

Small Business Package

INSURANCE TRAINING
INSTITUTE, Inc.

ITI – A Family Owned Business
Providing Continuing Education
To New York Insurance
Professionals
Since 1996

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The Insurance Training Institute (ITI) is licensed by the NYS Insurance Department to provide Continuing Education Courses throughout New York State. Our students can be assured that the courses offered by ITI meet the requirements of the New York State Insurance Law and the guidelines established by the NYS Insurance Department. Our Courses also meet the reciprocity requirements of most other states for your Non-Resident Licenses.

ITI provides its students with a broad range of up-to-date courses to meet their individual professional education needs. ITI is firmly committed to the belief that a classroom setting, with instructors who are among the best trained and qualified insurance professionals in our industry today, provides individual students with the greatest opportunity to learn. A consistent schedule of statewide public classes is our promise to you. As a convenience to larger agencies and groups, private classes are also conducted by special arrangement.

While ITI's primary goal is to meet your individual training needs, we are a family owned business with a strong focus on improving the level of professionalism and the public image of the insurance industry as a whole. Each of our instructors brings with them their individual industry experiences for the benefit of their students. With more than 39 years of experience in the industry, I personally offer my experiences as a licensee and then an employee of the Executive Branch of the NYS Insurance Department, (assigned to the Licensing Bureau) for each student to call upon. Since opening in 1996, ITI has supported thousands of individuals and agencies with their licensing questions and problems. Today, ITI continues to provide the same level of individualized support that our students have come to rely on.

I, along with the dedicated staff at ITI look forward to the opportunity to once again be your provider of quality continuing education services in New York.

Thank you for your time and consideration;

Robert Secovnie, Director
Insurance Training Institute, Inc. (ITI)
A family owned and operated business

Pre-Licensing & Continuing Education for Life/Health Insurance Agents Continuing Education for P&C Agents, Brokers & Adjusters SBLI Certificates

Course Introduction

The Small Business Package

With increasing specification within the insurance profession and continuous changes to product offerings through market cycles and regulatory actions, it is increasingly difficult for the individual and small business consumer to find a single source to counsel them on the purchase of a complete business insurance package.

This course is designed to introduce the insurance producer to each of the main insurance products a business owner may need. After completing this course, a producer will be prepared to discuss the products most commonly offered to businesses for their property casualty coverage needs, employee benefits packages and executive compensation packages.

Insurance professionals who are “Cross-Licensed” to sell both Property Casualty and Life/Accident & Health products will be better prepared to assist their clients with purchasing decisions, whether those insurance products are sold under one roof or through referrals to outside agencies with greater product knowledge and market access.

The coverage options described in this course are not intended to illustrate a preferred insurance program. As licensed insurance producers, you are encouraged to discuss your client’s specific needs with company underwriters and your clients to determine the coverages that best meet their individual needs.

The Commercial Marketplace

Agency and Brokerage

Too often in our industry, the role of an “insurance producer” is reduced to sales clerk whose primary purpose is to process a sale at the request of a customer. Seldom are the nuances of agency and broker relationships explained to insurance consumers.

While fiduciary responsibility is not specifically referenced in New York State Insurance Law, the common practice guidelines provide a strong framework for insurance producers to follow:

*A **fiduciary** is expected to be extremely loyal to the person they owe the duty (the "principal")*

New York State Law, section 2101, provides the following definition of insurance agent and broker

"insurance agent" means any authorized or acknowledged agent of an insurer... who acts as such in the solicitation of, negotiation for, or sale of, an insurance, health maintenance organization or annuity contract,

"insurance broker" means any person, firm, association or corporation who or which for any compensation, commission or other thing of value acts or aids in any manner in soliciting, negotiating or selling, any insurance or annuity contract or in placing risks or taking out insurance, on behalf of an insured other than himself, herself or itself or on behalf of any licensed insurance broker, except that such term shall not include:

A layman explanation of Fiduciary Responsibility for insurance producers can be reduced to the following statements:

An insurance agent is the direct representative of the insurance carrier, with the ability to bind coverage directly.

An insurance broker is the direct representative of the insurance consumer, assuming the responsibility of securing the best insurance coverage available to the broker.

These distinctions can have significant impact on the ability of an insurance producers' ability provide timely policy service to their client.

Section 1.3

Market Availability and Access

Changing economic cycles often have an impact on the availability of products from insurance companies, or markets, as their willingness to accept insurance risks is, to certain degrees, dependent of market conditions. Loss experience and competition between insurers also have impact upon product availability and price. Specific State Laws and Regulations may also have an impact on the willingness of carriers to accept risks and the limitations that are placed on coverage, if it is made available.

Insurance agents are directly limited in their ability to secure coverage by their relationships with carriers, while brokers have an ability to look to alternative markets on their customers' behalf. Insurance brokers should understand the important distinction between Admitted and Non-Admitted insurance companies when placing business.

An **admitted insurance company** is one that has applied for authority to conduct business within a state. In addition, it will comply with all of the dictates of that state including maintaining sufficient reserves, subjecting its self to tax laws, and abiding by the mandates of that state's Insurance Department regulations. That state will issue an officials accreditation - known as a Certificate of Authority – to the admitted insurance company.

A **non-admitted insurance company** must comply with the basic operating mandates of the state in which it does business, but does not seek Certification of Authority. It may want to solicit only certain classes of business but does not want to comply with the regulations of the state relating to maintaining reserves, residency, and tax regulations of the state.

Both admitted and non-admitted carriers are authorized to conduct business in a state. The terms authorized and unauthorized can be confusing. Both can conduct business in the state. The term unauthorized means that the insurance carrier possesses no authorized Certificate of Authority and thereby has not fully subjected itself to the full regulatory authority of the state.

An admitted insurance company, or Standard Market, offers the highest level of security to insurance consumer. The willingness of the admitted market to comply with state regulations provides the regulatory agency with an ability to intercede on behalf of the consumer in disputes between the parties.

Section 1.4

Excess and Surplus Market

When an admitted market is unavailable to an insurance producer, only a broker may pursue a non-admitted market, or Excess and Surplus Lines market. Lloyds of London is Excess and Surplus business is regulated in New York State by the **Excess Lines Association of New York, ELANY**. Specific regulations are in place covering the placement of every individual account. Most important of these regulations is the requirement for a "Total Cost Form" disclosure to be presented to the consumer. The Total Cost Form itemizes the individual charges to be paid, including policy premium, separate tax charges, policy fees and inspection fees.

NOTICE OF EXCESS LINE PLACEMENT

Date:

Consistent with the requirements of New York Insurance Law and Regulation 41 _____ is hereby advised that after a diligent effort to place the required insurance with companies authorized in New York to write coverages of the kind requested, all or a portion of the required coverages have been placed by _____ with insurers not authorized to do an insurance business in New York and which are not subject to supervision by this State. Policies issued by such unauthorized insurers may not be subject to all of the regulations of the Superintendent of Insurance pertaining to policy forms. In the event of insolvency of the unauthorized insurers, losses will not be covered by any New York State Insolvency Fund.

TOTAL COST FORM

In consideration of your placing my insurance as described in the policy referenced below, I agree to pay the total cost below which includes all premiums, inspection charges(**) and a service fee that includes taxes, stamping fees, and (if indicated) a fee(**) for compensation in addition to commissions received, and other expenses(**).

I further understand and agree that all fees, inspection charges and other expenses denoted by (**) are fully earned from the inception date of the policy and are non-refundable regardless of whether said policy is cancelled. Any policy changes which generate additional premium are subject to additional tax and stamping fee charges. *Where a portion of the risk is located outside the state of New York, taxes and stamping fees are only charged against the premium allocated to the New York portion of the risk.

Re: Policy No.

Insurer

Policy Premium		\$
New York Allocated Premium (where applicable)	\$	
Service Fee Charges:		
Excess Line Tax (3.60%) (*)		\$
Stamping Fee (*)		\$
Broker Fee (**)		\$
Inspection Fee (**)		
Other Expenses (specify)(**)		\$
	Total Policy Cost	\$

(Signature of Insured)



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
ONE COMMERCE PLAZA
ALBANY, NEW YORK 12257

The Office of General Counsel issued the following opinion on March 13, 2006 representing the position of the New York State Insurance Department.

RE: Excess Line Placement.

Question Presented:

If an excess line broker has obtained a quote from a authorized insurer for a liability policy that contains a defense within limits offset provision and a quote from an eligible excess line insurer for a liability policy with unlimited defense outside the liability limit, may the excess line broker place the policy with the excess line insurer if the excess line broker has also received three declinations from other authorized insurers?

Conclusion:

Yes, an excess line broker that has obtained a quote from a authorized insurer for a liability policy that contains a defense within limits offset provision and a quote from an eligible excess line insurer for a liability policy with unlimited defense outside the liability limit, may place the policy with the excess line insurer where the excess line broker has also received three declinations from other authorized insurers.

Facts:

No facts were provided. The inquirer requested further clarification of Opinion of General Counsel No. 05-12-14 (December 19, 2005) and has asked a question that is different from the question analyzed in that opinion.

Analysis:

An excess line broker placing business with an unauthorized insurer must comply with the provisions of N.Y. Ins. Law § 2118 (McKinney Supp. 2005) and N.Y. Comp. R. & Regs. tit. 11 Part 27 (Regulation 41) which require, *inter alia*, that a diligent effort be made to procure insurance from an authorized insurer and permit placement with an unauthorized insurer only when coverage can not be procured from the authorized insurer market and only to the extent it is in excess of any insurance available in the authorized market.

N.Y. Ins. Law § 2118(b)(3)(A) (McKinney Supp. 2005) provides, in relevant part, as follows:

The submission of insurance documents to the excess line association shall be accompanied by a statement subscribed to, and affirmed by, the licensee or sublicensee as true under the penalties of perjury that, *after diligent effort, the full amount of insurance required could not be*

procured, from authorized insurers, each of which is authorized to write insurance of the kind requested and which the licensee has reason to believe might consider writing the type of coverage or class of insurance involved, and further showing that the amount of insurance procured from an unauthorized insurer is only the excess over the amount procurable from an authorized insurer . . . (emphasis added)

N.Y. Ins. Law § 2118(b)(4) (McKinney Supp. 2005) provides, in relevant part, as follows:

The number of declinations constituting diligent effort in regard to placement of coverage with authorized insurers for purposes of paragraph three of this subsection shall be three . .

In Opinion of General Counsel No. 91-25 (NILS March 7, 1991), the Department stated, in relevant part, as follows:

Where the policy provides a broad range of coverages, such as a special multi-peril policy, the package policy may be placed with an unauthorized insurer if the coverages cannot be placed separately or as a package with an authorized insurer . . . or if the coverages not available from an authorized insurer . . . cannot be placed separately in the unauthorized market.

There are three caveats. First, the components must have some appropriate relationship to each other. One cannot tie some exotic risk to an unrelated commonplace exposure to obtain coverage in the unauthorized market. Second, the additional coverage must be material, covering a substantial, and not illusory exposure. Third, the coverages offered by the unauthorized insurer must not be illegal and must comply with appropriate statutory and regulatory requirements.

The exception described in Opinion of General Counsel No. 91-25 (NILS March 7, 1991) is clearly applicable to the circumstances that the inquirer described in his question where the broker was unable to procure a liability policy with unlimited defense costs coverage since the defense cost coverage is not permitted as a separate policy in either the authorized or excess line markets. All other things being equal, the coverage available in the unauthorized market providing for unlimited defense costs outside the liability limit of the policy would provide the insured with more coverage than the policy available in the authorized market that contains a defense within limits offset provision and is, therefore, superior coverage.

Thus, an excess line broker that has obtained a quote from a authorized insurer for a liability policy that contains a defense within limits offset provision and a quote from an eligible excess line insurer for a liability policy with unlimited defense outside the liability limit, may place the policy with the excess line insurer where the excess line broker has also received three declinations from other authorized insurers.

For further information you may contact Assistant Counsel Brenda M. Gibbs at the Albany Office.

Risk Retention Groups, Purchasing Groups and Trusts

In addition to traditional markets authorized for a class of business, specifically designed insurance companies have also been established that differ from standard admitted or non-admitted carriers.

Risk Retention Groups

Risk Retention Groups (RRG) are federally authorized under the Liability Risk Retention Act of 1986 (which specifically preempts contrary state laws) to assume liability exposure for a particular class or group. RRGs must be licensed under the laws of at least one state, maintain a minimum premium volume, and subject itself to the regulations of the state in which it conducts business. As of November 2006, 238 RRGs were operating nationwide.

Purchasing Groups

Purchasing Groups are also federally authorized under the Liability Risk Retention Act of 1986 (which specifically preempts contrary state laws). Unlike Risk Retention Groups, Purchasing Groups do not provide individual customers with their own specific policy, but provide coverage under a single policy issued to a homogenous group. Typically, an insurance customer will join an association or other professional entity prior to gaining access to a purchasing group.

Group Self Insured Trusts

In New York State, an alternative mechanism for workers compensation, exist through Group Self-Insured Trusts. Group Self-Insured Trusts are homogenous to specific industry classes and made up of member companies. Members contribute premiums to provide coverage to employees of member companies and agree to cover any shortfall when they assume, at time of application, joint and several liability. Membership in a Trust does not terminate upon an individuals exit from that trust. Members may be assessed additional premiums for losses incurred during their membership at any future date and can be held both jointly and individually liable for claims of fellow trust members.

Insurance producers should note that The New York Workers' Compensation Board Group Self-Insured Trusts Summary of Funding Status, dated October 22, 2004 indicated that 26 of the 64 New York trusts listed in the report were deemed under funded. Placement of risks in a Self-Insured Trust should be done with full disclosure of the potential future liability to the prospective member.

ISO Form vs. Carrier Specific Forms

Insurance Services Office, Inc., (ISO) an independent organization providing support to the insurance industry since 1971, has developed standard forms for different classes of business from homeowners and private passenger auto to commercial property and liability. Due to the complexity of developing insurance policies, many carriers opt to utilize the widely accepted standard ISO form.

ISO forms undergo constant review and updates are periodically published. Insurance producers should be careful to refer to the specific issue date of the form used by the issuing carrier, as updates may not necessarily have yet been introduced.

The numbering given the forms and endorsements offered by ISO for the Business owners Program (BOP) is very specific in its meaning. The sequence uses 10 digits:

- The first two digits are letters that represent the line of insurance, such as BP for Business owners policy forms or IL for Interline forms.
- The next two digits represent the category of insurance outlined in further detail below.
- The next two digits are the item or form number within the category.
- The last four digits represent the edition date month and year of the form. For simplicity, and because edition dates change frequently, this analysis does not include this information.

Many carriers continue to issue policies with proprietary language. Proprietary forms may enable a carrier to provide coverage specifically tailored to an underwriting philosophy or customer need.

Commercial Property and Commercial General Liability Policy

Section I – Property Protection

As with a personal lines homeowners policy, the commercial property policy covers buildings and structures and business personal property. Extensions of coverage may be automatically included by a carrier or offered through an endorsement.

Also paralleling the personal lines policy coverage for buildings, commercial property coverage is offered in basic, broad and special coverage forms.

Basic Form Coverage

This coverage protects your business against these perils (cause of loss):

- Fire, plus extended coverage, consisting of:
- Lightning
- Explosion
- Windstorm or hail
- Smoke
- Aircraft or vehicles
- Riot or civil commotion
- Vandalism
- Sprinkler leakage
- Sinkhole collapse
- Volcanic action

Broad Form Coverage - includes basic fire and extended coverages listed above plus:

- Breakage of glass
- Falling objects
- Weight of snow, ice or sleet
- Water damage (accidental discharge as a direct result of broken water system)

Special Form Coverage - includes basic form, plus broad form coverage plus:

- This form covers any other loss, unless the peril is specifically excluded, such as flood, earthquake, war, nuclear accident, etc. Check you policy for a complete listing of perils excluded.

Where the commercial property coverage policy differs from personal lines is in the **co-insurance** on the property covered. Co-insurance on commercial property is not the agreement that carriers will share a loss on a specific risk, as it typically is understood with our health insurance policies or with reinsurance arrangements between carriers. Co-insurance on commercial property is the agreement that property is insured to value as stated in the policy. Failure of the insured to maintain insurance to current value can result in reduced responsibility on the part of the carrier to pay following a loss. Using an accepted property valuation method

becomes increasingly important when insuring commercial property for full, or near full replacement value.

Insurance of commercial property typically is written with either Actual Cash Value or Stated Value on a building or with Coinsurance between 80% and 100%.

Consider the following:

Acme Manufacturing insures a building with 80% coinsurance and a value of \$100,000. The policy has a deductible of \$1000.

- The property sustains a \$50,000 loss
- ACME assumes that their contribution will be their \$1000 deductible and the Carrier will contribute \$49,000.
- The insurance producer assumes that ACME will be responsible for their \$1000 deductible plus 20% of the remaining \$49,000, or an additional \$9,800.
- The Carrier, following investigation, determines the property value, prior to loss, to have been \$200,000. The Carrier determines it's obligation as follows:

Current Value of Property	X	Coinsurance	=	Obligation
\$200,000	X	80%	=	\$160,000
Actual Coverage	/	Current Value	=	Responsibility
\$100,000	/	\$200,000	=	50%
Loss	X	Responsibility Less Deductible	=	Contribution

$$\$50,000 \times 50\% (\$25,000) - \$1000 = \$24,000$$

The Carrier contribution to the loss is \$24,000 and ACME's contribution is \$26,000.

Equipment Breakdown Coverage

Equipment breakdown coverage is included in many commercial property packages, however, specific care should be given to review the extent of coverage and the needs of individual clients. Higher limit needs of manufacturing clients or other industrial businesses may require additional limits or special property coverage.

Business Income Interruption

Business income interruption provides reimbursement for actual loss of income, typically for up to 12 months. Coverage may reimburse for down time and extra expenses incurred to restore business operations, such as renting equipment or securing other operation space.

Business Personal Property

Business Personal Property includes property that you own that is used in your business and property of others that is in your Care, Custody or Control. Business personal property may also cover Improvements or Betterments made to a building you occupy, Leased Property which you may be required to insure and Exterior Building Glass, if you are a tenant.

Section 2.2

Liability Protection

A **Commercial General Liability (CGL)** Policy provides coverage for the insured in the event a third party suffers an injury because of business activities of the insured. An insured's liability may be for Bodily Injury (BI), Personal Injury (PI), Advertising Injury (AI) or Property Damage (PD). Also covered under the liability section of the policy are Medical Expenses incurred for bodily injury caused by an accident regardless of negligence on the part of the insured and the obligation for the insurer to provide a defense of its policy holder against all valid suits.

CGL policies are typically written on an Occurrence Basis covering incidents that happen within the coverage period. Claims Made policies may be available covering past acts of the insured that were not reported prior to the coverage period.

The CGL policy is comprehensive in nature, covering all hazards within the scope of the insuring agreement that are not otherwise excluded. Producers should be aware that items excluded under the CGL may be as important as what is covered.

Premises and Operations

- Premises coverage exists when there is ownership or occupancy or property. Businesses entertaining customers at their location have premises exposure.
- Operations coverage exists when activity in addition to occupancy exists. Carpenters working at a customers property have operations exposure.

Products and Completed Operations

- Products hazards exist with the manufacturer or sale of a product.
- Completed Operations is a hazard the remains after a job is completed.

Advertising Injury

- Coverage for libel or slander, invasion of privacy, misappropriation of advertising ideas or style of doing business and infringement of copyright, title or slogan in the course of advertising.

Fire Legal Liability

- Provides coverage to property leased or rented to the insured.

Medical Payments

- Medical payments for persons other than the named insureds for Bodily Injury suffered on the premises, even though the insured was not negligent. The difference between Medical Payments and Premises Liability is negligence. You do not need to be held negligent for the insurance company to pay a medical claim.

Professional Liability

- Commercial General Liability policies generally exclude coverage for claims arising from the rendering or the failure to render professional services. Most professional

exposures are more appropriately covered by a Professional Liability or Errors and Omissions policy

Section 2.3

Commercial Package Policy

Like the standard Homeowners Policy, the **Commercial Package Policy (CPP)** combines Property and General Liability insurance products into one package. The CPP provides flexibility for carriers to cover a wide range of risks in one form and is generally used for larger commercial risks and those requiring an individual combination of coverages.

Business Owners Policy (BOP)

Like the Commercial Package Policy (CGL), the **Business Owners Policy (BOP)** also combines Commercial Property and General Liability insurance coverages into one convenient package. The BOP is used by carriers to expedite the underwriting and sales processes of smaller, homogenous risks. Sole proprietors, small contractors or small mercantile risks may be written on BOP forms, since each risk requires the same basic coverage and poses the same class of risk to the carrier.

A BOP covers building and contents. It will also pay to repair or replace your business property, including the items below, if they are damaged by fire or other covered loss in a building that you either own or rent.

- Inventory, equipment, stock (perishable included)
- Furniture and fixtures
- Computers
- Phone equipment
- A/C system
- Refrigeration system
- Building glass
- Money or securities on the premises or money or securities that are physically transferred to a bank
- Personal belongings at the business site
- Equipment leased or rented for business use
- Business signs
- Valuable records that have been damaged or destroyed
- Property belonging to someone else that is accidentally damaged

From what types of third party actions will my Business Owners Policy (BOP) protect me?

- Some accounts receivable may be insured if you are unable to collect outstanding balances as a result of lost or damaged account records.
- You will be protected against customers who pay with counterfeit money orders or currency.
- Your business' property will be protected while it is away from the principal business location, such as during an order delivery.
- You will be protected against business income interruption. A BOP would cover your business if something happens that causes a suspension of your business activities, such as a third party strike and/or if your business was forced to close down for an extended period of

time. Extra expenses may also be paid to keep your business going, like renting temporary office space. This coverage may be offered as optional.

- You will be protected if an employee who commits a dishonest or fraudulent act that causes the loss of money or property. This coverage may be offered as optional.

Commercial Auto

Every vehicle operated on public roads, with the exception of certain farm vehicles, must be insured. Questions often arise with business owners over the benefits of insuring vehicles through their business on a commercial auto policy, rather than on their own private passenger policy. Since the purpose of Business or Commercial insurance is the protection of the business entity and its owners, overlooking commercial auto may place a business in jeopardy.

A commercial auto policy can provide the same basic coverages as a private passenger auto (PPA) policy, but also has features not available in PPA. Arguably the most important feature of the commercial auto policy is having the business named as the insured.

Standard Coverages offered in the PPA and Business Auto Policy

- **Auto Liability**-Covers against Bodily Injury and Property Damage for which the insured may become liable.
- **Collision Coverage**- Provides coverage for loss or damage in excess of the deductible to an insured vehicle.
- **Comprehensive Coverage**- Provides coverage for your vehicle for damage other than collision.
- **Medical Payments**-Covers payment for injury to the insured and/or passengers in the insured automobile when a loss occurs.
- **Non-Owned Auto Coverage**- Covers bodily injury and property damage for your company while vehicles are used by employees for your business use.
- **Rental Car Coverage**- Includes coverage to rent a vehicle in the event of a covered loss.
- **Towing** - Covers cost to tow an insured vehicle.
- **Uninsured and Underinsured Motorist**- Pays damages for Bodily Injury caused by drivers of uninsured vehicles, when such drivers are legally liable for injury to the insured and/or passengers.

The important differences between a PPA and a Commercial Auto Policy deal with liability coverages for the business when vehicles not owned by the business are used for business purposes. Hired and Non-Owned Auto coverage may also be provided in a BOP or as an endorsement to a policy other than Commercial Auto.

- **Hired Auto Coverage**- Covers liability only, for your company while driving a leased, hired, rented, or borrowed vehicle
- **Non-Owned Physical Damage**- Covers property damage to vehicles you rent or hire for your business.

One important note for employees of businesses that provide vehicles for their business and private use is the inclusion of Drive Other Car Coverage, or Named and Non-Owned Auto Coverage.

- **Driver Other Car Coverage** - Unlike your personal auto insurance policy, business auto insurance does not cover you when you drive vehicles not owned by the business or listed on the business auto insurance policy. If you are a business owner and have your personal use vehicle insured on your business auto policy and don't have personal auto insurance, you need to add DOC Broad Form coverage to your business auto policy. With DOC you are then covered if you drive a vehicle not covered or listed on your business auto policy, such as a friend's or relative's vehicle.



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
25 BEAVER STREET
NEW YORK, NEW YORK 10004

The Office of General Counsel issued the following opinion on November 15, 2006 representing the position of the New York State Insurance Department.

Re: Personal meeting between the insurance producer and the insured

Issue

Must an insurance producer meet in person with a prospective insured before selling that person an assigned risk insurance policy over the internet?

Conclusion

Although there is no statutory requirement for an insurance agent or broker to personally meet the individual to whom an insurance policy is being sold, individual insurers may require it, and, in fact, the New York Automobile Insurance Plan, (hereinafter NYAIP), requires a producer to meet in person with the individual to whom an insurance policy is being sold.

Facts

None were provided.

Analysis

The inquirer is an insurance agent or broker, and wants to know whether he or she must meet in person with a prospective insured before selling such person an assigned risk insurance policy over the internet. Although there is no statutory requirement for an insurance agent or broker to personally meet the individual to whom an insurance policy is being sold, individual insurers may require it, and, in fact NYAIP requires a producer to meet in person with the individual to whom an insurance policy is being sold.

NYAIP states in pertinent part in Section 15(A)(1)(c):

Each application must be accompanied by a photocopy of the front side of the operator's license of the owner/applicant that is applying for insurance. . . The producer must personally compare the face and other descriptive features of the owner/applicant . . . with the photograph and descriptive information of the owner/applicant's or . . . driver's license. . . .

For further information one may contact Senior Attorney Susan Dess at the New York City Office.



**STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004**

**Circular Letter No. 2 (2005)
February 25, 2005**

TO: ALL AUTHORIZED PROPERTY/CASUALTY INSURERS, RATE SERVICE ORGANIZATIONS, NEW YORK AUTOMOBILE INSURANCE PLAN, NEW YORK PROPERTY INSURANCE UNDERWRITING ASSOCIATION, AND INSURANCE PRODUCER ORGANIZATIONS

RE: LIMITATIONS UPON AND REQUIREMENTS FOR THE USE OF CREDIT INFORMATION FOR PERSONAL LINES INSURANCE – EMERGENCY ADOPTION OF REGULATION NO. 182 (11 NYCRR 221)

STATUTORY REFERENCE: ARTICLE 28 OF THE INSURANCE LAW

This is to inform the property and casualty insurance industry that the Department has promulgated Regulation No. 182 (11 NYCRR 221) on an emergency basis.

Chapter 215 of the Laws of 2004, effective April 23, 2005, adds a new Article 28 to the Insurance Law entitled "Use of Credit Information." Article 28 establishes limitations upon, and requirements for, the permissible use of credit information to underwrite or rate risks for personal lines insurance. The purpose of Regulation No. 182 is to facilitate implementation of Article 28 by insurers doing business in New York State.

Article 28 and Regulation No. 182 apply to the use of credit information to underwrite and rate personal lines insurance policies applied for, or renewed, on and after April 23, 2005. Article 28 and the regulation provide:

- prohibitions on the use of credit information, permissible use of credit information, and the requirements for obtaining current credit information;
- standards for the disclosure of the use of credit information in the underwriting and rating of personal lines insurance policies;
- standards for notification when an insurer takes an adverse action based upon credit information; and
- requirements for the re-underwriting and re-rating of an insured when a current insured obtains a dispute resolution and error correction determination under the federal Fair Credit Reporting Act if the credit information used by the insurer was found to be incorrect or incomplete.

Regulation No. 182 requires that the insurer include in its disclosure notices a toll-free telephone number. The toll-free number should be answered by, or directed to, the division or department that is staffed by persons handling inquiries regarding the use of credit information by the insurer. A toll-free number with the appropriate telephone extension number for the applicable division or department is also acceptable.

Regulation No. 182 specifies requirements for filing the scoring model (or other scoring processes), including revisions thereto, with the Superintendent. Scoring models (or other scoring processes) in use as of April 23, 2005 and those that insurers start using after April 23, 2005 but prior to August 15, 2005, should be filed with the Superintendent as soon as possible but no later than July 1, 2005. With respect to a scoring model that an insurer intends to start using on or after August 15, 2005, the insurer shall file its scoring model (or other scoring processes) with the Superintendent at least 45 days prior to use. Summaries of revisions to previously filed scoring models (or other scoring processes) shall be filed no later than 45 days after its use, but insurers are strongly encouraged to file the summaries prior to use.

The regulation also requires that insurers complete and submit an Insurer Credit Information Compliance Certification in a form prescribed by the Superintendent, along with every scoring model (or other scoring processes) filing and every summary of revisions. Attached to this Circular Letter is the Insurer Credit Information Compliance Certification form required by Regulation No. 182. The form may also be found at the Department's website ([PDF Format](#)) ([WORD Format](#)).

Any question regarding this Circular Letter should be directed to:

Personal Auto Stephen Solomon, Supervising Examiner
New York State Insurance Department
25 Beaver Street
New York, NY 10004

by e-mail at [Stephen Solomon](#).

Other Personal Lines Lucy Cilione, Supervising Examiner

New York State Insurance Department
25 Beaver Street
New York, NY 10004

by email at [Lucy Cilione](#).



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
25 BEAVER STREET
NEW YORK, NEW YORK 10004

The Office of General Counsel issued the following opinion on January 9, 2006 , representing the position of the New York State Insurance Department.

RE: Use of Social Security Number to Obtain Insurance Quote

Question Presented

1. Are automobile insurance premiums based solely upon an individual's driving record?
2. May an insurer obtain an applicant's social security number in order to give an insurance quote?
3. What steps does an insurer need to take to protect the privacy of insureds and applicants?

Conclusion

1. No, there are a number of factors, including the applicant's driving record that determines an automobile insurance premium.
2. There is no law prohibiting insurers from requesting a social security number. An insurer has the right to ask for a social security number where the information is reasonably related to underwriting. One such purpose is to obtain a credit report of an insured.
3. The use of the social security number is subject to the requirements of the Department's Privacy Regulation, N.Y. Comp. R. & Regs. tit. 11 Part 420 (2001) (Reg. 169) and N.Y. Comp. R. & Regs. tit. 11 Part 421 (2002) (Reg. 173).

Facts

The inquirer states that the inquirer requested auto insurance quotes from the inquirer's local insurance agent who informed the inquirer that he needed the inquirer's social security number to obtain the quotes. The inquirer would like to know why insurers need the social security numbers, and whether driving records are the only factor that determines an automobile insurance premium. Second, is it mandatory to give the social security number, and finally what steps must an insurer take to protect the privacy of the insureds and applicants.

Analysis

The factors that go into a premium for an applicant are not limited to the applicant's driving record. There are a number of factors that insurers may use to determine an automobile insurance premium, including an applicant's driving record, place of residence, use of the vehicle, and creditworthiness.

While the Social Security Act limits the circumstances under which a state may require an individual to provide his or her social security number, 42 U.S.C.A. § 405(c)(2)(C)(i)(West 2003), there is no such prohibition directed at private entities in this regard. Nor is there a New York law that prohibits insurers from requiring and utilizing the social security numbers of insureds for a legitimate underwriting purpose. One such legitimate purpose is to obtain a credit report of the insured. The Insurance Law allows insurers to use creditworthiness in underwriting risks of insureds subject to the limitations found in N.Y. Ins. Law. Article 28 (McKinney 2006 Supp.) & N.Y. Comp. R. & Regs. tit. 11 Part 221 (2005) (Reg. 182).

When an applicant furnishes his or her social security number to an insurer, the use of this information by the insurer is subject to the requirements of the Department's Privacy Regulation, N.Y. Comp. R. & Regs. tit. 11 Part 420 (2001) (Reg. 169) and N.Y. Comp. R. & Regs. tit. 11 Part 421 (2002) (Reg. 173). Some examples of this regulation include the obligation of insurers to send out a yearly statement that is clear and concise and explains the company's privacy practices and policies. There are limits placed on what the insurer can disclose to third parties. More specific information on the privacy regulations can be found at the Department's website at www.ins.state.ny.us where this information can be accessed in the "Privacy Regulations" section.

Finally while it is not mandatory for an applicant to provide his or her social security number to an insurer, the insurer may in turn not give an insurance quote and/or issue an insurance policy.

For further information one may contact Principal Attorney Paul A. Zuckerman at the New York City Office.

CONSUMER CORNER

What's Your Number?

Landlords, judges and employers peek at credit scores

By Teresa Dixon Murray
Newhouse News Service

When Mary Pelley gets telemarketing calls about refinancing her home loan, she quickly announces she has an A++ credit score of 776.

"I say, 'Here are my terms: I want a low rate and low fees,'" said Pelley, a mother of three preschoolers in Cleveland. "It might sound cocky, but I tell them I know what I can get."

Pelley is part of a small but growing group of consumers who know their score — specifically, the number that results when their entire credit history is squeezed through a complicated formula and boiled down to three digits between 300 and 900.

It has been two years since credit organizations started allowing consumers to find out their scores when they get copies of their credit reports.

These scores are being used in ways beyond their original intent of deciding who qualifies for a loan or a credit card and at what rates. Scores are also being used by:

- Landlords to pick tenants.
- Employers to evaluate prospective workers.
- Utilities to determine if a customer should pay a deposit.
- Insurers to set property and auto insurance premiums.
- Judges to determine the character of people in court.

Half of the nation's 200 mil-

Keeping score

You can buy your credit report and score from three national credit bureaus and Fair Isaac Corp., whose scoring model is most often used. Each company charges about \$15.

You can also get a free copy if you think your file contains fraudulently inaccurate information. The request also blocks your files from being accessed without your permission:

Equifax
Phone: (800) 685-1111
For fraud: (800) 525-6285
Web site: www.equifax.com

Experian
Phone: (888) 397-3742
For fraud: (888) 397-3742
Web site: www.experian.com

TransUnion
Phone: (800) 888-4213
For fraud: (800) 680-7289
Web site: www.transunion.com

Fair Isaac
Web site: www.myfico.com

lion consumers have "A" credit, according to industry records. For the rest, a difference of just five points can determine if they're approved for loans or credit cards and what interest they're charged.

In 2001, new laws forced the national credit bureaus to disclose the scores and the way in which the numbers are calculated. California was the first state to require the bureaus — Equifax Inc., Trans Union LLC and Experian Information Solutions Inc. — to stop the secrecy. With other states and Congress considering similar legislation, the bureaus and Fair Isaac Corp., whose scoring model is most frequently used, agreed to release the scores.

Fair Isaac, which long had argued consumers wouldn't understand their scores, said it

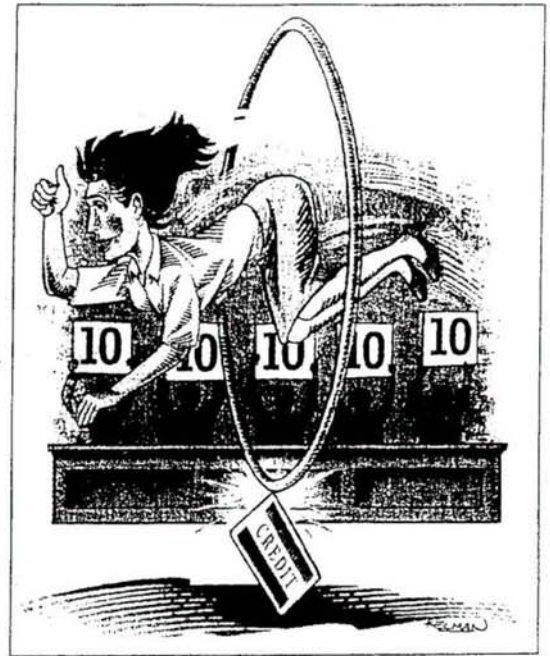
was bombarded with requests for credit scores in the first half of 2001.

"We thought the volume might ebb," said Craig Watts, speaking for the company. "What we found was that with word of mouth, there's been a steady rise month after month."

Watts declined to provide the number of customers who have requested their credit scores, as did Jeff Junkas, speaking for Trans Union.

Equifax said 5 million consumers have purchased products relating to credit histories and scores in the past two years, with revenue from consumers skyrocketing to \$40 million in 2002 from \$8 million in 2000.

Watts said two-thirds of consumers who obtain their credit scores plan to buy a



house or car.

"They're trying to get their ship in shape," Watts said. "Some people have moved scores from the 500s to the high 600s."

That's the difference between buying a house at great rates and getting laughed at.

The credit grade is being examined more widely, he said.

More apartment managers and utilities are checking a potential customer's credit. Utilities don't generally turn customers away but "use it to determine whether a deposit is required and how large," Watts said. "Telephone companies especially are starting to use it more."

Dan Kelso, president of the Ohio Insurance Institute, which represents property insurers, said nearly all insurance companies evaluate scores before accepting customers and setting premiums.

Some judges are reviewing people's credit scores before allowing them to be executors

of deceased relatives' estates.

There is still much that isn't disclosed about credit scores. Consumers are put in 10 categories based on things such as the length of their credit history (but not their age) and whether they own a home (but not if it's in an affluent or run-down area).

Fair Isaac won't discuss details, but it says factors such as gender, race, age and income don't count.

Brad Scriber of the Consumer Federation of America in Washington, D.C., said the bureaus and Fair Isaac need to be more accountable, such as explaining why consumers can be rated an A by one bureau and a C by another.

A federation analysis released in December found that scores from the three bureaus for a sample of 502,623 consumers had an average range of 41 points.

"If you're a 780, it's not a big deal, but if you're at 680, it is," said Scriber.

How people can shift their credit scores

- Do dispute credit report errors, unless they are in your favor.
- Don't point out that the oldest account listed is closed, unless it has a negative rating.
- Don't close unused credit card accounts. Consumers are judged on how long they've had accounts and what percentage of their available credit they're using. Craig Watts, speaking for Fair Isaac, said closing an account almost always lowers a score.
- Do use a credit card at least occasionally, especially if you don't have a home loan.
- Do pay your bills on time. If you have to choose, pay your mortgage, car loan and credit

card bills before paying utilities and medical bills. The last two don't hurt your credit unless they go to collection.

- Do consider shifting a credit card balance to a home-equity line or loan if it doesn't put your home at risk.

- Don't consolidate credit card balances into one account. If you owe \$3,000 each on three cards with \$10,000 caps, you're using less than a third of your limits. But if you put all three on one card, you'll owe \$9,000 on a card with a \$10,000 limit and be nearly maxed out.

- Don't think paying cash for cars or having off-the-book home loans is good for your

credit. They show no credit history, and that's bad.

- Don't casually open new accounts.

- Don't have all accounts with balances in both spouses' names. If you have two cards with balances, have one in each partner's name, and don't make the other an authorized user.

- Don't close a credit card account with a negative payment history and think it will disappear. It will stay on your history for seven years regardless. If you use it and pay the bills promptly, you'll start rebuilding your history.

— Newhouse News Service

How your credit history affects your auto and home insurance premiums

By *Insure.com*

Does having bad credit make you a worse driver or a riskier homeowner?

Think you are paying too much?

Most people believe they are paying too much for their car insurance. To find out how your state ranks in comparison with others in your region and across the country, read [Best and worst states for auto insurance premiums](#).

No, but your premium bills might make you believe that your insurance company thinks so.

According to a study by Conning and Co., more than 90 percent of auto insurance companies, and an increasing number of home insurers, use your credit information, filtered through a formula to create an "insurance risk score," to determine how likely you are to file a claim on an insurance policy. More than half of those insurers use that information to determine how much to charge you in premiums.

Insurance risk scores are similar to credit risk scores — used by lenders to determine whether or not to approve a loan or line of credit — because both look at your credit information, but the two are *not* the same thing, says Craig Watts, a spokesperson for Fair, Isaac, and Co., whose insurance risk scores are used by about 300 insurers nationwide.

A peak inside the "black box"

While Fair, Isaac & Co. will not release the details of their insurance risk scoring model to the public, spokesperson Craig Watts says that your credit score can give you an idea of your insurance risk score.

The five categories of your credit score are:

- **Past payment history (approx. 35%)**

How you've paid your credit bills in the past, if your bills have been paid on time, items in collection, the number of "adverse public records" (bankruptcy, wage attachments, liens), and the number and length of delinquencies or items in collection.

- **Amount of credit owed**

"Consumers are becoming more familiar with credit risk scoring, but insurance risk scoring is still fairly arcane," says Watts.

While both insurance scores and credit scores look at the same five characteristics of a person's credit report (*see list at right*), the data are weighted differently. This difference in weighting can swing 5 to 10 percent in each category.

"The biggest difference is that insurance risk scores look for stability, but credit risk scores look for a reliable pattern," says Watts. "Insurance scores are also more interested in how regularly you pay than in how much you already owe."

Insurers use these insurance scores to try to identify consumers who are consistent and reliable, as well as those who show a pattern of demonstrating common sense with money. Insurers say these people are less likely to file a claim on an insurance policy.

"We've studied millions of records and have found that there is a clear and reliable correlation between credit history and insurance risk," says Watts.

Allstate Insurance Co. and State Farm Mutual Auto Insurance Co., the nation's two largest auto and home insurers, have also noted this correlation and have developed their own insurance risk-scoring systems that incorporate credit information.

"We went in and looked at our data . . . to see if we could find differences between groups of people," says Mike Trevino, a spokesperson for Allstate. That analysis showed that people who have better credit — at least as reflected in their insurance scores — tend to file fewer claims, thus costing the insurer less money.

"Our feeling is that using credit information allows us to more fairly price our insurance," says Trevino. "Those that have better credit pay a lower rate."

Dick Luedke, a spokesperson for State Farm, which uses credit information only in deciding whether or not to issue an insurance policy, points out that in some cases use of credit information has allowed State Farm to cover people that wouldn't ordinarily have qualified.

"Study after study has shown that credit history can be correlated with the likelihood that someone will file a claim," says Luedke. "We don't claim to have the definitive answer as to why there is a correlation, but we believe one exists."

(approx. 30%)

How many accounts, what kind of accounts, and how close you are to your credit limits.

• **Length of time credit established (approx. 15%)**

How long you have had credit accounts and how long you have had specific accounts.

• **New credit (approx. 10%)**

Number and proportion of recently opened accounts, the number of credit inquiries, and the reestablishment of positive credit history after payment problems.

• **Types of credit established (approx. 10%)**

The number and activity of various types of credit accounts including credit cards, retail store accounts, installment loans, and mortgages.

Insurers place importance on the factors that show long-term stability, so by demonstrating responsible use of credit and keeping your balances low, you should be able to improve your insurance score. That could translate into lower insurance premiums, if you've been impacted by a negative credit history in the past.

You can purchase your credit score, credit report, and tips on how to improve your score from [myFICO](#), a Web site from Fair, Isaac & Co.

Correlations can't explain *why* insurance scoring works

"Study after study has shown that credit history can be correlated with the likelihood that someone will file a claim."

That reasoning for using insurance risk scoring infuriates Georgia Insurance Commissioner John Oxendine, who is also a member of the Consumer Protection Working Group of the National Association of Insurance Commissioners.

"I hear a lot of talk about correlation, but no talk about causation," says Oxendine. "Insurers don't have any reason for *why* scoring works, they just say 'correlation' over and over."

While Oxendine acknowledges that credit information — which has been used by some insurers for more than a decade — can be useful to insurance companies for avoiding insurance fraud-motivated arson and similar hazards, he places little faith in computer-modeled insurance scores and statistical relationships.

"If you punch enough numbers through a computer you can get anything," says Oxendine. "It's time we learn about how it works and make sure the criteria they use are in the best interest of the public."

So far Oxendine has had little success in getting insurers to divulge their methods for calculating insurance risk scores. "The information currently available to consumers seems designed to limit their understanding of [insurance] scores," says Oxendine. "If you don't know the rules of the game, you can't protect yourself."

It isn't quite that simple, says Dan Kummer, an expert on credit information issues and the director of auto insurance for the National Association of Independent Insurers, a property/casualty trade organization that has been an outspoken advocate for the use of credit-based insurance risk scores for selling and pricing insurance.

"If you punch enough numbers through a computer you can get anything."

The computer models used to generate insurance scores from credit information represent a tremendous investment of time and money for insurers and they don't want that proprietary information to be leaked to other companies, says Kummer.

"This is very disturbing — it's like a black box," counters consumer advocate J. Robert Hunter, the director of insurance for the Consumer Federation of America (CFA) and a former Texas Insurance Commissioner. "They haven't verified that minorities, people with disabilities, and the poor aren't discriminated against by these systems."

According to Kummer and Watts, insurance risk-scoring models *do not* discriminate. "In the studies we've done, we looked specifically at the scoring of low- to moderate-income and high minority areas," says Watts. "People in those areas score the same as in areas of higher income. We didn't see a pattern of indirect discrimination." Kummer attributes fears of discrimination to the growing pains of the system.

"They haven't verified that minorities, people with disabilities, and the poor aren't discriminated against by these systems."

As an example, Kummer points to previous credit-scoring systems that gave consumers lower scores based on the number of inquiries into their credit status. That meant that a person shopping around for the best deal on insurance could get the same black mark on their record as a person applying for lots of credit cards. This practice led to an outcry from consumers, and insurers are responding, says Kummer.

"A lot of companies have started changing their algorithms so the number of inquiries is no longer a factor," says Kummer. "An algorithm is not something that's locked in stone."

But those assurances aren't enough for Maryland Insurance Commissioner Stephen Larsen. Maryland has taken the lead in investigating the inner workings of insurance-scoring models, but currently allows insurers to use insurance scores to help set premium rates.

"Whenever insurance rates are based on what to the public is a black box, it raises legitimate concerns," says Larsen. "But I don't have the authority to bar insurers from using a tool if they can show a correlation and that it is reasonable to use that technique."

So the Maryland Insurance Administration adopted a regulation that requires insurers to provide their insurance-scoring model for review.

"It seems intuitive that someone with a low income would have a hard time getting a high credit[-based] score," says Larsen. "So we're trying to gather data to better illuminate the impact of credit[-based] scoring."

Gathering that data has not been an easy task. Even beyond the difficulties he is having in persuading Fair, Isaac and Co. to allow outside experts to review their proprietary insurance-scoring model, the fact that insurers use the same model in several ways has thinly stretched Larsen's resources.

"It's hard to get a handle on what the industry is doing."

"Insurers using models in different ways does create manpower issues," says Larsen. "It's hard to get a handle on what the industry is doing."

Larsen hopes to get a better idea of what goes into insurance scores, and to make sure that the poor and minorities are not being "double charged" as a result of insurance scores.

"Auto insurance rates are highest in the cities where there is also the highest concentration of poor and minorities," says Larsen. "So unfortunately there is already an adverse impact, but is [insurance] scoring exacerbating the problem?" He also hopes to persuade insurers to be more forthcoming on why they take any "adverse action" — meaning rejecting applications or charging higher rates — when they use credit-based insurance scoring.

Watts says that Fair, Isaac and Co.'s silence on the details of a person's insurance score isn't sinister at all — they simply want to make sure that consumers will be able to understand what they are given.

"We're in the process of figuring out the best way to disclose insurance scores to consumers, without harming the process."

"As lenders came to rely more heavily on credit scores, we helped lead the charge to open the box," says Watts. "Now we're in the process of figuring out the best way to disclose insurance scores to consumers, without harming the process."

You can currently buy a package including your credit score, a copy of your credit report, and an explanation of the score from Fair, Isaac and Co., and the company hopes that it will soon be able to provide a similar service for insurance scores.

scoring a bad tool, he says.

Advocates for consumer rights like Hunter of the CFA remain skeptical. The fact that no one can definitively show how having bad credit makes someone a worse driver or homeowner proves that credit-based insurance

"One of the ideas of classifying people into groups is to identify risk," says Hunter. "This is not a risk-identifying tool, this is a marketing tool so that the insurance companies can sell policies to the rich."

Last updated March 13, 2002



**STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004**

**Circular Letter No. 2 (2005)
February 25, 2005**

TO: ALL AUTHORIZED PROPERTY/CASUALTY INSURERS, RATE SERVICE ORGANIZATIONS, NEW YORK AUTOMOBILE INSURANCE PLAN, NEW YORK PROPERTY INSURANCE UNDERWRITING ASSOCIATION, AND INSURANCE PRODUCER ORGANIZATIONS

RE: LIMITATIONS UPON AND REQUIREMENTS FOR THE USE OF CREDIT INFORMATION FOR PERSONAL LINES INSURANCE – EMERGENCY ADOPTION OF REGULATION NO. 182 (11 NYCRR 221)

STATUTORY REFERENCE: ARTICLE 28 OF THE INSURANCE LAW

This is to inform the property and casualty insurance industry that the Department has promulgated Regulation No. 182 (11 NYCRR 221) on an emergency basis.

Chapter 215 of the Laws of 2004, effective April 23, 2005, adds a new Article 28 to the Insurance Law entitled "Use of Credit Information." Article 28 establishes limitations upon, and requirements for, the permissible use of credit information to underwrite or rate risks for personal lines insurance. The purpose of Regulation No. 182 is to facilitate implementation of Article 28 by insurers doing business in New York State.

Article 28 and Regulation No. 182 apply to the use of credit information to underwrite and rate personal lines insurance policies applied for, or renewed, on and after April 23, 2005. Article 28 and the regulation provide:

- prohibitions on the use of credit information, permissible use of credit information, and the requirements for obtaining current credit information;
- standards for the disclosure of the use of credit information in the underwriting and rating of personal lines insurance policies;
- standards for notification when an insurer takes an adverse action based upon credit information; and
- requirements for the re-underwriting and re-rating of an insured when a current insured obtains a dispute resolution and error correction determination under the federal Fair Credit Reporting Act if the credit information used by the insurer was found to be incorrect or incomplete.

Regulation No. 182 requires that the insurer include in its disclosure notices a toll-free telephone number. The toll-free number should be answered by, or directed to, the division or department

that is staffed by persons handling inquiries regarding the use of credit information by the insurer. A toll-free number with the appropriate telephone extension number for the applicable division or department is also acceptable.

Regulation No. 182 specifies requirements for filing the scoring model (or other scoring processes), including revisions thereto, with the Superintendent. Scoring models (or other scoring processes) in use as of April 23, 2005 and those that insurers start using after April 23, 2005 but prior to August 15, 2005, should be filed with the Superintendent as soon as possible but no later than July 1, 2005. With respect to a scoring model that an insurer intends to start using on or after August 15, 2005, the insurer shall file its scoring model (or other scoring processes) with the Superintendent at least 45 days prior to use. Summaries of revisions to previously filed scoring models (or other scoring processes) shall be filed no later than 45 days after its use, but insurers are strongly encouraged to file the summaries prior to use.

The regulation also requires that insurers complete and submit an Insurer Credit Information Compliance Certification in a form prescribed by the Superintendent, along with every scoring model (or other scoring processes) filing and every summary of revisions. Attached to this Circular Letter is the Insurer Credit Information Compliance Certification form required by Regulation No. 182. The form may also be found at the Department's website (PDF Format) (WORD Format).

Any question regarding this Circular Letter should be directed to:

Personal Auto Stephen Solomon, Supervising Examiner
New York State Insurance Department
25 Beaver Street
New York, NY 10004

by e-mail at Stephen Solomon.

Other Personal Lines Lucy Cilione, Supervising Examiner

New York State Insurance Department
25 Beaver Street
New York, NY 10004

by email at Lucy Cilione.

Commercial Umbrella

The **commercial umbrella**, or **excess liability** policy provides coverage in addition to the limits of an insured's BOP or Commercial General Liability policy. The umbrella increases the underlying policy limits and is secondary to the underlying policy. The umbrella can be primary in certain situations such as world-wide coverage and non-owned aircraft liability.

Principal features of most Umbrella policies typically consist of the following:

- World-wide coverage;
- Personal Injury coverage;
- Blanket Contractual Liability coverage for both written and oral contracts;
- Care, Custody and Control coverage;
- Non-owned Aircraft Liability;
- Watercraft Liability;
- Advertisers Liability;
- Liquor Law Liability;
- X. C. U. Liability; and
- Automatic coverage for additional insureds

When a loss is not covered by an underlying policy, a high Self Insured Retention typically applies. The SIR will often be from \$10,000 to \$25,000.

A common gap in umbrella coverage occurs in property or personal injury claims where non-owned autos used in the operations of an insured's partnership or joint venture are involved when the business has not been named as an additional insured on the auto policy. (Mr. Business owner uses his personal car but has not named the business as an additional insured on his personal policy and the business has no Hired Non-Owned coverage provision.)

Producers and customers should carefully compare underlying policies to the coverages in the umbrella. Gaps in coverage should be discussed with the umbrella policy underwriter.

Failure to maintain underlying coverage may enable the umbrella carrier to deny coverage.

Directors and Officers Coverage

The directors and officers of a corporation or other business entity, whether publicly traded or privately held, hold highly visible positions of great fiduciary responsibility. **Directors & Officers (D&O) Liability Insurance** covers the litigation costs and damages resulting from such lawsuits. Generally designed to help protect both the assets of the company and the personal assets of the individual, D&O Insurance normally covers liabilities that arise when individual or group acts in the capacity of a director or an officer of the firm.

Section 3.1

Workers Compensation

Workers' compensation is insurance that provides cash benefits and/or medical care for workers who are injured or become ill as a direct result of their job.

Employers pay for this insurance, and may not require the employee to contribute to the cost of compensation. Weekly cash benefits and medical care are paid by the employer's insurance carrier, as directed by the Workers' Compensation Board. The Workers' Compensation Board is a state agency that processes the claims and determines, through a judicial proceeding, whether a worker will receive benefits and/or medical care, and how much he/she will receive.

In a workers' compensation case, no one party is determined to be at fault. The amount that a claimant receives is not decreased by his/her carelessness, nor increased by an employer's fault. However, a worker loses his/her right to workers' compensation if the injury results solely from his/her intoxication from drugs or alcohol, or from the intent to injure him/herself or someone else.

A claim is paid if the employer or insurance carrier agrees that the injury or illness is work-related. If the employer or insurance carrier disputes the claim, no cash benefits are paid until the Workers' Compensation Law Judge decides who is right. If a worker is not receiving benefits because the employer or insurance carrier is arguing that the injury is not job-related, he/she may be eligible for Disability Benefits in the meantime. Any payments made under the Disability Program, however, will be subtracted from future workers' compensation awards.

Who Can Sell Workers Comp

New York State employers are required to provide workers' compensation and disability benefit coverage to their employees. The Workers' Compensation Law states that employers may provide this coverage in one of the following ways: (1) by insuring and keeping insured the payment of such compensation in the State Insurance Fund; (2) by insuring and keeping insured the payment of such compensation with any insurance carrier authorized to transact such business in New York State; or (3) by becoming self-insured.

Employers who wish to self-insure for either workers' compensation or disability benefits must apply to and be approved by the Board's Office of Self Insurance. As part of this process, each approved self-insurer must post with the Board a security deposit (cash, securities, letter of credit and/or surety bond), which will be used in the event that the self-insurer defaults on their obligation to provide benefits to their employees.

Employers may seek coverage directly through the State Insurance Fund or direct a representative, including an accountant or payroll administrator, or insurance broker to do so on their behalf. Self-Insuring, either through a dedicated Trust Fund or an individual plan does not require the involvement of a licensed producer, however several Trusts operate exclusively through licensed insurance producers. Only coverage with traditional carriers require a licensed insurance producer to place business on behalf of an employer.

Volunteer Firefighter's and Ambulance Worker's Guide to Benefits

Introduction to the VFAW Law

The Volunteer Firefighters' and Volunteer Ambulance Workers' Benefits Laws provide cash benefits and/or medical care for volunteer members who are injured or become ill in the line of duty. Recognizing the unselfish service of volunteer firefighters and volunteer ambulance workers, laws designed to protect such volunteers who are injured, or who become ill, in the line of duty, were enacted in 1957 and 1989, respectively.

The local political subdivision pays for this insurance, and cannot require the volunteer member to contribute to the cost of coverage. Weekly cash benefits and medical care are paid by the subdivision's insurance carrier, in accordance with the applicable law. The Workers' Compensation Board is a state agency that administers these laws, and if disputes arise, adjudicates them through a quasi-judicial proceeding.

In a volunteer firefighters' or ambulance workers' benefits case, no one party is determined to be at fault. The amount that a claimant receives is not decreased by his/her carelessness, nor increased by the company's fault. A volunteer member loses his/her right to benefits if the injury results solely from his/her intoxication from alcohol or drugs, or from the intent to injure him/herself or someone else.

Who is Covered by the Law?

All New York State **volunteer firefighters** are entitled to benefits under the law if they are active volunteer members of a fire company of a county, city, town, village or fire district and are injured in the line of duty.

Most New York State **volunteer ambulance workers** are entitled to benefits under the law if they are active volunteer members of an ambulance company and are injured in the line of duty. Volunteer ambulance companies which are not under contract with a county, city, town, village or other political subdivision, or that do not wish to become special improvement districts of towns, may provide optional coverage to their workers.

What Is and Is Not "In the Line of Duty"?

What is "In the Line of Duty" for Firefighters?

Any of the following activities, pursuant to orders/authorization:

- Participation at a fire, alarm of fire, hazardous material incident, or other emergency situation that triggers response by the fire company or its units;
- Travel to, from and during fires or other calls to which the company responds; travel in connection with other authorized activities;
- Some duties in the firehouse, such as construction, repair, maintenance and inspection;
- Inspection of property for fire hazards or other dangerous conditions;
- Fire prevention activities;
- Attendance at fire instructions or fire school; instruction at training;
- Participation in authorized drills, parades, funerals, inspections/reviews, tournaments, contests or public exhibitions conducted for firefighters;
- Attendance at a convention or conference as an authorized delegate;
- Work on or testing of fire apparatus/equipment, fire alarm systems and fire cisterns;
- Meetings of the fire company;
- Pumping water or other substances from a basement or building;
- Inspection of fire apparatus prior to delivery;
- Response to a call for general ambulance service by a member of an authorized emergency rescue and first aid squad;
- Participation in a supervised physical fitness class; or
- Fundraising activities (non-competitive events).

What is "In the Line of Duty" for Volunteer Ambulance Workers?

- Travel to, working at and travel from an accident, alarm of accident or other duty to which the ambulance company has responded; travel in connection with other authorized activities;
- Personal assistance rendered to another ambulance company;
- Performance of duties at the ambulance facility or elsewhere, directly related to the prevention of accidents or other disasters or the delivery of emergency health care;
- Instruction or being instructed in ambulance duties; attendance at a training school or course of instruction for ambulance workers, or attendance at, or participation in, any noncompetitive training program;
- Attendance at, or participation in, authorized drills, parades, funerals, inspections or reviews;
- Attendance or work at meetings of the ambulance department or ambulance company, or any organized unit thereof, at the ambulance facility or other regular or special headquarters of the department, company or unit;
- Work in connection with the construction, testing, inspection, repair or maintenance of the ambulance facility and the fixtures, furnishings and equipment thereof, and the ambulance vehicles, ambulance apparatus and equipment used by the ambulance department, ambulance company, or other unit;
- Practice for, or participation as a contestant or an official in any competitive tournament, contest or public exhibition conducted for ambulance workers which is intended to promote the efficiency of the ambulance department, ambulance company or any unit;
- Inspection of ambulance vehicles and ambulance apparatus prior to delivery under a contract or purchase, or performance of duties in relation to the delivery;
- Attendance at a convention or conference of ambulance workers or ambulance officers as the authorized delegate or representative of the ambulance department, ambulance company or any unit; or
- Work in connection with a fundraising activity of the ambulance company, not including competitive events in which volunteer ambulance workers are competitors.

What is NOT "In the Line of Duty?"

- Participation, including practice, in any recreational or social activity, other than noncompetitive fundraising activities;
- Work rendered in the service of a private employer; public corporation or special district;
- Work rendered while on leave of absence or suspended from duty, or work that the volunteer has been ordered not to perform; or
- Competitive events in which volunteer members are competitors, such as baseball, basketball, football, bowling, tugs of war, donkey baseball, donkey basketball, boxing, wrestling, contests between bands or drum corps, or other competitive events in which volunteer members are competitors and which involve physical exertion on the part of the competitors.

Section 3.2

New York State Insurance Fund

Due to the fact that New York employers are required to provide workers compensation for their employees, a residual market was established as a resource when voluntary market coverage is unavailable.

The New York State Insurance Fund (NYSIF) is the largest writer of workers' compensation insurance in New York State. By law, it is required that workers' compensation premiums offered by NYSIF are fixed at the lowest possible cost sufficient to maintain a solvent fund.

NYSIF does not provide any compensation to insurance producers placing business on behalf of employers.

Admitted Carriers

New York State remains a competitive market for a number of property casualty carriers active in the workers compensation market. Admitted carriers, operating through licensed insurance producers, have established underwriting guidelines limiting the eligibility of prospective customers. While many carriers may offer workers compensation as a benefit to their commercial policy holders, larger accounts may be aggressively sought.

Self Insuring & Trust Funds

An employer who wishes to self insure for workers' compensation can do so in one of two ways: (1) by becoming an individual self-insurer or (2) by becoming a member of a self insured group. Political subdivisions must also provide workers' compensation coverage to their employees, and they may elect to self-insure those benefits

Individual Self Insurance - Workers' Compensation

An employer who wishes to self-insure on an individual basis for workers' compensation must submit the following as part of the application process:

- SI-1 Application for Self Insurance - Workers' Compensation;
- Original copy of the applicant's most recent independently audited financial statement;
- Current payroll report of applicant broken out by classification code;
- Payroll history, broken down by classification code, for the last five years;
- Most recent carrier premium audit, with the current experience modification;
- Foundation documents (i.e. certificate of incorporation; partnership agreement; etc.);
- Applicant's safety program; and
- Incurred loss history of the applicant for the last five years.

If the applicant is deemed a good candidate for self-insurance, based upon all the information submitted, a conditional approval will be issued. Final approval will become effective when all documentation, as well as an adequate security deposit, have been received.

The amount of the initial security deposit will be based upon the current payroll report of the applicant broken down by classification code, and rates developed by the Compensation

Insurance Rating Board (CIRB). The current minimum security deposit is determined as described in Rule 316.1, usually \$624,000. Every year that the employer remains self-insured, the security deposit is reviewed for adequacy, based upon the payroll codes, CIRB rates, and the employer's reported incurred losses. If necessary, the employer must adjust the security deposit to adequate levels as determined by the Board. Failure to maintain security deposits in the amount determined by the Board may result in termination of the employer's self-insured status.

While actively self-insured, employers must submit the following information to the Office of Self Insurance on an annual basis:

- The most recent certified, independently audited financial statement;
- A payroll report filed by classification code;
- Statement of outstanding death and disability claims; and
- Statement of compensation and medical losses incurred by the self-insurer.

The Self Insurance Office will utilize this information to determine adequate security amounts for each self-insurer. Self-insurers must also report who their licensed third party administrator is if claims are not self-administered. Failure to meet any of the reporting requirements may result in termination of the employer's status as a self-insurer.

A self-insurer who has discontinued business in New York State, or has arranged for the payment of compensation by alternate methods (State Fund or carrier coverage), may terminate their status as a self-insurer at any time. The Board will maintain a security deposit for the discontinued self-insurer until all claims have been finally adjudicated and fully paid, and all expenses and assessments have been paid.

Group Self Insurance - Workers' Compensation

Joining a group is an alternative to carrier or State Fund coverage for employers who may not be able to self-insure on an individual basis. To qualify as a group self-insurer and to maintain authorization to operate as a group self-insurer, the group must: (1) include two or more employers that perform related activities in a given industry and that have been in business for a period of time which is acceptable to the Chair; (2) have and maintain an aggregate net worth of members which is at least one million dollars; and (3) have and maintain a combined annual payroll of group members which, when multiplied by the current rates promulgated by the New York Compensation Insurance Rating Board (CIRB), is at least \$500,000.

Any group of employers seeking initial authorization to operate as a group self-insurer must submit the following as part of the application process:

- GSI-1, Application for Group Self Insurance - Workers' Compensation Law;
- Trust Agreement and By-Laws of the Group Self-Insurer;
- GSI-1.1, Application for Participation in Group Self Insurance Plan, and Participation Agreement, for each employer participating in the group;
- A description of the safety program, if any, proposed for the employer group;
- An actuarial feasibility study directed and certified by an independent qualified actuary;
- Information about the group's trustees;
- Information about the officers, directors and general managers of the group administrator;
- A report identifying the projected rate of contribution and assessments to be paid by each member for the first year of the group's operation, and the manner in which such contributions and assessments were calculated;

- A description of the group's organization for the administration of claims as well as the duly executed contract between the board of trustees, the group administrator and the claims administrator;
- Any duly executed contract between the board of trustees and either an attorney-at-law licensed to practice in New York State or a representative of self insured employers licensed by the Workers' Compensation Board pursuant to subdivision (3-b) or (3-c) of Section 50 of the Workers' Compensation Law, pertaining to the representation of group members before the Workers' Compensation Board; and
- Evidence of relevant experience from the group administrator.

If the applicant is deemed a good candidate for group self-insurance, based upon all the information submitted, a conditional approval will be issued. Final approval will become effective when all documentation, as well as an adequate security deposit, have been received.

The amount of the initial security deposit will be based upon the current payroll report of the group members broken down by classification code, and rates developed by the Compensation Insurance Rating Board (CIRB). Group self-insurers are required to establish and maintain trust assets in an amount that exceeds trust liabilities, as those terms are defined in Section 317.2 of the Rules and Regulations. Group self-insurers who fail to comply with this capitalization standard shall be deemed "under-funded" and shall immediately provide the chair with an acceptable plan of action as may be appropriate in order to make up the deficiency in a timely manner. Such under-funded groups may also be subject to any or all of the provisions set forth in Section 317.9 of the Rules and Regulations.

In the event of the insolvency of a group self-insurer, participating members would be held jointly and severally liable for the unpaid obligations of the group incurred during the time of the employers' participation. For this reason, employers interested in participating in a group should review all relevant documentation of the group self insurer, including, but not limited to: the group's independently audited financial statement; the trust document and by-laws; and the group's methodology for developing contribution levels.

Group self-insurers are required to notify the Board, on properly executed prescribed forms, any time employers join or leave the group self insurance program. In addition, group self-insurers must submit the following information to the Office of Self Insurance on an annual basis:

A financial summary report in a form prescribed by the Chair;

- Certified, independently audited financial statements;
- Certified, independent actuarial report;
- A payroll report filed by classification code, for each group member and in aggregate.

The Self Insurance Office will utilize this information to determine that the Group Self Insurer is adequately funded. Group self-insurers must also report who their licensed third party administrator is if claims are not self-administered. Failure to meet any of the reporting requirements may result in termination of the group's status as a self-insurer.

Political Subdivisions - Workers' Compensation

Political subdivisions that elect to self-insure their workers' compensation must file a Notice of Election (Form SI-26), together with a resolution from its governing body, which states that they have elected to provide workers' compensation benefits through self-insurance.

Political subdivisions that elect to self-insure their workers' compensation are exempt from posting security deposits, and they are not required to submit annual reports. However, political subdivisions must report who their licensed third party administrator is, if claims are not self-administered.

Section 3.3

Who is Covered?

- Workers in all employments conducted for profit. Part-time employees, borrowed employees, leased employees, family members and volunteers are also included under the workers' compensation law.
- Employees of counties and municipalities engaged in work defined by the law as "hazardous".
- Public school teachers, excluding those employed by New York City, and public school aides, including New York City.
- Employees of the State of New York, including some volunteer workers.
- Domestic workers employed forty or more hours per week by the same employer (including full-time sitters or companions, and live-in maids).
- Farm workers whose employer paid \$1,200 or more for farm labor in the preceding calendar year.
- Any other worker determined by the Board to be an employee.
- All corporate officers if a for-profit corporation has more than two officers and/or two stockholders.
- Officers of one-or-two person corporations if there are other individuals in employment. These officers may choose to exclude themselves from coverage.
- Volunteer Firefighters and Volunteer Ambulance Workers are provided benefits for death or injuries suffered in the line of duty under the Volunteer Firefighters' Benefit Law and Volunteer Ambulance Workers' Benefit Law.

Who is not Covered?

- Individuals that volunteer their services for nonprofit organizations and receive no compensation. {compensation includes stipends (stipends used solely to offset expenses incurred while performing activities for the nonprofit are not counted as stipends), room and board, and other "perks" that have monetary value.}
- Clergy and members of religious orders that are performing religious duties.
- Members of supervised amateur athletic activities operated on a non-profit basis, provided that such members are not otherwise engaged or employed by any person, firm, or corporation participating in such athletic activity.
- People engaged in a teaching capacity in or for a nonprofit religious, charitable or educational institution (Section 501(c)(3) under the IRS tax code). To be exempt, the teachers must only be performing teaching duties.
- People engaged in a non-manual capacity in or for a nonprofit religious, charitable or educational institution (Section 501(c)(3) under the IRS tax code).
[Manual labor includes but is not limited to such tasks as filing; carrying materials such as pamphlets, binders, or books; cleaning such as dusting or vacuuming; playing musical instruments; moving furniture; shoveling snow; mowing lawns; and construction of any sort.]
- Persons receiving charitable aid from a religious or charitable institution who perform work in return for such aid and who are not under any express contract of hire, and certain persons receiving rehabilitation services in a sheltered workshop.
- People employed in certain maritime trades, interstate railroad employees, federal government employees and others covered under federal workers' compensation laws.

- People, including minors, doing yard work or casual chores in and about a one-family, owner-occupied residence. Casual means occasionally, without regularity, without foresight, plan or method. Coverage is required if the minor handles power-driven machinery, including a power lawnmower.
- The spouse and minor children (under 18 years old) of an employer who is a farmer as long as they are not under an express contract of hire.
- Certain employees of foreign governments and Native American Nations.
- New York City police officers, firefighters, and sanitation workers. Uniformed police officers and firefighters in other municipalities may also be excluded.
- Certain real estate salespersons who sign a contract with a broker stating that they are independent contractors.
- Certain insurance agents or brokers who sign a contract stating that they are independent contractors.
- Sole proprietors, partners, and one/two person corporate officers with no employees (although coverage may be obtained voluntarily).

Section 3.4

Workers Comp Fraud and Reform

Workers compensation benefits were last adjusted in 1994, providing a maximum weekly benefit of \$400. Continuing debate ensues over reform of the workers compensation system to increase benefits to recipients and reduce costs to employers and carriers.

Current proposals include:

- Increase weekly benefits from the current \$400 (no increase since 1994)
- Reform Permanent Partial Disability funding structure (12% of claims - 75% of costs)
- Reduce the Prevalence of Fraud through a Dedicated Inspector General for Workers Compensation Fraud
- Fully fund the Second Injury Fund to eliminate ongoing assessments against all employers (15% of workers comp premiums dedicated to Second Injury Fund)
 - Overhaul Workers Compensation Health Care Move from Fee for Service to Managed Health Care and Preferred Provider Networks
 - Reduce Prescription Drug Costs through a Preferred Drug List.
- Improve Wage Reporting Compliance by Employers
 - The Workers Compensation Board recently has adopted an electronic matching system designed to ensure that all employers obtain workers' compensation insurance. This works by matching employer records obtained from the Department of Labor and other sources with electronic reports that insurers are required to make regarding the maintenance of workers' compensation coverage. Despite this advance, some estimate that up to 20 percent of employers still may not comply with the coverage requirement. (New investigations indicate that non-compliance may be as high as 40%)

Disability Insurance

Disability insurance, or “Sick Pay”, is perhaps the most overlooked, yet affordable, employee benefit available to employers. While the New York Disability Benefits Law (DBL) mandates that all employers provide disability insurance to their employees, the coverage is minimal, short term and often highly insufficient to meet the basic needs of covered individuals. Higher limit DBL (short term) and long term disability insurance coverages are available from several carriers.

Disability Benefits Law (DBL)

New York State requires payment of cash benefits to wage earners who become disabled as a result of a Non-Occupational injury or illness. Any Employer in the State of New York with one or more employees in a calendar year becomes a "Covered Employer." This includes employers of one or more domestic employees working in a private home for at least 40 Hours per Week. Employees are eligible for 50% of their average weekly wage (based upon the last eight weeks earnings) to a maximum benefit of \$170 per week. Benefits are paid beginning with the 8th consecutive day of disability, for up to a maximum of 26 Weeks. The minimum weekly benefit is \$20.

DBL premiums may be paid entirely by the employer. If the employee contributes to the cost, the employee may not contribute more than one half of one percent of the first \$120 of weekly wages, to a maximum of \$.60 per week.

- Most Employees in the State of New York are eligible if working for a covered Employer.
- Full-time Employees, new to working are eligible after working for 4 consecutive weeks.
- Part-Time Employees, new to working are eligible on the 25th day of regular employment for one Employer.
- Employees receiving Unemployment Benefits are eligible Immediately upon beginning work.
- New Employees who have previously established eligibility with another Employer are eligible immediately upon beginning work, as long as the gap in employment is not more than four weeks.
- Personal or Domestic Employees working for the same Employer in a private home at least 40 hours a week.
- A Spouse working for a Sole Proprietor or Partnership unless an exclusion is elected.
- College Students are eligible for DBL Benefits if they meet any of the above requirements.
- A Corporate Officer is an Employee and will be covered, unless he receives no wages or remuneration for services.

Who is Not Eligible for Benefits?

- Minor Children of an Employer.
- Government, Railroad, or Maritime Employees.
- Ministers, Priests, Rabbis, Members of a Religious Order, Sextons, or Christian Science readers.
- Persons engaged in a professional or teaching capacity for a non-profit religious, charitable, or educational institution; persons receiving rehabilitation in a sheltered workshop, under a certificate issued by the Department of Labor.
- Persons receiving aid from religious, charitable, or educational institutions, who perform services in exchange for such aid.
- Golf caddies.

- Daytime elementary or high school students who work part-time during the school year or during vacation periods.
- Independent contractors.
- Employees during the first 45 days of "extra employment". These are persons not normally in the labor market who are hired to do work for a limited special period of time.
- Employees in "casual employment". An employee who normally works in a different occupation, who is hired for a day or less.
- Corporate Directors, acting only as such, and not as employees.
- Partners and Proprietors are not required to be covered. They must however cover any eligible employees.
- Executive Officers of an incorporated non-profit, religious, charitable, or educational institution. (President, Vice-President, Secretary or Treasurer)
- An Employer may elect to provide voluntary benefits to an excluded class of employees by filing an application for voluntary coverage with the Worker's Compensation Board.
- Employees working outside of New York are covered if their service is not localized in any other state, and some of their service is performed in New York State; or if there is no base of operation in any state, but the Employee is directed and controlled from New York State; or the place from which the Employee is directed or controlled is not in any state in which some part of the service is performed, and the Employee's residence is in New York State.

DBL Pregnancy Coverage

Pregnancy is treated like any other disability. Eligibility for benefits is based upon medical certification of disability, which may occur at any time during pregnancy. However, an employee on unpaid maternity leave who become disabled is eligible only within 4 weeks of the last day actually worked.

Disabilities Caused by an Automobile Accident

DBL is Primary over No Fault Automobile insurance. No Fault benefits may be reduced accordingly. DBL claims must be filed within the 30 day time limit.

Employees Collecting DBL and S. S. Retirement Benefits

Eligibility for Social Security Retirement Benefits does not affect the right to DBL.

FICA Tax Withholding from DBL Benefits

The Employee's regular share of FICA tax (7.65%) is withheld. The Employee may also elect to have Withholding Tax taken out as well.

Additional Disability Coverage

Additional disability insurance is available with short-term DBL and through Long-Term Disability plans. Many DBL carriers offer increased benefit plans that double the statutory maximum weekly benefit to \$340.

Length of benefits under DBL short-term plans is limited to 26 weeks. Long-term disability coverage can provide benefits for terms that expire when the insured reaches retirement age. Long-term disability may be purchased with higher benefit limits than DBL. Monthly benefits provide up to 60% of insured's wages.

Section 3.6

Need for Disability Insurance

Despite the relative affordability of long-term disability insurance, it is the least likely benefit to be provided.

Average annual medical benefit costs to employers among those companies reporting payments in 2000.

SOURCE: U.S. CHAMBER OF COMMERCE, FEBRUARY 2002

Benefit	DOLLARS PER employee	PERCENTAGE of payroll
Hospital, surgical medical and major- medical insurance	\$3,028	7.2%
HMO plan only	2,260	6.0
PPO plan only	2,623	6.8
Point-of-service plan	3,906	7.5
Indemnity plan only	5,417	8.4
Dental insurance	349	0.7
Vision care	35	0.1
Retiree health insurance	2,245	3.6
Prescription drug coverage	514	1.1
Health plan administration	397	0.8
Short-term disability	333	0.6
Long-term disability	114	0.3

The 1985 NAIC Commissioners Disability Table indicates that the percentage of people who can expect to suffer a long term disability of 90 days or more before they reach the age of 65 is significant.

Age	Percentage	Disabled
25	52%	1 out of 2
30	51%	1 out of 2
35	48%	4 out of 9
40	45%	4 out of 9
45	40%	2 out of 5
50	34%	1 out of 3
55	27%	1 out of 6
60	16%	1 out of 6

If a disability of 90 days or more lasts two years, it will probably continue longer.

Age when disabled 90 days	Percentage still disabled after 2 years and 90 days	Percentage still disabled after 5 years
25	63.5%	44.2%
35	69.7%	52.6%
45	73.6%	58.0%
55	77.6%	59.6%

Employers and employees should consider their individual income needs and the relative affordability of long-term disability insurance when reviewing their benefit plans.

Monthly Income Required

Let's look at your obligations which will continue even if you are disabled and are unable to work:

a) Mortgage/Rent	\$ _____
b) Utilities	\$ _____
c) Auto Payment	\$ _____
d) Auto and Homeowner's Insurance	\$ _____
e) Life and Medical Insurance	\$ _____
f) Groceries	\$ _____
g) Medical/Dental Expenses	\$ _____
h) Other Fixed Expenses such as credit card payments, school loans, etc.	\$ _____
i) Savings	\$ _____
Total	\$ _____

Section 3.7

Social Security Benefits

Social Security pays benefits to people who cannot work because they have a medical condition that is expected to last at least one year or result in death. Federal law requires this very strict definition of disability. While some programs give money to people with partial disability or short-term disability, Social Security does not.

You must be fully-insured and have worked at least 5 of the last 10 years before you became disabled. The benefit amount depends upon how much you earned and how much you paid into Social Security. You may obtain an estimate of your SSDI benefit by calling the Social Security Administration or by visiting [their website](http://www.ssa.gov) at www.ssa.gov.

Certain family members of disabled workers can also receive money from Social Security.

In general, to get disability benefits, you must meet two different earnings tests:

1. A “recent work” test based on your age at the time you became disabled; and
2. A “duration of work” test to show that you worked long enough under Social Security.

Certain blind workers have to meet only the “duration of work” test.

The table below, shows the rules for how much work you need for the “recent work” test based on your age when your disability began. The rules in this table are based on the *calendar quarter* in which you turned or will turn a certain age.

The calendar quarters are:

First Quarter:	January 1 through March 31
Second Quarter:	April 1 through June 30
Third Quarter:	July 1 through September 30
Fourth Quarter:	October 1 through December 31

Rules for work needed for the “recent work test”

<i>If you become disabled...</i>	<i>Then you generally need:</i>
In or before the quarter you turn age 24	1.5 years of work during the three-year period ending with the quarter your disability began. Work during half the time for the period beginning with the quarter after you turned 21 and ending with the quarter you became disabled. Example: If you become disabled in the quarter you turned age 27, then you would need three years of work out of the 6-year period ending with the quarter you became disabled.
In the quarter after you turn age 24 but before the quarter you turn age 31	Work during 5 years out of the 10-year period ending with the quarter your disability began
In the quarter you turn age 31 or later	

The following table shows examples of how much work you need to meet the “duration of work test” if you become disabled at various selected ages. For the “duration of work” test, your work does not have to fall within a certain period of time.

NOTE: *This table does not cover all situations.*

Examples of work needed for the “recent work” test

<i>If you become disabled...</i>	<i>Then you generally need:</i>
Before age 28	1.5 years of work
Age 30	2 years
Age 34	3 years
Age 38	4 years
Age 42	5 years
Age 44	5.5 years
Age 46	6 years
Age 48	6.5 years
Age 50	7 years
Age 52	7.5 years
Age 54	8 years

Age 56	8.5 years
Age 58	9 years
Age 60	9.5 years

Section 3.8

Social Security Online Benefit Calculators [Quick Calculator](#)
Retirement, Disability, and Survivor Estimates December 27, 2006

Retirement

At right is the information you provided. Below that are estimated benefit amounts for retirement at 3 different ages, including your [normal \(or full\) retirement age](#) (66). As you can see, you receive the largest monthly benefit if you wait until age 70 to begin receiving benefits. By postponing retirement, however, you lose lower benefits for many months.

At your , the accumulated value of higher benefits (from postponing retirement) will start to exceed the accumulated value of lower benefits (from choosing early retirement).

Social Security benefits are the foundation on which to build a financially secure retirement. Savings and pensions also are key components of your retirement plan.

Information you submitted
Date of birth: 6/15/1950
Current earnings: \$40,000.00
Benefit in year-2006 dollars

Retirement Benefit Estimates	
Retirement age	Monthly benefit amount ¹
62 and 1 month in 2012	\$917.00
66 in 2016	\$1,270.00
70 in 2020	\$1,741.00

¹ Assumes no future increases in prices or earnings.

We have calculated your benefits by making certain assumptions about your earnings. Please look at these earnings to see if they appear reasonable to you. You can change them and see the effect on your benefit estimates!

[See the earnings we used](#)

Disability/Survivor

For the disability and survivors estimates, we assumed that you became disabled or died **today**. We did not use future earnings in calculating those estimates.

Disability	Monthly benefit amount
You	\$1,140.00

Your spouse and children may also qualify for benefits.

Survivors	Monthly benefit amount
Your child	\$866.00
Your spouse caring for your child	\$866.00
Your spouse at normal retirement age	\$1,155.00
Family maximum	\$2,081.40

Retirement

At right is the information you provided. Below that are estimated benefit amounts for retirement at 3 different ages, including your [normal \(or full\) retirement age](#) (67). As you can see, you receive the largest monthly benefit if you wait until age 70 to begin receiving benefits. By postponing retirement, however, you lose lower benefits for many months.

At your break-even age, the accumulated value of higher benefits (from postponing retirement) will start to exceed the accumulated value of lower benefits (from choosing early retirement).

Social Security benefits are the foundation on which to build a financially secure retirement. Savings and pensions also are key components of your retirement plan.

Information you submitted
Date of birth: 6/15/1970
Current earnings: \$35,000.00
Benefit in year-2006 dollars

Retirement Benefit Estimates	
Retirement age	Monthly benefit amount ¹
62 and 1 month in 2032	\$913.00
67 in 2037	\$1,318.00
70 in 2040	\$1,644.00

¹ Assumes no future increases in prices or earnings.

We have calculated your benefits by making certain assumptions about your earnings. Please look at these earnings to see if they appear reasonable to you. You can change them and see the effect on your benefit estimates!

[See the earnings we used](#)

Disability/Survivor

For the disability and survivors estimates, we assumed that you became disabled or died **today**. We did not use future earnings in calculating those estimates.

Disability	Monthly benefit amount
You	\$1,159.00

Your spouse and children may also qualify for benefits.

Survivors	Monthly benefit amount
Your child	\$897.00
Your spouse caring for your child	\$897.00
Your spouse at normal retirement age	\$1,197.00
Family maximum	\$2,196.20

Social Security Benefits

The Social Security Benefit Formula

Fact Sheet

Laurel Beedon, AARP Public Policy Institute
Mitja Ng-Baumhackl, AARP Public Policy Institute
August 2003

Table of Contents:

- The Benefit Calculation
- The Weighted Formula
- How the Benefit Calculation Maintains Comparable Benefits Across Generations
- Illustrative PIA Calculations

The Benefit Calculation

A worker's Social Security benefits—either retirement or disability—are based upon his/her time and earnings in Social Security-covered employment and the age at which s/he leaves the labor force.

The number on which most initial Social Security disability, survivors, and retirement benefits are based is called the Primary Insurance Amount (PIA). It is reached through a two-step calculation: 1) the Average Indexed Monthly Earnings calculation, and 2) application of the PIA formula rates.

*Average Indexed Monthly Earnings*¹

First, a worker's 35 highest-earning years² are indexed to wage growth³, up to the year the worker turns age 60. These wage-indexed annual earnings are then averaged (divided by 35 years), and divided by 12 months, to get a monthly amount. The result is called the Average Indexed Monthly Earnings (AIME). The AIME expresses a worker's lifetime earnings in terms of today's wage levels.

Primary Insurance Amount

Second, the worker's Primary Insurance Amount (PIA) is calculated by applying three separate rates to portions of the AIME.

For those who became eligible in 2003, benefits were based on the following formula:

- 90 percent of the first \$606 of AIME, plus
- 32 percent of AIME over \$606 through \$3,653, plus
- 15 percent of AIME above \$3,653.

Thus, if a worker had an AIME of \$3,750, the PIA in 2003 would be:

90% of first \$606	\$545
32% of next \$607 through \$3,653	975
15% over \$3,653	15
<hr/>	
The PIA for this worker is:	\$1,535

The Weighted Formula

By applying the 90 percent, 32 percent, and 15 percent rates or "weights" to the AIME, the benefit formula ensures that low-wage workers will receive proportionately more from their Social Security contributions than average- or high-wage earners.

The weighting reflects the assumption that workers with higher earnings have a greater ability to protect themselves from financial risk—there is a higher probability they have private pension income and accumulated savings—than do low- and moderate-income workers who have less opportunity to save and invest.

How the Benefit Calculation Maintains Comparable Benefits Across Generations

The benefit calculation rates—90 percent, 32 percent, and 15 percent—do not change from year to year. However, the dollar amounts to which the rates are applied, called "bend points," are adjusted annually based on changes in average wages.⁴ This adjustment ensures that workers with comparable real earnings histories receive initial benefits replacing approximately the same percentage of their earnings, regardless of their nominal value or what year they retired.

According to estimates by the actuaries at the Social Security Administration, a worker with lifetime average earnings who retired in 2003 at the normal retirement age receives benefits that replace approximately 42 percent of prior earnings. Benefits are estimated to replace about 35 percent of prior earnings for high-wage earners, and about 56 percent for those with low wages.⁵ Successive generations of average earners will receive about that same replacement rate, even though their lifetime wages and benefits may be higher in dollar terms.⁶

Illustrative PIA Calculations

The following are illustrations of the benefit formula applied to lifetime low-, average-, and high-income earners who retired at age 65 in 2003.⁷

Low earnings are defined as earnings equal to 45 percent of the national average wage index.

Average earnings are defined as equal to the national average wage index.

High earnings are defined as equal to 160 percent of the national average wage index.⁸

High-Income Earner Eligible for Benefits in 2003

AIME (at age 65): \$3,792

90% of first \$606 = \$545.40

32% of the next \$607 through \$3,653
($\$3,653 - \$606 = \$3,047$)
($0.32 \times \$3,047 = \975.04) = **\$975.04**

15% of AIME over \$3,653
($\$3,792 - \$3,653 = \$139.00$)
($0.15 \times \$139.00 = \20.85) = **\$20.85**

Primary Insurance Amount

($\$1,541.29$ rounded
to the next lowest dollar = $\$1,541.00$) = **\$1,541.00**

Average-Income Earner
Eligible for Benefits in 2003

AIME (at age 65): \$2,438

90% of first \$606 = **\$545.40**

32% of the next \$607 through \$2,438

(\$2,438 - \$606 = \$1,832)

(0.32 x \$1,832 = \$586.24)

= **\$586.24**

Primary Insurance Amount

(\$1,131.64 rounded

to the next lowest dollar = \$1,131.00.)

\$1,131.00

**Low-Income Earner
Eligible for Benefits in 2003**

AIME (at age 65): \$1,097

90% of first \$606 = **\$545.40**

32% of the next \$607 through \$1,097

(\$1,097 - \$606 = \$491.00)

(0.32 x \$491.00 = \$157.12)

= **\$157.12**

Primary Insurance Amount

(\$702.52 rounded

to the next lowest dollar = \$702.00.)

\$702.00

Footnotes

¹. In most cases, for those eligible for benefits after 1979, the Average Indexed Monthly Earnings (AIME) formula is used. For those eligible for benefits before 1979, the Average Monthly Earnings (AME) method of calculation is used. For a small and declining number of workers, the Simplified Old Start Formula is used. See [www.ssa.gov/OACT/ProgData/retire benefit2.html](http://www.ssa.gov/OACT/ProgData/retire%20benefit2.html) for additional information on old-law benefits.

². Social Security considers 40 years a lifetime of work. The benefit formula drops a worker's five lowest earnings years, so 35 years are used in the final calculation. If a worker does not have 35 years of contributions, the years without earnings are included in the calculation as zeros.

³. Wage indexing of the average monthly earnings calculation was legislated in 1977 and took effect in 1979.

⁴. Bend points for the year 2003 were determined by multiplying the 1979 bend point amounts by the ratio of the national average wage index for 2001, \$32,921.92, to the wage index for 1977, \$9,779.44. See www.ssa.gov/OACT/COLA/piaformula.html.

⁵. Available at: www.ssa.gov/OACT/TR/TR03/VI_OASDHI_dollars.html#wp119381.

⁶. The replacement rates are expected to decline slightly over time as the normal retirement age is increased gradually from age 65 to 67.

⁷. These calculations are illustrative. Since the age at which a full benefit is received is gradually increasing from age 65 to age 67 for persons born after 1938, workers born after 1938 who retire at exactly age 65 and 0 months would have their benefit reduced for early retirement. See www.ssa.gov for benefit calculators that include all technical considerations.

⁸. This amount is not necessarily equal to the AIME of a lifetime taxable maximum worker.

Section 4.1 & 4.2

Health Insurance



A Small Business Guide



Health Insurance

A Small Business Guide

The Key

Health insurance is a key benefit of employment. Most organizations with more than 100 employees have a group health insurance plan. Yet many smaller firms do not. A large proportion of New York State's uninsured individuals are employed in small businesses.

This publication provides information to help small-business owners make informed decisions on health insurance plans for their employees.

Why do Small Businesses Offer Health Insurance?

Small businesses offer health insurance:

- to keep employees healthy and productive;
- to help attract and retain employees;
- because employees “need it;”
- because employees “demand it;” and
- because the owners/managers want the coverage for themselves and their families.

Why Don't Small Businesses Provide Health Insurance?

Small-business owners say the high cost of premiums heads the list of reasons why they do not provide health insurance.

Often small businesses have a difficult time getting the right help in understanding the insurance market. They may not receive satisfactory assistance from insurance representatives and consultants.

Small businesses may not seem like ideal clients for insurers selling group coverage. The costs of marketing, installation and maintenance are relatively high. There is also a greater relative risk of “adverse experience” when fewer individuals are being covered as part of a group. In any given year, only a few individuals in a group of thousands are likely to be frequent users of health services. They may not always be the same individuals, but the proportion tends to remain stable and predictable. This is an example of the pooling principle that underlies insurance: many individuals pay premiums to cover the claims generated by a few. In a small group, i.e. one that is comprised of between two to 50 employees or members, not including spouses and dependents, experience is likely to be more erratic.

COMMUNITY RATING New York State requires that the premium rates for all health insurance policies sold to small groups be calculated using a community rating methodology that is designed to help stabilize rates. The community rating requirement means that an insurer offering health insurance to small groups must set the premium rate for a given health insurance policy using the pooled experience of all persons covered by that policy. For example, the premium charged to a small group may not be based on the age, sex, health status or claims experience of that specific group. This requirement extends to coverage issued by health maintenance organizations (HMOs).

OPEN ENROLLMENT. In addition to the community rating requirement, all health insurance policies sold to small groups, including HMO coverage, must be offered on an open enrollment basis. The open enrollment requirement means that an insurer must accept all persons who apply for coverage, without taking into account an applicant's health status. Depending on the circumstances, however, there may be a period of up to one year during which pre-existing conditions are not covered. Refer to “Contract Provisions” on page 7 of this guide for further details concerning pre-existing conditions and waiting periods.

Health Insurance Plans

BASIC COVERAGE. A basic hospital and medical insurance plan covers necessary hospitalization for a predetermined number of days. Typically, it includes room and board charges, routine nursing and physicians' services provided in the hospital, x-rays, laboratory tests, in-hospital anesthesia, operating room charges, drugs, and surgical supplies. Usually, emergency room charges are covered as well.

Basic plans have significant limitations. They almost always have deductibles and co-payments and may also restrict the length of covered hospital stays or set limits on total payments.

MAJOR MEDICAL. Major medical plans protect against the high costs of serious or prolonged illness. Benefits may be payable after basic plan benefits are exhausted. In New York State, a major medical plan must provide at least \$100,000 of coverage.

Payments may be paid directly to a participating hospital, physician or other provider based on established charges or prior agreement.

Reimbursement to the insured individual can be based on "reasonable" charges, a percentage of reasonable charges or a stated dollar amount. This type of coverage is generally called a fee for service "indemnity" plan.

SELF-INSURING. To save costs, some employers are self-insuring their employees by assuming the responsibility of paying directly for claims. In the case of self-insuring plans, the employer controls the money that would otherwise go to premium payments and thus avoids State premium taxes.

There are also disadvantages. The employer is responsible for claims administration, although this may be contracted out to a health insurance company. For some employers, self-insuring will not result in any lower costs compared with purchasing a policy from an insurance company. Most importantly, the employer assumes the risk of unexpected increases in claims costs. To protect against this risk, self-insured groups seek "stop-loss" insurance. Stop-loss insurance will indemnify the employer for claims greater than a specified amount. Self-insured plans are not regulated by New York State. As a result, the mandated coverage imposed on insurers by state law need not be provided.

MULTIPLE-EMPLOYER WELFARE ARRANGEMENTS (MEWA). Before purchasing coverage from a MEWA, make sure that the plan offered meets the applicable federal and state laws and regulations concerning licensure, reserve requirements, plan benefit provisions, and premium rates.

Service Arrangements to Consider

HEALTH MAINTENANCE ORGANIZATIONS (HMOs). HMOs provide comprehensive health care benefits to the voluntarily enrolled group of members. Members pay premiums in advance to the HMO according to a set schedule. Premiums are charged independently of the amount of covered services any particular member may receive.

Under an HMO, members are provided services only by physicians and other providers employed or approved by the HMO. Except in an emergency or with an appropriate referral, members are fully responsible for paying all charges when they seek care outside the HMO.

There are three types of HMOs:

GROUP MODEL, which contracts with one or more large multi-specialty group practices;
STAFF MODEL, which has physicians who are salaried employees of the HMO; and
INDEPENDENT PRACTICE ASSOCIATION (IPA), made up of independent physicians who provide care for employees based on negotiated rates.

PREFERRED PROVIDER ORGANIZATIONS (PPOs). A PPO is a contractual agreement between providers of health care; *i.e.* physicians and hospitals and employers, unions, insurance carriers or third-party administrators to provide health care services at established fees. Providers are selected based on their willingness to discount their charges, their availability in certain geographic areas, and the perception of the quality and efficiency of their practice.

To encourage patients to use the preferred provider, there is either full payment of covered services or reduced deductibles and co-payments. Patients are free to use a non-PPO provider if they are willing to pay higher out-of-pocket costs.

POINT-OF-SERVICE PLANS. The point-of-service option provides the same benefits as an HMO plan. It provides more flexibility because it permits you to seek treatment from providers included in your plan's network or to "opt out" of network and select your own provider without a referral. If you stay within the network, you receive the full amount of covered health care benefits after satisfaction of any co-payments. If you choose to use physicians outside the network, you will be covered for a substantial part of the cost. As a result, you will generally pay more out-of-pocket expenses including a deductible and coinsurance.

Legislation and Regulation

The following legislative and regulatory requirements affect the design, administration, and cost of health insurance plans. Additional information is available from the New York State Insurance Department.

HCRA (HEALTH CARE REFORM ACT). The Health Care Reform Act of 2000 introduced a program entitled "Healthy NY" which promotes access to quality health care by providing lower-cost health insurance to those New Yorkers who need it most. The program began January 1, 2001 and has increased the availability of comprehensive health insurance coverage for New York's uninsured workers and their families. The Healthy NY program is designed to assist small business owners in providing their employees and their employees' families with the health insurance they need and deserve. In addition, uninsured workers whose employers do not provide health insurance may also purchase this coverage directly through the Healthy NY program.

Healthy NY is offered by all health maintenance organizations (HMOs) in the state and provides standardized benefits that are made more affordable through State sponsorship. Healthy NY includes coverage for essential health needs including inpatient and outpatient hospital services, physician services, maternity care, preventative health services, diagnostic and x-ray services, and emergency services. Applicants may choose to have an optional limited prescription benefit.

Healthy NY is available to certain businesses with 50 or fewer employees, sole proprietors and eligible uninsured individuals. For information on the program's eligibility criteria and participation rules, please visit www.healthyny.com or call 1-866-HEALTHYNY (1-866-432-5849).

TEFRA (TAX EQUALITY AND FISCAL RESPONSIBILITY ACT OF 1982, REVISED 1986) AND DEFRA (DEFICIT REDUCTION ACT OF 1984). Employers of 20 or more full- or part-time employees are responsible for providing the same coverage to working employees age 65 or older (TEFRA) and their non-working spouses age 65 or older (DEFRA) as they provide for employees under 65.

COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1988, 1989). Employers of 20 or more employees maintaining a group health plan are required to offer employees and their dependents the option of continuing membership in the group plan at their own expense after they leave employment under certain circumstances. The cost of the COBRA extension can be charged to the employee at 102 percent of the group's cost for an active employee. Furthermore, the law adds a "portability" feature to coverage wherein an insurer must credit the time a person was covered under a prior health insurance policy toward satisfying any pre-existing condition waiting period imposed by the subsequent policy, as long as the prior coverage was in force at least 63 days before the effective date of the subsequent policy.

OBRA (OMNIBUS BUDGET RECONCILIATION ACT OF 1986). Employers with 100 or more employees who provide a group health plan are required to continue coverage for active employees or dependents who become eligible for Medicare because of a disability.

ERISA (EMPLOYEES RETIREMENT INCOME SECURITY ACT OF 1974).

Self-insured plans that are not governed by state insurance law must meet the requirements of ERISA. ERISA requires a “creditable” claims review procedure and notices that state the reason for claim denials.

CONTINUATION OF COVERAGE. New York law requires insurers to offer continuation of group coverage, consistent with COBRA requirements for continuation, to employees and their dependents who do not qualify for continuation under COBRA. Employees who lose their group coverage and are not covered by COBRA are eligible for continuation under the group plan.

NOTIFICATION OF CESSATION OF BENEFITS FOR TERMINATED EMPLOYEES.

Employers with operations in New York State are required to provide a written notice to all terminated employees that specifies the date on which their employee benefits will be cancelled.

Coverage and Cost

SUPPLEMENTAL COVERAGE. In addition to basic and major medical plans, there is a wide variety of possible supplements to insurance coverage. Each has cost implications for the employer.

Popular supplements include dental care, prescription drugs and vision care plans. Coverage may also be provided for long-term care, hospice care and as a supplement to Medicare payments.

FIRST DOLLAR COVERAGE VS. COST SHARING. First dollar coverage pays virtually the entire cost of all covered services with little or no out-of-pocket expense to the insured. Cost sharing means that the employee contributes to the cost of the care, sometimes based on a fixed percentage of the cost or, in a way that is becoming more popular, at a rate connected with salary level. Many employers pay most or the entire premium for employees, but require contributions for all or part of the premium for dependents.

Deductibles and co-payments (co-insurance) are another form of cost sharing. Deductibles require the employee to spend a specified amount before insurance reimbursement begins. Co-payments require the employee to pay a specific percentage or a fixed amount of the plan’s allowable charges.

Many plans have a “catastrophic” or “stop-loss” feature that sets a maximum limit on cost sharing for the policy year. The plan pays the full amount of covered expenses after a predetermined amount of out-of-pocket payments have been made.

COSTS VS. COVERAGE. Designing a health insurance plan involves a continued trade-off between the comprehensiveness of coverage and the cost of the plan to the employer and employees. Many carriers offer both “high option” plans, with broad benefits, and “low option” plans, under which coverage is more limited and greater cost sharing is required. All plans offering basic hospital coverage, however, must also provide coverage for state-man-dated benefits.

When shopping for affordable group insurance look carefully at the levels of deductibles and co-payments. Also look at the range of coverage, items that are excluded from coverage and coverage maximums or “caps.” A plan with a \$100 deductible may actually provide less coverage than one with a \$500 deductible. This balancing between deductible and co-payment features is another trade-off.

Contract Provisions

While group contracts may seem similar, there are often significant differences that you should examine.

COVERED EMPLOYEES. Contracts usually limit coverage to “permanent” full-time employees and part-time employees who work more than a specified number of hours. Employers usually have the option of covering new employees when they are hired or can require waiting period.

DEPENDENT COVERAGE. Spouses and dependent children can be covered under a family plan. The eligibility for coverage of adopted or foster children and children of single parents should be defined in specific language. Dependent children are usually covered from birth until the age of 19 with extensions until the age of 25 if they are full-time students. Plans must continue coverage beyond these ages for disabled or handicapped children as long as they are dependent.

PRE-EXISTING CONDITIONS. Depending on the circumstances, conditions present prior to the employee’s enrollment date may be excluded from coverage for up to one year. This is known as a pre-existing condition exclusion. These exclusions are subject to reduction or elimination depending on the amount of creditable coverage an insured has accrued, provided such coverage was continuous to a date that was not more than 63 days prior to the enrollment date of the new coverage.

WAITING PERIODS. In lieu of the use of a pre-existing condition provision, some plans may impose a waiting or affiliation period of up to 60 days before coverage takes effect.

LIMITATIONS. Some plans limit the choice of physicians or hospitals to those in a specific geographic region except in the case of accidents and medical emergencies. Supplemental coverage may be required to cover employees and dependents who travel outside that region.

EXCLUSIONS. Most group plans exclude coverage for injuries and illnesses ordinarily covered under workers' compensation or sustained while serving in the armed forces or resulting from acts of war or riot.

COORDINATION OF BENEFITS. Coordination or non-duplication of benefits may apply when an individual is covered under more than one group insurance contract. Coordination ensures that the total amount of the benefits under all contracts does not exceed 100% of the actual medical expenses.

Your Rights as a Policyholder

GRIEVANCE PROCEDURES. Many types of insurance contracts are now required to have a grievance procedure in place to provide for times when the insurer denies access to a referral or determines that a benefit is not covered under the contract. The procedure must be set forth in the insurance contract and must also be provided in a written notice.

EXTERNAL REVIEW. Provides an independent appeal process for insureds who have been denied health insurance benefits on the basis that the services are not medically necessary or are experimental or investigational. Medical professionals who are not affiliated with your HMO or health insurer review the merits of the case and issue a determination. These professionals are called certified external appeal agents. Prior to this law, aggrieved consumers were limited to filing internal appeals through their health plans or filing lawsuits. You are not eligible for external review if you are covered by a self-funded plan.

How to Shop for Insurance

Selecting the health insurance program most appropriate to the needs and resources of your small business is a complex task. There are three groups of insurance professionals who can guide you in making the best decision:

AGENTS. Agents are representatives of insurance companies who are responsible for marketing its products. They usually earn commissions based on their sales.

BROKERS. Brokers are licensed sales people who represent a number of different carriers or plans. They are compensated by the insurance company through which the insurance is placed. The broker is responsible for ongoing servicing of the account for the insurance company.

CONSULTANTS. Insurance consultants can help evaluate a group's needs, design a plan and recommend the most economical carrier. The consultant is paid by the employer group based on a contract or agreement that outlines the scope, timing and fees of the service.

CHOOSE A CARRIER CAREFULLY. Remember, when you select a carrier you should base your decision not only on the plan it offers, but also on its reputation, stability and record in serving the small-business market. You should also consider its administrative policies and procedures. To assist you in choosing a carrier, insurers are required by law to disclose to insureds or, upon request, to potential insureds, information on matters such as coverage parameters; prior authorization requirements; utilization review policies; provider payment methodologies; premium and cost sharing responsibilities; grievance procedures; procedures for obtaining emergency services; and procedures for selecting, accessing and changing providers.

The New York State Department of Insurance also publishes a health insurance complaint ranking that includes information on Department complaints, grievance determinations, and appeals relating to medical necessity. The complaint ranking can be accessed through the Department's website at: www.ins.state.ny.us.

FINANCIAL STABILITY OF THE CARRIER. To find this out, ask for a copy of its rating by A.M. Best & Co., Standard & Poor's, or Duff & Phelps from the broker, consultant or the insurance company itself. For more information, contact the New York State Insurance Department, which is responsible for licensing carriers and monitoring their operations.

EFFICIENCY AND ACCURACY OF CLAIMS PAYMENT. Review and audit processes will help to control your costs by denying inappropriate reimbursement.

LEVEL OF PAYMENTS. Most carriers have their own schedules of “usual, customary and reasonable” fees on which they base their reimbursement. Low levels will reduce claims costs, but may also cause dissatisfaction among employees.

HOW PREMIUMS ARE SET. Community rates are those rates charged all insureds covered by a particular contract in a specific region.

There are many elements in an insurance plan that affect its cost and its ability to meet your needs. Plans differ in what they exclude. Under some circumstances, carriers may issue coverage only when a specific percentage or number of eligible employees enroll in the group.

It is important to consider that the lowest price may not represent the best value. Cost and coverage should be balanced and prudence exercised in selecting a carrier.

Managing Your Plan

HOW TO CONTAIN COSTS. While major factors contributing to health care costs are beyond the employer’s control, you can influence others. Employees and their dependents should learn about their coverage and how to use it. Your employees should receive information on how to select and talk to a physician, to ask about fees, and to question the necessity of tests and procedures. They need to understand that more is not necessarily better.

Carriers and sponsors of plans will usually provide informational brochures and will make their representatives available to answer questions. Make sure that information concerning their health insurance coverage is available to your employees in language that is easily understandable. To keep costs down, insurance carriers are introducing a group of strategies that have become known as “utilization review,” “utilization management,” or simply “managed care.” These include:

- Second surgical opinion when an elective, non-emergency procedure has been recommended;
- Pre-admission certification for non-emergency hospital admissions;
- Concurrent review to determine the continued need for inpatient care;

- Retrospective review to analyze the practice patterns of physicians and hospitals; and
- Claims audits to validate physician and hospital charges.

Your employees and their dependents should also be made aware of potential areas of provider abuse. These include:

- “Unbundling” or separation of a single procedure into multiple parts with separate fees for each part;
- “Phantom” charges for services that were not performed;
- Altering diagnoses so that services will be eligible for reimbursement; and
- Waiving co-payments and inflating fees to make up for the loss of revenue.

CHANGING PLANS AND CARRIERS. A variety of situations such as employee changes, claims experience or benefit agreements may suggest the need to change plans. Most carrier changes, however, happen in an effort to reduce costs. You should be aware that apparent cost savings may not really be what they seem. Carriers may offer higher commissions for new accounts than for renewals. Therefore, a change of carriers may be more advantageous to the broker than to you. Continuous coverage for your employees should be a priority.

THE NEW YORK STATE INSURANCE DEPARTMENT. The New York State Insurance Department regulates health insurers doing business in the state. The Department issues licenses to agents and brokers, monitors the financial condition of insurance companies, and approves health insurance policies and premium rates.

The Consumer Services Bureau investigates complaints against insurers, agents and brokers, and answers consumer inquiries concerning insurance. To contact the Bureau, call 1-800-342-3736. Informational booklets, as well as a variety of other information, may be found and downloaded through the New York State Insurance Department web site at: www.ins.state.ny.us For additional information concerning insurance coverage please see *Property & Casualty - A Small Business Guide*. This guide is available free of charge from the New York State Insurance Department and Empire State Development.

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Consumer Driven Health Plans

Consumer Driven Health Plans combine eligible high-deductible health plans with companion Health Savings Accounts.

Health Savings Accounts (HSAs) provide a tax-free incentive for employers and individuals to save for today's and tomorrows medical expenses. The funds contributed to a HSA are tax-deductible, and when used for medical expenses, distributions are totally tax-free. After age 65, the account can continue to be used tax-free for medical expenses. Also, after age 65, funds can be used for any purpose, but ordinary income tax would apply.

Husband and Wife High Deductible Indemnity Plan	
Male	\$145 monthly
Female	\$135 monthly
Annual Expenditure	\$3,360

Health Savings Account Contribution	
Monthly	\$430
Annual HSA Contribution	\$5,150

Total Health Care Annual Contribution (HSA + HDHP – High Deductible Health Plan)	\$8,510
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Type of Expense Under HSA	
Prescription	24 Scripts @ \$75 = \$1800
Dr. Visit	2 @ \$125 = \$250
Testing Labs	2 @ \$125 = \$250
Total HSA Deductions	\$2,300

Annual HSA Benefit	
HSA Contributions	\$5,150
Less Expenses	-2,300
Rollover / Retained	\$2,850

<http://www.irs.gov/publications/p553/ch01.html#d0e1187>

Health Savings Accounts (HSAs)

A health savings account (HSA) is a tax-exempt trust or custodial account that you set up with a U.S. financial institution (such as a bank or an insurance company) which allows you to pay or be reimbursed for certain medical expenses. This account must be used in conjunction with a high deductible health plan (HDHP), discussed later.

The HSA can be established using a qualified trustee or custodian that is different from the HDHP provider. Contributions to an HSA must be made in cash or through a cafeteria plan. Contributions of stock or property are not allowed.



If you have an Archer MSA, you can generally roll it over into an HSA tax free.

What are the benefits of an HSA? You may enjoy several benefits from having an HSA.

- You can claim a tax deduction for contributions you make even if you do not itemize your deductions on Form 1040.
- Contributions made by your employer (including contributions made through a cafeteria plan) may be excluded from your gross income.
- The contributions remain in your account from year to year until you use them.
- The interest or other earnings on the assets in the account are tax free.
- Distributions may be tax free if you pay qualified medical expenses. See *Qualified Medical Expenses*, later.
- An HSA is “portable” so it stays with you if you change employers or leave the work force.

Qualifying for an HSA

To qualify for an HSA, you must meet the following requirements.

- You have an HDHP.
- You have no other health insurance coverage except what is permitted under *Other health insurance*, later.
- You are not entitled to Medicare benefits.
- You cannot be claimed as a dependent on someone else's 2004 tax return.

Here is an Example for the Employee

A married employee claiming one exemption and earning \$1000 monthly with \$100 deducted for fringe benefits.

The Employee's Benefit Deductions....

Dependent Health	\$51
Medical Supplement	20
Disability Income	16
Cancer Supplement	13
	\$100

The Employee's Take Home Pay...

Company without Section 125 Gross Pay \$1000 Taxes \$250 Benefits \$100 <hr/> Take Home Pay \$650	Company with Section 125 Gross Pay \$1000 Benefits \$100 Taxes \$225 <hr/> Take Home Pay \$675	<p>The Employee Saves \$25 Per Month!</p>
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Here is an Example for the Employer...

A company having one hundred employees with salaries averaging \$1000 per month and fringe benefits deductions averaging \$100 per month.

Company without Section 125 Total Monthly Salaries \$100,000 Company FICA Taxes \$7650 <hr/> Total Expense \$107,650	Company with Section 125 Total Monthly Salaries \$100,000 Company FICA Taxes \$6885 <hr/> Total Expense \$106,885	<p>The Company Saves \$750 per Month or \$9000 per year!</p>
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Health Savings Accounts

A Health Savings Account (HSA) is an account that you can put money into to save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment. HSAs were signed into law by President Bush on December 8, 2003.

Who Can Have an HSA

Any adult can contribute to an HSA if they:

- Have coverage under an HSA-qualified “high deductible health plan” (HDHP)
- Have no other first-dollar medical coverage (other types of insurance like specific injury insurance or accident, disability, dental care, vision care, or long-term care insurance are permitted).
- Are not enrolled in Medicare.
- Cannot be claimed as a dependent on someone else’s tax return.

Contributions to your HSA can be made by you, your employer, or both. However, the total contributions are limited annually. If you make a contribution, you can deduct the contributions (even if you do not itemize deductions) when completing your federal income tax return.

Contributions to the account must stop once you are enrolled in Medicare. However, you can keep the money in your account and use it pay for medical expenses tax-free.

Advantages of HSAs

Security – Your high deductible insurance and HSA protect you against high or unexpected medical bills.

Affordability – You should be able to lower your health insurance premiums by switching to health insurance coverage with a higher deductible.

Flexibility – You can use the funds in your account to pay for current medical expenses, including expenses that your insurance may not cover, or save the money in your account for future needs, such as:

- Health insurance or medical expenses if unemployed
- Medical expenses after retirement (before Medicare)
- Out-of-pocket expenses when covered by Medicare
- Long-term care expenses and insurance

Savings – You can save the money in your account for future medical expenses and grow your account through investment earnings.

Control – You make all the decisions about:

- How much money to put into the account
- Whether to save the account for future expenses or pay current medical expenses
- Which medical expenses to pay from the account
- Which company will hold the account
- Whether to invest any of the money in the account
- Which investments to make

Portability – Accounts are completely portable, meaning you can keep your HSA even if you:

- Change jobs
- Change your medical coverage
- Become unemployed
- Move to another state
- Change your marital status

Ownership – Funds remain in the account from year to year, just like an IRA.

There are no “use it or lose it” rules for HSAs.

Tax Savings – An HSA provides you triple tax savings:

- (1) tax deductions when you contribute to your account;
- (2) tax-free earnings through investment; and,
- (3) tax-free withdrawals for qualified medical expenses.

What Happens to My HSA When I Die?

If your spouse becomes the owner of the account, your spouse can use it as if it were their own HSA. If you are not married, the account will no longer be treated as an HSA upon your death. The account will pass to your beneficiary or become part of your estate (and be subject to any applicable taxes).

Opening Your Health Savings Account

Banks, credit unions, insurance companies and other financial institutions are permitted to be trustees or custodians of these accounts. Other financial institutions that handle IRAs or Archer MSAs are also automatically qualified to establish HSAs

Need More Information about HSAs?

Treasury’s web site has additional information about Health Savings Accounts, including answers to frequently asked questions, related IRS forms and publications, technical guidance, and links to other helpful web sites. Treasury’s HSA website can be found through www.treas.gov (click on “Health Savings Accounts”) or directly at the following address: <http://www.treas.gov/offices/public-affairs/hsa/>.



High Deductible Health Plans (HDHPs)

You must have coverage under an HSA-qualified “high deductible health plan” (HDHP) to open and contribute to an HSA. Generally, this is health insurance that does not cover first dollar medical expenses. Federal law requires that the health insurance deductible be at least:

\$1,100* -- Self-only coverage
\$2,200* -- Family coverage

In addition, annual out-of-pocket expenses under the plan (including deductibles, co-pays, and co-insurance) cannot exceed:

\$5,500* -- Self-only coverage
\$11,000* -- Family coverage

In general, the deductible must apply to all medical expenses (including prescriptions) covered by the plan. However, plans can pay for “preventive care” services on a first-dollar basis (with or without a co-pay). "Preventive care" can include routine pre-natal and well-child care, child and adult immunizations, annual physicals, mammograms, pap smears, etc.

Finding HDHP Coverage

Any company that sells health insurance coverage in your state may offer HDHP policies. Although Treasury cannot recommend any specific names of companies selling these policies, you should be able to find a qualified policy by contacting your current insurance company, an agent or broker licensed to sell health insurance in your state, or your state insurance department.

HSA Contributions

You can make a contribution to your HSA each year that you are eligible. For 2007, you can contribute up to \$2,850* if you have Self-only coverage and \$5,650* if you have Family coverage

*2007 amounts; adjusted annually for inflation.

	HDHP Deductible	Maximum HSA Deposit (2007)
Single Coverage	\$1,100	\$2,850
	\$1,500	\$2,850
	\$2,000	\$2,850
	\$2,500	\$2,850
	\$3,000	\$2,850
Family Coverage	\$2,200	\$5,650
	\$3,000	\$5,650
	\$4,000	\$5,650
	\$5,000	\$5,650
	\$6,000	\$5,650

Individuals age 55 and older can also make additional “catch-up” contributions. The maximum annual catchup contribution is as follows:

2007 - \$800
2008 - \$900
2009 and after - \$1,000

Determining Your Contribution

Your eligibility to contribute to an HSA is determined by the effective date of your HDHP coverage. If you do not have HDHP coverage for the entire year, you will not be able to make the maximum contribution. All contributions (including catch-up contributions) must be pro-rated. Your annual contribution depends on the number of months of HDHP coverage you have during the year (count only the months where you have HDHP coverage on the first day of the month). For years after 2006 a special rule allows you to contribute the maximum amount for the year as long as you have coverage for December. However, if you fail to remain covered for 2008, the extra contribution above the pro rated amount is included in income and subject to an additional 10 percent tax.

Contributions can be made as late as April 15 of the following year.

Using Your HAS

You can use the money in the account to pay for any “qualified medical expense” permitted under federal tax law. This includes most medical care and services, and dental and vision care, and also includes over-the counter drugs such as aspirin.

You can generally not use the money to pay for medical insurance premiums, except under specific circumstances, including:

- Any health plan coverage while receiving federal or state unemployment benefits.
- COBRA continuation coverage after leaving employment with a company that offers health insurance coverage.
- Qualified long-term care insurance.
- Medicare premiums and out-of-pocket expenses, including deductibles, co-pays, and coinsurance for:
 - Part A (hospital and inpatient services)
 - Part B (physician and outpatient services)
 - Part C (Medicare HMO and PPO plans)
 - Part D (prescription drugs)

You can use the money in the account to pay for medical expenses of yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by your HDHP.

Any amounts used for purposes other than to pay for “qualified medical expenses” are taxable as income and subject to an additional 10% tax penalty. Examples include:

- Medical expenses that are not considered “qualified medical expenses” under federal tax law (e.g., cosmetic surgery).
- Other types of health insurance unless specifically described above.
- Medicare supplement insurance premiums.
- Expenses that are not medical or health-related.

After you turn age 65, the 10% additional tax penalty no longer applies. If you become disabled and/or enroll in Medicare, the account can be used for other purposes without paying the additional 10% penalty.

Section 4.6

ISSUED 10/30/2006 FOR IMMEDIATE RELEASE

**MILLS ANNOUNCES NEW HIGH-DEDUCTIBLE HEALTHY NY PLAN
Lower cost, featuring more benefits are newest enhancements to affordable insurance plan**

Superintendent of Insurance Howard Mills today announced Healthy NY will soon offer increased benefits as well as new options that will make the program even more affordable to New Yorkers. Healthy NY is the state's reduced cost health insurance program for the working uninsured, sole proprietors and small businesses.

"Governor Pataki's commitment to increasing the number of people with health insurance in New York State has been a hallmark of his tenure." Superintendent Mills stated. "The Insurance Department is proud that we have contributed to the Governor's success through our Healthy NY initiative, and I'm very pleased that for 2007, Healthy NY will receive enhancements that will make it even more attractive and effective."

Beginning Jan. 1, 2007, qualifying individuals, sole proprietors and small employers will be able to save substantially by purchasing a consumer-driven high deductible health plan through the Healthy NY program. This product is designed for use with a tax advantaged Health Savings Account.

The Healthy NY program will also have additional benefits in 2007. Members who require home health care or physical therapy following a hospitalization or surgery may receive these services beginning in 2007. The program will also cover prostate cancer screening.

Currently, Healthy NY enrollees may choose between two options – Healthy NY coverage with prescription drug coverage and without prescription drug coverage. Those two options will also be available to enrollees who choose the high deductible plan. Under the high deductible plan, insurance companies offering Healthy NY must provide the option to choose a deductible of \$1,150 per individual and \$2,300 per family, subject to the policy's out-of-pocket maximums. Enrollees can then set up tax advantaged Health Savings Accounts for up to the amount of the deductible in order to cover that cost.

The estimated premium savings under this plan would be 20% to 25% annually. That savings could be used to help fund a Health Savings Account (HSA). A HSA is a special account owned by an individual where contributions are used to pay current or future medical bills.

HSAs have several benefits. Employer contributions to a HSA are not taxable to the employee, and if an individual pays for his or her own HSA, that amount is deductible by the individual on his or her tax return. For example, the U.S. Treasury says a single taxpayer making \$20,000 who put \$1,000 into a Health Savings Account in 2006 would reduce his or her federal income tax by \$150.

Unlike Flexible Spending Accounts, the Health Savings Account is not a "use it or lose it" account. Funds placed in the HSA remain there until spent. The money in the HSA can also grow. It is owned by the individual, and may be invested under the same rules as Individual Retirement Accounts.

"The new high-deductible options can help both employers and individuals save money long term and short term, all while being covered by high quality health insurance," said Superintendent Mills. "These changes will help New York keep leading the nation in extending health insurance to everyone."

What Is A Medigap Policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage.

There are ten standardized Medigap plans called "A" through "J." The front of a Medigap policy must clearly identify it as "Medicare Supplement Insurance." **Each plan A through J has a different set of benefits.** Plan A covers only the basic (core) benefits. These basic benefits are included in all the Plans A through J. Plan J offers the most benefits. If you live in Massachusetts, Minnesota, or Wisconsin, different types of standardized Medigap plans are sold in your state.

When you buy a Medigap policy, you pay a **premium** to the insurance company. This premium is different than the Medicare Part B premium you must also pay. As long as you pay your premium, your policy is **guaranteed renewable**, which means it is automatically renewed each year. Your coverage will continue year after year as long as you pay your premium. If you buy a Medigap policy, it only covers your health care costs. It doesn't cover any health care costs for your spouse.

Important: In some states, insurance companies may refuse to renew a Medigap policy bought before 1990. At the time these policies were sold, state law was not required to say the Medigap policies had to be renewed automatically each year.

Medigap policies only help pay health care costs if you have the Original Medicare Plan. You don't need to buy a Medigap policy if you are in a Medicare + Choice Plan. In fact, it is illegal for anyone to sell you a Medigap policy if they know you are in one of these plans.

It is also illegal for an insurance company to sell you a Medigap policy if you have Medicaid except in certain situations.



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
25 BEAVER STREET
NEW YORK, NEW YORK 10004

The Office of General Counsel issued the following opinion on November 15, 2006 representing the position of the New York State Insurance Department.

RE: Sale of Medicare Supplement Insurance by Licensed Insurance Brokers

Questions Presented:

- 1) Does Medicare supplement insurance, known as "Medigap," constitute accident and health insurance under New York State Insurance Law?
- 2) Does a licensed insurance broker have authority to place Medicare supplement insurance policies on behalf of an insured pursuant to the 2003 revision of N.Y. Ins. Law § 2104¹ (McKinney 2006)?

Conclusions:

- 1) Yes, pursuant to New York Insurance Law § 1113(a)(3) (McKinney 2006) and N.Y. Comp. Codes R. & Regs. tit. 11, § 52.11 (Regulation 62), Medigap policies constitute accident and health insurance.
- 2) Yes, pursuant to New York Insurance Law § 2104, a licensed insurance broker may place Medicare supplement insurance policies for an insured. However, brokers had authority to place such policies prior to the 2003 amendments.

Facts:

No specific facts were provided.

Analysis:

New York Ins. Law § 1113 (McKinney's 2006) authorizes the various kinds of insurance policies that may be sold in New York and states in pertinent part:

(a) The kinds of insurance which may be authorized in this state, subject to other provisions of this chapter, and their scope, are set forth in the following paragraphs...

* * *

(3) "Accident and health insurance," means (i) insurance against death or personal injury by accident or by any specified kind or kinds of accident and insurance against sickness, ailment or bodily injury, including insurance providing disability benefits pursuant to article nine of the workers' compensation law, except as specified in item (ii) hereof; and (ii) non-cancellable

disability insurance, meaning insurance against disability resulting from sickness, ailment or bodily injury (but excluding insurance solely against accidental injury) under any contract which does not give the insurer the option to cancel or otherwise terminate the contract at or after one year from its effective date or renewal date.

N.Y. Comp. Codes R. & Regs. tit. 11, § 52.11 (Regulation 62) provides the parameters for the sale of Medicare supplement insurance (or "Medigap") and states in pertinent part:

(a) Medicare supplement insurance is an individual or group policy or certificate of *accident and health insurance* 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. This definition is applicable regardless of whether the policy form is labeled as Medicare supplement insurance (emphasis added).

Thus, according to the plain meaning of the statute and regulation, Medicare supplement insurance is a type of accident and health insurance. For the purposes of Regulation 62, accident and health insurance includes subscriber contracts issued by Article 43 corporations.

N.Y. Ins. Law § 2104 (McKinney's 2006) allows for the licensing of insurance brokers and states in pertinent part:

(b)(1) Such license shall confer upon the licensee authority to act in this state as insurance broker, and upon every natural person named as sub-licensee in such license authority to act in this state as insurance broker in the name of and on behalf of such licensee, with respect to the following lines of authority:

(A) life insurance, variable life and variable annuity products, accident and health insurance and sickness or any other line of authority deemed to be similar by the superintendent, including for this purpose, health maintenance organization contracts and legal services insurance; or

(B) any and every line of authority, except life insurance and variable life and variable annuity products.

A licensed insurance broker under either paragraph (A) or (B) of § 2104(b)(1) may sell accident and health insurance as specifically stated in the statute. The revisions made to § 2104 in 2003 were made to conform to the Gramm-Leach-Bliley Act (GLBA). Although some language was stricken from § 2104 and other phrases were added, "accident and health insurance" was not among them.

For further information you may contact Associate Attorney Sally Geisel at the New York City office

What Is Not A Medigap Policy?

A Medigap policy is not:

- Coverage you get from your employer or union,
- A Medicare + Choice Plan,
- Medicare Part B, and
- Medicaid.

Who Can Buy A Medigap Policy?

To buy a Medigap policy, you generally must have Medicare Part A and Part B. If you are under age 65 and you are disabled or have End-Stage Renal Disease (ESRD), you may not be able to buy a Medigap policy until you turn 65.

Can I Keep Seeing The Same Doctor If I Buy A Medigap Policy?

In most cases, yes. If you are in the Original Medicare Plan and you have a Medigap policy, you can go to any doctor, hospital, or other health care provider who accepts Medicare. However, if you have the type of Medigap policy called [Medicare SELECT](#), you must use specific hospitals and, in some cases, specific doctors to get your full insurance benefits.

Why Would I Want To Buy A Medigap Policy?

You may want to buy a Medigap policy because Medicare doesn't pay for all of your health care. There are "gaps" or costs that you must pay in the Original Medicare Plan. Remember, no Medigap policy will cover all the gaps in the Original Medicare Plan.

If you are in the Original Medicare Plan, a Medigap policy may help you:

- Lower your out-of-pocket costs, and
- Get more health insurance coverage.

What you pay out-of-pocket in the Original Medicare Plan will depend on the following:

- Whether your doctor or supplier accepts "assignment" which means takes Medicare's approved amount as payment in full,
- How often you need health care,
- What type of health care you need,
- Whether you buy a Medigap policy,
- Which Medigap policy you buy, and
- Whether you have other health insurance.

Section 4.8

MEDICARE BENEFIT SUMMARY (YEAR 2005)		
SERVICES	MEDICARE PAYS	YOU OR YOUR MEDIGAP INSURANCE PAYS
Hospital Inpatient Days 1-60 (Plan A does not pay) Days 61-90 Days 91-150 Days 151...	Full costs after \$876/stay deductible Full costs after co-insurance Full costs after co-insurance \$0	\$912 per benefit period \$228 per day per benefit period \$456 per day Full costs
Skilled Nursing Home Care Days 1-20 Days 21-100 Days 101...	(if patient meets Medicare's condition) Full Costs Full costs after co-insurance \$0	\$0 \$114 per day per benefit period* Full costs
Home Health Care Skilled Visits	100% if patient meets conditions	\$0
Hospice 210+ days	Full costs Most costs for drugs & respite care	\$0 Small co-payments
Medical Services	80% of approved amount after \$100 deductible	20% plus deductible and charges above approved amount
Clinical Lab Services	100% of approved amount	\$0
Outpatient Hospital Treatment	80% of approved amount	20% of billed charges
Most Outpatient Prescription Drugs	\$0	Full costs
<ul style="list-style-type: none"> • A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 50 days in a row or remain in a skilled nursing facility but do not receive care there for 60 days in a row. 		

MEDIGAP BENEFITS BY PLAN

MEDIGAP BENEFITS	A	B	C	D	E	F	G	H	I	J
BASIC BENEFITS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Hospital Deductible \$912		✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Skilled Nursing Home Co-Insurance – \$114.00			✓	✓	✓	✓	✓	✓	✓	✓
Part B: Deductible Plan C & F Only pay \$110			✓			✓				✓
Foreign Travel Emergence			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Part B: Excess Doctor Charges						100%	80%		100%	100%
Preventive (Care) Screening					✓					
Outpatient Prescription Drugs								Basic \$1,250	Basic \$1,250	Extend-ed \$3000
Notes:	<p>States may allow only some of the ten benefits plans to be sold. States may approve innovative additional benefit plans under certain circumstances. These standard benefit plans do not apply to policies sold in Massachusetts, Minnesota and Wisconsin. Availability of plans will vary from company to company.</p>									

Need help paying for Medicare? Ask your New York Medicaid Office about these Programs:

1) QMB — Qualified Medicare Beneficiary Program

- Pays your Medicare premiums, deductibles, and coinsurance
- You do not need Medicaid to get QMB

2) SLMB — Specified Low-Income Medicare Beneficiary Program

- Pays your Medicare Part B premium
- You do not need Medicaid to get SLMB

3) QI-1 — Qualifying Individual-1 Program

- Pays your Medicare Part B premium
- You do not need Medicaid to get QI-1

4) Medicaid

- May pay your Medicare premiums, deductibles, and coinsurance.
- Also covers additional benefits like prescription drugs and eyeglasses.
- If your income or savings seem a little too high, you should still contact your local Medicaid Office – you may qualify for a Medicaid “spend-down.”

Important Tips

- QMB, SLMB and QI-1 are sometimes called the “Medicare Buy-In,” “Medicare Premium Payment” or “Medicare Savings” Programs.
- If you are applying for Medicaid and want Medicaid to pay your Medicare premiums, be sure to check the “Medicare Buy-In” or “Medicare Savings” Programs box near the bottom of page one of the Medicaid application.
- If you think you were wrongly turned down for one of these programs, ask for a State Fair Hearing by the appeal deadline in your denial letter.

To get help paying for Medicare, just follow these 3 steps:

Check to see if your income and assets (savings) are within the limits for the government programs on this chart:

2003 New York Monthly Income Limits*			2003 New York Asset Limits**	
Program	Individuals	Couples	Individuals	Couples
QMB	\$ 769	\$1,030	\$4,000	\$6,000
SLMB	\$ 918	\$ 1,232	\$ 4,000	\$ 4,00
QI-1	\$1,031	\$1,384	None	None
Medicaid	\$ 662	\$ 954	\$3,850	\$5,600
* You may qualify even if your income is slightly higher. Ask a Medicaid counselor about eligible deductions.		** Asset limits do not include your house or car, and for all programs you and your spouse can each set aside an extra \$1,500 for a burial fund.		

Section 5.1

Group Life Insurance

What is group life insurance?

There are two different types of life insurance: **Permanent** and **Term**. Permanent covers a person for life, as long as he or she is paying the premium. A term policy provides coverage for an allotted amount of time. Most group life insurance policies are term policies - covering employees only while they are working for your business.

Group life insurance policies are taken out by an employer (the policy holder) and offered to employees (the insureds). As with any life insurance policy, if the employee dies, the benefit is paid to a beneficiary - often a family member - chosen by the employee. In most cases, once an employee retires or even takes a leave of absence, he or she isn't covered by a basic group life policy.

Although not the norm for small businesses, you can beef up a basic policy. Provisions like coverage of a spouse and children or coverage that pays out for a serious injury like dismemberment can be added on.

Most employers cover the basic premiums of group life insurance. If they offer additional coverage, employees will pay the extra cost. Businesses with 2 or more employees are eligible to receive group rates for their employee's health insurance. There are also plans for sole proprietors and self-employed individuals.

New York businesses with 2-50 employees are community rated. The age of the employees and other demographic factors do not affect the cost of the health plan. The health insurance rates for New York businesses with more than 50 employees are experience rated and determined by an employee census that shows the age, gender, resident zip code, and dependent status for all eligible employees. The underwriting department of the insurance company will also take into account other factors such as the SIC code, zip code and prior claims experience of the company. Generally, companies with a younger employee population will receive a lower rate than companies with an older staff. Whether you're a very small company with just a few employees or have several hundred employees our services can be of great value to your organization

Section 5.2

Carve Out Plans

The primary reason for the popularity of group term life insurance with employers is that it's viewed as a fairly inexpensive benefit. For the most part, it can be, especially if there are a number of younger, lower-paid workers on the payroll. However, when the business includes its older, higher-paid executives, including the owners themselves, the result can be a "so-so" benefit at an "oh-no" price.

The Group Carve-Out Alternative

Business owners may want to consider what could be a more cost-effective alternative: group carve-out insurance. If group term coverage is provided to employees, a group carve-out can provide a valuable alternative. Under most group policies, especially for small businesses, all employees are treated as part of a single group. Each individual receives a life insurance benefit

equal to a multiple of his or her salary. Example: If the benefit is three times salary, a worker earning \$24,000 a year will receive life insurance coverage equal to \$72,000. As benefits go, it just doesn't get any simpler than that.

There's also a very nice tax break. The cost of providing up to \$50,000 of death benefit is one hundred percent deductible to the employer.

Weaknesses of Group Term Life Insurance

Unfortunately, group term life insurance also has several serious weaknesses. This is especially true for businesses with older, higher-paid employees and owner-employees. Among the problems:

1. **Costs rise with age.** Group term insurance can be quite cost-effective when predominantly younger workers are involved. However, costs increase every year. Premiums for employees in their 50s can be many times higher than the costs for workers in their 20s. By the time they enter their 60s, costs to continue providing this benefit can become prohibitive.
2. **Costs rise with income.** Group term coverage works just fine when you are talking about incomes for lower-paid employees. But take an owner-employee or other key executive earning \$175,000. At three times earnings, he or she is now receiving \$525,000 of life insurance benefit.

Couple age and income: since most highly-paid employees are also older, you could have massive costs for group term coverage at the top end. Plus, since rates are pooled for the group, the cost for including even a small number of older, higher-paid employees can drive up costs across the board.

3. **The tax break disappears for benefit amounts above \$50,000.** Up to that point, the employee does not report the value of the benefit as income. However, the value beyond that limit is treated as imputed income to the employee, based on what is referred to as Table I costs provided by the IRS. The result can be an unpleasant tax surprise.
1. Take the example of a 60-year old employee with \$500,000 of group term coverage. That means the employee must count the cost of \$450,000 (everything above \$50,000) as imputed income. Under current Table I rates, that value is calculated as \$1.17 per \$1,000 of benefit per month, which comes to \$526.50 per month, or \$6,318 a year.

Do the costs ever stop rising, or stop completely? Yes. But, unfortunately, so do the benefits. The life insurance benefit generally expires at retirement, or shortly thereafter, without value. In many instances, a great deal of money is spent to furnish a benefit that is never used. The irony is that group term insurance is a benefit that can be quite expensive before retirement — and one that goes away after retirement.

The Mechanics of Group Carve-Out

The solution for a growing number of business owners is group carve-out insurance — so named because older, higher-paid employees are 'carved out' of the group plan and are instead provided with permanent, cash value life insurance.

The mechanics of group carve-out are fairly simple. You reduce the amount of group term coverage on your highly-paid individuals to \$50,000. The remainder of the benefit is put into permanent, cash value life insurance owned by the employee.

There are costs involved, but the more important question involves the value of the long-term benefit to the individual. There are several ways the costs can be arranged. For instance, let's say the corporation pays the employee the equivalent of what it would have paid for the comparable term coverage. Since the premium is treated as compensation, the amount is fully deductible to the corporation. While the employee pays taxes on the additional income, he or she acquires a growing asset in the form of a permanent life insurance policy.

There are a number of advantages to everyone under this arrangement. They include:

1. The corporation can deduct 100% of its payments as a bona fide business expense.
2. The benefit does not expire at retirement. Instead, since this is cash value life insurance, it accumulates cash value each year.
3. The premium need not increase with age. Under many cash value policies, the premium can be locked in at the level when the policy was issued. Premium costs do not become prohibitively expensive in later years.
4. It can dramatically improve the cost/benefit equation. Since higher-paid employees are carved out of the group term policy, the cost to the company for providing coverage for other employees is reduced.
5. The employee owns the life insurance. Especially for owner-employees, this becomes a permanent, life-long benefit.
6. It always pays, provided the coverage is maintained. Cash value life insurance provides lifelong insurance protection. With few exceptions, once the policy has been issued, it cannot be canceled by the carrier, provided all required premiums are paid. Regardless of health or other factors, the insurance remains in force.
7. Higher initial premiums can actually be less expensive than term in the long run. Many of today's interest-sensitive policies pay dividends and have a [premium offset plan](#) feature. The premium offset plan allows premiums to be paid from non-guaranteed policy values. (A reduction in the applicable dividend scale may result in further out-of-pocket cash premium payments being made necessary.) As a result, premiums can be paid from policy dividends, yet coverage can continue for life. As a result, the long-term net cost can be quite low compared to the total costs for a term policy.
8. It builds cash value. This amount can be used in the future for any purpose — for a down payment on a home, to help pay for children's education or to supplement income in retirement. (Note: Borrowing cash value from your policy will decrease total policy values.)

Is a group carve-out arrangement right for you and your business? That will depend on a number of factors. But it certainly is worth finding out.

Regulation 60 Disclosure Statement Completion Instructions **for Appendix 10A**

(To be used on all replacements other than annuity to annuity)

All questions must be completed. Use N/A (Not Applicable) when appropriate.

- 1. Name of Applicant** – Print name of person applying for coverage.
- 2. Telephone Number** – Home telephone number of applicant.
- 3. Address** – Full address of applicant.
- 4. Name of Agent** – Print name of agent writing new coverage.
- 5. Telephone Number** – Agent's business telephone number.
- 6. Company** – Name of Agency or Company affiliation, if any.
- 7. Address** – Agency business address.
- 8. Source used to complete information** – If any information on existing coverage was received from the replaced company, mark "X" in "the replaced company" box. If any approximations were used because requested information was not provided by the replaced company, mark "X" in the "approximations" box.

1. Description of Transaction Section

- 9. As of Date** – Date the stated values were measured.
- 10. Company** – Names of insurance companies for existing and proposed policies.
- 11. Customer Service Telephone Number** – Customer Service telephone numbers for existing and replacing insurance companies.
- 12. Type of Insurance** – Type of insurance (i.e. Term, Whole Life, Universal Life).
- 13. Face Amount** – Face amount of base policy excluding riders.
- 14. Riders** – Indicate type of rider and benefit amount (if applicable) for all riders attached to base policy.
- 15. Premium** – Include the premium for the base policy and all riders. Premium should be annualized if applicant is paying a premium mode other than annual.
- 16. Contract Number** – Policy/contract/certificate number of existing policies (blank for proposed policy).
- 17. Issue Date** – Issue date of existing policies.
- 18. Surrender Charge** – Specify current surrender charge of policies (if applicable).
- 19. Guaranteed Interest Rate** – Specify contract minimum guaranteed interest rate (if applicable) for existing and proposed policy.
- 20. Loan Interest Rate** – Indicate loan interest percentage (if applicable) for existing and proposed policy.
- 21. Contestable Expiry Date** – Indicate if contestable period has expired or contestable expiry date (month and year) for current policies and duration of contestable period for proposed policy.
- 22. Suicide Expiry Date** – Indicate if suicide period has expired or suicide expiry date (month and year) for current policies and duration of suicide period for proposed policy.
- 23. Lapse or Surrender** – Check if existing policy(ies) are to be lapsed or surrendered.
- 24. Amendment or Re-Issue** – Check if existing policy(ies) are to be amended or re-issued.
- 25. Loan or Withdrawal** – Check if existing policy(ies) cash value will be borrowed or withdrawn.
- 26. Reduction To** – Indicate reduced face amount of existing policies.

27. Reduced Paid Up For – Indicate new face amount if policy(ies) are being placed on reduced paid-up non-forfeiture option.

28. Extended Term For – Specify the duration of Extended Term Period if policy(ies) are being placed on Extended Term Insurance (ETI) non-forfeiture option.

29. Cash Release at Time of Change – Enter applicable year and dollar amount of funds released by exercising one of the above changes.

30. Use of Cash Released – Describe how the cash released will be used (e.g., 1035 Exchange, pay premiums on proposed policy).

2. Summary Result Comparison Section

New With Existing Coverage Changed [Values reflecting planned changes for existing policy(ies)]

31A, B&C Annual Premium – Indicate total annualized premium on a guaranteed and non-guaranteed basis at present, five years hence and ten years hence for proposed policies. Premiums should be annualized if applicant is paying a premium made other than annual.

32A,B & C Surrender Value – Indicate surrender value (net of loan) on a guaranteed and non-guaranteed basis at present, five years hence and ten years hence for proposed policies.

33A,B&C Death Benefit – Enter death benefit on a guaranteed and non-guaranteed basis at present, five years hence and ten years hence for proposed policies.

34A,B&C Dividends – Enter illustrated dividends, if applicable, at present, 5 years hence and ten years hence for proposed policies. [To be completed if dividends are not included above in Surrender Value and Death Benefit.]

Existing Coverage Unchanged

35A,B&C Annual Premium – Indicate total combined existing policy(ies) annual premium based on existing coverage unchanged on a guaranteed and non-guaranteed basis, at present, five years hence and ten years hence.

36A,B&C Surrender Value – Enter total combined existing policy(ies) surrender value on a guaranteed and non-guaranteed basis, at present, five years hence and ten years hence based on existing coverage unchanged.

37A,B&C Death Benefit – Enter total combined existing policy(ies) death benefit on a guaranteed and non-guaranteed (including paid-up additions) basis, at present, five years hence and ten years hence based on coverage unchanged.

38A,B&C Dividends – Enter illustrated dividends, if applicable, at present, five years hence and ten years hence based on existing coverage unchanged. [To be completed if dividends are not included above in Surrender Value and Death Benefit.]

3. Agent Statement Section

39. Disclosure Question 1 – Enter the reason(s) for recommending the new life policy or annuity contract (i.e., lower premium).

40. Disclosure Question 2 – Enter the reason why the existing insurance policy(ies) or annuity contract(s) cannot meet the applicant's objectives (e.g., too expensive, not enough coverage).

41. Disclosure Question 3 – List the advantages of continuing the existing insurance policy or annuity contract (e.g., contestability and suicide clause have expired).

42. Remarks – Enter any pertinent comments bearing on the transaction.

43. Proposal Used – Check the appropriate box indicating if a proposal/sales material was used to make the sale.

44. Agent Certification – Agent signs and dates.

45. Applicant's Acknowledgment – Applicant and spouse (if his/her policy will be replaced with new coverage) sign and date. If applicant and owner are different, owner must sign also.

DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

As PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?

Yes __ No __

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES?

Yes __ No __

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE?

Yes __ No __

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES?

Yes __ No __

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES?

Yes __ No __

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID?

Yes __ No __

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION No. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

To THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION:
YES __ No __

Date: _____ Signature of Agent: _____

Insurance Department of the State of New York
Important Notice
THIS NOTICE IS FOR YOUR BENEFIT
AND REQUIRED BY REGULATION NO. 60

YOU ARE CONTEMPLATING THE PURCHASE OF A LIFE INSURANCE POLICY OR ANNUITY CONTRACT IN CONNECTION WITH THE SURRENDER, LAPSE OR CHANGE OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. THE AGENT IS REQUIRED TO GIVE YOU THIS NOTICE TOGETHER WITH A SIGNED DISCLOSURE STATEMENT CONTAINING THE SUMMARY RESULT COMPARISON FOR THE NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT AND ANY LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS TO BE CHANGED THAT SETS FORTH THE FACTS OF THE TRANSACTION AND ITS ADVANTAGES AND DISADVANTAGES TO YOU. YOUR DECISION COULD BE A GOOD ONE – OR A MISTAKE – SO MAKE SURE YOU UNDERSTAND THE FACTS. YOU SHOULD:

- 1) CARFULLY STUDY THE DISCLOSURE STATEMENT, WHICH INCLUDES A SUMMARY RESULT COMPARISON, UNTIL YOU ARE SURE YOU UNDERSTAND FULLY THE EFFECT OF THE TRANSACTION.
- 2) ASK THE COMPANY OR AGENT FROM WHOM YOU BOUGHT YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS TO REVIEW WITH YOU THE TRANSACTION AND THE DISCLOSURE STATEMENT. YOU MAY BE ABLE TO EFFECT THE CHANGES YOU DESIRE MORE ADVANTAGEOUSLY WITH THEM. THEIR CUSTOMER SERVICE TELEPHONE NUMBER IS CONTAINED IN THE DISCLOSURE STATEMENT.
- 3) CONSULT YOUR TAX ADVISOR. THERE MAY BE UNFAVORABLE TAX IMPLICATIONS ASSOCIATED WITH THE CONTEMPLATED CHANGES TO YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

- 1) The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured's then attained age.
- 2) Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provision for surrender charges, therefore a replacement involving annuity contracts may result in the imposition of surrender charges.
- 3) The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.

**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DISCLOSURE STATEMENT**

IMPORTANT - IT MAY NOT BE IN YOUR BEST INTEREST TO SURRENDER, LAPSE, CHANGE OR BORROW FROM EXISTING UFE INSURANCE POLICIES OR ANNUITY CONTRACTS IN CONNECTION WITH THE PURCHASE OF A NEW UFE INSURANCE POLICY OR ANNUITY CONTRACT WHETHER ISSUED BY THE SAME OR A DIFFERENT INSURANCE COMPANY. YOU ARE URGED TO CONTACT YOUR EXISTING AGENT OR INSURANCE COMPANY PRIOR TO COMPLETING THE TRANSACTION. THEY CAN HELP YOU DECIDE WHETHER THE REPLACEMENT IS IN YOUR BEST INTEREST.

FOR YOUR PROTECTION, the Insurance Department of the State of New York requires that you be given this Disclosure Statement, the **IMPORTANT** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts and the Definition of Replacement, together with policy information on all proposed and existing coverage affected.

Name of Applicant(s) _____ Telephone Number _____

Address _____

Name of Agent _____ Telephone Number _____

Agents Address _____

The Information On Existing Coverage On This Form Was Obtained From:

The following replaced company (ies): _____

Approximations if the following replaced company (ies) failed to provide information

in the prescribed time:

Description of Transaction:				
Proposed Policy/Contract		Existing Policies/Contracts Affected		
		(1) As of _____	(2) As of _____	(3) As of _____
_____	Company Name	_____	_____	_____
_____	Customer Service Phone Number	_____	_____	_____
_____	Contract Number	# _____	# _____	# _____
_____	Issue Date	_____	_____	_____
_____	Type of Insurance	_____	_____	_____
\$ _____	Base Policy Face Amount	\$ _____	\$ _____	\$ _____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
_____	Rider _____	_____	_____	_____
\$ _____	Total Annualized Premium	\$ _____	\$ _____	\$ _____
N/A	Current Surrender Charge	\$ _____	\$ _____	\$ _____
_____ %	Guaranteed Interest Rate	_____ %	_____ %	_____ %
_____ %	Current Loan Interest Rate	_____ %	_____ %	_____ %
_____	Current Loan Balance	_____	_____	_____
_____	Contestable Expiry Date	_____	_____	_____
_____	Suicide Expiry Date	_____	_____	_____

Existing coverage to be changed			
Existing coverage to be changed by:	(1)	(2)	(3)
Lapse or Surrender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amendment or Reissue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loan or Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Death Benefit			
Reduction To	\$ _____	\$ _____	\$ _____
Reduced Paid-Up	\$ _____	\$ _____	\$ _____
For	_____	_____	_____
Extended Term to	_____	_____	_____
Other	_____	_____	_____

Use of cash released:

2. Summary Result Comparison

Proposed With Existing Coverage Changed			Existing Coverage Unchanged	
Guaranteed	Non-Guaranteed		Guaranteed	Non-Guaranteed
		Annualized Premium		
\$ _____	\$ _____	Current Year	\$ _____	\$ _____
\$ _____	\$ _____	5 Years Hence	\$ _____	\$ _____
\$ _____	\$ _____	10 Years Hence	\$ _____	\$ _____

		Surrender Value		
\$ _____	\$ _____	End of 1 st Year	\$ _____	\$ _____
\$ _____	\$ _____	5 Years Hence	\$ _____	\$ _____
\$ _____	\$ _____	10 Years Hence	\$ _____	\$ _____

		Death Benefit		
\$ _____	\$ _____	End of 1 st Year	\$ _____	\$ _____
\$ _____	\$ _____	5 Years Hence	\$ _____	\$ _____
\$ _____	\$ _____	10 Years Hence	\$ _____	\$ _____

		Dividends		
	\$ _____	End of 1 st Year		\$ _____
	\$ _____	5 Years Hence		\$ _____
	\$ _____	10 Years Hence		\$ _____

Agents Statement:

2. The primary reason (s) for recommending the new life insurance policy or annuity contract is (are):

3. The existing life insurance policy or annuity contract cannot meet the applicant's objectives because:

4. The advantages of continuing the existing life insurance policy or annuity contract without changes are:

Remarks

The attached proposal, including sales material, was used in this sale.

No proposal or sales material was used in this sale.

If more than three existing life insurance policies or annuity contracts are to be affected by this transaction or if more than one new life or annuity contract is proposed, Section 1 of this Disclosure Statement must be completed for such additional life insurance policies and annuity contracts. In addition, a composite comparison shall be completed of all existing life insurance policies or annuity contracts to all proposed life insurance policies or annuity contracts. The proposal, including sales material used in the sale of the proposed life insurance policy or annuity contract, must accompany the submission of this form to the insurer. Copies must be given to the applicant.

Date: _____ Signature of Agent: _____

I hereby acknowledge that I received and read the above Disclosure Statement before I signed the application for new coverage.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

Pensions and Profit Sharing

A **pension plan** is an agreement between an employer and its employees to pay retirement benefits. A defined benefit pension plan states the benefits that management must pay, according to a predetermined formula. A defined contribution pension plan states the required contributions management must make, not the benefits it must pay; outlays to beneficiaries depend on the investment return on funds invested in the pension plan. Employees may also be required or allowed to contribute to a firm's pension plan. A pension plan usually contains tax benefits for both the employer and beneficiary: the investment income of a pension fund is ordinarily tax-exempt, and benefits paid to retirees are taxed when paid, not earned. Nevertheless, the defined benefit pension plan has been losing ground in recent years: in 1985, defined benefit pension plans numbered 112,000 in the U.S., compared with just 31,000 in 2003.

Profit Sharing

Profit sharing refers to the process whereby companies distribute a portion of their profits to their employees. Profit-sharing plans are well established in American business. The annual U.S. Chamber of Commerce Employee Benefits Survey indicates that somewhere between 19 and 23 percent of U.S. companies have offered some form of profit sharing since 1963. Other estimates place the number of companies offering profit-sharing plans in the 1990s somewhere between one-fourth and one-third of all U.S. firms. For small businesses, profit sharing provides an important means of increasing employee loyalty and tying employee compensation to company performance. Profit sharing is a particularly attractive option for newer small businesses with uncertain profit levels, as it allows business owners to share the wealth during good times without obligating them to do so during lean years.

The Employee Retirement Income Security Act of 1974 (ERISA) provided a boost in the use of profit-sharing plans. ERISA regulates and sets the standards for pension plans and other employee benefit plans. Many employers found that a simple profit-sharing plan avoided many of ERISA's rules and regulations that affected pension plans.

Types of Profit-Sharing Plans

Companies may use any number of different formulas to calculate the distribution of profits to their employees and establish a variety of rules and regulations regarding eligibility, but there are essentially two basic types of profit-sharing plans. One type is a cash or bonus plan, under which employees receive their profit-sharing distribution in cash at the end of the year. The main drawback to cash distribution plans is that employee profit-sharing bonuses are then taxed as ordinary income. Even if distributions are made in the form of company stock or some other type of current payment, they become taxable as soon as employees receive them.

To avoid immediate taxation, companies are allowed by the Internal Revenue Service (IRS) to set up qualified deferred profit-sharing plans. Under a deferred plan, profit-sharing distributions are held in individual accounts for each employee. Employees are not allowed to withdraw from their profit-sharing accounts except under certain, well-defined conditions. As long as employees do not have easy access to the funds, money in the accounts is not taxed and may earn tax-deferred interest.

Under qualified deferred profit-sharing plans, employees may be given a range of investment choices for their accounts, including stocks or mutual funds. Such choices are common when the accounts are managed by outside investment firms. It is becoming less common for companies to manage their own profit-sharing plans due to the fiduciary duties and liabilities associated with them. A 401(k) account is a common type of deferred profit-sharing plan, with several unique features. For example, employees are allowed to voluntarily contribute a portion of their salary, before taxes, to their 401(k) account. The company may decide to match a certain percentage of such contributions. In addition, many 401(k) accounts have provisions that enable employees to borrow money under certain conditions.

Section 6.2

Other Issues Concerning Profit-Sharing Plans

Deferred profit-sharing plans are a type of defined contribution plan. Such employee benefit plans provide an individual account for each employee. Individual accounts grow as contributions are made to them. Funds in the accounts are invested and may earn interest or show capital appreciation. Depending on each employee's investment choices, their account balances may be subject to increases or decreases reflecting the current value of their investments.

The amount of future benefits that employees will receive from their profit-sharing accounts depends entirely on their account balance. The amount of their account balance will include the employer's contributions from profits, any interest earned, any capital gains or losses, and possibly forfeitures from other plan participants. Forfeitures result when employees leave the company before they are vested, and the funds in their accounts are distributed to the remaining plan participants.

Employees are said to be vested when they become eligible to receive the funds in their accounts. Immediate vesting means that they have the right to funds in their account as soon as their employer makes a profit-sharing distribution. Companies may establish different time requirements before employees become fully vested. Under some deferred profit-sharing plans employees may start out partially vested, perhaps being entitled to only 25 percent of their account, then gradually become fully vested over a period of years. A company's vesting policy is written into the plan document and is designed to motivate employees and reduce employee turnover.

In order for a deferred profit-sharing plan to gain qualified status from the IRS, it is important that funds in employee accounts not be readily accessible to employees. Establishing a vesting period is one way to limit access; employees have rights to the funds in their accounts only when they become partially or fully vested. Another way to limit access is to establish strict rules for making payments from employees accounts, such as upon retirement, death, permanent disability, or termination of employment. Less strict rules may allow for withdrawals under certain conditions, such as financial hardship or medical emergencies. Nevertheless, whatever rules a company may adopt for its profit-sharing plan, such rules are subject to IRS approval and must meet IRS guidelines.

The IRS also limits the amount that employers may contribute to their profit-sharing plans. The precise amount is subject to change by the IRS, but 1996 tax rules allowed companies to contribute a maximum of 15 percent of an employee's salary to his or her profit-sharing account.

If a company contributed less than 15 percent in one year, it may exceed 15 percent by the difference in a subsequent year to a maximum of 25 percent of an employee's salary.

Companies may determine the amount of their profit-sharing contributions in one of two ways. One is by a set formula that is written into the plan document. Such formulas are typically based on the company's pre-tax net profits, earnings growth, or some other measure of profitability. Companies then plug the appropriate numbers into the formula and arrive at the amount of their contribution to the profit-sharing pool. Rather than using a set formula, companies may decide to contribute a discretionary amount each year. That is, the company's owners or directors—at their discretion—decide what an appropriate amount would be.

Once the amount of the company's contribution has been determined, different plans provide for different ways of allocating the funds among the company's employees. The employer's contribution may be translated into a percentage of the company's total payroll, with each employee receiving the same percentage of his or her annual pay. Other companies may use a sliding scale based on length of service or other factors. Profit-sharing plans also spell out precisely which employees are eligible to receive profit-sharing distributions. Some plans may require employees to reach a certain age or length of employment, for example, or to work a certain minimum number of hours during the year.

Although profit sharing offers some attractive benefits to small business owners, it also includes some potential pitfalls. It is important for small business owners who wish to share their success with employees to set up a formal profit sharing plan with the assistance of an accountant or financial advisor. Otherwise, both the employer and the employees may not receive the tax benefits they desire from the plan. Also, small business owners should avoid making mentions of profit sharing or stock ownership to motivate employees during the heat of battle. Such mentions could be construed as promises and lead to lawsuits if the employees do not receive the benefits they feel they deserved.

Business Succession Planning / Buy Sell Agreements

In the sale of a business, a buy-sell clause (or shotgun clause) in a shareholder agreement preserves continuity of ownership in the business and insures that everyone is fairly treated, the buyer as well as the seller. It is a binding contract between business partners or [shareholders](#) about the future ownership of the business. A buy-sell agreement is made up of several legally binding clauses in a business partnership or operating agreement (or it can be a separate agreement that stands on its own) that can control the following business decisions:

- Who can buy a departing partner's or shareholder's share of the business (this may include outsiders or be limited to other partners/shareholders);
- What events will trigger a [buyout](#), and;
- What price will be paid for a partner's or shareholder's interest in the partnership and so on.

A buy-sell agreement may be thought of as a sort of "premarital agreement" between business partners/shareholders.

Section 7.1

Structuring Corporate Buy-Sell Agreements
Securing a Future for Closely Held Corporations

By David Joy, Jo Koehn, and Janice Klimek

Within a closely held corporation, shareholders are often concerned about what might occur if one of the owners dies. Will the deceased shareholder's family retain the economic value of the corporate interest? Can the surviving owners avoid interference from the deceased shareholder's family? Will the survivors have the economic resources to redeem the deceased owner's interest? Given these concerns, corporate owners are best served by entering into a buy-sell agreement while they are all alive.

Forms of Buy-Sell Agreements and Tax Implications

Owners usually choose from two basic types of buy-sell agreements. With a cross-purchase agreement, each owner of the corporation purchases an insurance policy on the other shareholders. The purchaser is both owner and beneficiary of the policies. Upon the death of a shareholder, the other shareholders are then able to use the life insurance proceeds to purchase the deceased owner's shares. Another commonly used type of agreement is a stock redemption agreement, in which the corporation owns policies on the lives of the shareholders. When a shareholder dies, the corporation buys the deceased shareholder's interest in the company with the insurance proceeds.

Cross-purchase agreements. The cross-purchase form of the buy-sell agreement offers several advantages. The family of the deceased owner will have a tax basis equal to the fair market value of the decedent's stock at the date of death, thus avoiding any income tax consequences as a result of the sale. The fair market value of the shares should be defined by the buy-sell agreement (see the [Exhibit](#)).

The life insurance proceeds received by the surviving owners are not subject to income taxation. For newly purchased shares, the corporate shareholders will be entitled to a tax basis equal to the purchase price. The stepped-up basis should reduce future income taxes if the surviving shareholders later sell their interests. The insurance proceeds are not subject to the corporate alternative minimum tax (AMT) and are also not subject to the claims of corporate creditors. The AMT avoidance and creditor protection exist because the proceeds are paid directly to the individual shareholders.

The cross-purchase form of the buy-sell agreement carries several disadvantages. The plan is difficult to administer if there are numerous shareholders that must buy a plan for each other. For example, for seven owners to cross-purchase life insurance would require 42 (7 × 6) policies. The number of policies can multiply even further if disability coverage is also part of the buy-sell agreement.

Another disadvantage of the cross-purchase agreement is that age or insurability can create a disparity in premiums. Younger or healthier owners may incur higher premiums to cover older and less healthy owners. A possible solution to this drawback is to have the corporation raise salaries to cover the premiums incurred by the owners. Inequities may persist, however, if

owners' marginal tax rates applied to the salary reimbursements are different. Additionally, cross-purchase agreement adopters should recognize that the cost of funding the buy-sell agreement will be greater if the shareholders have a higher tax rate than the corporation.

Stock redemption agreements. Under a stock redemption agreement, the corporation owns policies on the lives of the shareholders. When a shareholder dies, the corporation buys the deceased shareholder's interest in the company with the insurance proceeds. A prime advantage of the stock redemption agreement is that it is easier to administer for multiple shareholders. An additional advantage to the stock redemption structuring of the buy-sell agreement is that the corporation will bear the premium differences associated with age disparities among shareholders.

The corporation will not recognize income for tax purposes when it receives the insurance proceeds. The corporation must, however, heed the effect of the entire transaction (proceeds received and redemption accomplished) on the earnings and profits of the corporation. The earnings and profits will increase with the life insurance proceeds received and decrease as a result of the stock redemption, so the corporation must attend to the overall net effect on earnings and profits and consider how that might affect the dividend policy to shareholders. For example, in the Exhibit's Scenario 3, the corporation may have to issue dividends to avoid the accumulated earnings tax on earnings and profits, assuming that the reasonable needs of the business do not justify maintaining earnings and profits above the \$250,000 credit (IRC section 535). These dividends would be taxed to the remaining shareholders at ordinary income rates.

A significant disadvantage of the stock redemption form of the buy-sell agreement is that the remaining shareholders do not get the benefit of a step-up in basis when the corporation purchases the deceased shareholder's interest. The continuing shareholders retain their original bases in the company. Compared to the cross-purchase agreement, the stock redemption structuring will create greater capital gains upon the ultimate disposition of shares if made before death. After the stock redemption is accomplished, however, the corporate assets should be relatively unchanged (the insurance proceeds have been used to purchase the deceased's interest), but each owner now enjoys a greater percentage of ownership.

Section 7.2

Estate tax implications. When a cross-purchase plan exists, the proceeds from the life insurance are not included in the deceased shareholder's estate. The deceased is not the owner of the policy and, therefore, the insurance proceeds payable at death are not included in the estate. Under a redemption approach, however, the estate tax consequences can become more pronounced when the deceased shareholder has a controlling interest. A shareholder who owns more than a 50% interest either directly or indirectly is deemed to control a corporation, under IRC section 267. In this situation, the shareholder is deemed to have an ownership interest in the life insurance policy due to the shareholder's ability to designate a beneficiary, as well as other ownership interests. The fact that control exists over the policy in majority ownership instances would result in the proceeds being includable in the deceased's estate. Thus, the after-tax returns on life insurance policies can be substantially reduced if estate taxes are incurred as a result of the life insurance proceeds being included in the estate.

In the case of family-owned corporations, purchase prices specified by the buy-sell agreements are often disputed by the IRS as not representing fair value. If a corporation owns life insurance for the purposes of funding the redemption of the stock, and the deceased shareholder owns a

controlling interest in the corporation, the probability that the life insurance policy will be included in the decedent's estate is substantial. Note, however, that if the family members own the insurance policy on the decedent, they will receive the life insurance proceeds without including them in the taxable estate. Thus, the cross-purchase option may be preferable to the redemption option.

Section 7.3

Valuation Issues of Buy-Sell Agreements

There is a distinct difference between the values that should be established for the two alternative approaches to a buy-sell agreement. This difference is due to the ownership of the life insurance policy. In a cross-purchase agreement, the deceased shareholder has no economic interest in the life insurance policy on his life. Accordingly, the surviving shareholders should expect to pay the fair market value of the underlying net assets, which represents the value of the business operations.

Under the stock redemption approach, the corporation owns the policies, and therefore the value of the corporation includes both the business operations and the insurance policies. The redemption price of a buy-sell agreement should typically include a portion of the life insurance proceeds. If the stock redemption agreement is so structured, the tax implications may be negative, because the life insurance proceeds may be subject to both estate tax and income tax if the decedent is deemed to possess an ownership interest in the policy. Given these tax implications, including the value of life insurance proceeds in the buy-sell valuation price may result in an unsatisfactory after-tax return.

Another valuation issue is that the premiums on older shareholders can be considerably higher than the premiums on younger shareholders. As each unit of stock incurs the same cost, older shareholders will incur higher premiums than they would under a cross-purchase plan. Accordingly, younger shareholders expect to reap a greater benefit from the insurance policies than their older counterparts. Thus, younger shareholders would be entitled to a greater benefit at a lower cost under a stock redemption approach than for a cross-purchase approach.

This scenario suggests that the redemption price should include a portion of the life insurance payments, unless older shareholders are compensated for the disparity in the premiums. This would convert potentially nontaxable deferred income into accelerated taxable income. It would also precipitate similar adjustments for the purchase price for younger shareholders. The proper pricing for a buy-sell agreement becomes much more complex in the case under the redemption alternative.

Section 7.4

Funding of the Buy-Sell Agreement

Type of insurance. Any buy-sell agreement requires a decision regarding the type of insurance policy to purchase. The initial choice is between term and whole life insurance. Premiums for term life insurance increase throughout the coverage period, whereas premiums for whole life are level throughout the coverage period. If the shareholder dies in the first few years of coverage, the cost of term insurance will be less than the cost of whole life insurance. Conversely, the cost of term life may be much greater than whole life if an individual exceeds the life expectancy used for underwriting the whole life insurance policies.

Whole life insurance with cash value buildups can offer advantages. If policies are held for a significant number of years, the cash values of whole life policies can supplement pension benefits or help fund shareholder buyouts. Additionally, the policy's cash value is a liquid asset of the corporation that may help secure advantageous loan terms for the company.

Shareholders may choose to forgo whole life insurance and purchase term insurance. The early premiums saved may be invested in the company to either reduce debt or promote growth. In favorable economic conditions, the return on investment will typically be greater than the earnings attributed to the cash value of the whole life policy. The possibility of premium savings in the event of premature death and the excess expected returns on premium differences invested are advantages for term insurance.

In addition to cost, insurability is a key consideration. The ability to maintain life insurance throughout a shareholder's life is important. Whole life insurance policies grant coverage until death that may not be cancelled by the insurance company. This feature has persuaded many that whole life insurance is the proper means to finance corporate buy-sell agreements. The term life insurance industry has, however, modified its products so that policyholders can purchase term life with the same benefit. This can be accomplished with either a guaranteed insurability option or lengthy (20- to 30-year) policy terms. The addition of a guaranteed insurability option to a term policy will increase the cost of the term insurance. The increased premium, however, will still be lower than whole life premiums in the beginning years. Owners, therefore, must weigh the escalating premium structure of term insurance against the early returns that might be realized by purchasing less-expensive term insurance and investing the premiums saved.

With time, the value of a successful corporation will grow. Assuming the buy-sell agreement ties the purchase price to fair market value, owners should ensure that additional life insurance can be acquired over time to keep pace with the increasing value of corporate shares. Typically, guaranteed insurability options (available on either term or whole policies) allow the policyholder to acquire additional life insurance at timed intervals.

When a shareholder dies, several issues arise with respect to policy ownership by the deceased and the remaining shareholders in the cross-purchase arrangement. The policies insuring remaining shareholders but owned by the deceased will carry beneficiary designations, generally family members. With whole life, the family inherits the cash surrender value of the policies. With no continued business purpose, and out of courtesy to the surviving shareholders, the surviving family beneficiaries may choose to cash out the value of the policies.

Under a cross-purchase approach, the death of a corporate shareholder will not diminish the value of the enduring corporation. Because individuals and not the corporation hold the life insurance policies, the receipt of death benefits or cash values by the policy beneficiaries will not decrease the assets of the corporation. This fact does, however, create a funding issue for the remaining shareholders. The remaining cross-purchased policies will likely not cover the continuing value of the business. The surviving shareholders may need to address the shortfall by purchasing additional insurance if other funds are not readily available.

An alternative to purchasing additional insurance would be to use term life insurance to fund the buy-sell agreement. The value of a term life policy is normally equal to the unearned premium for the year of death, usually very small in comparison to whole life insurance. Given this low value of term life insurance, shareholders should consider purchasing term insurance as joint

tenants with rights of survival. The insurance policies could then transfer from the deceased shareholder to the surviving shareholders without triggering the recognition of income upon the death of the insured.

Uninsurable shareholders. The preceding discussion has assumed that the shareholders can obtain new insurance policies on each other. Some individuals, however, may not be insurable at the time that the buy-sell agreement is adopted. In this case, the only alternative is to use an existing policy of the uninsurable shareholder. Such shareholders hopefully own whole life insurance policies on their lives that have appreciated in value. A shareholder will typically expect to be compensated for the cash surrender value of the policy upon transferring it to either the corporation or fellow shareholders. The most important factor in determining which party to sell the policy to is the tax treatment afforded when the insurance proceeds are ultimately received. If the corporation purchases the policy, the insurance proceeds will not be taxable; if the shareholders purchase the policy, the insurance proceeds will be taxable. The shareholders must weigh the tax advantages of the corporate stock redemption against the tax advantage of using a cross-purchase buy-sell approach. If a policy must be purchased because there is an uninsurable shareholder, the issues are the same as previously discussed except that now the shareholders that have purchased the uninsurable's policy must pay taxes when the proceeds are received. Recall that although the insurance proceeds will be nontaxable to the corporation when the life insurance proceeds are received, the remaining shareholders must weigh this benefit against the fact that they will not receive a step-up in basis upon the death of the noninsurable shareholder. Accordingly, as the percentage of stock owned by the uninsurable shareholder increases, the likelihood that a stock redemption buy-sell agreement is preferable increases.

Funding without life insurance policies. Although risk-averse shareholders generally prefer to fund buy-sell agreements through the purchase of life insurance, not all shareholders are risk averse. Risk-seeking shareholders have two alternatives: to invest capital in life insurance to fund the buy-sell agreement, or to invest to grow (or perhaps to sustain) the corporate business operations. If capital funds are limited, shareholders may not have the luxury of funding both alternatives.

Actuaries typically base premiums on a relatively low rate of return to the insured. If it were not for the favorable tax treatment provided by life insurance proceeds, few would use life insurance as an investment. In contrast, the return on corporate business operations, especially in the early years, may yield substantially greater returns than those offered through life insurance. Thus, risk-seeking shareholders may reason that if they live at least as long as their actuarially determined life expectancy, the return on capital invested should be greater for funds invested in the corporation. Another reason not to fund the buy-sell agreement is that buy-sell settlements often occur at the date of retirement—not at death—leaving no need for life insurance to fund the settlement.

Shareholders that decide not to fund settlements with life insurance typically expect that corporate earnings and profits will increase as the corporation matures. In such situations, C corporations often must pay dividends to avoid the corporate accumulated earnings tax. Alternatively, corporations may elect S status, whereby earnings flow through to shareholders and are taxed then at the individual shareholder level. Either way, shareholders will likely incur increased taxes. Regardless of the corporate form, earnings may be strategically accumulated so they can fund needed buy-sell settlements. When the corporation executes the buy-sell agreements, the estate of a deceased shareholder will receive the proceeds for selling the stock

without incurring income taxes (the share basis will be the fair market value at the date of death). If the buy-sell agreements are executed at the date of retirement, not at the date of death, retired shareholders will benefit from capital gains treatment. Buy-sell agreements should specify an installment purchase option (rather than the immediate purchase of shares) where time might be needed to accumulate funds for the redemption of the stock (e.g., upon the sudden death of a shareholder).

Combination funding of the buy-sell agreement. Shareholders that are more risk averse may choose a combination approach to funding the buy-sell agreement. A portion of the buy-sell agreement can be funded with life insurance to guard against premature deaths, with the remainder funded by accumulated earnings and corporate profits. For example, shareholders could initiate a buy-sell arrangement to purchase 80% of the stock through a cross-purchase agreement (with funding provided by life insurance), and 20% of the stock would be redeemed by the corporation upon the death of a shareholder. Alternatively, shareholders may opt to initially fund 100% of the buy-sell agreement with a cross-purchase design funded by insurance. The funding of the agreement can then change annually, with the corporation assuming responsibility for purchasing any incremental increases in shareholder value as the corporation grows. This approach eliminates the need for shareholders to increase the amount of life insurance over time. It also provides assurance to the shareholder's family that it will receive a minimum amount whether or not the corporation can generate the funds needed for the buy-sell arrangement.

The combination approach may be especially appropriate for family corporations. Tax law limits the amount of stock purchased by the corporation that can be classified as redemption instead of as a dividend to the sum of the estate, inheritance, legacy, succession taxes, generation-skipping taxes, and funeral and administrative expenses allowable as deductions to the estate of the deceased. Share value in excess of IRC section 303 limitations may be purchased with life insurance proceeds. The basis of this purchase will be the fair market value of the shares at the date of death. To remove the value of the remaining shares from the deceased shareholder's estate free of taxes, the buy-sell agreement should provide a member of the family an option to buy the stock from the estate. The family member may then choose to exercise the right to purchase remaining shares, as determined by the IRC section 303 limitations. The combination approach (part corporate redemption, part family member purchase) can result in the total value of the deceased's corporate shares being extracted from the estate without income tax consequences. The case law [see *Estate of James J. Durkin, Sr.*, 99 TC 561 (1992) and *Zenz v. Quinlivan*, 213 F2d 914 (6th Cir. 1954)] indicates, however, that the taxpayer must not be obligated to purchase the stock.

Section 8.1

Retirement Plan Disbursements

Tax on Early Distributions from Traditional and ROTH IRAs

To discourage the use of IRAs for purposes other than retirement, the law imposes an additional 10% tax on early distributions from traditional and Roth IRAs unless an exception applies. Generally, early distributions are those you receive from an IRA before reaching age 59 1/2.

Distributions that you roll over to another IRA or qualified retirement plan are not subject to this 10% additional tax. For more information on rollovers, refer to [Topic 413](#).

There are exceptions to this additional tax for early distributions that are:

- made to a beneficiary or estate on account of the IRA owner's death,
- made on account of disability,
- made as part of a series of substantially equal periodic payments over your life or life expectancy,
- made to pay for a qualified first-time home purchase,
- not in excess of your qualified higher education expenses,
- not in excess of certain medical insurance premiums paid while unemployed,
- not in excess of your unreimbursed medical expenses that are more than a certain percentage of your adjusted gross income, or
- due to an IRS levy.

Refer to [Publication 590, Individual Retirement Arrangements](#), for more information on these exceptions.

Other exceptions apply to distributions from other qualified employee retirement annuity plans. For information on these exceptions, refer to [Topic 558](#), or to [Publication 575, Pension and Annuity Income](#). For more information on IRA distributions, refer to Publication 590.

The 10% tax is reported on [Form 5329 \(PDF\)](#). However, you do not have to file Form 5329 if your [Form 1099-R \(PDF\)](#) shows distribution code "1" or "J" in Box 7. In this instance, you need only enter the 10% tax on the appropriate line of your [Form 1040 \(PDF\)](#). If you meet one of the exceptions to the tax, and your Form 1099-R does not have a distribution code "2", "3", or "4" in the box labeled "distribution code(s)", or if the code shown is incorrect, you must file Form 5329 to claim the exception.

Federal income tax withholding is required for distributions from IRAs unless you elect out of withholding on the distribution. However, if you elect out of withholding, you may have to make estimated tax payments. For more information on estimated tax payments, refer to [Topic 355](#), or to [Publication 505, Tax Withholding and Estimated Tax](#).

Now is the time to fix Social Security

By SEBASTIAN MALLABY First published: Wednesday, November 29, 2006

The next six months could be a productive time for economic policy. After a wasted 2005-06 cycle, in which the Bush administration approached entitlement reform too confidently and Democrats refused to talk, both sides may return to the table. The administration, now led by a practical Treasury secretary with the heft to sideline ideologues, may be willing to make concessions. The Democrats, faced with the challenge of living up to their unexpectedly clear election victory, may decide it's time to make policy rather than just block it.

The most interesting debate will revolve around retirement. This will start with a rerun of the Social Security argument of 2005; but it could easily blossom into a discussion about the inequality and income volatility that's grown with globalization.

Top administration officials already have signaled that they want to return to the question of Social Security. They no longer regard "privatization" -- the diversion of payroll taxes into personal accounts -- as the starting point for negotiation. The solvency of Social Security, not a desire to promote an "ownership society," is their main concern.

A solvency fix will involve some cuts in future benefits. Democrats won't love this, but there are ways to do it progressively. During the 2005 debate, President Bush endorsed an idea that would inflict no cuts whatsoever on low-income workers and would allow the value of middle-class retirees' benefits to rise, albeit less quickly than now scheduled. Because this formula (devised by a Democrat named Robert Pozen) spreads the burden fairly, Democrats who worry about rising inequality should be open to it.

The solvency fix also will require increases in revenue. Again, during the last Social Security debate Bush left open the possibility of doing this in an extremely progressive way -- by lifting the cap on the payroll tax, which currently exempts income above \$90,000. This reform would raise revenue exclusively from the richest 6 percent of taxpayers. It's hard to see how Democrats could object to that.

The next question is where to put the extra revenue: into the notional Social Security trust fund or into personal accounts. The administration will prefer private accounts, partly because it would like a face-saving link to the President's 2005 proposal but also because personal accounts provide a way of walling the revenue off from the general budget and so reduce the government's tendency to spend it. Meanwhile, Democrats will prefer to put the money into the trust fund. They reason that any personal account created as part of a reform that cuts Social Security benefits is headed the wrong

way: toward replacing the security of the traditional guaranteed benefit with the uncertainty of 401(k)-type investments.

Judging from the hints flying around Washington, the administration sees how to bridge this divide. Democrats may be allergic to personal Social Security accounts, but they are enthusiastic about other ideas for personal retirement accounts that just don't have "Social Security" in the title. For example, Gene Sperling, a former Clinton adviser, has called for a "Universal 401(k)" that would extend the benefits of 401(k) saving to workers whose companies don't offer such accounts.

In Sperling's vision, everyone would get the chance to contribute to an account and receive a government contribution as a match, with the most generous match going to low-income workers. To pay for this program, the government could prune the existing \$150 billion patchwork of tax breaks for saving. This patchwork is extraordinarily, scandalously regressive: 90 percent of the tax breaks go to the richest 40 percent of taxpayers.

Sperling is motivated by a desire to help low-income people. As he writes in his book, "The Pro-Growth Progressive," 85 percent of workers in the bottom fifth of the labor force have no access to a company 401(k), nor do 75 percent of Hispanic workers or 60 percent of black workers. Globalization, which has boosted the volatility of family incomes, makes it especially important to help workers build assets that can cushion them against job loss, illness or the financial fallout from divorce. Although the Universal 401(k) would be primarily aimed at retirement security, there could be limited earlier withdrawals at times of misfortune.

So while Republicans have been pushing personal retirement accounts as part of an entitlement fix, Democrats have been pushing personal retirement accounts because they worry about worker insecurity. By enlarging the debate so that it's about savings in the era of globalization rather than just Social Security, negotiators can conjure up the common ground that was missing during the 2005 train wreck.

Personal accounts need not be merely the alternative to the traditional Social Security benefit. They can simultaneously be the alternative to the nation's outrageously regressive system of tax breaks for saving and a way to help ordinary people build nest eggs. When personal accounts become both of these things, perhaps Republicans and Democrats alike will back them.

Section 8.3

2007 Federal Tax Rate Schedules

Note: These tax rate schedules are provided so that you can compute your federal estimated income tax for 2007. To compute your actual income tax, please see the instructions for 2007 Form 1040, 1040A, or 1040EZ as appropriate when they are available.

Schedule X — Single

If taxable income is over--	But not over--	The tax is:
\$0	\$7,825	10% of the amount over \$0
\$7,825	\$31,850	\$782.50 plus 15% of the amount over 7,825
\$31,850	\$77,100	\$4,386.25 plus 25% of the amount over 31,850
\$77,100	\$160,850	\$15,698.75 plus 28% of the amount over 77,100
\$160,850	\$349,700	\$39,148.75 plus 33% of the amount over 160,850
\$349,700	no limit	\$101,469.25 plus 35% of the amount over 349,700

Schedule Y-1 — Married Filing Jointly or Qualifying Widow(er)

If taxable income is over--	But not over--	The tax is:
\$0	\$15,650	10% of the amount over \$0
\$15,650	\$63,700	\$1,565.00 plus 15% of the amount over 15,650
\$63,700	\$128,500	\$8,772.50 plus 25% of the amount over 63,700
\$128,500	\$195,850	\$24,972.50 plus 28% of the amount over 128,500
\$195,850	\$349,700	\$43,830.50 plus 33% of the amount over 195,850
\$349,700	no limit	\$94,601.00 plus 35% of the amount over 349,700

Schedule Y-2 — Married Filing Separately

If taxable income is over--	But not over--	The tax is:
\$0	\$7,825	10% of the amount over \$0
\$7,825	\$31,850	\$782.50 plus 15% of the amount over 7,825
\$31,850	\$64,250	\$4,386.25 plus 25% of the amount over 31,850
\$64,250	\$97,925	\$12,486.25 plus 28% of the amount over 64,250
\$97,925	\$174,850	\$21,915.25 plus 33% of the amount over 97,925
\$174,850	no limit	\$47,300.50 plus 35% of the amount over 174,850

Schedule Z — Head of Household

If taxable income is over--	But not over--	The tax is:
\$0	\$11,200	10% of the amount over \$0
\$11,200	\$42,650	\$1,120.00 plus 15% of the amount over 11,200
\$42,650	\$110,100	\$5,837.50 plus 25% of the amount over 42,650
\$110,100	\$178,350	\$22,700.00 plus 28% of the amount over 110,100
\$178,350	\$349,700	\$41,810.00 plus 33% of the amount over 178,350
\$349,700	no limit	\$98,355.50 plus 35% of the amount over 349,700

Section 9.1

Producer Compliance

Continuing Education Requirements

New York State Insurance Department Licensees are required to complete 15 hours of approved continuing education during their licensing term. Changes to the education requirements are being implemented by the New York State Insurance Department to transition from date specific renewals for lines of authority to the date of birth for individual licensees.

Traditionally, individuals holding licenses for different lines of authority, such as Property Casualty Agent and Life Health & Accident Agent, are issued separate licenses with separate renewal dates (Life/Health agent renewals on 6/30 in odd years, Property/Casualty agent renewals on 6/30 in even years.) While individuals will continue to receive separate licenses for Life/Health and Property Casualty lines of authority, they will begin to renew all licenses together renewing on their date of birth and in the odd or even numbered year corresponding with their date of birth.

Transition to Birth Date Renewal

- Beginning in 2007 individual/tba Producer Licenses will begin the transition from a fixed date renewal to a renewal date based on their date of birth.
- An Individual with multiple licenses will end up with them all renewing on the same date.
- The licensing period will remain two years once the transition period has past.
- This will effect all individual/tba Producer licensees.

Date of Birth renewal

- Following Classes of licenses issued to individuals/tba will be effected by this change
 - Life, A/H
 - PC, Personal Lines
 - Life Broker
 - Consultants
 - Brokers/Excess Line Brokers
 - Reinsurance Intermediaries

General Rules

- The renewal period will not be less than two years
- The license renewal process will begin 120 days before its expiration date
- If a Producer licensed for LA, PC, LB, or BR does not submit a renewal application 60 days prior to the expiration date there will be an additional fee of \$10

Note: These changes do not apply to Adjusters and Corporate Entities!



Skip to Content



George E. Pataki
Governor



Insurance Department

Serving New York Since 1860



Howard Mills
Superintendent



Online Renewal License Application

The application will be unavailable daily from 7:30am to 7:45am for regularly scheduled maintenance.

2006-08 Renewal Available for All Property/Casualty Agents

Additional note about using this Application: Please disable any "Pop-up Window" prevention software that you may be running before using this Application.

SYSTEM REQUIREMENTS

In order to renew your license online, you must use Internet Explorer version 5.5 or above OR Netscape Communicator version 4.7 or above. If you do not already have the required browser, please use one of the links below to access the Web site where you will be able to download the proper browser to use this online application.



In Addition:

Internet Explorer Users:

Internet Explorer Users must have a Cipher Strength of 128-bit encryption to use this application. To check:

1. Select the Help Button
2. Select the About Internet Explorer option
3. Verify that the Cipher Strength is 128-bit
4. If it is, select the OK Button
5. If not, select Update Information and follow the instructions on www.microsoft.com

Important Note: After you have upgraded your web browser, restart your computer.

Netscape Users:



Enter License Number:(Numeric Portion Only) 537826

User ID:

Your user ID is the last 4 digits of your SSN, your 8-digit date of birth in (MMDDYYYY) format.
Example SSN 432-98-1234, DOB 08/26/45= 123408261945
Entities - user ID is the last 4 digits of the SSN and 8-digit date of birth in (MMDDYYYY)
format of a sublicensee/designated responsible person.

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Please select the class to be processed from the following list.

Your Licenses Pending Renewal

Select	Business Type	Class	License Number	Expiration Date	CE Required
<input checked="" type="radio"/>	TBA	PROPERTY & CASUALTY AGENT	537826	06/30/2006	NO

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NEW YORK STATE INSURANCE DEPARTMENT
WEB RENEWAL INSTRUCTIONS FOR PROPERTY & CASUALTY AGENT LICENSE FOR AN INDIVIDUAL/TBA
 What must I submit to renew this license on the Web?

1. Completed Application.
2. Pay the required fee by Credit Card or Check. If paying by **CREDIT CARD**, the renewal license will be issued **within 2 business days**. See the [Fee Schedule](#). Separate payment is required for each application. **\$20.00** will be charged for each check dishonored by the bank.
3. If application reads: "**Continuing Education is required**" see the Continuing Education Note below.
4. **Submit online by 06/30/2006** or your license will expire.

Non-Resident - one who has declared a state OTHER than New York as their Home State. Home State is where you maintain a principal place of residence or business AND are licensed in good standing for the lines of authority being renewed in this application.

Resident - one who has declared New York as their Home State.

COMPUTATION OF TOTAL FEE

LICENSE FEE: If you declare New York as your home state, pay the license fee listed in the [Fee Schedule](#) for New York. If you declare a state OTHER than New York as your home state, pay the license fee listed in the [Fee Schedule](#) for the declared home state.

CONTINUING EDUCATION FILING FEE: Add \$10.00 if your application indicates that CE is required.

STATUTORY LATE FILING FEE: *If Applicable.

*If you are renewing your license with a prefix of LA, LB, PC, BR there will be a \$10.00 late fee if the renewal application is filed LESS than 60 days before expiration of the license.

TOTAL FEE: Add Continuing Filing Fee (if applicable) and Late Fee (if applicable) to License Fee listed in the [Fee Schedule](#). If license includes VARIABLE ANNUITIES, add additional VA fee to calculate total license fee if your home state charges extra for Variable Annuities.

CONTINUING EDUCATION NOTE

2006 Renewal: 15 credit hours of Continuing Education are required if the application indicates "CE REQUIRED." Do NOT submit Continuing Education documentation. Credits must be accumulated during the biennial licensing period and before submitting this application.

Non-residents who have met the Continuing Education requirements of their Home State need not take New York Continuing Education Courses.

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STATE OF NEW YORK INSURANCE DEPARTMENT
TBA PROPERTY & CASUALTY AGENT APPLICATION

07/01/2006 TO 06/30/2008

LICEN SEE REILLY | JOHN | B | 537826
*LAST NAME *FIRST NAME MIDDLE NAME SUFFIX LICEN SE NUMBER

TBA NAME REILLY AGENCY

- 1. SOCIAL SECURITY# ***_**_**** 2. DATE OF BIRTH **_**_**** 3. GENDER M F
4. INSURANCE BUSINESS ADDRESS (MUST BE COMPLETED, NUMBER AND STREET REQUIRED) DO YOU WANT TO MODIFY THIS ADDRESS? Yes No

1344 ROUTE 9

* ADDRESS LINE 1

ADDRESS LINE 2

PO BOX- GANSEVOORT SARATOGA COUNTY (FOR NY STATE ONLY)
New York 12831 (518) . 285 . 9637
*STATE / COUNTRY *ZIP TELEPHONE #

- 5. INSURANCE RESIDENCE ADDRESS (MUST BE COMPLETED, NUMBER AND STREET REQUIRED) DO YOU WANT TO MODIFY THIS ADDRESS? Yes No

56 BURNT HILLS DRIVE

* ADDRESS LINE 1

ADDRESS LINE 2

PO BOX- QUEENSBURY SARATOGA COUNTY (FOR NY STATE ONLY)
New York 12804 (518) . 285 . 9637
*STATE / COUNTRY *ZIP TELEPHONE #

- 6. INSURANCE MAILING ADDRESS (MUST BE COMPLETED, NUMBER AND STREET REQUIRED) DO YOU WANT TO MODIFY THIS ADDRESS? Yes No

Mailing Address: Same as Residence Business

56 BURNT HILLS DRIVE

ADDRESS LINE 1

ADDRESS LINE 2

PO BOX-

PO BOX / DROP BOX / OTHER

QUEENSBURY

*CITY

SARATOGA

COUNTY (FOR NY STATE

ONLY)

New York

*STATE / COUNTRY

12804 -

*ZIP

(518) - 265 - 9637

TELEPHONE #

6a.

*HOME STATE

7. I CERTIFY THAT I AM CURRENTLY LICENSED AND IN GOOD STANDING IN MY STATE OF DOMICILE FOR THE LICENSE APPLIED FOR IN THIS APPLICATION (Non-resident must complete this question in lieu of submitting a hardcopy home state certification.) Yes No

8. FOR FUTURE CORRESPONDENCE PROVIDE THE FOLLOWING : (Optional)

Primary E-mail : JOHN@REILLYCONSULTING.COM

Confirm Primary E-mail : JOHN@REILLYCONSULTING.COM

Secondary E-mail :

9. WEB SITE ADDRESS (optional) :

10. SUBMITTED BY (If not applicant):

Name:

Company:

Telephone #:

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Background Qualifications

The Applicant must read the following very carefully and answer every question:

1. Are you under obligation to pay child support? Yes No

If Yes: a) Are you not in arrears or less than 4 months in arrears? Yes No

b) Are you paying by Income Execution Plan agreed to by courts or parties? Yes No

c) Is the obligation the subject of pending court proceeding? Yes No

d) Are you receiving public assistance or supplemental security income? Yes No

2. Since execution and filing of your last application, other than traffic violations, have you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, been convicted of, or are you currently charged with, committing a crime, whether or not adjudication was withheld? Yes No

"Crime" includes a misdemeanor, felony, or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses.

"Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having been given probation, a suspended sentence or a fine.

3. Since execution and filing of your last application, other than traffic violations, have you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, been involved in an administrative proceeding regarding any professional or occupational license? Yes No

"Involved" means having a license censured, suspended, revoked, canceled, or terminated; or being assessed a fine, placed on probation or surrendering a license to resolve an administrative action.

"Involved" also means being named as a party to an administrative or arbitration proceeding which is related to a professional or occupational license.

"Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may exclude terminations due solely to non-compliance with continuing education requirements or failure to pay a renewal fee.

4. Since execution and filing of your last application, has any demand been made or judgment rendered against you, OR any business in which you are or were an owner, partner, officer or director, during your connection therewith, for overdue monies by an insurer, insured or producer, or Yes No

have you been subject to a bankruptcy proceeding? (Only include bankruptcies that involve funds held on behalf of others.)

5. Since execution and filing of your last application, have you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment agreement? (Any obligation that has been repaid or was a part of a bankruptcy proceeding may be excluded.) Yes No

6. Are you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, currently a party to, or have you or any business in which you are or were an owner, partner, officer, or director, during your connection therewith, been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, or misrepresentation or breach of fiduciary duty? Yes No

7. Since execution and filing of your last application, have you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct? Yes No

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STATE OF NEW YORK INSURANCE DEPARTMENT WEB RENEWAL AGREEMENT FORM

THE APPLICANT MUST READ THE FOLLOWING VERY CAREFULLY:

I HEREBY CERTIFY THAT, UNDER PENALTY OF PERJURY, ALL OF THE INFORMATION SUBMITTED IN THIS ON-LINE APPLICATION IS TRUE AND COMPLETE. I AM AWARE THAT SUBMITTING FALSE INFORMATION OR OMITTING PERTINENT OR MATERIAL INFORMATION IN CONNECTION WITH THIS APPLICATION IS GROUNDS FOR LICENSE REVOCATION OR DENIAL OF THE LICENSE AND MAY SUBJECT ME TO CIVIL OR CRIMINAL PENALTIES.

WHERE REQUIRED BY LAW, I HEREBY DESIGNATE THE COMMISSIONER, DIRECTOR OR SUPERINTENDENT OF INSURANCE, OR OTHER APPROPRIATE PARTY IN EACH JURISDICTION FOR WHICH THIS APPLICATION IS MADE TO BE MY AGENT FOR SERVICE OF PROCESS REGARDING ALL INSURANCE MATTERS IN THE RESPECTIVE JURISDICTION AND AGREE THAT SERVICE UPON THE COMMISSIONER, DIRECTOR OR SUPERINTENDENT OF INSURANCE, OR OTHER APPROPRIATE PARTY OF THAT JURISDICTION IS OF THE SAME LEGAL FORCE AND VALIDITY AS PERSONAL SERVICE UPON MYSELF.

I FURTHER CERTIFY THAT I GRANT PERMISSION TO THE COMMISSIONER, DIRECTOR OR SUPERINTENDENT OF INSURANCE, OR OTHER APPROPRIATE PARTY IN EACH JURISDICTION FOR WHICH THIS APPLICATION IS MADE TO VERIFY INFORMATION WITH ANY FEDERAL, STATE OR LOCAL GOVERNMENT AGENCY, CURRENT OR FORMER EMPLOYER, OR INSURANCE COMPANY.

I FURTHER CERTIFY THAT, UNDER PENALTY OF PERJURY, EITHER a) I HAVE NO CHILD-SUPPORT OBLIGATION, OR b) I HAVE A CHILD-SUPPORT OBLIGATION AND I AM CURRENTLY IN COMPLIANCE WITH THAT OBLIGATION.

I AUTHORIZE THE JURISDICTIONS TO GIVE ANY INFORMATION CONCERNING ME, AS PERMITTED BY LAW, TO ANY FEDERAL, STATE OR MUNICIPAL AGENCY, OR ANY OTHER ORGANIZATION AS REFERENCED IN SECTION 110 OF THE NEW YORK STATE INSURANCE LAW AND I RELEASE THE JURISDICTIONS AND ANY PERSON ACTING ON THEIR BEHALF FROM ANY AND ALL LIABILITY OF WHATEVER NATURE BY REASON OF FURNISHING SUCH INFORMATION.

I ACKNOWLEDGE THAT I UNDERSTAND AND WILL COMPLY WITH THE INSURANCE LAWS AND REGULATIONS OF THE JURISDICTIONS TO WHICH I AM APPLYING FOR LICENSURE.

FOR NON-RESIDENT LICENSE APPLICANTS, I CERTIFY THAT I HAVE BEEN LICENSED WITHIN THE LAST NINETY (90) DAYS AND IN GOOD STANDING IN MY HOME STATE/RESIDENT STATE FOR THE LINES OF AUTHORITY REQUESTED FROM THE NON-RESIDENT STATE.

NOTIFICATION:

PERSONS FOUR MONTHS IN ARREARS IN CHILD SUPPORT OR WHO HAVE FAILED TO COMPLY WITH A SUMMONS, SUBPOENA OR WARRANT RELATING TO PATERNITY OR CHILD SUPPORT PROCEEDING MAY BE SUBJECT TO SUSPENSION OF THEIR BUSINESS, PROFESSIONAL DRIVER AND/OR RECREATIONAL LICENSE AND PERMITS INCLUDING BUT NOT LIMITED TO LICENSES ISSUED PURSUANT TO §11-0713 OF THE ENVIRONMENTAL CONSERVATION LAW.

INTENTIONAL SUBMISSION OF FALSE STATEMENTS FOR PURPOSES OF FRUSTRATING/DEFEATING LAWFUL ENFORCEMENT OF SUPPORT OBLIGATIONS IS PUNISHABLE UNDER §175.35 OF THE PENAL LAW.

PRIVACY NOTIFICATION:

PURSUANT TO ART. 1 SEC. 5 OF THE NYS TAX LAW, IT IS MANDATORY THAT YOU REPORT YOUR SOCIAL SECURITY NO. AND/OR EMPLOYER IDENTIFICATION NO. YOUR FAILURE TO RESPOND MAY BE REPORTED TO THE DEPT. OF TAXATION AND FINANCE. THESE TAX IDENTIFICATION NUMBERS ARE



CONTINUING EDUCATION QUESTION

15 credit hours of Continuing Education are required. Do not submit Continuing Education Documents. Credits must be accumulated during the biennial licensing period.

If you are a non-resident, you must have met the Continuing Education requirements of your State of Domicile. Section A OR Section B must be completed. You will be charged an additional \$10.00 to renew this license.

(A) New York Approved Continuing Education.

I ATTEST THAT I HAVE COMPLETED STATUTORY CONTINUING EDUCATION AS INDICATED BELOW AND MAINTAIN CERTIFICATES EVIDENCING THIS

Yes No radio buttons

IT WILL BE NECESSARY FOR YOU TO ENTER THE DETAILS BELOW FOR THE CONTINUING EDUCATION COURSES THAT YOU HAVE TAKEN FOR THIS RENEWAL.

Table with 6 columns: COURSE, CREDITS, COURSE COMPLETED DATE (MM/DD/YYYY), COURSE, CREDITS, COURSE COMPLETED DATE (MM/DD/YYYY). It contains 8 rows of input fields for course details.

OR

If you answered (A) above and provided New York Course information, DO NOT answer (B). You can now proceed by selecting 'Next.'

(B) Non-Resident Continuing Education Certification Attestation:

I HEREBY CERTIFY THAT I HAVE MET THE CONTINUING EDUCATION CRITERIA OF THE STATE SELECTED IN THE BOX BELOW.

Yes No radio buttons

MY STATE IS: [dropdown menu]

Next Reset buttons



Pay License By Credit Card

Credit cards accepted    

WARNING: PLEASE VERIFY THAT YOUR CREDIT CARD INFORMATION IS CORRECT. IF THE INFORMATION IS NOT CORRECT, YOU WILL BE REQUIRED TO LOG-IN AND ENTER THE INFORMATION ON THE APPLICATION AGAIN.

Credit Card Number		Card Type	Mastercard	<input checked="" type="checkbox"/>
Card Holder Name	JOHN REILLY	Zip	12831 -	
Credit Card Amount	80.00	Expiration Date(mm/yy)	02	09

[ACCESSIBILITY](#) | [PRIVACY POLICY](#) | [DISCLAIMER](#)



Credit Card Confirmation

Thank you for completing your licensing application online.	
Please print a copy of this invoice document for your records.	
Invoice Number	9433556
License Number	REN-PC-537826
Applicant Name	JOHN B REILLY
(TBA name, if applicable)	
Applicant Address	56 BURNT HILLS DRIVE QUEENSBURY, NY 12804
Amount Charged to your credit card(in US \$)	80.00
Inquiries regarding this charge can be made to:	STATE OF NEW YORK INSURANCE DEPARTMENT LICENSING SERVICES BUREAU One Commerce Plaza Albany, NY 12257
Your application will be processed within 1 to 2 Business Days	
Home	Process Another Application

Section 9.2

Unlicensed and Support Staff Guidelines Part

Any person who "Acts as such in the solicitation of, negotiation for, or making of an insurance or annuity contract" must be licensed. Anyone who performs these acts without a license is guilty of a misdemeanor.

The following are exempt from being licensed:

- A. Regular salaried officers of employees who do not solicit or accept applications or orders outside the office of the Insurance Agent.
- B. Regular salaried officers and employees who do not receive compensation or commission dependent upon the amount of business transacted.
- C. A regular salaried employee of an insurer who devotes very little of his time to the soliciting of insurance and whose compensation doesn't depend directly on the amount of business obtained.
- D. Licensed attorneys acting in their capacity as such.
- E. Actuaries of CPA's not soliciting insurance.

If you have unlicensed employees setting appointments for licensed agents and you pay them a "bonus" for each appointment, this may be a violation of this section of the Law. It is better that you pay them a regular salary that is based on performance. The only alternative is to have them licensed as agents.

Authorized Activities

- Perform secretarial/receptionist duties such as:
 - Answering the phone
 - Scheduling appointments (provided there are no discussions about insurance coverages, cost, or related issues)
 - Maintaining files and records
 - Referring prospect or customer to the Agent or a licensed Sales Producer, where appropriate
 - Word processing and data entry
 - Assisting with advertising and mailing campaigns
- Accept payments on existing policies that are made in the office in situations in which there are no coverage discussions
- Secure expiration dates from prospects limited to the date the policy expires and the current carrier, and whether they would be interested in speaking to the Agent or a licensed Sales Producer.
- Take loss information from customers and report this information to the Claims Department.
- Handle changes to existing policies that do not involve any discussion of coverages or require the binding of additional coverages, increasing or decreasing coverages, removal of coverages, or the addition of vehicles
- Inform insureds as to coverages indicated in the policy record.
- Receive requests for coverage for transmittal to the Agent or a licensed Sales Producer.

Unauthorized Activities

Don't:

- Prospect or solicit for insurance
- Quote premiums
- Discuss or provide advice concerning coverages, limits, or deductibles
- Interview customers for the purpose of developing information as part of the completion of an application
- Bind new policies or make changes to existing policies that require the binding of additional coverages, increasing or decreasing coverages, removal of coverages, or the addition of vehicles
- Accept payments on new policies
- Accept payments on existing policies outside the office
- Receive compensation based on sales

Be involved in any activity or transaction that is not in compliance with company policies and procedures or that is in violation of state licensing or other laws.

Section 9.3

Broker Disclosure

In August 1998, the New York State Insurance Department issued *Circular Letter 22* providing insurance brokers with “guidance” regarding the disclosure of compensation arrangements between insurers and brokers to consumers. The Department stated that “undisclosed receipt of additional compensation is sufficient to create the perception that brokers are conflicted in their loyalties and that such conduct may constitute a violation of Section 2110 as a dishonest or untrustworthy practice.”

In the fall of 2004, the New York Attorney General's office and the New York Insurance Department announced a joint probe of misconduct in the insurance industry. This investigation resulted in guilty pleas from 20 insurance company executives and officers on charges of customer steering, bid-rigging and improper finite reinsurance transactions.

The impact of the 2004 investigation continues to have significant impact on the insurance industry for years to come. Specifically, 4 major insurance companies agreed to end contingency commission payments to their producers effective January 1, 2007.

Insurance Producers are encouraged to explain the relationship they have with the carriers providing quotes to individual insurance prospects. Producers who provide quotes from carriers they represent directly as agents and from carriers they only have access to through brokerage agreements should be sure to explain both arrangements. If an individual prospect's coverage is placed through a brokerage agreement, the producer should disclose their compensation arrangement in writing to the insured.

The disclosure of broker compensation should not be confused with written disclosure of service fees charged under Section 2119c. Service fee disclosures are required whenever a fee is charged by a broker for additional services provided to a client and are separate from compensation received by a broker from the carrier.



**STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004**

Circular Letter No. 22 (1998)
August 25, 1998

TO: All Licensed Brokers and Property/Casualty Insurers

RE: Disclosure of Brokers' Compensation

An alleged market development has recently come to the attention of the Department that appears to warrant scrutiny. The development centers on the allegation that undisclosed compensation, in addition to commissions, is being paid to brokers by insurers as additional compensation for the placing of business without such information being furnished to insureds. Pursuant to Section 2101(c) of the New York Insurance Law ("NYIL"), a broker is the legal representative of the insured. It is the position of the Department that the undisclosed receipt of additional compensation is sufficient to create the perception that brokers are conflicted in their loyalties and that such conduct may constitute a violation of Section 2110 as a dishonest or untrustworthy practice.

Accordingly, pursuant to the sections of law noted above, as well as Article 23 of the NYIL, this Department offers the following guidance.

- All compensation arrangements between an insurer and a broker should be reduced to writing and agreed to by both parties;
- All such compensation arrangements should be disclosed to insureds prior to the purchase so as to enable insureds to understand the costs of the coverage and the motivation of their broker in placing the business;
- All fees paid to brokers should be included as factors in the establishment of an insurer's premium rates;
- All fees paid to brokers (and reasons for such fee payments) should be included in a broker file maintained by the insurer; and
- The insurer's internal auditing procedures should include verification that all fees paid to brokers are proper and within the parameters of the New York Insurance Law and Department regulations.

The Department will review these matters in future market conduct investigations of insurers and brokers.

ST. PAUL TRAVELERS SETTLES BID-RIGGING PROBE

Agreement is Part of Ongoing Effort to Restore Competition in Insurance Industry

Attorney General Eliot Spitzer and State Insurance Department Superintendent Howard Mills today announced an agreement with one of the country's largest property casualty insurance companies to resolve charges of customer steering, bid-rigging and improper finite reinsurance transactions. Connecticut Attorney General Richard Blumenthal and Illinois Attorney General Lisa Madigan also joined in today's settlement.

Under the agreement, St. Paul Travelers, a major provider of automobile and homeowners insurance for individuals and commercial insurance for small businesses, will pay \$77 million in restitution and penalties and adopt a series of reforms. In addition, St. Paul Travelers has issued an apology acknowledging its improper conduct.

"St. Paul Travelers has joined the growing number of insurers, brokers and agents who have pledged to make the market for insurance coverage more transparent and competitive," Spitzer said. "This development will benefit all consumers, from individuals buying car insurance to small businesses to large corporations."

State Insurance Superintendent Howard Mills said: "St. Paul Travelers is now reforming its business so that consumers are given access to more information about their insurance transactions while at the same time compensating policyholders who were economically harmed by their past conduct. Both initiatives are welcome news for all those involved in the property casualty insurance market."

As described in the Assurance of Discontinuance settling this case, the investigation found that St. Paul Travelers made undisclosed payments to insurance brokers and agents in exchange for business referrals, and participated in a scheme to fix insurance prices in the excess casualty area.

For example, the assurance cites an e-mail from a broker at Marsh & McLennan Companies to a St. Paul underwriter seeking a phony bid for an insurance contract that was being steered to one of St. Paul's competitors, Zurich:

"Specs were forwarded in November for [Client C]. Zurich's renewal quote is \$175,000 for [the lead excess layer]. Primary AL is \$2MM. Josh is asking for non-quotes. If you didn't already respond to [the Marsh executive] . . . , please feel free either to decline for class or quote higher (please)."

The next day St. Paul responded by issuing a quote 30 percent higher than Zurich's bid.

The assurance also details St. Paul's use of improper "finite reinsurance" to bolster both its own financial results and those of its clients. For example, in the years 1999 through 2002, St. Paul entered into aggregate excess of loss reinsurance contracts with an insurer in Barbados, despite a side agreement that any losses suffered by the insurer would be made up by St. Paul.

In a statement today, St. Paul Travelers apologized for its actions, saying: "St. Paul Travelers acknowledges that certain of its employees violated acceptable business practices and St. Paul Travelers' own standards of conduct by engaging in improper bidding practices and certain "finite insurance" activities. St. Paul Travelers apologizes and has enacted business practice reforms to ensure that these incidents do not occur again. Further, St. Paul Travelers has agreed to support legislation eliminating contingent compensation for brokers and agents."

Under today's agreement, \$37 million will be paid to St. Paul Travelers policyholders harmed by the company's bid-rigging activities. In addition, St. Paul Travelers will pay penalties of \$24 million to New York and \$8 million each to Connecticut and Illinois.

In the fall of 2004, the New York Attorney General's office and the New York Insurance Department announced a joint probe of misconduct in the insurance industry. This investigation has resulted to date in guilty pleas from 20 insurance company executives and officers, and the recovery of approximately \$3 billion for consumers and workers compensation plans.

The investigation underlying today's Assurance of Discontinuance was conducted by Assistant Attorneys General Maria Filipakis, Matthew Gaul, and Mel Goldberg under the direction of David D. Brown IV, Chief of the Attorney General's Investment Protection Bureau.

Susan Donnellan, a Deputy Superintendent and General Counsel of the New York State Department of Insurance, led the Insurance Department's investigation.

Press Releases

Office of New York State Attorney General Eliot Spitzer

Disclaimer

Department of Law Department of Law 120 Broadway

The State Capitol New York, NY 10271 Albany, NY 12224

For More Information: For Immediate Release 518-473-5525 November 30, 2006

INSURERS TO MOVE AWAY FROM "CONTINGENT COMMISSIONS"

Attorney General Eliot Spitzer today announced that his office, under agreements reached over the last year, has notified four leading insurance companies that they can no longer pay controversial "contingent commissions" to agents and brokers that sell automobile, homeowners and certain other insurance products to consumers.

This notice comes as part of settlements that each of the insurers – ACE, AIG, St. Paul Travelers and Zurich – entered into earlier this year, resolving charges of bid rigging and other improprieties related to contingent commissions, a previously undisclosed form of compensation that was found to have led brokers and agents to put their own interests ahead of their clients’.

The Attorney General’s Office investigation, which began in 2004, revealed that insurers paid contingent commissions to insurance agents and brokers, causing them to breach their fiduciary duties to their clients by steering business to the insurers even when their clients would have been better served by purchasing coverage from other insurers.

Under the settlement agreements, the insurers must change their compensation structure for brokers and agents in any type of insurance where more than 65% of the insurance is sold by companies that do not pay contingent commissions, including those that have signed agreements with the Attorney General. Spitzer today sent the companies formal notice that this 65% "tipping point" has been reached for homeowners, personal automobile, boiler and machinery, and financial guaranty insurance. As a result, the four companies must stop paying contingent commissions for these insurance products beginning on January 1, 2007. They have already given them up for excess casualty insurance.

Connecticut Attorney General Richard Blumenthal and Illinois Attorney General Lisa Madigan also joined in today’s notices sent to ACE, St. Paul Travelers and Zurich. The Connecticut and Illinois Attorneys General participated with New York in the agreements signed with those insurance companies.

The settlement agreements were negotiated by Assistant Attorneys General Maria Filipakis, Matthew Gaul and Melvin Goldberg of the Investment Protection and Consumer Frauds Bureaus, under the supervision of Investment Protection Bureau Chief David Brown IV.

November 30, 2006

The St. Paul Travelers Companies, Inc.
Attn: Kenneth F. Spence, III
385 Washington Street St. Paul, Minnesota 55102
Re: Notice of 65% "Tipping Point"

Dear Mr. Spence:

This is to notify you that, pursuant to paragraph 23 of the Agreement between the Attorneys General of the States of New York, Connecticut and Illinois and The St. Paul Travelers Companies, Inc.. ("St. Paul Travelers) dated July 31, 2006 ("Agreement"), the Attorneys General have made a determination, based on market share information for calendar year 2005 from A.M. Best Company, Inc., for certain insurance lines listed below that (a) insurers who do not pay Contingent Compensation, within the meaning of the Agreement, in those lines, including but not limited to direct writers and insurers that employ only captive agents in those lines and (b) insurers who as of this date have signed Agreements or Assurances with the Attorneys General or agreements with any other Attorney General containing this paragraph as applied to them (i.e. ACE, AIG, St. Paul Travelers, and Zurich), together represent more than 65% of the national gross written premiums in those lines in calendar year 2005. The insurance lines for which the 65% threshold has been reached are:

- 1 Homeowners Multi Peril;
- 2 Private Passenger Automobile Physical Damage;
- 3 Private Passenger Automobile No-Fault;
- 4 Other Private Passenger Automobile Liability;
- 5 Boiler and Machinery; and
- 6 Financial Guaranty.

Accordingly, pursuant to paragraph 23 of the Agreement, St. Paul Travelers is notified to stop paying Contingent Compensation for the insurance lines listed above beginning January 1, 2007.

Sincerely,
ELIOT SPITZER Attorney General of the State of
New York

Office of the New York State Attorney General 120
Broadway, 23rd Floor New York, New York 10271
cc: Bryce Friedman, Esq.

Spitzer Notifies Insurers Contingent Commissions No Longer an Option

November 30, 2006 <http://www.insurancejournal.com/news/national/2006/11/30/74667.htm>

New York Attorney General Eliot Spitzer has notified four leading insurance companies that, under agreements reached with his office earlier this year, they may no longer pay "contingent commissions" to agents and brokers who sell automobile, homeowners and certain other insurance products.

This notice comes as part of settlements that each of the insurers — ACE, AIG, St. Paul Travelers and Zurich — entered into earlier this year, resolving charges of bid rigging and other improprieties related to contingent commissions.

Under the settlement agreements, the insurers must change their compensation structure for brokers and agents in any type of insurance where more than 65 percent of the insurance is sold by companies that do not pay contingent commissions, including those that have signed agreements with the Attorney General. Spitzer sent the companies formal notice that this 65 percent "tipping point" has been reached for homeowners, personal automobile, boiler and machinery, and financial guaranty insurance. As a result, the four companies must stop paying contingent commissions for these insurance products beginning on Jan. 1, 2007. They have already given them up for excess casualty insurance.

Connecticut Attorney General Richard Blumenthal and Illinois Attorney General Lisa Madigan also joined in today's notices sent to ACE, St. Paul Travelers and Zurich. The Connecticut and Illinois Attorneys General participated with New York in the agreements signed with those insurance companies.

Agents immediately disagreed and expressed disappointment with Spitzer's decision, calling the order "grossly unfair."

"It is grossly unfair to impose contrived restrictions on the ability to compensate producers in a legal and honest manner," said National Association of Professional Insurance Agents Executive Vice President and CEO Len Brevik. "PIA believes that authorities should be prohibited from using their settlement powers to bring about a ban on all contingent compensation."

Independent Insurance Agents & Brokers of America CEO Robert A. Rusbuldt said carriers are now unable to use what otherwise is a perfectly legal way to compensate their sales forces. He noted contingent compensation is done in virtually all industries across America.

"The independent agent and broker community is greatly distressed by this development," Rusbuldt said.

"Many industries -- not just the insurance industry -- rely on performance-based compensation, which is legal, honest and brings many benefits to the insurance marketplace, as it does to our entire American economy," Brevik said. "Eliminating all contingent compensation is patently unfair to those who never committed abuses, such as Main Street insurance agents. Main Street agents are not Mega-brokers."

Rusbuldt also noted that the illegal activities uncovered by Spitzer occurred in commercial lines, not personal lines, yet, his recent decision will largely affect personal lines. "The solution imposed on carriers and agents of banning incentive compensation is totally misplaced and directed at business that was never a problem to begin with," Rusbuldt said.

"There is no doubt that a few bad actors in the commercial lines area abused the system, and we have always agreed that those who break the law should be punished to the fullest extent possible," Rusbuldt said. "But it is absolutely wrong and indefensible to penalize the innocent majority for the misdeeds of a

handful of people. This decision will impact thousands of agencies across the country as they face reductions in compensation that will hamper their ability to create jobs in their communities, train staff, invest in their agencies, and provide consumers access to insurance. On behalf of the hundreds of thousands of agents and brokers across America who had no part in the dishonest activity of a few, we will continue to fight to preserve the right of companies to pay legal incentive compensation."

"This is an example of settlement powers run amok. Our job is to make sure that this judicial madness does not become a model imposed on the entire insurance industry," Brevik said.



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
25 BEAVER STREET
NEW YORK, NEW YORK 10004

The Office of General Counsel issued the following opinion on November 15, 2006 representing the position of the New York State Insurance Department

Paying for leads and endorsements.

Questions Presented

1. May an insurance agent make a contribution to an organization that recommends the agent to its members?
2. May an insurance agent pay fees, on a per-policy sold basis, to an organization that recommends the agent to its members?
3. If such referral fees are permissible is there a limit as to the amount the agent may give?

Conclusions

1. Pursuant to N.Y. Ins. Law §§ 2114, 2115 and 2116 if there is no discussion of particular policy provisions and the compensation is not based on whether a sale was made, the agent may compensate the referring party.
2. No, an agent may not pay an organization on a per-policy sold basis as this would violate N.Y. Ins. Law §§ 2114, 2115 or 2116.
3. The agent is not limited as to the amount of the referral fees paid as permitted under §§ 2114, 2115 and 2116.

Facts

An insurance agent who sells long term care insurance was endorsed by several not-for-profit organizations that send out newsletters and flyers recommending the agent as an insurance agent to their members for their long term care insurance needs. The agent inquired whether a contribution could be made to these organizations and whether that contribution may be based on the number of policies sold through the organizations' endorsements.

Analysis

N.Y. Ins. Law § 2102 (McKinney 2006) states in pertinent part:

(a)(1) No person, firm, association or corporation shall act as an insurance producer or insurance adjuster in this state without having authority to do so by virtue of a license issued and in force pursuant to the provisions of this chapter.¹

Long term care insurance is a type of accident and health insurance. N.Y. Ins. Law § 2114(a) (McKinney 2006) applies to life and accident and health insurance and annuity contracts and states in relevant part:

(3) No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting, negotiating or selling in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article.²

(4) Services of the kind specified in this subsection shall not include the referral of a person to a licensed insurance agent or broker that does not include a discussion of specific insurance policy terms and conditions and where the compensation for referral is not based upon the purchase of insurance by such person.³

Generally, only a licensed insurance agent or broker may be compensated for soliciting, negotiating or selling insurance as provided in § 2102. However, an exception exists whereby a licensed insurance agent or broker may compensate a referring party if the referral to the agent or broker does not include a discussion of the insurance policy terms and conditions. Further, the referral fee with respect to a long term care policy may not be based on whether insurance was sold. Paying a referral fee based on a per-policy sold basis would violate § 2114(a)(4) and the referring party would be in violation of § 2102.

Referral fees under §§ 2114, 2115 and 2116 are not limited to a maximum dollar amount.

For further information you may contact Principal Attorney Paul A. Zuckerman at the New York City Office.

¹ "Insurance producer" as defined in N.Y. Ins. Law § 2101 (McKinney's 2006), includes insurance agent or broker.

² See also N.Y. Insurance law § 2115, which applies to property/casualty insurance agents, and § 2116, which applies to insurance brokers.

³ This provision is effective until September 10, 2007 pending further extension by the legislature. Similar provisions in § 2115 and § 2116 are also effective until September 10, 2007 pending extension by the legislature.



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
25 BEAVER STREET
NEW YORK, NEW YORK 10004

The Office of General Counsel issued the following opinion on January 11, 2006, representing the position of the New York State Insurance Department.

Re: Broker Estate

Question Presented:

Upon an insurance broker's death what is the agency, with which the broker had placed business, obligated to pay to the broker's estate?

Conclusion:

The estate of the insurance broker may receive all of his contractually agreed upon earned commissions as well as all future commissions based on automatic renewals of an insured's policy.

Facts:

The inquirer states that a broker who worked in the inquirer's insurance producer office for many years has recently passed away. The inquirer did not specify whether the broker was employed by the agency or if he just placed insurance business with the inquirer's company. The inquirer maintained a broker agreement with him but had no agreement as to the transfer of business upon his death. The inquirer now wishes to know what, if anything, he is obligated to pay to his estate.

Analysis:

New York courts have generally held that absent an agreement to the contrary, an insurance broker earns its commission when it brings about the relationship of insurer and insured. See Hamond & Co., Inc. v. Risk Specialists Co. of New York, Inc., 210 A.D.2d 202, 619 N.Y.S.2d 744 (2d Dept. 1994); Western Nat. Ins. Co. v. Haph Brokerage, 277 A.D. 6, 97 N.Y.S.2d 447 (1st Dept. 1950), aff'd, 302 N.Y. 678 (1951). In accordance with this principle, absent an agreement to the contrary, the deceased broker earned his commission, including the renewals thereof, at the time that the service was rendered. Therefore his estate would be entitled to the earned commissions under the Insurance Law.

However, these commissions are based on the contractual relationship between the broker and the inquirer's company, the specifics of which the Department is not aware of nor will opine on. The opinion is limited to the Insurance Law and does not express an opinion on any other law.

For further information please contact Principal Attorney Paul A. Zuckerman at the New York City Office.

Rebating and Discrimination (New York State Insurance Law)

§ 2324. Rebating and discrimination.

(a) No authorized insurer, no licensed insurance agent, no licensed insurance broker, and no employee or other representative of any such insurer, agent or broker shall make, procure or negotiate any contract of insurance other than as plainly expressed in the policy or other written contract issued or to be issued as evidence thereof, or shall directly or indirectly, by giving or sharing a commission or in any manner whatsoever, pay or allow or offer to pay or allow to the insured or to any employee of the insured, either as an inducement to the making of insurance or after insurance has been effected, any rebate from the premium which is specified in the policy, or any special favor or advantage in the dividends or other benefit to accrue thereon, or shall give or offer to give any valuable consideration or inducement of any kind, directly or indirectly, which is not specified in such policy or contract, other than any article of merchandise not exceeding fifteen dollars in value which shall have conspicuously stamped or printed thereon the advertisement of the insurer, agent or broker, or shall give, sell or purchase, or offer to give, sell or purchase, as an inducement to the making of such insurance or in connection therewith, any stock, bond or other securities or any dividends or profits accrued thereon, nor shall the insured, his agent or representative knowingly receive directly or indirectly, any such rebate or special favor or advantage, provided, however, a licensed insurance agent or a licensed insurance broker may retain the usual commission or underwriting fee on insurance placed on his own property or risks, if the aggregate of such commissions or underwriting fees will not exceed five percent of the total net commissions or underwriting fees received by such licensed insurance agent or insurance broker during the calendar year.

(b) Within the meaning of subsection (a) hereof, the sharing of a commission with the insured shall be deemed to include any case in which a licensed insurance agent or a licensed insurance broker which is a subsidiary corporation of, or a corporation affiliated with, any corporation insured, received commissions for the negotiation or procurement of any policy or contract of insurance for the insured.

(c) This section shall not prohibit any insurer from equitably distributing to its policyholders dividends payable from surplus on earned premiums, nor prohibit the return at any time during the term or at the termination of the contract of insurance of dividends, savings or the unused or unabsorbed portion of premiums and premium deposits to policyholders of a mutual insurer or to subscribers of a reciprocal insurer, nor prohibit any insurer or insurance agent from paying commissions to a licensed insurance broker for negotiating a policy or contract of insurance, nor prohibit any licensed insurance broker from sharing or dividing a commission earned or received by him with any other licensed insurance broker or brokers who shall have aided him in respect to the insurance for the negotiation of which the commission has been earned or paid.

(d) This section shall not prohibit the making of temporary contracts of insurance, either by temporary binders or other memoranda, if the premium applicable to the insurance shall be due and shall be paid for the time during which the insurance is in force by virtue of the temporary contract.

(e) This section shall not apply to any policy or contract of reinsurance nor to any contract or policy of life insurance, accident insurance or health insurance which is subject to the provisions of section four thousand two hundred twenty-four of this chapter, nor to any contract or policy of

marine insurance, other than contracts or policies of automobile insurance, or of marine protection and indemnity insurance, nor to any insurance contract, or rate of insurance in connection with any insurance contract either against loss or damage to, or legal liability in connection with, any property located wholly outside of this state or any activity carried on outside of this state or any motor vehicle or aircraft principally garaged and used outside of this state.

(f) Any person or corporation violating the provisions of this section shall, in addition to all other penalties provided by law, pay to the people of this state as a penalty the sum of five hundred dollars for each such violation.



**STATE OF NEW YORK
INSURANCE DEPARTMENT**
25 BEAVER STREET
NEW YORK, NEW YORK 10004

The Office of General Counsel issued the following informal opinion on October 15, 2004, representing the position of the New York State Insurance Department.

RE: N.Y. Ins. Law §§ 2324 & 4224; Inducement to Purchase Insurance

Questions Presented

1. May an insurance broker provide an insurance client with administrative health services for issues that arise with health care providers, insurers, or bill collectors after the purchase of insurance at no additional charge or do such administrative services constitute an unlawful inducement under N.Y. Ins. Law § 2324?
2. Does the offering of "human resource services" and "administrative health services" at a negotiated rate or at no cost to insurance clients constitute an unlawful inducement under N.Y. Ins. Law § 2324?

Conclusion

1. By providing administrative health services for the health insurance sold to clients at no additional charge, the broker would be providing a valuable consideration or inducement on such policies in violation of N.Y. Ins. Law § 4224(c) (McKinney 2000 & Supp. 2004), not N.Y. Ins. Law § 2324.
2. An insurance broker in New York, who sells administrative health services and human resources services (such as payroll and benefits administration services), may not make a distinction in the fees charged for these services based on whether the client also purchases the insurance brokerage services. If the services are offered at no cost or at a reduced cost to insurance clients, then such services would constitute a valuable consideration or an inducement in violation of N.Y. Ins. Law § 4224 or § 2324 (McKinney 2000 and Supp. 2004), dependent upon whether the agent is selling life, health or property insurance. However, such insurance broker, in its capacity as an administrative service provider, is not prohibited from making a distinction in the fees charged for these services where such distinction is based on the type and amount of such services provided to a particular client, independent of whether the client has insurance or how much insurance.

Facts

A licensed insurance broker wishes to assist insurance clients by providing "administrative health services," consisting of contacting health care providers, insurers, or bill collectors pertaining to claims made under health insurance policies. The services provided only to insurance clients would consist of resolving claims and paperwork problems, assisting clients with coverage and benefit questions, negotiating fees with health care providers, reviewing questionable bills, assisting clients with filing complaints or grievances, assisting clients in identifying alternative coverage options, and assisting clients in locating health care providers. The broker is considering hiring and paying a company to perform this function on behalf of the brokerage.

The broker also maintains a non-insurance business that provides "human resources services" consisting of coordinating, employee benefits, compensation, discipline, job descriptions, leave of absence issues, organizational development, business policy and practice, safety issues, staffing and recruiting, benefits administration, human resource administration, development of employee handbooks and employee training. These services are provided to insurance and non-insurance clients at different rates depending on company size.

Analysis

Although the inquirer asked whether N.Y. Ins. Law § 2324 applied, it is N.Y. Ins. Law § 4224 that is relevant with respect to accident and health insurance as well as life insurance and annuities.

N.Y. Ins. Law § 4224(c) (McKinney 2000 & Supp. 2004) states:

No such life insurance company and no such savings and insurance bank and no officer, agent, solicitor or representative thereof and no such insurer doing in this state the business of accident and health insurance and no officer, agent, solicitor or representative thereof, and no licensed insurance broker and no employee or other representative of any such insurer, agent or broker, shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an *inducement* to any person to insure, or shall give, sell or purchase, or offer to give, sell or purchase, as such inducement, or interdependent with any policy of life insurance or annuity contract or policy of accident and health insurance, any stocks, bonds or other securities, or any dividends or profits accruing or to accrue thereon, or any *valuable consideration or inducement whatever not specified in such policy or contract*; nor shall any person in this state *knowingly receive as such inducement, any rebate of premium or policy fee or any special favor* or advantage in the dividends or other benefits to accrue on any such policy or contract, or knowingly receive any paid employment or contract for services of any kind, *or any valuable consideration or inducement whatever which is not specified in such policy or contract.*

An insurance agent or broker subject to the provisions of N.Y. Ins. Law § 4224(c) (McKinney 2000 & Supp. 2004), may not provide " . . . an inducement to any person . . . or any valuable consideration or inducement whatever not specified in such policy or contract; . . . " in connection with the sale of health insurance. Therefore, an insurance agent selling health insurance may not provide free administrative services to an employer because this service constitutes valuable consideration or an inducement in violation of N.Y. Ins. Law § 4224(c) (McKinney 2000 & Supp. 2004).

The inquirer's other question was more general, pertaining to all of the inquirer's insurance clients not necessarily restricted to accident and health insurance. N.Y. Ins. Law § 2324(a) (McKinney 2000 & Supp. 2004), which applies to contracts of property/casualty insurance, states:

No authorized insurer, no licensed insurance agent, no licensed insurance broker, and no employee or other representative of any such insurer, agent or broker shall make, procure or negotiate any contract of insurance other than as plainly expressed in the policy or other written contract issued or to be issued as evidence thereof, or shall directly or indirectly, by giving or sharing a commission or in any manner whatsoever, pay or allow or offer to pay or allow to the insured or to any employee of the insured, either as an inducement to the making of insurance or after insurance has been effected, any rebate from the premium which is specified in the policy, or any special favor or advantage in the dividends or other benefit to accrue thereon, or shall give or offer to give any valuable consideration or inducement of any kind, directly or indirectly, which is not specified in such policy or contract, other than any article of merchandise not exceeding fifteen dollars in value which shall have conspicuously stamped or printed thereon the advertisement of the insurer, agent or broker, or shall give, sell or purchase, or offer to give, sell or purchase, as an inducement to the making of such insurance or in connection therewith, any stock, bond or other securities or any dividends or profits accrued thereon, nor shall the insured, his agent or representative knowingly receive directly or indirectly, any such rebate or special favor or advantage, provided, however, a licensed insurance agent or a licensed insurance broker may retain the usual commission or underwriting fee on insurance placed on his own property or risks, if the aggregate of such

commissions or underwriting fees will not exceed five percent of the total net commissions or underwriting fees received by such licensed insurance agent or insurance broker during the calendar year.

Therefore, an insurance broker licensed in New York is generally prohibited from offering or giving as an inducement, or interdependent with any policy, any valuable consideration that is not specified in a policy or contract of insurance to its insurance brokerage customer, except that with respect to making, negotiating or procuring a property/casualty insurance policy, an insurance broker may give its customer an article of merchandise not exceeding fifteen dollars in value that has conspicuously stamped or printed thereon the advertisement of the broker.

An insurance broker, however, is not prohibited under the New York Insurance Law from making a distinction in the fees it charges for administrative services where such distinction is based on a factor other than the insurance status of the customer; for example, if the distinction was based on the type and amount of administrative services provided to a particular customer. Therefore, if the insurance broker finds that more time is expended providing administrative services for a particular customer, the service for that particular customer may be priced accordingly. What an insurance broker may not do is make a discount available to only its insurance brokerage customers or provide these administrative services in its capacity as an insurance broker.

It is important to note that this opinion is limited to the specific facts provided and that any change in the facts could also change the analysis and conclusion of this opinion. This opinion is limited to inducement issues. Please be aware that this opinion does not address the issue of whether the administrative health services provided by the broker would require public adjuster licensing under the New York State Insurance Law or whether it falls within the exception of N.Y. Ins. Law § 2101(g)(2). The New York State Insurance Department web site www.ins.state.ny.us has further discussion of this issue.

For further information one may contact Special Counsel Athan Shinas at the Albany Office.

Glossary

Many of the coverage terms used in this course are familiar to all insurance producers. However, certain terminology does not carry across the P&C / L&H boundary.

Accident

An unforeseen, unintended, unexpected event, mishap, or casualty. (HL GL-1)

Actual cash value

An amount equivalent to the replacement cost of lost or damaged property at the time of the loss, less depreciation

AD&D

Accidental Death and Dismemberment

Additional PIP

Additional First Party Benefits paid for extended loss on account of personal injuries sustained by an eligible injured person. Coverage applies to named insured's and other persons sustaining injuries.

Additional Disability Coverages

Wage loss benefits exceeding state minimums typically opted for by high income earners.

Admitted Company

An insurance company authorized and licensed to do business in a given state

Agent

One who solicits, negotiates, or effects contracts of insurance on behalf of an insurer.

Arbitration clause

The provision in a property insurance contract which states that if the insurer and insured cannot agree on an appropriate claim settlement, each will appoint an appraiser, and they will select a neutral umpire.

Assignment

Transfer by the policy owner of legal rights or interest in the policy contract to a third party

Auto liability

Covers against bodily injury and property damage for which the insured may become liable

BI – Bodily Injury

Bodily Injury means bodily harm, sickness or disease, including required care, loss of services and death that result. BI coverage is provided to a named insured under auto coverage policies.

Binder

A temporary contract or agreement executed by an agent or insurer putting the insurance in force before the contract has been written or the premium paid

Broker

One who represents an insured in the solicitation, negotiation, or procurement of contracts of insurance, and who may render services incidental to those functions.

Buy Sell Agreement

In the sale of a business, a buy-sell clause (or shotgun clause) in a shareholder agreement preserves continuity of ownership in the business and insures that everyone is fairly treated, the buyer as well as the seller. It is a binding contract between business partners or [shareholders](#) about the future ownership of the business.

General Liability (CGL)

CGL Policy provides coverage for the insured in the event a third party suffers an injury because of business activities of the insured. An insured's liability may be for Bodily Injury (BI), Personal Injury (PI), Advertising Injury (AI) or Property Damage (PD). Also covered under the liability section of the policy are Medical Expenses incurred for bodily injury caused by an accident regardless of negligence on the part of the insured and the obligation for the insurer to provide a defense of its policy holder against all valid suits.

Cancellation

When a portion of the premium is returned by insured and coverage has ended. Possible reasons for cancellation include fraud and non-payment of premiums

COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1988, 1989).

Employers of 20 or more employees maintaining a group health plan are required to offer employees and their dependents the option of continuing membership in the group plan at their own expense after they leave employment under certain circumstances. The cost of the COBRA extension can be charged to the employee at 102 percent of the group's cost for an active employee. Furthermore, the law adds a "portability" feature to coverage wherein an insurer must credit the time a person was covered under a prior health insurance policy toward satisfying any pre-existing condition waiting period imposed by the subsequent policy, as long as the prior coverage was in force at least 63 days before the effective date of the subsequent policy.

Coinsurance clause for property

A clause under which the insured shares in losses to the extent that he is underinsured at the time of loss.

Coinsurance clause for health

A provision stating that the insured and the insurer will share all losses covered by the policy in a proportion agreed upon in advance.

Collision –

Sudden damage to a vehicle caused by it coming in contact with another object. This definition is usually modified by terms and conditions in an automobile insurance policy.

Community rating

A rating system in which the charge from insurance to all insured's depends on the medical and hospital costs in the community or area to be covered. Individual characteristics of the insured's are not considered at all

Comprehensive

This is the broadest form of coverage and will provide for any loss except for collision or overturn of the vehicle.

Conditions

These are provisions of an insurance policy which state either the rights and duties of the insured or the rights and duties of the insurer

COORDINATION OF BENEFITS

Coordination or non-duplication of benefits may apply when an individual is covered under more than one group insurance contract. Coordination ensures that the total amount of the benefits under all contracts does not exceed 100% of the actual medical expenses.

Cross Purchase Agreement

With a cross-purchase agreement, each owner of the corporation purchases an insurance policy on the other shareholders. The purchaser is both owner and beneficiary of the policies.

Declaration

A term used in insurance other than life or health to denote that portion of the contract in which is stated such information as the name and address of the insured, the property insured, its location and description, the policy period, the amount of insurance coverage, applicable premiums, and supplemental representations by the insured.

Disability Income (DBL)

Standard disability income insurance provides wage earners with temporary cash payment/benefits to partially replace wages lost for disabilities due to non-occupational injury or illness. The New York Disability Benefits Law (DBL) provides for payment of 50% of the average weekly wage to a maximum of \$170 per week for maximum of 26 weeks within a consecutive 52 week period and commences on the eight day of disability.

Direct loss

A loss which is a direct consequence of a particular peril. Fire damage to a refrigerator would be a direct loss.

Dividend Options-

The insured is given the option to apply dividends as follows: receive the dividend in cash, apply the dividend toward the payment of any premium due on the policy, apply the dividend to the purchase of paid-up insurance, or leave the dividend with the insurance company to accumulate at interest. Some companies have additional options.

ERISA (EMPLOYEES RETIREMENT INCOME SECURITY ACT OF 1974)

Self-insured plans that are not governed by state insurance law must meet the requirements of ERISA. ERISA requires a “creditable” claims review procedure and notices that state the reason for claim denials.

Ethics

Honesty, integrity i.e. Insurance professionals should give full disclosure of information used for underwriting decisions

Felony

A charge in criminal conduct. The most serious of a crime from committing insurance fraud.

Fidelity Bond

Protects insured regarding money and securities. Protects retirement plans against loss resulting from acts of fraud and dishonesty on the part of the fiduciary either directly or in collusion with others

Fiduciary

A person holding the funds or property of another in a position of trust.

Fraud

Deliberate deception used as a means of obtaining money, goods, and/ or services

Hazard-

A specific situation that increases the probability of the occurrence of loss arising from a peril, or that may influence the extent of the loss

Health Insurance-

A broad term covering the various forms of insurance relating to the health of persons. It includes such coverage as accident, sickness, disability, and hospital and medical expense. This term is used instead of sickness and accident insurance.

Health Maintenance Organization (HMO)-

An organization that provides for a wide range of comprehensive health care services for a specified group in consideration of fixed periodic premium payments. An HMO may be sponsored by a medical school, hospital, employer, labor union, consumer group, insurance company, hospital medical plan, or the government.

Home Owners policy-

A multi-line policy for owner occupied residences. Homeowner’s policies provide property and liability coverage for dwelling and other structures and personal property.

IRA

An Individual Retirement Account (or IRA) is a retirement plan account that provides some tax advantages for retirement savings in the United States.

There are a number of different types of IRAs which may be either employer-provided or self-provided plans. The types include:

- Roth IRA - contributions are made with after-tax assets, all transactions within the IRA have no tax impact, and withdrawals are usually tax-free. Named for Senator [William Roth](#).
- Traditional IRA - contributions are often tax-deductible (often simplified as "money is deposited before tax" or "contributions are made with pre-tax assets"), all transactions and earnings within the IRA have no tax impact, and withdrawals at retirement are taxed as income (except for those portions of the withdrawal corresponding to contributions that were not deducted).
- SEP IRA - a provision that allows an employer (typically a small business or self-employed individual) to make retirement plan contributions into a Traditional IRA established in the employee's name, instead of to a pension fund account in the company's name.
- SIMPLE IRA - a simplified employee pension plan that allows both employer and employee contributions, similar to a 401(k) plan, but with lower contribution limits and simpler (and thus less costly) administration. Although it is termed an IRA, it is treated separately.
- [Self-Directed IRA](#) - a self-directed IRA that permits the account holder to make investments on behalf of the retirement plan.
- More IRA types listed here.

Indirect loss

Loss resulting from a peril but not caused directly and immediately by that peril

Insurance fraud

Deliberate deception used as a means of obtaining money, goods, and/ or services in the insurance industry. Common types include arson, theft, staging vehicle accidents

Insurance Law

Statutory laws made by the assembly, senate and governor. Violation of these laws may also be imposed by the Superintendent of Insurance in addition to civil and criminal penalties

Insurance scheme

A plot to receive money from unsuspecting customers looking to buy insurance. Insured's should be suspicious of the price of insurance seems to good to be true. They should contact the NYS Insurance department in order to make sure the agent and company are licensed as well as always check the bills closely for accuracy

Insurance Services Organization (ISO)

An organization of the property and liability insurance business designed to gather statistics promulgate rates, and develop policy forms. They print and distribute manuals, provide rules and forms. They also collect and compile data

Insuring agreement

That proportion of an insurance contract which states the perils insured against, the persons and/or property covered, their locations, and the period of the contract

Life Insurance

Insurance upon the lives of human beings that creates an immediate and guaranteed estate at the death of an insured and which may also provide living benefits through cash value.

Litigation

To contest in legal proceedings. Legal actions are typically employed by an injured individual against an insurance company to gain policy benefits to stated maximums. Litigation based on liability of an insured may also be used as a measure to obtain additional money to provide for additional losses.

Long Term Care

Long term care is the type of care that you may need if you can no longer perform "activities of daily living" by yourself, such as eating, bathing or getting dressed. It also includes the kind of care you would need if you had a severe cognitive impairment like Alzheimer's disease. Care can be received in a variety of settings, including your own home, assisted living facilities, adult day care centers or hospice facilities. Long term care can be covered completely or in part by long term care insurance. Most plans let you choose the amount of the coverage you want, as well as how and where you want to use your benefits. A comprehensive plan includes benefits for all levels of care, custodial to skilled.

Material misrepresentation

The most serious type of misrepresentation; i.e. a fraudulent statement made by the application of an insurance policy (also see Misrepresentation)

Medical Payments (Med Pay)

Medical Payments paid as reimbursement for medical and funeral expenses because of bodily injury, paid on a per-person, per-accident basis. Benefits are paid only to third parties under homeowner's policies and to first and third parties under auto coverage. Claims generally must be made within 3 years.

Medicare-

A program of health insurance and medical care for persons who are 65 years of age or over, and certain other disabled persons under age 65, operated under the provisions of the Social Security Act. Medicare has two parts: Part A (Hospital Insurance), and Part B (Medicare Insurance, helps cover doctors' services, outpatient hospital care, and some other medical services that Part A does not cover).

Medigap policies-

Issued to supplement Medicare benefits (paying for deductibles, coinsurance and even charges not covered by Medicare). In 1991, Congress established 10 standardized Medigap policies.

Miscellaneous expenses-

Hospital charges other than room-and-board; i.e. X-rays, drugs, laboratory fees, etc. (in connection with hospital insurance).

Misdemeanor

Criminal conduct i.e. filing an insurance claim which contains a fraudulent statement. It is less serious than a felony

Misrepresentation-

A false statement, which the prospective insured makes in an application for a policy. A misrepresentation is material if the insurance company, having known the true facts, would have refused to issue the policy or taken other underwriting action such as charge an additional premium or requiring the attachment of an impairment waiver. Statements are considered representations and not warranties. If an insurance company discovers an insured's misrepresentation on a policy they may cancel any coverage not required by law, giving the named insured usually 20 days notice.

Moral hazard

A condition of morals or habits that increases the probability of loss from a peril.

Morale hazard

Hazard arising out of an insured's indifference to loss because of the existence of insurance.

Motives for insurance fraud

Reasons why people file false claims and commit insurance crimes. They include loss of a large account, desire to change locations, gambling debts, economic loss, facing bankruptcy, inability to fill contracts, etc

Non admitted Insurer (unauthorized or unlicensed insurer)

An insurer not licensed to do business in the jurisdiction in question.

Non-Owned Auto Coverage

Covers bodily injury and property damage for your company while vehicles are used by employees for your business use.

Non Renewal

When an insurance company does not renew a policy. In auto and home owners insurance the non-renewal notice is sent to the insured and must include the reason for non renewal

NYS Fraud Bureau

The investigative unit that are assigned to insurance fraud cases. They often work with law enforcement agencies as well as the insurance company's special investigative unit. They require insurance companies to develop thorough plans for prevention and detection of insurance fraud

OBEL – Optional Basic Economic Loss

Basic Economic Loss consists of medical expense, work loss, other expense and death benefit not to exceed \$50,000. Basic Economic Loss coverage is provided under statutory personal injury protection (PIP). Optional Basic Economic Loss provides an additional \$25,000 of coverage that may be applied as directed by the recipient, subject to policy language.

Open Enrollment Period

A period of time during which people, who would otherwise have to submit evidence of insurability, can apply for group insurance or HMO coverage, without such evidence.

Peril-

The cause of a possible loss

Permanent Insurance

Permanent covers a person for life, as long as he or she is paying the premium.

Physical hazard

Any hazard arising from the material, structural, or operational features of the risk itself apart from the persons owning or managing it.

PIP - No Fault

Personal Injury Protection coverage provides reimbursement for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident. Benefits include Basic Economic Loss, Medical Expense, Death Benefit and Other Expenses defined in a policy. Benefits are limited by the insuring agreement.

Pro Rata

Distribution of the amount of insurance under one policy among several objects or places covered in proportion to their value or the amounts shown

Regulation 60

The New York State Insurance Department Regulation governing the replacement of life insurance policies and annuity contracts in New York State.

Rental Car Coverage

Includes coverage to rent a vehicle in the event of a covered loss.

Replacement cost

The cost of replacing property without a reduction for depreciation

Representation

A statement in legal terms, made on an application for insurance that the applicant represents as correct to the best of his knowledge and belief

Section 125 Plan

Section 125 Plans go by a variety of names, such as Premium Only Plans (POP), Salary Reduction Plans, Flexible Benefit Plans and Premium Conversion Plans, all are based on the guidelines of the Internal Revenue Code Section 125. In layman's terms, a Section 125 Plan permits employees to purchase fringe benefits with PRE-TAX dollars instead of AFTER TAX dollars.

Self Insurance

Making financial preparations to meet pure risks by appropriating sufficient funds in advance to meet estimated losses, including enough to cover possible losses in excess of those estimated.

Small business fraud

A small business committing insurance fraud. They have a higher tendency to consider arson and other crimes as a way out of financial difficulties. Statistics show a rise in small business fires when facing economic loss and/or bankruptcy

Social Security

A government program which provides economic security for portions of the public.

Soft fraud

When a normally honest person tells little white lies to their insurance company i.e. a homeowner inflating the value of their stereo stolen during a robbery

Special investigative unit (SIU)

An insurance company's fraud investigation department. They investigate fraudulent practices

State Insurance Fund

A fund set up by a state government to finance a mandatory insurance system such as Workers Compensation and Non occupational disability benefits.

Stock Redemption Agreement

A stock redemption agreement is an agreement in which the corporation owns insurance policies on the lives of the shareholders. When a shareholder dies, the corporation buys the deceased shareholder's interest in the company with the insurance proceeds.

Subrogation

The right of one who has taken over another's loss to also take over his right to pursue remedies against a third party

Superintendent of Insurance

The person in charge of the NYS Insurance department i.e. commissioner. He may revoke a license for any violation of the NYS Insurance law. Punishments include possible fines and imprisonment for up to one year plus suspension or revocation of all licenses

Supplemental Spousal Liability

Supplemental Spousal Liability Insurance means coverage against liability of an insured because of death or injuries to his or her spouse up to the liability insurance limits provided under the policy even where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse.

Term Insurance

A term policy provides coverage for an allotted amount of time. Most group life insurance policies are term policies - covering employees only while they are working for your business.

Towing

Covers cost to tow an insured vehicle

Twisting

Inducing an insured to cancel his preset insurance and replace it with insurance in the same or another company by misrepresenting the facts or by presenting an incomplete comparison.

Uninsured and Underinsured Motorist

Pays damages for bodily injury caused by drivers of uninsured vehicles, when such drivers are legally liable for injury to the insured and/or passengers.

Workers Compensation

Benefits paid for an injury (or disease contracted) arising out of and in the course of employment. The amount of the benefits and the conditions, under which employees are eligible, are determined by the workers' compensation law. In Most states, the insurance providing these benefits may be purchased from private insurance companies. In a few states, only a monopolistic state workers' compensation fund is permitted to issue such insurance. In some states, the coverage may be obtained from either a state fund or from a private insurance company.

Viaticals

Viatical, or a life settlement, is the sale of a life insurance policy by the beneficiary of the policy, before the policy matures. Such a sale, at a price discounted from the face amount of the policy but usually in excess of the current cash surrender value, provides the seller an immediate cash settlement. Generally, viatical settlements involve insured individuals with a life expectancy of less than two years. The life settlement market is currently focused on individuals with life expectancies of three to ten years. A life settlement can be an innovative wealth and estate planning tool, especially when the policy holder encounters changed circumstances, such as bankruptcy, divorce, unaffordable premiums, change in tax laws, or a serious or life threatening illness. From the perspective of the investor, purchasing a life settlement is similar to buying a bond with a negative coupon and an uncertain redemption date.

Sample Questions:

- 1) The Disability Benefits Law is designed to provide benefits for an employee:
 - a. because of occupational injury or illness
 - b. because of disabilities that arise in the course of employment
 - c. because of a non-occupational injury or illness
 - d. for any illness or injury

- 2) The Funeral Expense benefit under the NYS Workers Comp Law is:
 - a. a maximum of \$6,000
 - b. a minimum of \$7,000
 - c. unlimited
 - d. there is no funeral expense benefit

- 3) Under the Disability Benefits Law (D.B.L.) the minimum benefit is:
 - a. \$20 per week
 - b. the lesser of \$20 or 100% of the claimants average weekly wage
 - c. 100% of the claimants average weekly wage for the 8 weeks preceding the disability
 - d. 50% of the claimant's average weekly wage for the 8 weeks preceding the disability

- 4) Physical damage coverage (part D) of the personal auto policy:
 - a. includes physical damage to non-owned autos
 - b. excludes physical damage to non-owned autos
 - c. excludes physical damage to covered autos
 - d. none of the above

- 5) Which of the following is an unauthorized activity for unlicensed support staff:
 - a. Take loss information from customers
 - b. Accept payment from customers
 - c. Assisting with advertising and mailing campaigns
 - d. Discuss and provide advice on coverages, limits or deductibles

Answers: 1, C; 2, A; 3, A ; 4, A; 5, D