A. UNDERWRITING BASICS

1. WHAT IS UNDERWRITING?

The underwriting process is how insurers select who they will insure and what premium rates the insured will be charged.

Underwriting usually starts when the producer accepts an application from the applicant, then continues when the application reaches the home office underwriter. Every insurance application is analyzed by an underwriter to determine if the applicant meets the insurer's standards for coverage.

2. WHY IS UNDERWRITING NECESSARY?

An underwriter's job is to make sure that the insurer charges the right amount for the coverage it provides. The underwriter assesses how much risk an applicant represents, how much coverage the company can offer, if any, and how much that coverage should cost.

Another important purpose for underwriting is to guard against adverse selection. Adverse selection is the tendency for poor risks to seek and be covered under insurance more often than average risks. Essentially, people who are in poor health tend to seek out and apply for health or life insurance more often than healthy people. Insurance companies would go broke quickly if they were to insurance a large number of people who were in poor health.

3. RELATIONSHIP BETWEEN RISK AND PREMIUMS CHARGED

The underwriting process consists of evaluating information and resources to determine how an individual will be classified (whether a standard or substandard risk). After this classification procedure is completed, the policy is rated in terms of the premium that the applicant will be charged.

4. SOURCES OF INSURABILITY INFORMATION

When an insurance producer writes an application with the applicant, this starts the initial underwriting process. Because the producer is normally in a position to decide whether or not to submit an application, the initial meeting with the applicant may be referred to as “field underwriting.”
The producer can visually observe the applicant and make a judgment on the appearance of good health.

**a. Application**

Underwriting starts when a producer accepts an application from an applicant and continues when the application reaches the home office underwriter.

**(1) Making Changes on the Application**

It is important for the producer to complete the application thoroughly and accurately. After the application is completed, any changes made to the application must be initialed by the applicant/owner. All changes must be known and approved by the applicant/owner.

Some insurers require the producer to also initial the application. This protects the insurer in the event that the applicant/owner or producer does not recall changes made to the application.

**(2) Consequence of an Incomplete Application (Blanks)**

The producer must be diligent in completing the application to ensure that all the information is accurate and nothing is omitted. Incomplete applications are returned to the producer for proper completion. Since this delays the underwriting process and issuance of the policy, it could result in the applicant withdrawing the application.

**(3) Required Signatures on the Application**

The application and other related forms must be signed by the applicant, the insured and/or policyowner (if different than the applicant), and the producer before it is submitted to the insurer for underwriting. If a corporation is listed as the policyowner, the application must be signed by one or more of the corporate officers.

These forms should be forwarded to the insurer by the producer immediately upon completing the paperwork.

**b. Agent/Producer’s Reports**

Part III of the insurance application is the agent (or producer) report. Based on the producer’s observations, the producer answers several questions about the applicant.

Note that the applicant signs Parts I and II of the application but is not required to sign Part III.

**c. Medical Information & Medical Exams**

When medical exams are required by an insurer, the exams are usually conducted by a physician or paramedical company that specializes in insurance exams. The insurer pays for the completion of the exam. These exams are usually connected to life insurance underwriting, rather than medical insurance underwriting.
d. The Medical Information Bureau (MIB) and Disclosures

The MIB is a nonprofit central information repository supported by more than 600 member insurance companies that supports the underwriting process.

The MIB maintains medical information on applicants for life and health insurers. When an underwriter from a member insurer underwrites an applicant, they request information on the applicant from the MIB. The MIB information is reported in code form to the member insurers to help protect the confidentiality of the information. The underwriter then compares the information on the application to that in the MIB report. The MIB report assists the underwriter by disclosing any misleading, erroneous, or fraudulent applicant information.

The MIB Report Contains:

- Medical Information
- Avocation Information
- The Insurance Activity Index (IAI)

The IAI lists the number of times information has been requested on the applicant in the last two years. It is an important factor in preventing an applicant from over-insuring by purchasing several smaller face amount policies that may not require medical exams.

An insurer may not, however, decline an application based solely on information contained in the MIB report. There must also be other factors that substantiate the denial of coverage.

The following disclosures are required:

- Applicants must be notified in writing that the insurer may make reports on the applicant’s health to the MIB
- Information stored and reported in the MIB files are available to all MIB members;
- The applicant must sign an authorization form allowing the MIB information to be given to a member company and
- MIB information files on applicants must be disclosed to the applicant’s physician upon the request of the applicant

e. Attending Physician’s Reports (APS)

Certain medical conditions reported in the application may require an attending physician’s statement (APS) from the physician who has treated the applicant. An APS is simply the applicant’s medical records from the applicant’s physician.
f. Credit Reports
Under certain circumstances, underwriters will use an applicant's credit history as a part of the underwriting process.

(1) Fair Credit Reporting Act (FCRA) & Mandatory Disclosures
Congress passed the Fair Credit Reporting Act (“FCRA”) in 1970 to protect the consumer’s rights to privacy and from the disclosure of inaccurate and arbitrary personal information held by consumer reporting agencies. Included in this protection are applicants for insurance. Insurance companies must inform applicants about any investigations being made in the processing of their applications.

Note that, while the FCRA regulates the disclosure of personal information, it does not restrict the amount or type of information that can be collected. Under the FCRA, consumer reporting agencies may only disclose personal information to third parties under specific conditions.

Additionally, information may only be released to a third party with the written consent of the person the report is about, or when the reporting agency has reason to believe the requesting party intends to use the information for the following:

1. For a credit, employment, or an insurance evaluation
2. In connection with the granting of a license or other government benefit
3. For another “legitimate business need” involving the consumer

g. Inspection Reports
An additional financial and lifestyle investigation may be required for applicants who apply for large amounts of insurance. These investigations are typically conducted by an independent investigative company.

5. SELECTION & CLASSIFICATION FACTORS
Underwriting factors include the applicant’s age, gender, health, avocation (occupation), medical history, moral character, finances, income, and zip code.

6. AIDS, HIV & UNDERWRITING
In 1996 the Federal Government passed into law the Health Insurance Portability and Accountability Act (HIPAA) require that appropriate safeguards are in place to protect the privacy of personal health information. The Privacy Rule sets limits and conditions on how this information can be used and shared related to HIV. The applicant must be informed of the insurer’s practices with respect to the treatment of this information, the applicant’s right to privacy and an opportunity to refuse the distribution of this information.
While state laws vary, many states require insurers to treat AIDS, ARC, and HTLV-III infection in the same exact manner as other diseases or illnesses in the following ways:

- Underwriting decisions must be applied in the same manner as for other diseases
- Provisions regarding coverage limitations, deductibles, exclusions, coinsurance, and similar clauses must be applied in the same way as for other diseases
- Claim settlement considerations (such as when an illness begins or when a new claim should be submitted, rather than being considered a continuation of an old claim), must be on the same basis as other diseases

Legislation requires insurers to make no basic distinctions in the way insurers handle insureds or applicants with AIDS-related conditions and the way they handle insureds or applicants with other diseases.

State laws vary regarding the use of certain tests to detect AIDS. Normally, the applicant must sign a consent form before any blood tests can be performed. All test results are confidential and require certain procedures for informing an applicant of any positive results. A release form signed by the applicant is required when tests will be disclosed to third parties who are not normally entitled to the information.

### 7. CLASSIFICATION OF RISKS & EFFECTS ON PREMIUMS CHARGED

#### a. Preferred Risk

A preferred risk is an above average risk. Premiums are generally lower than standard risk rates.

#### b. Standard Risk

Standard risks are average risk category policies that are issued without any special restrictions or additional rating. There are no discounts or rate-up in premium for standard risks.

#### c. Substandard Risk

Substandard risks are risks that are below the standard risk level. Companies use extra percentage tables, flat extra premiums, temporary extra premiums, and rate-up in age to adjust premiums for substandard risks.

#### d. Declined

If the proposed insured does not meet the company’s guidelines for the insurability, then the application will be declined. Insurers rarely do this; rather, they seek to insure for a higher premium, and/or by limiting or excluding certain losses.

If applicants are declined, it is generally due to a serious health condition, age or dangerous job. After underwriting the application, if the applicant is rated or declined, the producer should explain to the applicant the reasons for the rating or declination.
8. GROSS PREMIUM FACTORS

The gross annual premium is the amount that must be paid each year for the insurance coverage. It includes mortality costs, interest and expense assumptions, and a specific amount of profit.

To calculate the gross premium, add the amount the policyowner actually pays for the policy, equals the mortality (Life insurance) or morbidity (Health insurance) risk discounted for interest, plus expenses. Formula: gross premium = mortality − interest + expenses

9. NET PREMIUM

The net single premium is an amount that, if paid at the start of the contract along with compound interest, is sufficient to pay the policy benefits when due. The premium without expense loading is a net premium. Net premiums are calculated by subtracting interest from the mortality risk. Formula: net premium = mortality − interest

10. PREMIUM MODES

a. Effect on Premiums

Insurance companies always calculate premiums on an annual basis to be paid in advance. Not all policyowners can afford to pay annual premiums; therefore, additional premium modes are made available.

Mode refers to the frequency of premium payments on insurance policies. Policyowners may pay their premiums annually, semiannually, quarterly, monthly, and in some cases, weekly. If the monthly premium mode is used, premiums are typically paid directly to the insurer or withdrawn from the policyowner's checking or savings account.

Typically, the less often premiums are paid, the less the premiums will be over the policy year. Why? Because most insurers give discounts for paying premiums in advance. Annual premiums are the least costly mode, while the most expensive is the monthly premium mode.

Annual premium = least expensive mode
Monthly premium = most expensive mode
B. INITIAL PREMIUMS AND RECEIPTS

If possible, it is usually a good idea to collect the initial premium at the time of application. Statistics show that applications that are taken with the initial premium are more likely to be accepted by the insured when issued.

1. CONDITIONAL RECEIPT

The conditional receipt is most commonly used by life insurers today. It is conditional because the producer cannot guarantee that the coverage will be issued.

A conditional receipt is given to the proposed insured when the initial premium is paid at the time of application. Coverage usually starts immediately after the initial premium is paid and the medical exam is completed.

The receipt provides proof of initial coverage and the insurer conditionally assumes the risk during the underwriting process; however, if the proposed insured dies during the underwriting process, benefits will be paid only if the insurer would have issued the coverage had the proposed insured been living. No benefits will be paid if the insurer would not have issued the policy as applied for.

2. INSPECTION RECEIPT

The proposed insured does not pay any premium until the policy has been issued and the insured has time to inspect the policy before accepting it. The insured will be required to sign a health statement certifying that the applicant has not had a change in health since the application was taken.

No coverage is in effect until the policy has been accepted by the proposed insured and the initial premium is paid.

3. BINDING RECEIPTS

With a binding receipt, the insurer is bound to provide coverage during the underwriting period starting from the date of the application. The initial premium must be paid. The coverage is guaranteed if the applicant dies before the policy is issued, even if the applicant is found uninsurable. This type of receipt is rarely used in life insurance.

4. POLICY EFFECTIVE DATE

The effective date is established by the date of the premium receipt. The date the policy goes into effect (receipt date) is important because it establishes coverage and the starting date from which premiums will be paid. If no initial premium is paid, the insurance company establishes the effective date as the issue date.
C. POLICY ISSUE AND DELIVERY

Once underwriting has agreed to issue the policy, the insurer will issue the policy for delivery to the applicant by the producer. It is usually a good idea for the producer to personally deliver the policy to the policyowner and review the coverage.

Policies may be issued all of the following ways:
• As applied for
• As a modified or amended policy
• With a waiver excluding death by certain causes

1. PARTIES TO THE CONTRACT

It is important to understand the different roles that individuals play in a policy.

Forexample:

a. Applicant
This is the person who completes the application and applies for coverage.

b. Policyowner
This is the person who pays the premium and has owner’s rights such as naming beneficiaries and making policy changes. The applicant is usually the policyowner, but not always.

c. Insured
This is the person whose life is insured.

d. Beneficiary
This is the person or persons designated to receive the policy benefits.

2. THIRD-PARTY OWNERSHIP

Usually, the applicant, policyowner, and the insured are the same person. In some cases, a third party will own the policy. For example, a person may name a trust as the beneficiary of a policy, or a corporation may be the owner of a policy on a key employee.

The following are a few of the typical third-party ownership arrangements as used with life insurance:
• A parent or legal guardian owning a child’s policy bought during the child’s school years
• A grandparent owning a policy on a grandchild where the application is signed by the custodial parent
• A spouse, fiancé(e), or domestic partner owning his or her partner's policy
• Business partners owning policies on each other for buy-sell purposes
• A business entity owning a policy on a key employee
• Coverage to pay taxes on a substantial estate, where ownership of the policy is wisely relegated to a third party or trust to keep it out of the taxable estate and
• A policy owned by a former spouse or other third party to comply with a divorce decree

3. DELIVERING THE POLICY

It is usually a good idea to deliver the policy to the policy applicant/owner in person to review the policy coverage, provisions and riders. Doing this will help the applicant/owner to understand the coverage they have purchased and avoid any future misunderstandings about the policy terms and coverage.

4. CONSTRUCTIVE DELIVERY

Constructive delivery is the act of delivering the policy to the policyowner. Constructive receipt does not require delivering the policy in person.

When the insurer mails the policy to the producer for unconditional delivery, this is considered constructive delivery. If someone other than the insured receives the policy on behalf of the insured, with the insured's knowledge this is also considered constructive delivery.

5. STATEMENT OF GOOD HEALTH

If the insurance policy was submitted to underwriting without the initial premium, the producer will usually be required to collect the premium upon delivering the policy to the owner.

At this time, the insurer may require the producer to obtain a signed statement from the insured verifying the insured's continued good health since completing the application.

6. BUYER’S GUIDE

A buyer’s guide should be given to each applicant at the time of the application. This guide offers information to help consumers shop for insurance.

The guide discusses how to:

• Find a Policy That Meets Your Needs and Fits Your Budget
• Decide How Much Insurance You Need
• Make Informed Decisions When You Buy a Policy