Addendum: for use with Idaho Life and Health study guides version number 28020en/28021en, per exam content outline updates effective 9/1/2023.

***Please note that Idaho is changing their testing provider. Effective 9/1/2023, state insurance exams will be administered by Pearson Vue**. For additional information about exam requirements and complete exam content outlines, please review the Insurance Licensing Candidate Handbook at* www.pearsonvue.com/id/insurance.

IDAHO LIFE

The new exam breakdown is as follows:

Idaho Carolina Life Insurance Examination
86 Total Questions (75 scored; 11 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
Completing the Application, Underwriting, and Delivering the Policy	16%
Types of Life Policies	20%
Life Policy Provisions, Riders and Options	20%
Retirement and Other Insurance Concepts	11%
State Law:	
Idaho Statutes, Rules, and Regulations Common to All Lines	16%
Idaho Statutes, Rules, and Regulations Common to Life and Health Insurance Only	4%
Idaho Statutes, Rules, and Regulations Pertinent to Life Insurance Only	13%

*The following are content **additions** to supplement your existing text.*

Life Insurance Basics

Unique Aspects of Insurance Contracts

Aleatory

Insurance contracts are **aleatory,** which means there is an exchange of unequal amounts or values. The premium paid by the insured is small in relation to the amount that will be paid by the insurer in the event of loss.

Unilateral

In a **unilateral contract,** only one of the parties to the contract is legally bound to do anything. The insured makes no legally binding promises. However, an insurer is legally bound to pay losses covered by a policy in force.

Adhesion

A ***contract of adhesion*** is prepared by one of the parties (insurer) and accepted or rejected by the other party (insured). Insurance policies are not drawn up through negotiations, and an insured has little to say about its provisions. In other words, insurance contracts are offered on a take-it-or-leave-it basis by an insurer. Any ambiguities in the contract will be settled in favor of the insured.

Conditional

As the name implies, a **conditional contract** requires that certain conditions must be met by the policyowner and the company in order for the contract to be executed, and before each party fulfills its obligations. *For example*, the insured must pay the premium and provide proof of

Third-Party Ownership

Most insurance policies are written where the insured and owner of the policy is the same person. However, there are situations in which the contract may be owned by someone other than the insured. These types of contracts are known as **third-party ownership.** *Third-party owner* is a legal term used to identify an individual or entity that is not an insured under the contract, but that has a legally enforceable right under it. Most policies involving third-

party ownership are written in business situations or for minors in which the parent owns the policy.

Stranger-Originated Life Insurance (STOLI) and Investor-Originated Life Insurance (IOLI)

Stranger-originated life insurance (STOLI) is a life insurance arrangement in which a person with no relationship to the insured (a "stranger") purchases a life policy on the insured's life with the intent of selling the policy to an investor and profiting financially when the insured dies. In other words, STOLIs are financed and purchased solely with the intent of selling them for life settlements.

STOLIs **violate the principle of insurable interest**, which is in place to ensure that a person purchasing a life insurance policy is actually interested in the longevity rather than the death of the insured. Because of this, insurers take an aggressive legal stance against policies they suspect are involved in STOLI transactions.

Note that lawful life settlement contracts do not constitute STOLIs. Life settlement transactions result from existing life insurance policies; STOLIs are initiated for the purpose of obtaining a policy that would benefit a person who has no insurable interest in the life of the insured at the time of policy origination.

Investor-owned life insurance (IOLI) is another name for a STOLI, where a third-party **investor who has no insurable interest in the insured** initiates a transaction designed to transfer the policy ownership rights to someone with no insurable interest in the insured and who hopes to make a profit upon the death of the insured or annuitant.

Social Security Benefits

Social Security, also referred to as **Old Age Survivors Disability Insurance** — OASDI, is a Federal program enacted in 1935, which is designed to provide protection for eligible workers and their dependents against financial loss due to old age, disability, or death. With a few exceptions, almost all individuals are covered by Social Security. In some aspects, Social Security plays a role of federal life and health insurance, which is important to consider when determining an individual's needs for life insurance.

Social Security uses the Quarter of Coverage (QC) system to determine whether or not an individual is qualified for Social Security benefits. The type and amount of benefits are determined by the amount of **credits** or **QCs** a worker has earned. Anyone working in jobs covered by Social Security or operating his/her own business may earn up to a maximum of 4 credits for each year of work.

The term **fully insured** refers to someone who has earned **40 quarters** of coverage (the equivalent of 10 years of work), and is therefore entitled to receive Social Security retirement, premium-free Medicare Part A, and survivor benefits. If an individual is entitled to premium-free Medicare Part A, they are automatically eligible for Medicare Part B, but must pay a monthly premium.

An individual can attain a **currently insured** status (or partially insured), and by that qualify for certain benefits if he or she has earned **6 credits** (or quarters of coverage) during the 13-quarter period *ending with the quarter in which the insured*:

- Dies;
- Becomes entitled to disability insurance benefits; or
- Becomes entitled to old-age insurance benefits.

For younger workers, the number of quarters required to qualify for the benefits differs by age according to a table established by Social Security.

CONDITIONS FOR PAYMENT	PAID TO	TYPE OF PAYMENT
RETIREMENT BENEFIT:		
Fully insured status and age 66* (or reduced benefits at age 62)	Retired individual and eligible dependents	Monthly benefit equal to the primary insurance amount (PIA)
DISABILITY BENEFIT:		
Fully insured status and total and permanent disability prior to the retirement age	Disabled worker and spouse and eligible dependents	Monthly disability benefit after a 5-month waiting period

SURVIVOR BENEFIT:		
Worker's death	Surviving spouse and dependent children	Lump-sum burial benefit if fully or currently insured Monthly income payments if fully insured

**The current full retirement age is 66, and is gradually increasing to age 67.*

USA PATRIOT Act and Anti-Money Laundering

The Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act, also known as the **USA PATRIOT Act** was enacted on October 26, 2001. The purpose of the Act is to address social, economic, and global initiatives to fight and prevent terrorist activities. The Act enabled the Financial Crime Enforcement Network (FinCEN) to require banks, broker-dealers, and other financial institutions to establish new **anti-money laundering (AML)** standards. With new rules in place, FinCEN incorporated the insurance industry into this group.

To secure the goals of the Act, FinCEN has implemented an AML Program that requires the monitoring of all financial transactions and reporting of any suspicious activity to the government, along with prohibiting correspondent accounts with foreign shell banks. A comprehensive customer identification and verification procedure is also to be set in place. The AML program consists of the following minimum requirements:

Assimilate policies, procedures and internal controls based on an in-house risk assessment, including:

- Instituting AML programs similar to banks and securities lenders; and
- File suspicious activity reports (SAR) with Federal authorities;
- Appointing a qualified compliance officer responsible for administering the AML program;
- Continual training for applicable employees, producers and other; and
- Allow for independent testing of the program on a regular basis.

Suspicious Activity Reports (SARs) Rules

Any company that is subject to the AML Program is also subject to SAR rules. SAR rules state that procedures and plans must be in place and designed to identify activity that one would deem suspicious of money laundering, terrorist financing and/or other illegal activities. Deposits, withdrawals, transfers or any other business deals involving $5,000 or more are required to be reported if the financial company or insurer "knows, suspects or has reason to suspect" that the transaction:

- Has no business or lawful purpose;
- Is designed to deliberately misstate other reporting constraints;
- Uses the financial institution or insurer to assist in criminal activity;
- Is obtained using fraudulent funds from illegal activities; or
- Is intended to mask funds from other illegal activities.

Some "red flags" to look for in suspicious activity:

- Customer uses fake ID or changes a transaction after learning that he or she must show ID;
- Two or more customers use similar IDs;
- Customer conducts transactions so that they fall just below amounts that require reporting or recordkeeping;
- Two or more customers seem to be working together to break one transaction into two or more (trying to evade the Bank Secrecy Act (BSA) requirements); or
- Customer uses two or more money service business (MSB) locations or cashiers on the same day to break one transaction into smaller transactions (trying to evade BSA requirements).

Relevant SAR reports must be filed with FinCEN within 30 days of initial discovery. Reporting takes place on FinCEN Form 108.

Life Insurance Policies

B. Whole Life Insurance

Interest-Sensitive Whole Life

Interest-sensitive whole life, also referred to as **current assumption** life, is a whole life policy that provides a guaranteed death benefit to age 100. The insurer sets the initial premium based on current assumptions about risk, interest and expense. If the actual values change, the company will lower or raise the premium at designated intervals. In addition, interest-sensitive whole life policies credit the cash value with the current interest rate that is usually comparable to money market rates, and can be higher than the guaranteed levels. The policy also provides for a minimum guaranteed rate of interest.

Interest-sensitive whole life provides the same benefits as other traditional whole life policies with the added benefit of current interest rates, which may allow for either greater cash value accumulation or a shorter premium-paying period.

F. Group Life Insurance

Contributory vs. Noncontributory

The employer or other group sponsor may pay all of the premiums or share premiums with the employees. When an employer pays all of the premiums, the plan is referred to as a **noncontributory plan**. Under a noncontributory plan, an insurer will require that 100% of the eligible employees be included in the plan. When the premiums for group insurance are shared between the employer and employees, the plan is referred to as a **contributory plan**. Under a contributory plan, an insurer will require that 75% of eligible employees be included in the plan.

Life Policy Provisions, Riders and Options

A. Standard Provisions

Insuring Clause

The insuring clause (or insuring agreement) sets forth the basic agreement between the insurer and the insured. It states the insurer's promise to pay the death benefit upon the insured's death. The insuring clause usually is located on the policy face page, and also defines who the parties to the contract are, how long coverage is in force, and the type of loss insured against.

D. Riders

Waiver of Monthly Deductions

The **waiver of monthly deductions** rider pays all monthly deductions while the insured is disabled, after a 6-month waiting period. This rider only pays the monthly deductions, and not the full premium necessary to accumulate cash values. The length of time this rider will pay monthly deductions will vary based on the age at which the insured becomes disabled. This rider is usually found in Universal Life and Variable Universal Life policies.

Monthly deductions include the actual cost of insurance charges, expense charges, and costs or charges for any benefits added to the policy by rider, endorsement or amendment, and which are specified in the policy to be deducted from the account value.

HEALTH:

Idaho Accident and Health Insurance Examination
86 Total Questions (75 scored; 11 pretest)

CHAPTERS	PERCENTAGE OF EXAM
General Knowledge:	
Field Underwriting Procedures	11%
Types of Policies	21%
Policy Provisions, Clauses, and Riders	20%
Social Insurance	8%
Other Insurance Concepts	7%
State Law:	
Idaho Statutes, Rules, and Regulations Common to All Lines	16%
Idaho Statutes, Rules, and Regulations Common to Life and Health Insurance Only	4%
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Health Insurance Basics

Modes of Premium Payment

In regard to insurance premiums, mode refers to the **frequency** the policyowner pays the premium. An insurance policy's rates are based on the assumption that the premium will be paid annually at the beginning of the policy year and that the company will have the premium to invest for a full year before paying any claims. If the policyowner chooses to pay the premium more frequently than annually, there will be an additional charge because the company will have additional expenses in billing the premium. However, the premium may be paid annually, semi-annually, quarterly, or monthly.

Higher Frequency = Higher Premium
Monthly > Quarterly > Semi-Annual > Annual

D. Limited Policies

2. Types of Limited Policies

Cancer Policy

Cancer policies cover only one illness: cancer, and pay a lump-sum cash benefit when the insured is first diagnosed with cancer. It is a supplemental policy intended to fill in the gap between the insured's traditional health coverage and the additional costs associated with being diagnosed with the illness. There are no restrictions on how the insured spends the funds, so the benefit can be used to pay for medical bills, experimental treatment, mortgage, personal living expenses, loss of income, etc.

Short-Term Medical

Short-term medical insurance plans are designed to provide temporary coverage for people in transition (those between jobs or early retirees), and are available for terms from one month up to 11 months, depending on the state. Unlike regular individual major medical plans, short-term health insurance policies are not regulated by the Affordable Care Act and their enrollment is not limited to the open enrollment period; they also do not meet the requirements of the federally mandated health insurance coverage.

Like traditional health plans, short-term plans may have medical provider networks, and impose premiums, deductibles, coinsurance and benefit maximums. They also cover physician services, surgery, outpatient and inpatient care.

Individual Health and Disability Insurance Policy General Provisions

C. Other General Provisions

Deductibles

A **deductible** is a specified dollar amount that the insured must pay first before the insurance company will pay the policy benefits. The purpose of a deductible is to have the insured absorb the smaller claims, while the coverage provided under the policy will absorb the larger claims.

Consequently, the larger the deductible, the lower the premium that is required to be paid.

Most major medical policies feature an **annual deductible** (also called a calendar year deductible) that, as the name implies, is paid once in any year, regardless of the amount of claims in that year. The policy may contain an **individual deductible**, in which each insured is personally responsible for a specified deductible amount each year, or a **family deductible** (usually 2 to 3 times the individual deductible) whereby the annual deductible is satisfied if two or more family members pay a deductible in a given year, regardless of the amount of claims incurred by additional family members. Some policies contain what is known as a **per occurrence deductible** or **flat deductible** which the insured is required to pay for each claim, possibly resulting in more than one deductible being paid in a given year.

The policy may also contain a provision which applies when more than one family member is injured in a single accident, also called the **common accident provision**. In this case, only one deductible applies for all family members involved in the same accident.

Some supplemental major medical plans also include an **integrated deductible** in which case the amount of the deductible may be satisfied by the amount paid under basic medical expense coverage. For example, if the supplemental coverage included a $1,000 integrated deductible, and the insured incurs $1,000 in basic medical expenses, the deductible will be satisfied. If the basic policy only covered $800 of the basic expenses, the insured would have to satisfy the remaining $200 difference.

Some policies also include a **carry-over provision** that states that if the insured did not incur enough expenses during the year to meet the deductible, any expenses incurred during the last 3 months may be carried over to the next policy year to satisfy the new annual deductible.

Disability income and long-term care policies usually have a **time deductible** in the form of elimination period.

Eligible Expenses

Eligible expenses are those medical expenses covered by a health insurance plan. The eligible expenses are specified in the policy.

Pre-Authorization and Prior Approval Requirements

Some health insurance policies will require the pre-authorization or prior approval of certain medical procedures, tests, or hospital stays. The insured must obtain the insurer's approval before the procedure, test, or hospital stay to be sure the policy will cover the expenses.

Impairment Rider

The **impairment** (exclusion) rider may be attached to a contract for the purpose of eliminating coverage for a specifically defined pre-existing condition, such as back injuries. Impairment riders may be temporary or may become a permanent part of the policy. Attaching this rider excludes coverage for a condition that would otherwise be covered. Often a person's only means of purchasing insurance at a reasonable cost when they have an existing impairment is through a policy which excludes coverage for the specific impairment.

For example, a physician may have suffered from a back injury prior to applying for a disability policy. The company may agree to issue a disability policy, but with an exclusion rider, excluding coverage for any claim related to his back. The policy would cover any other disability he may incur in the future, as long as it is not related to his back. This may be the only way the insured is able to obtain coverage. The underwriter makes a decision when writing the contract whether to make the exclusion permanent, or, for a short time only (such as if the insured is able to go a specified period of time with no further treatment). The terms of the rider will be clearly stated in the policy.

Most riders in both life and health insurance add some form of additional coverage and often, there is extra cost added to the premium for the rider. The impairment (exclusion) rider is an exception in that it takes something **away from** standard coverage. There is no extra charge for this, nor is the premium reduced to reflect a reduction in coverage.

Primary and Contingent Beneficiaries

Any death benefits available in a policy will be paid to a beneficiary. A **primary beneficiary** is the first person so designated. However, if the primary beneficiary should die before the benefits become payable, the benefits would go to a **contingent** or **secondary beneficiary**. If no beneficiary is designated, the benefits will be placed in the deceased's estate.

Multiple primary and contingent beneficiaries may be designated in a policy. If multiple primary beneficiaries are named, each individual will receive a proportionate percentage of the death benefit. If one of multiple primary beneficiaries dies, equivalent percentages are re-established.

For example, if there were two primary beneficiaries named in a policy, each would receive 50% of the death benefit. If one of the two beneficiaries died, the remaining beneficiary would receive 100%.

If an individual health insurance policy provides a death benefit, it must also include a **change of beneficiary** provision. This provision gives the policyholder, unless he/she has made an irrevocable designation of a beneficiary, the right to change any primary and/or contingent beneficiary or make any other change without the consent of the beneficiary or beneficiaries.