

## CHAPTER 6 UNDERWRITING

It is important to understand all of the individuals who are involved in an insurance contract. These parties include the applicant, insured, policyowner, premium payor, and beneficiary.

Applicant—the individual who fills out the application form and applies for the policy.

Insured—the person whose life is being insured by the policy.

Policyowner—the person or entity that owns the contract and makes all decisions regarding the policy.

Premium payor—the party who pays the premiums.

Beneficiary—the party who is named by the policyowner to receive the policy proceeds upon the death of the insured.

The applicant is frequently the insured, policyowner, and premium payor. However, this is not always necessarily so. An employer might be the applicant for a policy on a key employee who would be the insured. In this case the employer would also be the policyowner and premium payor and would designate himself/herself as the beneficiary. If a person gifted a policy to a charity, he/she could continue to be the premium payor although the charity is now the owner of the policy. Obviously, there can be a number of parties involved in the insurance policy.

Underwriting is the process of examining applications, accepting or rejecting the risks, and classifying those that are acceptable in order to charge the appropriate premium. The purpose of underwriting is to spread the risk among a large pool of insureds in a way that is equitable for the insureds while still being profitable for the insurance company. Underwriting is to protect the insurer from **adverse selection**. Adverse selection is a process by which an applicant, who is uninsurable or presents a higher than average risk, attempts to obtain a policy from an insurer at standard rates. Every insurer has its own underwriting guidelines to determine what is an insurable risk and every insurer sets the premium rates that it will charge.

Agents are important in the underwriting process as they are considered to be **field underwriters**. Agents should solicit applications that represent good business from which the insurer can profit. The agent is required to submit all applications that he/she takes. The agent represents the insurer and, therefore, must protect the interest of the insurer while serving the best interest of the applicant/client. At times agents feel in conflict with underwriting. Agents wish to sell policies in order to make commissions. Underwriting wants to insure good risks and, consequently, not all applicants will be found acceptable.

Underwriting will check to make sure that insurable interest exists if the applicant and the proposed insured are two different people. Insurable interest must exist at the time of application, but it is not required at the time of the insured's death. Third-party contracts—those in which the owner and insured are different people—will be questioned by underwriting. The applicant will bear the burden of proof to show that insurable interest exists.

Preselection activities are those that take place before an application is submitted and involve the agent's role of selecting acceptable risks. All applicants must be treated equally and fairly. Discrimination on the basis of race, age, religion, gender, or sexual

preference is not allowed. Postselection underwriting activities are those that occur after an application has been submitted to underwriting for evaluation and rating.

There are a number of sources of underwriting information that underwriters can use in developing a risk profile of the applicant. The number of sources underwriting checks can vary, but usually the larger the face amount of the policy for which the insured has applied, the more comprehensive the underwriting research. Any questions raised by statements on the application that might affect insurability could trigger the use of more sources of information.

Some of the sources used in underwriting are:

- The application
- Medical examination
- Attending Physician's Statement (APS)
- Medical Information Bureau (MIB)
- Inspection Reports/Special Questionnaires
- Credit Reports
- Department of Motor Vehicle Reports (DMV)

## THE APPLICATION AND MEDICAL EXAMINATION

The application is the offer on the part of the applicant for an insurer to issue the policy. It is the primary source of information and will be reviewed thoroughly. As it is the basic source of information, it is important for the agent to make sure it is filled out completely and accurately by the applicant. The applicant must sign the application and the agent may witness the signature. The application is attached to the policy and thus becomes part of the entire contract.

There are three parts to the application consisting of Part I General Information; Part II Medical Information; and Part III Agent's Report. Part I is general information and contains the name of the proposed insured, address, date of birth, sex, questions concerning occupation and hobbies including if the applicant is a private pilot, and information regarding habits such as smoking. . The applicant also will be asked if replacement of another insurance contract is to occur, if the applicant has other insurance applications pending, and if the applicant presently has other insurance in force. This first part will also include the name of the beneficiary.

Part II is the medical information section. The face amount of the policy for which the insured is applying will dictate whether a medical examination is required. Companies will have their own standards, but many companies will not require a medical examination if the policy has a small face amount, e.g. \$50,000 or \$100,000. However, the medical information section always is required. The proposed insured is asked his/her height and weight and a whole series of questions regarding physical conditions for which the applicant may have been receiving treatment or may have been diagnosed as having one of these conditions. There are questions regarding family members—parents and siblings—as to whether they are living or, if deceased, the age at death and cause of death.

Policies that do not require a medical examination are referred to as **non-medical applications**. The underwriter reviews the information given in Part II. If there is any uncertainty regarding the applicant's insurability, the underwriter may request the applicant take a physical examination.

On large policies a medical examination will be required. The cost of the medical examination is borne by the insurance company. Companies frequently will have medical personnel come to the proposed insured's home or office. There will be a medical questionnaire, blood pressure reading, blood test, and urine specimen. Some companies may require an electrocardiogram and chest X-ray.

Part III is the agent's report. This will contain the agent's observations and knowledge about the proposed insured. As the agent represents the insurer, it is important for the agent to disclose all material information regarding the proposed insured's insurability. This section includes information regarding the applicant's financial condition, character, and habits. The agent must state whether replacement of another insurance policy is involved.

#### ATTENDING PHYSICIAN'S STATEMENT

The underwriter may wish to request additional information from the applicant's physician. This is to obtain more specific details regarding a medical problem including test results, treatment of injury or illness, hospitalization, and any treatment recommended but not yet received.

#### MEDICAL INFORMATION BUREAU (MIB)

The Medical Information Bureau is a non-profit organization supported by member insurance companies. It has approximately 700 member companies that represent most of the life and health companies transacting insurance in the U.S.A. The member companies have agreed to report information to this bureau if an applicant for insurance has been found uninsurable or has been special rated. The purpose of the MIB is to protect the member insurance companies against fraud on the part of applicants. The insurer who receives a report from the MIB will compare this information with information provided by the applicant in the application. If the information in the report and application are not consistent, the insurer will seek further information. The MIB does not have information on the majority of applicants for life and health insurance as the only reason it would have information is if someone applied for insurance and was found to have a condition significant to health or longevity. Some of the conditions that can be reported include height and weight, blood pressure, EKG readings and x-rays. Some non-medical information that can be contained in the report includes hazardous hobbies and a bad driving record. Member companies do not report information as to claims made on life, health, and disability insurance.

Applicants must be informed in writing that the insurer may report health information to the MIB. Information is shared only with other member companies. Applicants will have to sign an authorization form allowing for this sharing of information. An individual can request a report from the MIB to see if there is any such information. A one-page request form will need to be completed. Medical information will be disclosed only to the applicant's physician who is in a better position to evaluate the medical facts. The applicant has a right to request incorrect information be corrected. Insurance companies are not supposed to deny coverage based solely on information obtained from an MIB report. Obviously it could be a substantiating factor in finding a risk unacceptable.

An individual may contact the MIB at the following address:

Medical Information Bureau  
P.O. Box 105, Essex Station  
Boston, MA 02112  
(617) 426-3660  
HYPERLINK "http://www.mib.com" [www.mib.com](http://www.mib.com)

## INSPECTION REPORTS/SPECIAL QUESTIONNAIRES

Large policies may involve an inspection report from an independent investigating firm that collects more data regarding the applicant's mode of living, reputation, financial situation, and exposure to unusual hazards. This is accomplished through interviews with neighbors, fellow employees, and associates in order to establish a more comprehensive character profile of the applicant. The applicant must be notified in advance of the investigation.

Insurance companies may request the completion of special questionnaires regarding the proposed insured's work and hobbies. If an individual has a hazardous job or participates in hazardous hobbies, mortality and morbidity rates increase. This normally results in being rated as a substandard risk and in paying higher premiums.

## CREDIT REPORTS

Insurance companies may check an applicant's retail credit report. Poor credit risks are more likely to allow a policy to lapse. It costs the insurance company money to issue a contract and it takes several years for a company to recover its costs. Consequently, underwriting may turn down a poor credit risk or a situation in which it appears that an applicant is applying for more insurance than he/she can afford.

## DEPARTMENT OF MOTOR VEHICLES REPORTS

The insurance company may request a Department of Motor Vehicles report on an applicant. In Part I of the application, an applicant is asked if he/she has had moving violations. An individual who drives carelessly represents a morale hazard as this person is at greater risk of being hurt or killed in an auto accident.

## THE FAIR CREDIT REPORTING ACT OF 1970

The Fair Credit Act of 1970 applies to financial institutions, including insurance companies, that request inspection and credit reports. Some of the more salient points of this act include:

The right to be notified in writing that a report has been requested. The applicant must be notified that he/she can request disclosure of the scope and nature of the investigation.

The right to receive the names of all people contacted by the credit bureau.

The right to be told the name and address of the credit reporting agency if insurance/credit was denied on the basis of the information in the report.

The right of the applicant to receive from the consumer reporting agency, not the insurer, disclosure of the information in the report. The Fair Credit Act does not require that the reporting agency give the consumer the actual file, but must disclose the nature and substance of the report.

The right to dispute incorrect information in the file. The credit agency must reinvestigate the disputed matter. If the disputed information is not accurate or cannot be verified, it must be deleted. If the problem is not settled after reinvestigation, the consumer may file a statement of no more than 100 words regarding the matter.

It is a good idea to check credit reports for inaccuracies yearly. Under the Fair and Accurate Credit Transactions Act, everyone is entitled to a free credit report annually from each of the three main credit bureaus. The free credit report does not come with a person's credit score. The fee to receive the credit score is approximately \$6 apiece from each credit bureau. Following are the addresses and phone numbers of these three bureaus.

Equifax  
P.O. Box 105873  
Atlanta, GA 30348  
1-800-685-1111 or [www.equifax.com](http://www.equifax.com)

Experian  
P.O. Box 2104  
Allen, TX 75013-2104  
1-888-397-3742 or [www.experian.com](http://www.experian.com)

Trans Union  
P.O. Box 390  
Springfield, PA 19064-0390  
1-800-888-4213 or [www.transunion.com](http://www.transunion.com)

#### THE PRIVACY ACT OF 1974

This act was passed as there are many agencies collecting personal information. Consequently, guidelines needed to be established to protect the public from inaccurate and misused information. Insurance companies are one of the largest collectors of personal information. The three goals of the act are to (1) minimize intrusiveness, (2) be fair and impartial in collecting and analyzing information, and (3) allowing the public to know that personal information should be handled in confidence.

People applying for insurance must be given advanced written notice of the insurance company's practices regarding collection and use of personal information. The notice must include the people with access to personal information, sources of information, the kind of information collected, any information the company can receive without the applicant's prior approval, and persons to whom information may be released without the applicant's prior approval.

The disclosure forms used by insurers are required by law to be approved by the

insurance commissioner. These forms contain the type of persons authorized to disclose information (e.g. friends and neighbors), the sort of information that may be disclosed (e.g. work habits, personal habits), the reason why the information is being collected and how the information will be used. The applicant will have to sign the disclosure authorization giving the insurer the permission to gather the data.

## ISSUES RELATING TO HIV/AIDS

Acquired Immune Deficiency Syndrome (AIDS) has had a great impact on the insurance industry resulting in increased medical expenses for health insurers and increased premature death claims for life insurers. Most large life insurance applications will require an applicant to take an HIV test. The applicant must sign a separate disclosure form to allow for this testing. The disclosure form addresses the meaning of the test results, the procedure for notifying the applicant of the results, and the persons to whom the results may be released. Insurers may not consider the applicant's marital status or suspected sexual orientation in determining whether an HIV test is required. No policy shall limit benefits payable if a loss is caused or contributed to by AIDS. In order to prevent discrimination, the only criteria that an insurer can use in deciding if an HIV test is needed is the face amount of insurance for which the applicant is applying. (CIC 799)

## GENETIC TESTING

Insurers cannot engage in unfair discrimination among individuals of the same class in the underwriting of life or disability income insurance on the basis of a person's genetic characteristics. Written informed consent by the applicant is needed. The consent will include a description of the test, including its purpose, potential uses, and limitations, the meaning of its results, procedure for notifying the applicant of the results, and the right to confidential treatment of the results. No life or disability income insurer shall require a genetic characteristic test if the results of the test would be used exclusively or non-exclusively for the purpose of determining eligibility for hospital, medical, or surgical insurance coverage or eligibility for coverage under a non-profit hospital service plan or health care service plan. No policy shall limit benefits otherwise payable if loss is caused or contributed to by the presence or absence of genetic characteristics.

There are civil penalties for disclosing genetic information that range from \$1,000 to \$10,000 and possible imprisonment depending on whether the disclosure was negligent or willful and whether or not the disclosure resulted in economic, bodily, or emotional harm to the subject of the test. (CIC 10146-10149.1)

## RATING RISKS

After underwriting has gathered all the necessary information on an applicant and evaluated it, a determination of whether or not the risk is acceptable to the insurer is made. If it is decided that the risk is too great for the insurer, the application will be denied, the applicant will be notified of the rejection, and any premium submitted with the application will be returned. However, most applicants for life insurance will fall within the insurers' guidelines. Acceptable risk include:

- Preferred risks
- Standard risks
- Substandard risks

A standard risk is one that falls within the company's guidelines without requiring additional charges or special restrictions.

A preferred risk is one that presents a less than average risk for the insurer. In order to be a preferred risk, the applicant must be in excellent health, exercise routinely, not engage in hazardous hobbies or occupations, does not smoke, and meets certain weight limitations. A person rated as a preferred risk will have lower premium payments.

A substandard risk presents a greater than average risk for the insurer. An applicant could be rated substandard based on physical condition, health history, hazardous occupation, or hazardous hobbies. A higher than normal premium will have to be paid by a substandard risk. Methods for obtaining the higher premium include extra percentage tables, permanent flat extra premium, temporary flat extra premium, rated-up age, and graded death benefit.

The **extra percentage table** is the method used most frequently today. Each insurer will determine its own tables. Essentially, the company assigns numerical ratings to various conditions. These rating then are applied to the premiums charged. If an applicant had a condition with a 150 percent rating, his/her premium would be 150 percent of the standard premium. These extra percentages can go up to 500 percent of the standard premium.

A **permanent flat extra premium** can be charged for the length of the policy. This extra premium is a certain number of dollars per thousand dollars of insurance coverage. This additional charge has no effect on the growth of cash values in the policy. The extra premium can be removed if the insured's condition improves to a point that the added risk to the insurer is eliminated.

A **temporary flat extra premium** is like the permanent flat extra premium except this extra charge lasts for a fixed number of years or until the condition changes.

With the **rated-up age** approach, the insurer charges a premium based on an older age than the applicant really is. This results in a higher premium. This method is less common today.

Using the **graded death benefit** approach, the insured pays a standard premium for a life policy but the face amount of the policy issued is less than it would be if the insured were a standard risk. The insured might be paying the premium for a \$25,000 life policy, but the policy issued has a face amount of \$20,000. The insurer may increase the amount of insurance periodically and, if the substandard condition ceases, the full face amount of the policy can be granted.

## RECEIPTS

When an applicant for insurance pays a premium payment to the agent, the agent will give the applicant a premium receipt. The two major types of receipts are conditional and binding. The type of receipt given will determine when and under what conditions the insurance will go into effect.

The agent should ask for the premium payment at the time of application. This can be indicative of the applicant's serious intentions and act to solidify the sale. The agent should explain to the applicant that there is no contract without consideration. The

consideration in insurance is the initial premium and the application. The benefit to the applicant is that if he/she is found to be an insurable risk, the insurance policy will go into effect sooner.

### Conditional Receipt

If the applicant gives the agent the initial premium at the time of application, the agent may give the applicant a conditional receipt. Before the policy becomes effective a condition needs to be satisfied. This condition can be the insurer finding the applicant to be an insurable risk. If the policy requires a medical examination, the applicant will have to take the examination to determine insurability. If the applicant is found to be insurable, the effective date of the policy will either be the application date or the date of the medical exam.

It could happen that underwriting finds the applicant to be insurable but only as a substandard risk. In this case, there is no contract. The applicant would have to accept the substandard policy and pay the additional premium required of a substandard risk in order to have a valid contract.

Situations like the following should be considered. A person applying for a non-medical type policy has filled out the application, paid the initial premium, and received a conditional insurability receipt. If this person were killed in an auto accident before the policy is issued, the beneficiary would receive the policy proceeds as long as the applicant qualified for the policy. On the other hand, if the applicant did not qualify for the policy, the benefit would not be paid. Of course, the premium would be returned.

### Binding Receipt

A binding receipt gives the applicant insurance coverage from the date of application as long as a premium payment has been made. The applicant has coverage for a specified number of days (usually 30 to 60 days) or until the insurer issues the policy, rejects the application, or offers to insure on another basis (substandard risk). Normally there is a maximum amount of insurance coverage offered under a binding receipt (e.g. \$100,000). These types of receipts are used rarely due to the liability it poses to the insurer. As underwriting can require a number of weeks to complete, it is possible that the applicant could die during this process. The insurance company would have to pay a death benefit to the beneficiary.

### Temporary Insurance Agreement

The temporary insurance agreement provides the applicant with term insurance immediately and is in effect during the underwriting period. The death benefit of the temporary term coverage will be paid to the beneficiary if the applicant dies during the underwriting process whether or not the applicant is found to be insurable.

### Preliminary or Interim Term Coverage

Occasionally an applicant might want to have insurance protection but might desire for a permanent policy to take effect at a later date. In this case preliminary or interim term coverage can be used to provide the applicant insurance coverage. Depending on the insurer, the effective date of the primary policy can be deferred from 1 to 11 months. As this interim coverage is term insurance, the premium will be lower than on the primary



policy. The premium on the primary policy will be based on the applicant's age when the primary insurance takes effect.

### Policy Issue and Delivery

The best manner in which to deliver a policy is having the agent deliver it to the policyowner. When the agent hands the policy to the policyowner, it is called *actual delivery*. The agent can review the policy, its provisions, riders, and exclusions with the policyowner. This personal contact helps to reinforce the sale and to build the policyowner's confidence in the agent. This, of course, may lead to referrals and future sales.

If the applicant did not pay the premium at the time of application, the agent will need to collect it at the time of policy delivery. It is common in these cases that the agent also will have to have the insured sign a statement attesting to his/her continued good health.

*Constructive delivery* takes place when the insurer relinquishes control of the policy and turns it over to someone acting for the policyowner, including the agent. Mailing also constitutes constructive delivery.

### Effective Date of Policy

When a policy is delivered, the delivery date is not the effective date of the policy. The effective date normally is the date of the application for the insurance policy. With some companies the effective date may be the date of the medical examination on policies requiring a medical examination.

The effective date of the policy is important as this starts the two years in which the policy is contestable. It also is of relevance regarding the suicide clause as death by suicide is an exclusion during the first two years a policy is in effect.

### PREMIUM DETERMINATION

An insurance company's actuaries are responsible for determining what would be an appropriate premium to cover a given risk. Premiums need to be high enough to cover a company's operating expenses and to have enough funds to pay claims. Premiums also need to be affordable and competitive with other companies. Rates are stated as an annual dollar amount per \$1,000 of insurance coverage. If the rate is \$10, it means \$10 for every \$1,000 of insurance coverage per year. The three factors that determine a life insurance rate are:

- Mortality
- Interest
- Expenses (Loading)

### Mortality

Mortality tables predict the average number of deaths that will occur each year in each age group. The death rate is expressed as number of deaths per 1000 people every year until age 100. The mortality tables assume that everyone is dead at age 100. In

order to develop such tables a large cross-section of people had to be monitored over a large cross-section of time. Some companies may use the 1980 Commissioner's Standard Ordinary (CSO) Mortality Table while many large companies have developed their own tables. These tables predict life expectation (number of years of life remaining) and the probability of death (number of deaths at a certain age). This mortality factor is the cost of providing the death protection. Without such statistics, it would be impossible to determine an adequate premium to charge.

## Interest

Premiums are paid in advance and insurance companies invest the money to earn interest. An assumption is made that premium payments will be made annually at the beginning of the year. It also is assumed that a conservative specific net rate of interest will be earned. The interest earned helps to reduce the cost of insurance.

## Expenses (Loading Charge)

Insurance companies have operating expenses and every premium must include its share of these costs. Loading consists of acquisition costs (issuance of policies, commissions, etc.), general overhead (rent, supplies, clerical and management salaries, etc.), contingency funds (reserves), and payment of death claims. Companies frequently cede part of large risks to other carriers. Conversely, they accept some part of risks insured by other carriers. This is reinsurance, and companies need to have the needed reserves to cover any reinsurance obligations. This is another component that comes into consideration when establishing adequate premiums.

The gross annual premium is the amount the policyowner pays for the insurance coverage. The net premium simply consists of mortality costs minus the interest element.

$$\text{Net Premium} = \text{Mortality} - \text{Interest}$$

$$\text{Gross Premiums} = \text{Mortality} - \text{Interest} + \text{Expenses}$$

## Premium Mode

As noted in an earlier chapter, the frequency of premium payment affects the cost of insurance. The least expensive way to pay is annually as this is how actuaries assume the premium will be paid. If more frequent payments are made, such as quarterly payments, the company will have less money to invest to earn interest and administrative costs will be increased due to more frequent billings. Consequently, the policyowner will have to pay more and this will increase his/her annual outlay for the cost of insurance.

## OTHER PREMIUM FACTORS

In underwriting an individual life insurance policy, other factors will play a role. These include age, sex, health, occupation, hobbies, and habits. Obviously, as an individual ages, his/her life expectancy decreases and life insurance rates will need to be raised correspondingly. Sex may affect rates as women tend to live longer than men by five or six years making their rates lower. However, some insurance companies use unisex tables and charge men and women the same rates.

Health of an applicant is of primary consideration. A person in poor physical condition represents a greater risk to the company. The relationship of height to weight is

important as overweight people are more subject to heart disease and other problems.

If an individual is engaged in a hazardous occupation, he/she is at a greater risk of being killed or disabled than an individual in a non-hazardous job. This also applies if a person participates in dangerous avocations (hobbies). Someone who sky dives and mountain climbs is more of a risk to an insurance company than someone whose hobby is fast walking. People with hazardous occupations and hobbies normally will be rated as substandard risks.

Habits are considered in establishing premiums. Smoking, consumption of alcohol, and over-eating can adversely affect health and longevity.

## LIFE INSURANCE POLICY COST COMPARISON METHODS

There are two cost comparison indices that may be used to compare the costs of two similar policies from different companies. Of course, such indices do not reflect the strength or reputation of a company, the services and integrity of the agent, or small differences in policies. These two methods are the traditional net cost and interest adjusted net cost.

With the traditional net cost method, the projected premiums for a given period of time (e.g. 10 or 20 years) are totaled. The cash value at the end of the period and the projected dividends (if a participating policy) are subtracted from the total of premiums paid. This number is then divided by the number of years in the comparison. This yields the net cost per thousand per year.

The traditional net cost method ignores the time value of money. Money placed in investments will earn interest. As different companies will apply different interest rates to their policies, this method does not project the real cost of a policy.

The interest adjusted net cost method is similar to the traditional net cost method except it adds the extra component of interest to the formula. The interest factor is based on each company's projected interest rate. The total of dividends and cash values at the end of a given period of time (e.g. 10 or 20 years) is divided by the interest rate factor. This answer is subtracted from the annual premium. This method of comparison more accurately reflects the actual cost of a policy.

## RESERVES

When a company issues a life insurance policy, it is promising to pay a certain amount of money at a future date when the insured dies. In exchange for this promise, the policyowner must pay premiums. A portion of every premium must be set aside as a reserve against the future claim from the policy as well as other obligations such as non-forfeiture options. Reserves represent liabilities that an insurer has to its policyowners. The reserve is an amount together with interest earned and premiums paid that will equal the company's contractual obligations. To make sure that a company is solvent, the insurance commissioner will check reserves of companies operating in the state. The reserve must be computed using the mortality table and assumed interest rate specified by the commissioner. Therefore, the commissioner is legally requiring that a certain reserve be maintained by each company. This legal reserve is the amount required to pay future claims.