SAGE HILL
Advisory & Management

Life Insurance Program Review, Plan Design, Underwriting, Implementation & Management

Phase I – Client Medical, Lifestyle, and Financial Due Diligence

- Informal Inquiry completion
  - Names/contact information of primary care physician
  - Names/contact information of all specialists, hospitals, treatment centers, executive physical facilities
  - Complete supplemental impairment forms/questionnaires

- HIPPA Forms/Authorization signed
  - Many hospitals and managed care providers require special authorization forms (Kaiser, Mayo Clinic, VA Hospitals)

- Supplemental forms completion
  - Aviation, avocations, foreign travel questionnaires

- Financial documentation, face amount determination, and justification
  - Agent/Advisor completed Personal/Business Supplement forms
  - Supporting documents if required (Business Financial Statements)
  - Product type and needs identified

Phase II – Informal Carrier Submission

- Carrier selections identified by product design or competitive underwriting offers

- Cover letters to Carriers
  - Provide client background, address any unusual or privately held information, and clarify medical or lifestyle issues.
  - Compile all information into one package. It is important to be a translator of information, rather than just a transmitter.
  - Communicate to the client/advisor/agent risk classification expectations.

- Facilitates compliance with HIPAA and Fair Credit Reporting Act (FCRA) regulations.

- Preliminary and tentative underwriting offers will specify additional requirements (formal application, special forms, MIB search, Examination, Labs, Telephone Interview, MVR) for making the final underwriting risk assessment. These preliminary offers are therefore non-binding by the carriers.

- If additional information needs to be obtained or clarified, the underwriter may request complete information before providing a preliminary offer.

Phase III – Formal Application, Medical Examination, Telephone Interview, and Underwriting Approval

- Formal application and carrier selection is influenced by product design and carrier preliminary offers. Occasionally, large face amounts or total lines of coverage will require multiple carrier formal applications.
  - Carrier retention and auto-jumbo binding limits may influence carrier selection. With multi-carrier applications, a strategic analysis and an agreement on a game plan are critical.
  - The accurate completion of all required application and New Business forms is an onerous and detailed task. Since all formal application forms are state specific, there is zero tolerance for mistakes by the carrier.

- Examinations and other requirements are generally valid for a limited time. Good judgment must be used to schedule these requirements when it is convenient for the client, but not too far in advance of the formal application submission.
  - To ensure the best possible results it is important for the client to prepare for the exam. Early morning examinations allow for convenient fasting. The client will also be relaxed, which provide lower blood pressure and pulse rates.
  - Carrier's examination forms are available for review by the advisor and client prior to the examination.

- Many times the carrier will require a telephone interview or inspection report by a third party vendor. The questions are similar to application questions; however, answers may lead to more detailed questions. Consistency of information between application, examination, and interview are critically important.

- When the carrier receives the formal application, there will be an MIB database search and an internal carrier search for inforce policies or past activity.
  - On occasion, MIB information, or past activity documented on the MIB Activity Index, will prompt the underwriter to request further information from the agent and client.

- The carrier underwriter typically has the authority to make a final risk classification decision and approve the application without notifying or submitting the case to the carrier's reinsurers.
  - If an underwriter seeks permission to send the case facultatively to their reinsurers, the agent and advisor should request an explanation.
  - Seeking a facultative reinsurance opinion will usually prevent the carriers from making their own underwriting assessment and decision.
  - Facultative underwriting by the reinsurers should only be utilized under special circumstances. Usually, facultative submission is required to secure large capacity facilities, which are beyond the carrier auto-jumbo binding limits.

- Upon final approval, the underwriter will communicate the approval to the agent. If approved as applied for, the case is transferred to the carrier's New Business department for issue. If a counter offer is made, the underwriter will ask the agent if the case can be placed at the different risk classification.

Phase IV – Policy Delivery and Premium Payment

- After the application is approved, the New Business department will issue the policy within a few days of the approval.
  - Policy inspection and review by the agent and advisor should be completed as soon as possible.
  - When a 1035 exchange is being performed, the carrier will request the proceeds immediately from the other carrier. Individual carrier policies dictate if they will issue a policy prior to the receipt of the 1035 funds.

- The carrier must receive the initial premium, as well as any delivery requirements, amendments, and/or statement of good health before the coverage is considered inforce.

Product Pricing: Mortality Charges

When it comes to life insurance product pricing, the most important – and variable – component may be mortality charges. Regardless of the product type (Term Universal Life, Variable Life, of Whole Life), mortality charges, which are ultimately governed by the underwriting risk assessment process and decision, must be considered as part of the overall case design and due diligence process.

Within the last two decades, stratification of the Standard Mortality Class has created even more complexity and additional underwriting requirements. Carriers have added Preferred risk classes, which account for a high percentage of placed and inforce policies.

To assess risk in a more complex environment, carriers now focus on lifestyle guidelines and documentation beginning with the field underwriting process. Agents see greater scrutiny from carriers on foreign travel, driving records, avocations and common cardiovascular risk factors such as hypertension, build, and hyperlipidemia (elevated blood lipids). This fine-tuned risk stratification has created the need to approach multiple carriers in order to achieve the optimal mortality risk assessment decision for the client.

Soliciting Underwriting Offers

Within the last five years, most carriers have seen a substantial increase in the number of Informal Inquires; this is a departure from the traditional process of choosing a carrier and immediately proceeding with the submission of a formal application. This creates challenges for the carriers, many of whom have responded by creating minimum face amount of premium thresholds to reduce the number of small transactional Term inquiries. The ultimate consequence for the agent and the Firm is that Case Managers need to become more knowledgeable on all facets of medical and non-medical underwriting to summarize medical records and other pertinent information for "Quick Quote" submission to multiple carriers. Carrier's limitations on Informal Inquiries have also created a higher demand for outsourcing to medical record acquisition providers (vendors) who also provide medical records summaries for the Firms and agents.

The actual solicitation of underwriting offers has changed in both complexity and in the number of carriers that willingly invite impaired risk business (and have dedicated and highly proficient underwriters devoted to this segment). Many of the carriers that specialized in impaired risk underwriting are no longer in business, or have left this market to become more mainstream and risk averse. This has been partially driven by reinsurance pressures, and market consolidation, which create new corporate directives.

When the motivation to pursue an Informal Inquiry is to ascertain the most competitive Preferred Risk Classification, it is essential to recognize the two types of Preferred Risk Classification, it is essential to recognize the types of Preferred Risk Programs that exist. The most common is the "knock-out" program, which includes guidelines designed by the carrier that allow for little flexibility. Current treatment for even mild, well-controlled conditions is not allowed at the

carrier's best class, and there is strict adherence to published builds, blood pressure, and cholesterol results. The other type of Preferred program focuses more on "lifestyle" risk factors and a numerical scoring. While there are still published Preferred guidelines and criteria, the underwriter has the flexibility to use normal cardiovascular test results, exercise capacity, and other favorable risk factors to influence the outcome of the risk classification.

On impaired risk solicitation, one challenge involves recognizing the differences between each carrier's willingness to accept extra risk using their own retention (versus binding their reinsurance partners on certain situations). Many of the former table shaving programs that flourished in the 1990s were eliminated or have been replaced with "Lifestyle Credit" programs. While traditional table shave programs still exist, many of the remaining programs have limitations and are not suitable for the moderate to higher-level mortality risk. The astute Case Manager will recognize the importance of soliciting carriers that utilize a particular program for best results.

The Informal Inquiry process is an important element of the majority of cases being underwritten today. In addition to determining a predictable risk classification, the nature of the Informal process allows agents and Firms to solicit cases "under the radar" of the traditional formal process that includes Medical Information Bureau (MIB) notification and reporting responsibility. In recent years, many distribution entities have developed dedicated platforms that can deliver Informal Inquiries electronically to carriers in a secured environment. While this is a favorable development, it requires discipline from the agent and the Firm to appropriately target their Informal submissions, as carriers are very mindful of Informal Inquiry to Formal Application ratios.

Medical Information Bureau (MIB)

The MIB, which formed in 1902, is owned by approximately 470 member insurance companies in the U.S. and Canada. The mission of the MIB is to protect its members from fraudulent applicants. The MIB estimates that on an annual basis it saves member companies an estimated $1 billion in early claims and other fraudulent activity. All agents and Firm employees should become familiar with the MIB and the process clients can follow to obtain their free annual MIB Consumer File Disclosure.

The MIB website (www.mib.com) provides a consumer oriented overview of the MIB, as well as with contact information. It is important for agents and Firms to understand that only a Formal Application triggers an MIB inquiry from an insurance carrier. Generally, Informal Inquires do not contain the pre-notice disclosure language, nor are they given a copy of an MIB pre-notice, which is a requirement under the Fair Credit Reporting Act (FCRA). When a Formal Application is submitted to the carrier, the applicant is automatically searched in the MIB database before the underwriter reviews the case. Every search through the MIB is documented; carriers can typically see the MIB codes reported (medical history is denoted on the MIB in coded format) and the history of all search inquiries. Unexplained and frequent MIB activity will often cause concern and influence underwriter behavior. Frequent MIB activity also influences facultative reinsurance participation, as reinsurers use MIB activity and replacement history as a basis for risk participation.

Underwriting Limits

Many agents, advisors, and clients have questions about the complexities of diminished industry capacity. Mergers and acquisitions among reinsurers, and more conservative risk tolerance philosophies from both reinsurers and carriers have changed since 9/11 have had a significant impact on capacity. Today, five reinsurers account for more than 80 percent of the reinsurance face amount and premium. Direct carriers are now retaining the majority of the industry's capacity. If there is good news to report, carriers have increased their internal retention and are comfortable retaining significant face amount risk exposure.

While a number of new reinsurance carriers have entered the market, and together are providing meaningful retention, the market remains tight. The main impact for the agent and client is that carriers can no longer issue $100 million and over face amount policies utilizing reinsurance capacity. Large capacity cases are typically split among multiple carriers. Carriers may be selected to obtain facultative reinsurance capacity to supplement their own retention, while other carriers are used strictly for their internal retention. Therefore, today's environment is not conducive to multiple agents flooding the market with Informal Inquiries and Formal Applications. While a client may feel that multi-agent competition will benefit the bottom line policy cost, the reality is that this approach creates reinsurance gridlock and an unwillingness to participate within the reinsurance community.

Presenting Offers to the Client

In most cases, the underwriter who will make the risk assessment decision will never know or meet the client, the advisor, or any other client fiduciary. The responsibility for providing due diligence information and managing the perception of the client falls squarely on the shoulders of the agent and the Firm. The best way to provide this information is through a detailed, well-written cover letter, along with any other supplemental documents or questionnaires. The cover letter should provide an introduction to your client, as well as key background information, followed by the explanation of how the face amount was determined and the purpose of the coverage. Any unusual risk factor, activity, or medical condition (items that may not be fully covered in the file) should be specifically addressed.