identifiable health information, if Congress did not enact privacy legislation within three years of the passage of HIPAA. Because Congress did not enact privacy legislation, HHS developed a proposed rule and released it for public comment on November 3, 1999. The Department received over 52,000 public comments. The final regulation, the Privacy Rule, was published December 28, 2000.[2]

In March 2002, the Department proposed and released for public comment modifications to the Privacy Rule. The Department received over 11,000 comments. The final modifications were published in final form on August 14, 2002.[3] A text combining the final regulation and the modifications can be found at 45 CFR Part 160 and Part 164, Subparts A and E.

Who is Covered by the Privacy Rule

The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities"). For help in determining whether you are covered, use CMS's decision tool.

Health Plans. Individual and group plans that provide or pay the cost of medical care are covered entities.[4] Health plans include health, dental, vision, and prescription drug insurers, health maintenance organizations ("HMOs"), Medicare, Medicaid, Medicare+Choice and Medicare supplement insurers, and long-term care insurers (excluding nursing home fixed-indemnity policies). Health plans also include employer-sponsored group health plans, government and church-sponsored health plans, and multi-employer health plans. There are exceptions—a group health plan with less than 50 participants that is administered solely by the employer that established and maintains the plan is not a covered entity. Two types of

government-funded programs are not health plans: (1) those whose principal purpose is not providing or paying the cost of health care, such as the food stamps program; and (2) those programs whose principal activity is directly providing health care, such as a community health center,[5] or the making of grants to fund the direct provision of health care. Certain types of insurance entities are also not health plans, including entities providing only workers' compensation, automobile insurance, and property and casualty insurance. If an insurance entity has separable lines of business, one of which is a health plan, the HIPAA regulations apply to the entity with respect to the health plan line of business.

Health Care Providers. Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA Transactions Rule.[6] Using electronic technology, such as email, does not mean a health care provider is a covered entity; the transmission must be in connection with a standard transaction. The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Health care providers include all "providers of services" (e.g., institutional providers such as hospitals) and "providers of medical or health services" (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

Health Care Clearinghouses. *Health care clearinghouses* are entities that process nonstandard information they receive from another entity into a standard (i.e., standard format or data content), or vice versa.[7] In most instances, health care clearinghouses will receive individually identifiable health information only when they are providing these processing services to a health plan or health care provider as a business associate. In such instances, only certain provisions of the Privacy Rule are applicable to the health care clearinghouse's uses and disclosures of protected health information.[8] Health care clearinghouses include billing services, repricing companies, community health management information systems, and value-added networks and switches if these entities perform clearinghouse functions.

Business Associates

Business Associate Defined. In general, a business associate is a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information. Business associate functions or activities on behalf of a covered entity include claims processing, data analysis, utilization review, and billing.[9] Business associate services to a covered entity are limited to legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. However, persons or organizations are not considered business associates if their functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all. A covered entity can be the business associate of another covered entity.

Business Associate Contract. When a covered entity uses a contractor or other non-workforce member to perform *"business associate"* services or activities, the Rule requires that the covered entity include certain protections for the information in a business associate agreement (in certain circumstances governmental entities may use alternative means to achieve the same protections). In the business associate contract, a covered entity must impose specified written safeguards on the individually identifiable health information used or disclosed by its business associates.[10] Moreover, a covered entity may not contractually authorize its

business associate to make any use or disclosure of protected health information that would violate the Rule. Covered entities that had an existing written contract or agreement with business associates prior to October 15, 2002, which was not renewed or modified prior to April 14, 2003, were permitted to continue to operate under that contract until they renewed the contract or April 14, 2004, whichever was first.[11] See additional guidance on Business Associates and sample business associate contract language.

What Information is Protected

Protected Health Information. The Privacy Rule protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."[12]

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.[13] Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

De-Identified Health Information. There are no restrictions on the use or disclosure of de-identified health information.[14] De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either: (1) a formal determination by a qualified statistician; or (2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.[15]

General Principle for Uses and Disclosures

Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.[16]

Required Disclosures. A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action.[17] See additional guidance on Government Access.

Permitted Uses and Disclosures

Permitted Uses and Disclosures. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following

purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations.[18] Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

(1) To the Individual. A covered entity may disclose protected health information to the individual who is the subject of the information.

(2) Treatment, Payment, Health Care Operations. A covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities.[19] A covered entity also may disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship. See additional guidance on Treatment, Payment, & Health Care Operations.

Treatment is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.[20]

Payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual[21] and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual.

Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.[22]

Most uses and disclosures of psychotherapy notes for treatment, payment, and health care operations purposes require an authorization as described below.[23] Obtaining "consent" (written permission from individuals to use and disclose their protected health information for treatment, payment, and health care operations) is optional under the Privacy Rule for all covered entities.[24] The content of a consent form, and the process for obtaining consent, are at the discretion of the covered entity electing to seek consent.

(3) Uses and Disclosures with Opportunity to Agree or Object. Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. Where the individual is incapacitated, in an emergency situation, or not available, covered entities generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.

Facility Directories. It is a common practice in many health care facilities, such as hospitals, to maintain a directory of patient contact information. A covered health care provider may rely on an individual's informal permission to list in its facility directory the individual's name, general condition, religious affiliation, and location in the provider's facility.[25] The provider may then disclose the individual's condition and location in the facility to anyone asking for the individual by name, and also may disclose religious affiliation to clergy. Members of the clergy are not required to ask for the individual by name when inquiring about patient religious affiliation.

For Notification and Other Purposes. A covered entity also may rely on an individual's informal permission to disclose to the individual's family, relatives, or friends, or to other persons whom the individual identifies, protected health information directly relevant to that person's involvement in the individual's care or payment for care.[26] This provision, for example, allows a pharmacist to dispense filled prescriptions to a person acting on behalf of the patient. Similarly, a covered entity may rely on an individual's informal permission to use or disclose protected health information for the purpose of notifying (including identifying or locating) family members, personal representatives, or others responsible for the individual's care of the individual's location, general condition, or death. In addition, protected health information may be disclosed for notification purposes to public or private entities authorized by law or charter to assist in disaster relief efforts.

(4) Incidental Use and Disclosure. The Privacy Rule does not require that every risk of an incidental use or disclosure of protected health information be eliminated. A use or disclosure of this information that occurs as a result of, or as "incident to," an otherwise permitted use or disclosure is permitted as long as the covered entity has adopted reasonable safeguards as required by the Privacy Rule, and the information being shared was limited to the "minimum necessary," as required by the Privacy Rule.[27] See additional guidance on Incidental Uses and Disclosures.

(5) Public Interest and Benefit Activities. The Privacy Rule permits use and disclosure of protected health information, without an individual's authorization or permission, for 12 national priority purposes.[28] These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside of the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the individual privacy interest and the public interest need for this information.

Required by Law. Covered entities may use and disclose protected health information without individual authorization as required by law (including by statute, regulation, or court orders).[29]

Public Health Activities. Covered entities may disclose protected health information to: (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect; (2) entities subject to FDA regulation regarding FDA regulated products or activities for purposes such as adverse event reporting, tracking of products, product recalls, and post-marketing surveillance; (3) individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law; and (4) employers, regarding employees, when requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration (OHSA), the Mine Safety and Health Administration (MHSA), or similar state law.[30] See additional guidance on Public Health Activities and CDC's web pages on Public Health and HIPAA Guidance.

Victims of Abuse, Neglect or Domestic Violence. In certain circumstances, covered entities may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.[31]

Health Oversight Activities. Covered entities may disclose protected health information to health oversight agencies (as defined in the Rule) for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.[32]

Judicial and Administrative Proceedings. Covered entities may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.[33]

Law Enforcement Purposes. Covered entities may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.[34]

Decedents. Covered entities may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.[35]

Cadaveric Organ, Eye, or Tissue Donation. Covered entities may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.[36]

Research. "Research" is any systematic investigation designed to develop or contribute to generalizable knowledge.[37] The Privacy Rule permits a covered entity to use and disclose protected health information for research purposes, without an individual's authorization, provided the covered entity obtains either: (1) documentation that an alteration or waiver of individuals' authorization for the use or disclosure of protected health information about them for research purposes has been approved by an Institutional Review Board or Privacy Board; (2) representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research; or (3) representations from the researcher that the use or disclosure sought is solely for research on the protected health information of decedents, that the protected health information sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is sought.[38] A covered entity also may use or disclose, without an individuals' authorization, a limited data set of protected health information for research purposes (see discussion below).[39] See additional guidance on Research and NIH's publication of "Protecting Personal Health Information in Research: Understanding the HIPAA Privacy Rule." - PDF

Serious Threat to Health or Safety. Covered entities may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). Covered entities may also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.[40]

Essential Government Functions. An authorization is not required to use or disclose protected health information for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.[41]

Workers' Compensation. Covered entities may disclose protected health information as authorized by, and to comply with, workers' compensation laws and other similar programs providing benefits for work-related injuries or illnesses.[42] See additional guidance on Workers' Compensation.

(6) Limited Data Set. A limited data set is protected health information from which certain specified direct identifiers of individuals and their relatives, household members, and employers have been removed.43 A limited data set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specified safeguards for the protected health information within the limited data set.

Authorized Uses and Disclosures

Authorization. A covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule.[44] A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.[45]

An authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party. Examples of disclosures that would require an individual's authorization include disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or lab test, or disclosures to a pharmaceutical firm for their own marketing purposes.

All authorizations must be in plain language, and contain specific information regarding the information to be disclosed or used, the person(s) disclosing and receiving the information, expiration, right to revoke in writing, and other data. The Privacy Rule contains transition provisions applicable to authorizations and other express legal permissions obtained prior to April 14, 2003.[46]

Psychotherapy Notes.[47] A covered entity must obtain an individual's authorization to use or disclose psychotherapy notes with the following exceptions:[48]

- The covered entity who originated the notes may use them for treatment.
- A covered entity may use or disclose, without an individual's authorization, the psychotherapy notes, for its own training, and to defend itself in legal proceedings brought by the individual, for HHS to investigate or determine the covered entity's compliance with the

Privacy Rules, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight of the originator of the psychotherapy notes, for the lawful activities of a coroner or medical examiner or as required by law.

Marketing. Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service.[49] The Privacy Rule carves out the following health-related activities from this definition of marketing:

- Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication;
- Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefits plan;
- Communications for treatment of the individual; and
- Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual.

Marketing also is an arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information, in exchange for direct or indirect remuneration, for the other entity to communicate about its own products or services encouraging the use or purchase of those products or services. A covered entity must obtain an authorization to use or disclose protected health information for marketing, except for face-to-face marketing communications between a covered entity and an individual, and for a covered entity's provision of promotional gifts of nominal value. No authorization is needed, however, to make a communication that falls within one of the exceptions to the marketing definition. An authorization for marketing that involves the covered entity's receipt of direct or indirect remuneration from a third party must reveal that fact. See additional guidance on Marketing.

Limiting Uses and Disclosures to the Minimum Necessary

Minimum Necessary. A central aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.[50] A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose. See additional guidance on Minimum Necessary.

The minimum necessary requirement is not imposed in any of the following circumstances: (a) disclosure to or a request by a health care provider for treatment; (b) disclosure to an individual who is the subject of the information, or the individual's personal representative; (c) use or disclosure made pursuant to an authorization; (d) disclosure to HHS for complaint investigation, compliance review or enforcement; (e) use or disclosure that is required by law; or (f) use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules.

Access and Uses. For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the

specific roles of the members of their workforce. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the categories of protected health information to which access is needed, and any conditions under which they need the information to do their jobs.

Disclosures and Requests for Disclosures. Covered entities must establish and implement policies and procedures (which may be standard protocols) for *routine, recurring disclosures, or requests for disclosures*, that limits the protected health information disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of the disclosure. Individual review of each disclosure is not required. For non-routine, non-recurring disclosures, or requests for disclosures that it makes, covered entities must develop criteria designed to limit disclosures to the information reasonably necessary to accomplish the purpose of the disclosure and review each of these requests individually in accordance with the established criteria.

Reasonable Reliance. If another covered entity makes a request for protected health information, a covered entity may rely, if reasonable under the circumstances, on the request as complying with this minimum necessary standard. Similarly, a covered entity may rely upon requests as being the minimum necessary protected health information from: (a) a public official, (b) a professional (such as an attorney or accountant) who is the covered entity's business associate, seeking the information to provide services to or for the covered entity; or (c) a researcher who provides the documentation or representation required by the Privacy Rule for research.

Notice and Other Individual Rights

Privacy Practices Notice. Each covered entity, with certain exceptions, must provide a notice of its privacy practices.[51] The Privacy Rule requires that the notice contain certain elements. The notice must describe the ways in which the covered entity may use and disclose protected health information. The notice must state the covered entity's duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must describe individuals' rights, including the right to complain to HHS and to the covered entity if they believe their privacy rights have been violated. The notice must include a point of contact for further information and for making complaints to the covered entity. Covered entities must act in accordance with their notices. The Rule also contains specific distribution requirements for direct treatment providers, all other health care providers, and health plans. See additional guidance on Notice.

- **Notice Distribution.** A covered health care provider with a *direct treatment* relationship with individuals must have delivered a privacy practices notice to patients starting April 14, 2003, as follows:

- Not later than the first service encounter by personal delivery (for patient visits), by automatic and contemporaneous electronic response (for electronic service delivery), and by prompt mailing (for telephonic service delivery);

- By posting the notice at each service delivery site in a clear and prominent place where people seeking service may reasonably be expected to be able to read the notice; and

- In emergency treatment situations, the provider must furnish its notice as soon as practicable after the emergency abates.

Covered entities, whether direct treatment providers or indirect treatment providers (such as laboratories) or health plans must supply notice to anyone on request.[52] A covered entity must

also make its notice electronically available on any web site it maintains for customer service or benefits information.

The covered entities in an organized health care arrangement may use a joint privacy practices notice, as long as each agrees to abide by the notice content with respect to the protected health information created or received in connection with participation in the arrangement.[53] Distribution of a joint notice by any covered entity participating in the organized health care arrangement at the first point that an OHCA member has an obligation to provide notice satisfies the distribution obligation of the other participants in the organized health care arrangement.

A health plan must distribute its privacy practices notice to each of its enrollees by its Privacy Rule compliance date. Thereafter, the health plan must give its notice to each new enrollee at enrollment, and send a reminder to every enrollee at least once every three years that the notice is available upon request. A health plan satisfies its distribution obligation by furnishing the notice to the "named insured," that is, the subscriber for coverage that also applies to spouses and dependents.

- **Acknowledgement of Notice Receipt.** A covered health care provider with a direct treatment relationship with individuals must make a good faith effort to obtain written acknowledgement from patients of receipt of the privacy practices notice.[54] The Privacy Rule does not prescribe any particular content for the acknowledgement. The provider must document the reason for any failure to obtain the patient's written acknowledgement. The provider is relieved of the need to request acknowledgement in an emergency treatment situation.

Access. Except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information in a covered entity's designated record set.[55] The "designated record set" is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider's medical and billing records about individuals or a health plan's enrollment, payment, claims adjudication, and case or medical management record systems.[56] The Rule excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, covered entities may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion.[57] Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.

Amendment. The Rule gives individuals the right to have covered entities amend their protected health information in a designated record set when that information is inaccurate or incomplete. [58] If a covered entity accepts an amendment request, it must make reasonable efforts to provide the amendment to persons that the individual has identified as needing it, and to persons that the covered entity knows might rely on the information to the individual's detriment.[59] If the request is denied, covered entities must provide the individual with a written denial and allow the individual to submit a statement of disagreement for inclusion in the record. The Rule specifies processes for requesting and responding to a request for amendment. A covered entity must amend protected health information in its designated record set upon receipt of notice to amend from another covered entity.

Disclosure Accounting. Individuals have a right to an accounting of the disclosures of their protected health information by a covered entity or the covered entity's business associates.[60] The maximum disclosure accounting period is the six years immediately preceding the accounting request, except a covered entity is not obligated to account for any disclosure made before its Privacy Rule compliance date.

The Privacy Rule does not require accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to the individual or the individual's personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Restriction Request. Individuals have the right to request that a covered entity restrict use or disclosure of protected health information for treatment, payment or health care operations, disclosure to persons involved in the individual's health care or payment for health care, or disclosure to notify family members or others about the individual's general condition, location, or death.[61] A covered entity is under no obligation to agree to requests for restrictions. A covered entity that does agree must comply with the agreed restrictions, except for purposes of treating the individual in a medical emergency.[62]

Confidential Communications Requirements. Health plans and covered health care providers must permit individuals to request an alternative means or location for receiving communications of protected health information by means other than those that the covered entity typically employs.[63] For example, an individual may request that the provider communicate with the individual through a designated address or phone number. Similarly, an individual may request that the provider send communications in a closed envelope rather than a post card.

Health plans must accommodate reasonable requests if the individual indicates that the disclosure of all or part of the protected health information could endanger the individual. The health plan may not question the individual's statement of endangerment. Any covered entity may condition compliance with a confidential communication request on the individual specifying an alternative address or method of contact and explaining how any payment will be handled.

Administrative Requirements

HHS recognizes that covered entities range from the smallest provider to the largest, multi-state health plan. Therefore, the flexibility and scalability of the Rule are intended to allow covered entities to analyze their own needs and implement solutions appropriate for their own environment. What is appropriate for a particular covered entity will depend on the nature of the covered entity's business, as well as the covered entity's size and resources.

Privacy Policies and Procedures. A covered entity must develop and implement written privacy policies and procedures that are consistent with the Privacy Rule.[64]

Privacy Personnel. A covered entity must designate a privacy official responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices.[65]

Workforce Training and Management. Workforce members include employees, volunteers, trainees, and may also include other persons whose conduct is under the direct control of the entity (whether or not they are paid by the entity).[66] A covered entity must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions.[67] A covered entity must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the Privacy Rule.[68]

Mitigation. A covered entity must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce or its business associates in violation of its privacy policies and procedures or the Privacy Rule.[69]

Data Safeguards. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure.[70] For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes. See additional guidance on Incidental Uses and Disclosures.

Complaints. A covered entity must have procedures for individuals to complain about its compliance with its privacy policies and procedures and the Privacy Rule.[71] The covered entity must explain those procedures in its privacy practices notice.[72]

Among other things, the covered entity must identify to whom individuals can submit complaints to at the covered entity and advise that complaints also can be submitted to the Secretary of HHS.

Retaliation and Waiver. A covered entity may not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule.[73] A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.[74]

Documentation and Record Retention. A covered entity must maintain, until six years after the later of the date of their creation or last effective date, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions, activities, and designations that the Privacy Rule requires to be documented.[75]

Fully-Insured Group Health Plan Exception. The only administrative obligations with which a fully-insured group health plan that has no more than enrollment data and summary health information is required to comply are the (1) ban on retaliatory acts and waiver of individual rights, and (2) documentation requirements with respect to plan documents if such documents are amended to provide for the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO that services the group health plan.[76]

Organizational Options

The Rule contains provisions that address a variety of organizational issues that may affect the operation of the privacy protections.

Hybrid Entity. The Privacy Rule permits a covered entity that is a single legal entity and that conducts both covered and non-covered functions to elect to be a "hybrid entity."[77] (The

activities that make a person or organization a covered entity are its "covered functions."[78]) To be a hybrid entity, the covered entity must designate in writing its operations that perform covered functions as one or more "health care components." After making this designation, most of the requirements of the Privacy Rule will apply only to the health care components. A covered entity that does not make this designation is subject in its entirety to the Privacy Rule.

Affiliated Covered Entity. Legally separate covered entities that are affiliated by common ownership or control may designate themselves (including their health care components) as a single covered entity for Privacy Rule compliance.[79] The designation must be in writing. An affiliated covered entity that performs multiple covered functions must operate its different covered functions in compliance with the Privacy Rule provisions applicable to those covered functions.

Organized Health Care Arrangement. The Privacy Rule identifies relationships in which participating covered entities share protected health information to manage and benefit their common enterprise as "organized health care arrangements."[80] Covered entities in an organized health care arrangement can share protected health information with each other for the arrangement's joint health care operations.[81]

Covered Entities with Multiple Covered Functions. A covered entity that performs multiple covered functions must operate its different covered functions in compliance with the Privacy Rule provisions applicable to those covered functions.[82] The covered entity may not use or disclose the protected health information of an individual who receives services from one covered function (e.g., health care provider) for another covered function (e.g., health plan) if the individual is not involved with the other function.

Group Health Plan disclosures to Plan Sponsors. A group health plan and the health insurer or HMO offered by the plan may disclose the following protected health information to the "plan sponsor"—the employer, union, or other employee organization that sponsors and maintains the group health plan:[83]

- Enrollment or disenrollment information with respect to the group health plan or a health insurer or HMO offered by the plan.

- If requested by the plan sponsor, summary health information for the plan sponsor to use to obtain premium bids for providing health insurance coverage through the group health plan, or to modify, amend, or terminate the group health plan. "Summary health information" is information that summarizes claims history, claims expenses, or types of claims experience of the individuals for whom the plan sponsor has provided health benefits through the group health plan, and that is stripped of all individual identifiers other than five digit zip code (though it need not qualify as de-identified protected health information).

- Protected health information of the group health plan's enrollees for the plan sponsor to perform plan administration functions. The plan must receive certification from the plan sponsor that the group health plan document has been amended to impose restrictions on the plan sponsor's use and disclosure of the protected health information. These restrictions must include the representation that the plan sponsor will not use or disclose the protected health information for any employment-related action or decision or in connection with any other benefit plan.

Other Provisions: Personal Representatives and Minors

Personal Representatives. The Privacy Rule requires a covered entity to treat a *"personal representative"* the same as the individual, with respect to uses and disclosures of the individual's protected health information, as well as the individual's rights under the Rule.[84] A

personal representative is a person legally authorized to make health care decisions on an individual's behalf or to act for a deceased individual or the estate. The Privacy Rule permits an exception when a covered entity has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual.

Special Case: Minors. In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise individual rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative. In these situations, the Privacy Rule defers to State and other law to determine the rights of parents to access and control the protected health information of their minor children. If State and other law is silent concerning parental access to the minor's protected health information, a covered entity has discretion to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment. See additional guidance on Personal Representatives.

State Law

Preemption. In general, State laws that are contrary to the Privacy Rule are preempted by the federal requirements, which means that the federal requirements will apply.[85] "Contrary" means that it would be impossible for a covered entity to comply with both the State and federal requirements, or that the provision of State law is an obstacle to accomplishing the full purposes and objectives of the Administrative Simplification provisions of HIPAA.[86] The Privacy Rule provides exceptions to the general rule of federal preemption for contrary State laws that (1) relate to the privacy of individually identifiable health information and provide greater privacy protections or privacy rights with respect to such information, (2) provide for the reporting of disease or injury, child abuse, birth, or death, or for public health surveillance, investigation, or intervention, or (3) require certain health plan reporting, such as for management or financial audits.

Exception Determination. In addition, preemption of a contrary State law will not occur if HHS determines, in response to a request from a State or other entity or person, that the State law:

- Is necessary to prevent fraud and abuse related to the provision of or payment for health care,
- Is necessary to ensure appropriate State regulation of insurance and health plans to the extent expressly authorized by statute or regulation,
- Is necessary for State reporting on health care delivery or costs,
- Is necessary for purposes of serving a compelling public health, safety, or welfare need, and, if a Privacy Rule provision is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served; or
- Has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances (as defined in 21 U.S.C. 802), or that is deemed a controlled substance by State law.

Enforcement and Penalties for Noncompliance

Compliance. The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) establishes a set of national standards for the use and disclosure of an individual's health information – called protected health information – by covered entities, as

well as standards for providing individuals with privacy rights to understand and control how their health information is used. The Department of Health and Human Services, Office for Civil Rights (OCR) is responsible for administering and enforcing these standards and may conduct complaint investigations and compliance reviews.

Consistent with the principles for achieving compliance provided in the Privacy Rule, OCR will seek the cooperation of covered entities and may provide technical assistance to help them comply voluntarily with the Privacy Rule. Covered entities that fail to comply voluntarily with the standards may be subject to civil money penalties. In addition, certain violations of the Privacy Rule may be subject to criminal prosecution. These penalty provisions are explained below.

Civil Money Penalties. OCR may impose a penalty on a covered entity for a failure to comply with a requirement of the Privacy Rule. Penalties will vary significantly depending on factors such as the date of the violation, whether the covered entity knew or should have known of the failure to comply, or whether the covered entity's failure to comply was due to willful neglect. Penalties may not exceed a calendar year cap for multiple violations of the same requirement.

A penalty will not be imposed for violations in certain circumstances, such as if:

- the failure to comply was not due to willful neglect, and was corrected during a 30-day period after the entity knew or should have known the failure to comply had occurred (unless the period is extended at the discretion of OCR); or
- the Department of Justice has imposed a criminal penalty for the failure to comply (see below).

In addition, OCR may choose to reduce a penalty if the failure to comply was due to reasonable cause and the penalty would be excessive given the nature and extent of the noncompliance.

Before OCR imposes a penalty, it will notify the covered entity and provide the covered entity with an opportunity to provide written evidence of those circumstances that would reduce or bar a penalty. This evidence must be submitted to OCR within 30 days of receipt of the notice. In addition, if OCR states that it intends to impose a penalty, a covered entity has the right to request an administrative hearing to appeal the proposed penalty.

Criminal Penalties. A person who knowingly obtains or discloses individually identifiable health information in violation of the Privacy Rule may face a criminal penalty of up to $50,000 and up to one-year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain or malicious harm. The Department of Justice is responsible for criminal prosecutions under the Privacy Rule.

Compliance Dates

Compliance Schedule. All covered entities, except "small health plans," must have been compliant with the Privacy Rule by April 14, 2003.[90] Small health plans, however, had until April 14, 2004 to comply.

Small Health Plans. A health plan with annual receipts of not more than $5 million is a small health plan.[91] Health plans that file certain federal tax returns and report receipts on those returns should use the guidance provided by the Small Business Administration at 13 Code of Federal Regulations (CFR) 121.104 to calculate annual receipts. Health plans that do not report receipts to the Internal Revenue Service (IRS), for example, group health plans regulated by the

Employee Retirement Income Security Act 1974 (ERISA) that are exempt from filing income tax returns, should use proxy measures to determine their annual receipts.[92] See What constitutes a small health plan?

Copies of the Rule & Related Materials

See our Combined Regulation Text of All Rules section of our site for the full suite of HIPAA Administrative Simplification Regulations and Understanding HIPAA for additional guidance material.

What Is a Conditional Binding Receipt?

A conditional binding receipt is involved in life, health, and certain property insurance contracts; if the insured is deemed to be covered by the insurer, the coverage begins on the date the insured receives the conditional binding receipt.

Typically, a premium payment must be received by the insurer along with a completed acceptable application in order for the insured to obtain the receipt. This may also be called a "conditional receipt" or a "binding receipt," depending on the type of insurance.

Key Takeaways

- A conditional binding receipt is involved in life, health, and certain property insurance contracts.
- If the insured is deemed to be covered by the insurer, the coverage begins on the date the insured receives the conditional binding receipt.
- A life and health insurance policy without a conditional binding receipt is not effective until it is delivered to the insured and the premium is paid.
- The function of a conditional binding receipt can actually be divided into two separate receipts: a conditional receipt and a binding receipt.

Understanding Conditional Binding Receipts

If a premium accompanies an application, a conditional binding receipt provides that coverage will be in force from the date of application or medical examination, so long as the insurer would have issued the coverage on the basis of the facts revealed on the application, medical examination, and other usual sources of underwriting information. A life and health insurance policy without a conditional binding receipt is not effective until it is delivered to the insured and the premium is paid.

So long as the insured is going to receive the policy anyway, the insurer is obliged to cover a claim should one occur between the time the application is received and the time the policy is officially in place. If, however, the insured is denied coverage as the typical underwriting process progresses, the insurer could nullify the conditional binding receipt, even if a premium was collected.

The function of a conditional binding receipt can actually be divided into two separate receipts: a conditional receipt and a binding receipt.

Conditional Receipts

The conditional receipt is most common. Under a conditional receipt, the applicant and the insurance company form a "conditional" contract that is contingent upon the conditions that existed when an application or medication exam is completed. It provides that the applicant is covered immediately as long as they pass the insurer's underwriting requirements. It is the

insurance agent's responsibility to tell the applicant they are covered on the condition they prove to be insurable and pass a medical exam if one is required.

A conditional receipt gives an insurance company a window of time in which they can ultimately issue or refuse to approve the policy. If during this time, the applicant for a life insurance contract dies, the company will pay a death benefit if the policy would have been issued.

Binding Receipts

A binding receipt states an insurance policy is effective upon receipt of initial premium payment. However, should the insured die before the application is processed, benefits are fully payable, subject to limitations.

The binding receipt binds an insurer to the agreement unconditionally when benefits are due up to the limits of the policy.

Face-to-Face Delivery

It is critical to promptly deliver all policies and contracts to customers. Prompt delivery helps:

- Initiate the timing of the free-look period
- Ensure customer receives quality service
- Build relationships between financial professional and customers
- Obtain high quality referrals
- Enhance the financial professional's professional image
- Improve persistency

Examination Offer

The examination offer is a standard provision in all current contracts. It entitles the owner to a refund if cancellation of the policy within ten days (in most cases) of the date the contract is delivered.

The examination offer on such requests starts when the owner receives the contract—not when it's mailed from the home office or received by the financial professional. Therefore, it is essential that the policy be delivered promptly and a delivery receipt secured.

If Financial Professional...	Possible Outcomes...	Then...
Delays delivery	• Violation of company policy • Free look period does not begin until delivery to customer • Policy or Contract may be made not taken, resulting in reversed commissions • Loss of goodwill and referrals	Agency management must: • Deliver policy/contract • Obtain signed delivery receipt • Advise customer of free look period • Counsel financial professional on company delivery policies and ensure all are promptly delivered

	• Customer complaint • Harm to reputation (financial professional's and company's) • Business Conduct review • Sanctions against financial professional	
Does not obtain signed delivery receipt	• Violation of company policy • Free look period may not begin until signed by owner • Policy or contract may be made not taken, resulting in reversed commissions • Loss of goodwill and referrals • Customer complaint • Errors and Omissions Claim • Harm to reputation • Business Conduct review • Sanctions against financial professional	Agency management must: • Deliver policy/contract • Obtain signed delivery receipt • Advise customer of free look period • Counsel financial professional on company delivery policies and ensure all are promptly delivered
Accepts or requests from customer, or submits, delivery receipt signed by someone other than customer	• Violation of company policy • Violation of confidentiality or privacy • Void delivery receipt • New free look period may be required • Commission reversal • Customer complaint • Business Conduct review	Agency management: • Assists home office with Business Conduct • Delivers policy/contract • Obtain signed delivery receipt • Advises customer of free look period • Reviews any actions taken with financial professional

	• Jeopardize contract with Principal Life • Sanctions against financial professional	
Miscommunicates medical information	• Violation of privacy or confidentiality laws • Customer complaint • Business Conduct Review • Jeopardize contract with Principal Life • Sanctions against financial professional	Agency management: • Application may be declined • Deliver policy/contract • Obtain signed delivery receipt • Advises customer of free look period • Assists home office with Business Conduct review and any actions taken with financial professional
Keeps Possession of Policy or Contract	• Violation of company delivery requirements • Violation of state regulations • Void delivery receipt • New free look period may be required • Commission reversal • Customer complaint • Errors and Omissions Claim • Jeopardize contract with Principal Life • Business Conduct review • Sanctions against financial professional	Agency management: • Delivers policy/contract • Obtains signed delivery receipt • Advises customer of free look period • Assists home office with Business Conduct review and any actions taken with financial professional
Opens Personal and Confidential letter prior to delivery to customer	• Violation of company policy • Violation of privacy or confidentiality laws • Customer complaint	Agency management: • Notifies Business Conduct and Underwriter • Assists home office with Business Conduct review and

	• Business Conduct Review • Jeopardize contract with Principal Life • Sanctions against financial professional	any actions taken with financial professional • Assists home office with any action taken with customer
Does not deliver Buyer's Guide	• Violation of state regulation • Violation of company policy • Customer complaint • Business Conduct Review • Jeopardize contract with Principal Life • Sanctions against financial professional	Agency management must: • Deliver policy/contract and Buyer's Guide • Obtained signed delivery receipt • Advise customer of free look period • Assist home office with Business Conduct review and any actions taken regarding financial professional

Delivery by Mail

Applications which were taken by mail might result in having to deliver the policy or contract issued by mail. The financial professional must:

1. Comply with all company guidelines, policies, and state requirements.
2. Call the customer as soon as possible after receiving the policy/contract.
3. Review with the customer the policy/contract, delivery receipt, amendment forms, and riders.
4. Mail the policy/contract and other required forms to the customer.
5. Follow up regularly to ensure delivery receipt, signed Part D and any other delivery requirements are promptly signed and returned.

Elements Of an Insurance Contract

What Does Elements of An Insurance Contract Mean?

The elements of an insurance contract are the standard conditions that must be satisfied or agreed upon by both parties of the contract (the insured and the insurance company). In terms of insurance, these are the fundamental conditions of the insurance contract that bind both parties, validate the policy, and make it enforceable by law.

By signing the insurance contract, you have essentially agreed to follow the different elements. Without all of the elements of an insurance contract present, the policy may not be valid, and that means the obligations of both parties may not be enforceable in court.

The elements of an insurance contract are very similar to the elements required for any other legally binding contract with a few extra elements that are special to insurance contracts. You need both types of elements to be present before a valid and proper insurance policy is produced.

Explanation of the Elements of An Insurance Contract

In order for an insurance contract to be legally binding, the document must meet the essential elements required of all legally binding contracts, plus a few special elements that are specific to and required by insurance contracts.

First let us talk about the elements required of legally binding contracts in general:

- **Offer and Acceptance** – This refers to an offering being made and then being accepted by the other party. When you fulfill this legal requirement, you are saying that all of the negotiations have been settled and you've come to an agreement. This is also often called "agreement" or a "meeting of the minds". In the insurance context, that means you have made an application to the insurance company, they have accepted it and you have accepted the policy terms they offered.
- **Consideration** – This refers to a fair exchange of value. A contract where one party gets everything while another party contributes nothing does not meet this requirement. In the example of an insurance policy, you are paying them premiums while they are providing you with a promise to pay claims in the future.
- **Legal Capacity** – To satisfy this requirement, everyone that is a party to the contract must have the legal capacity or competence to enter into a contract. This means you have to meet certain requirements such as being above the age of majority in your jurisdiction and have the mental capacity to understand what you are signing and agreeing to.
- **Legal Purpose** – Obviously, the courts will not enforce a contract that is not legal. For example, a contract for the provision of illegal services would not be a legal and valid contract because the course would not enforce it.

The other elements required are specific to insurance contracts:

- Indemnity.
- Insurable Interest.
- Utmost Good Faith.
- Subrogation.
- Assignment and nomination.
- Warranties.
- Proximate Cause.
- Return of Premium.

What Does Adhesion Insurance Contract Mean?

Adhesion Insurance contract is a contract where one party states the provisions of the contract while the other party is not involved in its drafting, but whose participation is in either agreeing with it or declining it. An insurance policy is known as an adhesion contract.

In most contracts, all parties are involved in the wording or the details before they reach an agreement and make it legally binding. In insurance, that is not the case. The standard insurance policy already has its own terms and conditions before it is signed and bought by the insured. The participation of the insurance client is often only about consenting or dissenting (by not buying) with the policy presented to him or her. That explains why an insurance contract is considered as an adhesion contract.

However, there are policies in which the policyholder can make modifications by way of riders. In some automobile insurance policies, the insured can add a provision later on such as adding more risks to be covered or adding more names in the policy.

What Is an Aleatory Contract?

An aleatory contract is an agreement whereby the parties involved do not have to perform a particular action until a specific, triggering event occurs. Events are those that cannot be controlled by either party, such as natural disasters and death. Aleatory contracts are commonly used in insurance policies. For example, the insurer does not have to pay the insured until an event, such as a fire that results in property loss. Aleatory contracts—also called aleatory insurance—are helpful because they typically help the purchaser reduce financial risk.1

Key Takeaways

- An aleatory contract is an agreement whereby the parties involved do not have to perform a particular action until a specific event occurs.
- The trigger events aleatory contracts are those that cannot be controlled by either party, such as natural disasters or death.
- Insurance policies use aleatory contracts whereby the insurer doesn't have to pay the insured until an event, such as a fire resulting in property loss.1

Understanding an Aleatory Contract

Aleatory contracts are historically related to gambling and appeared in Roman law as contracts related to chance events. In insurance, an aleatory contract refers to an insurance arrangement in which the payouts to the insured are unbalanced. Until the insurance policy results in a payout, the insured pays premiums without receiving anything in return besides coverage. When the payouts do occur, they can far outweigh the sum of premiums paid to the insurer. If the event does not occur, the promise outlined in the contract will not be performed.

How Aleatory Contracts Work

Risk assessment is an important factor to the party, taking a higher risk when considering entering into an aleatory contract. Life insurance policies are considered aleatory contracts, as they do not benefit the policyholder until the event itself (death) comes to pass. Only then will the policy allow the agreed amount of money or services stipulated in the aleatory contract. The death of someone is an uncertain event as no one can predict in advance with certainty that when the insured will die. However, the amount which the insured's beneficiary will receive is certainly much more than what the insured has paid as a premium.

In certain cases, if the insured has not paid the regular premiums to keep the policy in force, the insurer is not obliged to pay the policy benefit, even though an insured has made some premium payments for the policy. In other types of insurance contracts, if the insured doesn’t die during the policy term, then nothing will be payable on maturity, such as with term life insurance.

Annuities and Aleatory Contracts

Another type of aleatory contract where each party takes on a defined level of risk exposure is an annuity. An annuity contract is an agreement between an individual investor and an insurance company whereby the investor pays a lump sum or a series of premiums to the annuity provider. In return, the contract legally binds the insurance company to pay periodic payments to the annuity holder—called the annuitant—once the annuitant reaches a certain milestone, such as retirement. However, the investor might risk losing the premiums paid into

the annuity if they withdraw the money too early. On the other hand, the person might live a long life and receive payments that far exceed the original amount that was paid for the annuity.

Annuity contracts can be very helpful to investors, but they can also be extremely complex. There are various types of annuities each with its own rules that include how and when payouts are structured, fee schedules, and surrender charges—if money is withdrawn too soon.