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FOREWORD

This Manual is an exam preparation tool for future life insurance agents registered in the Life License Qualification Program (LLQP). Its contents will help candidates develop the competency targeted in the accident and sickness insurance module of the LLQP Curriculum: *Recommend individual and group accident and sickness insurance products adapted to the client's needs and situation*.

Chapter overview page

The first page of every chapter outlines the Curriculum module competency components and sub-components that will be covered. Highlighting which of the evaluation objectives are addressed in each of the manual's chapters serves to identify the contents that are essential to attain these objectives.

It is thus recommended that candidates regularly review the competency components and sub-components in order to contextualize and assimilate them as they read each chapter. This will help develop an understanding of the nature and scope of the evaluated competency. Candidates must have fully understood the knowledge, strategies and skills covered in each chapter in order to successfully pass the corresponding module of the LLQP licensing exam.

In this text, the masculine form is used for both men and women.

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APPENDIX A

Adults with disabilities that need help with everyday activities, by sex and age groups, Canada, 2001 and 2006 216

LIST OF ABBREVIATIONS

A&S	Accident and sickness
ACB	Adjusted cost base
AD&D	Accidental death and dismemberment
ADLs	Activities of daily living
APS	Attending physician's statement
ASO	Administrative services only
BOE	Business overhead expense
CCAC	Community Care Access Centre
CI	Critical illness
COB	Coordination of benefits
COLA	Cost of living adjustment
CPI	Consumer Price Index
CPP	Canada Pension Plan
CRA	Canada Revenue Agency
CSD	Canadian Survey on Disability
CSV	Cash surrender value
DI	Disability insurance
DTC	Disability Tax Credit
EAP	Employee assistance plan
EHT	Employee health trust
EI	Employment Insurance
ESDC	Employment and Social Development Canada
FPO	Future purchase option
GA	General agency
GIB	Guaranteed insurability benefit
GIO	Guaranteed insurability option
HELOC	Home Equity Line of Credit
HWT	Health and welfare trust
LLQP	Life License Qualification Program

LTC	Long-term care insurance
LTD	Long-term disability
MIB	Medical Information Bureau
OAS	Old Age Security
PHSP	Private health services plans
POA	Powers of attorney
PUC	Paid-up capital
QPIP	Québec parental insurance plan
QPP	Québec Pension Plan
RDSP	Registered disability savings plan
RFQ	Request for a quote
ROP	Return of premium
RRIF	Registered retirement income fund
RRSP	Registered retirement savings plan
STD	Short-term disability
TFSA	Tax-free saving account
WP	Waiting period

CHAPTER 1

FINANCIAL PROTECTION PROVIDED BY ACCIDENT AND SICKNESS INSURANCE

Competency component

- Assess the client's needs and situation.

Competency sub-component

- Articulate the client's needs based on the risks that could affect his or her financial situation.

1

FINANCIAL PROTECTION PROVIDED BY ACCIDENT AND SICKNESS INSURANCE

The Insurance Companies Acts of the various provinces define what is considered to be “accident and sickness” (A&S) insurance. The provincial Acts are similar in content and most will include the following when defining A&S insurance:

- Benefits for loss due to accidental bodily injury to the life insured;
- Benefits for loss due to accidental death of the life insured;
- Benefits for loss resulting from the sickness or disability of the life insured;
- Benefits for loss due to the death of the life insured;
- Benefits for healthcare, including dental and preventive care of the life insured.

More simply put, accident and sickness insurance relieves insured individuals of the burdens of medical expenses or income loss arising from illness, injury or necessary medical treatment not covered by the provincial health insurance plans.

This Chapter describes the risks that businesses, individuals and their families face, and the ensuing needs that are met by various types of A&S insurance products. The products themselves, as well as the process of recommending and implementing them, will be discussed in more detail in the chapters to come.

1.1 For individuals and their families

Although various types of accident and sickness insurance can play a critical role in protecting the financial viability and longevity of many businesses, the primary role of most A&S policies is to protect the finances of individuals and their families during times of medical or health crisis.

1.1.1 Financial goals of individuals and their families

Most families have a fairly common set of goals that require regular cash flow and a surplus that can be invested for the long term. Although the specific amounts and details will vary from family to family, the general objectives remain similar.

1.1.1.1 Wealth accumulation

Once immediate needs (food, accommodation, clothing, means of travel, entertainment, etc.) have been provided for from current income, any surplus should first be allocated to setting up an emergency fund: three to six months of current expenses. Excess income can then be earmarked for wealth accumulation goals, both short and long-term. Wealth (assets) can be employed to achieve a wide variety of family goals:

- To be invested in a home or vacation property;
- Building a portfolio of securities, registered and non-registered, to provide additional current income, growth or funds to draw on in retirement;
- Building a legacy to pass along to the next generation or to posterity in general.

1.1.1.2 Retirement income

At some point nearly everybody retires. But “retirement” means different things to different people: some want to travel, some want to sit by the lake at the cottage and enjoy nature, others want to spend their time engaging in community help projects. The list is as diverse as are people. But all types of retirement have one thing in common: they all require income in one degree or another.

Retirement income can come from a variety of sources:

- Government pension plans (Canada/Québec Pension Plans (CPP and QPP) and Old Age Security (OAS));
- Employment pension plans;
- Private pension plans (Registered Retirement Savings Plans (RRSPs));
- Non-registered investments;
- Inheritances;
- Part-time employment or self-employment;
- Liquidation of assets.

But almost all of these sources require that the retiree has worked, saved and invested for a significant number of years prior to retirement. And continuity of work can be interrupted by a number of factors, including economic downturns and disability. It is in the area of disability and the recommendation of products that can replace income during periods of disability that the life insurance agent has a significant role to play in protecting the financial welfare of individuals and their families.

1.1.1.3 Family needs

Prior to retirement and prior to (or concurrent with) investing for wealth accumulation, families need to generate income and set aside savings to meet ongoing family needs. Tuition (and room and board) for higher education for children, orthodontics, family vacations – these and more all need to be provided for long before retirement. And many families are faced with providing extra support for special needs children, dependent ageing parents or "boomerang" children forced by economics or other circumstances to return to the "nest."

1.1.2 Financial risks that threaten individuals and their families

Meeting the above-noted family goals is primarily dependent upon clients' ability to generate sufficient income and savings over time. Unfortunately, there are a number of risks that could disrupt those plans, such as:

- Unexpected expenses;
- Loss of income or savings;
- Lower standard of living;
- Inflation;
- Longevity;
- Debt.

1.1.2.1 Unexpected expenses

In theory, a budget will help clients to match income and expenses and prepare for future financial eventualities. But not everyone has a budget. Not everyone who has a budget is good at making a realistic budget. And certainly many people with budgets are not good at sticking to them.

But even the best budget cannot anticipate every possible expense. Some expenses, like the need to replace a vehicle every six years or so, can be anticipated and planned for by setting up a "sinking" (savings) fund to prepare for the expense. But others may come "out of the blue" and have the potential to completely derail the family budget.

EXAMPLE

Emily, a single mother of 35 with two pre-teen children, suffered a debilitating stroke last year. Not only has she been unable to work and earn an income ever since, she had to spend $75,000 to modify her two-story home to accommodate her motorized wheelchair. The combination of income loss and medically related expenses have depleted her savings and much of her RRSPs and driven her into debt. The prospect of having to sell her house and move the family into an apartment is looming.

1.1.2.2 Loss of income

During a person's working years, especially the "early" years, financial success and security are all about income. Unless someone wins the lottery or inherits young, the only way that they can accumulate savings or a long-term asset base is by generating more income annually than they currently need to live on. But income is dependent upon both availability and the individual's ability to continue working. And even those with jobs could suddenly find themselves without income if injury or illness caused a disability that kept them off the job for a prolonged period of time.

1.1.2.3 Loss of savings

Either unplanned large expenses or a decline or loss of income, or both, could compel a family to draw down their savings to meet current demands. And depending on the amount of savings involved and the family income resources available, it could take years to build them up again.

1.1.2.4 Lower standard of living

A lower standard of living is not really a risk in and of itself, but it may be a consequence of other losses: loss of income, loss of savings, loss of assets, etc., which in turn may all stem back to income lost or unexpected medical expenses incurred due to injury or illness. This "domino effect" could often be avoided if the client has an effective A&S insurance program in effect. Otherwise, changing financial circumstances could compel the family to sell one of their cars, move to a smaller home or a rental unit or cut back on, or eliminate, family vacations. And a reduced standard of living isn't merely a physical change for the family; it could also create psychological changes that are a roadblock to ambition and productivity in the future. A reduced standard of living today could translate into substantially reduced income, assets and lifestyle in the future.

1.1.2.5 Inflation

Using the Consumer Price Index (CPI) as a guide, for example, a "basket" of goods that cost $100 in 1994 cost $144.57 just 20 years later, in 2017,[1] an increase of 45%; and that during a period of historically low inflation. Looking at the long term, $100 worth of goods bought in 1917 cost $1,652 one century later.[2]

Although inflation in Canada has been historically low over the past years (1.24% in 2013), it was not so long ago that it was at a much higher level (12.12% in 1982).

For those earning a living in times of high inflation, salaries have to increase substantially year over year just to allow the worker to maintain his standard of living. Likewise, disability income replacement products, like A&S disability insurance, need to be indexed to inflation in order for

1. Bank of Canada. *Inflation calculator*. [online]. [Consulted August 3, 2017]. http://www.bankofcanada.ca/rates/related/inflation-calculator/
2. Trading Economics. *Canada inflation rate*. [online]. [Consulted August 3, 2017]. http://www.tradingeconomics.com/canada/inflation-cpi

benefits to retain their buying power, particularly during periods of prolonged disability and/or high inflation.

1.1.2.6 Longevity

In North America, in 1900, the average male had a life expectancy at birth of only 46.3 years. Many men never reached the age of retirement. But for those who did manage to reach age 65, their average remaining lifespan was roughly 12 years. By the year 2000 that lifespan had been increased to 16 years for males age 65,[3] and 18 to 19 years in most Canadian provinces by 2009.[4] In general, people are living longer and spending more years in retirement. As a consequence clients are going to need to accumulate more retirement assets than in the past if they want to avoid "outliving their money." Increased longevity has the same implications for care costs for the elderly. Those who live longer are more likely to incur health complications requiring in-home or institutional care and are likely to require that care for a longer period of time than in past – both sound reasons to ensure that a strong long-term care insurance program is in place.

Not only has the average lifespan of "retirees" increased by over 50% over the past century or so, but so has the cost of living longer. In 1900 most people who lived well into their 70s, but who had health problems, were cared for at home, by their families. Today it is more common for the elderly who are in need of care to live in chronic care facilities: "retirement homes" or nursing care facilities. With nursing home costs running as high as $5,000 a month, with monthly fees for private retirement homes often running much higher than that, many seniors may well be faced with outliving their money and being dependent on the government or their children. In any event, many will find themselves in the position of being able to leave a much smaller (or no) estate for the benefit of their children.

1.1.2.7 Debt

Debt can insidiously erode financial plans and goals. Debt, of course, reduces net worth – the value of a person's assets less his liabilities.

Average household debt in Canada in 2013 rose to an all-time high: $1.63 of debt for every $1.00 of family disposable income. Overall, in 2013, Canadians owed $1.1 trillion in mortgage debt and $500 billion in credit debt.[5]

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3. ElderWeb. *History of long term care.* [online]. [Consulted August 3, 2017]. http://www.elderweb.com/book/history-long-term-care
4. Statistics Canada. *Life expectancy, at birth and at age 65, by sex and by province and territory*. [online]. Revised May 31, 2012. [Consulted August 3, 2017]. http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health72a-eng.htm
5. Huffington Post. *Canadian's household debt reaches new high: $1.63 for every dollar earned*. [online]. Revised September 13, 2013. [Consulted August 3, 2017]. http://www.huffingtonpost.ca/2013/09/13/household-mortgage-debt-canada_n_3920887.html

But it is not just the amount of debt that is a concern, but the carrying costs on that debt, most particularly credit debt. For example, consumer credit cards often carry annual interest rates on unpaid balances in the 18% to 24% range, or higher. At that rate, the $500 billion of credit card debt could have servicing costs in the range of $90 to $120 billion dollars annually.

In fact, many Canadians who are entering retirement carry substantial debt load: an impediment to the long-term financial viability of their retirement plans.

Debt servicing (interest and minimum payments) usually comes out of current income, and current income may be put at risk in the event of health problems, like disability or critical illness. A client's failure to service debt could, in the extreme, result in lawsuits, foreclosure and bankruptcy unless insurance is put into place to replace the client's own capacity to generate income or cover current medical costs.

1.1.3 Personal risks that threaten individuals and their families

Aside from all the financial risks discussed above, people also face personal health risks that could derail their financial plans and imperil their financial security, such as likelihood of disability, loss of independence and costs of long-term care.

1.1.3.1 Likelihood of disability

In 2012, about 3.8 million people, or 13.7% of Canadians aged 15 and older, reported being limited in their daily activities because of a disability. The results come from the 2012 Canadian Survey on Disability (CSD).[6]

Persons were identified as having a disability if they had difficulty performing tasks as a result of a long-term condition or health-related problem and experienced a limitation in their daily activities.

The prevalence of disability increases steadily with age. Nearly 1 in 10 working-age persons (aged 15 to 64) reported having a disability in 2012, compared with almost one-third of seniors (aged 65 and older). Women (14.9%) have a higher prevalence of disability than men (12.5%).

In 2012, 26.0% of persons with disabilities were classified as very severe; 22.5%, severe; 19.8%, moderate; and 31.7%, mild.

1.1.3.2 Loss of independence and costs of long-term care

Lastly, with people living longer (see above) and in receipt of better health care than in the past, there are more persons living for more years with medical conditions, both physical (stroke, Parkinson's disease, for example) and cognitive (like Alzheimer's), that leave them unable to care

6. Statistics Canada. *Canadian survey on disability, 2012*. [online]. Revised December 3, 2013. [Consulted August 3, 2017]. http://www.statcan.gc.ca/daily-quotidien/131203/dq131203a-eng.htm

for themselves independently. Many of these people rely on long-term care facilities for basic daily living, but often at a cost of $3,000 to $5,000 a month for full-time care.

1.1.4 Needs met by accident and sickness insurance for individuals

In the event of illness, injury or medical necessity, accident and sickness insurance can provide needed funds to buy time for employees, the self-employed, business owners and their families – time to recover and return to productivity, time to adapt to a changed health status and time to weather the storms of an unexpected financial burden. As such, the needs met by A&S insurance for individuals include protection for:

- Income;
- Savings;
- Assets.

1.1.4.1 Protection for income

Although perhaps not immediately apparent from the title “accident and sickness insurance,” one of the most common forms of coverage is disability income protection: insurance that will replace a percentage of a person’s regular income from employment or self-employment if the insured is ill or injured and unable to work. After a suitable waiting period following the onset of disability, during which no benefits are payable, the insured will receive a monthly income payment from the insurer. The benefits will be payable for a prescribed benefit period or until the disabled insured is able to return to work, whichever comes first.

EXAMPLE

Raoul is an independent contractor working in the plumbing trade, earning $80,000 a year. In order to protect his family financially, in the event that he becomes disabled for a period of time and unable to work, he has taken out a disability income replacement (A&S) insurance policy. The policy has a 90-day waiting period, a monthly benefit of $4,200 and a five-year benefit period. If Raoul was to be injured and unable to work, after waiting for three months, the policy would begin to pay him $4,200 a month for up to five years, to replace income lost due to disability.

1.1.4.2 Protection for savings

During a person’s working lifetime one of the many family goals is the accumulation of capital: savings (in bank accounts, term deposits and other short-term financial vehicles) as an emergency fund or for near-term financial goals (like an education fund, a boat or a new car, etc.) and investments (stocks, bonds, mutual funds, RRSPs) for longer-term goals like retirement.

Unforeseen circumstances (sickness, disability, medical expenses, etc.) can lead to the erosion of both short-term and long-term savings. Fortunately, extended health insurance, which is a form of accident and sickness insurance, can defray the financial impact of many of these risks by providing needed cash to replace lost income or pay medical bills.

EXAMPLE

This has been an unusually difficult year for the Johnson family. Mrs. Johnson, who runs a consulting sole proprietorship business, was injured in a slip and fall accident in January and was unable to work for 8 months. As a result, she was unable to earn her regular $5,000 a month of consulting fees for those months, resulting in a nearly 50% reduction in family income. The Johnsons' son was hit in the mouth with a puck in a recreational hockey game and required over $10,000 of reconstructive dental surgery. And the Johnsons' daughter developed a serious viral infection requiring 10 days of hospital treatment in a private room, at a cost of $125 a day over and above what the provincial health plan pays.

Fortunately, the family has extensive A&S insurance coverage, both private and through Mr. Johnson's group plan where he works. All of their daughter's $1,250 of extra hospital expenses were covered under the group plan, as was $5,000 of their son's dental expenses. And Mrs. Johnson has a disability income replacement plan that paid her $3,000 a month for five of the eight months that she was off work, a total of $15,000. Without adequate insurance coverage, the Johnsons' savings would have been reduced by $21,250 ($1,250 + $5,000 + $15,000).

1.1.4.3 Protection for assets

Most people save for their retirement, although amounts saved vary. For example, according to a survey published by the CBC[7] on January 4, 2013, almost 6,000,000 Canadians contributed to an RRSP in 2010, holding a total of $782 billion in assets in their plans. And those assets, among others, do not necessarily get consumed during the retirement years: they are often passed on to the next generation through the retirees' estates. Or, at least, that is the intent.

Unfortunately, health issues in the senior years can bring expenses that deplete retirement and estate assets. Most retirees' group health benefits terminate at retirement, leaving them without coverage for dental and vision care expenses. For those who can no longer live independently, due to physical or cognitive impairments, the cost of provincially subsidized nursing home care

7. CBC News. *Retirement savings in Canada – by the numbers*. [online]. Revised January 4, 2013. [Consulted August 3, 2017]. http://www.cbc.ca/news/business/taxes/retirement-savings-in-canada-by-the-numbers-1.1303371

can run as high as $3,200 a month[8] (in British Columbia, for example), with private retirement home facilities potentially costing much more.

Critical illness and long-term care insurance can provide benefits to offset much of these costs, permitting the senior to maintain the value of his estate, to pass on to his heirs.

EXAMPLE

Eudora, age 69, worked her whole life as a legal assistant, but never earning a large salary. She had no pension plan at her place of business, but did manage to accumulate about $250,000 in RRSPs and non-registered investments, in addition to her $150,000 home in rural P.E.I. To date she has been able to live off of her $1,250 a month ($15,000 a year) in government benefits and some interest and dividends from her investments.

Eudora recently discovered that she has a degenerative disease that will force her to move into a nursing home, at a cost of $2,750 a month ($33,000 a year). Despite her health problems Eudora has a normal life expectancy of age 85 (16 years). The shortfall in her income versus the cost of the nursing home would require Eudora to liquidate $18,000 a year of her assets ($33,000 – $15,000), reducing her estate by about $290,000 over her lifetime ($18,000 × 16 years): money she had planned to leave to her three grand-nieces, to help them to get a start in life.

Fortunately, Eudora took out a long-term care policy when she was in her mid-50s. The policy will cover $1,000 of her monthly expenses ($12,000 annually), reducing the erosion of her estate to less than $100,000 over her lifetime (($18,000 – $12,000) × 16 years = $96,000), and enabling her to still leave a substantial legacy for her family.

1.2 For business owners

The needs and goals of business owners that require protection are, in many ways, similar to those of individuals and their families. That is because the “business owner” does not exist in a vacuum: he is both an individual and, often, a member of a family. The sections below describe goals, risks and needs of business owners as they relate to accident and sickness.

1.2.1 Goals

All owners of private businesses typically have similar goals, which may change with circumstances and over time. The goals for the business/business owner translate directly into individual goals:

8. Sun Life Financial. *Long Term Care in British Columbia 2016.* [online]. [Consulted August 11, 2017]. https://www.sunnet.sunlife.com/files/advisor/english/PDF/Completereport-LTC-Costs-BC.pdf

- Business profitability (income protection);
- Business succession (capital protection);
- Sale at fair market value (protection of estate value).

1.2.1.1 Business profitability

At the outset of a new business, simple survival is often the immediate goal of the business owner(s). Once the business gets through the first year or two and has established itself, the goal of the owner(s) shifts from survival to profitability and growth. Whatever else their motives, business owners are in business to earn a living: for themselves, their families and their employees. Among the many factors that contribute to profitability is business continuity.

1.2.1.2 Business succession

Many business owners consider their business to be their legacy: to carry on their reputation and identity beyond their working lives. And many of those would like to see the business eventually taken over by their children. This is true whether those children are indeed children, perhaps currently preschoolers, are in university, or are currently (or prospectively) employed in the business. However, the majority of “family-owned” private businesses do not transition down to the next generation, primarily because of a lack of planning. Even where the children might be willing to take over the business, a lack of proper preparation can result in the business failing before any transition can be affected. Chapter 5 of this manual outlines the role of accident and sickness (A&S) insurance to provide funds to cover the business operation expenses of a disabled owner, to ensure that he has a business to return to or to pass along to the next generation.

1.2.1.3 Sale at fair market value

In many cases the business cannot be passed down to the next generation: there is no next generation, or the next generation is not capable of taking over the business, the members of the next generation cannot agree on how to divide up or carry on the business, or the next generation simply has their own life plans and are not interested in taking over the business. In such cases the next best scenario is for the retiring owner, or the estate of a deceased owner, to be able to sell the business for its fair market value. This can usually not be accomplished without forward planning. A spur-of-the-moment sale, unplanned, is often a “fire sale,” with potential successors or competitors looking to take advantage of the situation by paying a fraction of fair value for the business itself, its client/customer base or the hard assets of the business. Ideally, owners should take the time to identify in advance a suitable buyer for a business, lock in that buyer and a fair price with appropriate legal documentation (a “buy/sell agreement”) and ensure that adequate funding will be available, when needed, to provide for the purchase. Chapter 5 of this manual examines the role of accident and sickness insurance in securing the necessary funding, along with proper legal documentation, to ensure that a disabled business owner can obtain a fair price for the business.

1.2.2 Business risk

Business success or failure can be related to a number of factors, both internal and external. Such issues as productivity, quality of production and the management of finances and personnel are internal matters, subject to the control of the business owner. Risk is generally defined as the chance that a given result (usually negative) might occur. Risks may be systematic – common to the business environment itself, or unsystematic – unique to the client's business itself.

Businesses are, first and foremost, exposed to business risk (also known as unsystematic risk): factors that relate to a specific business, rather than to the market or the economy as a whole, that could impact profitability, or even survival, of the business. An important consideration in business risk is the health of the owner/operator and other key personnel: their ability to continue to provide services essential to the profitability and survival of the business.

1.2.3 Risk management

When it comes to the risk that a business might suffer when an owner or an essential employee is injured or ill and unable to fulfill his function with the business, the business only has two options to deal with the costs associated with such a risk:

- Self-funding;
- Insurance.

1.2.3.1 Self-funding

Self-funding risk is simply a form of risk retention – assumption of the cost of the risk by the business owner. An individual who wishes to self-fund the cost of a loss associated with a risk really only has three options:

- Pay the cost out of current cash flow;
- Borrow to acquire funds to pay the cost;
- Erode savings or sell assets.

None of the options is very appealing. If the cost of the loss is the reduction or elimination of earned income due to disability, where is the current cash flow to come from to pay for it? Borrowed funds could be used to pay for the loss, but borrowing money can be expensive and the funds have to be repaid. If the borrower happens to be ill and unable to work, lenders may not find him to be an attractive risk: where would he get the cash flow to repay the loan? Savings or other assets could be sacrificed to pay for the loss, provided that the individual has the necessary assets. But those assets were likely earmarked for other purposes: needs that might go wanting, now or in the future.

1.2.3.2 Insurance

The better solution than self-funding is often to insure against the potential loss posed by risks, such as death, disability or medical expenses triggered by injury or illness. For a modest premium, paid regularly to the insurance company, an individual can be assured that funds will be available, when needed, to replace income lost or expenses incurred due to disability or a medical crisis.

Of course, the premiums paid for insurance may be "lost" if the insured person never needs to file a claim, but the cost of this loss is likely to be less than the loss that would be incurred if no insurance was present. Conventional wisdom usually says that, with insurance, "it is better to have it and not need it than to need it and not have it."

1.2.4 Needs met by accident and sickness insurance for businesses

Businesses, particularly smaller, private businesses, all rely upon two common factors for success: ongoing revenue generated by the efforts of owners and/or key employees of the business and hiring and keeping quality employees.

If a business relies extensively upon the services of the owner or a key employee to generate the revenue needed to pay bills and turn a profit, a disability of more than a few days of such a person could spell the death of the business. Even if little or no revenue is coming in, expenses like rent, utilities, staff salaries and other payables still need to be met. Specific A&S insurance policies, such as business overhead expense (BOE) plans, among others, can provide funds to keep the business afloat financially for several months while the disabled owner/employee recovers.

EXAMPLE

Ingrid is the sole owner and primary salesperson for a small import/export business that rents office space in an industrial mall and employs three staff. Last month, she was in an automobile accident and was injured severely enough that she was off work for 7 months. During the period of her disability, which promised to be temporary, the income of the business declined by 70% after the initial couple of months. Without cash flow the business would be forced to close its doors. However, Ingrid had the foresight to take out a BOE disability insurance policy on herself, which would pay out up to $15,000 a month to cover ongoing business expenses. The funds were sufficient to pay the rent and staff salaries and keep the business operating until such time as Ingrid was able to return to work.

There are many components that serve to attract and retain employees: salary, pensions, good working conditions, good management, positive management and employee relations, and attractive benefits, including accident and sickness insurance. An employee wants to know that, if he has to be off work for a period of time due to accident or illness, his income will continue during

his absence to support him and his family. Even single employees would like to see health care benefits (dental, vision, extended hospital care) to cover medical expenses: a need that is even more important for those employees with families. If a prospective (or current) employer does not offer adequate employee benefits, employees or prospective employees are likely to look elsewhere for employment security.

CHAPTER 2

INSURANCE TO PROTECT INCOME

Competency component

- Analyze the available products that meet the client's needs.

Competency sub-components

- Analyze the types of contracts that meet the client's needs;
- Analyze the riders that meet the client's needs.

2
INSURANCE TO PROTECT INCOME

Disability insurance provides financial protection to working individuals who become injured or ill and unable to work. Benefits paid to or on behalf of qualifying insured individuals range from income replacement to paying monthly mortgage, loan, and credit card payments on behalf of the disabled claimant.

2.1 Sources of income protection

There are many sources of disability insurance (DI) coverage available in the marketplace. Anyone who has earned income (from employment or self-employment), and who is insurable medically, may obtain disability income replacement coverage from one or several of the following sources:

- Personally owned policy, acquired directly from the insurance company;
- Group insurance coverage, as an employee or as a member of a union or association offering group insurance coverage;
- Creditor insurance, including mortgage insurance, offered to borrowers or credit card holders dealing with major financial institutions;
- Provincial Workers' Compensation Boards;
- Disability pensions offered through the Canada or Québec Pension Plans.

2.1.1 Individual disability insurance

Individual DI contracts are entered into directly between the applicant, who is also both the insured and the life insured[9] under the contract, and the insurance company. Once the policy is issued, the policyholder is typically the premium payor, the life insured and the beneficiary under the policy. These policies are usually taken out to replace earned income in the event of disability, but may also have business-use purposes, such as insuring against financial loss in the event of the disability of a key employee or of an employer in a small business. Insurance for business use is addressed in Chapter 5.

9. The "insured" is the policyholder and the person who receives the policy benefits. The "life insured" is the person whose disability triggers benefits.

Generally speaking, premiums payable under personally owned (rather than corporately owned) individual DI policies are not deductible for income tax purposes, but then benefits are not a taxable receipt.

2.1.2 Group disability insurance

Group disability insurance is provided to many individuals (plan members) under the umbrella of one (group) policy. In the case of an employer/employee group plan (the most prevalent type), the employer is the policyholder and the employee is the life insured and the beneficiary. Group coverage is priced based on the underwriting characteristics of the group as a whole, rather than the individual lives insured.

2.1.3 Creditor disability insurance (and other providers)

A number of commercial lenders (creditors) offer their clients (borrowers) DI coverage designed to pay scheduled or minimum loan payments in the event that the insured borrower should become disabled and unable to work. The coverage is provided through an affiliated or other third-party insurance company. In the case of an insured traditional loan, the insurance would pay the scheduled monthly loan repayment on behalf of the disabled borrower. In the case of credit card loans, the insurance would pay the minimum monthly required payment for the disabled borrower. These plans typically have at least a 90-day waiting period and a stringent definition of disability.

2.1.3.1 Mortgage disability insurance compared to individual disability insurance (traditional)

A specialized subsection of creditor insurance is the mortgage DI market. Mortgage insurance is normally provided through the lending institution (the mortgagee) on the life of the borrower (the mortgagor) to ensure that the monthly mortgage payment will be made during a time of disability of the borrower. Alternatively, the borrower might take out an individual disability income replacement policy, with the intent of using part of the monthly claim proceeds to make the scheduled mortgage payments. Both approaches have their strengths and weaknesses, as illustrated in Table 2.1. Generally, mortgage insurance arranged through the lending institution is less expensive and has less stringent underwriting requirements, but a personally owned policy offers the policyholder much more flexibility in the use of the benefits, which could be applied towards whatever purpose is most pressing for the policyholder.

TABLE 2.1

Comparison of mortgage disability insurance and individual disability insurance coverage

	MORTGAGE INSURANCE	INDIVIDUAL DISABILITY INSURANCE
Type of policy	Group term	Individual, to age 65
Provider of policy	Selected by lender	Selected by borrower
Policyholder	Lender	Borrower
Life insured	Borrower	Borrower
Underwriting	Limited	Full
Definition of disability	Total disability/Any occupation	Various definitions
Premium levels	Low group rates	Higher individual rates
Premium payor	Borrower	Borrower
Beneficiary	Lender	Borrower
Use of benefits	To pay monthly mortgage payments	Whatever purpose the borrower might elect

2.2 Individual disability insurance

There are various types of individual DI policies, each defined by the benefits it offers, the factors used to calculate premiums and the riders that may be added to it in order to customize the coverage offered.

2.2.1 Types of individual policies

One of the ways that personally owned DI policies can be differentiated from each other is by the level of guarantees afforded the policyholder in the contract. These can range from an absolute guarantee that the policy can never be altered or canceled, or the premium increased during the lifetime of the policy, to contracts that can be canceled at any time by the insurer. The most common types of contracts are the following:

- Non-cancelable policies;
- Guaranteed renewable policies;
- Cancelable policies;
- Guaranteed issue policies;
- Non-traditional disability insurance plans.

2.2.1.1 Non-cancelable policy

Non-cancelable ("non-can") policies offer the policyholder the highest level of guarantees. These plans are sometimes referred to as "non-cancelable and guaranteed renewable" contracts. The rights afforded the policyholder are virtually incontestable for the life of the contract, which is usually to age 65. The policy cannot be cancelled unilaterally by the insurance company. The policy premiums cannot be increased. Policy benefits cannot be reduced or modified. The insurer is compelled to renew the policy annually to the life insured's age 65. Only the policyholder has the right to modify the policy, subject to underwriting if applicable, prior to its maturity.

Once the policyholder turns 65, he typically has the option to convert the policy, without medical evidence, to a "guaranteed renewable" contract with a shortened benefit period, usually only a year or two. The converted policy will have premiums based on the insured's age at time of conversion and will typically run to the insured's age 72 or 75.

2.2.1.2 Guaranteed renewable policy

Guaranteed renewable policies bind the insurer to renewing the coverage each year until the maturity date of the policy (usually at age 65), but the insurer has the right to modify premiums unilaterally. The policy of an individual insured cannot be changed: any alterations must apply to the entire class of policies, impacting all lives insured under that contract type. Any changes to the contract must be communicated to the policyholders, in writing, at least 30 days before a change or cancellation takes effect. The changes are initiated at the time of the annual policy renewal, if at all.

These plans usually have an "any occupation" definition of disability and are available to the higher-risk occupations.

2.2.1.3 Cancelable policy

Cancelable policies offer the fewest guarantees for the policyholder. These policies can be modified, the benefits reduced, or the premiums increased by the insurer, at any time, without the consent of the policyholder. In fact, the insurer could unilaterally cancel the policy. The only constraint on the insurer is that the policy of just one individual insured cannot be changed: any alterations must apply to the entire class of policies, impacting all lives insured under that contract type. The contract will require that the insured be advised in writing prior to a policy change or modification, a minimum of 30 days in advance.

Because of the lack of long-term certainty afforded the policyholder, all other factors being equal, premiums for cancelable contracts will be lower than those for other policy types. These policies are most often issued to higher-risk occupational classes, such as labourers or taxi drivers.

2.2.1.4 Guaranteed issue policy

A few insurers currently offer guaranteed issue DI plans. These plans involve individually issued policies that are an alternative to traditional long-term disability (LTD) group insurance coverage and are available to groups in the low-risk occupational classes of executives and professionals: lawyers, doctors, accountants, etc. These plans guarantee that the member of the target group will be offered coverage.

Because of the guaranteed nature of the plans, they are subject to a number of possible restrictions based on:

- Size of the group;
- Occupational class of the group members;
- Minimum annual premium commitment;
- Minimum average age for the group members.

The guaranteed issue plans typically carry a higher premium than traditional group insurance coverage and the insurer generally has the right to terminate the guaranteed aspect of the plan at any time by refusing to accept any further lives insured on a guaranteed basis.

Guaranteed issue plans are generally available in two forms:

- Guaranteed standard risk;
- Guaranteed-to-issue.

Both types of plan typically require that the applicants must work a minimum number of hours per week and must be actively at work (not on disability claim) at time of application.

Guaranteed standard risk

These plans guarantee not only that they will issue coverage, but that they will issue the policy without any coverage restrictions or premium ratings. There will usually be extra restrictions on the administration of the plan, such as a requirement that 100% of the members of the group in question must participate in the insurance coverage (to limit anti-selection)[10] or that 100% of the premiums must be employer-paid.

Guaranteed-to-issue

These plans guarantee to issue some form of coverage, but not necessarily exactly the coverage applied for. The insurer generally requires full medical underwriting and reserves the right to apply premium ratings or exclusion riders to accommodate non-standard risks.

10. Anti-selection, in this instance, is an imbalance in the levels of risk presented by members of the group which could result when members presenting a higher level of risk subscribe for insurance in greater numbers than do lower-risk members of the group.

2.2.1.5 Non-traditional disability insurance plans

With the advent of the 21st century, Canada has experienced a significant growth in the percentage of workers who define themselves as "self-employed" – contract workers. By 2012 the self-employed represented 15.4% of the Canadian workforce.[11] This is a dramatic shift from the primary market of "employees" that the disability insurance industry has traditionally served.

Changing markets require changing products to serve them. Although many contract workers, who typically receive no benefits from their employers, may be looking for standard disability coverage, others find that sickness coverage is too expensive or that it requires too long a waiting period to be of practical benefit to someone whose income would stop immediately if they fell ill. Many of these self-employed workers would prefer just an affordable injury (accident) policy that would offer first-day benefits. To accommodate this market, some insurers have separated the accident and sickness elements of their DI policies, offering contracts that insure against loss of income due to one cause or the other, but not both.

Other adaptations are changing definitions of disability. Some policies have changed the requirement for total disability to the inability to perform specified functions, rather than job duties, since workers who are not employees are offering skills and services, rather than being restricted to specified duties. That is to say, the contract worker is not bound by a job description that defines those things which he is obliged to do for the benefit of an employer (duties). Rather he offers a range of skills (e.g., marketing, authorship of texts or reports, actuarial consulting) which the principal (his "employer") can choose to avail himself or not. Still other companies are offering an income-based definition of disability – the inability to earn a certain percentage of regular income due to disability – recognizing, again, that job functions may vary from contract to contract.

Policies are even now available for the self-employed workers who are "unemployed" – currently not under contract. The definition of disability then becomes the inability to seek new contracts due to disability arising from injury or illness.

And some insurers will even offer limited benefits to those who do not have gainful employment: individuals who provide full-time care to their children at home or who perform volunteer services, for example. The policy will provide the insureds with limited monthly benefits, while disabled, to enable them to "contract out" the services they were previously providing.

As self-employment and contract work become more and more the option of choice, or necessity, for workers in the 21st century, products will continue to evolve to meet their changing needs.

2.2.2 Policy benefits

Disability income replacement policies provide monthly income benefits to lives insured should they meet the definition of "disabled" under the policy, but the disability landscape is more complex than

11. Industry Canada. *Key small business statistics, July 2016*. [online]. Revised June 16, 2016. [Consulted August 7, 2017]. http://www.ic.gc.ca/eic/site/061.nsf/eng/h_02689.html

just that. Disability insurance (DI) policies vary as to the amount of benefit paid, when benefits commence and for how long benefits might be payable, if they are payable at all in the circumstances.

2.2.2.1 Amount of benefit

One of the risks is that an insured will act differently because insurance is in place. In the case of disability insurance specifically, by being or claiming to be disabled, or to still be disabled, an insured individual could potentially "earn" an "income" without having to work. One way of minimizing the risk of this occurring is to ensure that the insured person will not be better off financially while on claim than he was when he was working.

Personally owned DI policies normally pay a tax-free disability benefit. Allowing for income tax and other benefits normally applicable to income from business or employment, many insurers will not issue coverage that would pay the disabled life insured more than 60% of their net pre-tax, pre-disability income. This is a relatively simple calculation when the insured's only source of income is salary or self-employment income.

EXAMPLE

Heinrich is a sole proprietor, working as a consulting computer technician. Most years, he earns $70,000 in consulting fees and has about $12,000 in business expenses which are only incurred if he is working. After allowing for income taxes annually, he gets to keep roughly $38,000 of the $70,000 that he earns. Based on his pre-tax income of $70,000, less $12,000 of deductible business expenses, an insurance company would offer him maximum DI coverage of about $34,800 ([$70,000 - $12,000] × 60%). This is close to the $38,000 that he gets to keep, after-tax, while he is working. He is financially neither advantaged nor disadvantaged if he is on a disability claim, minimizing the chances that he would submit a false claim or artificially prolong a valid claim in order to continue receiving an income without working.

The computation of maximum allowable benefit becomes more complex if the life insured had sources of unearned income that will continue during a period of disability, in addition to his earned income.

EXAMPLE (cont.)

Consider the case of Heinrich, above. Assume that, in addition to his earned income of $70,000 a year, he has income from a family trust of $20,000 a year, income that will be paid to him whether he is working or not. If the insurance company were to ignore the trust income and issue him $34,800 (or 60% of ($70,000 – $12,000)) of disability protection, during a period of disability, he would receive $34,800 a year from the insurance company and

$20,000 from the trust – or $54,800 a year of total income: almost 78% of his gross, pre-disability earned income as a consulting computer technician. There would be little incentive for Heinrich to return to work.

Even if the insurance company were to include the $20,000 of trust income in Heinrich's computation of "earned income," he would end up being over-insured; 60% of Heinrich's total income of $78,000 ($58,000 net in fees plus $20,000 from the trust) equals $46,800 a year in disability benefits. However, Heinrich would still be receiving the full $20,000 from the trust, making his total income while on disability claim $66,800. This would represent about 86% of Heinrich's pre-disability income, well in excess of the 60% threshold that would place him in a neutral position.

The way that many insurers deal with this problem is to treat the ongoing, non-earned income source as if it were part of the disability benefit and reduce the coverage offered accordingly.

EXAMPLE (cont.)

In Heinrich's case, the insurer would be willing to insure a benefit equal to 60% of Heinrich's total pre-disability income of $78,000, or $46,800. However, the coverage offered would then be reduced by the $20,000 of trust income that he would still be receiving while disabled, leaving a DI benefit of $26,800. The combination of the disability benefit and the trust income would then total $46,800, or 60% of Heinrich's total pre-disability income of $78,000.

2.2.2.2 Waiting period

Most DI policies have a waiting period (also often called the "elimination period"), which is a time frame between the onset of disability and the commencement of benefits under the policy. The primary purpose of a waiting period is to eliminate the need for the insurance companies to process claims of very short duration, which require a significant amount of administrative effort and expense on the part of the insurance company in relation to the insured's lost income and the benefits paid.

EXAMPLE

Alfred injured his leg in a fall while hiking on the weekend. He was unable to work for 8 months. His DI policy has a 90-day waiting period and a 24-month benefit period, maximum. Because of the waiting period, the insurer paid out 5 months of benefits (8 months of disability less the 3-month waiting period) rather than the full 8 months.

Some policies permit a 0-day waiting period, but waiting periods of 30 days to 12 months are more the norm, with a 90-day waiting period being the most common. The shortest waiting periods are often available only to insured individuals in the highest, less risky occupational classes. All other factors being equal, policies with a longer waiting period will charge lower insurance premiums.

2.2.2.3 Benefit period

The benefit period under a DI policy is the maximum duration for which benefits will be payable. The benefit period starts once the waiting period has expired and benefits run until the insured is well and able to return to work full-time or the benefit period has expired, whichever comes first. Generally, each instance of disability is treated individually and the full benefit period could apply to each disability (for example, under a policy with a two-year benefit period, the insured might be disabled more than once over the life of the policy and could claim up to two years of benefits for each disability). The most common benefit periods for long-term individual disability income replacement policies are:

- 2 years;
- 5 years;
- 10 years;
- To age 65.

Short-term disability (STD) insurance policies are more likely to have a benefit period of only 10 to 26 weeks, but this period may be longer in certain cases.

The longer the benefit period, the greater the amount of claim the insurer is at risk of paying and the greater the policy premium will be.

2.2.2.4 Exclusions and limitations

Almost all policies contain provisions for standard, common exclusions: causes of disability for which no benefits will be payable. These exclusions are not specific to the health, vocation or lifestyle of a specific insured, but apply to all persons insured under that type of policy. The most common exclusions include disabilities arising from the following circumstances:

- War, whether declared or not;
- Terrorist acts;
- Self-inflicted wounds;
- Attempted suicide;
- Participating in illegal activities;
- Normal pregnancy and delivery.

The underwriting departments could also limit their exposure to payout if they consider the life to be insured to be an unusual risk by imposing any one, or more, of the following limitations on the coverage applied for:

- Reduction of the amount of monthly benefit;
- Reduction of the length of the benefit period;
- Increase in the length of the waiting period.

2.2.2.5 Denial of benefits

Life and disability insurance companies have a legal obligation to pay valid claims on in-force policies. However, a number of circumstances may arise where a claim is denied and no benefits are paid. Among the reasons for a denial of benefits are:

- Misstatement of a material fact on the insurance application;
- Fraud;
- Absence of loss;
- Absence of proof;
- Delay in filing a claim.

Misstatement of a material fact on the insurance application

A policy may be voided (declared legally invalid) if, within two years of the date of policy issue, it is discovered that the insured made a false statement on the application or failed to disclose information that was material to the underwriting process. This two-year period is called the "contestability period." The rationale for voiding such a contract is the assumption that the policy might never have been put in force in the first place, had the insurance company been in possession of all relevant facts at the time of application. A material misrepresentation is one involving a fact that would/could have impacted the underwriting decision (such as disclosure of a previous back injury).

Fraud

If the misrepresentation was accidental (the applicant forgot about a health factor or honestly thought it not to be important), then no fraud is deemed to have taken place. However, if the applicant purposely misstated information or failed to disclose information with the intent of trying to deceive the insurance company to issue a policy it might otherwise not issue, then a fraud against the insurer has occurred and the insurer has the right to void the policy at any time, even many years after policy issue. Similarly, if the insured commits fraud at time of claim (makes a false claim), the insurer has the right not only to deny the claim, but to cancel the policy.

Absence of loss

Benefits are only payable under a disability claim if the claim is proven to be valid and there is evidence of loss of income as a consequence of the disability.

If the insured was unemployed at the time of occurrence of the disability or was earning considerably less than the amount he had been insured for, benefits might be reduced or denied entirely, in keeping with the actual level of loss, even though the disability itself may be valid.

EXAMPLE

Haroon took out a disability income replacement policy in 2009, when he was earning $60,000 a year, which would pay him a $3,000 monthly benefit equivalent to 60% of his income ((12 × $3,000) ÷ $60,000) if he were to become disabled. By 2014, Haroon had lost his former job and was now working for a different employer at a reduced salary of $48,000 a year. If Haroon was to become disabled now, his maximum monthly benefit would be only $2,400 a month equivalent to 60% of his current salary ($48,000 × 60% ÷ 12).

Absence of proof

The disability that is at the heart of the claim must be proven medically – the insurance company will not simply accept the claimant's word that he is disabled and unable to work. The insurer will, at a minimum, request a report from the insured's doctor and may ask for a medical exam or other tests from a physician of its choice. In the case of a prolonged disability, it is usual for the insurer to require periodic medical updates, to ensure that the disability actually is persisting.

Delay in filing a claim

Lastly, benefits may be denied if a claim is not filed in a timely fashion. Ideally, the insured should contact the insurer as soon as possible after the onset of the disabling condition, even if it will be some time before a claim would warrant the payment of benefits because of the waiting period. In any event, a claim must generally be filed within 90 days of the onset of the disabling condition, if practical, but contracts and applicable legislation may vary. The disability insurance policy specifies the timeline during which a claim may be filed and insurers have the right to decline claims that are not filed by the deadline specified in the policy.

2.2.2.6 Rehabilitation benefit

It is generally in the best interests of all parties involved if a disabled insured can return to work as soon as is safe and practical: best for the insured who will be back to work earning a full salary; best for the insured's employer who will regain the insured's services; and best for the insurance company, who will no longer have to pay the claim. For all of these reasons, the insurer will encourage the disabled insured to take steps to get well and back to work, including taking

physical rehabilitation treatments. Although rehabilitation is not mandatory under DI policies, it is encouraged and will generally be paid for, in whole or in part, by the insurer.

The policy may specify a dollar amount that may be claimed for rehabilitation services or simply provide a list of services for which the insurer will pay. It is usually a requirement that the insured submit a rehabilitation proposal to the insurer and get approval of the services and fees in advance. Rehabilitative services for which the insurer will pay include, but are not limited to:

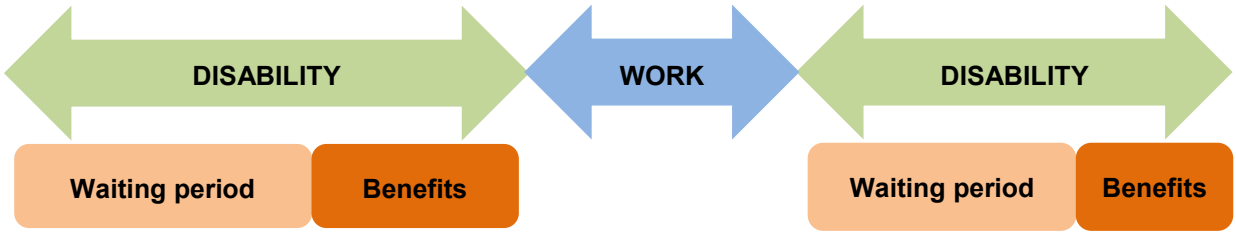
- Physiotherapy treatment;
- Occupational training;
- Medical treatment;
- Job placement;
- Psychotherapy.

2.2.2.7 Benefits for recurring disability

It sometimes happens that an individual who suffers a disabling injury or illness will return to work only to suffer a recurrence of the disability attributable to the same cause. As Diagram 2.1 illustrates, if the policy has a fairly lengthy waiting period, the disabled worker could find himself subject to two waiting periods, with no benefits, over the course of a relatively short period of time.

DIAGRAM 2.1

Recurring disability with two waiting periods



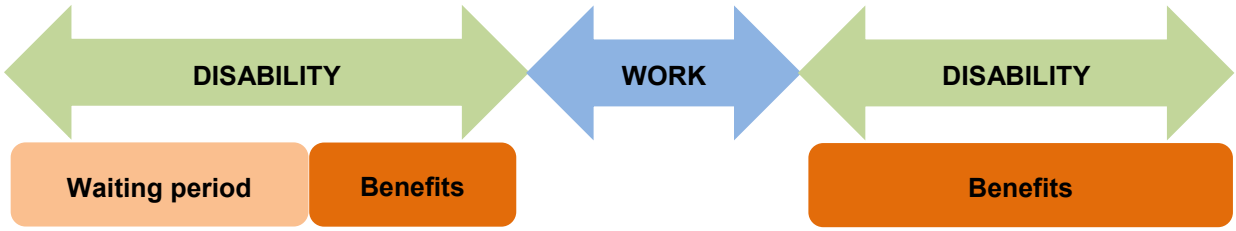
EXAMPLE

Ophelia injured her back in January of 2014, in a fall on ice in the parking lot of the office where she works. She was off work for five months, collecting disability benefits for two of those months after allowing for the 90-day waiting period under her DI coverage. Two months after returning to work she was forced to take time off again, another four months in this instance, as sitting at her computer chair all day long aggravated her previous back injury. If she was required to undergo another 90-day waiting period for the second instance of disability, she would have received only three months of benefits during a period when she was disabled for nine months out of eleven.

The recurring, or recurrent, disability clause found in many DI contracts is designed to prevent subjecting the insured to two, or more, waiting periods, without benefits. The insured must qualify on two or more instances of suffering a disability attributable to the same cause within a short period of time. Most often a second period of disability that commences within six months of the termination of a previous period of disability, due to the same cause, will be treated as one instance of disability and a second waiting period will not apply, as illustrated in Diagram 2.2.

DIAGRAM 2.2

Recurring disability with a single waiting period



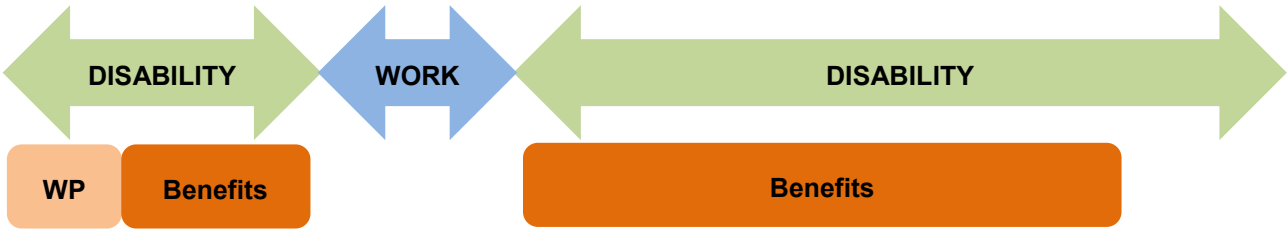
EXAMPLE (cont.)

In Ophelia's case, above, if her policy contained a recurring disability clause, she would not be subject to a second waiting period and her benefits would recommence immediately upon the onset of the second instance of disability, incurred after only two months back on the job. As such, she would receive six months' worth of benefits during the eleven-month period, not merely three.

The downside to a recurring disability clause can be the fact that the two, or more, periods of recurring disability are treated as one for purposes of calculating the benefit period. Particularly if the benefit period is relatively short, two to five years for example, this could significantly impact the total amount of benefits received due to a prolonged disability. Diagram 2.3 illustrates how benefits could run out before the end of the second disability period ("WP" refers to the waiting period).

DIAGRAM 2.3

Recurring disability with expended benefit period



EXAMPLE

Abdul has a DI policy that will pay him 24 months of benefits, maximum, after allowing for a 90-day waiting period. He was injured and went off on disability claim lasting 8 months, receiving 5 months of benefits, after allowing for the waiting period. Three months after returning to work he was forced to take an additional 24 months off due to the same cause of disability. Because Abdul's policy contained a recurring disability clause, he did not have to undergo a second 90-day waiting period when the second period of disability arose. However, the two periods of disability were added together, treated as one, for purpose of the 24-month benefit period. For the second disability claim, Abdul received only 19 months of benefits, not 24, because the 5 months of benefits he received under the first claim were deducted from his remaining benefit period.

2.2.2.8 Benefits for presumptive disability

Presumptive disability occurs when an insured suffers certain specified injuries or conditions which are deemed to be so severe that the person is presumed to be disabled, even if the "disability" does not result in a loss of earnings. The types of injury/condition are set out in the policy and would typically include:

- Total and permanent loss of hearing;
- Total and irreversible blindness;
- Loss of, or loss of use of, both arms or both legs or one arm and one leg.

In such instances, the normal waiting period under the policy is waived (benefits start immediately) and full total disability benefits are payable for the life of the benefit period, even if the insured is able to return to work full-time and even if he can now fulfill all of the duties of his previous employment at full salary.

To qualify for presumptive disability benefits, unlike the case for most definitions of disability, the insured does not have to prove a loss of income due to the disability, only that the qualifying "disability" exists.

Presumptive disability is a benefit offered in most, but not necessarily all policies.

2.2.2.9 Survivor benefit

Some disability policies offer a survivor benefit, payable to the insured's estate, should the insured die while on disability claim. In some instances, the policy requires a qualification period, such that a survivor benefit is only payable provided the insured had been disabled for a minimum period prior to his death, such as 12 months. The benefit is paid out in a lump sum, upon proof of death,

and is usually equal to three times the monthly total disability benefit (e.g., if the monthly benefit was $3,000, the survivor benefit would be a lump sum of $9,000).

2.2.3 Policy premium factors

Aside from the amount of monthly benefit requested, there is a wide range of factors that are taken into consideration in setting premiums for a disability income replacement policy, such as:

- Age of the insured;
- Gender of the insured;
- Health of the insured;
- Smoker or non-smoker status;
- Occupation;
- Definition of disability used;
- Claims history of the insured;
- Length of waiting and benefit periods for the policy.

These factors will be examined in the following pages and their impact on disability insurance (DI) premiums discussed.

Other factors not related to a specific life insured are also taken into consideration in setting premiums, namely an estimate of investment returns on accumulated premiums and general operating expenses. Most importantly, morbidity[12] tables must be taken into consideration in assessing, and pricing, the potential cost of taking on risk. These factors will be addressed later on in the Module.

2.2.3.1 Impact of gender and age

As with life insurance, both the gender and the age of the life insured under a DI policy are two of the most influential factors in setting policy premiums. In the case of gender, insurance companies' disability claims history illustrates that the number and length of claims is higher for women than men.

Although the likelihood of disability occurring decreases with the age of the life insured, the duration of a disability claim generally increases with age. Table 2.2 illustrates the risk of becoming totally disabled prior to age 65 for more than 90 days, and the average duration of the

12. Morbidity is the actuarial estimate of the risk of disability within segments of the population, broken down by age, gender, occupation, etc.

disability. It is a sample table only – insurance carriers compile their own morbidity tables based on their claims experience with their target markets.

TABLE 2.2

Sample morbidity table based on age

AGE	RISK OF BECOMING TOTALLY DISABLED	AVERAGE DURATION OF DISABILITY
25	58%	1.2 years
30	54%	2.5 years
35	50%	2.8 years
40	45%	3.1 years
45	40%	3.2 years
50	30%	3.1 years
55	25%	2.6 years
60	14%	1.6 years

The probability of disability is greater among those who are 25 years old than for those who have already reached 45. However, the average duration of the disability is longer among those in the second group.

Consequently, women are likely to pay higher DI premiums than males of the same age for the same coverage and older applicants will likely be faced with higher premiums than young ones.

2.2.3.2 Health issues

The health of a disability insurance applicant – past, present and future – is a critical factor in the underwriting process. Standard premiums and benefits are based on the assumption that the applicant is a standard life, likely to face the same risks of disability as the average individual. If the applicant has had health issues in the past, or is currently ill or injured, he may be uninsurable, or would at least be subject to premium ratings or exclusion of coverage for specified causes of disability. For example, if the applicant filed a disability claim within one year prior to application, the condition that led to that claim will be classified as a “pre-existing condition.” Insurers will usually issue DI policies with a one-year exclusion rider from the date of policy issue for claims relating to a pre-existing condition. Even the health of parents or siblings may come into the underwriting process if the applicant’s family members suffered from conditions that are inherited or are likely to “run in families,” where, for instance, more than one family member (parent, grandparent, etc.) may have had cardiovascular disease or breast cancer.

Insurers gather relevant medical and health information on prospective insureds from a variety of sources:

- Non-medical form on the application;
- Attending physician's statements (APS) from the applicant's doctor;
- Paramedical exam from a nurse, if required;
- Full doctor's medical exam, if required;
- Blood, saliva and urine samples;
- Data from the Medical Information Bureau (MIB);
- Inspection report from an investigator for lifestyle issue.

2.2.3.3 Definitions of disability

The definition of when an insured is "disabled" for purposes of disability insurance is not just a single one. Disability can be measured as "partial" or "total" and within that range there are four distinct definitions that are employed by different policies:

- Own occupation;
- Regular occupation;
- Any occupation;
- Total disability (according to the CPP).

With the exception of Workers' Compensation coverage (which deals exclusively with work-related injuries and illnesses), the cause of disability is generally not considered. Partial disability will be defined later in this Chapter.

Own occupation

The "own occupation" definition of disability is the most liberal in that it is the easiest under which to qualify as being "disabled." With this definition the insured is considered to be totally disabled if he cannot perform all of the primary duties of his regular occupation, even part of the time. There is no requirement that he return to work, either in his previous role or some other suitable role, until and unless he can perform all the primary duties of his regular occupation. While he meets the definition of disabled under "own occupation," benefits will be paid, even if the insured works in a different occupation.

EXAMPLE

Tobias worked as a surgeon, earning $240,000 a year. Four years ago, he was injured in his home workshop and lost all the dexterity in his right hand. As a consequence, he can no longer function as a surgeon. After rehabilitation, Tobias took up a position at the local medical school, teaching other surgeons the techniques that he had developed. He also travels on the lecture circuit and has published two books since his accident. In total, he now earns $300,000 a year from his various enterprises but, since he can no longer function as a surgeon, he continues to receive benefits under his DI policy, which has an "own occupation" definition of disability.

Because of the generous benefits under an "own occupation" definition of disability, its availability is generally restricted to the highest classification of occupations, those which are least likely to need to file claims, and it can be the most expensive product from a premium perspective. What makes "own occupation" expensive is the larger policy purchased by high income professionals who qualify for a cheaper rate/$100. They are least likely to need to file claims and tend not to stay on claim as long as other occupation classes, who earn less and therefore have to purchase smaller policy coverage (i.e. If two policies were issued for the same amount, e.g. $3,000 per month, the "own occupation" policy of high income professionals would be less expensive than the "any occupation" policy of other occupation classes who earn less). The key here is, "for the same coverage."

Regular occupation

"Regular occupation" uses essentially the same definition and has the same implications as "own occupation" but with one difference: if the disabled insured elects to go back to work in any capacity, benefits from the policy will be reduced and could, in fact, be terminated. However, the insured is not compelled to return to any occupation, even if physically able: the choice is left strictly up to the insured. As with the "own occupation" definition of disability, "regular occupation" is generally restricted to the highest classification of occupations, primarily professionals such as doctors, dentists, lawyers, etc.

Any occupation

The "any occupation" definition of disability is the easiest under which to qualify for coverage but, the most stringent under which to file a claim since the insured's ability to perform the duties of any suitable obligation disqualifies her from being classified as "disabled". The "any occupation" definition is, therefore, available to the most insured individuals, particularly those in the higher-risk occupational classifications. The insured will be considered to be disabled if he is ill or injured, unable to perform some or all of the functions of his regular occupation and is not able to perform the functions of any other occupation for which he is suited by education or experience. In effect, an insured who is disabled and unable to function in his regular occupation will be expected,

within a reasonable period of time, to become re-employed in a suitable alternative occupation, if possible, or his insurance benefits will be terminated.

Total disability according to the Canada Pension Plan (CPP)

"Total disability" is essentially the definition used by the Canada Pension Plan (CPP)[13]: the inability to perform the functions of any occupation for which the insured is suited by education and experience. It also entails that the insured will likely never recover and be able to return to employment and, in fact, will likely eventually die from the cause of the disability. Such a drastic definition is seldom employed by individual or conventional group DI policies, but may be found more often in creditor insurance coverage.

2.2.3.4 Occupational clause

In underwriting disability insurance, the occupation of an applicant has a significant impact on:

- Whether the applicant is insurable;
- The type of policy available;
- The riders and benefits available;
- The cost (premium level) for the coverage.

Certain occupations are inherently more susceptible to injury or stress than others and are therefore more prone to claims.

In order to codify the risks that insurers are willing to assume, occupations are generally divided into occupational classes. Although different insurers use different methods of classification, the following is the most common:

4A Professionals, such as doctors, lawyers, dentists and senior executives.

3A Administrative office workers who face few, if any, workplace hazards, such as clerical staff.

2A Supervisors in low-risk environments, salespersons and like occupations.

A Skilled manual workers who face few or no workplace hazards, or those working, for instance, as courier truck drivers.

B Manual labourers who work in hazardous environments, such as home construction workers.

Aside from the simple issue of price (a 3A occupation would command a higher premium than a 4A occupation for the same coverage), there may be certain policy types or benefits not available

13. In Québec, the Québec Pension Plan (QPP) defines total disability in similar terms: the disability must be considered serious (inability to hold any employment on a full-time basis) and permanent (last indefinitely, without any chance of improvement).

to those in higher-risk classifications. For example, an applicant in the 2A class would not usually qualify to acquire “own occupation” coverage or a non-cancellable contract.

Because occupational class plays such a critical role in risk assessment and policy pricing, most DI contracts have an occupational clause that specifies that the insurance company has the right to increase premiums or adjust benefits if the insured changes occupations to one in a higher-risk classification during the term of the policy.

EXAMPLE

Eunice took out a disability income replacement policy when she worked as an administrator in the office of a printing factory, a 3A classification. She paid $225 a month for her insurance coverage. Five years later Eunice changed jobs with the same employer, and is now working as a staff supervisor on the floor of the printing plant, an A classification job. Her policy was guaranteed renewable, so she was able to keep her coverage but her premium increased to $350 a month and her waiting period was extended from 60 to 90 days.

On the other hand, the insured also usually has the option to request a re-assignment to a higher classification and a premium adjustment in his favour should he change jobs from a lower-classification occupation to a higher-classification one.

At the underwriting stage, the insured could also be eligible for an occupational class upgrade if he fits the right parameters, such as staying with a job or holding a certain income for a certain length of time.

An upgrade would translate into a lower premium even though the insured remains in a higher-risk occupation. Such re-assignment would, of course, be subject to medical underwriting, to ensure that the insured hadn’t developed into a higher risk for reasons other than occupation.

2.2.3.5 Waiver of premium

For DI policies, waiver of premium is not a rider (as it is with life insurance policies) but is an intrinsic provision of the contract for which no additional premium is charged. The waiver provisions void (waive) the policyholder’s obligation to pay premiums during the time that the life insured under the policy is on disability claim.

Typically the premium must be paid by the policyholder during the first 90 days of claim and then the waiver commences. Many policies will refund the premium paid during the 90-day waiting period.

The premium will be waived for the duration of the disability claim, or for a period of anywhere from 2 to 5 years, to the end of the benefit period (or even to the life insured’s age 65), whichever comes first. Depending on the terms of the contract, waiver of premium may apply only to claims involving total disability, or to instances of partial disability as well.

2.2.4 Riders to address needs

Disability insurance is not a "one-size-fits-all" proposition. As noted above, there are standard provisions inherent in almost all disability insurance (DI) policies, but the circumstances of individual lives insured may require special benefits or restrictions. The insurance industry accommodates these special circumstances by adding "riders" to policies – special provisions that are unique to that policy.

2.2.4.1 Concept of customization

Customizing means modifying the terms and conditions of a "standard" DI policy by adding riders to the contract: special clauses that add, remove or restrict benefits in accordance with the needs of the applicant for protection or the wishes of the insurance company to limit its exposure to risk. A number of the more common riders are described in some detail below.

2.2.4.2 Differences between "equivalent" riders

In reviewing a policy or recommending the purchase of a new policy, it is important to carefully consider the exact details of definitions or riders. There are "standard" definitions within the industry, but that does not mean that each contract or each rider adheres strictly to the standard. One cannot simply assume that a given rider will offer standard benefits: the rider text must be carefully scrutinized, or competing riders compared, to ensure that the riders in question are, in fact, "equivalent."

2.2.4.3 Future purchase option (FPO)

The future purchase option (FPO), (also sometimes called the "guaranteed insurability benefit" (GIB) or "guaranteed insurability option" (GIO)), on a disability income replacement policy serves the same purpose as a GIB on a life insurance contract: guaranteeing the insured the right to purchase additional coverage in the future, regardless of future changes in the life insured's health.

Traditionally, options to increase coverage were offered every two years or so. Policies issued more recently offer the options on each policy anniversary. Assuming that the underlying policy was issued at standard premium rates, any new coverage subscribed for under the FPO would also be issued "standard" based on the life insured's attained age[14] at the time the option is exercised. Options are usually available up to the life insured's age 50 or 55, depending on the contract.

14. Attained age is calculated in a variety of ways, depending on the terms of the contract. It could be based on age on last birthday, age on next birthday or age nearest a birthday (i.e., within six months before or after the option date).

There will always be a maximum limit to the amount of coverage that can be purchased under the FPO: both on how much coverage can be purchased per option and how much can be purchased overall. The per option limit is often based on 20% of the base coverage, to a maximum of $1,500 a month of new coverage. The overall limit is typically in the range of two to five times the initial amount of coverage under the base policy.

New coverage acquired under the option will be based on the same occupational class as the original policy, provided the insured has not changed occupations. If the life insured is on disability claim at the time the option arises, the contract may permit the FPO to be exercised immediately or the exercise may be delayed until the termination of the current claim.

The key restriction to exercising the FPO is that the insured must qualify for the additional coverage financially. As noted earlier in this Chapter, the amount of disability income replacement insurance for which an individual can qualify is restricted to about 60% of his pre-disability earned income. This same limit applies to the exercise of an FPO option: if the coverage currently in force is equal to 60% of earned income, no further coverage can be purchased, even though the right to purchase coverage without medical evidence is guaranteed.

Two rules apply:

- If the insured's current income has not changed since policy issue or exercise of the last option, and the coverage currently in force equals 60% of current income, the current option may not be exercised.
- If the insured's current income is such that 60% is greater than the current coverage in force, the current option may be exercised, to a maximum of the current option or an amount that would bring the coverage up to 60% of current income, whichever is less.

EXAMPLE

Fritz was earning $60,000 a year, net as a freelance handyman two years ago when he applied for disability insurance. He qualified medically and financially and was issued a DI policy with coverage of $3,000 a month ((60% × $60,000) ÷ 12). His policy has an FPO rider which permits him to increase coverage, guaranteed, by 20% of his original coverage (or $600 a month), this year, if he can qualify financially. His income has increased by $6,000, to $66,000 a year. At his new income level, Fritz could qualify financially for $3,300 a month of disability coverage ((60% × $66,000) ÷ 12). Since he already holds $3,000 a month of coverage, he could only exercise the FPO to acquire an additional $300 a month of coverage, despite the fact that the option allows for up to $600 a month of coverage without medical underwriting.

In order to exercise an FPO option, the insured must provide the insurer with proof of current income. Also, exercising the FPO would add additional coverage, resulting in a corresponding increase in premium.

2.2.4.4 Cost of living adjustment (COLA)

One of the problems faced by insureds living off the benefits of a long-term disability (LTD) claim is that the cost of goods and services (cost of living) that the disability benefits are intended to provide for are constantly rising with inflation, while the disability benefit may be fixed. A cost of living adjustment (COLA) rider provides for an annual increase in the monthly benefits being paid under a disability income replacement contract, starting the second year that benefits are paid. The benefit is payable by one of two methods:

- Simple — The benefit is indexed by a flat rate (2.00 or 4.00%, for example) based on the initial benefit payable.
- Compound — After the first year of claim, the benefit is indexed to the rate of inflation, on a compound basis,[15] usually based on the inflation rate for the previous calendar year. The indexing is based on the Consumer Price Index (CPI).

EXAMPLE

Jennifer is entitled to $3,000 a month in benefits under a DI policy indexed to the CPI and under which the COLA is compounded. The following table illustrates how her monthly benefit will increase yearly due to the application of the compounded COLA.

Year	Change in CPI	Annual increase in benefits	Monthly benefit
1	3.10%	N/A	$3,000
2	2.80%	3.10%	$3,093
3	2.50%	2.80%	$3,180
4	4.00%	2.50%	$3,259

There may be a maximum indexing rate for any one year (5% perhaps) but many policies allow for a carry-forward of unused indexing. For example, if the indexing rate for year 4 of claim is 1.5% lower than the maximum allowed under the contract, that 1.5% can be carried forward to future years, to create more indexing room for years when the inflation rate exceeds the maximum annual indexing permitted under the contract. On the other hand, the maximum amount of indexing is capped at a pre-determined limit, such that the annual benefit ultimately paid out under an indexed policy might not be able to exceed two or three times the initial, un-indexed, annual benefit.

15. The second increase will be based on the previous year's adjusted benefit, rather than on the initial benefit.

Some DI policies offer an alternative to COLA, called an automatic coverage enhancement, or automatic benefit increase, which automatically increases the benefit by a small set amount (2 or 3%) without underwriting (medical or financial), but with a corresponding increase in premium. The option is subject to review, and possibly later underwriting, on a periodic basis, such as every five years. The automatic enhancement is offered instead of, rather than in addition to, COLA. The benefit provides an indexed policy with increasing premiums that applies the increase in coverage after the policy is issued and does not wait for a claim to be made. It basically attempts to keep up with annual raises that most employees receive.

2.2.4.5 Accidental death and dismemberment (AD&D)

The accidental death and dismemberment (AD&D) rider provides additional benefits, over and above those benefits payable on account of income loss due to disability, should the life insured incur death or specified severe injuries due to an accident. For a claim to be receivable, the death or loss must occur within 365 days of the accident in question and the death/loss must be directly attributable to the accident. Typically, a specified lump-sum benefit (referred to as the principal sum) will be paid in the event of death and lesser benefits (a percentage of the principal sum) would be payable for the loss of, or loss of use of, sight, hearing, or one or more limbs, etc. Because benefits are only payable in the event of accidental loss, no medical underwriting is required at time of issue of the rider.

Standard exclusions apply, like loss or death due to:

- Self-inflicted wounds;
- Attempted suicide;
- Participation in dangerous sports;
- Flying other than as a passenger on a commercial airliner.

2.2.4.6 Partial and residual disability benefits

If disability insurance were an “all or nothing” proposition – where you got full benefits if you were totally disabled, but no benefits at all if you were to return to work part-time – it would be very difficult to encourage a disabled worker to return to work part-time.

Residual disability benefits

As an incentive for disabled workers to return to work as soon as possible, many DI policies offer a residual disability benefit, one that will pay the disabled a portion of his benefits if he is able to work part-time following a period of total disability. In order to qualify for the benefit, the insured must first meet specified criteria: usually a minimum period of total disability under the contract, often six months, including the waiting period. If the disabled worker is then able to return to work and perform some of the substantial duties of his job, or all of the substantial duties but only for

part of the time, he will have two sources of income: part of his employment income and part of his disability benefits.

There are minimum and maximum income requirements for an insured to qualify for residual benefits: there must be at least a 20% reduction in his pre-disability income before he can qualify for benefits. Or, expressed another way, if he can earn 80% or more of his pre-disability income, he will not qualify for any benefits. On the other hand, if the insured can only earn 20% or less of his pre-disability income, he will qualify for full benefits. Earnings between 20% and 80% of pre-disability income will result in a pro-rata benefit, proportional to the percentage of income lost to disability.

EXAMPLE

Jorge was earning $80,000 a year working as a graphic artist for a small company that offered no group benefits. To protect himself against income loss due to disability, Jorge took out an individual DI policy that would pay him $3,000 a month (45% of his income) in the event of total disability. Last year Jorge was injured in an auto accident and was off work for 10 months, receiving disability benefits of $3,000 a month for 7 of them (after allowing for a 90-day waiting period). A doctor advises Jorge that he could now return to work 2 days a week, which would result in his earning the monthly equivalent of $32,000 a year (40% × $80,000). Jorge's policy has a standard residual disability clause. As a percentage, his loss of pre-disability income while working part-time is calculated as:

$$\frac{\text{Pre-disability income – part-time income}}{\text{Pre-disability income}} = \frac{\$80{,}000 - \$32{,}000}{\$80{,}000} = 60\%$$

While working part-time, Jorge would receive 60% of his maximum disability benefit, or $1,800 a month ($3,000 × 60%). Combined with the $2,667 a month that Jorge would earn in salary ($32,000 ÷ 12), he would total $4,467 a month (or $53,604 a year).

Partial disability benefits

Some insurance contracts will pay a partial disability benefit from the outset of disability, not requiring a period of total disability. If the insured is unable to perform some of the substantial duties of his job, or is able to perform all of the substantial duties but only for part of the time, he would receive 50% of the total disability benefit for a period of two to three years (considered the partial disability benefit), or the residual disability benefit, whichever is greater. Some DI contracts require a qualification period of total disability before partial disability benefits will be paid and all contracts require that the insured be under a physician's care.

2.2.4.7 Return of premium (ROP)

A common concern with disability insurance (as with most types of insurance) is that the policyholder may pay thousands, or tens of thousands, of dollars in premiums over time but, if no valid claim is ever filed, never receive any benefit for the premiums paid. The return of premium (ROP) rider addresses this concern. Typically, the rider provides for a tax-free return (refund) of premiums paid if the policy expires (at the life insured's age 65, for example) and the total claims paid over the life of the policy do not exceed the total premiums paid. For example:

- If there are no claims by age 65, when the coverage expires, 70% of all premiums paid are repaid to the policyholder;
- If claims are filed during the life of the policy but the total of benefits paid out is less than the total of premiums paid in, the difference would be paid to the policyholder when the coverage expires;
- If the total of benefits paid out over the life of the policy exceeds the total of premiums paid in, no return of premiums is payable.

Some policies provide that if a policy is cancelled prior to its maturity date with no claims having been filed, a partial ROP is paid. Other policies provide that, if the contract goes for a specified period, typically 8 or 10 years, without a claim having been filed, anywhere from four times the annual premium to 70-80% of the premiums paid during that period or a proportion of the annual premium will be returned to the policyholder. The rider is expensive however, often adding 40-60% to the cost of the base DI premium.

2.2.4.8 Ratings and exclusion riders

If an applicant for disability insurance has health or lifestyle issues that result in his being assessed as a higher risk than "standard," the underwriting department has three options for dealing with the application:

- Decline to issue the policy;
- Impose a premium rating;
- Add an exclusion rider to the policy.

A "decline" is usually the option of last resort. It means that the policy is not issued.

Premium rating can be used to assume risks that are substandard, but not so high a risk as to be uninsurable. This is particularly true where the applicant has an overall health issue, like diabetes or hypertension, which could impact the applicant's general health or ability to function. The increased premium, the "premium rating," compensates the insurance company for the increased risk that it is willing to assume. If the condition in question is controlled with treatment in the future,

the insured may have the option to be re-underwritten medically and have the rating lowered or removed, once the condition is under control.

In some cases, the circumstances that make the life to be insured a substandard risk might be a specific lifestyle or vocational activity or a specific condition that is more likely to trigger a period of disability. In such cases, the insurance company might issue the policy but with an exclusion rider that specifies that no benefits will be payable on account of a disability arising from the identified activity or condition.

EXAMPLE

Eldridge applied for disability income replacement insurance despite the fact that he had a damaged disk in his back, the consequence of his sporting activities. The life insurance company was willing to issue the policy, at standard premium rates, but with an exclusion rider that stipulated that no benefits would be payable on account of a disability related to Eldridge's back problems.

In instances where an exclusion rider has been added to a DI policy, it is typical for the contract to be issued with a standard premium and for it to cover episodes of disability resulting from any other standard cause not covered by the rider.

2.2.4.9 Hospitalization benefit

Basic disability income protection insurance provides benefits to replace earned income lost during a period of disability but does not provide additional cash flow to cover extra expenses incurred as a consequence of that disability. For example, if the injury or illness that caused the disability results in the life insured having to spend time in the hospital, extra expenses may be incurred. Special riders may be added to a DI policy to cover those expenses.

One such rider is the first day hospitalization rider. Hospitalization costs may arise long before any benefits become payable during the waiting period under the base policy. The first day hospitalization rider is designed to bridge the gap between the first day of hospitalization and the first day that disability benefits begin (often 90 days later). The rider has no waiting period, but typically requires a minimum hospital stay of from 18 to 72 hours for benefits to be payable. The benefits involved are a daily pro rata of the monthly disability benefit under the base policy.

The hospital indemnity rider provides a daily benefit, usually between $50 and $250 a day, to cover specific expenses incurred as a consequence of hospitalization. It might, for example, cover child care expenses for a spouse visiting a hospitalized spouse on a regular basis over a prolonged period of hospitalization or parking costs at the hospital, which can be substantial, for that same visiting spouse. It is typically a first-day benefit, providing the hospitalized individual has a stay of at least 24 hours and may provide benefits for 3 or 4 months, maximum.

2.2.5 Taxation of individual disability insurance (DI) benefits

The amount of disability insurance for which an applicant can qualify will, in part, be impacted by whether or not any benefits would be received as taxable income, or tax-free, since tax-free benefits would obviously represent a higher proportion of the insured's pre-disability, after-tax income. In a similar vein, whether or not premiums paid for disability insurance can be deducted for income tax purposes could have a significant impact on the affordability of the coverage.

2.2.5.1 Tax treatment of premiums and benefits

Generally speaking, premiums paid for individual disability income replacement policies are not deductible for income tax purposes and benefits received do not have to be included in taxable income. This is the case for disability benefits, treatments paid for by the insurer on behalf of the insured and waiver or return of premium (ROP) benefits.

This remains true almost regardless of the purpose for which the policy was purchased. For example, a key person DI policy taken out on the life of an employee of a sole proprietorship falls into the category, so long as the employer pays the policy premiums and is beneficiary of the contract. The policy premiums may be a valid business expense but they are not a tax-deductible expense.

There are some exceptions to these rules, such as business overhead expense (BOE) insurance, that are covered in detail in Chapter 5. Individual DI policies taken out by an employer on a class of employees on a "grouped" basis are subject to different tax rules, but, again, these are outlined in some detail in Chapter 5.

If a DI policy is taken out by an unincorporated employer on the life of an employee and the benefits are payable to the employee, then the premiums will likely be tax-deductible by the employer and either the premiums paid by the employer, or the benefits received by the employee (but not both) would be treated as taxable income in the hands of the employee.

2.2.5.2 Taxation differences between personally owned and corporately owned disability insurance (DI) policies

Many of the same rules apply to corporately owned DI policies as personally owned DI policies. Disability insurance purchased to protect the corporation's financial interests in the event of the long-term disability of a key employee, or to buy out the interest of a permanently disabled shareholder, is treated the same as a personally owned DI policy: the premiums paid are not tax-deductible, nor are benefits received by the corporation a taxable inclusion.

If a corporately owned DI policy is insuring the life of an employee and the employee is the beneficiary of any policy benefits, the premiums paid will be a deductible business expense for the employer but a taxable item in the hands of the employee for the year in which they are paid. On the other hand, if the life insured under a corporately owned policy is a shareholder of the

company (or both an employee and a shareholder), the Canada Revenue Agency (CRA) is likely to rule the premiums paid to be a shareholder benefit, non-deductible by the employer but taxable in the hands of the shareholder.

2.2.6 Conversion of policy

Conversion is a provision most commonly associated with life insurance policies: the right to convert a term insurance policy into a permanent policy with the same insurer without having to provide medical proof of insurability. Since individual disability income replacement insurance policies are not "term" contracts, the normal concept of conversion does not apply. However, buy/sell insurance policies and BOE insurance policies usually will contain a conversion clause.

In instances where the coverage is no longer required for business purposes (the business has been disbanded or the life insured is no longer an employee or co-owner of the business), the conversion privilege will permit the life insured to transfer the policy and coverage into his own name, without medical underwriting, such that the policy is now personally owned individual DI coverage. At time of conversion, the insurance company may not re-underwrite the coverage financially, to re-determine if the insured can qualify for the face amount. That decision would have to be made at time of claim.

As noted early in this Chapter, many non-cancelable DI policies also offer the policyholder the option to convert the contract to a guaranteed renewable policy at age 65, with a limited duration and benefit period.

2.3 Group disability insurance

Group disability insurance is provided to many individuals under the umbrella of one master policy. With employer/employee group plans (which will be the primary focus of this Section), the employer is the policyholder and the employee is the life insured and the beneficiary. Group plans offer cost-efficient coverage with little or no administrative effort on the part of the insured. For that reason, many people have primarily, or only, group coverage in their portfolio.

2.3.1 Providers of group disability insurance

Because group disability insurance (DI) coverage is usually offered to the members of the group without medical underwriting, it is important to the issuing insurance company that the group members have some element of commonality, so that their risk can be pre-assessed based on criteria other than actuarial tables. For that reason, group insurance is not just offered to anyone who wishes to take advantage of it, but to potential lives insured who exhibit some common trait such as:

- Work for the same employer;
- Work in the same industry;

- Are members of the same association;
- Are alumni of the same university;
- Belong to the same union, etc.

The common factor offers the insurer at least two advantages: the opportunity to underwrite based on shared characteristics and risks, and a central organization of some sort to administer the plan: enrol members, collect premiums, etc.

2.3.1.1 Employer

Employer/employee groups are by far the most prevalent. Many employers, particularly large companies, find that it is essential to offer current and prospective employees competitive group coverage in order to attract and retain good employees. Many job-seekers will not consider a prospective employer unless the employer offers an attractive employment package, including salary, vacation days, a pension plan and group insurance benefits. From the employees' perspective, obtaining insurance coverage from the employer's group is a simple, convenient and cost-effective way to build a base for their risk-management program.

2.3.1.2 Association

Association groups are comprised of individuals who have characteristics in common but who do not work for the same employer.

However, the association may consist of individuals who have employers in common. The association may be formed by several employers in the same industry (such as the automotive industry) or by franchise owners of the same franchise organization (such as a doughnut shop franchise). The plan members are the employees of these employers or franchise owners. The members are able to access the many advantages of participating in an employer/employee group, such as the cost efficiencies that come from volume discounts on coverage.

A second type of association group brings together individuals who do not have employers in common. Often the members participate in the same profession, as in the case of the Canadian Bar Association group plan or the Canadian Medical Association group plan. Or the plan members have past associations in common, such as being alumni of the University of Toronto. For this type of association, membership in the group plan is solicited by the plan administrator and the potential members are free to join or not join as they wish. There is no requirement that a certain percentage of the "group" must participate in the plan. Benefits are similar to those offered by other group plans. The plan members are responsible for paying 100% of the insurance premium, usually by direct bank debit.

2.3.2 Types of group disability insurance (DI) policies

Disability coverage is usually divided into two distinct categories, each of which may have different definitions of disability, different benefit levels and different waiting and benefit periods: short-term disability and long-term disability. Also, there is usually a different set of rules applicable to those group members who experience disability while on a leave of absence.

2.3.2.1 Short-term disability (STD)

Short-term disability (STD) coverage, also sometimes called "weekly indemnity," is designed to provide benefits for disabilities of short duration, usually less than one year. It also typically provides one level of benefit for the early stages of a long-term or a permanent disability, to be replaced after one year by the long-term coverage. STD benefits are based on a percentage of salary. Because plans are usually designed such that the employer pays 100% of the premiums for the STD coverage and benefits are taxable income, the percentage of salary is usually higher than that used for long-term disability benefits. STD benefits are likely to be in the range of 70 – 75% of pre-disability income.

The definition of disability for STD coverage is generally "own occupation" – the inability of the insured to perform the duties of his regular occupation. Benefits often start after a 7-day waiting period in the case of disabilities arising from illness and on the first day for disabilities arising from an accident. In either case, the maximum benefit is almost always 12 months.

EXAMPLE

Myron works for a company that offers its employees a group disability plan which includes both STD and LTD coverage, providing for a combined 5-year benefit period (12 months for STD and 48 months for LTD). Normally, Myron earns $4,000 a month, when working. A couple of months ago Myron injured himself when a golf cart that he was riding on during a weekend tournament tipped over and badly damaged his leg. Myron's job as a plant supervisor requires him to walk around the plant regularly to oversee the work of the employees, so his injury qualified him as "disabled" under the "own occupation" definition of disability under his STD coverage. The plan provides for a benefit equal to 70% of salary, so Myron will receive disability payments of $2,800 a month ($4,000 × 70%) for up to 12 months or until he returns to work, whichever comes first. If Myron is still disabled after 12 months, his coverage will change from short-term disability to long-term disability.

Some plans insuring lower-paid workers stagger their waiting and benefit periods, to co-ordinate benefits with Employment Insurance (EI) benefits. EI has a waiting period of one week, followed by a 15-week benefit period, but EI is a second payor to many other forms of disability coverage, including group plans. Plans designed to co-ordinate with EI and avoid the dollar-for-dollar offset

of EI benefits will pay a first-day benefit for one week, then no benefits for the next 15 weeks, resuming benefits starting at the beginning of week 17, at the end of the EI benefit period.

2.3.2.2 Long-term disability (LTD)

Long-term disability (LTD) coverage takes over when benefits under the short-term disability coverage expire with the plan member still being disabled. The waiting period for the LTD coverage is, in effect, the benefit period for the STD coverage.

The LTD monthly benefits are generally lower than those paid under STD, typically between 50 and 60% of previous income, and are generally payable for a period of 2 years, 5 years or 10 years, or to age 65. The benefits are usually based on an "own occupation" definition of disability for the first 12 months of LTD, changing to an "any occupation" definition thereafter.

EXAMPLE (cont.)

After 12 months Myron's leg still had not healed sufficiently for him to return to his regular occupation as a mobile supervisor. He remained on disability claim, but now under the long-term disability coverage from the group plan. His monthly benefit was reduced from 70% to 60% of salary, from $2,800 a month to $2,400 a month. Myron's qualifying definition for disability would last for another 12 months, if the disability lasts that long, but will change to an "any occupation" definition at the end of month 24. By that time Myron would be expected to take up another suitable occupation within the company, if possible.

If a suitable alternative was available to him and he failed to take advantage of it, his benefits would stop. If he was unable to perform the duties of another suitable occupation, his benefits could continue for up to three more years, completing the 5-year benefit period that his group plan provides for a combined STD/LTD claim.

2.3.2.3 Leave of absence

There is a wide variance of coverage and restrictions that are applicable if a group plan member becomes disabled while on a leave of absence.[16] Leaves may be granted on compassionate grounds, to permit an employee to care for an ailing family member, for example. Or a leave may be granted to permit an employee to do independent research, or just to permit a break from work routine. In some jurisdictions, for example, teachers are permitted to work four for five: work for

16. A leave of absence is a period of time away from work for any purpose sanctioned by the employer. Leaves may be paid or unpaid.

four years receiving 80% of salary and then take the fifth year as a leave of absence (sabbatical), still receiving 80% of regular salary during the leave.

Various group DI plans handle disabilities during a leave of absence differently. Some offer no coverage during a leave. Others will provide coverage but only if the group premiums are still being paid monthly, either by the employer or directly by the employee. Often even under an employer-pay-all plan, disability premiums coming due during a leave of absence will be the responsibility of the employee alone. Some plans do not pay benefits during an unpaid leave of absence since the plan member has no income to lose to the disability. There are no hard and fast general rules, one must look to the details of the master contract to determine which benefits are, or are not, applicable.

2.3.3 Plan enrolment and membership

Member enrolment and maintenance of member records are the responsibility of the group administrator. However, the function goes beyond mere enrolment and claims administration, and involves record-keeping and reporting to the insurer both before a new member qualifies for benefits and after the member leaves the group plan.

2.3.3.1 Qualification period

Most group DI plans require a new employee to undergo a qualification period before they can join the group plan. Not to be confused with the waiting period for disability benefits, the qualification period is a set number of days that must expire between the date of employment and the date that the employee qualifies to join the group plan. Often the qualification period is tied to the probationary period for employment: that period of 30 to 90 days when a new employee may be terminated without recourse. In part, the qualification period relieves both the employer and the group plan administrator from having to enrol and then terminate from the group plan an employee who does not stay with the employer beyond the probationary period.

2.3.3.2 Premium payment

In the case of non-participating[17] employer/employee group DI plans, the premium process is straightforward: the employer makes one payment to the insurance company each month, representing premiums on behalf of all of the group members.

Premium payment for large participating group DI plans (where the employees pay part of the premiums) could be more complex. If the individual plan members were to pay their portion of the monthly premiums directly, the insurance company might have to deal with hundreds, or thousands, of individual payments. For this reason most insurers insist that the employer collect

17. In a non-participating (or “non-par”) plan, the employer pays all of the premiums for the coverage: the employee/plan member makes no financial contribution.

the employees' portion of the premiums from each plan member monthly, via payroll deduction, and remit a single payment representing both the employer and the employee portions of the monthly group premium.

In the case of association or union-sponsored group plans, each member usually pays his own premium monthly, via direct debit from his bank account.

2.3.3.3 Terminating membership

A plan member could find his participation in the group DI plan terminated for any one of a number of reasons:

- The master contract itself might be terminated, at the initiation of either the employer or the insurance company;
- The member might cease to be an employee of the sponsoring employer;
- The member might cease to meet the definition for membership in the class of the covered group (for example, his weekly employment hours might be reduced below the minimum requirement for group plan membership);
- The employee/group plan member might retire.

In circumstances where the plan member no longer qualifies for membership, he may have the option to convert his group coverage to an individual DI policy with the issuer of the master plan, without having to provide medical evidence of insurability. The conversion must be made within 30 days of termination of participation in the group plan and is usually subject to some restrictions as to the type of policy to which the group coverage may be converted. This right of conversion is virtually universal with group life insurance coverage but may also apply to group DI coverage.

2.3.4 Amount of benefit

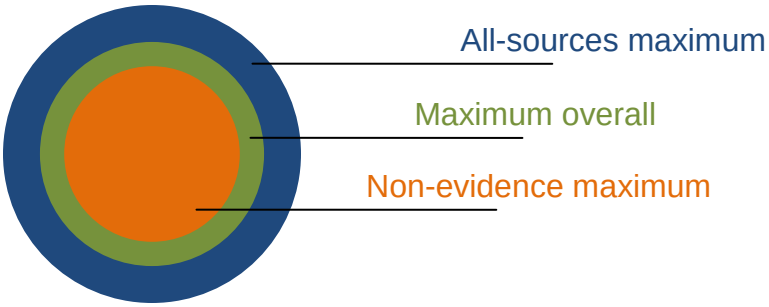
The amount of disability benefit available to group disability insurance (DI) plan members is subject to restriction on several different levels:

- A maximum non-evidence amount that is absolute, spelled out in the master contract, regardless of the plan member's qualifying income;
- A maximum overall amount based on a percentage of the group member's qualifying income;
- An "all sources" maximum that is governed by group offset rules set out in the master contract.

Diagram 2.4 illustrates the relationship between the various types of benefit amounts.

DIAGRAM 2.4

Group disability insurance benefit amounts



2.3.4.1 Non-evidence maximum coverage

To ensure all group members can receive some benefit regardless of their health, most group DI plans offer a basic amount of coverage for which medical underwriting is not required. This is the non-evidence maximum and it is set by considering the costs to the plan sponsor and the claim risk to the insurer.

2.3.4.2 Maximum overall coverage

Recognizing that some plan members may wish to obtain a higher level of coverage, group plans may permit plan members to apply for additional coverage over and above the basic non-evidence amount. This additional coverage is restricted to the amount individual members can qualify for financially. It is also subject to medical underwriting, and would be paid for solely by the member who wishes to obtain it.

The overall maximum amount of monthly benefit that a plan member may receive (non-evidence and evidence) is spelled out in the master group plan. Larger groups typically offer larger maximum monthly benefits, often in the $10,000 to $15,000 range, while smaller groups may be restricted to a maximum benefit of $2,500 a month. A given plan member will have his coverage maximum determined by a percentage of his income or the group plan maximum, whichever is less.

EXAMPLE

Chiang and Eng are members of the same employer-group DI program which provides for maximum long-term disability coverage of 60% of salary, or $5,000 a month, whichever is less. Chiang, who earns $90,000 a year, qualifies for a maximum benefit of $4,500 a month (($90,000 × 60%) ÷ 12). Eng, who earns $120,000 a year, is restricted to the maximum monthly benefit of $5,000, despite the fact that his income could qualify him for $6,000 monthly benefit (($120,000 × 60%) ÷ 12).

The percentage of earnings that will be considered in setting the overall maximum coverage will, in part, depend on whether benefits will be treated as taxable income or will be non-taxable. STD benefits are typically in the higher percentage range, 70 to 75% of pre-disability income, allowing for the fact that STD benefits are normally taxable. LTD benefits, which are usually structured to be tax-free, are typically based on a lower percentage of salary, in the 60 – 66.66% range.

As stated earlier, if members elect the maximum coverage available, the difference between the overall maximum and the non-evidence maximum amount of coverage is subject to both financial and medical underwriting.

EXAMPLE

Brandi works for a company that offers group DI coverage. The non-evidence maximum amount of LTD coverage is 50% of salary and the maximum benefit is set at 66.66% of salary, to a maximum of $10,000 a month. Brandi, who earns $90,000 a year, has elected to take full coverage of $60,000 (66.66% of $90,000 – $5,000 a month). The first $45,000 of annual coverage (50% of salary) would be provided on a non-evidence basis, but Brandi would have to qualify medically to add the additional $15,000 of coverage (16.66% of salary).

The employer or the employee has the possibility of electing coverage that is less than the maximum set out in the master contract.

2.3.4.3 All-sources Maximum (also sometimes called "Group offset amendment")

The reason that DI plans, whether group or individual, set benefit maximums somewhere below 75% of the insured's regular income is to provide a disabled insured with an incentive to return to work. The same rationale applies when looking at the maximum benefits available from all disability income sources (the "all sources" maximum).

The group offset amendment found in virtually every group master contract specifies the maximum amount of coverage permitted from all sources. These benefit sources can be classified as being direct or indirect. Direct sources are disability plans that pay monetary benefits directly to the disabled plan member, such as the Canada Pension Plan (CPP), Employment Insurance (EI) or the Workers' Safety Boards. Indirect sources are benefits paid to or for the benefit of dependent spouses or children of the disabled life insured. Such benefits could come from sources such as the CPP.[18]

Benefits arising from personally owned DI policies are usually exempt from the all-sources maximum rules, but these plans may have their own offset rules set out in the contract.

18. In Québec, these benefits may come from the Québec Pension Plan (QPP).

The offsets in group master contracts usually state that benefits from all specified sources cannot exceed 85% of the plan members' pre-disability income. If the total benefits available exceed this level, then the group benefits paid will be reduced – offset – to bring the overall benefits paid back down to the 85% maximum.

EXAMPLE

Mr. Lee earns $60,000 a year as a plumber. He is employed with a company that provides an LTD benefit equal to 66.67% of its employees' regular, pre-disability income, or $3,333 a month (($60,000 × 66.67%) ÷ 12). In the event of disability Mr. Lee could also qualify for benefits of $1,020 a month from a personal policy, for a total of $4,353 a month of benefits. This would represent benefits of $52,236 a year, or 87.1% of his regular income. The 87.1% exceeds the 85% all sources maximum specified in the group plan's master contract, so Mr. Lee's monthly benefit from the group plan would be offset by $103 a month ($4,353 – (85% × $60,000 ÷ 12)) to an amount of $3,230, bringing the total monthly benefit from all sources to $4,250, or 85% of his pre-disability income level.

2.3.4.4 Denial of benefits

Benefits from group DI plans can be denied for the same reasons as benefits from individual plans, addressed earlier. In addition, benefits from group plans would not be paid if the member had ceased to be a member of the group.

2.3.5 Taxation of group disability insurance benefits

In the case of employer/employee group DI plans, STD coverage is usually fully paid for by the employer and benefits received by the employee are treated as taxable income. Since short-term benefits are typically a larger percentage of pre-disability income (often in the 70-75% range), a plan member on claim should still be able to live on the after-tax benefit. Premiums paid by the employer for the coverage are a deductible business expense for income tax purposes.

In the case of LTD coverage, which often pays about 60% of pre-disability income, if the premiums are paid by the employer, the benefits received by the employee will be taxable income. As with STD, the employer-paid premiums are a deductible expense. However, if the employee/plan member pays 100% of the premium, the benefits will be received tax-free. The plan is taxed in the same way as a personally owned DI policy. For this reason, most LTD coverage found in contributory group insurance plans is structured such that the employee pays 100% of the premium for the LTD coverage.

In circumstances where both the employer and the employee contribute to the premiums for LTD coverage, an anomaly occurs. The employee's benefits (if any) are assumed to be a tax-free

refund of premium up to the amount of aggregate premium paid by the employee since his last claim. Any benefits received in excess of that amount are treated as a taxable benefit in the hands of the employee.

EXAMPLE

Matti is a member of a group DI plan where the employer and the employee share the premium cost for all group benefits on a 50/50 basis. Up until now, Matti has never made a claim against the LTD benefits available under the plan. However, this year he was injured and ended up receiving a total of $17,000 in group LTD benefits. To date Matti and his employer had shared the $8,200 in total premium paid on his behalf for the LTD coverage. For tax purposes, $4,100 of Matti's benefits (his 50% of the $8,200 of total premiums paid) would be a tax-free refund of premium and the other $12,900 ($17,000 - $4,100) would be treated as taxable income.

Table 2.3 summarizes the tax consequences to the recipient of benefits, based on the person or entity that pays the premiums for the disability coverage.

TABLE 2.3

Taxation of disability insurance premiums and benefits based on payor

TYPE OF POLICY	PAYOR	DEDUCTIBILITY OF PREMIUM BY PAYOR	TAX STATUS OF BENEFITS
Personally owned individual policy	Policyholder	No	Tax-free
Group policy	Employer only	Yes	Taxable
	Employee only	No	Tax-free
	Employer and employee	Portion paid by employer: Yes Portion paid by employee: No	Taxable with employee premiums reducing amount taxable

2.3.6 Integrating a group policy with an individual policy

Clients may rely on either group insurance or individual insurance to meet their financial protection needs in the event of disability, or may employ both options: using an individual policy to fill any potential gaps or shortfalls in their group program. The following is a brief discussion of two ways the types of plan can be integrated to meet all of the client's disability protection needs.

Benefit amount

Group disability insurance (DI) plans will usually restrict coverage to a maximum of no more than 60 to 66.66% of income in the case of LTD and 70 to 75% of income for STD. Plan members who might wish a higher level of benefit could supplement their group coverage by purchasing an individual DI plan with the same waiting and benefit periods as the group plan, but with benefits that would fill the gap.

EXAMPLE

Andre's group policy offers LTD coverage of 60% of his $80,000 annual salary, or $4,000 a month of benefits ($80,000 × 60% ÷ 12). He would be more comfortable with a 75% benefit level, or $5,000 a month ($80,000 × 75% ÷ 12). He could supplement his group coverage by taking out an individual DI policy paying $1,000 a month of disability benefit, but otherwise on the same basis as the group plan.

Care must be taken to ensure that the total amount of coverage in place between the two plans does not exceed the 85% all sources maximum laid out in either, or both, contracts. Otherwise, offsets might void some of the advantage of the extra coverage, leaving the client paying for coverage from which he could never benefit. Claims are filed against the group policy first (as "first payor") and then against the personally owned plan, where there is an overlap in coverage.

Benefit period

A plan member might also wish to extend the length of time that benefits are available under his group contract. He could do so by purchasing an individual plan with the same benefit level and definition of disability as the group policy, but a benefit period that would extend the benefits payable. The waiting period of the individual policy would be tied to the benefit period under the group coverage.

EXAMPLE

Jacinta works for a company that offers group DI coverage based on 66.66% of salary, with a 60-day waiting period, but a benefit period of only 12 months each for STD and LTD. She would much prefer a 5-year benefit period. She could supplement her group coverage by taking out an individual DI policy paying a 66.66% benefit for three years, with a waiting period of 26 months (the combined waiting and benefit periods under the group plan), thereby extending her overall benefit period to five years.

2.4 Creditor disability insurance (and other providers)

There is another classification of a group association not yet examined: creditors of the same financial institution. Lenders (banks, credit unions and other lending institutions), via mortgages, personal or secured lines of credit and credit cards, will often partner with a life insurance company to offer disability insurance (DI) coverage, to ensure that regularly scheduled payments on the debt are made even during a period when the debtor is disabled and unable to earn an income.

Creditor disability insurance is offered as a "package deal" with the loan itself, on an optional basis. Depending on the size of the debt being insured, the coverage may be offered with little, or no, medical underwriting at time of application, although the insured may be underwritten at time of claim, retroactively. There will invariably be a waiting period, often 60 days, and the policy premiums are blended in with the monthly loan payment and debited to the same account that provides the loan payment. The definition of disability qualifying the insured for benefits is invariably "total disability" – the inability to earn income due to illness or injury.

2.4.1 Amount of benefit

The benefits available from group creditor DI coverage are tied to the insured's obligations to make payments, usually monthly, on the outstanding balance of the insured loan. The benefit is typically a percentage of the outstanding balance, subject to a maximum allowable monthly and overall limit.

EXAMPLE

A bank offers mortgage disability insurance that will pay a maximum benefit equal to the monthly principal and interest payments on the mortgage, to a maximum of $3,000 a month for 24 months. It also offers credit card coverage with a maximum benefit of the lesser of 3% of the balance and $600 a month, capped at an overall limit of $20,000.

2.4.2 Taxation of creditor disability insurance benefits

The tax treatment of group creditor DI premiums is simple and straightforward, mimicking the treatment of individual disability insurance:

- Premiums paid are a personal, non-deductible expense, unless the purpose of the loan in question was to earn income from business or property (i.e., a business or investment loan);
- Benefits are received (paid to the creditor on behalf of the debtor) tax-free.

2.5 How they compare

There are similarities, differences, strengths and weaknesses to the three common sources of disability protection: individual, group and creditor insurance. Table 2.4 briefly summarizes, compares and contrasts these characteristics.

TABLE 2.4

Characteristics of individual, group and creditor income protection

	INDIVIDUAL INSURANCE	GROUP INSURANCE	CREDITOR INSURANCE
Source of insurance	Directly from insurance company	Group plan through an insurance company	Lending institution via third-party insurer
Policyholder	Applicant/insured	Group sponsor	Lending institution
Life insured	Applicant	Plan member	Borrower
Beneficiary	Policyholder	Group member	Lending institution
Underwriting	Full	Not for basic coverage, only for additional coverage	Limited or none at time of application (but some retroactively at time of claim)
Premium level	Highest	Lowest	Generally high to intermediate
Method of premium payment	Cheque/direct debit	Payroll deduction/direct debit	Incorporated into loan payment
Convertibility	Depending on policy	In some cases	No
Portability	Yes	No	In some cases
Flexibility	At discretion of applicant, subject to options available and limitations	Minimal, subject to rules of the group plan	No

CHAPTER 3

INSURANCE TO PROTECT ASSETS

Competency component

- Analyze the available products that meet the client's needs.

Competency sub-components

- Analyze the types of contracts that meet the client's needs;
- Analyze the riders that meet the client's needs.

3
INSURANCE TO PROTECT ASSETS

Life insurance policies provide cash to protect the financial interests of dependents and beneficiaries in the event of the death of the individual whose life is insured. Disability income replacement policies protect the financial interests of a life insured should he become disabled and unable to work and earn any income, due to injury or illness. Yet neither life insurance or disability insurance protect an insured's assets (investments, RRSPs, real estate, etc.) and future estate value with a tax-free benefit to assist him for the payment of any health-related expenses if he suffers a catastrophic illness or condition and survives, perhaps for years or decades. The insured could possibly even return to work albeit with altered health circumstances. Critical illness insurance (CI) and long-term care insurance (LTC) provide such living benefits and help protect assets from erosion due to prolonged health-related expenses.

Critical illness policies are designed to provide a tax-free sum of money to assist an insured in adapting to his changed circumstances caused by a life-threatening illness. And long-term care policies provide tax-free funds for care services for those insured persons who can no longer care for themselves independently, due to illness, injury or the effects of aging.

3.1 Critical illness insurance (CI)

Individuals that suffer such catastrophic health events as a life-threatening cancer, heart attack or stroke may, or may not, eventually be able to return to work full-time, but they will almost certainly incur expenses or changes in their lifestyle that are not covered by conventional disability insurance. These individuals might require funds to permit them to make substantial lifestyle changes to accommodate the changes brought about by their medical condition:

- Paying off debt, such as mortgages or credit card balances, to ease the financial stress arising from a prolonged recovery period, increased medical expenses and/or a reduced future earning capacity;
- Alternative treatments to those covered by provincial medical plans;
- Home renovations required to accommodate changes in the individual's physical capacity (for example, widened doorways and ramps to accommodate a wheelchair);
- Choice to work part-time, due to reduced physical capacity or simply a desire to spend less time at work to engage in other activities: a common psychological response to a brush with a life-threatening condition;

- Conventional medical expenses not covered by provincial health plans;
- Vacations to help lower medical stress;
- Changes of employment to a job with lower stress or physical requirements, with an attendant decline in earning capacity, etc.

Without CI insurance benefits, these lifestyle changes could have a significant negative impact on one's assets.

With improvements in emergency medical treatment, and medical care in general, the pool of individuals who suffer a life-threatening condition and live is expanding. Consider the following Canadian statistics for the four most prevalent critical illness conditions alone:[19]

- One out of every two heart attack victims is under the age of 65 and 95% survive their first attack;
- One out of three Canadians will develop some form of cancer and 65% of them will survive for at least five years;
- One out of 20 Canadians will suffer a stroke before age 70 and 75% of those will survive it;
- Between 3 and 5 % of critical illness claims are made by people who had coronary bypass surgery.

Most people will know of, or be related to, someone within this group and will appreciate the value of, and need for, CI insurance.

3.1.1 Coverage provided

Introduced in Canada in the mid-1990s as a stand-alone contract, CI insurance offers insured individuals a lump-sum payout to be used at the discretion of the insured should he suffer any one of a broad range of life-threatening or life-altering conditions.

3.1.1.1 Minimum/Maximum issue ages

For adults, policies will usually be issued for qualifying applicants between the ages of 18 and 65, after which the risk of claim becomes too high for most insurers to wish to assume. There are also special, more limited, children's plans available offering much lower benefits than the adult plans.

19. Jacqueline Figas. *Disability Insurance and Other Living Benefits*, CCH Canadian Limited, 2012, pages 301-302.

3.1.1.2 Minimum/Maximum face amount

Policy minimum and maximum face amounts vary by insurer, with some issuing contracts for as little as $10,000 and others willing to go as high as $2,000,000. The more typical face amounts are in the range of $50,000 to $500,000.

The actual amount of coverage issued to a given applicant will depend on a number of factors, including:

- Age;
- Financial status relative to the amount of insurance applied for (to avoid over-insurance);
- Current health status;
- Applicant's medical history;
- Applicant's parents' and siblings' medical history.

3.1.1.3 Qualification period

It is standard for a critical illness policy to have an exclusionary clause that specifies that an otherwise covered condition that is first diagnosed or which first manifests itself within 30 days of policy issue will not be covered. This 30-day period is called the "qualification period."

3.1.1.4 Survival (waiting) period

Some insurers may require an exclusionary period, between the issue date of the policy and the onset or diagnosis of a condition listed in the policy, before that condition would be covered for purpose of a claim. For example, in the case of cancer, the exclusionary period may be as much as 90 days. This period may vary in time or application from carrier to carrier. The purpose of the exclusionary period is to protect the insurer against anti-selection: applicants seeking coverage because they fear that they may have a covered condition.

As well, since critical illness insurance is designed to provide benefits to insureds who survive a covered condition, there is also waiting period between the date that a covered condition is diagnosed and benefit becomes payable, such that the insurer can have a reasonable expectation the insured will, in fact, survive the condition. The waiting period is often 30 days, but may be longer in relation to certain conditions.

3.1.1.5 Duration of coverage

CI insurance policies are issued both as term and permanent contracts. Term policies run for a specific number of years, typically for 10 or 20 years, or to age 65 or 75. Permanent plans run from date of issue to the life insured's age 100, much like Term-100 life insurance.

The 10 and 20-year term contracts are often guaranteed renewable, but with an increase in premium, to age 75. These plans may also be convertible to permanent coverage, up until age 65. Conversion may be affected without medical evidence, but the insured may not be on claim at the time of conversion.

Most policies will expire after the payment of a claim at any age. However, as critical illness insurance is a relatively new product, coverage offered will undoubtedly evolve in the years to come.

3.1.2 Types of policies

One of the main ways by which critical illness policies are distinguished from each other is in the number of conditions that are covered:

- Many basic policies cover three or four conditions: three-condition contracts cover heart attack, stroke and cancer, and four-condition contracts also cover coronary bypass surgery;
- Many policies extend that coverage to 10 conditions (outlined below under *Conditions covered*);
- Comprehensive policies will cover 20 or more conditions (also outlined below).

Children's policies (under age 18) typically cover most, or all, of the conditions insured by comprehensive plans, but also a variety of conditions that are more closely associated with minors, like:

- Muscular dystrophy;
- Type 1 diabetes;
- Cerebral palsy;
- Cystic fibrosis.

Many of these plans are convertible to an adult plan once the child reaches a set age, such as 18 or 25.

Some critical illness policies are offered through financial institutions which also issue mortgages. These plans are issued with minimal underwriting and are designed specifically to discharge the outstanding mortgage balance in the event that the individual applying for the mortgage should suffer a critical illness while the mortgage remains outstanding. Benefits are paid directly to the

financial institution, subject to underwriting at time of claim. Some stand-alone mortgage life and disability insurance policies also contain a clause for the payout of a benefit in the event that the insured should suffer a critical illness.

Guaranteed issue contracts are issued by some insurers without medical underwriting. All that is required is a brief declaration of good health at time of application. Understandably, such coverage will often be more expensive than a similar coverage that is medically underwritten, and the benefits are limited, typically restricted to less than $100,000.

Some life insurance policies also offer an optional critical illness benefit of a relatively modest amount.

3.1.3 Conditions covered

Not all critical illness policies cover the same illnesses or conditions and there are some illnesses or conditions that are not covered by most policies, such as AIDS. In addition, the precise definition of a covered condition may vary from plan to plan. For example, the type of cancer or the degree to which it has progressed as a qualifying condition will vary from one insurer to another. Or the degree of heart muscle damage may determine whether a heart attack is severe enough to warrant benefits under the definition included in a given contract.

3.1.3.1 “Big 4” – heart attack, stroke, cancer, and coronary bypass surgery

Most critical illness policies at least provide benefits for a qualifying life-threatening occurrence of the “Big 4” conditions:

- Heart attack;
- Stroke;
- Cancer;
- Coronary bypass surgery.

3.1.3.2 Expanded coverage

In addition to the “Big 4” covered conditions, insurers offer more far-reaching policies that may provide benefits to those lives insured who contract some of the following conditions. The additional conditions covered may often be added in the form of a rider. The list of conditions that may be offered as a rider to the basic plan and their number may vary from one carrier to the next. The following example is an indication of the type of coverage that may be offered.

EXAMPLE

Conditions	10-condition contracts	20-condition contracts
Alzheimer's		✓
Aortic surgery		✓
Aplastic anemia		✓
Bacterial meningitis		✓
Benign brain tumor		✓
Blindness	✓	
Cancer	✓	✓
Coma		✓
Coronary bypass surgery	✓	✓
Deafness	✓	
Heart attack	✓	✓
Heart valve replacement		✓
Kidney failure	✓	
Loss of independent existence		✓
Loss of limbs		✓
Loss of speech		✓
Major organ failure on waiting list		✓
Major organ transplant		✓
Motor neuron disease		✓
Multiple sclerosis	✓	
Occupational HIV infection		✓
Organ transplant	✓	
Paralysis	✓	
Parkinson's disease		✓
Severe burns		✓
Stroke	✓	✓

Of course, the more conditions that a policy covers, and the easier it is to meet the definitions of those conditions, the more at risk the insurer is of having to pay a claim, so the higher the policy premiums will be.

The exact definition of these conditions may vary from policy to policy, although most conditions must be severe enough to be life-threatening before benefits would be payable.

3.1.4 Riders available

The two most common riders available under critical illness policies are the return (refund) of premium rider and the waiver of premium rider.

3.1.4.1 Return of premium

As an optional benefit (rider) many insurance companies offer their critical illness policyholders the opportunity to add a return (refund) of premium clause to their contracts that would pay back some, or all, of premiums previously paid by the policyholder should the insured die or the policy expire with no claim ever having been filed.

The following types of returns can be offered:

- On death — Premiums would be refunded to the estate of the policyholder, or to a named beneficiary, in whole or in part, should the insured die from a cause not covered as a critical illness under the policy, or should he die due to a critical illness but before the end of the qualification and waiting periods.
- On surrender — Premiums would be refunded to the policyholder, in whole or in part, should the policyholder surrender (cancel) the policy after a prescribed number of years (10, for example) with no claim having ever been filed.
- On maturity — Premiums would be refunded to the policyholder in whole or in part, should the policy mature (expire – at age 75, for example) with no claim having ever been filed.

3.1.4.2 Waiver of premium

A waiver of premium rider may be added to a critical illness policy provided the insured qualifies medically and pays an additional premium. The rider waives all premiums ordinarily payable under the policy in the event of, and for the duration of, a period of total disability of the insured (or the policyholder, if the insured is not the one paying the premiums). The rider is added at the time of policy issue and is usually only available if the insured is age 55 or younger at the time of application. The waiver is usually subject to a waiting period of between four and six months from the onset of the qualifying disability and premiums paid by the policyholder may be refunded once the waiting period has expired. Waiver will continue until the earlier of:

- The recovery of the insured from the disabling condition;
- A successful claim for benefits for a critical illness;
- The expiry date of the policy.

The conditions (disability) that would result in a waiving of premiums under the policy are different from those that would result in a successful claim for critical illness benefits. For example, an insured could suffer a minor stroke that is temporarily debilitating and triggers the waiver provision, but is neither severe nor permanent enough in the damage caused to trigger the critical illness benefit.

3.1.5 Payment of benefits

The payment of benefits under a critical illness contract is subject to a number of restrictions:

- The diagnosis or first manifestation of the condition, or disease, must occur more than 30 days after the issue date of the policy (the qualification period);
- The life insured must survive the diagnoses of the covered condition for at least 30 days (the waiting period, which may be extended to 90 days in some instances, such as a diagnosis of cancer or in the event of a stroke) – however, benefits would still be payable to the estate of the insured or another named beneficiary should the insured survive the waiting period but die prior to approval or payment of the claim;
- The life insured must usually make a claim within 30 days of diagnosis of the qualifying condition;
- The claimant must provide medical proof of the qualifying condition within 90 days of filing a claim and the insurance company's medical advisors must concur that the condition in question meets the requirements of the policy.

Benefits are normally payable in a lump-sum but the policy may provide that the claim be paid in instalments.

There is usually only a one-time payout of benefits under a critical illness policy, similar to the situation with a life insurance policy. After a successful claim the policy is cancelled.

EXAMPLE

Sylvia successfully claimed a $100,000 benefit under her CI insurance policy in 2011, due to diagnosis of a qualifying cancer. When she subsequently had a heart attack in 2013, she was unable to make a second claim under her policy because the contract had been terminated upon payout of the 2011 cancer claim.

Some policies, however, offer an optional second event rider, whereby coverage remains in force after a successful claim and a lesser level of benefits may be paid in the event of a future, unrelated claim. For example, if the first claim was related to a heart attack, a subsequent claim related to life-threatening cancer might give rise to the payment of a second, lesser benefit.

The payment of benefits is subject to the standard exclusions. No benefits will be paid for conditions arising from:

- Act of war, declared or otherwise;
- Act of terrorism;
- Attempted suicide;
- Self-inflicted wounds;
- Normal pregnancy;
- Criminal activities;
- Abuse of non-prescription drugs;
- Non-occupational AIDS/HIV.

3.1.5.1 Tax treatment of critical illness premiums, benefits and return of premium benefit

Similar to the circumstances with individual disability income replacement policies, premiums paid for individual critical illness coverage are not deductible for income tax purposes. Neither do premiums paid qualify for the Medical Expense Tax Credit.

On the other hand, benefits received as the result of a claim or a refund of premium are not taxable income in the hands of the recipient policyholder.

3.2 Long-term care

The phrase “long-term care” often evokes the image of the aged ailing in a nursing care facility. Although that can be part of the scenario, long-term care is so much more. Those in need of long-term care are individuals of any age who can no longer look after their daily physical needs independently. They could be young people suffering from a debilitating condition like muscular dystrophy or multiple sclerosis, those of any age who have suffered an injury (brain or spinal injuries, for example) that have left them severely physically or mentally restricted, or those suffering from the diseases of age (Alzheimer’s or dementia). Long-term care itself can range from home care, provided in the patient’s own residence, to assisted living facilities and nursing homes, depending on the needs of the patient. The balance of this Chapter will examine the extent of the need for long-term care, the types of care available and insurance coverage available to help pay for the costs of long-term care.

3.2.1 Canadian demographics

Despite the diversity in long-term care patient situations, the need for long-term care remains primarily restricted to those over age 65. And, as the "baby boomers" age, the percentage of the Canadian population over age 65 is going to balloon over the next 20 to 30 years.

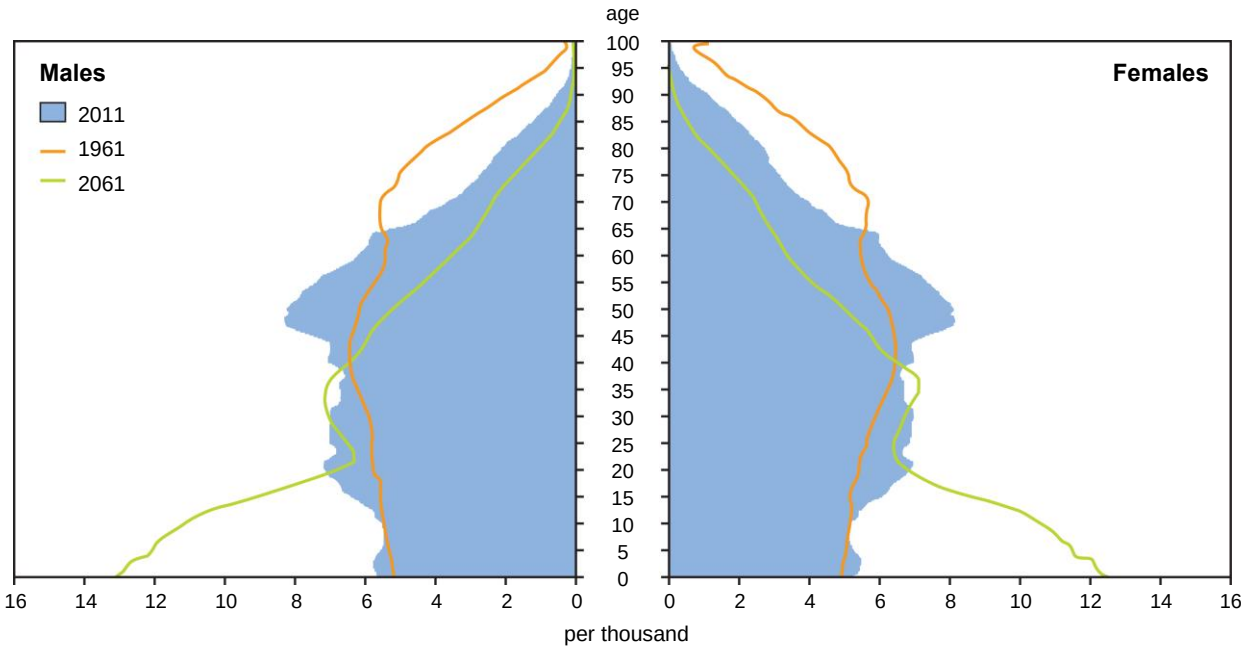
Diagram 3.1 illustrates population trends by age and gender between 1961 and 2061.[20] In the last 50 years, the age and sex structure of Canada's population has changed considerably. In 1961, toward the end of the baby boom, Canada's population pyramid had a wide base because of the large number of young people, reflecting the large cohorts born during this period.

More than 50 years later, the bulge has moved up the pyramid as baby boomers, aged 46 to 65 in 2011, have grown older. The drop in fertility is apparent in the pyramid with a slightly narrower base.

As the baby-boom cohorts grow older and Canada's population continues to age, the structure of the population can be expected to increasingly resemble a rectangle, as shown by the pyramid for 2061 based on the medium-growth scenario of the most recent population projections.

DIAGRAM 3.1

Age pyramids of the population, Canada, 1961, 2011 and 2061[21]



20. Statistics Canada. *Changes in the age structure of the Canadian population by sex, 1956, 2006 and 2056*. [online]. Revised February 19, 2016. [Consulted August 3, 2017]. http://www.statcan.gc.ca/pub/91-003-x/2007001/figures/4129870-eng.htm
21. Statistics Canada. *Canadian Demographics at a Glance, Second edition*. Revised February 19, 2016. [Consulted October 10, 2017]. http://www.statcan.gc.ca/pub/91-003-x/91-003-x2014001-eng.pdf?contentType=application%2Fpdf

The proportion of seniors has been steadily increasing for the past 50 years due to below-replacement fertility and the lengthening of life expectancy. This increase will accelerate in the coming years as more baby boomers reach 65 years of age.

According to the medium-growth scenario of the most recent population projections, the proportion of seniors could start to exceed the proportion of children in 2017, with a subsequent widening of the gap.

The proportion of the population that is of working age (15 to 64 years of age) has remained at around 68% since the 1980s due to the presence of the baby boomers in this age group.

In the next 50 years, as baby boomers exit this age group, this proportion could drop down to the levels recorded in the late 1950s and throughout the 1960s, that is, to approximately 60% of the population.[22] With so many likely to need long-term care assistance and relatively so few entering the workforce to earn and pay taxes to support them, where will future funding for long-term care come from? Individual long-term care insurance (LTC) coverage could be part of the solution to the problem.

3.2.2 Long-term care options

Long-term care isn't just about a stay in a nursing home. The health care community offers a wide range of public and private services, each progressively more comprehensive. The most common private/public services available are:

- Home care;
- Respite care;
- Assisted living;
- Nursing home (facility) care.

3.2.2.1 Home care

The first tier of long-term care services involves health care in the home of the afflicted individual. This is usually the first choice for many seniors. If at all possible they would prefer to receive services that could keep them at home for as long as practical. Even those suffering from cognitive disorders, like Alzheimer's, often take comfort from remaining in a familiar environment.

Home care can improve seniors' quality of life, while still allowing them to retain their self-esteem and a feeling of security. Home care is most often provided where there is an informal caregiver (family member) in attendance and the patient's need is relatively minimal and likely to be only temporary. However, it can also be provided by professional health care workers or community service workers.

22. *Ibid*.

Home care services are typically charged by the hour and may not be required on a daily basis. Examples of home care services include:

- Nursing care;
- Companionship services;
- Home help services, such as Meals-on-Wheels and housekeeping/cleaning services;
- Personal care services (with the activities of daily living – addressed in a later Section);
- Overnight stay.

3.2.2.2 Respite care

In circumstances where the primary caregiver is a member of the patient's family (spouse, child, grandchild, etc.) in a home care situation, the need to provide care 24/7, as in the case of an Alzheimer's sufferer, can become very wearing on the caregiver, both physically and emotionally. So that the caregiver's health, both physical and mental, does not suffer unduly, provision needs to be made to provide relief (respite) for at least a short period, from time to time.

Relief might come from a few hours of assistance by friends or other family members, from community services or from a paid, formal care facility like a nursing home. Of course, such relief may come with a monetary cost: an overnight stay (or longer) at a nursing care facility, adult day care, transportation costs, etc.

EXAMPLE

Rudi, age 62, a retired accountant, looks after his 86-year old mother, who has Parkinson's disease, on an essentially full-time basis. She lives with Rudi and he has to assist her with many day-to-day activities and keep a watchful eye on her to prevent her from accidentally injuring herself. Although Rudi has nurses and care workers coming to his home to offer his mother regular therapy and assistance, the situation is still very wearing on him. Respite care would provide for Rudi's mother to spend a few days each quarter in a temporary stay at a nursing home facility, to give Rudi a much-needed break from the stresses of the day-to-day care routine.

3.2.2.3 Assisted living

The next step up from home care is an assisted living facility. These are usually transitional residences which offer support services to individuals who can no longer function in an independent living situation, or in their own homes, but whose debilitation is not severe enough to require 24-hour supervision or medical attention. Assisted living facilities offer on site, part-time nursing support, and assistance with such functions as shopping, cleaning, cooking, and other daily activities which the individual cannot perform or cannot perform without aid. These facilities

may be smaller units with only a handful of residents or large, apartment-like structures housing dozens or hundreds of seniors. They are often referred to as “seniors’ residences.”

3.2.2.4 Nursing home (facility) care

For those individuals who have lost the ability to live independently, nursing homes are the preferred solution for those in need of chronic care. Nursing homes offer 24-hour supervision, 24-hour nursing care and the on-site services of a medical doctor. Their in-house facilities typically offer assistance with the activities of daily living, fully prepared meals, and group and individual recreation activities for their more active members. Some also offer field trips and special facilities for entertaining the patients’ families.

3.2.3 Providers of long-term care

There are a number of sources of long-term care services in the community and a number of providers of long-term care insurance coverage.

In a given community, services may be provided by all or any of the following:

- Provincial government;
- Not-for-profit organizations;
- Religious organizations;
- For-profit organizations: private service providers, assisted living centres and nursing homes.

3.2.3.1 Publicly funded facilities

Nursing home facilities are licensed and regulated by the provincial governments. The governments also provide various levels of subsidy for nursing home patients unable to afford the full monthly fees. The provincial health care plans will subsidize care in provincially licensed facilities for those low-income individuals who qualify based on a means test.

3.2.3.2 Publicly funded home care

As stated earlier, home care may involve both health and support services provided for in the patient’s home. When services offered are publicly funded, they may be received in one of two ways:

- Through a contracted agency paid for by the government;
- Through a home care agency selected and paid for by the client with an allowance received from the government.[23]

23. The University of British Columbia. *Evidence and perspectives on funding healthcare in Canada.* [online]. [Consulted August 3, 2017]. http://healthcarefunding.ca/home-care/

3.2.4 Cost of long-term care

The cost of long-term care can vary from province to province, dependent upon whether the care provided is basic or extensive and the comprehensiveness of the care itself. The degree to which the provincial government will cover the services needed by the insured would also impact the risk exposure assumed by the insurer. Nevertheless, the cost is always substantial. Accommodation in a nursing care facility can cost between $900 and $5,000 per month or more, depending on the type of room and the level of public funding.

Table 3.1 illustrates the monthly cost (not subsidized) for full-time residence in a nursing care facility throughout the Canadian provinces.

TABLE 3.1

Monthly costs (not subsidized) for full-time nursing care facilities by province[24]

PROVINCE	PRIVATE	ONE BEDROOM SUITE
	$ PER MONTH	
Alberta	953 – 4,285	2,658 – 4,440
British Columbia	995 – 3,500	1,595 – 5,400
Manitoba	1,359 – 2,475	1,690 – 3,300
New Brunswick	800 - 2 533	1 943 - 3 500
Newfoundland	1,500 – 1,800	1,065 – 4,200
Nova Scotia	1,705 – 3,100	1,900 – 3,490
Ontario	1,236 – 6,000	1,849 – 8,000
P.E.I.	1,825 – 2,880	1,959 – 3,750
Québec	850 – 6,700	750 – 2,500
Saskatoon	1,380 – 3,700	1,200 – 4,300

The above figures are representative only and often show the average cost for nursing care facilities. Provincial health care plans will cover some, but not all, of these costs, often leaving a substantial gap for the patient to cover. And, as many of the provincial subsidies are means-based, more affluent individuals may be required to cover much of the care costs themselves. These costs and subsidies are subject to periodic revision to reflect the impact of inflation.

24. Canadian Life and Health Insurance Association (CLHIA). *A Guide to Long-term Care Insurance.* [online]. [Consulted August 11, 2017]. https://www.clhia.ca/domino/html/clhia/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/$file/Brochure_Guide_Long_Term_Care_ENG.pdf

The costs of private nursing care would deplete the resources of most patients, and possibly their families, within a few years. It is exactly this type of financial burden that long-term care insurance (LTC) is intended to relieve, leaving the afflicted free to seek the level of care that they need rather than just what they can afford.

3.3 Individual long-term care insurance (LTC)

Long-term care coverage is most often acquired as a stand-alone policy, but can also often be offered as an optional rider on life insurance and critical illness insurance contracts. The long-term care rider is added, if at all, at time of application of the base contract and will be subject to separate medical and financial underwriting. It could be that the prospective life to be insured could qualify for the life or critical illness coverage, but not for the long-term care rider. The rider typically carries its own premium in addition to the premium for the underlying policy.

Long-term care contracts are not “disability insurance” in the classic sense; they do not provide income replacement in the event that the insured is unable to engage in gainful employment due to injury or illness. Rather, long-term care plans are structured to provide a daily maximum benefit to cover the costs of professional health care services for insured individuals who, due to illness, injury or aging, are no longer able to function independently.

Long-term care benefits can be paid directly to the service provider like a nursing home (indemnity model) or, more often in the case of home care, to compensate the patient for expenses already paid for out of pocket (reimbursement model).

3.3.1 Purpose/Who needs it

Many insurers do not offer long-term care policies to individuals, aged 65 or older, because of the high risk of claims in these latter years. Conversely, the risk of claims for young individuals is very low. For these reasons, prospects for long-term care insurance are most often those in the range of ages 45 to 55.

Although government funding is available to support long-term care services and facilities, the health care system is stressed and the situation will only get worse as developments in modern medicine and technology continue to extend the lifespan of the average individual, seniors in particular. In 2011, almost 5 million Canadians were aged 65 and older, and 7% of them lived in care facilities, according to Census data. That proportion climbs to 30% for those aged 85 or older.[25]

25. BC Medical Journal. *Statistics Canada: Almost 5% of seniors in long-term care*. [online]. Revised November 2012. [Consulted August 3, 2017]. http://www.bcmj.org/pulsimeter/statistics-canada-almost-5-seniors-long-term-care

Insurance coverage is needed, on either a stand-alone basis or as a rider to life insurance and other policies, to provide funds and benefits for home care and facilities care services for years, or decades, to come.

3.3.2 Advantages

The most obvious advantage of having LTC insurance coverage is minimization, or even elimination, of the burden of costs for needed long-term care services. This can take the strain off the insured, and often the insured's family, where the cost of care could otherwise deplete their estates and/or financial well-being.

A by-product of the relief of this financial burden is the fact that the individual is now free to seek the level of care he needs rather than the one he can afford to pay for himself. For most insureds, this ensures a better quality and quantity of services than they would otherwise obtain.

Lastly, as the individual will be able to afford the services he requires, it will give him a feeling of dignity and self-control, the knowledge that he will not have to depend on the good graces of the government in a time of need in his old age.

3.3.3 Coverage provided

LTC insurance contracts provide protection for the costs of in-home, assisted living or facilities services required by individuals who are recovering from an illness or injury or those who have a condition (for example, Parkinson's Disease) that requires chronic care. The policy covers many of those expenses that are not covered by provincial health care plans or, within limits, costs for covered services that exceed the benefits permitted under provincial plans. Many long-term care policies also provide funds for respite benefits, as an alternative to, or in addition to, benefits provided for professional in-home care or care in a long-term care facility.

Coverage is subject to an elimination period, usually somewhere between 0 and 90 days, chosen based upon the number of days of care that the insured feels that he can self-fund. As with other types of insurance, the shorter the elimination period the higher the policy premium will be.

Coverage is medically underwritten based on a number of factors, including:

- Age of the life to be insured;
- Gender;
- Whether the life to be insured is a smoker or a non-smoker;
- Current health;
- Medical history;
- Cognitive ability;
- Current ability to perform the six activities of daily living (see below).

The amount of coverage is computed based on a maximum daily rate multiplied by a number of days (care days) of coverage, to an overall maximum specified in the contract ($200,000 for example). While the daily maximum cannot be exceeded, the number of days over which benefits may be payable is flexible.

EXAMPLE

Gregory has an LTC insurance policy with a rider that offers him up to one year (365 days) of home care coverage at a maximum of $200 a day. His overall maximum benefit for home care would be $73,000 ($200 × 365 days). If some of his care days required less than $200 of benefits, the term of the benefits payable could be extended beyond 365 days until the entire $73,000 of benefits had been paid out.

The payment of benefits is subject to the standard exclusions. No benefits will be paid arising from:

- Act of war, declared or otherwise;
- Act of terrorism;
- Attempted suicide;
- Self-inflicted wounds,
- Normal pregnancy,
- Criminal activities;
- Abuse of non-prescription drugs;
- AIDS/HIV.

3.3.3.1 Activities of daily living (ADLs)

The most common ways that most insurers use to determine whether an insured qualifies for long-term care assistance is if the insured is unable to independently perform any two or more of the activities of daily living (ADLs):

- Dressing — The ability to dress or undress oneself (take off and put on clothes) without the assistance of a third party.
- Bathing — The ability to wash oneself in a tub or shower without the assistance of a third party.
- Toileting — The ability to get to and from the toilet, and on and off it, independently.

- Transferring — The ability to move from bed to chair, to a wheelchair or to another location without the aid of a supporting device (e.g., cane or crutches) or the assistance of a third party.
- Eating — The ability to feed oneself without assistance (not merely the ability to prepare food, but to actually eat food without assistance).
- Maintaining continence — The ability to control one's bladder.

In addition to assessing an insured's ability to perform the ADLs, an umbrella test for qualification for long-term care benefits is to determine whether the insured is cognitively impaired. That is to say, can he understand and/or communicate the written or spoken word or non-verbal cues? A person who is severely cognitively impaired would be considered sufficiently "disabled" to qualify for LTC insurance benefits. Cognitive impairment could arise from a number of causes, including stroke, heart attack and such conditions as Alzheimer's or Parkinson's disease.

Certification of cognitive impairment, or of qualification under the ADLs, would be provided by the patient's attending physician, or by a physician associated with a care facility. Such certification could, of course, be subject to verification by a physician chosen by the insurance company.

3.3.4 Long-term care riders available

Although there will, of course, be exceptions in the marketplace, the following are the most common riders available under long-term care contracts:

- Cost of living adjustment (COLA);
- Return of premium.

3.3.4.1 Cost of living adjustment (COLA)

Long-term care services are, by their very nature, required on a long-term – often permanent – basis. Benefits provided by long-term care insurance are limited to a maximum daily rate. Over time, inflation could easily push the daily rate for long-term home care or nursing home care well beyond the maximum allowed for under a long-term care policy.

For the above reason, most policies offer an inflation protection rider, at an additional premium cost, that will automatically increase the maximum benefit available, typically in the range of 2% to 3% per year, to help the benefit to keep pace with rising costs. A more detailed analysis of COLA can be found in Chapter 2 of this Module.

3.3.4.2 Return of premium

Many long-term care policies offer a return of premium benefit at time of death of the insured if the policy has been claims-free. The amount returned (refunded) will vary from contract to contract, but is usually a function of the number of years the policy has been in force and claims-free: as much as 50% of premiums paid for a 10-year period or 100% for 20 years. The cost of the rider can add anywhere from 25% to 50% to the basic policy fee.

EXAMPLE

Antonia paid $1,800 a year for her LTC insurance policy, including a $400 annual extra premium for a return of premium rider providing for a 25% refund of total premiums paid over an 8-year claim-free period. She died this year after having paid into the policy and been claims-free for 10 years. Upon her death, her estate received a $4,500 (25% × $1,800 × 10) return of premium benefit from the insurance company.

Benefits received by way of a return of premium rider, like all benefits paid out under a long-term care policy, are tax-free to the insured whether those benefits are paid directly to the caregiver/care facility involved in providing care or to the insured by way of reimbursement for services previously paid personally.

3.3.5 Policy benefits

Long-term care benefits are payable on either a reimbursement (repaying the insured for expenditures already made) or an indemnity (paid directly to the care provider) basis, subject to daily and overall limits specified in the contract.

While nursing home care benefits are generally paid directly to the facility providing the care, home care benefits are paid on a reimbursement basis, with the insured first being required to pay for the services provided himself and then provide the insurance company with receipts, in order to seek reimbursement for the funds expended on qualifying services.

EXAMPLE

Kashif, age 71, suffered a stroke 18 months ago that resulted in limited mobility. Consequently, he was restricted to his home most of the time and had to have nurses, a physiotherapist and a housekeeper attend him regularly. Kashif paid for these services himself and then claimed a re-imbursement from the home care clause under his LTC insurance policy. Unfortunately, Kashif suffered a second stroke 3 months ago and is now confined to a nursing care home full-time. Costs not covered by the provincial health care plan are now paid directly to the nursing home under the indemnity benefit provided by Kashif's policy.

Reimbursement is determined as a maximum amount per day or per service/equipment, and the insured is only reimbursed for the amount actually spent on care. The maximum is not simply paid out regardless of the actual expenses incurred. Daily maximums for home care can be acquired in increments of anywhere from $10 to $350 a day and the maximum overall benefit is calculated as a number of days of coverage at the maximum daily rate.

Qualification for benefits is subject to medical evidence of need certified by the attending physician, using the ability to perform the ADLs as a guideline. Benefits will commence upon the date of certification and upon the provision of the qualifying services.

3.3.5.1 Tax treatment of long-term care benefits

All benefits paid out under a long-term care policy are tax-free to the insured, whether those benefits are paid directly to the caregiver/care facility involved in providing care or to the insured by way of reimbursement for services previously paid personally.

3.3.6 Premiums

Premiums for LTC insurance are generally payable for the life of the contract, subject to a waiver of premium provision if and while the policyholder is on claim. However, some insurers offer a fixed-term option for premiums, 20 years for example. This could permit the insured to pay up the policy prior to retirement.

Long-term care policies are generally guaranteed renewable, meaning that the policy must be renewed annually for the life of its term. Most policies, however, contain a provision that premiums may be increased at the discretion of the insurance company, provided the increase is applied to a given class of policies, not merely to the policy of one policyholder.

Each premium payable is subject to a grace period, such that the policy will remain in force for 30 calendar days after the due date of a monthly or annual premium, should the premium not have been paid on time. The policy will usually lapse (become void) should the premium due not be paid during the grace period.

The amount of premium payable depends on a number of factors:

- Amount of coverage provided (daily and overall maximums);
- Number of days for which benefits are payable;
- Type of coverage provided;
- Elimination period under the contract;
- Underwriting characteristics of insured;
- Requirements to qualify for benefits.

3.3.6.1 Tax treatment of long-term care premiums

Premiums paid for LTC insurance are not a deductible expense for income tax purposes. They may, however, qualify as eligible expenses for purposes of claiming the federal Medical Expense Tax Credit.

3.4 Coordinating long-term care insurance (LTC) with other types of accident and sickness insurance

LTC insurance has both similarities and differences with the type of coverage provided by disability income replacement and critical illness insurance (CI) contracts. Many of those factors are outlined in Table 3.2.

TABLE 3.2

Characteristics of disability insurance, critical illness insurance and long-term care insurance

CHARACTERISTICS	DISABILITY INSURANCE	CRITICAL ILLNESS INSURANCE	LONG-TERM CARE INSURANCE
Event triggering benefits	Inability to work due to injury or illness	Stroke, heart attack, etc. meeting the definition of covered conditions	Inability to care for one's self independently as defined by the 6 ADLs
Determination of benefits	Percentage of loss of income due to disability	Fixed amount pre-determined by contract	Qualifying expenses incurred by the insured, subject to contractual maximums
Factors determining premiums	Age, gender, medical history, coverage, waiting and benefit periods	Age, medical history, number of conditions covered, dollar amount of benefit requested	Age, gender, medical history, current health, waiting and benefit periods
Payment of benefits	Monthly benefit	Lump sum (or set number of periodic payments)	As qualifying expenses are incurred

3.4.1 Long-term care insurance (LTC) and disability insurance

There is really no risk of overlap or duplication in benefits between the two types of coverage because disability insurance replaces lost income and does not provide cash specifically to cover the expenses of the disabled insured; however, long-term care coverage covers medical and related expenses but provides nothing in the way of income replacement for the afflicted.

However, some insurers permit conversion of a disability insurance policy to long-term care coverage, up to a prescribed age of the insured.

3.4.2 Long-term care insurance (LTC) and critical illness insurance (CI)

There may or may not be a risk of overlap or duplication in benefits between the two types of coverage, but the potential overlap is difficult to avoid. CI insurance provides cash to allow the insured to adapt to costs and life changes arising from a specific cause, like a stroke or heart attack. The consequences of the event may not place the insured in a condition that would require the types of service/support provided by a long-term care policy: nevertheless, cash would be provided by the critical illness plan. On the other hand, the event that triggers critical illness benefits (a stroke, for example) could easily result in cognitive or other impairment that would also result in impairment qualifying for benefits under a long-term care policy. There is no way of knowing in advance which type of consequence might arise from a critical illness and, since critical illness proceeds are not specifically tied to any use, there would seem to be no practical way to build in offsets between the two types of coverage.

3.5 Limitations of critical illness insurance (CI) and long-term care insurance (LTC)

The existence of insurance coverage is not a guarantee that all medical and care needs of an afflicted individual will be accommodated. Even with the most comprehensive coverage, gaps may exist between the insured's needs and the conditions covered, as well as the benefits available. Particular attention needs to be paid to contract wording, definitions and differing medical opinion.

The importance of contract wording

As with all forms of insurance, the wording in the contract is crucial. The start date for benefits will be set out in the contract, for example, and only benefits that meet that determination will be payable. Never assume that a client should be covered; the contract wording needs to be examined closely and applied to his situation.

The importance of definitions

Definitions of covered conditions are critical in determining whether an individual qualifies for benefits. The insured may feel that his condition qualifies him for benefits, and his medical advisors and a care facility may agree. However, benefits may not be payable unless his condition meets the precise definition found in the contract. For example, contracts will set out the degree of cognitive impairment that will qualify an insured to claim benefits and any level of impairment that fails to meet the conditions of that definition will not warrant benefits. Furthermore, statistics from Munich RE indicate that by far, the most common reason to decline claims under their policies

was that the insured's condition did not meet the definition of the condition as specified in the contract (over 40% of declines).[26]

It is important to note that definitions evolve over time and different contracts issued by the same insurer at different times may vary in their definition of a given condition, depending on when the contract was issued. With the advancement of medical technology it has now become much easier than in the past to diagnose severity and damage. Again, some claims that would be paid out under the old definitions would no longer qualify with the new definitions and the new technology.

Different medical opinions from the insurance company's and the policyholder's medical advisors

Unless he resorts to courts, the insured is at the mercy of the insurance company's medical advisors when it comes to determining whether he qualifies for benefits. Even if the insured has written opinions from one or more qualified medical practitioners asserting that his condition qualifies for benefits, the insurance company's experts may not agree.

26. Munich RE. *Misconceptions demystified – Life and critical illness insurance*. [online]. Revised 2014. [Consulted August 3, 2017]. https://investissement.ssq.ca/astranet/en/accueil/general/docElectronique/SSQ_Roadshow_-_Kris_Boundy_2014_-_Published-1.pdf

CHAPTER 4

INSURANCE TO PROTECT SAVINGS

Competency components

- Analyze the available products that meet the client's needs.

Competency sub-components

- Analyze the types of contracts that meet the client's needs;
- Analyze the riders that meet the client's needs.

4
INSURANCE TO PROTECT SAVINGS

Almost everyone strives to earn a living: to have sufficient income to look after their family and to have a little left over for recreation. An equally important part of the process is to be able to put some funds aside for savings: both a “rainy day” emergency fund for the present (in the event of illness, unemployment or unexpected expenses) and a retirement fund for the long term. Unfortunately, extra, sometimes unexpected expenses can come along to drain savings. Some expenses are difficult to avoid, like vehicle repairs and home maintenance, and cannot be fully protected against. Many health care expenses (prescription drugs, dental care, emergency care, etc.), whether predictable or not, can significantly drain cash flow and savings, leaving one without an adequate emergency fund and impairing the ability to save adequately for retirement. Fortunately, there are many avenues available for persons to acquire extended health insurance, to at least partially, or fully, fund these expenses and relieve individuals of their financial stress.

4.1 Types of extended health coverage to protect savings

In this Chapter, the most common sources of extended health insurance coverage are explored, and compared and contrasted:

- Individual extended health insurance, including travel insurance;
- Group extended health insurance.

Banks and other financial institutions (credit unions, trust companies, caisses populaires) also may offer a form of extended health coverage to their credit customers, but this coverage is usually quite limited and is not sufficiently widespread to be addressed here.

4.1.1 Individual extended health insurance

An individual extended health insurance policy is purchased directly from a representative of the issuing insurance company. The plan is owned by, paid for by and usually payable to the applicant. The terms of the plan can be customized to the needs of the applicant, who can terminate the contract at any time. Individual plans are used to “top up” the protection provided by the provincial health care plans by those who are not members of a group plan, or to enhance coverage provided by a group plan for those who are members of such a plan.

4.1.2 Group extended health insurance

By far the greatest number of people covered by extended health insurance, other than through provincial health care, receives coverage via a group plan, typically provided by their employer. Group plans usually offer a package of benefits along with some options, such as family coverage. Group plans cover several individuals with a common factor, such as employment or occupation. They are offered by employers to their employees and by associations whose members are not employed by the same employer but who have some other element of commonality.

4.2 Types of individual extended health coverage

Individual extended health coverage options generally parallel those available with group plans:

- Medical care;
- Dental care;
- Travel insurance.

All of these coverages may be combined in one contract (as with a group plan) or policies may be acquired that offer only one or more coverages, as meets the needs of the individual client. One of the advantages of an individual contract (as contrasted with group coverage, which is a “package deal” of pre-set benefits and limits) is that the insured can pick and choose what types and levels of coverage to include in the contract. Similar to selecting a deductible under an automobile policy, the prospective insured may have a range of deductible and co-insurance levels and annual maximums to choose from, to suit his needs and budget.

Individual extended health policies are subject to full medical underwriting prior to issue, except for travel insurance, for which underwriting generally occurs at time of claim.

4.2.1 Medical care

Most residents of Canada are covered by provincial health care plans. For those few newly arrived who are not yet covered, due to a waiting period, individual medical insurance provides protection against the costs of regular or emergency medical care, whether in a hospital or in the doctor’s office. For other Canadian residents, an individual insurance policy will fill in the gaps between their needs and the coverage provided under the provincial plans (chiropractic services, for example). Even those individuals who are members of group plans may want to “top up” or otherwise augment their provincial and group coverages with a customized individual policy.

4.2.1.1 Coverage provided

The types of coverage available under individual medical care plans cover most of the medical and related services required by insureds:

- Extended health care (for hospital or home care medical services not covered under the provincial plans);
- Prescription drugs;
- Accidental death and dismemberment (AD&D);
- Dental care;
- Vision care;
- Emergency travel medical services.

As mentioned earlier, the applicant for individual extended health insurance can choose what types and levels of coverage to include in the contract. He may have a range of coverage, deductible and co-insurance levels and annual maximums to choose from, to suit his needs and budget. Within contractual restrictions, the policy can be as limited or broad as he wishes.

4.2.1.2 Deductibles and co-insurance

The insurance company's exposure to claims can, in part, be managed through the imposition of deductibles and a co-insurance factor: provisions that require the insured to pay at least a portion of the qualifying medical expenses himself. While co-insurance factors are common to both individual and group policies, deductibles are much rarer in individual contracts.

A deductible is a dollar amount of otherwise qualifying expenses that must be paid 100% by the insured before the plan picks up any of the expense. Deductibles are applied annually and start anew each year.

EXAMPLE

Jose's plan has a $100 annual deductible for dental benefits: he must pay the first $100 of dental expenses annually himself, without reimbursement from his plan.

The co-insurance factor indicates the percentage of a qualifying expense that will be covered by the plan and, by default, the percentage that would have to be paid by the insured himself. In addition to the insured's coverage being somewhat restricted by the co-insurance factor, it is also subject to coverage limits.

EXAMPLE

Consuela has purchased an individual extended health policy that has an 80% co-insurance factor for dental claims. The plan pays for 80% of each claim and Consuela assumes responsibility for the other 20%.

Deductibles and co-insurance factors help to reduce premiums, first by shifting some of the burden for qualifying expenses from the insurance company to the insured. Secondly, the fact that the insured will be responsible for at least part of the cost of covered products or services tends to discourage undiscerning use of products and services by the insured and, therefore, unnecessary claims.

4.2.2 Dental care

Because most of the provincial health care plans do not offer coverage for dental fees and appliances, dental care is often a mainstay of any extended health insurance plan.

4.2.2.1 Coverage provided

Benefits provided under an individual dental plan fall into one of two categories: routine maintenance and major restorative services.

Routine maintenance includes such items as:

- Regular check-ups;
- Periodic x-rays;
- Cleaning;
- Fillings;
- Extractions.

Regular maintenance items are covered to an annual maximum amount, perhaps $1,000, and are subject to the policy's basic co-insurance factor, with the insured usually having to pay in the 20% to 25% range.

Major restorative services include such things as crowns and inlays and are usually subject to a much higher co-insurance factor, generally 50%.

The amount that insurance will cover is based on a fee schedule set by the provincial dental associations and revised periodically. Amounts of fees in excess of the schedule are not covered.

EXAMPLE

Igor's dentist charges $300 for a basic tooth extraction. The provincial dental schedule sets the price of a standard extraction at a maximum of $225. Igor will have to pay the difference of $75 himself, since his dental coverage is restricted to the amount specified in the schedule. The policy's co-insurance factor will further increase the amount he must pay.

For extensive work, often in the range of $500 or more, most insurers will require that the insured have the dentist submit an estimate in advance, for a predetermination of coverage, so that he knows how much of the cost will be covered.

4.2.2.2 Deductibles and co-insurance

Deductibles and co-insurance factors for dental coverage are similar to those outlined above, and are used to manage premiums for individual extended health coverage in general. However, dental coverage is the area in which deductibles and co-insurance are most prevalent. At least some of the cost (or, in many cases, all of the cost) for medical services, like doctor's office visits and hospital stays in a ward room are covered by the provincial health care plans; therefore, the insurer's exposure to health care expenses is limited to such items as a hospital stay in a semi-private room, or medical appliances, like wheelchairs and crutches. Most provincial plans offer little or no coverage for dental services, leaving the full responsibility for cost to the individual and his insurance company.

4.2.3 Travel insurance

The term "travel insurance" is an umbrella name for a wide variety of coverages for those who travel outside of their home province. Plans may offer some or all of the following protections:

- Emergency medical expenses;
- Costs for lost or damaged luggage;
- Trip cancellation;
- Return of an ill or injured traveller to his home, etc.

Provincial health care benefits differ from province to province, so an expense covered in one jurisdiction might not be covered in another. Consequently, the individual insured may have to cover expenses out of pocket and then seek reimbursement, over and above the provincial coverage, from the insurer.

With the cost of hospitalization being generally higher abroad than it is in Canada, the need for travel insurance to offset the risk of catastrophic medical expenses for travellers outside the country is critical.

In the past, travel insurance was obtained primarily directly from insurers or from travel agents. Over the last decades the availability of travel insurance has grown to the point where coverage is available from a wide variety of sources, including financial institutions, airlines and online providers. In some jurisdictions an insurance license is not required to sell this type of product.

For all types of issuers, medical underwriting of the coverage is generally done retroactively, at time of claim, not when the policy is issued.

Although availability may be broad-based, this does not mean that all travellers are adequately covered. It is important for the insurance agent to consider his clients' travel insurance needs and determined whether or not the coverage they could have purchased from other providers is appropriate.

4.2.3.1 Coverage provided by an insurer

The most comprehensive travel insurance coverage can be obtained by purchasing a customized contract directly from an insurer or its representative. Coverages available include, among others:

- Doctors' and nurses' fees;
- Hospitalization costs;
- Medical equipment;
- Ambulance services;
- Dental costs for accidental injury;
- Return of the injured traveller to his province of residence;
- Return of a deceased traveller's remains to his province of residence;
- Return of the insured's vehicle to his province of residence;
- Lost baggage insurance;
- Trip interruption or cancellation due to illness.

In addition, it is normal for the insurer to issue the insured with a card with the name and number of a provider that can be contacted in the event of an emergency. The contact can provide the insured with such assistance as the names and addresses of medical professionals or directions to the nearest hospital, or can order an ambulance to assist in an emergency situation.

4.2.3.2 Coverage provided through a credit card

Many credit cards offer travel insurance protection, either as standard coverage automatically provided with the issuance of the card or as an option. However, the coverage provided is often more limited than the one that can be obtained directly from an insurer and may vary greatly depending on the issuer and the type of card. Most importantly, credit card travel insurance is issued automatically, without any form of medical evidence being required. At time of claim, the issuing insurer's underwriting department seeks to determine whether the cause of the claim is covered under the terms of the coverage. Of particular concern to the insurer is whether the claim can be attributed to a pre-existing condition (in place for anywhere up to six months prior to the date of departure on the trip), in which case the claim may be voided. This leaves the "insured" with an element of uncertainty about whether a claim might be honoured, versus policies that are subject to even basic underwriting, so that the issue of pre-existing conditions might be resolved up front.

4.2.3.3 Pre-existing conditions

Since the coverage is typically issued with little or no medical underwriting "up front," underwriting takes place at claim time. In many cases a common reason for the denial of a claim is that the expense incurred was the result of a "pre-existing condition." Generally, a pre-existing condition is considered to arise if, during a period of anywhere from 90 to 180 days (depending on the contract) prior to departure on the insured's trip, the insured:

- Saw a doctor for specific symptoms requiring treatment;
- Underwent tests, or additional tests were recommended by a doctor;
- Had treatment for the condition;
- Was prescribed medical tests or treatment, or had a prescription changed prior to the trip for which the coverage was required.

In extreme circumstances, even failing to disclose that the prospective insured is taking a daily baby aspirin as a preventative measure against stroke or heart attack could be viewed as non-disclosure of a pre-existing condition (medication) leading to denial of a claim, even one unrelated to stroke or heart attack.

Conditions that were diagnosed prior to the 90- or 180-day period but which are chronic (like diabetes) may also result in restricted coverage if the individual is not under the care of a physician and symptom-free for up to one year prior to departure on a trip. For example, an insured might be required to be able to demonstrate that he has been symptom-free of diabetes for a minimum of one year to qualify for full coverage.

The existence of a pre-existing condition will not void all coverage, but a claim may be denied if treatment is required specifically related to the pre-existing condition.

EXAMPLE

Antonio, a resident of Québec, scheduled a 30-day trip to his native Italy. Before departure he took out travel insurance through his local credit union. Antonio has been taking medication for epilepsy for the past 12 years, medication that does not always fully control his symptoms. If Antonio were to require treatment due to an epileptic seizure while in Italy, his treatment expenses would not be covered. On the other hand, if Antonio was injured in an automobile accident while travelling from the Rome airport, due to the carelessness of his taxi driver, his resulting medical expenses would be covered by his travel insurance policy.

4.2.3.4 Benefits

The payment of benefits is often provided on a reimbursement basis. The insured is often expected to pay for the services received up front and then submit the claim to the insurance company, allowing for any portion of the claim to be covered by a provincial health insurance plan.

The insured is expected to contact the insurer's representative immediately upon admittance to hospital and prior to undergoing surgery, in any event. Failure to contact the insurer promptly could result in a reduction of benefits or denial of claim.

Contractual exclusions are particularly important in travel insurance policies. Most policies include those exclusions that are common to almost all insurance contracts. There would be no coverage for emergencies stemming from:

- Attempted suicide;
- Self-inflicted injuries;
- Act of war;
- Normal pregnancy;
- Drug or alcohol abuse.

In addition, there could be many excluded causes not common to other types of insurance:

- Engaging in hazardous activities (such as hang gliding, parasailing or scuba diving);
- Travelling to countries on a "watch list";
- Medical treatment in non-emergency situations.

4.2.3.5 Factors affecting premiums

The two most important factors impacting travel insurance premiums are the amount of coverage and the number of days that the traveller expects to spend outside his province of residence.

The greater the amount of coverage and the more risks that the policy covers, the bigger the premium. For example, a policy that includes trip cancellation insurance will cost more than a policy that doesn't.

The longer the trip, the higher the premium cost. However, the premium will not necessarily be proportionately higher (for example, a 30-day policy will not cost three times as much as a 10-day policy) because there is a basic processing fee attached to any policy, regardless of the length of the trip.

The traveller's proposed destination can also have a significant impact on premium.

- Someone travelling to another province in Canada, where provincial coverages are similar (but not necessarily identical) and costs are low in comparison to other jurisdictions (like the United States), is going to pay a relatively low premium.
- Someone travelling outside of Canada, particularly to the United States (where hospitalization costs can run much higher than those of Canada), will be required to pay a much higher premium.
- Some destinations, particularly in the Middle East and Latin America, are considered high-risk and command more expensive insurance premiums as a consequence.
- Other destinations may be so high-risk that insurers will not issue coverage.

Lastly, the age and medical history of the traveller can have a major impact on premiums. Older individuals, particularly those over age 65, are more susceptible to injury and illness and so pay a much higher insurance premium than younger ones.

EXAMPLE

Trent, age 60, applied for a deluxe travel insurance package for a 21-day trip outside Canada and was quoted a premium cost of $698. His associate, Quince, age 40, booked the same plan for 21 days for $554.[27]

27. RBC Insurance. *Travel insurance quote and online application*. [online]. [Consulted August 3, 2017]. https://www.worldprotect.com/cgi-bin/weblinkca/en/travel-insurance.cgi

4.2.4 Taxation of individual extended health insurance premiums and benefits

Premiums paid for individual extended health coverage are not deductible for income tax purposes but may qualify for the federal medical expense tax credit. Benefits are received tax-free.

4.3 Group extended health coverage

Group extended health insurance is structured to cover a broad range of medical services and products not covered, or not fully covered, by the provincial health care plans. It offers coverage to group members and their families without medical underwriting. Its benefits are usually subject to deductibles and co-insurance clauses.

4.3.1 Types of coverage

The following types of coverage are almost universal to group plans, to some degree or another:

- Prescription drugs;
- Enhanced medical and hospital care;
- Dental care;
- Vision care;
- Accidental death and dismemberment (AD&D).

4.3.1.1 Prescription drugs

Every group insurance plan that offers health care benefits will include a prescription drug plan. Every day hundreds of thousands of people across the country avail themselves of pharmaceuticals (drugs) to treat an almost endless variety of illnesses and conditions.

First and foremost, these drugs are divided into two broad categories: prescription and non-prescription (or over-the-counter) drugs. Prescription drugs cannot be acquired legally without a prescription from a medical professional, such as a medical doctor or dentist, and must be obtained from a pharmacist. Over-the-counter drugs, such as aspirin, may be obtained at virtually any drug store, grocery store, variety store, etc., without a prescription, simply by taking the drug in question to the checkout counter. It is only the cost of prescription drugs that is covered by group health insurance plans.

Covered prescription drugs are further subdivided into two categories: brand-name and generic. A brand-name drug is manufactured by the pharmaceutical corporation that researched and developed it. The company's investment (which can run into hundreds of millions of dollars) is protected by a patent. Once the patent runs out, other manufacturers will be free to make and sell

their own version of the same drug, the generic version, with similar properties to the brand-name version. However, because the manufacturers of generic drugs are not burdened with massive research and development costs, the generic drugs typically sell at a much lower price than their brand-name counterparts.

Each insurance company will have a formulary (a list) of the drugs that are covered by the group plan, the types of drugs covered within that list (brand-name or generic) and the price that the insurer will pay for a covered drug. If the plan member insists on receiving the brand-name rather than the generic drug, the member will usually be covered or reimbursed only for the cost of the generic drug, having to pay the difference between the two himself.

4.3.1.2 Enhanced medical and hospital care

Although all provinces and territories offer their residents health care, the services and products provided by these plans are not wholly comprehensive. The enhanced medical (also called enhanced health care) benefit offered under group plans is designed to “top up” or otherwise supplement benefits offered through the provincial plan.

The enhanced medical benefit covers professional and semi-professional medical and related services not insured by the provincial health care plans. This might include the services of the following practitioners, among others:

- Chiropractors;
- Massage therapists;
- Naturopaths;
- Optometrists.

The benefit often covers other medical expenses like transportation by ambulance, and such medical equipment as crutches, wheelchair rental and oxygen equipment, to a maximum annual limit.

The hospitalization coverage is generally structured to provide for an upgrade in accommodations, where available, up to a maximum daily dollar amount and for a maximum number of days.

EXAMPLE

As a resident of Ontario, Jonah is entitled to a ward bed in a hospital, paid for entirely by the provincial health plan, if he is ill or injured and requires hospital treatment. His group plan will pay the difference if Jonah wishes to upgrade to a semi-private room. If Jonah wants a private room, he will have to pay the difference in cost between semi-private and private accommodation himself.

Enhanced medical or hospital benefits are not usually subject to an annual deductible, but may incur a co-insurance payment on the part of the insured member.

4.3.1.3 Dental care

Dental care is, for most group insurance plans, the most significant and the most costly element. Generally speaking, provincial health care does not cover dental expenses, excepting emergency medical dental care in the event of an accident. This leaves the entirety of dental expenses to be covered by the individual or his insurance company. And those expenses can easily run into hundreds, or thousands, of dollars a year.

Four main reasons help explain why those costs are magnified for group dental coverage:

- Costs of dental care are high;
- Group dental coverage often includes the family of the group plan member;
- Access to dental care is discretionary (not merely on an emergency basis) and does not need a referral from a physician;
- Premiums for the coverage (or at least the plan member's personal coverage) are usually covered by the sponsor of the plan (employer) if any.

The way to control costs is to incorporate deductible and co-insurance charges, and annual and lifetime maximums on some services.

Dental care typically covers annual or semi-annual teeth cleanings, periodic check-ups, x-rays, fillings, extractions and restorative work. Orthodontic work may be covered but, if so, will be subject to maximum limits and will typically require a submission of proposed procedures and costs by the dentist or orthodontist, to predetermine how much, if any, of the proposed work will be covered by the group plan.

Purely cosmetic dental work (caps, teeth straightening or whitening) is typically excluded from coverage.

4.3.1.4 Vision care

Vision care coverage is another standard feature for most group health plans. This benefit provides a reimbursement supplement for a variety of expenses incurred to assist with visual impairment:

- Prescription eyeglasses;
- Contact lenses;
- Optometrist fees (where not covered by provincial health plans).

Eyeglasses (both lenses and frames) and contact lenses are covered if prescribed by an optometrist. The maximum benefit is usually in the $100 to $350 range every 24 months, provided the glasses are either a first pair or are recommended by the optometrist owing to a change of prescription. Not all plans will also cover optometrist's fees. If they are covered, a maximum dollar amount will be applied every 24 months.

4.3.1.5 Accidental death and dismemberment (AD&D)

Accidental death and dismemberment (AD&D) coverage is common to most group insurance and individual extended health insurance plans. It pays a benefit if the plan member dies, loses or permanently loses the use of a limb, hearing or eyesight as the consequence of an accidental occurrence (as contrasted with illness or a medical condition, such as diabetes).

In the case of accidental death, a fixed amount (known as the principal sum) is payable to the plan member's named beneficiary. For loss of a limb, sight, etc. a lesser amount (a percentage of the principal sum) is payable, depending upon the severity of the loss (for example, the loss of two limbs would result in a greater benefit than the loss of one limb). Table 4.1 is a sample schedule of the level of benefits payable under an AD&D policy for a few types of loss.

TABLE 4.1

Sample accidental death and dismemberment schedule of loss

LOSS	BENEFIT AS A PERCENTAGE OF THE INSURED AMOUNT
Loss of life	100%
Loss or loss of use of both arms or both legs	100%
Loss or loss of use of one arm or one leg	75%
Complete loss of sight in both eyes	100%
Complete loss of sight in one eye	67%
Complete loss of hearing in both ears	75%
Complete loss of hearing in one ear	33%

To qualify for benefits the death, or the loss, must occur within one year (365 days) of the accident and the loss must be as the direct result of the accident.

4.3.2 Benefits

Benefits under group extended health care coverage may not cover all possible expenses, nor may they be immediately payable to the plan member. There are, of course, expenses that may not be covered by a given plan. And many benefits (vision care and dental, for example) are subject to annual maximums as well as co-payments. For example, benefits may provide for

12 professional visits per year, at a maximum of $100 a visit, or simply a maximum benefit of $1,200 in total, regardless of the number of visits.

Typically, an extended health group plan will provide benefits on either a reimbursement or a direct billing (see below) basis, but some plans may provide some benefits (like prescription drugs) using direct billing and others (like dental care) strictly on a reimbursement basis.

4.3.2.1 Deductibles and co-insurance

Most plans require an element of co-payment on the part of the plan member, to keep the group plan costs (and, by extension, the premiums payable by an employer) under control. The two types of co-payment by plan members are annual deductibles and co-insurance factors.

Once the annual deductible has been absorbed by the plan member, additional expenses will qualify for payment or reimbursement by the plan.

EXAMPLE 1

Clarissa is a member of a group plan that has an annual $100 deductible on dental benefits. Clarissa filed her first claim for the current year last month, an $80 bill for dental x-rays. She paid the bill herself and then submitted the bill to her group plan administrator, for the record. The group plan did not reimburse Clarissa anything, but her deductible for dental benefits for the current year was reduced to $20 ($100 - $80).

EXAMPLE 2

Tomas is a member of the same group plan as Clarissa. His first dental claim of the year was $800 for a complicated extraction, requiring a general anesthetic. Tomas submitted his claim but was not reimbursed for the first $100 of the claim, due to the deductible. The balance of $700 ($800 - $100) qualified for reimbursement under the group plan.

In circumstances where group extended health insurance covers both the plan member and his family members, there may be two types of annual deductible: an individual deductible and a family deductible. The family deductible is usually greater than the individual deductible. Once any member of the family has filed claims sufficient to use up his or her individual deductible, no further deductible will apply to that person for the current year. Application of the individual deductible to claims arising from any member of the family will, in turn, reduce the family deductible dollar-for-dollar. Once the family deductible has been used up, individual deductibles will no longer apply to any family members for the current year, regardless of whether their individual deductibles have been used.

EXAMPLE

John and Marsha are a married couple with one child, Colton. John is a member of a group extended health insurance plan that covers his whole family. For dental claims, the plan has a $100 individual deductible and a family deductible of $250.

In February of the current year, John filed a dental claim for $80. He received no reimbursement, but his individual deductible was reduced from $100 to $20 and the family deductible was reduced from $250 to $170.

In March, Marsha filed a dental claim for $120. Her individual deductible was reduced to $0 and the remaining family deductible was reduced from $170 to $70. Consequently, $20 of the claim qualified for reimbursement.

In May John filed another dental claim for $100. His remaining individual deductible was reduced from $20 to $0 and the remaining family deductible was reduced from $70 to $50. $80 of the claim qualified for reimbursement.

In July a claim was filed for $70 of dental expenses for Colton. With a family deductible of $50 at that time, $20 of the claim for Colton qualified for reimbursement. The family deductible is now reduced to $0.

In September an additional claim for $130 of dental expenses was filed for Colton. The entire $130 qualified for reimbursement, because the family deductible had already been reduced to $0.

In addition to the deductible, which applies annually and starts anew every year (based on the anniversary of the date of initiation of the group contract), some benefit claims are also subject to the co-insurance factor, which applies against every claim once the deductible has been eliminated. Co-insurance factors are most commonly found in relation to dental benefits, but may apply to other benefits as well, depending on the plan. In the case of claims filed early in the year, or where few claims are filed by a plan member, both a deductible and a co-insurance factor could apply.

EXAMPLE

Kashif is a member of an employer's group insurance plan that has a $100 annual deductible and a 80% co-insurance factor for dental claims. Last week Kashif went to the dentist and had two extractions and some other work done, costing $800. Kashif paid the $800 bill himself and submitted a claim for $800 to the group plan administrator, his first claim of the current year. The first $100 was not reimbursed because of the plan's $100 deductible (but the deductible was reduced to $0 for future claims for the current year). Of the remaining $700 of the claim, the group plan reimbursed Kashif $560, 80% under the co-insurance factor ($700 × 80%). In total, the plan paid $560 of the $800 claim and Kashif paid $240 ($800 – $560).

4.3.2.2 Reimbursement

For a plan operating on a reimbursement basis, the plan member must pay for the covered product or service up front and then file a claim, with accompanying receipts, with the administrator of the plan. The administrator will then pay the member, by cheque or direct deposit to his bank account, for that portion of the claim covered by the plan.

4.3.2.3 Direct billing

In the case of group plans that pay for products or services (such as prescription drugs or dental care) on a direct billing basis, the plan member is given a membership card, or the plan is registered with his pharmacist, dentist, etc., and covered expenses are billed directly to the group plan. The only portion of expenses that the member has to pay up front would be for those not covered by the plan or costs in excess of the plan limits (e.g., the difference between the cost of brand-name and generic drugs, if the patient insisted upon receiving the brand-name product) or the excess over what the plan covers where the dental or pharmacy plan has coverage limits.

4.3.3 Taxation of group extended health insurance premiums and benefits

Under employer-sponsored group plans it is normal for the employer to pay 100% of the premiums for the employee coverage, although premiums for family coverage may have to be assumed by the employee/group plan member. In most provinces and territories across Canada employer-paid premiums for group health care coverage are a deductible expense to the employer but are not considered a taxable benefit in the hands of the covered plan member. Employee-paid premiums are not tax-deductible but may qualify for the medical expense tax credit. Benefits received under the group plan are also tax-free to the plan member and his family.

The exception is found in the province of Québec, where employer-paid premiums for group health care coverage are a deductible expense to the employer but are also treated as a taxable benefit to the covered plan member for the calendar year in which they are paid. Benefits received under the group plan are tax-free to the plan member and his family.

4.3.3.1 Premiums and the medical expense tax credit

In the case of most group benefit plans, group health premiums are paid 100% by the sponsoring employer. However, in non-employer group situations (e.g., association groups), where the extended health coverage premiums are paid by the group member, the premiums are not deductible by the member, but are a qualifying expense for the medical expense tax credit.

4.3.4 Integrating an individual policy with a group policy

It was noted above that persons who do not have access to group insurance extended health benefits often access individual coverage in order to supplement the benefits provided by the provincial health care plans. However, those who already have group coverage may also consider acquiring an individual contract to "top up" their group coverage or fill in coverage gaps that might arise due to coverage limits, co-insurance limits or simply because the coverage is not provided under the group plan.

EXAMPLE

Aarne is 38 years old, married and the father of two pre-teen girls. He is a resident of British Columbia and his whole family has basic health coverage through the universal provincial government plan. Additionally, Aarne participates in the group benefits plan where he works, which offers, among others, group extended health benefits. Aarne is concerned, however, that the group plan, which is fairly basic, may not meet all of his family's needs, for the following reasons:

- It offers no accidental death and dismemberment coverage;
- It only allows for vision care benefits to a maximum of $100 every two years;
- It limits orthodontic dental care to a maximum of $2,500 lifetime, per insured person;
- Orthodontic dental care is covered to a degree, but with a 50% co-insurance factor;
- Hospital coverage will only pay for semi-private accommodation.

Aarne believes that the group plan leaves him less protected than he would like. His father lost an arm in a construction accident, so he sees AD&D coverage as a necessity. All of his family members wear glasses, so he feels that generous vision care benefits are important. With two daughters about to enter their teenage years, he can see large bills for orthodontic appliances looming in the near future. To resolve his concerns Aarne took out an individual extended health policy, with family coverage, structured to provide the following benefits:

- AD&D coverage;
- Vision care benefits of up to $250 per family member, every year;
- Orthodontic dental care coverage to a maximum of $2,500 a year with no co-insurance factor (thereby doubling his coverage and eliminating the 50% co-insurance concern on the first $2,500 of expenses);
- Private room hospital coverage (to avoid the extra expense of a private room over and above what the group policy provides).

4.4 Comparing individual and group policies

Table 4.2 highlights some of the characteristics of individual and group extended health coverage, comparing one type of plan to the others under various categories.

TABLE 4.2

Characteristics of individual and group extended health insurance policies

CHARACTERISTICS	INDIVIDUAL POLICY	GROUP POLICY
Policyholder	Applicant/insured	Sponsor of the group plan
Control by the life insured	Insured has full control over the policy coverage	Plan member has some control over coverage selected but not over the master contract
Portability	Fully portable	Coverage terminates if the plan member leaves the group
Underwriting at time of application	Yes – usually fully underwritten	No underwriting for basic coverage – potential underwriting for enhanced or additional coverage
Retroactive underwriting, at time of claim	No – claims adjudication by the insurance company's claims department only	No – claims adjudication by the claims department only
Premiums	Based on the underwriting characteristics of the insured	Based on the generic makeup of the group as a whole and the claims history of the group
Premium costs	Relatively high compared to group policy	Generally lower than for an individual policy
Variety of benefits	Highly flexible with the capacity to customize the policy	Fairly extensive but subject to the limitations of the master contract
Availability of family coverage	Yes – available for an extra premium	Yes – paid for by the plan member
Coverage levels	Fairly rigid maximum coverage levels	Levels of coverage generally higher than for individual policies
Pre-existing conditions	Pre-existing conditions will typically be excluded by a rider at time of policy issue	Because there is no medical underwriting, pre-existing conditions are covered by the plan
Possibility of sharing costs	No – 100% paid for by the insured	Yes – premiums may be paid 100% by an employer or shared
Deductibles	Not usually a deductible	Yes – with most plans, particularly in regard to dental care

CHARACTERISTICS	INDIVIDUAL POLICY	GROUP POLICY
Co-insurance	Co-insurance usually applies	Yes – with most plans, particularly in regard to dental care
Taxation of premiums and benefits	Premiums qualify for medical expense tax credit	Premiums paid by the employer are deductible for the employer and do not constitute a taxable benefit for the employee (except in Québec)
	Benefits are tax-free	Benefits are tax-free

CHAPTER 5

INSURANCE TO PROTECT BUSINESSES

Competency components

- Analyze the available products that meet the client's needs;
- Implement a recommendation adapted to the client's needs and situation.

Competency sub-components

- Analyze the types of contracts that meet the client's needs;
- Propose a recommendation adapted to the client's needs and situation.

5
INSURANCE TO PROTECT BUSINESSES

Many of the disability and accident and sickness (A&S) insurance plans dealt with in earlier chapters of this Module relate to income protection and health benefits of individuals, whether owners or employees of businesses, or the self-employed. There is also a whole field of disability insurance (DI) designed to protect the businesses themselves in the event of the disability either of an owner or of an employee who is critical to the success of the business. These plans include:

- Disability business overhead expense (BOE) insurance;
- Business loan protection;
- Disability buyout coverage;
- Key person coverage.

Before looking in detail at how these plans work and the benefits they provide, it is important to understand the different types of business structures and the various risks faced by business owners.

Additionally, this Chapter will touch on some of the less common insurance benefits offered by businesses to their owners and employees, such as health and welfare trusts (HWT) and health spending plans.

5.1 Forms of business ownership

The type of business structure an individual (or group of individuals) chooses for business operation can impact a wide variety of issues, including the simplicity of operating the business, the administrative costs of operating the business, the tax rate at which business profits are taxed and the degree to which the business owner is personally exposed to the liabilities (including creditors) of the business. The following types of business structures and some of their advantages and disadvantages are described in detail in this section:

- Sole proprietorships;
- Partnerships;
- Corporations.

5.1.1 Sole proprietorship

A sole proprietor is the only owner of an unincorporated business. Sole proprietorships encompass a wide variety of business enterprises, from consultants to independent tradesmen to artists and so on. In fact, by far the majority of businesses operating in Canada are sole proprietorships.

The main attraction of a sole proprietorship is that it is inexpensive and easy to set up and operate. Some provinces require that a sole proprietorship business be registered with the province, for a relatively modest fee.

The primary downside to operating a sole proprietorship is that the business financial affairs of the proprietorship and the personal financial affairs of the sole proprietor are inseparable. The net income of the proprietorship is income of the proprietor, to be reported on his personal income tax return. There is no opportunity for the business income to be taxed at a separate, lower rate as there is with an incorporated business. And the personal assets of the sole proprietor are exposed to the business creditors of the proprietorship.

5.1.2 Partnership

A partnership involves two or more individuals carrying on a business together with a view to making a profit. The partners share in the net profits or losses of the business.

Partnerships are more complex than proprietorships. Revenues and expenses are computed at the partnership level and net income is reported to the individual partners, pro rata, according to the terms of a partnership agreement. Income tax is not computed at the partnership level, but the net income is reported to the partners and taxed at each partner's personal marginal tax rate.

The prime disadvantage to the partnership structure is that partners may be jointly liable for debts and liabilities of the partnership. For example, a lawsuit filed against the ABC partnership as a consequence of the negligence of partner A could also be the responsibility of partners B and C, even though they had no role in creating the liability.

5.1.3 Corporation

A corporation is a separate legal and tax entity – separate from its owners – the shareholders. The corporation itself carries on business through the efforts of its owner/operator(s) and employees. Ownership of the corporation is in the form of shares, which represent a pro rata interest in the net value of the corporation. For example, someone who owns 5% of the outstanding common shares of a corporation owns 5% of its net value. Control of the corporation is affected through share voting rights. Corporations may be small, closely held businesses (with as few as one shareholder) or large, multinational operations, with perhaps hundreds of thousands of shareholders.

Corporations are legal entities separate from their shareholders, such that the liabilities of the corporation do not become the liabilities of their shareholders. Corporations are taxed on their net income, often distributing their after-tax income to shareholders in the form of dividends, which are taxed in the hands of the business owner at substantially lower rates than salary or interest.

Corporations are divided into two general categories: private and public.

5.1.3.1 Privately held

Privately held corporations do not offer their shares for purchase to the general public. The shares are owned by a limited number of shareholders, sometimes only one, who are typically owners/operators of the business. A private (or closely held) corporation is generally established to operate a business either for tax advantages and/or protection for owners from the creditors of the business.

In Canada, the net income of a private operating company is taxed at a low rate. If a shareholder, who may be in a 45% marginal tax bracket, does not require current access to all of the net income generated by the business, the corporation can be an effective tool for deferring tax on the profits of the company.

EXAMPLE

Willy operates a business that has net income of $200,000 a year, only $150,000 of which is needed to maintain Willy's personal standard of living. He is in a 45% marginal tax bracket. If he operates a sole proprietorship, the "extra" $50,000 is subject to $22,500 of income tax ($50,000 × 45%), leaving Willy with $27,500 ($50,000 – $22,500) to invest.

On the other hand, if Willy's business was incorporated, the $50,000 of undistributed income would likely be taxed at about 15% in the corporation, leaving about $42,500, after-tax, ($50,000 × (1 – 15%)) to be invested within the corporation. The extra $15,000 ($42,500 – $27,500) accumulated after-tax annually would be subject to tax in Willy's hands if it was ever withdrawn from the corporation, but affords Willy much more investment capital in the meantime.

5.1.3.2 Publicly held

Public corporations, like Bell Canada, often have tens (or hundreds) of thousands of shareholders and their shares are usually traded freely on a public stock exchange. Their shareholders are not owners/operators, but merely investors, who hold the shares for their income (dividends) or growth (capital gains) potential. As such, the shareholders are not exposed to the liabilities of the corporation.

5.2 Risks to the business owner

In the operation of a business, business owners must often deal with three risks specific to the operation of a business, all of which are related to the risk of disability:

- Risk of being unable to work due to disability;
- Risk of being unable to sell the business – a need triggered by disability;
- Loss of a key employee to disability.

All three of these risks need to be examined in some detail and all can be mitigated through the use of proper documentation and specific forms of disability insurance.

5.2.1 Inability to work

Whether a sole proprietor, a partner or the owner or co-owner of an incorporated business, the business owner's ability to earn an income and meet obligations to creditors (suppliers, the bank, the Canada Revenue Agency, etc.) rests primarily on his ability to work and generate revenue. That ability can be compromised, sometimes permanently, due to disability arising from accident or illness. A 45 year-old male (a fairly typical age for a business owner) has about a 40% chance of suffering a disability lasting longer than 90 days prior to age 65. And the average duration of such a disability is 4.3 years. In the case of two partners or co-shareholders, both age 45, owning and operating a business, the likelihood that at least one of them will experience a disability lasting 90 days or longer prior to age 65 rises to 62.5%.[28] These risks become slightly more pronounced for younger individuals and slightly less pronounced for older ones. Statistics such as these[29] illustrate the significant risk to financial security to which business owners are exposed: risk could imperil their financial security and their retirement plans.

5.2.2 Inability to sell the business

A business owner's business interest is usually his most significant asset: greater than a home, registered retirement savings plan (RRSP), investment portfolio, pension or any other asset. The business is the owner's source of current income, the primary retirement asset and, in a worst case scenario, emergency fund. But the business can only fulfil these roles if it can be sold at the discretion of the owner, within a reasonable time frame and for a fair price.

28. Transactions of Society of Actuaries. *Group long-term disability (GLTD) valuation tables*. Vol. 39, 1987.
29. For more recent and detailed Canadian statistics, consult Appendix A, at the end of this Module.

5.2.2.1 In the event of disability

A business owner who becomes disabled may be forced to sell the business in order to maintain a reasonable standard of living. Where the onset of disability is sudden – leaving little or no time for advanced planning – a number of obstacles to a successful sale may arise:

- How to identify a potential buyer;
- How to convince such a buyer to commit to acquiring the business;
- How to negotiate a fair price – particularly if the seller is negotiating from a position of weakness: the need to sell;
- How to ensure that the buyer has sufficient resources to execute the sale and to do so in a timely fashion.

Every day that the sale is delayed while these obstacles are being overcome – if they can be overcome – the likelihood of achieving a sale at a fair price diminishes. And the business owner's interest isn't the only thing at risk due to his disability. Employees of the business will be concerned about the security of their jobs in the absence of the owner. And co-owners may be burdened with sharing business profits with a non-productive disabled co-owner or concerned about having to work with the spouse or other family members of the disabled owner.

5.2.3 Loss of a key employee

A "key employee" is one who contributes materially to the success of the business and whose skills and services would be difficult to replace. The business may rely substantially, or fully, on the services of the key employee. If the employee should leave the business (quit, retire, die or leave for any other purpose), particularly if the parting is sudden, the financial survival of the business – and by extension of the business owner – could be at risk.

5.2.3.1 In the event of prolonged disability

The disability of the business owner or a co-owner is not the only disability risk: the loss of the services of a key employee to disability could equally cripple the business. This loss might make it impossible for the business to function effectively if the disability is total and lasts for several months, or longer.

Fortunately, the impact of these risks can be reduced or eliminated with proper insurance planning.

EXAMPLE

Matti's sole proprietorship printing business relies heavily on the efforts of his sales manager, Ruttu, to develop new business and keep current clients satisfied. If Matti were to lose Ruttu to a disability lasting more than a month or so, the net business income of $200,000 a year would be substantially reduced, particularly since Ruttu is paid a base salary plus commission. Ruttu is an ideal candidate for key person disability insurance coverage.

5.3 Insurance to address owners' inability to work

If a sole proprietor operating a consulting business with no employees becomes disabled and unable to work, the proprietor's income can be replaced using individual disability income replacement insurance. In the case of a disabled business owner who operates a small manufacturing business or similar enterprise involving business premises, equipment and employees, the solution to maintaining the business during a period of disability becomes far more complex.

5.3.1 Disability business overhead expense (BOE) insurance

Disability BOE insurance is available to qualifying businesses and business owners, and is designed specifically to pay specified ongoing business expenses while the business owner is disabled and unable to generate revenue for the business.

5.3.1.1 Purpose of the coverage

While many business owners have insured their net income against possible loss due to disability, the revenue stream of the business, and accompanying expenses, are often overlooked.

EXAMPLE

Tamirru is a professional photographer, operating out of a rented studio, using a leased van for business and employing one part-time assistant. His business earns, on average, $15,000 a month. After allowing for fixed expenses of $4,000 a month, on average, and variable expenses of $2,000 a month, Tamirru's gross take-home income is $9,000 a month. He has taken out personal disability income replacement insurance that would pay him $5,400 a month (60% of $9,000). That ensures Tamirru has funds to live on during a period of disability, but provides no cash flow to maintain the ongoing expenses of the business. If Tamirru were disabled for any length of time, he might have to lay off his assistant and give up his studio and van.

BOE insurance is designed to help business owners meet operating expenses and keep the business and business assets viable, so that the disabled business owner will have a business to return to upon recovery.

5.3.1.2 Who needs/qualifies for business overhead expense (BOE) insurance?

BOE insurance is specifically designed to meet the needs of the small business owner. Sole proprietorships and partnerships or closely held corporations with five employees or fewer may qualify. The thinking is that the services of the owner of the business are so vital to its profitability and success that an interruption of revenues due to disability could cripple, or kill, the business. However, if there is a co-owner or employee whose services could replace those of a disabled owner, then the business might only qualify for a lesser amount of coverage, or be disqualified entirely.

5.3.1.3 Definition of disability

The definition of total disability for these policies is some form of “own occupation” (see Chapter 2 for a definition of “own occupation”). If the business owner is unable to perform his regular duties with the business, the definition has been met. An owner who cannot perform regular duties will trigger a decline in business revenues and a likely inability for the business to meet its ongoing obligations. Any definition of disability that would allow for the insured to perform the duties of some other occupation would be inappropriate, since that would not help the business to survive.

5.3.1.4 What expenses qualify for reimbursement?

BOE policies are designed to reimburse the business for regular, ongoing business expenses incurred while the owner is disabled. Such expenses include, but are not limited to:

- Rent of the business premises;
- Property taxes on owned business premises;
- Business income taxes;
- Utilities (heat, water, natural gas, electricity);
- Vehicle leases;
- Salaries of (most) employees;
- Phone, internet and other communications charges;
- Loan interest;
- Lawyers’ and accountants’ fees.

There are, however, a number of expenses that would not be covered, including:

- Capital portion of loan payments;
- New capital expenditures;
- Salary of the disabled owner;
- Salary of someone hired to temporarily replace the services of the disabled owner;
- Salaries of employees who are able to independently continue to generate revenue for the business;
- Salaries of relatives of the disabled owner who were brought into the business after the onset of the disability.

5.3.1.5 Benefits

BOE policy benefits are normally payable (monthly) on a reimbursement basis. Details of the amount and administrative procedure for the payment of benefits are outlined below, under *Benefit maximums* and *Carryover of benefits/expenses*.

5.3.1.6 Waiting period

BOE policies typically have a fairly short waiting period before benefits begin, sometimes as short as 15 days and seldom longer than 90 days. This is in recognition of the fact that, in light of the total disability of an owner, the business might quickly fall behind in its financial obligations.

5.3.1.7 Benefit maximums

At first glance, the benefit amounts and benefit periods associated with a BOE policy seem the same as for personal disability income replacement policies. For example, a BOE policy might provide $6,000 a month for 24 months. But the $6,000 a month is a maximum monthly reimbursement benefit, not really a fixed benefit, as with an income replacement policy. The full $6,000 is only payable in a given month if at least $6,000 of qualifying expenses is claimed.

Policy benefits remain in force until the earliest of the following events: the business owner recovers and returns to work, the benefit maximum has been claimed or the business has been sold or terminated.

EXAMPLE

Todd's BOE policy provides for benefits of $6,000 a month for 24 months, but only $4,200 of expenses are claimed for the first month that benefits are payable. The benefit for that month was only $4,200. The benefit period (24 months) does not really indicate that benefits are only payable for a maximum of 24 months. The maximum monthly benefit multiplied by the benefit period determines the maximum benefit payable under the contract: $144,000 in this

case ($6,000 × 24 months). If the full $144,000 of expenses was not claimed within the 24-month period, the policy benefit period would be open-ended, possibly continuing until such time as the entire $144,000 had been claimed.

5.3.1.8 Carryover of benefits/expenses

The more flexible contracts permit a carry-forward of unused monthly benefit maximums and/or unclaimed expenses, to be used in subsequent months. This is in recognition of the fact that many business expenses are not spread evenly over the course of the year. Some, like business premises rent, internet charges, vehicle leases and other expenses may be equal each month and predicable in advance. Other expenses, like heating, lawyer's and accounting fees, and fuel costs, may be seasonal or only sporadic throughout the year. In recognition of this, it makes sense to have a reimbursement schedule that can handle monthly disparities.

Flexible contracts permit two types of carry-forward: expenses in excess of the available benefit maximum in one month can be carried forward and claimed in future months, should claimable expenses in those months be less than the benefit maximum.

EXAMPLE

Marie's BOE contract allows for a monthly benefit maximum of $6,000. In the first month of benefits eligibility, the business has qualifying expenses of $6,900. $6,000 of that amount will be reimbursed for the current month and the unclaimed $900 would be carried forward to the next month. If, during the next month, a total of $6,600 of qualifying expenses were incurred, another $6,000 would be reimbursed and the $1,500 of unclaimed expenses ($900 from month one and $600 from month two) would be carried forward to month three. And so on. On the other hand, if there were only $3,000 of qualifying expenses incurred in month three, $4,500 in benefits would be paid out for the month (the $3,000 incurred in month three plus the $1,500 in unclaimed expenses carried forward from the previous months).

Conversely, unclaimed benefit maximum room can be carried forward to be used in future months.

EXAMPLE (cont.)

If, in the above example, instead of $6,900 of expenses being incurred in month 1 there has been only $4,800 in qualifying expenses, the full $4,800 would have been reimbursed and $1,200 in potential benefits would have been carried forward to month 2. If $6,600 in qualifying expenses were incurred in month 2, the full $6,600 would have been reimbursed and the remaining $600 ($1,200 + $6,000 – $6,600) would be available for carry forward to month 3. And so on.

Other policies may carry forward unused benefit amounts, but only to be used at the end of the "normal" benefit period (e.g., 24 months), in the event that the entire benefit maximum had not been claimed at that time and the business owner was still disabled.

5.3.1.9 Provisions/exclusions

In addition to base benefits, BOE policies may offer a variety of standard or optional provisions, including:

- Waiver of premium;
- Return of premium;
- Future purchase option (FPO);
- A presumptive disability clause;
- A partial disability clause;
- Residual disability benefits.

BOE policies are subject to standard disability exclusions, including disabilities arising from war, self-inflicted injuries, normal pregnancy and injuries or illnesses contracted in the course of carrying out criminal activities.

5.3.1.10 Tax treatment of premiums and benefits

BOE policies are normally owned by, paid for by and payable to the business owner or, in the case of partnerships or incorporated companies, to the business itself. So long as the policy only covers qualifying expenses, the premiums are a tax-deductible business expense for the payor. On the other hand, any benefits paid to the policyholder, or on the policyholder's behalf, are treated as taxable income. This is an exception to the rule, where benefits payable under business life and disability policies are normally paid tax-free to the business. However, since the expenses covered by the BOE policy are normally themselves tax-deductible as business overhead, the tax on the benefits and the deductions for the expenses generally offset each other for tax purposes.

EXAMPLE

Lucien's BOE policy provides for benefits of $6,000 a month, but only $4,200 of expenses are claimed for the first month that benefits are payable. That claim accounted for reimbursement to Lucien's business of $1,800 of business premises rent, $2,000 of employee salary and $400 of shipping costs for goods distributed. The $4,200 received by the business was treated as taxable income. On the other hand, the $4,200 of expenses paid is a tax-deductible expense. The net effect of the benefits paid and expenses paid is that the business had no tax to pay on the $4,200.

5.3.2 Business loan protection disability insurance

Separate from BOE insurance, businesses and business owners can purchase disability insurance intended solely to make business loan payments during a period of disability.

5.3.2.1 Purpose

As outlined under the topic of BOE, one of the many types of expenses covered under such policies is periodic interest payments required under a business loan. Loan protection can also be provided under stand-alone contracts, called “business loan protection disability contracts.” These policies will discharge periodic or lump-sum business loan payment obligations on behalf of a disabled business owner.

5.3.2.2 Who needs the coverage?

These policies are designed to protect sole proprietors, business partners and sole owners of incorporated private businesses. The coverage applies where the business has incurred qualifying loans and the revenue stream of the business is dependent upon the continued good health and active participation of the business owner.

5.3.2.3 Eligible loans

For a loan to qualify for business loan protection coverage, it must meet three criteria:

- The loan must be essential to the successful operation of the business.
- Interest paid on the loan must be tax-deductible. That is to say, the loan must have been undertaken for the purpose of earning income from business or property.
- The loan must have been issued by a financial institution; bank, trust company, credit union or loan company.

The purpose for which the loan was undertaken must be related to the business operations. Examples include (but would not be restricted to):

- Mortgages on the premises from which the business operates;
- Equipment loans;
- Lines of credit and account overdrafts.

5.3.2.4 Who qualifies for such coverage?

In order to qualify for a business loan protection disability policy, the business must have a history of profitable operation; typically at least three years. Insurers usually require that the business meets a minimum standard of net worth. And the business enterprise must be engaged in operations ranked in the higher occupational categories.

Normally the business owner, or the business itself, will be the owner of the policy, will pay all policy premiums, and will be the recipient of any benefits payable. The life insured under the contract will be the business owner and the definition of disability will be “own occupation.”

5.3.2.5 Benefits

Benefits may be payable in one of two ways: periodic (monthly) or lump-sum. Periodic payments, of up to $10,000, are the most common and typically may run for up to 24 months. Lump-sum payouts, of up to $250,000, are possible, but not to exceed 75% of the loan value and only after a lengthy elimination period (usually one year). Overall, of course, benefit payments are designed to discharge the loan balance, so they could not exceed the amount of the loan.

5.3.2.6 Optional benefits

Other optional benefits may be possible, with waiver of premium being the most common.

5.3.2.7 Exclusions

As with most disability contracts, no benefits are payable if any disability occurs as a consequence of war, normal pregnancy, criminal activity, or self-inflicted wounds.

5.3.2.8 Tax treatment of premiums and benefits

Since the loan payments being protected are a capital asset to the business (rather than taxable income), premiums paid on these policies are not tax-deductible by the business. Benefits received (the discharge of loan principal and interest), on the other hand, are tax-free.

EXAMPLE

Hideki is an independent contractor, operating a proprietorship with two employees. Hideki’s business involves digging trenches for the installation of water lines and drainage systems for building contractors and on private property for homeowners. In order to operate his business, Hideki needed to acquire a front-end loader and a small flatbed truck to transport it from site to site, at a total cost of $200,000. Hideki took out a five-year loan from the bank to finance the purchases.

Although the work is not overly dangerous, there is always the risk of injury or illness that could interrupt Hideki's ability to work and earn an income. That, in turn, would impact his ability to make the monthly loan payments to the bank, raising the possibility that the bank could seize his equipment to protect its interests. With this in mind, Hideki applied for a business loan disability policy, with a 60-day waiting period and 60 months of maximum benefits, to protect his investment and the viability of his business.

5.4 Insurance to address the owner's inability to sell the business

At some point, every business owner must dispose of his business in one way or another: sell it, pass it down to the next generation or let it die or retire with the business owner. If the business has a value beyond the involvement of the owner, it is in the best interest of the owner and the owner's family to prepare for and pre-plan that eventuality.

5.4.1 Buy/sell agreements

Buy/sell agreements can be used to predetermine the purchase and sale of business assets in the event of the death, disability, critical illness or retirement of a business owner. Often agreements are drafted covering all eventualities. Buy/sell agreements in the event of death are covered elsewhere in another Module. This Module will deal exclusively with the disability of a business owner.

5.4.1.1 Purpose of an agreement

For the owner/operator of a closely held business, the business is often the owner's primary asset and sole source of income. The greatest concern for the business owner is, should he suddenly become disabled, "What will become of the business?" If the business cannot be carried on, or sold to a third party, how will the business owner, or the business owner's family, survive financially? On the other hand, without a clear succession plan for the business, employees are concerned for their jobs, should the business owner become disabled. And co-owners (if any) will be concerned about having to support a non-productive disabled co-owner and the possibility that they might be compelled to work with that co-owner's spouse, children or other family members. A properly structured and funded buy/sell agreement can provide assurances for all parties involved.

EXAMPLE

Lawrence, Daryl and Darrin were three cousins, all in their early forties, who formed a partnership to operate a dental practice. The practice was very successful, with the cousins sharing office space and net profits from the practice, but each owning their own dental equipment. They had often talked about where they hoped the practice would go in the future and how they would look after each other's families if something happened to one of them, but never took any specific action.

Darrin was severely injured in an automobile accident, never to be able to return to work or manage his own affairs. His wife, Emily, became responsible for managing his assets, including his dental equipment and his share of the partnership. Lawrence and Daryl wished to acquire Darrin's equipment, to be used by a young dentist they hoped to bring into the practice, and to buy out Darrin's partnership interest. Unfortunately, the two dentists and Emily were unable to come to an agreement on price, because the two remaining partners lacked the necessary cash on hand to buy Darrin's interest outright. An instalment purchase was finally worked out, which Lawrence and Daryl will be paying off for some years to come yet.

Even so, Emily would not relinquish ownership in Darrin's dental equipment, hoping that her eldest son would be able to use it in his own dental office in a few short years. The remaining partners were forced to go to market to replace the equipment at a cost that was twice what they had hoped to pay for Darrin's.

The problems could have been handled with a buy/sell agreement. The agreement would spell out the terms under which a buyout might occur and the method of valuation for the practice and its assets, and binding the partners and their estates and families to the terms of the agreement.

Funding for the agreement could be accompanied by a DI policy specifically designed to provide capital to meet the needs of the buyout.

5.4.1.2 Parties to the agreement

Often, the most difficult type of buy/sell agreement to arrange is one covering a sole proprietorship, particularly if the business in question has no employees, or at least no key employee. In the event of the permanent disability of the current owner who is there to buy the business? In the case of a partnership, the surviving partner(s) are the obvious market for the business interest of a permanently disabled owner. If the business is incorporated and has more than one shareholder, the shareholders who are not disabled are the most logical, potential purchasers of the business interest. In the case of any type of business entity, a key employee could also be a potential successor owner and, therefore, a potential party to a buy/sell arrangement.

Regardless of who the potential buyer might be, it is also important that both the seller and the seller's spouse/common-law partner (if any) be parties to the agreement. In most Canadian provinces and territories, the spouse or common-law partner of a business owner may have an ownership or equalization claim against the business owner's property in the event of marriage or relationship breakdown. If the spouse/partner is not also bound by the agreement, ownership rights and other legal entanglements could delay or completely derail the sale of the business interest of a disabled owner.

5.4.1.3 Elements of an agreement

The key to an effective buy/sell agreement is certainty: the parties to the agreement must know in advance:

- Under what circumstances is the agreement triggered?
- Will the current owner be required to sell the business interest?
- Who is required to buy the business interest?
- When must the purchase and sale take place?
- At what price will the purchase and sale take place?
- How will funding for the sale be affected?

Typically, the provisions of a business buy/sell agreement specify that the agreement is to be effective in the event of the disability, critical illness, death or retirement of a current owner. “Disability” is defined as the inability of an owner to carry out the main functions of his regular role with the business (“own occupation”). The buyout mandated under the agreement will not usually take effect until the business owner has been disabled for a lengthy period of time, 12 months or longer, to ensure that the disabled owner wouldn’t be able to recover and resume full participation in the business.

The current owner and the owner’s estate, heirs or assignees are bound under the agreement to sell the business interest upon the occurrence of a specified event (permanent disability, in this case). Once the agreement is triggered, the owner (the “seller”) has no choice but to sell his interest upon the conditions set out under the agreement. This affords the other party(ies) to the agreement (the “buyer(s)”) the comfort of knowing that they will be able to buy the business.

On the other hand, the agreement also compels the buyer to buy the business interest, according to the terms of the agreement, once the triggering event has occurred. This prevents the potential buyer from leveraging his advantage to compel an unfairly low price. It also gives the seller (or the seller’s representative) the certainty that a sale will take place at a fair price.

Obviously, the time frame for the purchase and sale of the business cannot be open-ended. Under a disability buy/sell the purchase and sale must take place, at the latest, within one year of a current business owner becoming disabled, but typically sooner – as little as 90 days after expiry of the waiting period.

It is important to establish the price, or the method of establishing the price, of a business interest in advance. A buy/sell agreement should commit the buyer and the seller to a price that will not be subject to negotiation at the time that the buy/sell is triggered. This is normally affected in one of three ways:

- A fixed price — The parties agree in advance to the price to be paid under the agreement. This is the least preferable method, in that the value of the business interest will likely change over time, requiring that the buy/sell price will have to be amended regularly or run the risk of being out of date and inappropriate.
- A price formula — The parties agree in advance upon a formula to be used to value the business interest: a multiple of earnings, for example. This formula is then imbedded in the buy/sell agreement.
- Use of a third-party valuator — The parties agree in advance to employ the services of a professional business valuator to value the business interest when the agreement is triggered. The identity of the valuator is written into the buy/sell agreement and the valuator's assessment will be binding on all parties.

A mandatory purchase and sale at a predetermined price is only of value to the parties involved if the purchaser has the financial capacity to meet his obligations under the agreement: to afford the purchase price. In the absence of guaranteed funding, the agreement to buy the disabled owner's business interest may be nothing more than a hollow promise. The agreement is most often funded in one of four ways:

- Use of personal assets — The buyer has liquid assets (or liquidates other assets) sufficient to cover the purchase price. Unfortunately, few buyers are likely to have sufficient funds on hand to make such a large purchase.
- A loan — The buyer borrows funds from a financial institution to affect the buyout, possibly using the business itself as collateral. This approach has a number of drawbacks:
  - there is no guarantee that the buyer will be in a position to obtain the loan;
  - the loan has to be paid back, with interest;
  - the loan payments will have to be drawn, presumably, from business profits at a time when business revenues are reduced.

- Instalment payments from the business profits

  The buyer purchases the business interest with a series of instalment payments drawn from the revenues of the business. This approach has the dual disadvantages of:

  - leaving the seller (or the seller's family) uncertain about whether the instalment schedule will be able to be maintained;
  - the new owner would have the challenge of trying to generate a personal income from the business while also maintaining the instalment schedule.

- Insurance on the life of the disabled owner

  A disability buyout policy on the life of the business owner can provide a guaranteed lump-sum benefit to fund the buyout. The policy would be owned by, paid for by and payable to the prospective buyer who would, in turn, use the policy proceeds to buy the interests of the disabled business owner. Funded in advance with premium payments, the policy would guarantee that the necessary funds would be available when needed. The policy could be customized to parallel the terms of the buy/sell agreement: amount of benefit, definition of disability, waiting period, etc. In most instances, this option would be the preferable one from the standpoint of both the potential seller and the potential buyer.

5.4.1.4 Types of agreement

There are two basic types of buy/sell agreement.

Where two partners or co-shareholders of an incorporated business are required to purchase the business interest of the other the agreement is called a "cross-purchase" (or criss-cross) agreement. If the agreement is funded by insurance, each party owns, pays for and is beneficiary of a policy on the life of the other(s). In the case of a disability buy/sell agreement, the insurance proceeds are used to purchase the interest of the disabled business owner.

Where the business entity itself is required to purchase the business interest of a partner or shareholder in the business, the agreement is called an "entity purchase" (or share redemption) agreement. This form is often used in the case of a partnership or an incorporated closely held business with two or more shareholders. In the case of a disability buy/sell, any insurance funding is owned by, paid for by and payable to the partnership or corporation. The insurance proceeds are then used to buy out, and cancel, the business interest of the disabled partner/shareholder.

EXAMPLE

Harold and Kendrick are equal shareholders of an incorporated business, White Tower Towels. They plan to implement a buy/sell agreement funded with life insurance. If the agreement is a cross-purchase agreement, Harold would own a policy on Kendrick's life, pay the premiums and be the beneficiary, and vice versa. In the event of Kendrick's death, Harold would use the insurance proceeds to purchase Harold's shares. If the agreement is a share redemption (entity purchase) agreement, the corporation would own policies on the lives of Harold and Kendrick, pay the premiums and be the beneficiary. In the event of disability of either shareholder, the corporation would use the insurance proceeds to redeem the disabled's shares.

5.4.1.5 Taxation issues

In the case of a cross-purchase agreement, sale of the business interest is a disposition for income tax purposes at the purchase price, resulting in the selling business owner having to report a capital gain or loss for the year of sale. This will be the case regardless of the type of business structure involved. The purchaser will acquire the business interest with an adjusted cost base equal to the purchase price paid.

If the business is either a partnership or closely held corporation, and the business acquires the disabled owner's interest, the tax consequences would differ. If a partnership buys out a partner's interest the transaction is a capital transaction, resulting in a capital gain or loss reported to the seller for the year of sale. If an incorporated company purchases its shares directly from a shareholder, the portion of the proceeds equal to the paid-up capital (PUC) value of the shares is treated as a tax-free capital transaction. Any amount paid for the shares in excess of the PUC value is treated as a deemed dividend in the hands of the seller, subject to tax.

5.4.2 Disability buyout insurance

As noted, a disability buy/sell agreement may be of little value if it is not accompanied by a disability insurance (DI) policy specifically designed to provide capital to meet the needs of the buyout. Although the insurance is sometimes put into place before the buy/sell agreement is implemented, ideally the two should be designed in tandem so that the features of both (waiting period, benefit amount, definition of total disability, structure of payout, etc.) can be properly coordinated.

5.4.2.1 Definition of disability

Since the purpose of the buy/sell agreement, and the funding DI policy, is to provide capital to buy out a business owner who can no longer function within the business, the most frequently used definition of total disability is "own occupation." In some cases that is extended to "own occupation and not working," meaning that the insured owner is not able to carry out his regular duties within the business and is not working at any other occupation within or outside the business.

5.4.2.2 Waiting period

The waiting period on a disability buyout plan is much longer than for other types of disability contracts. Disability buyout plans usually have a waiting period of 12 months, sometimes as long as 18 to 24 months. Likewise, the buy/sell agreement most often calls for the buyout to occur 12 months (or longer) after the onset of total disability. Note that the waiting period in the insurance policy should be based on the period outlined in the agreement, not the other way around. The long waiting period is to give the disabled business owner time to recover and return to active participation in the business, if possible.

5.4.2.3 Benefit and benefit period

Benefit periods on DI policies can run from 2 to 5 years, and sometimes 10, all the way to the life insured's attainment of age 65. But the benefit period for a disability buyout policy is often only one day: a lump-sum benefit is paid out to fund any buyout at the end of the waiting period.

While lump-sum payouts are common, some contracts (and the corresponding buy/sell agreements) provide for part of the benefit (50%) to be paid in a lump-sum, with the balance paid out in equal instalments over as many as 60 months (5 years). Others pay no lump-sum, only instalment payments. Should the disabled business owner recover during the benefit period, there is no impact on either the buyout or the payout. Once the waiting period has been met, the buyout is triggered and the payment begins, regardless of the subsequent health of the owner.

5.4.2.4 Coverage amount

Disability buyout policies often provide coverage for as much as $1,000,000, with some contracts extending the coverage to as much as $2,000,000.

5.4.2.5 Features of the policy

Disability buyout contracts are conditionally renewable and non-cancellable. The insurance company cannot amend the premium and must renew the contract up to a specified age unless certain conditions are not met (for example, the insured owner is no longer an owner of the business).

Policies often have a reducing benefit schedule after the life insured attains age 60, reducing by 20% of the original face amount per annum, in recognition of the pending retirement age for the insured.

Most contracts will include a future purchase option (FPO), guaranteeing the right to increase coverage at pre-set dates, to allow the value of the insurance benefit to keep pace with future increases in the value of the business interest.

5.4.2.6 Termination of coverage

Disability buyout policies will provide for termination of the coverage in the event that the life insured is no longer an owner or co-owner of the covered business or the business itself is no longer operating. Some policies offer a conversion privilege, however, permitting the insured to convert the policy (or a portion of the policy) to personal coverage, without medical evidence of insurability. The insured would, however, have to be able to justify the level of the converted coverage financially.

5.4.2.7 Tax treatment of premiums and benefits

Disability buyout policies are owned by, paid for by and payable to the prospective buyer of the business. They insure the life of the current owner or co-owner. Premiums paid are not tax-deductible by the policyholder. Nor are they reported as a taxable benefit to the covered life insured. Benefits received by the policyholder, in the event of disability of the life insured, are received tax-free.

EXAMPLE (cont.)

A year after Darrin (from the previous example under *Buy/sell agreements*) had to retire, the remaining two dentists took in a "junior partner," Michael, who purchased 20% of the practice. When Lawrence, Daryl and Michael met with their lawyer to have a buy/sell agreement drawn, the lawyer came up with the following parameters:

- Type of agreement: Cross-purchase
- Parties to the agreement: Lawrence, Daryl and Michael
- Business interests: Lawrence (40%), Daryl (40%) and Michael (20%)
- Business valuation: $1,200,000, growing at 5% per annum
- Payout: Lump-sum
- Triggering date: 12 months after onset of disability
- Definition of disability: Own occupation

Once the agreement was drawn up and signed the lawyer sent the three business owners to meet with a DI specialist, to arrange funding for the buyout. In keeping with the terms of the buy/sell agreement, the specialist applied for the issuance of disability policies on the lives of the three owners with the following characteristics:

Policy No. 1

Insuring Lawrence in the event of disability for $480,000. The policy is owned 66.67% by Daryl and 33.33% by Michael, with premiums to be paid pro rata by each. In the event of a claim, $320,000 is payable to Daryl and $160,000 to Michael, for them to meet their obligations under the buy/sell agreement.

Policy No. 2

Insuring Daryl in the event of disability for $480,000. The policy is owned 66.67% by Lawrence and 33.33% by Michael, with premiums to be paid pro rata by each. In the event of a claim, $320,000 is payable to Lawrence and $160,000 to Michael, for them to meet their obligations under the buy/sell agreement.

Policy No. 3

Insuring Michael in the event of disability for $240,000. The policy is owned 50% by Lawrence and 50% by Daryl, with premiums to be paid pro rata by each. In the event of a claim, $120,000 is payable to each of the policyholders, for them to meet their obligations under the buy/sell agreement.

All three policies have an "own occupation" definition of disability, a 12-month waiting period and provision of a lump-sum payout of benefits, to match the parameters of the buy/sell agreement. In addition, all of the policies carry a waiver of premium rider, after 90 days, and an FPO, to allow the coverage to keep pace with increases in the value of the business, if necessary.

5.5 Insurance to address the loss of a key employee

Disability insurance is generally employed to protect the income of an individual in the event of a prolonged period of disability. But the business employing that individual is an entity unto itself and the income of the business may equally need protecting should it be interrupted due to the disability of an employee.

5.5.1 Key person insurance

Key person insurance is a life insurance, critical illness insurance (CI) or DI policy on the life of a key person, intended to protect the employer in the event of the loss of services of the key person due to death, disability or critical illness.

5.5.1.1 Who is a "key person"?

There are often one or two employees within an organization whose skills and contributions are so unique, and whose contribution is so important to the success of the business, that they are very

difficult to replace. Such a person is referred to as a "key employee" or "key person." Their services could be as a business owner, a key executive, a technical expert, a systems designer, a trainer/motivator of the sales force, or a variety of other roles that contribute materially to the success of the organization. The key person's services are very difficult to replace, particularly on a short term and temporary basis. The business cannot protect against any eventuality, but insurance on the life of a key person can be used to protect the business financially in the event of the death or disability of the individual.

5.5.1.2 Purpose of the coverage

Key person disability insurance is designed to provide the employer with cash flow to offset a number of potential losses to the business arising from the key person's absence from work due to disability. The types of situations the funds are typically intended to offset include:

- A decline in productivity due to the loss of the key person's services;
- A decline in productivity of other employees due to the loss of the key person's support or guidance;
- A decline in sales or networking contacts;
- The cost of recruiting and training a replacement for the key person, if necessary.

One of the main restrictions on who can be considered a key person for insurance purposes relates to the issue of ownership of the business. Various insurers place a maximum limit on ownership, ranging from 10% to 50%, before an individual is disqualified from coverage.

5.5.1.3 Terms of the contract

The definition of disability under a key person policy is some form of "own occupation." The whole point of setting up the coverage is to protect the employer because the business cannot function profitably without the regular services of the key person. The policies are conditionally renewable, provided the life insured continues to be employed full-time with the same employer.

5.5.1.4 Riders

Most key person policies include provisions for waiver of premium and recurrent disabilities and many may include a replacement expense benefit rider, which provides for an additional payout to cover the costs associated with hiring a replacement employee, if necessary.

5.5.1.5 Benefits

Key person disability benefits are usually restricted to no more than 100% of the life insured's annual salary, paid monthly, to a maximum of about $15,000 a month. The addition of riders, such as a replacement expense benefit, may increase the standard payout.

5.5.1.6 Waiting and benefit periods

Because the whole point of insuring a key employee is that the employer's business will be adversely impacted without the benefit of his essential services, the waiting period for these policies is usually kept short, in the range of 30 to 90 days.

Benefit periods are usually no more than 12 months, because the business cannot carry on indefinitely without the services of the key person. If the life insured is going to be off work for more than a few months, at the longest, the employer will likely have to find a replacement.

5.5.1.7 Tax treatment of premiums and benefits

Key person disability policies are usually owned by, paid for by and payable to the employer. Premiums paid are not tax-deductible by the policyholder, nor are they reported as a taxable benefit to the covered employee. Benefits received by the employer, in the event of disability of the insured employee, are tax-free.

EXAMPLE

Signs and Lines is an incorporated business with two co-owners and three full-time employees. The company is in the business of designing and installing logos, signs and decorator artwork for commercial enterprises. Mona, their graphic designer, is responsible for 45% of the company's annual revenue, with about $300,000 of receivables attributable directly to her annually. The two owners are involved primarily in management and promotion and the other two employees handle production, framing and delivery of goods.

Realizing that the business depends heavily on the services of Mona, the owners have taken out a key person disability policy on her life, with a 60-day waiting period and a 12 month benefit period, paying $12,500 a month. This would be sufficient to cover overhead and salary expenses for the other two employees, to at least keep the business operating if Mona were to be disabled for a prolonged period of time.

5.6 Other types of business insurance plans

Although not strictly "business insurance" in the sense that they do not necessarily insure the interests of the business or the business owner, there are a number of other types of disability and health insurance arrangements that warrant brief consideration. These plans are sometimes broadly referred to as health spending accounts (or healthcare spending accounts).

5.6.1 Health and welfare trusts (HWTs)

When employers wish to provide health benefits (dental care, vision care, a prescription drug plan, etc.) for the benefit of their employees they typically do so by setting up an insured group plan. An alternative to group insurance is the health and welfare trust (HWT). These are trusteed arrangements funded for the sole purpose of providing the employees with health care benefits. The HWT often offers employees more flexibility in the choice of benefits than can be found under a typical group plan.

Specific requirements for an HWT are set out in the Canada Revenue Agency's Income Tax Folio S2-F1-C1, *Health and Welfare Trusts*, dated 27-07-2015 and modified 2015-11-27. It replaced and cancelled Interpretation Bulletin IT-85R2, *Health and Welfare Trusts for Employees* dated July 31, 1986.

5.6.1.1 Contributions to the trust

Contributions are usually made by the employer only, on a mandatory basis, and may never revert to the employer. There is no statutory restriction on the amount of annual or cumulative contributions, although the Income Tax Folio S2-F1-C1 specifies that the employer's contributions "…must not exceed the amount required to provide health and welfare benefits to employees." There is no time limit specified during which the employees are required to utilize the contributions to acquire benefits.

5.6.1.2 Income tax implications

Provided the HWT meets the requirements of Income Tax Folio S2-F1-C1, contributions are tax-deductible by the employer. Employees who are beneficiaries of the trust are not required to report a taxable benefit at any time: not at the time of the employer's contributions to the trust nor at the time of receipt of health benefits paid for by the trust.

5.6.2 Employee health trusts (EHTs)

Introduced in 2010, employee health trusts (EHTs) are a variation of the HWT. The EHT is specifically provided for under s. 144.1 of the *Income Tax Act*. HWTs, on the other hand, rely solely on the administrative practices of the Canada Revenue Agency. Also, the trust that administers an EHT must be resident in Canada, a restriction that does not apply to HWTs.

As with HWTs, employer contributions to an EHT in order to provide accident and sickness (but not life insurance) benefits for employees are tax-deductible for the employer, but are not treated as a taxable benefit for the employee. Contributions to the trust cannot revert to the employer and must be used to provide specified benefits for the employee and family, usually for the payment of premiums on individual or group accident and sickness (A&S) insurance plans. The provision of benefits for employees, former employees and their family members may be the only purpose for which contributions to an EHT may be used.

In general, EHTs are used by medium-to-large employers, because of the complexity and cost of administration.

5.6.3 Personal health spending plans (PHSPs)

Personal health spending plans, also referred to as private health services plans (PHSPs), are designed to provide health care benefits for sole proprietors, partners and their families. Contributions are made to the plan, to a prescribed maximum, and may be used to directly pay for health care services, such as prescription drugs, vision and dental care and a wide variety of other medical services. Any service or product qualifying for the medical expense tax credit qualifies for these plans.

Contributions for business owners and adult members of their families (spouses, for example) are limited to $1,500 per year for sole proprietors. Contributions on behalf of family members under the age of 18 are limited to $750 per year. The contributions and disbursements are handled by an administrator, who will charge a fee for the service. The plans offer tax advantages not otherwise available and are beneficial to the business owner so long as the tax advantages outweigh the administrative costs of the plan. The only real restriction is the fact that contributions to the plan must be used to purchase qualifying services within two years of contribution or they will be forfeited.

Employer contributions that fund purchases of qualifying health care products and services are 100% tax deductible for the employer, up to the maximums stated above and do not constitute taxable income for employees.[30]

Most of these PHSPs include travel insurance coverage and an exceptional expense rider, to cover such items as a semi-private hospital room.

5.6.4 Grouped disability/critical illness plans

A “grouped” plan is an arrangement whereby an employer agrees to acquire, fund and hold DI, A&S, or CI contracts, for the benefit of two or more (one employee does not constitute a “group”) of its employees, rather than using a group insurance plan offered by an insurance company. Benefits claimed under the policies are paid directly to the disabled employee.

30. Except in Québec, where they constitute taxable income for provincial tax purposes.

The employees who are beneficiaries of a grouped plan must be members of a given class of employees within the organization; they cannot be either selected or chosen at random from within the whole workforce. Each member of the identified group must be offered similar benefits, if insurable. However, different grouped plans may be set up for different classes of employees. The group may not be comprised exclusively of shareholders of the employer or the tax status outlined below will not be afforded the plan. However, shareholders may be members of the group, along with non-shareholder employees, so long as the shareholders are also employees of the company.

If the grouped plan is properly structured, the employer can tax-deduct premiums in the year in which they are paid. On the other hand, the employees do not have to report these employer-paid premiums as income. However, if the employees claim benefits from the plan, those benefits are taxable in the hands of the employee.

EXAMPLE

The XYZ Corporation established a grouped disability plan for its office staff in 2011. The plan, in turn, purchased individual disability income replacement policies on the lives of each of its employees. In respect of one employee, Hans, the company paid $800 in premiums in 2012. The company was able to tax-deduct the full $800, but Hans did not have to report a taxable benefit for the premiums paid in 2012. In 2013 Hans received $3,600 in income replacement benefits from the plan when he had to be off work for several weeks due to a severe knee injury sustained while playing football with some friends. Hans had to report a taxable benefit of $3,600 in 2013 as a result of the disability claim.

5.7 Taxation of benefits

Table 5.1 provides a brief summary of the income tax implications to the employer and employee arising from the payment of premiums and receipt of benefits under business use DI policies.

It is important to note that, if the business in receipt of policy benefits is a private corporation, there is no credit to the corporation’s capital dividend account, as there is with life insurance proceeds. Funds distributed to shareholders by way of a dividend would be treated as a taxable dividend in their hands.

TABLE 5.1

Income tax implications of premiums paid and benefits received for business accident and sickness and disability coverage

TYPE OF COVERAGE	CHARACTERISTICS	
Disability business overhead expense (BOE) insurance	Ownership of the contract	Employer/Business
	Who pays the premiums?	Employer/Business
	Who receives the benefits?	Employer/Business
	Premiums tax-deductible?	Yes
	Premiums reported to life insured as taxable income?	No
	Benefits reported to employer/business as taxable income?	Yes
	Expenses tax-deductible by the employer/business?	Yes
Business loan protection	Ownership of the contract	Employer/Business
	Who pays the premiums?	Employer/Business
	Who receives the benefits?	Employer/Business
	Premiums tax-deductible?	No
	Premiums reported to life insured as taxable income?	No
	Benefits reported to employer/business as taxable income?	No
Disability buyout insurance – Entity purchase agreement	Ownership of the contract	Employer/Business
	Who pays the premiums?	Employer/Business
	Who receives the benefits?	Employer/Business
	Premiums tax-deductible?	No
	Premiums reported to life insured as taxable income?	No
	Benefits reported to employer/business as taxable income?	No

TYPE OF COVERAGE	CHARACTERISTICS	
Disability buyout insurance – Cross-purchase agreement	Ownership of the contract	Shareholders/Partners
	Who pays the premiums?	Shareholders/Partners
	Who receives the benefits?	Shareholders/Partners
	Premiums tax-deductible?	No
	Premiums reported to life insured as taxable income?	No
	Benefits reported to life insured as taxable income?	No
	Benefits taxable to the shareholder/partner?	No
Key person insurance	Ownership of the contract	Employer/Business
	Who pays the premiums?	Employer/Business
	Who receives the benefits?	Employer/Business
	Premiums tax-deductible?	No
	Premiums reported to employee as taxable income?	No
	Benefits reported to employee as taxable income?	No
	Benefits taxable to the employer/business?	No
Health and welfare trusts (HWTs)	Ownership of the contract	Trust
	Who pays the premiums?	Employer
	Who receives the benefits?	Employee
	Contributions tax-deductible by employer?	Yes
	Contributions reported to employee as taxable income?	No
	Benefits reported to employee as taxable income?	No
Employee health trusts (EHTs)	Ownership of the contract	Trust
	Who pays the premiums?	Employer
	Who receives the benefits?	Employee
	Contributions tax-deductible by employer?	Yes
	Contributions reported to employee as taxable income?	No
	Benefits reported to employee as taxable income?	Yes

TYPE OF COVERAGE	CHARACTERISTICS	
Personal health spending plans (PHSPs)	Ownership of the contract	Employee
	Who pays the premiums?	Employer/Business
	Who receives the benefits?	Employee
	Contributions tax-deductible by employer?	Yes
	Premiums reported to employee as taxable income?	No[31]
	Benefits reported to employee as taxable income?	No
	Expenses tax-deductible by employer/business?	Yes
Grouped DI/CI insurance plans	Ownership of the contract	Employer/Business
	Who pays the premiums?	Employer/Business
	Who receives the benefits?	Employee
	Premiums tax-deductible?	Yes
	Premiums reported to life insured as taxable income?	No
	Benefits reported to life insured as income taxable?	Yes

5.8 Integrating business and personal disability coverage

DI coverage can arise from a large variety of potential sources:

- Canada Pension Plan (CPP);[32]
- Government Employment Insurance (EI);
- Provincial Workers' Compensation Plans;
- Group or grouped plans provided by an employer;
- Individual accident and sickness (A&S) policies;
- Disability benefits attached to life insurance contracts;
- BOE plans;
- Business loan protection plans;

31. Yes; in Québec, for provincial income tax purposes.
32. In Québec, the Québec Pension Plan (QPP) fills this role.

- Disability buyout policies;
- Disability key person insurance.

The challenge for insurance advisors is to coordinate all these plans to ensure that:

- There are no gaps in coverage protecting the client or the client's business;
- There is no needless, and expensive, duplication in coverage.

5.8.1 Owner's need for personal insurance

The most obvious situation where gaps/overlaps might occur is when the client is the owner/operator of a business, particularly one with employees. A disability program focussed on protecting the employees might indirectly strengthen the position of the business, through increased loyalty and productivity, but would do little or nothing to cover business expenses, generate profits or protect the net income of the business owner. A sole proprietor with a personal income replacement disability policy might find his income adequately provided for in the event of a prolonged disability, but if his business and employees are not also protected the proprietor might not have a source of income to return to when he recovers.

Coverage levels and waiting and benefit periods need to be coordinated to avoid any gaps or overlaps in coverage.

EXAMPLE

Carly is a co-shareholder in an incorporated business with 30 employees. She has three co-owners. The company has key employee coverage on its owners, to ensure the viability of the business in the event of a prolonged disability. It also holds disability buyout policies on the lives of each, to fund a buy sell agreement. The buyout policies have a 12 month waiting period, so the firm has also taken out disability policies on the shareholders, paying a benefit equal to 50% of their net income, to help the owners maintain their lifestyle during the period between the onset of disability and the triggering of the buyout. The contracts are owned and paid for by the corporation and are payable to it, which would in turn pay "salary continuation" to a disabled owner/operator. The plans have a 90-day waiting period and a nine-month benefit period.

Since the disability benefits paid to Carly would be taxable, the after-tax income would be insufficient to fully sustain her during a year of disability. She needs to consider taking out a personal DI policy to supplement the coverage provided by her company. Her personal policy might have a waiting period of as little as 30 days and a 12-month benefit period. The level of monthly benefit should be in the range of $10,000 a month for the first 60 days (when no income would be coming from the company plan) and $5,000 a month

($60,000 a year) for the balance of the 12 months. If Carly was to remain disabled, long-term, coverage would not be necessary after 12 months, as her interest in the company would have been bought out under the insurance-funded buy/sell agreement.

At the other end of the spectrum, care must be taken not to over-insure the business or the business owner. Some plans, like EI, are second payers and will pay little or nothing in the way of benefits if other disability payments are available (except those coming from a privately owned income replacement plan). In any event, most plans will have an “all sources maximum” built into their benefit schedule, capping benefits from all plans at 85% of pre-disability income. If the business owner is receiving group or grouped benefits, in addition to benefits from government plans and a private disability income replacement policy, benefits could be prorated to ensure that the total payout does not exceed the 85% level.

CHAPTER 6
CLIENT PROFILE

Competency components

- Assess the client's needs and situation;
- Implement a recommendation adapted to the client's needs and situation.

Competency sub-components

- Determine the client's situation;
- Assess the appropriateness of the client's existing coverage in regard to his or her situation;
- Articulate the client's needs based on the risks that could affect his or her financial situation;
- Propose a recommendation adapted the client's needs and situation.

6
CLIENT PROFILE

As explained in previous chapters, disability, critical illness, the need for long-term care and other health issues related to accident and sickness may cause great strain on a client's financial and emotional situation through loss of income and increased expenses. The effects of these health situations may be mitigated by accident and sickness insurance; however, before presenting a recommendation to an individual client, an agent must first analyze the client's situation to ensure that he has a clear picture of the risks the client faces and the needs he must meet. Due to the wide array of products that offer accident and sickness (A&S) coverage, the client profile should cover the following aspects, at a minimum:

- Personal situation;
- Financial situation, including income and expenses;
- Insurance situation.

Once a complete client profile is drawn, the agent will be empowered to suggest the disability, critical illness, long-term care and extended health insurance products that are most appropriate to meet the client's A&S insurance needs and budget.

6.1 Personal situation of client

There are a wide range of factors to take into consideration when conducting a fact-finding interview for an insurance review on a client where the review focuses on A&S insurance through disability, critical illness, long-term care or extended health insurance. All of the following need to be taken into consideration:

▪ Personal factors unique to the client, like age, gender and avocation	These may impact the risk of disability and the duration of need for benefits or care.
▪ Marital status of the client	A spouse constitutes possible alternate sources of income/support.
▪ Dependents, if any, of the client	They may also need financial support in the event of the client's disability or impairment.
▪ Client's occupation	This highlights risk of disability and the likelihood of continued employment in the event of disability.

▪ Current health and health history of the client and his family	This constitutes an indicator of possible future health problems.
▪ Client's retirement goals	These outline when the client hopes to retire and what his expectations are for his retirement lifestyle.

All of these personal details should be explored and their ramifications considered before the agent considers purely empirical data like income, assets and liabilities.

6.1.1 Personal details

There are personal characteristics of a client, aside from his health, income or assets, etc., that can significantly impact his need for accident and sickness insurance and the type of insurance that is most appropriate for him. Specifically, the client's age at the time of the review, his gender and the type of non-work activities that he engages in can influence the types of risk that he is exposed to, the analysis process and the agent's recommendations.

6.1.1.1 Age

Whether a client is new to the agent or a long-standing client whose program is under review, the client's current age is significant in the A&S review and planning processes.

Age is a factor in the risk of illness or disability, but it also impacts the number of years that corresponding disability benefits might be needed and the medical care expenses that may need to be covered. Consequently, the client's age can impact the cost of insurance protection.

6.1.1.2 Gender

Gender is another important factor in estimating both mortality (life expectancy) and morbidity (risk of disability).

At any age, statistics show that the average life expectancy of a woman is longer than the life expectancy of a man of the same age.[33] Particularly in relation to long-term care, then, it would have to be anticipated that overall care costs would be greater for a woman than for a man, because care would likely have to be provided for a longer period.

Moreover, women generally have a higher likelihood of incurring a disability than would men of the same age.

33. Statistics Canada. *Life expectancy, at birth at age 65, by sex and by province and territory*. [online]. Revised May 31, 2012. [Consulted August 3, 2017]. http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health72a-eng.htm

6.1.1.3 Sports, hobbies, activities or pursuits

Aside from what activities a client engages in to earn a living (these are described later on in the Chapter), what that same client does in his off-work hours can have a major impact on his risk exposure for disability – short- or long-term.

A client who exclusively leads a sedentary lifestyle outside the office (watching TV, reading, playing chess, etc.) might be courting health problems due to a lack of exercise.

One who takes regular walks, cycles recreationally or plays golf or non-contact hockey has a much better chance of remaining fit and reduces many of his health risks.

At the other end of the spectrum, the client who engages in extreme sports or activities (rugby, skydiving, rock climbing, etc.) is much more at risk of incurring injury and possible permanent disability. It should also be kept in mind that these clients may be uninsurable for disability or long-term care coverage or, at least, subject to exclusions of coverage.

6.1.2 Marital status

It is important to determine whether a client is currently single, married, living common-law, or has previously been married or in a common-law relationship because this will have an impact on sources of income and expenses during periods of disability or illness.

The simplest situation, at least in terms of variables to consider, is the client who is single, has always been single and who has no immediate intention to change his status.

In this case, the client likely has fewer, or no, financial obligations to others that must be considered in calculating the amount of income required to support him in the event of disability. Similarly, the single client has only his own needs to consider should he suffer a critical illness or require long-term care. Of course, there will always be the exception, like the client responsible for the care or financial support of an ageing or ailing parent.

On the other hand, the single client does not have the financial or moral support of a spouse or common-law partner: no second family income to draw upon or life partner to provide caregiver support, although other family members (parents, siblings) might help out.

For the client currently married or living common-law, the spouse/partner could provide a second source of family income, to partially mitigate the need for insurance coverage in the event of disability.

EXAMPLE

Henri is single and earns $60,000 a year and would require 60% of his current income to survive during a period of prolonged disability. If he had no other source of income or income replacement, he would need $3,000 a month of disability insurance to support him during a period of disability (($60,000 × 60%) ÷ 12).

Henri's brother, Jacques, and his wife, Marie, each earn $60,000 a year and would require 60% of their combined incomes, or $6,000 a month, to live if either of them was to become disabled (($60,000 × 2) × 60% ÷ 12). However, in the event of Jacques' disability, Marie would still be earning $5,000 a month, and vice versa, leaving a shortfall of only $1,000 a month should one of them become disabled and unable to work. Each of Jacques and Marie might only require $1,000 a month of disability insurance to protect the family in the event of the disability of one or the other, although a higher level of coverage would likely be prudent, to guard against eventualities (one spouse might need to work part time to help to care for the other).

The agent should be conversant with the laws of the province(s) in which he practices with regard to matrimonial property, support and civil or common-law rights of married or common-law couples. These help understand rights and obligations that could intervene in cases where medical occurrences such as disability or illness impact the couple's financial situation.

In the case of clients who have previously been married and are now separated or divorced, or who were previously in a common-law relationship, the agent should inquire about ongoing support obligations to the ex and/or children and seek a copy of any agreements or court orders governing such support.

6.1.3 Dependents

In assessing the financial needs (and therefore the insurance needs) of a client in the event of disability, critical illness or other health crisis, the insurance agent must consider not only the personal needs of the client, but also the needs of others that the client may support. These add to the expenses that must be met by the client and may thus suggest a need for increased A&S coverage.

The following can constitute dependents for the A&S client:

- **Spouse** — A spouse who has suffered disability due to illness or injury could require special treatment, medical aid or adaptations to the home environment; an ageing spouse may require in-home or nursing home care.
- **Children** — Up until the end of their children's secondary school careers, parents are usually fully responsible for their housing, food, clothing, educational expenses and often entertainment expenses. Responsibilities could continue for a few years if the children go on to higher education or for much longer in the case of a child with special needs due to physical or developmental challenges, for instance.
- **Other family members** — Clients may be financially responsible, or active caregivers, for others outside of their immediate families, such as ageing parents or grandparents or siblings in need of special care.

6.1.4 Occupation

A client's occupation is the most critical factor in determining the type, benefits and costs of disability insurance coverage. For example, the "own occupation" definition of disability and the right to acquire a policy that is guaranteed to be renewable without modification of costs or benefits are only available for those in low-risk classifications of occupation, such as doctors, lawyers and senior management personnel. The degree of risk of disability inherent in the occupation may also determine the minimum waiting period that the insured must take, the duration of benefits and, of course, the premiums payable. Some occupations may be so inherently risky that the client could be subject to stringent exclusions of coverage, or may simply be uninsurable. As such, elements of the client's occupation must be carefully scrutinized and documented.

While knowledge of a client's occupation is useful for any insurance, the amount of critical illness and long-term care insurance required is not primarily determined by occupation.

6.1.4.1 Duties

As explained in Chapter 2, occupations are classified according to risk of disability, with the highest classification being reserved for professionals who function in environments that offer the fewest physical risks. Risks may relate not only to the physical environment in which the client works (hazardous conditions, noxious chemicals, etc.), but also to the amount of physical exertion required by the job and the amount of stress to which he is exposed.

After considering these aspects, insurance company underwriting departments look to the physical requirements of the job itself. Does the applicant work exclusively in an office environment (low risk) or does he work on a construction site or around heavy equipment (high risk), for example. How many hours a week is the applicant required to work? How much vacation time does he receive each year?

6.1.4.2 Work history

It is helpful to know not only the details of the client's current occupation, but what sort of work that he has done in the past. Some jobs involve inherently dangerous environments, mining for example, which could lead to postponed physical ailments (lung damage, for example) that could in turn result in disability in the future, even if the client is now working in less hazardous conditions. How long the client has worked in previous positions could also be an important factor.

As for the details of a client's current occupation, they could be less influential in determining the client's current insurability if he is in the habit of changing occupations every couple of years or so, particularly if the changes involve jobs with dramatically different duties and risks.

6.1.4.3 Future work plans

It is valuable to know the details of what the client does now in his occupation, but what if he plans to change occupations or retire in the near future? He could be changing to a job that pays more, or less, than he is currently earning, or have little or no earned income in retirement: a critical factor in determining the amount of disability insurance the client needs, or can qualify for. The intended new job may carry greater physical risks than the current job, resulting in a lower classification for insurance purposes, restrictions on coverage or even a decline to issue coverage.

6.1.5 Health

A person's health is a critical factor in determining his qualification for all types of accident and sickness insurance. How is the client's current health? Has he had health problems in the past? Are there factors that would tend to be an indicator of health problems in the future? Health issues could be an indicator of potential needs, and claims, under all types of A&S insurance:

- Current or past health problems could lead to illness or injury that would impact the client's ability to work and result in a claim under a disability income replacement policy;
- Health factors like diabetes, high blood pressure or smoking are significant risk factors for heart attack and stroke, which would result in a claim under a critical illness policy;
- Factors like diabetes could also lead to debilitating conditions in the future (loss of or loss of use of limbs, for example) that could require home care or residency in a chronic care facility, covered by long-term care insurance.

The insured's health is also an obvious factor for extended health coverage. Those with health problems, present or past, are likely to have increased numbers of claims and medical expenses.

6.1.5.1 Personal health history

Aside from current health, a person's health history, including past disability claims and previous health issues, is a major consideration for risk assessment for A&S insurance.

The medical underwriting questionnaire associated with all types of A&S coverage places extensive emphasis on the applicant's current health and health history and a client might be subject to severe coverage restrictions or have coverage denied completely if his medical history is too negative. In completing the questionnaire, care must be taken to answer every question fully, providing all details necessary for the insurer's underwriters to evaluate the client, particularly in regard to "positive" answers. For example, if the questionnaire asks about previous episodes of disability, the agent should not just put "Yes" on the form. Full details would be required: nature of the injury or illness, date of the disability, duration of the disability, treatment and any lingering effects.

6.1.5.2 Family health history

Of almost equal interest as personal health history to the insurance company's underwriting department is the health history of members of the client's immediate family: parents and siblings. As explained in previous chapters, certain health issues, although not strictly hereditary, tend to "run in families."

Family longevity is a positive factor in underwriting life insurance (longer life expectancy means lower premiums) but may be a negative for critical illness or long-term care insurance: the longer a client is expected to live, the greater the likelihood of a claim and, in the case of long-term care insurance, the larger the claim is likely to be.

Clients may be at greater risk of developing certain health issues, particularly later in life, if the same problems manifest themselves in their parents or grandparents. It is not unusual for a client to experience adult-onset type II diabetes if his parents or grandparents were also type II diabetics.[34] Women whose mothers had breast cancer are more likely than the general population of women to develop breast cancer themselves.[35]

Some genetic conditions are actually "inherited" and pose the risk of future health problems.

Particularly in the case of critical illness or long-term care insurance, such family risk factors would likely lead to a restriction of coverage and/or benefits or a decline of coverage altogether.

6.1.6 Retirement goals

When the client plans to retire and the type of retirement lifestyle he anticipates having are factors to consider when the agent designs an A&S insurance program. When retirement is scheduled will have an impact on how long benefits need be payable under a disability income replacement program: ideally from the present until the retirement date.

6.1.6.1 Travel and living abroad or living at home

The quality of retirement that the client anticipates could also dictate the nature and scope of A&S coverage required, particularly critical illness (CI) and long-term care (LTC) insurance.

If the client plans to travel extensively in retirement, there may be increased impetus to put critical illness and LTC coverage in place. For example, should the client suffer a debilitating heart attack or stroke, the consequences could curtail his mobility or necessitate special medical care or appliances, like a wheelchair or manual controls on a vehicle. While these aids would be important to the client in any event, the need, and costs, might be even greater to those who plan on a more active lifestyle.

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34. Canadian Diabetes Association. *Risk factors*. [online]. [Consulted August 3, 2017]. http://www.diabetes.ca/about-diabetes/risk-factors
35. Canadian Cancer Society. *Breast cancer statistics*. [online]. [Consulted August 3, 2017]. http://www.cancer.ca/en/cancer-information/cancer-type/breast/statistics/?region=pe

On the other hand, retirement living arrangements could also be an important factor, particularly if the client is considering living abroad, even part of the year (winters in Florida, for example). Health costs in a foreign jurisdiction might be much higher than in Canada and might not be covered, or entirely covered, by provincial health insurance. Travel insurance, health insurance or long-term care policies might be required as supplemental coverage.

6.2 Client income

Disability income replacement insurance is, naturally, all about the client's earned income. The insurance is designed to replace earned income lost because of a period of illness or injury. But sources of unearned income must also be considered: investments, annuities, pensions, income from trusts, etc., as these may be a continuing source of cash flow to support the client and his dependents regardless of whether he is able to work.

The client's income, particularly earned income, is a less important factor in assessing critical illness and long-term care insurance needs, since the products are intended to provide benefits to defray expenses, not replace income.

6.2.1 Sources of earned income

For the pre-retirement client, aside perhaps from investment income, income from employment or self-employment will be the mainstay of providing for living expenses, savings and investments, etc. It is critical for the agent to be able to identify not only the source and amount of employment income, but to assess its consistency and future viability.

6.2.1.1 Salary, bonuses and commission income from working

If the client is an employee, the agent will want to obtain some history of that employment in order to determine the stability of the client's employment income (length of current and previous employments, trending career path). It is vital to obtain a breakdown of the client's employment income sources and amounts, broken down between salary, bonuses and commissions considering that they do not all offer the same level of predictability and stability of income. It is important to keep in mind that, where an employee is a member of an employer/employee group plan, the group plan only covers his income from that employer, not possible outside sources of earned income.

If the employment income comprises a base salary plus bonuses, how consistent have the bonuses been in the past? Can they be counted on to form part of the client's income in the future? How are the bonuses calculated?

If the client earns income, in whole or in part, from commissions, it is important to obtain a trend of that commission income over several years (about five years) to ascertain the stability of the client's current income and the viability of his income in the future.

6.2.1.2 Business income

If the client is not an employee, but works for himself or in partnership with others, or is an employee with one organization but also has additional sources of earned income, it is important to discover details of the business itself and the history of the non-employment income source(s) in order to assess the viability and consistency of the business income stream.

In the case of an employee, disability income replacement insurance coverage is generally based on a percentage of pre-tax income and, in the case of the self-employed, on pre-tax but after-expense (net) income. However, in the case of a self-employed client, business expenses may also need to be taken into consideration. If the business has substantial fixed overhead (premises rent, employees' salaries, etc.), a separate disability business overhead expense policy may be required, in addition to insurance to replace the income of the owner/operator himself. In the case of a smaller operation, a consultant or freelance salesperson, perhaps, whether or not overhead needs to be factored into the amount of coverage required will depend on the nature of the overhead. A consultant operating from a home office may incur overhead only when he is working: travel expenses, courier costs, supplies, etc. If so, the cost of overhead does not need to be factored into the amount of coverage required during periods of disability. On the other hand, if the same consultant has fixed overhead (a rented office outside the home, a vehicle leased exclusively for business use, a business accountant, etc.), those expenses will still need to be covered during periods of disability and should probably be factored into the amount of coverage required.

6.2.2 Sources of unearned income

When considering a client's overall sources of replacement income, or income to defray medical or care expenses, earned income is generally the first thing that an agent will review. However "passive" income must also be taken into consideration: income available to the client even when he is not working. Passive income could include income earned by other family members, investment income, income received as beneficiary of a trust or sources of cash flow that are not strictly "income" but which could be utilized as a substitute for income.

6.2.2.1 Income earned by spouse

For couples who are married or living common-law, it should be kept in mind that the income of a spouse, whether earned income or passive income, could be considered to be passive income to the benefit of a client. It is passive income in the sense that it is a source of income that could be expected to continue even if the client were disabled, suffering from a critical illness or in need of long-term care.

It should be kept in mind, however, that the spousal income is, in this sense, family income and not an income source available exclusively to the benefit of the client. The spousal income has to be valued in the context of the overall family needs, not merely the needs of the client. Consideration must also be given to the possibility that the spouse may have to assume the role of caregiver for an afflicted client, resulting in a reduction or elimination of that spousal income.

6.2.2.2 Investment income

Investment income (interest, dividends and capital gains) may be earned on either registered or non-registered investments. In the case of registered investments, the “income” is normally locked within the registered plan and forms part of the growth of the registered plan, rather than the cash flow of the client. As such, income on registered investments is not normally taken into consideration in conducting an accident and sickness insurance review.

Interest and dividends derived from non-registered investments may either be paid to the investor periodically or reinvested within the investments, as is often the case with mutual funds and segregated funds. If the investment income is paid out to the client, it becomes part of the client’s cash flow and should be taken into consideration when determining disability income replacement needs. If the investment income is normally reinvested, a decision must be made in the planning process: in the event of an emergency, disability for example, would the client wish to convert current investment income into current cash flow or continue to reinvest it.

If investment income is currently being paid to the client, or would be converted from accumulation mode to payout mode in the event of an emergency, it needs to be factored into an income replacement calculation, both as a pre-disability and a post-disability income source. Allowance needs to be made, however, for possible market downturns, when investment values may have been depleted and it might not be prudent to liquidate assets.

6.2.2.3 Support payments

A divorced or separated client may be in receipt of either spousal or child support payments or both. These payments would be a factor in calculating both pre-disability and post-disability income, since payments to the client would still be payable regardless of whether the client was disabled, had suffered a critical illness or was in need of long-term care. It is important to know how much the payments are, whether they are taxable or tax-free income, how frequently they are paid, and for how long into the future they will be payable.

As part of the review and planning process it would also be important to ascertain the long-term ability of the payor to continue meeting his support obligations, particularly if he himself was to die or become disabled. An insurance review of the payor could also be an important element in an overall plan.

6.2.2.4 Pension income

Pension income – government, corporate or private – can be a source of replacement income for a disabled earner or a resource to help defray the costs of a critical illness or of long-term care.

In the case of the pre-retirement client, it is important to ascertain what sources of pension income can be available in the future, when the pension can begin and how much would be payable at different start dates. Should the client become long-term or permanently disabled, prior to

retirement, future pension income could replace much or all of his income lost to disability. The amount of disability income replacement benefit would then be the amount required to fill the income gap between the date of a possible disability and the date(s) that the client's pension(s) could commence.

Government plans will be addressed later in the Chapter. Some offer disability benefits and/or may allow for a government retirement pension to begin earlier.

6.2.2.5 Royalties and other income sources

Similar to investment and pension income, ongoing royalties and residuals for past work continue to be paid regardless of the client's ability to work in the present or the future. These payments must be taken into consideration in calculating the client's current and future income, regardless of any potential disability or need for extraordinary medical or lifestyle treatment or support (e.g., home care or residency in a nursing home).

The agent should also inquire as to the possibility that the client is, or will be in the future, the recipient of income from a trust or estate established by a grandparent, parent or other family member or individual. If such funds are being received currently, it is important to ascertain the amount of trust income received annually, the frequency of payments and the future duration of the payments. If such payments are prospective only, it is still important to record the particulars, for future reference.

EXAMPLE

Clarence is named as income beneficiary for his father's estate, with the capital residue of the estate to be paid to Clarence's children at his death. At present Clarence's father, age 78, is alive and relatively healthy for his age, so no income is forthcoming from the "estate" to Clarence, nor is it known when such income might commence or how much it might be. Such speculative income cannot be factored into Clarence's estate and financial planning, but its potential existence still should be recorded as part of an overall review.

6.2.2.6 Disability income

As outlined later on in the Chapter, the client's existing sources of disability income benefits must be taken into consideration when assessing the need for additional coverage. Existing sources of disability income could be private insurance plans, group plans, or government plans like CPP or the Québec Pension Plan (QPP) and Workers' Compensation and Employment Insurance. The availability of these disability income sources, benefit amounts and duration and the qualifying definition of disability should all be explored. Details can be obtained from policies, group benefits booklets, Service Canada or provincial agencies responsible for managing government plans.

6.2.3 In-kind income

Not all income comes in the form of cash payments. “In-kind income” is provided in the form of goods or services, offered on an exchange basis for goods and services previously provided by the client, or gratuitously, most often by a close family member.

6.2.3.1 Contribution to elder care from stay-at-home caregiver

In the case of a client in need of in-home care due to illness, injury or the effects of ageing, the care services of a live-in family member can be considered to be a form of “income.” The care provided for free replaces professional services. Such care could be in the form of cooking, cleaning, bathing or other personal or household services that the client might not be able to perform for himself. The caregiver might be a spouse, child or a friend or other relative, typically living with the afflicted individual. The “income” provided by such services is indirect: the free care eliminating expenses that would otherwise be paid to a third party.

The offset to such in-kind income might be the actual income that the caregiver could otherwise earn outside the home, particularly if the caregiver is a spouse or child who was previously working and contributing to the household budget.

6.2.3.2 Community programs

Of similar value as family caregiver support are the free services available through government and community associations, including in-home care, rehabilitative care at community centres, Meals on Wheels, and like services available in the client’s community. The simplest way to find information about the types of service available to the client is through an organization like the Community Care Access Centre (CCAC)[36] (Ontario). The CCAC can provide contact information for such services and for visiting health professionals, including: nurses, physiotherapists, occupational therapists, speech-language pathologists, dietitians, pharmacists, respiratory therapists and social service workers.

6.2.4 Other sources of income

The concept of “income” is classically defined as “… the money or other gain periodically received by an individual, corporation, etc., for labour or services, or from property, investments, etc.…”[37] In times of need, like when a client is disabled and unable to generate income on his own, savings and assets may be converted into cash flow to replace the lost income, thereby becoming a source of “income” in their own right.

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36. Ontario Ministry of Health and Long-Term Care. *Home, community and residential care services*. [online]. [Consulted August 3, 2017]. http://www.health.gov.on.ca/en/public/programs/ltc/21_other.aspx
37. *Webster’s New World Dictionary*, College Edition, Nelson, Foster and Scott, Ltd., Toronto, Canada 1968.

6.2.4.1 Emergency funds and other assets

The purpose of having an emergency fund is to have a liquid source of cash – ideally three to six months' worth of expenses – to cover expenses in the event that extraordinary expenses should arise or regular income flow should be interrupted by disability or another health-related crisis.

Other assets may not be expressly designated as an emergency fund but, if they can be accessed quickly and with little or no negative tax consequences, they could also fulfill the role of, or augment, emergency funds.

6.3 Client expenses

Disability income replacement needs can be calculated as a percentage of income, usually about 60% of pre-tax income since private disability insurance benefits are generally tax-free. Or the need can be calculated based on the amount of net income required to meet household and other expenses. It is the role of the agent, in consultation with the client, to ascertain which approach is better in a given situation.

EXAMPLE

Sofia is a freelance translator and earns on average $60,000 of pre-tax income annually. Her portion of family expenses such as mortgage payments and groceries amounts to $2,000 a month. Because she would not be able to continue obtaining contracts if she was to become disabled, she wishes to purchase disability insurance.

Based on an income approach, her agent could recommend monthly benefits of $3,000, i.e. 60% of her monthly pre-tax income ($60,000 ÷ 12 × 60%). Based on an expense approach, her agent could recommend monthly benefits of $2,000. Both would be appropriate and the final decision would have to take into consideration other factors, such as affordability.

Critical illness insurance benefits are usually pre-determined as a lump sum based on the agent and the client's best estimate of how much might be needed to cope with a critical illness. The amount of the benefit selected is often tied to lifestyle or an estimate of expenses that might be incurred, but is not based on a percentage of the client's income. Affordability of the premiums is, of course, always a consideration, as with any other form of insurance.

Long-term care benefits are based on a maximum reimbursement amount expected to be required to provide the covered services. There is no specific link to the client's income other than the consideration of affordability.

If the expense route is taken for computing disability income replacement needs, the agent will have to solicit a variety of information and documentation from the client to get a clear and complete picture of needs. Expenses can be broken down into three categories:

- Living expenses;
- Savings and investments;
- Debt.

6.3.1 Living expenses

Living expenses make up the majority of outflow under most family budgets. Living expenses encompass a wide range of items: accommodation, food, light and heat, car maintenance or lease payments, etc. A compilation of the client's living expenses indicates the minimum amount of after-tax income from all sources required on a month-by-month basis to operate.

6.3.1.1 Mortgage statement or rental agreement

A client's mortgage or rent payments are usually the single largest monthly expenditure, usually running many hundreds or thousands of dollars each month. However, it is not sufficient for an agent to know only how much the client is required to pay monthly because the expense must be mapped out in the future to foresee how it may be impacted by a period of disability or illness. The terms of the mortgage or rental agreement, sometimes found on monthly statements, such as renewability, term, interest rates, balance outstanding, etc., must be explored.

6.3.1.2 Bank statements

Most, but not all, other living expenses can be identified through a review of the client's bank statements over a period of one year. This will tell the agent not only how much the client spends each month, but on what the funds are spent and when. In consort with the family budget, explained below, the bank statements will give a clear indication of the minimum amount required to maintain the client and his family.

If the agent is able to get the client to complete net worth and income and expense statements, there might be no need to review the bank statements.

6.3.1.3 Budget

Not every client will have a formal budget: but each one should. A budget, in theory at least, permits a client to plan ahead for expenses and live within his means. Also, the budget helps to give the agent a clear picture of when and where the client spends his money, permitting identification of which expenses are "need to," that must be provided for in a disability plan, and which are "nice to" and can be left out of the plan if necessary.

The following example presents a sample budget indicating the types of income and expenses that should be tracked on a monthly basis.

EXAMPLE

Monthly budget[38] for Matthew C. for the month of _____

Category	Monthly budget amount	Actual amount	Difference
Income			
Wages/Income	$872	$810	$62
Interest Income	$232	$196	$36
Income subtotal	**$1,104**	**$1,006**	**$98**
Expenses			
Taxes	$386	$397	($11)
Rent/Mortgage	$298	$239	$59
Utilities	$99	$95	$4
Groceries/Food	$121	$100	$21
Clothing	$66	$60	$6
Shopping	$55	$46	$9
Entertainment	$44	$44	$0
Miscellaneous/Other	$35	$31	$4
Expenses subtotal	**$1,104**	**$1,012**	**$92**
Net income (Income – Expenses)	**$0**	**($6)**	

Tracking income and expenditures, month by month, on both an “expected” and an “actual” basis allows for the assessment of the viability of the budget and for modification, as needed.

6.3.2 Savings and investments

Saving and investing are a two-sided coin in regard to cash flow in times of disability or a debilitating illness. If the client has savings and investment accounts, they can obviously be utilized as a capital source to replace or augment current income if earned income is curtailed due to disability. From that perspective, the savings or investments are an asset. However, if the client is in the habit of contributing regularly, perhaps monthly, to these plans, he may wish to continue the contributions, even during periods of reduced income, in order to ensure the accumulation of sufficient retirement

38. Money Instructor. *Sample monthly household budget*. [online]. [Consulted August 3, 2017]. http://content.moneyinstructor.com/437/sample-budget.html

income or wealth for his estate. These plans could also be seen as a form of liability, with the contributions being a cash drain, similar to other personal and household expenses.

The best way to determine the nature and extent of savings/investment plans is to review the client's documentation and statements pertaining to:

- Registered investment accounts;
- Non-registered investment accounts;
- Pension plans;
- Life insurance.

6.3.2.1 Registered investment account statements

The client's registered retirement savings plans (RRSPs) and tax-free savings account (TFSAs) can be a source of capital to replace lost income or pay extraordinary medical or care expenses. Details of the plans and their holdings can be derived from the client's regular statement for these accounts. Of particular interest would be:

- the balance in the account;
- the character of the individual investments (liquid or non-liquid);
- maturity dates for any term deposits; and
- surrender fees if the accounts hold mutual funds or segregated funds.

Of course, in the case of RRSPs or registered retirement income funds (RRIFs,) allowance would have to be made for tax payable on withdrawals if consideration was being given to surrendering part or all of the account to supplement lost income or to pay medical or care bills. It should also be kept in mind that both capital investments and accrued income can be withdrawn from a TFSA tax-free.

If the client, or a member of the client's family, is already suffering from a disabling condition that qualifies for the Disability Tax Credit (DTC), he may also have a registered disability savings plan (RDSP).

RDSPs are registered plans approved by the federal government to provide qualifying disabled beneficiaries with a tax-deferred savings program and support payments in their later years.

A disabled person is eligible to be a beneficiary of an RDSP who:

- Is eligible for the Disability Tax Credit (disability amount);
- Is a Canadian resident;
- Is under 60 years of age (if 59, the individual must apply before the end of the calendar year in which he turns 59);
- Has a social insurance number.

Contributions are not tax-deductible. There is no annual limit for a private contribution to a plan. The lifetime private contribution limit for an RDSP was $200,000 in 2014.

The federal government may pay a matching Canada Disability Savings Grant, depending on the amount contributed and the beneficiary's family income. The government may also pay a Canada Disability Savings Bond into the RDSPs of low-income and modest-income Canadians.

Investment income earned in the plan accumulates tax-free. However, grants, bonds and investment income earned in the plan are included in the beneficiary's income for tax purposes when paid out of the RDSP.

6.3.2.2 Non-registered investment account statements

Most of the same considerations apply to non-registered savings and investments as to the registered accounts, with all relevant information being found on the account statements. The tax considerations are different though, with capital gains upon surrender of investments being the main consideration. The statements from the account manager or fund should provide the current adjusted cost basis (ACB) for the client's account or investments, facilitating the calculation of capital gains reportable upon surrender of assets.

6.3.2.3 Pension plan statements

In the case of those approaching retirement, a client's pension plan may be a source of income to supplement earnings lost to disability or to help to pay medical bills or the costs of long-term care. A review of the client's annual pension statement should provide an overview of:

- Commuted value of pension funds on deposit to the credit of the client;
- Portability of the funds;
- Earliest age at which the pension may be commenced;
- Whether the pension is structured to bridge (co-ordinate) with CPP/QPP or OAS;
- Based on current credits on hand, the amount of pension payable depending on the age at which pension payments commence.

6.3.2.4 Life insurance statements

Cash value life insurance can also serve as a valuable asset. The client is likely to be able to provide both the policy itself and the most recent annual statement from the issuing insurance company.

The annual statement will disclose the premium and the frequency with which it is payable; annually, monthly, etc. The statement will also state the most recent policy dividend, in the case of participating whole life policies, and may state the cash surrender value (CSV) of the policy at last anniversary.

A review of the policy itself will likely be required to determine if the contract provides for "premium holidays": periods during which no premiums need be paid by the policyholder; the premiums are supported by the cash value of the contract. The policy will also note if there is a waiver of premium rider in force: providing that premiums due are paid for by the insurance company during a period of disability (after a three to six-month waiting period).

As such, cash value life insurance could be a source of cash flow during emergencies four ways:

- annual policy dividends paid to the policyholder;
- cash value loans;
- premium holidays (not a source of incoming cash, but a reduction in expenses); and
- waiver of premium during disability (again, a reduction in expenses).

6.3.3 Debt

A client's personal debt load is of particular interest to an insurance agent for three reasons:

- debt must generally be serviced monthly, establishing one of the primary base lines for a monthly budget and, therefore, the minimum amount of monthly cash flow required in the event of disability;
- at some point debt must be discharged, ideally at least prior to retirement age, establishing a deadline for debt retirement; and
- the client's debt load is a telling indication of his ability to manage cash flow and his willingness to assume risk.

6.3.3.1 Personal line of credit and Home Equity Line of Credit (HELOC) statements

The client may have an unsecured personal line of credit with his financial institution and/or a home equity line of credit, secured by his home. These credit lines are amounts that the client can draw upon at any time. The monthly statements for these lines of credit will indicate the maximum amount that may be borrowed, the current balance outstanding and the rate of interest applied against any outstanding balance. Typically, only the monthly interest owing need be repaid regularly (and perhaps a percentage of the outstanding principal), but not the entire balance owing. Secured lines of credit, particularly, have much lower rates of interest than consumer debt (see next section).

As with credit cards, the unused portion of personal lines of credit can, in extreme cases, be regarded as a source of emergency funds. It may also be prudent to draw against these low-rate sources of capital to discharge high-rate sources of debt, like credit cards, which often have annual interest rate charges in excess of 20%.

6.3.3.2 Credit card statements

Bank of Canada research conducted in 2010[39] indicated that 80% of Canadian adults held at least one credit card and for the majority of larger purchases ($50 or more) the credit card was the payment method of choice. Credit cards are available from a wide variety of sources: banks, credit unions, retail stores and gas stations, among others. So odds are that a client will have at least one card.

The simplest way to review the status of a client's credit card accounts is to examine his three most recent monthly statements. This will provide an indication of how often the client uses the cards, the level of purchases normally made, the average monthly payment and whether the client discharges the balance in full each month. If not, the most recent statement would provide information regarding the current balance on hand and the interest charged on the balance. Additionally, the statement will outline any other benefits available from the issuer (theft protection, accidental death insurance, job loss protection, etc.). And the statement will outline the amount of credit limit still available on the card: a potential source of emergency funds.

6.3.3.3 Tax liabilities

Clients may have a variety of different tax account balances pending or outstanding that need to be taken into account when assessing the current and future financial position:

- Personal Income Tax — The client's personal tax situation can be determined by reviewing his most recent Federal Income Tax Return (and for Québec residents, the most recent Provincial Income Tax Return) and related Notice of Assessment, and any subsequent Tax Statements. Tax arrears owing, if any, and unpaid quarterly instalments may be subject to both interest and penalties.
- Corporate Income Tax — If the client is the sole owner of an incorporated business, the agent will need to review the provincial and federal tax returns for the corporation and Notices of Assessment, to determine whether any current tax is due or owing or the corporation has tax arrears.

39. Bank of Canada. *The changing landscape for retail payments in Canada and the implications for the demand for cash*. [online]. Revised Autumn 2012. [Consulted August 3, 2017]. http://www.bankofcanada.ca/wp-content/uploads/2012/11/boc-review-autumn12-arango.pdf

▪ GST/HST	If the client is a sole proprietor or partner and has gross business revenues of more than $30,000 a year, he will be required to collect and remit taxes. Details of any amounts owing (current instalments or arrears) can be obtained by the client's GST Return, GST Notice of Assessment or Quarterly Remittance Statements.[40]
▪ Residential rental, or vacation Property Tax	If the client owns his own residence (house, condominium, etc.) or a rental or vacation property, he will be required to pay property tax to his local municipality. Details of tax owing, instalments pending or tax arrears can be obtained from his annual Property Tax Statement from his municipality and any subsequent statements.

6.3.3.4 Other liabilities

In addition to those debts and liabilities discussed above, the insurance agent should be watchful of such additional items as:

- Commitments under support agreements for a child or ex-spouse;
- Actual or potential lawsuits against the client in progress or pending;
- Likely need to provide financial support for family members (ageing parents, for example) in the foreseeable future.

6.4 Financial situation of the client

Aside from income sources, especially those that could continue in the event of disability, the biggest factor in determining a client's ability to weather the storm of a prolonged disability, critical illness, etc. is the soundness of the client's overall financial position. Does he have the assets available to replace lost income or pay for unexpected medical and care expenses, or will insurance benefits be needed to fill the gap? And does the client have the resources available to pay premiums for needed insurance coverage?

6.4.1 Net financial position

A client's overall financial position is generally referred to as "Net Worth": assets less liabilities. However, net worth might not be quite as simple as it sounds and the following questions may need to be answered:

40. Government of Canada. *GST/HST*. [online]. Revised August, 29, 2017. [Consulted September 26, 2017]. https://www.canada.ca/en/revenue-agency/services/tax/businesses/topics/gst-hst-businesses.html

- Should assets be valued at fair market value or on an after-tax basis?
- In terms of emergency situations can the client count on the accessibility of non-registered assets that can easily be converted to cash, provided market conditions are favourable?
- By how much and for how long could assets be converted to cash flow before other key financial objectives (retirement, for example) would be put at risk?
- Should net worth be computed on a living or at a death-time basis? Concurrently, should assets like insurance be valued at their death benefit or investment value? And do additional liabilities at death (final expenses, income tax, etc.) need to be taken into consideration?

It is important for the agent to ensure the approach taken is consistent throughout his analysis in order to produce a coherent recommendation.

6.4.1.1 Review of assets

A net worth statement will ideally list all assets (rather than cash flow), valued at their current fair market value. It should note whether the assets are registered (as an RRSP, for example) or non-registered and provide the adjusted cost base (ACB) for all non-registered assets. It would also be helpful if the cost of registered assets was listed, to simplify identifying “winners” and “losers” if consideration must be given to liquidating investments. In terms of assessing the availability of assets to assist in emergency situations, it is important to identify assets as “current” or not. Current assets would be those that could be easily converted to cash immediately, or at least within 12 months. Certain assets, like the family home, should be eliminated from consideration as a source of emergency funds except in the most dire of circumstances.

6.4.1.2 Review of liabilities

The liability statement would include such items as mortgages, bank loans, credit card balances and unpaid taxes. Included in the tax analysis should be potential taxes payable on registered funds or capital gains should assets have to be liquidated. As with assets, liabilities can be divided into “current” and “long-term.” Current liabilities would include the service cost of debt, whereas longer-term liabilities might include the principal value of the debt itself.

The key to the overall exercise is to determine two things:

- In the event of loss of earned income due to disability, does the client have sufficient resources (cash flow and liquid net assets) to cover the income loss for at least one year?
- In the event of a medical emergency (critical illness, need for long-term care or emergency medical treatment), does the client have sufficient resources (cash flow and liquid net assets) to cover medical and care expenses for at least one year?

The following example presents a sample format for a standard Net Worth Statement.

EXAMPLE

Net Worth Statement for John and Jane H., as of _____ (date)

Assets	
Home	$526,000
Cottage	$360,000
Two vehicles (Owned)	$40,000
RRSPs	$105,000
TFSA	$3,300
Life insurance CSV	$22,000
Cash	$7,100
Total assets	**$1,063,400**
Liabilities	
Mortgage home	$112,000
Mortgage cottage	$86,000
Line of credit	$23,600
Credit cards	$8,900
Car loans	$5,300
RRSP loan	$4,400
Total liabilities	**$240,200**
Net worth (assets less liabilities)	**$823,200**

6.4.1.3 Cash flow statement

The cash flow statement lists all sources of net income (income after income tax) and all expenses including debt payment for liabilities. Reviewing such a document with the client can assist the agent in a number of areas:

- It can provide a more detailed summary of amounts and sources of the client's income;
- If the statement shows a surplus of income over expenses, it can identify possible cash flow resources to offset lost earned income or increased medical expenses;
- The expenses portion of the statement can be used to identify those cash outflow needs that must be met, helping in calculating the minimum amount of accident and sickness (A&S) coverage required;
- If the statement shows a surplus, it can be used to determine resources available to fund an A&S insurance program; and
- Even if the statement does not show a surplus, it could be used to identify current expenses that could be cut back, freeing up cash to fund such a program.

The cash flow statement can be developed for a period of time as long as a year or as short as a month. It is most accurate when it is backed up with a budget based on actual spending patterns. The following example illustrates a cash flow statement drawn up over a period of three months.

EXAMPLE

Cash flow statement for John and Jane H., as of _____ (date)

	Month 1	Month 2	Month 3
Net Income			
John's salary	$5,500	$5,500	$5,500
Jane's salary	$3,800	$3,800	$3,800
Total net income	**$9,300**	**$9,300**	**$9,300**
Expenses			
Mortgage payments: home	$475	$475	$475
Mortgage payments: cottage	$350	$350	$350
Line of credit	$35	$35	$35
Credit card payments	$600	$200	$1,600
Car loan payments	$400	$0*	$0
RRSP loan interest payments	$100	$100	$100
Child care payments	$850	$850	$850
RRSP deposit	$200	$200	$200
Insurance premium	$160	$160	$160
Cell phones	$90	$90	$90
Hydro, heating, water bills	$500	$500	$500
Clothing	$400	$200	$300
Food	$800	$800	$800
Entertainment	$400	$500	$7,000**
Miscellaneous/Other	$1,250	$1,250	$250
Total expenses	**$6,610**	**$5,710**	**$12,710**
Cash flow	**$2,690**	**$3,590**	**-$3,410**

* Car payments are finished; cash flow increases.

** Entertainment increases due to family holiday; miscellaneous costs are less for the month.

6.5 Insurance situation of the client

First the agent must assess the client's level of risk of disability or other accident and sickness events, and his non-insurance income and capital resources to deal with the cost of disability and the need for care. This will enable the agent to assess the client's overall need for A&S insurance protection. The next step is to catalogue and assess the client's current insurance protection, if any, and compare that with his needs.

6.5.1 Personal and/or group coverage in place

A&S insurance can come in many forms: individual policies, group insurance coverage and protection associated with debt, for example. It is not only important for the agent to know the type and amount of coverage that the client currently holds, but the character of that coverage as well.

6.5.1.1 Type of policy/policies

A&S insurance policies can be classified in different ways:

- By source:
  - Individual, personally owned policies;
  - Individual, corporately owned policies;
  - Group insurance;
  - Individual, lender-owned policies (associated with debt obligations such as a mortgage or credit cards).
- By benefits:
  - Disability income replacement;
  - Business overhead;
  - Disability buyout;
  - Extended health insurance;
  - Critical illness insurance;
  - Long-term care insurance.

Depending on the source of the coverage there may be inherent limitations on the coverage provided. For example, credit card disability coverage usually only covers the monthly minimum required payment in the event of a total disability lasting longer than three months.

With group insurance coverage it is important to note whether the source of protection is an employer's group or some other group plan, like alumni or association group. An employer's group plan is only available to employees of the company and could terminate without rights of conversion when the plan member leaves the employ of the employer. Association coverage, on the other hand, does not have such restrictions.

6.5.1.2 Characteristics of coverage

It is important for the agent to document the characteristics of each source of coverage and then prepare a spreadsheet co-ordinating the coverage for each type of risk. For each type of coverage/policy the agent needs to know:

- The risk covered (disability, critical illness, long-term care, etc.);
- Conditions covered;
- Exclusions on coverage;
- The type of benefits available;
- The amount of benefits available;
- The duration or maximum amount of benefits available;
- Ancillary benefits (waiver of premium, death benefits, etc.);
- The tax status of premiums paid and benefits received;
- Definitions of disability, critical illness, etc.;
- When coverage terminates;
- Is the coverage renewable or convertible?

Only by comparing these factors for all the client's sources of protection can the agent develop a clear picture of the client's current circumstances and assess future needs.

6.5.1.3 Cost of coverage

Lastly, the cost of the coverage currently provided could be a factor in developing a comprehensive risk management plan, particularly if the client has limited resources with which to pay premiums. Some plans, like association group coverage, may be able to provide duplicate benefits to those offered by individual policies, but at a lower unit cost. Others, like credit card coverage, may provide limited benefits but at a comparatively high price. If these coverages are optional, premium costs might be better allocated elsewhere. And if the client has limited resources to commit to an insurance program, triage may be necessary, deciding which coverages are most critical and should therefore be retained.

6.5.2 Government coverage

In Canada the federal and provincial governments provide a variety of programs that offer benefits to those participants who are unable to work due to injury or illness. The following discussion provides an overview of the benefits available from these various government-sponsored plans. The features of government plans may be updated regularly and, consequently, it is important for agents to stay informed of current contribution and benefit levels as well as eligibility requirements.

6.5.2.1 Employment Insurance (EI)

Employment Insurance (EI), formerly known as Unemployment Insurance (UI), is a federal government program designed to provide support to workers who are unable to work or who have been laid off from previous employment. The sickness benefits under the plan are payable to covered employees who are unable to work due to illness, injury or quarantine. To qualify for benefits the employee must have worked a set number of hours for a set period of time and suffered a minimal reduction in income due to disability. Currently, requirements are to have worked at least 600 hours in the previous 52 weeks and suffered at least a 40% reduction in income due to the disability.

In 2014 EI paid a maximum benefit of $514 per week based on 55% of the average weekly eligible income. A benefit of up to 80% of the average weekly eligible income can be payable if the employee is the head of a low-income family.

Benefits start on the 8th day of disability and are payable for a maximum of 15 weeks, so EI benefits will not likely be a major portion of most clients' disability program. Additionally, EI is a second payor to most other forms of disability benefit (CPP, QPP, Workers' Compensation, group insurance) except personally owned disability policies. There is a dollar-for-dollar offset for other disability benefits, so no benefit would be payable if an amount equal to the maximum benefit was received from other sources (except privately owned policies).

EI contributions are based on the employee's eligible income and are shared between the employer and the employee based on provincial annual contribution rates. Residents of Québec have a lower contribution rate since a provincial parental insurance plan is in place (QPIP). Self-employed individuals may voluntarily choose to participate in the plan; they must pay 100% of the employee contribution but do not have to pay the employer contribution.

6.5.2.2 Canada Pension Plan (CPP)/Québec Pension Plan (QPP)

In addition to paying retirement benefits, the Canada Pension Plan (CPP) and Québec Pension Plan (QPP) also offer disability benefits to plan members under the age of 65. CPP is a contributory plan operated by the federal government for the benefit of all Canadians residents

outside the province of Québec. The QPP is a Québec provincial plan operated exclusively for the benefit of Québec residents.[41]

These plans' disability benefit is payable to plan participants who have a disability (injury or illness) that qualifies as "severe and prolonged." A "severe" disability is one that prevents the plan member from working in any capacity, not just the capacity in which he was working prior to the disability. A "prolonged" disability is one which will be long-term, usually permanent, and/or which is likely to ultimately result in death. Evidence of the disability must be supported by a doctor's report.

EXAMPLE

Tim and Tom are twin brothers, age 45, working in the logging industry in Alberta. Until last year they both worked in the field, trimming and cutting down trees. Unfortunately, the two were involved in a serious automobile accident last year, while on their way to a job site.

Tim suffered severe and permanent nerve and muscle damage to his right arm and is no longer able to work in the field. Fortunately, he was able to secure an administrative position in the logging company's head office, albeit at a lower salary. Because he is still able to work, Tim would not qualify for CPP disability benefits.

Tom was more severely injured in the accident, suffering permanent, debilitating spinal damage. Due to reduced mobility and chronic pain Tom is unable to work in any capacity and unlikely to recover. Tom would qualify for CPP disability benefits.

Contributions to the plans are based on qualifying income and are shared 50/50 by an employer and employee, or paid 100% by the self-employed.

Where payment of disability benefits is approved, the benefits are payable for each month commencing with the fourth following month in which the plan member became disabled. They are payable until the earlier of:

- Recovery of the disabled plan member;
- Disabled plan member reaches age 65; or
- Death of the plan member.

At age 65 the disability benefit is automatically converted into a retirement benefit. The CPP and QPP determine a maximum disability benefit and a maximum retirement benefit.

41. For more information regarding the QPP, consult the *Ethics and professional practice (Québec)* manual and the *Retraite Québec* website: http://www.retraitequebec.gouv.qc.ca/en/Pages/accueil.aspx
For more information regarding the CPP, consult the Government of Canada website: https://www.canada.ca/en/services/finance/pensions.html

6.5.2.3 Workers' Compensation

Workers' Compensation is provided mainly by provincially operated plans providing disability benefits to those qualifying employees who suffer a loss of employment income due to an injury incurred on the job or a workplace-related illness (such as asbestos or chemical poisoning). Contributions are paid 100% by the employer as a payroll tax. Benefits vary by province but average 80 to 90% of pre-disability net income.

6.5.2.4 Tax treatment of contributions paid and benefits received under government programs

The tax treatment of contributions paid and benefits received under the three public insurance and pension plans varies by type of plan and with who is the payer of the contributions. Tables 6.1 and 6.2 provide a brief summary of the tax rules.

TABLE 6.1

Taxation of contributions paid for government programs

PLAN	PAYOR	TAX TREATMENT
Employment Insurance	Shared by employer and employee	Deductible by employer for the employer portion
		Qualifies for tax credit for the employee portion
CPP/QPP	Shared by employer and employee	Deductible by employer
		Qualifies for tax credit for the employee portion
	100% paid by the self-employed	50% tax-deductible
Workers' Compensation	Employer	Deductible by employer
		Not a taxable benefit to employee

TABLE 6.2

Taxation of benefits received from government programs

PLAN	TAX TREATMENT
Employment Insurance	Taxed as income
CPP/QPP	Taxed as income
Workers' Compensation	Tax-free to the recipient

6.6 Client profile finalized

Once the agent has developed a clear picture of the risks that a client may face and the resources, including insurance, that he currently has to meet those risks, the process can begin of prioritizing needs and drafting recommendations to meet those needs.

It is important that the recommendation take into consideration the various types of client needs:

- Needs based on personal factors, such as age and gender, occupation and avocation as well as health;
- Needs based on financial situation, including the availability of financial resources to meet health-related risks such as disability, illness and need for medical care;
- Needs based on existing coverage.

Prioritization of coverage needs is firstly based on the client's personal circumstances: factors associated with the client, such as age, medical history, occupation, avocation and health that are likely to make him more prone to what types of risk.

All of these issues must be explored and taken into consideration when an agent is developing a personal accident and sickness risk management program for the client.

Once the client's risk factors have been identified and assessed, the next step is to assess the client's current financial ability to cope with those risks.

It must be determined whether the client has the financial resources to deal with the consequences of risk without resorting to A&S insurance. If the answer to this question is either "No" or "Not entirely," consideration must be given to appropriate insurance coverage.

Assuming that the client has some form of existing insurance coverage, the nature and extent of coverage provided must be compared to the risks identified and appropriate recommendations made. There are four possible scenarios:

- The existing coverage is complete, adequate and entirely appropriate — In this case, there is no need for an additional coverage – it is always more prudent to leave current coverage in place if it fully meets the client's needs.
- There is an unnecessary surplus of existing coverage — Surplus coverage is, by definition, unnecessary and an unproductive expense; it should be avoided by modifying existing coverage.
- The existing coverage is adequate but there is overlap among sources — Most sources of insurance protection have an "all sources maximum" provision in their contracts that limit the amount of benefits that the insured can receive from all sources. If existing coverage exceeds those limits, then the insured's attention should be drawn to the fact that benefits may be scaled back accordingly.

▪ There are gaps between needs and the existing coverage (the most likely situation)	Gaps in coverage may include: risks not insured, benefits insufficient to meet needs, waiting periods that are too long for the client to be able to self-fund risks, benefit periods that are too short or definitions of qualifying conditions that are too restrictive, etc. The key role of the agent is to identify and prioritize these gaps and formulate a plan to deal with them.

Once all the risk factors and resources have been identified and prioritized, and any gaps have been identified, the agent will be in a position to begin the process of formulating recommendations regarding the types and amounts of insurance protection that the client should apply for.

CHAPTER 7

INSURANCE RECOMMENDATION, CONTRACT AND SERVICE NEEDS

Competency components

- Analyze the available products that meet the client's needs;
- Implement a recommendation adapted to the client's needs and situation;
- Provide customer service during the validity period of the coverage.

Competency sub-components

- Analyze the types of contracts that meet the client's needs;
- Analyze the riders that meet the client's needs;
- Consider the impact of underwriting criteria as they apply to the client's situation;
- Propose a recommendation adapted to the client's needs and situation;
- Confirm the requirements that must be met to implement the recommendation;
- Validate the appropriateness of contract amendment, renewal and termination applications in regards to the client's situation;
- Inform the claimant of the claims process.

7
INSURANCE RECOMMENDATION, CONTRACT AND SERVICE NEEDS

Assuming that the fact finding process has been thorough, and the client profile is accurate and comprehensive, the next important steps in the client service process includes:

- Insurance recommendation;
- Application for insurance;
- Underwriting by insurer;
- Insurance contract;
- Policy claims;
- Client service.

7.1 Insurance recommendation

The first step is the development and presentation of a solution to the client's needs: the insurance recommendation. The life insurance agent has a duty of care to develop a recommendation, or series of recommendations that are suitable to the client's needs and to present the recommendation(s) in such a way that the client can understand the nature of his problems and the solutions offered and make an informed decision.

Many considerations go into preparing an accident and sickness insurance recommendation:

- Basis for the recommendation;
- Recommendations to manage premiums;
- Head-office modifications for non-standard risks;
- Providing quotes;
- Documenting the recommendation;
- Presenting complementary policies;
- Revising the recommendation.

7.1.1 Basis for the recommendation

The fundamentals of any insurance recommendation start with the client profile, which was discussed in the previous chapter and outlines the client's goals, needs and wants and his available resources to meet his objectives. With the client's overall A&S needs clearly established the agent then needs to compare those needs against the client's current resources (income, assets and existing insurance) to determine where shortfalls and gaps may exist.

Assuming that there are shortfalls/gaps, the agent should first consider whether the client's existing policies could be modified, through changes in coverage or the addition of riders, to create a more comprehensive insurance portfolio to meet these needs. And then consideration should be given to recommending new product acquisitions, to complement existing coverage and to complete the portfolio.

7.1.2 Recommendations to manage premiums

Accident and sickness (A&S) insurance is a complex product, in all its variations, and tends to carry a relatively higher premium compared with other types of insurance. This is due to the greater likelihood of occurrence of the covered conditions, as evidenced in insurers' claims ratios.

The result is that the premium commitment required of the client may be higher than anticipated, providing a roadblock to a successful completion of the recommendation process that would ensure any coverage gaps are closed. Assuming that "cost" remains an issue, the agent may need to consider modifying the product recommendation to manage the premium. Many A&S products have variations that can be selected to suit a proposed insured's needs and budget.

7.1.2.1 Extending waiting period, shortening benefit period, reduced benefits

Waiting periods, benefit periods and the scope of benefits can all be varied to suit a proposed insured's needs and budget. The longer the waiting period and shorter the benefit period, the lower the premium will be. A lower premium would also result from reducing the scope of the benefits.

Waiting period

One of the simplest and most effective means of reducing premiums is to extend the waiting period: the length of time between the commencement of a qualifying disability, critical illness, etc. and the commencement of the payment of benefits. If, for example, the client had selected a 60-day waiting period on his disability policy, extending that to 90 days (assuming that the client has the resources to survive financially for 90 days without an earned income source) could substantially reduce his policy premiums.

Benefit period

Similarly, shortening the benefit period under a disability or a long-term care plan would reduce the amount of benefit that the insurer would have to pay out and reduces premiums as a consequence. Again, care would have to be taken to ensure that the shorter benefit period would meet the client's needs, considering the uncertainty surrounding the duration of a disability or a need for care.

Benefits

Lastly, the actual amount of benefits provided by the policy could be reduced. This is, however, the more radical solution to policy cost since, if the agent has done his job properly, the benefit applied for is the amount that the client needs. Reducing benefits should likely be a "last resort" solution.

For any and all of the above suggestions to modify premium costs, care must always be taken to ensure that the client gets the best value for the premium dollars spent. Before considering any reduction in benefits, or benefit periods, every effort should be made to impress upon the client the need for the recommended coverage and the agent should work with the client to find the needed premium dollars, wherever practical.

7.1.3 Head office modifications for non-standard risks

Insurance companies set premiums to cover, among other items, administrative costs, including the anticipated level of claims. To keep premiums at an affordable level for all insureds, insurance companies consider the level of risk of claim associated with each proposed insured prior to accepting the risk to insure. The underwriting process will place a prospective life to be insured in one of three categories:

- Standard insurable risk;
- Non-standard insurable risk;
- Uninsurable risk (a "decline").

In the case of non-standard risks the company would normally still like to accept the risk, provided they can limit the extent of the risk to acceptable levels. Typically, the insurer will modify the policy applied for in one, or more, of four ways:

- Imposing exclusions;
- Imposing limitations;
- Rating the premium;
- Imposing a deductible on claims.

The client will not know the specifics of changes to the policy as applied for until time of policy delivery by the agent, but the agent may have an idea that the insurance company has some concerns and help prepare the client if, for example, he is required to take additional medical tests. Underwriters/ companies will usually notify the agent of placement and/or any modifications and why. This should provide an adequate amount of time for the agent to prepare for the delivery interview.

7.1.3.1 Suggesting exclusions, limitations and ratings

Exclusions (activities or conditions that are not covered under the contract) and limitations (restrictions on the amount of benefits, benefit period, etc.) are both elements that the insurance company might integrate into the contract being offered to the client to limit the insurer's otherwise excess risk exposure with a non-standard life. A rating is simply applying a premium to the contract that is higher than would be warranted if the applicant was rated "standard." The higher premium allows the insurer to build up a higher reserve – to help offset the higher risk of having to pay benefits.

7.1.3.2 Suggesting deductibles

An alternative, or complement, to modifying the benefits available under the plan is to require the insured to share in the cost of the covered treatments or benefits otherwise payable by imposing a deductible: an amount of the claim that must be paid by the insured before any benefits are forthcoming from the insurance company. Deductibles would be most common in extended health plans: plans which would normally require the insurer to pay, or reimburse the insured for, covered goods or services. Instead of being covered for the first dollar of claims, the insured is required to cover a dollar amount of the covered items himself, usually with a new deductible being applied each coverage year. In this way, the insurance company's exposure to payouts is somewhat reduced.

EXAMPLE

Elvira's group extended health insurance plan offers coverage of up to $2,500 a year for preventative and restorative dental services, after allowing for a $200 annual deductible per calendar year. Elvira's first claim this year was $300, for x-rays, cleaning and one filling. She had to pay the first $200 herself, under the deductible, and was reimbursed the additional $100. For any subsequent dental claims during the same calendar year no deductible would apply.

7.1.4 Providing quotes

There are two schools of thought about presenting multiple quotes or not (alternative product recommendations or policies) at the recommendation interview:

- Present only one product solution — The agent has already done all the work and is presenting the "best" solution. The client only has one decision to make: to accept the recommendation or not. However, the agent will research the market and make product comparisons prior to the presentation interview and should maintain a record of his research and the reason for his final recommendation.
- Present two suitable, but different, options — The client is engaged in the decision-making process based on the agent's preliminary research.

Which route to go is a matter of personal choice, but the agent who presents complementary choices should prepare a clear comparison (perhaps in chart form) that highlights the main points of each policy and their differences and similarities. Trying to compare more than a few basic points is likely to confuse the client and lead to "analysis paralysis" where the client has too many choices to make to be able to make a decision.

In making comparisons the agent should focus on where the policies may be similar (but not necessarily identical) and where they differ in any significant degree. On the issue of similarities, it would be important to highlight, for example, that both of two disability policies being recommended offer indexing of benefits tied to the Consumer Price Index (CPI), starting at the first day of disability. On the other hand, two critical illness policies that are both suitable for the client's needs might have very different definitions of a qualifying stroke: both as to the level of permanent neurological impairment required for a successful claim and the number of days that must pass before a declaration of impairment can be made.

Once the applicant has a clear understanding of the elements of each contract, the agent can help him make an informed decision between the policies being considered.

7.1.5 Documenting the recommendation

In the client's and the agent's best interests, it is vital that the particulars of any recommendations made, both written and verbal, be recorded in the agent's client file. Both the rationale for the recommendation and the client's expectations should be documented in order to confirm that the client's needs were at the forefront of the process.

7.1.5.1 Rationale for recommendation

The details of the recommendation itself are obviously important, but communicating and documenting the rationale behind the recommendation might be equally important.

Of course, it is preferable that this rationale should be provided in writing to the client at the culmination of the recommendation process, but there may be much background information that the client would not normally be privy to (comparative product quotes and other research, for example). This material should all be retained in the client file for future reference.

EXAMPLE

Agent Horst had to defend himself against a client complaint after another agent had reviewed the product that Horst had recommended, suggesting that Horst had not done due diligence in his research and therefore had not made the "best" recommendation for his client.

In fact, Horst had compared five similar products that could meet his client's needs and recommended the one that he felt was the best fit. Horst had wisely kept copies of his product research and a grid that he created to compare the products from a variety of perspectives. These documents proved invaluable in defending the fact that he did his due diligence and made a valid recommendation.

7.1.5.2 Client expectations

The complement to providing the rationale for the recommendation is to address, manage and document client expectations. During the fact finding interview and follow-up, dealing with goals, objectives and needs, the client may express his expectations regarding:

- The type and amount of insurance he feels that he needs;
- The type of insurance he expects he could qualify for (e.g., non-smoker rates);
- Whether he is in good health (i.e., a "standard" risk);
- The cost (premium) of the product, etc.

Meeting, or managing those expectations could be just as important to the recommendation process as selecting the most effective product for the client's needs. The details of those expectations should be addressed throughout the sales and service process. The client file should contain:

- A record of the expectations disclosed in the fact finding interview;
- A record of the agent having taken those expectations into consideration in his recommendations and where the product recommended meets those expectations or not, and why.

As well, at the policy delivery interview, when the agent reviews the new contract with the client, the issue of client expectations should be addressed again; if there are any serious divergences, it would be good for the agent to have prepared a waiver for the client to sign, pointing out any differences between the expectations and the reality, and have the client sign it.

7.1.6 Presenting complementary policies

Sometimes a single policy is not the answer to the client's needs and a combination of policies must then be recommended to provide a comprehensive solution. Even though the client may not be ready to purchase the complementary coverage just yet, its usefulness should be discussed early on so that the client may be aware that coverage gaps will remain until all his needs are fully addressed.

EXAMPLE

Elijah owns a computer software consulting firm with three employees: two part-time employees and one full-time employee named Malik. Malik's services are critical to the success of the business. If this key employee was to die or become disabled for a lengthy period of time, business revenues would suffer significantly, perhaps to the point where the business would have to be wound up. At the same time, Malik has a wife and two children who are wholly reliant on him for their financial support.

Elijah feels that the business could survive for at least 6 months without Malik's contribution, but his family would be in serious financial straits after only 60 days. The business would need replacement cash flow of $10,000 a month for up to 2 years whereas the family would need $3,000 a month for at least 5 years, if the disability lasted that long.

It would appear that one disability contract would not meet the needs of both the business and the family, so Elijah's agent recommended that the company take out two policies: a key person disability contract for $10,000 a month with a 180-day waiting period, payable to Elijah's company, and a disability policy for $3,000 a month with a 60-day waiting period, payable to Malik.

7.1.7 Revising the recommendation

For practical purposes, the agent's recommendation cannot be a "take it or leave it" proposition. If there are aspects of the recommendation that do not suit the prospect's needs, or expectations, the agent has an obligation, both moral and legal, to serve the client by providing as suitable a solution to the client's needs as possible under the circumstances. If the recommended product solution is not acceptable (too expensive, doesn't contain all the features desired, etc.) it is the obligation of the agent to restructure the recommendation to make it acceptable to the client, while still ensuring that it meets the client's coverage needs as closely as possible. This may be accomplished in the recommendation interview or the agent may have to go "back to the drawing board" to develop a new approach to be presented at a subsequent interview.

7.2 Application for insurance

Whether for life insurance or accident and sickness insurance, in the case of individual coverage (as contrasted with group coverage) the insurance application is the cornerstone of the issue process. Subsequent evaluations and investigations of the needs and health of the individual to be covered will be based, initially at least, on the information provided in the application. The application provides for information on the health and financial status of the applicant and/or life to be insured, in addition to the type of insurance being applied for and the reason for which the insurance proceeds would be required.

7.2.1 Attention to detail required

Because the entire insurance underwriting and issue process begins, and sometimes ends, with the application, it is critical that the agent involved in taking the application gathers information that is as complete and as accurate as possible.

It is the role of the agent to ask the applicant, and/or the life to be insured (if different from the applicant), every applicable question on the application form and to record the answers fully and accurately. Within limits, the agent is expected to be the "expert" on what information is required for the underwriting department. The applicant, and the life to be insured, are assumed to be "lay persons," unschooled in the world of insurance. From a practical standpoint, and legally, the applicant and life to be insured are, within reason, entitled to rely upon the expertise of the agent for interpretation of the questions being asked on the application and an explanation of the nature of the answers expected. If the head office underwriters are to be expected to do their jobs properly, the answers provided to them must be precise and unambiguous.

Inaccurate or incomplete information on the application could, at the least, result in a delay of the underwriting process. At the worst, incomplete or inaccurate information on the application could result either in coverage being declined where circumstances actually warranted it being issued, or in coverage being offered where there should have been more investigation done before a policy was issued. This second scenario could set the stage for a possible lawsuit down the road, should a claim be denied on account of misrepresentation.

Particular attention must be paid to the following aspects of the application:

- Product type and coverage details — The application should be completed to identify the type of insurance being applied for (disability or critical illness, for example) and the insurer's name for the type of policy. Coverage includes type and amount of benefits provided. It is up to the agent and the applicant to work out together the most appropriate amount of coverage to be applied for in the applicant's circumstances.
- Owner, life insured and beneficiary — It is important to determine the owner, the life insured and the beneficiary of the contract. In many cases, these will all be the applicant, but under certain circumstances, such as business insurance, the owner, life insured and beneficiary may differ. In all situations, care must be taken to ensure that the correct parties are named under the policy.

- Premium — The agent will normally have access to software to determine the premium rate for a standard life insured, for the type of plan being applied for and the profile of the applicant. The actual premium applicable to the issued policy may differ from that quoted on the application, depending on whether the life to be insured is rated "standard" and any restrictions or exclusions applied in the contract. The quoted rate will, however, give the applicant a reasonable expectation of the cost of coverage.
- Riders — In addition to the base coverage and benefits provided by a given type of insurance contract, optional benefits (riders) may be added to the policy at the discretion of the applicant, subject to financial and medical underwriting. Riders are subject to separate premium pricing and underwriting requirements.

7.2.1.1 Naming of beneficiary

As stated previously, in the case of most personally owned accident and sickness policies, the contract owner, the life insured under the contract and the beneficiary will generally be the same person. Most people will indeed wish to insure themselves against loss of income due to disability, the impact of a critical illness or the costs of long-term care.

EXAMPLE

Concerned about not burdening his children financially, Andre is applying for a long-term care policy on his own life, to cover nursing home fees and other medical costs should he need care in his elder years. Andre will be the owner, the life insured, and the beneficiary of the policy.

In business cases, however, care must be taken to ensure that the correct beneficiary is named under the policy, for both practical and tax reasons.

EXAMPLE

Hanif runs a private incorporated business with three employees. He has struck different compensation arrangements with each employee and has taken out individual disability insurance policies on two of them, Alfred and Blanche, for different purposes.

The policy on Alfred is a key person plan, designed to compensate the business for the loss of his services should he become disabled for a period of time. Hanif's business should be both the owner and the beneficiary of that policy. Neither the payment of premiums by the employer nor the payment of benefits (if any) to the employer would have a tax impact on the employee who is the life insured under the policy.

A second policy, on the life of Blanche, is intended to replace her personal income should she become disabled, thereby relieving the business of any obligation to continue Blanche's salary even though she is not productive and contributing to business revenues. The business should be the owner of the policy. If Blanche is named as beneficiary of the policy, she should report the premiums that the business pays on the policy as a taxable employment benefit. Otherwise, the business could be named as beneficiary and use the policy benefits to replace the salary otherwise payable to a disabled Blanche. But in that case the entire benefit paid to Blanche would be taxable, not merely the premiums paid on the policy. Either outcome is acceptable, but Hanif and Blanche would need to know the tax consequences arising from the structure chosen.

7.2.2 Agent's contribution to application

In completing the application form the agent need not be a mere recorder of information provided by the applicant. Aside from prompting the applicant to provide information to fill in the blanks on the application, or to answer the specific questions presented there, the agent can be pro-active, soliciting information that he knows the head office underwriting department may require, even if it is not specifically requested on the application. Additionally, the agent may record impressions gleaned from the client interview. The agent is certainly the first, and perhaps the only, representative of the insurance company that will meet with the applicant face-to-face, so the agent's thoughts, impressions and concerns may be critical to the underwriting process.

The agent intervenes in the following aspects of the application:

- Agent's comments;
- Medical questions;
- Inspection report;
- Hazardous sports and occupations questionnaires.

In certain cases, additional questionnaires or interview questions could be required.

7.2.2.1 Agent's comments

Aside from all the specific questions on the application form, dealing with such subjects as income and medical history, there is an "open" section called the *Agent's Comments* or *Agent's Report* where the agent has the option of reporting information or impressions that he feels would be important for the underwriting department to know. These additional comments might be beneficial or detrimental to the applicant's case, depending on the circumstances. Generally, however, the

comments section is used to expand upon answers that don't "fit in the box" of specific questions asked by the application form. For example:

- The application might ask for the applicant's level of income, but the agent knows, through the interview process, that the applicant plans to leave his current employer in the next few months, striking out on his own, and likely suffering a significantly reduced income for the next couple of years. This information should be communicated to the underwriting department via the agent's comments section of the application;
- The client, conversely, may be earning $75,000 a year today but his employment contract calls for a guaranteed increase to $100,000, starting in 6 months' time. If the applicant requests coverage based on the $100,000 figure the request will likely be modified or declined unless the agent advises the underwriting department of the pending raise;
- During the course of the application, the agent might observe something that an insurance company should explore further. For instance, if the client's clothes smell like cigarette smoke but the client claims not to be a smoker, an agent should draw the insurer's attention to it. Continuous exposure to second hand smoke may have a lasting negative effect on a proposed insured's health, which could also impact premiums.

The agent's comment section then becomes a handy catch-all to ensure that the insurance company is in possession of all of the information that the agent is privy to – and this is a good thing because, at law, the company is deemed to be in possession of all such information, whether they are in fact or not.

7.2.2.2 Medical questions

A significant part of the agent's role in the application process is assisting the applicant with the completion of the "non-medical" form: a questionnaire that requires the applicant to respond to a series of questions about his and his family's health history, either in lieu of or as a precursor to undergoing a medical examination. It is the role of the agent to interpret the answers given by the applicant, to get the applicant to expand upon his answers where necessary and to faithfully record the applicant's answers for the benefit of the underwriting department.

EXAMPLE

A question on the non-medical form on an application asks, "When was the last time you visited a doctor and what was the reason for the visit?" The applicant, who was also to be the life insured under the policy, answered, "Last July, for a check-up." The agent recorded the applicant's answer and moved on to the next question. However, this left a number of unanswered questions in the mind of the head office underwriter:

- Was this an annual or semi-annual scheduled check-up or was there a specific problem that triggered the visit to the doctor?
- If the latter, what was the specific problem?

- What were the symptoms, if any?
- What did the doctor conclude?
- Were you subsequently sent for tests? If so, which tests? What feedback did you or your doctor receive?
- Was any medical procedure required?
- Were any drugs or therapies prescribed?
- What was the result of the treatment, if any?

An answer simply recording the date of the applicant's last doctor visit might have satisfied the needs of the question, in its simplest form, but would not have satisfied the underwriters.

7.2.2.3 Inspection report

Upon reviewing an application for insurance the head office underwriting department may seek an Inspection Report from a third party. The agent has no role to play in the ordering of such reports or any additional reports or medical tests. Such reports are just one of the numerous investigative tools that the applicant authorizes when he signs the application form. The third party, a specialized investigative agency, may seek input from the applicant's employer, neighbour, etc., with regard to the applicant's lifestyle, spending habits, hobbies, any dangerous sports or recreation activities, drinking habits, etc. – any activities that might impact on the degree to which the applicant might be a claims risk.

7.2.2.4 Hazardous sports and occupations questionnaires

If the applicant indicates on the application that he engages in hazardous sports or other recreational activities (flying a private plane, skydiving, etc.) or that his job involves unusual hazards (as a firefighter, perhaps), he will likely be asked by the insurer to fill out a special questionnaire at time of application, such as a drug questionnaire or one dealing with alcohol consumption. The form will ask for details of the activity itself in addition to seeking such information as to how often the applicant engages in the activity or intends to engage in it in the future. If the activity is sufficiently risky, an exclusion rider may be added to the policy denying benefits from any claim arising from the hazardous activity.

7.2.3 Necessary documents and procedures

Almost all types of insurance require the applicant to provide documentation in support of health, income or insurance needs and perhaps to undergo specific medical procedures.

An applicant for disability, critical illness, and long-term care insurance also has to provide specific information regarding income and insurability (health). All types of business insurance have at least parallel requirements to their personal underwriting counter-parts (for example, personal

disability and key person coverage would both require health information on the life to be insured and financial information to assess the impact of disability). Extended health insurance tends to rely primarily on the health questionnaire.

7.2.3.1 Medical exam

Every insurance company has its own set of rules as to whether, or when, an applicant for insurance is required to undergo medical tests or a medical examination as part of the underwriting process.

The medical evidence may be automatically required in all cases if the life to be insured is over a certain age or the face amount of insurance (monthly benefit, etc.) exceeds a certain limit. An exam may also be required in instances where the applicant's medical history indicates a need for the insurance company's underwriters to have more information.

EXAMPLE

In completing the non-med questionnaire on an application for long-term care insurance, Jorge disclosed the fact that he had a "minor" heart attack four years ago. In order to determine the extent of the damage to his heart muscle, the insurance company asked for an Attending Physician's Report and a doctor's medical with a stress test.

7.2.3.2 Confirmation of income

Particularly in the case of an application for disability income replacement insurance, proof of the applicant's income and identification of the source(s) of income is essential to the underwriting process. The amount of disability coverage that an insurance company will issue is, in part at least, based on the amount of pre-disability income that the applicant has. Typically, coverage cannot exceed 60-70% of pre-disability income, but some policies extend this range as high as 85%. But, of course, the insurance company will not simply take the applicant's word regarding his income sources; independent verification is required.

In addition to answering income-related questions on the application, the applicant may be required to provide copies of his most recent tax year's T-4 and T-5 slips and/or a copy of at least his most recent T1 Income Tax Return and the corresponding Notice of Assessment from the Canada Revenue Agency (CRA). In fact, companies may require more than one year's evidence, in order to establish consistency of income and income trends.

In the case of an application of coverage in a business situation, the insurance company would normally request financial statements (income and expenses and a balance sheet) for, at least, the past three years.

7.2.3.3 Replacing existing coverage

If the accident and sickness insurance being applied for is replacing currently existing coverage, in whole or in part, prescribed procedures have to be followed in order to provide sufficient disclosure for the client to understand whether or not the change recommended is in his best interest. The agent will normally be required to complete a form comparing the old and the new policies from a number of perspectives:

- Premium;
- Covered conditions;
- Excluded causes of disability or critical illness;
- Riders and other benefits;
- Expiration of coverage;
- Waiting and benefit periods (particularly in the case of disability insurance); and
- Definitions of covered conditions.

Failure to act in the best interests of the client when recommending a replacement could place the client at risk of coverage gaps.

7.3 Underwriting by insurer

Insurance companies underwrite (assess) applicants in two different ways:

- Financial underwriting — To verify the applicant's level of income, so as to be able to assess the maximum level of coverage to which the applicant could be entitled and to determine his ability to pay for the coverage over the long term.
- Medical underwriting — To determine whether the applicant is an acceptable claims risk from a health perspective.

However, there are also distinct pricing factors that affect premiums, no matter the conclusions arrived at during the underwriting process. These are addressed in the following Section.

7.3.1 Factors affecting premiums

In pricing disability and other A&S products, insurance companies rely on several different factors but the extent to which they can control them varies.

The following considerations have an impact on how insurers set premiums:

- Administrative costs and expenses — Ongoing costs of staffing, marketing and issuing contracts and maintaining records – increased costs and expenses lead to higher premiums.
- Investment returns — Returns generated by investing capital reserves – increased returns lead to lower premiums.
- Lapse rates — Number of active policies that are cancelled or terminated due to non-payment (lapse) – higher lapse rates lead to potentially fewer claims and lower premiums.
- Morbidity rates — Rate of illness or injury within the population – increased risk of illness or injury lead to higher premiums.
- Ratings and exclusions — Ratings are a higher premium set for non-standard risks; exclusions limit or eliminate benefits for specific conditions or causes. Both ratings and exclusions lead to lower premiums for standards risks.

7.3.1.1 Morbidity rates

Morbidity is the instance of disability – injury or illness – in the population at large. Morbidity tables predict not who, but how many persons of a given age and gender in a given population will likely become disabled (or critically injured, or in need of nursing home care or health care, etc.). Morbidity tables work with large numbers – millions of people – but are rather less reliable in predicting disability among a smaller population, like the lives insured with a given insurance company. In part, insurance companies base their insurance pricing (premiums) on the estimated number of claims they are likely to incur in a given time period.

As noted, morbidity tables only represent the best estimates of the actuaries. Actual numbers of claimants may vary – greater or less than estimated – with the potential variance becoming more severe if the mix of lives insured by the insurance company varies significantly from the mix of lives in the population as a whole.

Moreover, the tables only estimate the number of claims, their causes and their duration: not the dollar amount of exposure per claim. That figure is a function of the level of insurance provided under each policy.[42]

The degree to which a given company's claims exceed or fall short of the assumptions built into premium pricing will impact profits and, therefore, future premium pricing.

42. An example of a morbidity table can be found in Chapter 2 – please see Table 2.2 *Sample morbidity table based on age*.

7.3.1.2 Ratings and exclusions

The insurance company might use premium ratings (a premium schedule higher than that for "standard" risks) and exclusions (denying claims arising from excluded causes or conditions) to mitigate their exposure to risk (and therefore to excessive claims). Generally, insurers prefer to avoid completely denying coverage to non-standard applicants. The use of ratings and exclusions allows the insurer to offer coverage to those applicants who do not fit within the "standard" range while limiting the insurer's exposure to undue risk and thereby reducing its costs.

7.3.2 Financial underwriting

As noted earlier, the amount of disability income replacement insurance issued on a given applicant is calculated according to the applicant's income. Coverage that insurers will issue is restricted to a percentage of pre-disability income from all sources and is coordinated with benefits available from all other sources (group and government plans, for example). This is to ensure that the policyholder/beneficiary would not be better off financially while on claim than while healthy and working. Such over-insurance could, in some cases, lead to anti-selection: the tendency for an insured to file a false claim or needlessly prolong (malinger) a valid claim simply because policy benefits might leave them better off financially than when they were working full-time.

Additionally, verification of an applicant's income and expenses (cash flow) could provide an indication as to whether he is likely to be able to afford the policy premiums over the long term. Issuing an insurance policy is an expensive proposition and it often takes several years from issue date before the insurance company will be in a profit position from a given sale. The insurer will want the reassurance that the applicant would be able to maintain the policy at least until that "crossover" date.

Aside from the issue of the likely duration of a newly issued policy, an applicant wishing to acquire coverage that he obviously cannot afford to maintain should send up red flags to the insurer: perhaps the applicant wants the coverage in anticipation of filing a claim in the near term.

This affordability issue is a concern for critical illness, long-term care and health insurance policies, as well as for disability insurance, so financial underwriting is a factor here as well, although the amount of coverage is not directly tied to the applicant's income.

7.3.3 Medical underwriting

In addition to seeking a medical evaluation of a life to be insured through a medical examination performed by a doctor or a paramedical professional, insurance companies also regularly (but not automatically) rely on reports solicited from the applicant's personal physician and input from the Medical Insurance Bureau (MIB) in order to assess whether to accept the risk of insuring a given applicant.

7.3.3.1 Attending Physician's Statement (APS)

The insurer may seek input from the personal physician of the applicant or from other physicians who may have attended him for specific ailments in the past. The request for an attending physician's statement (APS) may be automatic, under the insurer's procedures based on the age of the applicant or the amount of insurance being applied for. Or the past medical history of the applicant, or his family, revealed in the completed non-medical questionnaire on the application, may trigger a request for an APS.

A request for an APS is made directly between head office underwriting and the physician in question and the cost of the APS is borne by the insurer.

In addition to the APS, the insurer may request additional information or tests, such as a medical exam by a paramedical technician (paramed) or physician, blood or urine tests, or an electro-cardiogram.[43]

7.3.3.2 Medical Information Bureau (MIB)

The Medical Information Bureau (MIB) or MIB Group Inc. is an organization serving the life and health insurance industry by compiling historical data on lives insured and those applying for insurance. The insurer reports coded information to the MIB when an individual applies for insurance and also seeks such coded information currently on file with the MIB. The information shared with the MIB is not so specific that it could be used to underwrite an applicant, but provides general "markers" that would indicate a possible health problem and could trigger the insurer to seek additional input from physicians, etc.

In addition to health data the MIB may also collect information about coverage currently in force, or currently being applied for, and instances where coverage was declined on an applicant.

By sharing such information among insurance companies, via the MIB, the insurance companies are able to protect themselves against those applicants seeking to "over-insure" themselves (by purchasing coverage from several different companies and failing to declare the existing coverage or other current applications) or seek to obtain coverage to which they are not entitled due to medical conditions not disclosed to the insurer. Without the assistance of the MIB, this latter problem could be particularly prevalent among applicants who are turned down, or rated by one company and would otherwise be inclined to turn around and apply to a second insurer without disclosing either the decline/rating or the reason for it.

When signing an application for insurance the applicant will be required to sign a specific authorization entitling the insurance company to solicit information about him and to communicate information with the MIB regarding the application.

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43. An attending Physician's Statement (APS) is a report from the applicant's doctor, outlining details of a condition or treatment incurred in the past. An examination or report from a paramed is provided by a medical nurse or technician who performs additional tests required by the insurer's underwriting rules or requested by the underwriting department.

7.4 Insurance contract

The delivery of a newly issued insurance policy completes the contractual process. The completion of an application by the applicant is the first step in the establishment of a contract, the "offer to treat." If the insurer issues the contract, either as applied for or with modifications, and delivers the contract to the applicant (usually via the underwriting agent) this becomes the offer by one party (the insurer), requiring acceptance by the other (the applicant) and an exchange of consideration (the policy premium) to complete the legal process. Once the policy, including the application itself, is legally in force, it becomes the basis of all future transactions between the insured and the insurer – determining the rights of the insured and the obligations of the insurer.

7.4.1 Need for prompt delivery

The underwriting process for A&S insurance can be complicated and lengthy, requiring assessment of the application by the head office underwriting department of the insurance company and possibly the ordering of an APS and/or a physical exam and other medical tests. It is not unusual for many weeks, or even months, to go by between the date of application and the date that the policy (if underwritten) is available for delivery to the applicant. It is the norm for the newly issued policy to be sent to the field agent who took the application, with the expectation that the agent will personally deliver the contract to the applicant.

Convention allows the new policyholder a 10-day "free look" at a newly issued contract: 10 days from the date of contract delivery to determine whether to keep the policy. At any point during that period the policyholder has the right to return ("rescind") the policy to the insurer for cancellation and get a refund of all premiums paid to date. The 10-day period doesn't begin until the policy is physically delivered to the new owner, so the client's option remains open as long as the contract remains undelivered, plus 10 days.

It is critical that the delivery be affected as promptly as possible by the agent. As noted in the following Section, there is a legal requirement that a contract cannot be put into force if the health or financial status has changed between date of application and date of contract delivery. The longer the delay in delivering the contract, the greater the risk of such a change occurring.

Moreover, it is not unheard of for an applicant to have second thoughts about his purchase and decide not to accept the contract, even though the coverage is needed to protect him and/or his family. Prompt delivery, accompanied by a delivery interview reinforcing the rationale for acquiring the coverage, ensures that the recommendation will be effectively put in place to meet the identified need.

7.4.2 Need for agent awareness of change since application

The provincial insurance acts have specific requirements that must be met before a contract of life or A&S insurance is legally in force. Generally, the acts require that:

- The issued contract is delivered to the policyholder;
- The initial premium payment has been made by the policyholder;
- Neither the financial situation of the insured nor the health of the life insured under the contract has changed between the time of application and the time of policy delivery.

This last requirement is to ensure that the coverage being delivered is still appropriate. In the case of a disability insurance policy, for example, if the applicant has incurred a reduction in income since time of application, the coverage under the contract may now be excessive and an amount for which the insured would not qualify to claim. If the life insured's health had declined in the interim, the parameters that the insurance company now has to contend with are different from those at time of application and the offer of coverage has to be re-assessed. The agent needs to enquire of the applicant, prior to handing over the issued policy, if the applicant has experienced a negative change in health or income since the date of application. If the answer is "yes," the agent should record the particulars of the change, not deliver the contract, but return it along with his notes to the insurance company, for the application to be reviewed and re-underwritten, if necessary.

EXAMPLE

Agent Todd was delivering a newly issued critical illness policy to Lucille. In response to questions asked by Todd in the delivery interview Lucille acknowledged that she had experienced chest pains, diagnosed as angina, starting about two weeks after she had submitted her application for insurance. Rather than deliver the contract to Lucille, Todd took particulars of Lucille's change in health (dates, the diagnosis, name of the doctor involved, etc.) and forwarded a copy of his notes, with his report and the contract, to the insurance company for reassessment.

7.4.2.1 Dealing with rated cases

Delivering a policy that has been rated in some fashion (increased premium, exclusions, reduced benefits, etc.) can be a sensitive issue, especially if the applicant was not previously aware of the condition that led to the rating. The applicant is likely to have any of several initial responses:

- A sense that the policy is now too expensive, if the required premium is greater than was quoted at time of application;

- Disappointment that the policy does not now provide the coverage as applied for if the contract is subject to reduced benefits or exclusions;
- Surprise that he is suffering from some medical condition of which he was previously unaware.

Any and all of these reactions could give cause for the applicant to reject the policy as presented at the delivery interview and thereby decline to put in place coverage that is needed to protect himself and his family. There are a number of steps that the agent can take to encourage the applicant to accept the policy as issued, even though it is different from the initial application.

- During the application process, if health or other issues are disclosed that the agent thinks might lead to a rating, he could mention this possibility to the applicant, so that the delivery of a rated policy is not totally unexpected.
- In circumstances where the rating might be temporary, or subject to reassessment in the future, this should be explained to the client, to lessen the emotional impact of the rating.
- The agent should gently point out that the rationale for purchasing the coverage has not changed and perhaps indirectly imply that the need for coverage is even greater now that the applicant has been found to have additional risk factors.

7.4.3 Providing contract disclosure

The agent should always keep in mind that the client is generally not knowledgeable regarding the intricacies of insurance and it is the role of the agent to explain the contract at time of delivery, with particular emphasis on those contract clauses which might impact the rights of the insured:

- Benefits/coverage limits;
- Riders;
- Key definitions of covered conditions, particularly in regard to critical illness policies;
- Exclusions.

Particular attention should be paid to the last two items: definitions and exclusions. Absent a clear explanation from the agent, the client may be under the misimpression that all manifestations of a given condition are covered and not be aware that there are specific nuances in the contract regarding the level of disability or type and severity of a given condition that must be met before benefits are payable. And exclusions are typically added to the contract by the insurer's head office after the application was taken. Coverage that the applicant thought he was going to get has been removed from the contract itself. It is critical that the applicant (and his family, particularly in the case of critical illness or long-term care contracts) has a clear understanding and appreciation of what is covered and what is not, in order to minimize conflict between the insured and the insurer at time of claim.

7.4.3.1 Factors that limit coverage (statutory provisions)

The agent should also point out to the client that the coverage and benefits provided under any given contract may not be absolute.

Where coverage from different contracts overlap, the insured is not entitled to be reimbursed more than once for the same loss. Benefits from one contract may supplement, but cannot duplicate, those from another.

EXAMPLE

Jorge has disability insurance coverage through his group plan at work that will pay him benefits of up to $2,500 a month (50% of salary) for up to 2 years after a 30-day waiting period. If he wants more comprehensive coverage than that, he could, for example, take out an individual policy that would top up his coverage by another $500 a month (totalling 60% of salary) for 2 years and then increase to $3,000 a month for an additional 3 years. This would give him $3,000 a month of coverage for the full 5 years through the 2 plans combined. He could not, however, collect more than $3,000 a month from the 2 policies combined.

Policies will normally contain a provision outlining priority of payor, in the event that excess coverage is provided through multiple insurers.

In any event, there are conventions that restrict disability coverage from all sources to a prescribed maximum of pre disability income from all sources (usually 85%), again setting out priority of payers.

In critical illness policies there are no specific limits on the amount of benefit that the insured can collect, since benefits are not tied either to specific income or expenses.

For long-term care insurance, the insured cannot be reimbursed for more than the actual expenses incurred, no matter how much overlapping coverage he might have.

7.4.3.2 Tax treatment of premiums benefits

Questions frequently heard from applicants in the delivery interview for an insurance purchase are “Can I deduct the premiums?” and “Will the benefits be taxable?” Agent should respond carefully to such questions and should focus on items that were discussed during the recommendation process, if the applicant had specific tax requirements that needed to be met. In most instances, unless he is also an accountant or tax specialist, the agent is not an expert in taxation and providing extensive tax advice takes him outside his area of competence. However, the possible tax treatment of premiums and benefits should be taken into consideration, and discussed with the client, in the formulation and explanation of product recommendations. Caution should be taken in

making definitive statements as the agent may not be aware of all factors relating to the client's situation that could take the tax treatment of premiums and benefits outside the norm. The client should always be referred to his accountant or a tax lawyer for specific tax advice.

7.4.4 Policy feature opportunities

Many accident and sickness policies, disability policies in particular, contain contractual features that provide specific opportunities for the issuing insurance company, and/or the agent, to contact the policyholder face to face in order to affect a change in the contract. These changes often require the assistance and advice of the agent and also provide an opportunity for the agent to review the client's current situation and suggest modifications or additions to current coverage. Among the most frequent opportunities to review coverage are those linked with:

- Future Purchase Option (FPO) rider;
- Conversion options;
- Timing factors for ratings and exclusions.

Future Purchase Option (FPO) rider

As seen in previous chapters, an FPO affords the policyholder of a disability plan the right to acquire additional coverage with little or no medical underwriting, but subject to financial underwriting to establish that the additional coverage is warranted under the insurer's rules. The options to increase coverage arise periodically, at pre-established dates. Each option is limited to a specified amount, but that does not preclude opening a discussion with the client if additional coverage is now required, or affordable, with medical underwriting.

EXAMPLE

Two years ago Consuela purchased $2,500 a month of disability insurance coverage. The coverage was based on her income of $90,000 a year. At the time she could have qualified for up to $4,500 a month of benefits, but some extraordinary personal expenses limited the funds that she had available for insurance. The policy she purchased has a future purchase option for up to $500 a month of additional coverage, without medical underwriting, provided she qualifies financially for the additional coverage. The first option to increase coverage comes up later this month. Consuela met with her agent and confirmed that she would like the extra coverage; in fact her cash flow would permit her to afford $4,000 a month of insurance benefit now. Consequently, she agreed to exercise the $500 option and to apply for an additional $1,000 of coverage with full underwriting.

Conversion Options

Many group disability insurance plans offer a covered group member the option to convert the group coverage into an individual policy upon ceasing participation in the group plan. The conversion option must be exercised within 30 days of leaving the plan and the acquisition of the new policy can be affected without the insured having to prove medical evidence of insurability.

Timing Factors for Ratings and Exclusions

Many ratings and exclusions are permanent, for the life of the policy. But others may be subject to review. This is especially true if the policy limitation is due to a medical condition that may be resolved over time or a hazardous activity. If the medical condition has been resolved to the satisfaction of the insurance company or the insured no longer is engaging in the hazardous occupation or activity, he may apply to have the rating amended or removed. An agent would normally meet with the insured to review his situation and assist him to fill out the requisite form, again offering an opportunity to review the coverage as a whole. If a rating is reduced or removed the insured's premium will also be reduced – possibly freeing up funds to allow for the purchase of additional coverage, if warranted.

7.5 Policy claims

The claims process is as important to the policyholder as the application process, if not more so. The timing and content of the claim by the insured will be critical to its success. Needless delay in filing the claim could impact available evidence and the credibility of the claim. And the client should be careful that the information they enter on the claim form is complete, accurate and wholly truthful. If not, careless or incorrect statements could come back to haunt him in the adjudication process with the insurer.

If the agent intervenes in the insurance claims process, helping the claimant to complete the claims form, for example, he has to be careful not to put himself in the position of a conflict of interest: as a representative of both the insurer and the insured. For this reason, some insurance companies require that their agents restrict themselves to delivering blank claim forms to the client and returning the completed ones to the insurance company. On the other hand, the client often looks to the agent for assistance in both the application and the claims process, since the client is often an uninformed "lay person" when it comes to the intricacies of insurance. In any event, the completion of a claims form is a sensitive legal matter and the agent should be careful to follow the carrier's guidelines if he is involved in the process.

7.5.1 Requirements for a claim

There are several basic steps that are critical to the claims process in most instances:

- The insured must first notify the insurance company, or its representative (the agent), of the event (injury, illness, diagnosis, etc.);

- The insurance company then provides the insured with the appropriate claim forms, either by mail or delivered by the agent;
- The insured must complete the claim form, along with any supplemental information (receipts, etc.) and forward them to the insurance company;
- The insurance company may seek further information, either through an interview with the insured, physician's statements, tests or additional physical exams;
- The insurance company finally adjudicates the claim and either pays it, in full or in part, or denies benefits entirely.

Each insurer has its own requirements for how soon after an event triggering a claim the notification to the insurer must be filed. Most require a claim form be filed within 30 days, but never more than 6 months in any event. To be safe, if contacted by the client (or when discussing the issue of claims at time of policy delivery) the agent should advise the client to notify the insurance company as soon as possible if he expects to file a claim.

7.5.1.1 Receipts

If benefits being applied for require reimbursement for medical or other services already rendered (such as dental work, chiropractic care, prescription drugs, etc.), the insurance company will want original copies of receipts for the expenditures, in order to verify both the amount and appropriateness of the claim. These receipts should be forwarded by the claimant to the insurance company along with the appropriate claims form.

7.5.1.2 Medical proof of diagnosis or treatment

All types of accident and sickness contracts require the occurrence of some medical event prior to the payment of benefits. For instance:

- Disability policies require an inability to work and earn an income due to injury or illness;
- Critical illness policies require that the life insured suffer a covered condition or medical event (heart attack, stroke, etc.) triggering a claim;
- Long-term care policies pay benefits based on covered expenses for an insured unable to fulfill at least two of the activities of daily living (ADLs);
- Business overhead expense contracts require an inability to work and contribute to the business' productivity on the part of the life insured, due to injury or illness;
- Extended health policies may require an assessment of medical treatment (such as extensive restorative or cosmetic dental procedures) before expenditures are authorized for reimbursement.

The insurer will not, of course, simply take the insured's word for the fact that he is suffering a disability, etc., it is going to want supporting medical evidence for the diagnosis. This will, at a minimum, require a report from the attending physician regarding the nature, degree and prognosis for the event that triggered the claim. In some cases, the insurer may also request additional tests or a physical examination by a physician of their choice, to verify the condition.

In addition, particularly in the case of disability, the insurance company may also want ongoing proof of treatment to rectify the situation. This again would require reports from the physician or other practitioner (chiropractor, physiotherapist, etc.) treating the claimant.

7.5.1.3 Review factors that reduce benefits

It may be that, at time of claim, the client receives benefits less than the maximum provided for under the contract, or no benefits at all. It is important that the agent assist the client to understand any such discrepancies. Possible reasons for a modification of benefits payable would include situations related to standard contract limitations seen in previous chapters (such as suicide, alcohol or drug abuse, criminal activity, etc.). Similarly, all contracts provide that benefits are not payable if it is determined that the applicant made a material misrepresentation at time of application.

Furthermore, in cases where financial underwriting is required to determine the amount of benefits payable, reduced benefits may result from a change in the insured's financial situation. For example, disability benefits could be reduced if the insured's income at time of claim is less than was reported at the time of application.

7.6 Client service

A successful long term relationship between the client, the agent and the insurance company relies on service. It is seldom that only one company, or one agent alone can provide the product solution that the client needs; there is plenty of competition in the marketplace with excellent products. What makes the difference is service: the speed and efficiency with which the insurance company responds to the client's needs at every step of the relationship, from application to claim. And the agent is at the forefront of that service relationship every step of the way.

7.6.1 Agent's service role

An insurance agent's first role is to recommend solutions to meet clients' needs. An agent also has a role in servicing a client once a policy is in force.

The agent's service role includes:

- Providing claim forms and other relevant documents;
- Being prompt and accurate;

- Developing a strategy for ongoing awareness of client situation and needs;
- Determining suitability of recommendation and/or the need for change;
- Documenting services provided;
- Staying in touch with the client on an annual or semi-annual basis.

7.6.1.1 Providing claim forms and other relevant documents

There are a number of instances where the client will need to interact with the insurance company over the life of a policy, for example:

- To elect an option available under the contract (like a future purchase option);
- To change or add a beneficiary to the contract;
- To advise the insurer of a personal change of address;
- To file a claim.

The agent can have a role to play by providing the client with the insurer's prescribed form for performing any of these functions and, except perhaps in the case of a claim form, assisting the client with the completion of the form and forwarding the completed documents to the insurer.

7.6.1.2 Importance of promptness and accuracy

In providing client service, at any point in the agent/client relationship, promptness and accuracy on the part of the agent may be crucial to ensuring that the client receives full benefit from his relationship with the insurance company.

If an agent contacts or is contacted by an existing client or a prospect in need of insurance coverage, it is important that the agent meet with the individual as soon as possible, to start the application process. Delay could result in the applicant incurring what could have been a covered event or condition before the insurance is in place, nullifying the opportunity for protection.

Once a policy is issued, it is critical that it be delivered and explained to the new policyholder as soon as possible, both to ensure that the coverage issued is in fact the coverage that the client needs/wants and to limit the possibility that the insured's health may have changed between the time of application and time of policy delivery.

And something as simple as a beneficiary change should be processed promptly, to guard against the risk that a claim could occur in the interval between the client's contact with the agent and the completion of the necessary paperwork.

It goes without saying that the agent is responsible for ensuring that forms completed by the insured are complete and accurate and the information that the agent conveys to the insurer is

equally accurate. Failure in either regard could result in the agent being at risk financially if a claim goes awry for want of complete, accurate and timely information being provided to the insurance company.

7.6.1.3 Strategy for ongoing awareness of client situation and needs

The agent cannot wait for the client to come to him with updated service needs. Part of the responsibility of the agent is to ensure that the client's coverage meets his current and changing needs and to evaluate the suitability of potential recommendations to adjust coverage. This requires that the agent be in regular (annually or semi-annually) contact with the client (by mail or email) and schedule regular review appointments, ideally at least once a year. The agent should also stress the need for the client to contact the agent if there is any material change in his circumstances.

EXAMPLE

Agent Seng stresses with his disability insurance clients that they must contact him immediately if there is a significant change in their employment status: change of income level (up or down), change of employer, change of duties, or should they become unemployed.

In review meetings, the agent will review the appropriateness of the recommendations that were put in place previously – are they still suitable? Are any changes to current coverage or plans needed, etc.?

7.6.1.4 Documenting services provided

As with the recommendation process, discussed above, it is critical that the agent document every step of the service process, for his own protection and the protection of the insurance company.

If the client contacted the agent seeking some level of service (a beneficiary change, for example), the agent should document the date of the contact and what was discussed, when he met with the client, what was said and what action was taken, and when and how the matter was resolved. Similar detail should be recorded if the agent initiated the contact. And particular care should be taken to set out the specifics of any instance where the client expressed concerns about the product sold or service provided by either the agent or the insurance company.

Copies of all written communications between the client, the agent and the insurance company should be retained in the agent's file, including the application, forms filed, waivers signed, and letters or emails passing between all or any of the parties in regard to the client's situation.

All of these records could be vital in ensuring that the client is properly served and in establishing a record in the event there should be a claim or legal dispute in the future.

CHAPTER 8
GROUP PLAN SPECIFICS

Competency components

- Assess the client's needs and situation;
- Analyze the available products that meet the client's needs;
- Implement a recommendation adapted to the client's needs and situation;
- Provide customer service during the validity period of the coverage.

Competency sub-components

- Determine the client's situation;
- Assess the appropriateness of the client's existing coverage in regards to his situation;
- Analyze the types of contracts that meet the client's needs;
- Consider the impact of underwriting criteria as they apply to the client's situation;
- Propose a recommendation adapted to the client's needs and situation;
- Validate the appropriateness of contract amendment, renewal and termination applications in regards to the client's situation;
- Inform the claimant of the claims process.

8
GROUP PLAN SPECIFICS

According to a 2005 StatsCan survey,[44] almost 75% of Canadian workplaces offer their employees some form of non-wage benefits, primarily through group insurance plans. Since many of those group plans offer benefits to the families of the workers as well, millions of Canadians are covered by group benefits of one form and another: life insurance and extended health insurance being the primary benefits, with disability insurance an equally important factor. As such, group insurance coverage is an integral part of the insurance protection program for many Canadians.

Previous chapters in this manual have already outlined, in context, the role that group accident and sickness (A&S) benefits play in providing extended health, disability and other personal coverage for workers and members of association groups. But it is also important for a life insurance agent to have a basic understanding of how group insurance works from an operational and administrative perspective. It is the purpose of this Chapter to outline the rudiments of group A&S insurance pricing and the role that both the insurance company and the agent play in the placement and operation of a group plan.[45]

8.1 Understanding the group

Unlike the situation with individual insurance, the group member is automatically covered upon joining the plan provided he is actively at work. Absent specific health data on the plan members, the pricing actuaries at the insurance company must rely on general actuarial statistics, and previous claims experience for the group, where available. It is important, then, for the insurance company to have a sense of:

- The makeup of the group;
- The nature of the business;
- Comparative businesses.

Part of the information required on the members and the group itself is provided by the employee data sheet, also addressed in this Section.

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44. Statistics Canada. *Section 4 Compensation practices*. [online]. Revised September 21, 2009. [Consulted June 13, 2017]. http://www.statcan.gc.ca/pub/71-585-x/2008001/sec4-eng.htm
45. Life insurance is an integral part of group plans. Group life insurance characteristics, its structure and administration are addressed in the Life insurance manual.

8.1.1 Makeup of the group

Group underwriting starts with an understanding of the character and makeup of the group in question. Since the group members generally are not medically or financially underwritten, as they are with individual insurance policies, it is the composite identity of the group members that is used to determine coverage and set premiums. In addition to dealing with factors such as the number of members and their average age and gender, that composite identity also relies on the stability of the group (turnover rate).

8.1.1.1 Number of members

The number of members in a given group of insureds has an impact on the ability of the insurance company to estimate future claims and, therefore, to effectively price premiums. In the case of a relatively small group, 25 lives or less for example, the “law of large numbers” doesn’t work: claims experience of that group cannot be counted on to resemble actuarial norms and, as such, historical experience has little validity. As such, smaller groups may face higher premium rates. Often, the experience of smaller groups is “pooled” with the experience of similar small groups for pricing purposes. With large groups, with perhaps thousands of members, risk is spread over a much wider range and claims experience in areas like disability claims is much more likely to replicate both past experience and actuarial assumptions. And more certainty can translate into more accurate premium rates.

8.1.1.2 Age/Gender

As has been discussed several times throughout this manual, both age and gender can be risk factors for different types of claims, especially disability and long-term care. A primarily female membership is likely to file more health and disability claims than a primarily male group. Groups with predominantly older members are more likely to file drug and long-term care claims than are groups with younger members. As such, the age/gender makeup of the group can influence the types and flexibility of benefits offered and the pricing of those benefits.

8.1.1.3 Turnover rate

It is important for the insurer to be able to know not only the makeup of the group today, but the makeup for the foreseeable future: a month, six months, a year into the future, etc. Underwriting, claims experience and premium projections will not be accurate unless it can be assumed that the group will continue to be made up of essentially the same members as at present. One of the most effective means of estimating future makeup is turnover rate: the percentage of the group members that is likely to leave the group and be replaced by others on a year by year basis. Historical turnover rate, like historical claims experience, can often be an accurate predictor of future turnover rates.

Groups that have demonstrated low turnover rates, 5 to 10% per annum, offer an element of consistency that makes them much more attractive to insurance companies. Low turnover rates mean that past claims experience will be more credible (see *Premium rates* Section, below), allowing the insurer to largely base premiums on past claims experience.

Higher turnover rates diminish the value of past claims experience (past claims mean few if any of the past group members will belong to the group in the future).

For that reason, high turnover rates will result in higher group premiums and longer waiting periods for such benefits as disability and long-term care.

8.1.2 Nature of the business

In the case of employer/employee groups, especially, the type of business engaged in will be a significant factor in determining the level of benefits offered and premium pricing under the group plan. Generally, a construction business that requires hands-on activity by its employees will obviously expose members to greater physical risks than a firm with little on-site exposure. And yet, some "white collar" occupations may be subject to longer hours and more work-related stress than others, leading to the risk of more claims. Traditionally, some classifications of occupation, like architects, have very low disability claims rates, compared to other occupations, primarily, one could assume, because of a low physical risk work environment.

8.1.3 Comparative businesses

Particularly in the case of smaller groups and/or groups who are applying for group insurance for the first time, where claims experience statistics may be unreliable or non-existent, insurance companies will look to their, or the industry's, experience with groups in the same or a comparative line of business (forestry workers, for example) to estimate future claims and thereby establish benefit types and levels offered and premium rates.

8.1.4 Employee data sheet

When a prospective group plan member completes an enrolment card and the employer completes the employee census report, the insurance company is provided with a wide variety of information from all of the prospective group members which it uses to determine claims projections and costing for the plan. Specifically, some of the important information provided through the employee census report includes:

- Date of birth — Used to determine eligibility for certain benefits. For example, long-term disability benefits typically terminate at age 65. Also helpful in determining the overall age mix of the group members, for manual rating[46] of benefits like disability and long-term care, where the incidence of claims can, in part, be linked to age.

46. Manual rating is addressed later in the Chapter.

▪ Gender	As with age, the gender mix of the group could be a significant factor in pricing such benefits as disability income replacement.
▪ Occupation/occupational class	The plan may have different benefit packages for different classifications of employees: for example executives versus factory workers. In such cases, it is critical to know the occupational classification of a plan member in order to determine the benefits that he can qualify for.
▪ List of dependents	Required if the group plan offers either standard or optional coverage which includes the plan member's spouse and children.
▪ Social Insurance Number	Required for reporting purposes if premiums or benefits are taxable to the group member.
▪ Salary/earnings	Used to determine benefits for disability income replacement coverage. For larger groups (more than 25 members), there may be more than one class of employee, with each class qualifying for a different level of benefits. Either job title or salary level may be used to determine into which class a given employee falls.

8.2 Products and services

Group products have been covered in some detail in previous chapters, but the following provides a brief recap of the main coverages offered.

- Disability income replacement insurance
  - Short-term disability (STD)
  - Long-term disability (LTD)
- Extended health insurance
  - Prescription drug plans
  - Vision care
  - Dental
  - Accidental death and dismemberment (AD&D)
- Critical illness (some group plans only)
- Long-term care (less common than other coverages)

In addition to the above, which are also available through individual policies (as are many forms of A&S business insurance coverage, like disability business expense overhead coverage), group plans may also offer employee assistance plans (EAPs), a benefit not available from individual contracts.

8.2.1 Elements of an Employee Assistance Plan (EAP)

A part of the overall package of group benefits offered to employees, many employer/employee group plans offer an EAP, designed to offer counselling services outside the more traditional health care benefits like dental, vision care, prescription drugs and other extended health services.

In part, as with other group benefits, the addition of an EAP to group benefits is designed to help to attract and retain good employees through a comprehensive overall compensation package. The addition of EAP benefits is also an acknowledgement that employees may have personal or work-related stresses in their lives that may impact negatively on their ability to do their jobs efficiently and accurately.

EAP services are designed to assist employees to overcome, or at least cope with, these personal challenges. Additionally, EAP benefits can serve as a positive alternative to traditional forms of sanction for employees who have drug, alcohol, or other problems, for example.

While some employers may provide onsite EAP counselling services, through in-house staff, most provide the support through off-site, third-party providers, to reduce costs and to reinforce the fact that the employee's use of the program is kept strictly confidential.

The benefits provided are typically in the form of consultation, by telephone or face-to-face, with a professional counsellor. Use of the services provided is solely at the discretion of the group plan member. The services provided are typically subject to annual deductibles, a co-insurance provision, a maximum number of hours of services per annum and a maximum allowable hourly rate.

EXAMPLE

Sacha-Rae works for a large medical supply company that is in fierce competition with another major supplier. Market forces are putting a lot of financial pressure on her company and the senior executives are in turn putting a lot of pressure on their employees. As a consequence, Sacha-Rae is suffering from stress-induced stomach complaints, headaches and minor depression. Fortunately her company has an excellent group benefits plan with an EAP. Through this program, Sacha-Rae is entitled to up to 10 hours of counselling with a psychologist, to help her develop coping strategies to deal with the pressure and avoid having to submit a stress-related disability claim.

The following provides a brief summary of the types of counselling and other services typically provided to employees and, often, members of their immediate family, under an EAP:

- Psychological counselling — May be provided on a crisis management basis (via a 24-hour emergency hotline) and/or through face-to-face sessions with a qualified psychologist. The services are designed to assist the employee to cope with a wide variety of factors, from work-related stress to psychological disorders.

- Addiction counselling — Provides limited professional counselling services from an accredited drug or alcohol rehabilitation center.
- Marriage counselling — Assists the employee in coping with marital stress arising from such issues as infidelity, incompatibility or financial difficulties and/or to assist couples to work out difficulties within their marriage.
- Legal counselling — Many EAP programs also offer employees access to prepaid legal services for such matters as: divorce, wills and powers of attorney (POA), adoption, debt problems and indictable offenses.

Although statistics tend to be somewhat inconclusive, it is felt that the benefits to an employer from an EAP, in reduced sick days absenteeism and increased productivity by employees, outweigh the costs of the program.

EAP premiums are based on the experience rating of the group (see below).

Premiums paid by an employer for EAP benefits are tax-deductible by the employer. Benefits are not a taxable benefit to the recipient employee for counselling services relating to:

- Physical or mental health of the employee or an individual related to the employee;
- Retirement or other financial counselling;
- Employment placement for a terminated employee.

Benefits for counselling for legal or financial matters are generally treated as a taxable benefit.[47]

8.2.2 Group insurer's services

Aside, of course, from providing insurance coverage for the group benefits offered under the group plan, the insurer typically also provides a number of ancillary administrative services, like:

- Enrolment of plan members;
- Billing services for employer and employee premium contributions;
- Claims adjudication.

47. Government of Canada. *Income Tax Folio S2-F3-C2, Benefits and Allowances Received from Employment*. [online]. Revised October 12, 2016. [Consulted September 26, 2017]. https://www.canada.ca/en/revenue-agency/services/tax/technical-information/income-tax/income-tax-folios-index/series-2-employers-employees/series-2-employers-employees-folio-3-employment-benefits/income-tax-folio-s2-f3-c2-benefits-allowances-received-employment.html

8.2.2.1 Plan member enrolment

It is the responsibility of the employer sponsoring an employee group plan to enroll the individual employees in the group plan. In larger organizations, this task would normally be handled by the human resources department. The process is, however, usually more than simply getting the employees to complete an enrolment form.

Typically, a prospective member's enrolment in the group plan will be subject to a qualification (waiting) period between the time he joins the sponsoring company and the time he is allowed to join the group plan. This period is often three months, to coincide with a new employee's probationary period with the employer.

If the plan was totally non-contributory and had nothing but fixed, pre-determined benefits, completion of enrolment cards provided by the insurer might be the sum total of the process. Since the coverage would be cost-free to the employees, enrolment would be mandatory and all benefits and costs would be equal.

However, most group plans are contributory and, in the case of groups of more than a few potential members, 100% participation is not a requirement, although some pre-determined percentage of the employees must sign up before the plan can be put into place. Since the employees are not specifically required to join the group plan, and the benefits elected may vary from employee to employee, particularly in the case of flexible-benefit ("cafeteria") plans, there is a need to actively solicit participation in the plan.

Regardless of when a new employee qualifies to join a group plan that has optional participation (either upon date of employment or after expiry of a qualification period), it is not unusual to offer the employee a limited period (perhaps 30 or 60 days) during which the decision to join may be exercised. This gives the employee reasonable time in which to make the decision, but does not leave the option open-ended indefinitely.

And if the employee/plan member has the option to add additional coverage, over and above the base coverage, for himself or his family members, there may be a requirement for medical, or other, underwriting proof of insurability.

In such cases, the expertise of the agent, and/or an account executive from the insurer, is necessary to explain the options and benefits to the prospective plan member and to assist the members in the enrolment process.

8.2.2.2 Premium billing

The group insurer sets the premium for each group and advises the group sponsor accordingly. In the case of a non-contributory employer/employee plan, where the employer pays for all the premiums, the process is straight forward: the insurer bills the employer one amount monthly that the employer is then required to remit to the insurer.

In the case of a contributory plan, where the group members are required to pay at least some of the premiums, premium billing is a two-step process. As with the non-contributory plan, the insurer bills the employer an amount monthly that represents the employer's portion of the premium and that employer is then required to remit to the insurer. The insurer also advises the employer of the contributory portion of the premium allocated to each plan member. The employer is then required to payroll deduct the requisite premium from each member and remit one payment for the total to the insurer.

8.2.2.3 Claims adjudication

The primary administrative function provided by the insurance company, whether for an insured or administrative services only plan, is the adjudication of group claims. This involves a series of steps, from review of the claim form to denial or payment of the claim.

- The first step is to compare the claim form to the terms of the contract, to determine if the event being claimed for is covered under the contract: if not, the claim is summarily declined.
- If so, the next step is to assess whether or not a benefit is payable and, if so, how much and to whom. This may require additional evidence from the claimant and/or other parties, regarding the nature and severity of the event giving rise to the claim.
- If the claim is approved, it is the responsibility of the insurer to make appropriate payment, either in a lump-sum or on a periodic basis, as the case may be.
- In the case where periodic payments are required (as with most disability and long-term care claims), it would also be the responsibility of the insurer to ensure that the payout does not exceed the maximum allowable under the contract and to monitor the ongoing claim to ensure that the claimant continues to qualify for benefits (for example, that he continues to meet the definition of "disabled" under the terms of the contract).

8.2.3 Group brokerage services

The role of a group broker, usually operating as part of a general agency (GA), is primarily to solicit group quotes on behalf of his clients. The broker gathers the necessary data regarding the makeup of the group and past claims experience, from the existing group plan administrator, under exclusive mandate from the group plan sponsor. The broker then confers with the sponsor to determine which benefits and their characteristics within the current group plan are negotiable and which are non-negotiable. Armed with this information, the broker may approach several group providers with a request for a quote (RFQ).

Part of the value-added service of the broker is his familiarity with the marketplace, knowing which providers are targeting which type of group, particularly if they are seeking a number of groups within a given business/occupational sector so as to be able to pool their combined claims experience in order to more accurately set premium rates. Once quotes have been submitted, it is the role of the broker to sift through the submissions to select those which most closely meet the

client's requirements for both price and plan design. The broker will then meet with the client to present the quotes and make his recommendation.

Assuming that one of the quotes is selected, it is then the group broker's responsibility to act as liaison between the client and the account executive with the insurance company in question.

8.3 Coverage

There could be many reasons for a group sponsor of an existing plan to want to shop the market at renewal time, including:

- Price;
- A desire to have additional benefits or more flexible benefits;
- Dissatisfaction with service, including claims turnaround times and the percentage of claims denied.

When presented with the opportunity to shop the market for quotes, the group agent or broker will consider:

- Existing coverage;
- Proposed new coverage;
- Appropriate funding mechanisms;
- Appropriate premium payment structure.

8.3.1 Existing coverage

One of the first things that a group agent needs to do is to understand the coverage provided by the existing plan and any shortfalls that it may have in the eyes of the plan sponsor or its members. Evaluation of the existing group coverage relies on three separate elements:

- An in-depth analysis of the benefits offered (plan design);
- An evaluation of the group's claims experience;
- Overall level of satisfaction with the current group provider.

8.3.1.1 Existing plan design

The existing plan coverage is the starting point for any review of existing coverage and analysis of needs should the plan sponsor wish to consider other insurers' offerings. Not only the type of coverage, but the nature and scope of coverage (covered conditions, products and services; benefit limits; definitions; deductibles and coinsurance factors, etc.) and the type of funding in

place for the current plan must be examined. A detailed summary of potential points of comparison is provided under the *Proposed new coverage* Section, below.

8.3.1.2 Claims experience

A group's past claims experience is often seen as a strong indicator of likely future claims and, as such, can play a crucial role in both premium pricing and plan design. A group with comparatively high claims can expect to face equally high premiums at plan renewal or when shopping the market for a new carrier. But of equal consideration could be the reason for the high claims rate. It might not simply be that the group members incur more bouts of disability or medical expenses than other, similar groups. In part, the plan design might permit, or even encourage, a high level of claims. Many factors need to be considered and the following questions need to be answered:

- Is the coverage very broad?
- Are the definitions of a covered event, product or service very liberal?
- Are benefit maximums very high?
- Are there deductibles, coinsurance factors and waiting periods designed to minimize claims?

An unusually high past claims experience might be attributed as much to the plan design as to the plan members, particularly if there are no pro-active programs in place, like an EAP.

8.3.1.3 Satisfaction with current group provider

Before determining the criteria for adjusting the current plan or setting up a new plan, the agent must ensure that the services provided by the carrier of the current plan have been satisfactory to date. Important considerations include the level of support offered by the provider in administering the plan and the turnaround time on claims. Any concerns voiced by the plan sponsor or the administrator should be taken into consideration when determining whether or not it would be appropriate to approach a new carrier.

8.3.2 Proposed new coverage

Switching to a new group carrier is not a decision that should be made on price alone. A lower price may be an indication that the new plan is more efficiently designed and managed or that is has some deficiencies when compared to the existing plan. An in-depth examination of the plan design would be warranted to determine whether value or price is the key element to the proposed plan.

8.3.2.1 New plan design

On the surface, a proposed new group plan may offer the same benefits as the plan that the group is seeking to replace: disability benefits, extended health, etc. But are those benefits really the "same" or merely just "similar"? Looked at more carefully, they may not really offer the same benefits as the existing plan.

To determine true value, both the existing and the proposed new plans must be examined from a variety of perspectives.

- Disability benefits
  - Definition of disability
  - Waiting period
  - Benefit periods for both short-term disability (STD) and long-term disability (LTD)
  - Percentage of income covered under STD and LTD
  - Rehabilitation and retraining services offered
- Extended health benefits
  - Services covered
  - Maximum benefits
- Drug benefits
  - Deductibles
  - Coinsurance factors
  - Drugs covered
  - Brand name or generic only
  - Benefits provided on a pay-direct or reimbursement basis
- Vision care
  - Maximum benefits
  - How often may claims be presented
  - Covered products and services
- Dental benefits
  - Deductibles
  - Coinsurance factors
  - Covered procedures
  - Maximum annual/lifetime benefits

- Long-term care
  - Waiting periods
  - Maximum benefits
  - Services covered
- Critical illness
  - Amount of coverage
  - Covered conditions
  - Definitions of covered conditions
- Employee Assistance Plan (EAP)
  - Inclusion of an EAP in the insurance plan
  - Benefits provided
  - Maximum benefits

All of these elements have to be taken into consideration in order to determine whether the proposed new plan offers value (not merely a lower price) in comparison to the plan being replaced.

8.3.3 Funding formulas

The funding of a group insurance accident and sickness plan can basically be structured in one of three ways, depending on the services being provided by the insurance company and whether the plan sponsor wants a guaranteed premium structure or one that can vary with claims and costs:

- Non-refund accounting;
- Refund accounting;
- Administrative services only.

8.3.3.1 Non-refund accounting

The more traditional form of funding a group insurance plan is through the use of a fully insured (pooled) plan: non-refund accounting. As with most individual insurance contracts, the insurance company bears the full financial responsibility for paying all claims. The insurance company sets premiums based upon the anticipated cost of claims for the period, which in turn is based on past claims experience. If the actual cost of claims exceeds the anticipated cost, the plan sponsor (usually the employer) has no liability to cover the excess costs. On the other hand, if claims costs for the period are less than were estimated in setting the premiums, the insurance company benefits from a windfall: there is no provision for a refund of premiums to the plan sponsor.

However, excess claims over those predicted will be taken into consideration in setting future premium rates (higher) at time of contract renewal.

8.3.3.2 Refund accounting

Refund accounting for group insurance is, in effect, a form of “participating” insurance from the perspective of the plan sponsor (most often the employer of the group members). Premiums are set prospectively, based on the group’s past claims experience. If the claims experience of the group is better than the group premiums were priced for, the employer benefits through a partial refund of its premiums paid. If the actual experience is worse than anticipated, the insurance company has the opportunity to recoup its losses at time of contract renewal. Refund accounting is also referred to as “retention accounting.”

8.3.3.3 Administrative Services Only (ASO)

An “administrative services only” (ASO) group plan is one where the insurance company is responsible only for providing an administrative role, not for funding the benefits paid out to claimants. There is no “insurance” element to the plan – the plan sponsor assumes all of the risk of paying claims. The plan sponsor is comfortable in assuming the costs of funding the plan and does not see the need to pay a third party to assume the risk.

However, the plan sponsor (the employer) is unlikely to have either the qualified staff, the time, or the inclination to handle the myriad of administrative functions of running a group plan and so outsources the administration – record-keeping, pricing, adjudicating and paying claims, etc. – to an insurance company.

ASO plans are most appropriate for large organizations with thousands of employees and substantial assets and cash flow, so as to be able to absorb the cost of claims.

8.3.4 Responsibility for premium payment

Employer/employee plans can be structured either as a contributory plan, with premiums shared between the employer and the employee, or as an employer-pay-all non-contributory plan. Group association plans are typically fully contributory: the premium is fully paid by the member, since there is no incentive for the plan sponsor (for example, the Canadian Medical Association) to pay part of the premium on behalf of the member. The plan is offered strictly as a service.

8.3.4.1 Non-contributory

A non-contributory group insurance plan is one under which all premiums are paid for by the plan sponsor, generally an employer of a group of employees that make up the group members. Under non-contributory group plans it is usually a requirement that 100% of qualifying employees join the plan and there is little or no opportunity for the group members to vary their benefits from a set schedule.

8.3.4.2 Contributory

Conversely, a contributory group plan is one under which some, or all, of the premiums are paid for by the group members themselves. Participation in a contributory plan is usually optional, although there will almost always be a requirement that a minimum percentage of qualifying employees must participate in the plan, in order to ensure a broad cross-section of risk. Contributory plans often offer the members more freedom in selecting benefits, although certain coverages may be mandatory.

8.4 Costs

The overall costs of group insurance are determined by a confluence of a number of different factors:

- Premium rates;
- Taxation and group plan registration;
- Claims experience and other product cost drivers.

These elements are briefly discussed in the following sections.

8.4.1 Premium rates

Group premium rates are affected by a variety of factors, some of which have been addressed earlier in this Chapter:

- **Makeup of the group** — The number of members in a group has an impact on the ability of the insurer to accurately estimate future claims. In the case of smaller group (25 lives or less), claims experience cannot be counted on to resemble actuarial norms and smaller groups may face comparatively higher premium rates. The average age and gender of the group members also factors significantly in premium pricing, as does the turnover rate.
- **Nature of the business** — The level of benefits offered and premium pricing under the group plan depend on the nature of the business, namely the type and level of risk that employees are exposed to. For various types of reasons, different occupations may also have traditionally lower (or higher) claim rates than others, despite their potential similarities.
- **Group benefits offered** — Premium pricing is directly linked to the nature and the level of benefits offered, with increased coverage yielding generally higher premiums. However, the increase in premium rates is not always proportional to the increase in coverage.
- **Past claims experience** — Even if the group's past claims experience is not always reliable (new or small group), the carrier will want to predict future claim rates in order to determine an appropriate premium.

This last factor is addressed differently according to the nature of the group. First year rates, or renewal rates, can be based, in whole or in part, on past claims experience (experience rated), on the claims experience of a pool of plan members in similar situations (pooled or manual rated), or often on a combination of these two methods (blended rating).

8.4.1.1 Manual rating

If a prospective group applying for coverage has had no previous group coverage on which to assess its claims experience, the group premiums will be based exclusively on a rate derived on a "manual" basis. The manual rating sets out premium standards for groups of a similar size and makeup within the same industry sector, based primarily on their past claims experience. This method is also sometimes referred to as "pooled" pricing.

8.4.1.2 Experience rating

In the case of a group seeking to renew their coverage, either with the same carrier or a replacement carrier, premiums will largely be based on an estimate of future claims, which is in turn largely based on the past claims experience of the group. It is assumed that, if the group is sufficiently large for past claims experience statistics to be meaningful, and the makeup of the group has not changed in a meaningful way, past claims are a reasonable predictor of future claims and can be used to set premium rates.

8.4.1.3 Blended rating

Unless a prospective group has never had coverage previously, group premium rates are seldom based entirely on either a manual rating or an experience rating basis: they are set based on a blend of rates derived from both rating methods. The degree to which previous claims experience weighs on the pricing process is a function of how credible past claims experience is considered to be.

8.4.1.4 Credibility

Credibility is not a rating method in and of itself. Rather it is a means of determining how reliable experience rating is in a given case, thereby setting the mix of experience rating and manual rating used in a blended rating situation.

In a situation where a large group is highly stable (has a very low employee turnover rate) and has had group coverage in place for a number of years, the group's past claims experience might be considered highly credible: in other words, reliable in predicting future claims rates. On the other hand, smaller groups with higher employee turnover rates and a short history of group coverage would have a much lower credibility rating for past claims experience. Groups with existing coverage will likely have an experience credibility rating somewhere between high and low. Groups with no previous group coverage will have a null experience credibility rating and premium rates would be based exclusively on a manual rating approach.

EXAMPLE

The Master Mobile Company has a workforce of 37 employees and an annual employee turnover rate of 18%. The company has had a group benefits plan in force for four years. Their claims experience credibility has been rated at 40%, meaning that insurance premiums will be based 40% on their previous claims experience and 60% on the standard manual rate for a group of their size in a comparable industry.

8.4.2 Taxation and group plan registration

As for individual plan, group A&S plans have tax implications that must be considered when determining the overall cost of the coverage for the plan sponsor and the plan members. Of particular interest are the impacts of:

- Employee payment of long-term disability premium;
- Registration of short-term disability plan with Employment and Social Development Canada (ESDC);
- Group premium tax.

8.4.2.1 Employee payment of long-term disability premium

One factor that must be considered in the design of a long-term group disability plan is the tax ramifications of premiums and benefits.

In all cases, employer paid group premiums for disability, extended health and other forms of group A&S insurance are a tax-deductible expense for the employer, regardless of whether or not they are a taxable benefit for the covered employees.

Of particular interest is the tax treatment of disability benefits, depending upon who pays, and pays what portion, of the group premium.

If the employer pays 100% of the premium, any disability benefits paid out under the plan will be treated as taxable income in the hands of the recipient group member for the year in which they are received.

If the employee/group member pays 100% of the group plan premiums, any benefits paid to him will be tax-free but the employee does not get to tax-deduct the premiums paid.

If the employer and employee share the group disability premiums, in the event of a claim, the plan member receives a portion of the benefits equal to his aggregate premiums paid, tax-free, and the balance of the benefits is treated as taxable income.

EXAMPLE

Shawna is a member of the group insurance plan where she works, which provides her with disability benefits of $1,200 a month. Shawna and her employer share the cost of disability premiums 50/50. Since the inception of the plan each has paid $3,600 in group disability premiums and, until last year, Shawna never had a claim. She was sick last January and was off work for 10 months, receiving $9,600 in disability benefits, Her first $3,600 of benefits (equal to the premiums that she had paid into the plan) were tax-free, while the other $6,000 of benefits was a taxable benefit to Shawna.

For this reason, most contributory group plans are structured such that the employee's portion of the group premiums paid are allocated, first and foremost, to pay 100% of the group disability premiums.

8.4.2.2 Registration of short-term disability plan with Employment and Social Development Canada (ESDC)

ESDC is responsible for, among other duties, administering the federal Employment Insurance (EI) program. Among the benefits provided to EI participants is a 15-week disability benefit, following a one week waiting period. If an employer has short-term group disability coverage in place that is equal to or greater than the coverage provided by EI, the employer can apply for a partial reduction in its EI premiums otherwise payable. This is because EI is a second payer to group insurance coverage: the group short-term disability (STD) benefits would relieve EI of having to pay any disability benefit with respect to that insured. In order to qualify for the reduction, the employer must register the group plan with ESDC based on their specific schedule.

8.4.2.3 Group premium tax

Premiums paid for all forms of group accident and sickness and extended health coverage, both personal and business, are subject to the provincial premium tax, generally between 2 and 3% of the net premium payable. The tax is applicable whether the premiums are paid by the insured plan member or an employer. The premium tax is part of the overall premium quoted, rather than being broken out as a separate charge.

EXAMPLE

Jorge pays $150.81 per month for his group long-term disability insurance coverage. The $150.81 monthly charge represents the base premium for the coverage of $147.06 plus a 2.55% premium tax of $3.75 ($147.06 × 2.55%).

8.4.3 Claims experience and other product cost drivers

The main driver of premium costs for a group plan is, of course, anticipated claims. But there are specific elements within a plan that can impact the frequency and severity (magnitude) of those claims:

- The frequency of claims can be modified through the implementation of deductibles and coinsurance factors: both providing amounts that the plan member must pay of the expense being claimed. If the benefits are "free" to the member (no deductible or coinsurance factor), they are more likely to be claimed, because there is no perceived downside for the user. If the plan member is going to be responsible for at least part of the cost of a claim, he may reconsider whether the product or service being contemplated is really necessary. It is the same concept as imposing user fees in a health care system;
- For disability coverage, extending the waiting period can eliminate all really short-term claims, reducing both benefits paid out and administrative expenses associated with the coverage;
- For drug benefits, eliminating coverage for brand name drugs, unusually expensive drugs and non-prescription drugs can all significantly reduce the insurer's exposure to claims;
- A contributory plan, particularly for benefits for short-term disability, can give rise to higher claims. Plan members may not be so unwell as to have to file (or continue) a disability claim but, if they have paid for the coverage, may feel a sense of entitlement.

All these and similar elements must be taken into consideration by the insurer in designing and costing a group plan.

8.5 Claims administration

It is the responsibility of the group insurer to administer claims from first notification to final payment (if any). This is a multi-step process:

- First the insurer must receive notification of the claim, usually on an insurer-provided claim form, and any attendant proof of claim (such as a physician's statement);
- Next the insurer must check both that the group plan in question is still in force and the claimant is a member of that plan;
- It must also determine whether the products or services being claimed are covered by the plan. For example, under a drug claim is the drug a qualified item and is the brand name drug covered or just the generic version;
- Adjudication of the claim (see *Claims Adjudication* Section, above) is the next, all-important step;
- If the claim is approved, it is the responsibility of the insurer to make appropriate payment, either in a lump-sum or on a periodic basis, as the case may be.

With large groups, communication with the group sponsor and the group members would be the responsibility of the representative of the insurer, or representatives of the insurer and the plan sponsor, together. However, in the case of groups with only a few members, 25 or less for example, the agent may be called upon to communicate insurer requirements and processes to the members directly.

8.6 Coordination of benefits

Almost all group insurance plans, particularly those offering accident and sickness or extended health benefits, have a "coordination of benefits" (COB) clause in their master contract. In situations where a claimant is covered by two group plans (perhaps his own and through family coverage via a spouse's plan) which plan pays first and, in effect, for how much of the expense each plan is liable, is determined by the COB rules.

The basic rules are fairly straight-forward:

- The group plan covering the claimant as a primary insured is the first payer;
- Assuming that the first payer does not fully cover the expense, the spouse's plan (under which the claimant is also insured via family coverage) becomes the second payer;
- The entire expense (not just the portion paid or reimbursed by the first payer) is filed as a claim with the second payer, which then pays the lesser of:
  - What it would have paid had it been the first payer;
  - The difference between the total expense and what the first payer paid or reimbursed.

In the case of a claim on behalf of expenses incurred by children of the insureds, the insurance company covering the parent with a birth date that is earliest in the calendar year, regardless of age, becomes the first payer.

An example might help to clarify these rules about the coordination of benefits.

EXAMPLE

Jasmine and Abdul are a married couple, both working in the computer industry, but each for a different company. Each of them is a member of a group plan that offers benefits to employees and their spouses. The plans are provided by two different insurance companies. Both plans offer dental benefits, including restorative services, like caps and bridges.

Jasmine's plan has a $100 annual deductible on dental claims and a $1,500 annual maximum on restorative services.

Abdul's plan has a $50 annual deductible on dental claims and a $2,000 annual maximum on restorative services.

Last year Jasmine fell while hiking and damaged her front teeth. The dentist bill for the restorative work was $2,500. It was the first dental claim against either plan for the year.

As the patient in question, Jasmine claimed first against her group plan carrier. She was responsible for the first $100 of expenses, under the plan's deductible. Of the other $2,400 of expenses, her plan reimbursed her $1,500 – the maximum allowable in one year for restorative services. That left Jasmine with $1,000 of dental expenses that her group plan did not cover.

The couple then submitted the entire $2,500 bill to Abdul's plan as well. If it had been the primary carrier, Abdul's plan would have covered $2,000 of the claim, after allowing for the $50 deductible. Since Abdul's plan, as second payer, is required to cover (under the coordination of benefits rules) the lesser of what it would have paid had it been the primary carrier ($2,000) and the amount of the claim not covered by Jasmine's plan ($1,000), the plan covered $1,000 of the expense.

By combining the two plans Jasmine was fully reimbursed for her dental expenses.

8.7 Agent's service role

In instances where the agent associated with a group plan is not actively involved in group business, his sole role in the marketing and administration process may be the identification of a group prospect and introducing that prospect to a group representative or the insurance company's group representative (account executive). If the group plan is successfully placed, the agent receives a commission.

On the other hand, if the agent/broker is personally actively involved in both sales and service process, he has a two-pronged responsibility:

- Remaining up-to-date on the client's needs and situation;
- Documenting the services provided.

If a new or replacement plan is to be initiated, the agent may be directly involved in an education and promotion program (meetings, presentations, written communications, etc.) with the employees to encourage participation in the plan.

8.7.1 Ongoing awareness of client situation and needs

Many factors influence the decision to offer group benefits to members, including business growth and retraction, and the changing needs of members. Agents should not only be aware of new offerings from insurance companies, but also be aware of changing circumstances of their clients.

Preparing a plan for periodic client contact will serve agents and clients well to strengthen client relationships and foster referrals. This plan will allow the agent to:

- Be a conduit between the client and the insurance company, to anticipate and help to “head off” any issues of dissatisfaction;
- Be in contact with the client 90 days prior to the plan’s yearly renewal date, to see if any plan modifications are required or if the client wishes to go to market in order to decide whether to renew the current plan or to seek an alternate provider;
- To solicit quotes from other providers and make recommendations to the plan provider, if the client wishes to “shop” the plan.

8.7.2 Documentation of service provided

It is critical that the agent document every step of the service process, for his own protection and the protection of both the client and the insurance company.

If the client contacted the agent seeking some level of service, the agent should document the date of the contact and what was discussed, when and if he met with the client and what was said, what action was taken, and when and how the matter was resolved. Similar detail should be recorded if the agent or the insurance company initiated contact. Particular care should be taken to set out the specifics of any instance where the client expressed concerns about the product or service provided by either the agent or the insurance company.

Copies of all written communications between the client, the agent and the insurance company should be retained in the agent’s file, including quotes obtained and letters or emails passing between all or any of the parties in regard to the client’s situation. Details of phone conversations should also be recorded in writing.

All of these records could be vital in ensuring that the client is properly served and in establishing a record in the event there should be a claim or legal dispute involving either the agent or the insurance company in the future.

CONCLUSION

Accident and sickness (A&S) insurance is a complex and multi-faceted subject. It encompasses a wide variety of products, with variable characteristics, designed to meet an even wider variety of needs. Developing a comprehensive A&S program is a multi-step process involving a multitude of possible product solutions, designed to protect both personal and business income and assets.

This being said, for many Canadians, their group package is the core, or the totality, of their financial protection plan. However, it must be remembered that, unless the group plan benefits are convertible to an individual contract (and, in many cases, A&S benefits are not), the group coverage is "owned" by the plan sponsor, not the group member. Should the member leave the group (by leaving the employ of the employer, for example), the group coverage would terminate. It is the responsibility of the life insurance agent to ensure that, within the confines of the client's financial situation, the client has adequate individually owned A&S coverage.

The process of developing a quality A&S program, whether for an individual or a group, encompasses a series of five separate steps.

- Ascertaining the client's needs
  - Insurance to protect income
  - Insurance to protect assets
  - Insurance to protect savings
- Comparing those needs with the client's current resources
  - Alternative income sources
  - Capital assets
  - Existing insurance coverage: individual and group
  - Community resources
- Researching appropriate product solutions (with appropriate features/riders)
  - Individual and group
  - Disability income replacement coverage
  - Critical illness

- Long-term care
- Extended health (individual and family coverage: prescription drugs, dental, vision care, hospitalization, etc.)
- Business overhead expense disability coverage
- Key person business insurance
- Buy/sell disability coverage

- Developing recommendations
  - Researching optional product solutions and comparing features and benefits
  - Selecting one or two options as the most appropriate to present to the client
  - Explaining the options to the client and making a final recommendation
  - Completion of the appropriate application forms and submitting them to the insurance provider(s)
- Conferring with the client
  - Reviewing the policy features with the client upon policy delivery, focusing on benefits and limitations (such as exclusions)
  - Interviewing the client to ensure that there has been no change in his medical or financial status
  - Coordinating with the client to complete any outstanding documentation required (such as acceptance of a rated contract)

The agent's responsibilities do not end with the provision of product solutions, either individual or group. He must document all client contacts and recommendations and stay in touch with the client on a regular basis, once a year at a minimum. It is important to apprise the client of new product developments in the marketplace that might augment the client's plan and to ascertain any changes in the client's health, personal, financial or business circumstances that might warrant a revision of the plan.

Client relationships can be a lifetime commitment, for both the agent and the client.

APPENDIX A

ADULTS WITH DISABILITIES THAT NEED HELP WITH EVERYDAY ACTIVITIES, BY SEX AND AGE GROUPS, CANADA, 2001 AND 2006[48]

	2001			2006		
	TOTAL	MALES	FEMALES	TOTAL	MALES	FEMALES
Total – 15 years and over	**2,397,960**	**904,050**	**1,493,910**	**2,652,890**	**980,850**	**1,672,050**
Receiving help but needing more	652,660	231,810	420,860	971,190	342,380	628,810
Not receiving help but needing some	130,590	50,970	79,620	212,630	83,760	128,870
Receiving all help needed	1,614,710	621,270	993,430	1,469,080	554,710	914,370
Total – 15 to 64	**1,303,100**	**513,390**	**789,710**	**1,464,490**	**569,400**	**895,090**
Receiving help but needing more	360,610	131,950	228,670	546,080	200,670	345,400
Not receiving help but needing some	95,700	36,620	59,080	141,360	54,060	87,290
Receiving all help needed	846,790	344,820	501,970	777,060	314,660	462,400
Total – 65 and over	**1,094,860**	**390,660**	**704,200**	**1,188,400**	**411,450**	**776,960**
Receiving help but needing more	292,050	99,860	192,190	425,110	141,700	283,400
Not receiving help but needing some	34,890	14,350	20,540	71,280	29,700	41,580
Receiving all help needed	767,920	276,450	491,470	692,020	240,040	451,970

48. Statistics Canada. *Table 1 - Adult with disabilities that need help with everyday activities, by sex and age groups, Canada, 2001 and 2006.* [online]. Revised November 30, 2015. [Consulted September 26, 2017]. http://www.statcan.gc.ca/pub/89-628-x/2010015/tbl/tbl1-eng.htm

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MONEYINSTRUCTOR.COM

http://content.moneyinstructor.com

Sample monthly household budget.
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www.nei.nih.gov

Facts about age-related macular degeneration.
http://www.nei.nih.gov/health/maculardegen/armd_facts.asp#2

ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE

www.health.gov.on.ca/en

Home, community and residential care services.
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RETRAITE QUÉBEC

www.retraitequebec.gouv.qc.ca

RBC INSURANCE

www.rbcinsurance.com

Travel insurance quote and online application.
https://www.worldprotect.com/cgi-bin/weblinkca/en/travel-insurance.cgi

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www.servicecanada.gc.ca

Canada Pension Plan payment amounts.
http://www.servicecanada.gc.ca/eng/services/pensions/cpp/payments/

SERVICE CORPS OF RETIRED EXECUTIVES (SCORE©)

www.score.org

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www.soa.org

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www.statcan.gc.ca

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www.ubc.ca

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