

# *Test Alert!*

Colorado

Life, Accident, and Health Insurance

License Exam Manual, 3rd Edition  
Exams Effective 7/1/08

8/12/08

# L&H

The information included in this release, in addition to your other Kaplan Financial Education materials, is designed to assist you in preparing for concepts that your exam may include. We urge you to read it carefully and take time to review the sample questions and rationales.

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On page 15, add the following content before “3. Distribution systems”:

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- a. Principles of Agency Law** By legal definition, an agent is a person who acts for another person or entity (known as the principal) with regard to contractual arrangements with third parties. Implicit in this definition is the concept of power—an authorized agent has the power to bind the principal to contracts (and to the rights and responsibilities of those contracts). These are the main principles of agency law:
- The acts of the agent (within the scope of his authority) are the acts of the principal.
  - A contract completed by an agent on behalf of the principal is a contract of the principal.
  - Payments made to an agent on behalf of the principal are payments to the principal.
  - Knowledge of the agent regarding business of the principal is presumed to be knowledge of the principal.

On page 24, add the following to par. 2 before “IV. Delivering the Policy”:

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As part of its role in regulating insurance company activities, state insurance departments also regulate premium rates that insurers assign when underwriting policies.

On page 26, add the following to “1. Conditional”:

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- a.** If a policyowner fails to pay the premiums, the insurer may cancel the policy.
- b.** A policyowner has the option of refusing to renew a policy at the end of its term.
- c.** A policyowner and insurer have the right to rescind a contract under certain circumstances.

On page 27, add the following to the end of the unit:

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- 6. Valued or indemnity contract** An insurance contract is either a valued contract or an indemnity contract. A valued contract pays a stated sum, regardless of the actual loss incurred, when the contingency insured against occurs. Life insurance contracts are valued

contracts. If an individual acquires a life insurance policy insuring his life for \$1 million, that is the amount payable at his death. There is no attempt to value “actual” financial loss. An indemnity contract, however, is one that pays an amount equal to the loss—it attempts to return the insured to his original financial position. Fire and health insurance policies are examples of indemnity contracts. An insured who owns a \$100,000 fire insurance policy and suffers a \$5,000 loss due to fire will be able to collect up to \$5,000, not \$100,000.

On page 54, add the following to “A. Waiver of premium”:

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- 3. Waiver of premium with disability income rider** This rider waives premium payments while the policyowner is disabled and pays a specified amount each month to the policyowner while the disability continues.

On page 74, insert the following before “II. Group Life Insurance”:

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- B. Transfer-for-value rule** If a policy is transferred by assignment or otherwise for valuable consideration (i.e., the policy is sold to another party) and the insured dies, the person who then owns the policy will be taxed on the excess of the proceeds over the consideration paid, including any premiums paid by the transferee. However, the rule does not apply to certain transfers, including transfers for value to the insured, to a partner (or partnership) of the insured, or to a corporation in which the insured is a shareholder or an officer.

On page 76, insert the following before “III. Retirement Plans”:

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- G. Credit life insurance** Credit life insurance is designed to cover the life of a debtor and pay the amount due on a loan if the debtor dies before the loan is repaid.
- 1. Policyowner and beneficiary** The debtor buys the coverage and pays the premium, which is usually a cost added to the amount of the principal debt. He receives an individual policy or a certificate of insurance. He usually names the lender as the beneficiary of such a policy.
  - 2. Policy type** Credit life insurance is decreasing term with the term matched to the length of the loan period (though usually limited to 10 years or less) and the decreasing insurance amount matched to the declining loan balance. Credit life is sometimes issued to individuals as single policies, but most often it is sold to a bank or other lending institution as group insurance that covers all of the institution’s borrowers.

- 3. Guaranteed issue [Sec. 10-10-108]** If the named insurer rejects the risk, it must substitute another insurer and notify the debtor of this substitution and the amount of premium to be charged. If the premium is less than the amount specified in the notice of proposed insurance, the debtor is entitled to a refund.
- 4. Cancellation** A debtor who prepays or refinances a loan is entitled to have the credit life insurance canceled and any unearned premium refunded to him. Otherwise, coverage ends when the debtor pays the debt, when the debt is transferred to another creditor, when the loan is refinanced, or when the debt is significantly overdue.
- 5. Rule of 78** The Rule of 78 is a method of refunding finance charges or credit insurance premiums on consumer credit transactions when the debtor prepays the account in full.
- A creditor cannot charge interest on more than 28 days for a loan that the debtor has prepaid. When buying credit life insurance, debtors must be notified of the interest rate per quarter. Requests for an early settlement of the loan must be processed within seven business days.
- 6. Commissions and rates [Sec. 10-10-117]** A creditor may receive commissions on the premium paid for credit life insurance if the creditor is licensed as an insurance producer in Colorado. However, the commission is not to be computed as an additional cost of a loan.
- 7. Rescission** Any contract obtained through fraud, misrepresentation, or duress is voidable at the option of the party who was subject to the fraud, misrepresentation, or duress. This party may choose to void the policy and rescind, or repudiate, the contract.

On page 106, replace paragraph “2.) Premiums” with the following:

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- 2.) Premiums** When an employer pays the entire premium on a disability income contract covering a key employee, the premiums are tax deductible to the employer, but the employee pays income taxes on the benefits.

On page 131, add the following content to “6. Waiver of premium”:

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In the context of a disability income policy, a waiver of premium provision is a valuable provision. It exempts the policyowner from paying the premiums even while the disability income policy pays a specific monthly amount. In some cases, a waiver of premium provision will apply not only to the period of disability but also for a time after the insured recovers. This provision can therefore be very beneficial to a person who resumes work but at a lower salary.

On page 184, add the following content before “4. Continuing education”:

- g. Conflict of interest** A conflict of interest arises when a fiduciary is in a position that presents an opportunity for personal interests to clash with the fiduciary’s duties to another party. In other words, regard for one duty may lead to disregard of another duty. As a fiduciary of the insurer and the insured, a producer must be careful not to place personal interests above their welfare.

On page 190, insert the following content before “A. Policy Replacement” and re-letter succeeding paragraphs accordingly:

- A. MARKETING AND SALES OF LIFE INSURANCE AND ANNUITY CONTRACTS [Regs. 4-1-2, -11, -12]** Colorado regulates the advertising of life insurance policies and annuity contracts to ensure that all material and relevant information is given to the public.

- 1. Advertisements [Reg. 4-1-2]** An insurer is responsible for all advertisements of its policies. It must establish and follow procedures to control the content, form, and method of distribution of its advertisements. It must communicate these methods at least annually to anyone who advertises for the company.

An insurer is to keep a copy of every advertisement used in the state for 5 years after it was last used. These copies are subject to examination by the insurance department.

All advertisements are to be truthful and cannot mislead in fact or implication. The Commissioner determines whether an ad is misleading from the general impression that it can reasonably be expected to create in the mind of a person with average education or intelligence within the targeted audience. In general, ads cannot use “investment,” “investment plan,” “founder’s plan,” “charter plan,” “deposit,” “expansion plan,” “profit,” “profits,” “profit sharing,” “interest plan,” “savings,” “savings plan,” “private pension plan,” “retirement plan,” “risk-free,” or other similar terms. They cannot use the term “vanish” or “vanishing premium” to imply the policy becomes paid up in order to describe a plan using nonguaranteed funds to pay future premiums.

Advertisements must clearly and prominently describe the type of policy advertised. Life insurance policies and annuity contracts are to be labeled as such unless other accompanying documents so label them.

The use of testimonials is limited to genuine statements that represent the current opinion of the author with respect to the policy advertised, if any. They are to be produced in a manner that does not mislead the public.

Failure to comply with these regulations is an unfair and deceptive trade practice. Violators are subject to license suspension, revocation, or a fine.

## 2. Suitability of annuity purchase or exchange [Reg. 4-1-11]

When recommending the purchase or exchange of an annuity, an insurance company or producer must have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of information obtained from the consumer with respect to his investments, other owned insurance products, and his financial situation and needs.

This information is to be based on the consumer's financial status, tax status, investment objectives, and other relevant information. However, an insurance company or producer has no obligation to a consumer who refuses to give this information, acts contrary to the recommendations of the producer, or fails to provide complete or accurate information. Records of this information are to be kept on file with the insurer for five years and are subject to examination by the Commissioner.

Insurers must supervise producers' recommendations in order to ensure compliance with these regulations.

The Commissioner may order an insurer or producer to take corrective action for any violations of this regulation. Penalties may be reduced or eliminated if corrective measures were taken immediately after the violation. Otherwise, an insurer or producer is subject to a cease and desist order, fine, and suspension or revocation of license.

## 3. Buyer's Guide and disclosure statement [Reg. 4-1-12]

Insurers must send applicants for annuity contracts a disclosure statement and *Buyer's Guide to Fixed Deferred Annuities*.

When the application is taken in person, these documents should be delivered no later than that time. When the application is not taken in person, the documents must be sent no later than five business days after the insurer receives the application. In this case, the applicant must also be notified that he may contact the Division of Insurance for a free annuity *Buyer's Guide*.

If the *Buyer's Guide* and disclosure statement are not given to the applicant by the time the application is taken, the applicant is entitled to a free look period of at least 15 days. This means that the applicant has at least 15 days after receiving the annuity contract to review it and return it for any reason.

The disclosure statement must contain the following:

- a. the generic name of the annuity contract, the company's product name if different from the generic name, the form number, and the fact that the contract is for an annuity;
- b. the insurer's name and address;
- c. a description of the contract and the benefits;

- d. the guaranteed and non-guaranteed elements of the contract, their limitations, if any, and an explanation of how they function;
- e. an explanation of the initial crediting rate, duration of the rate, and how rates can change and are not guaranteed;
- f. periodic income options on a guaranteed and non-guaranteed basis;
- g. value reductions caused by withdrawals from or surrender of the contract;
- h. how the contract values can be determined;
- i. the death benefit, if any, and how it is calculated;
- j. a summary of the federal tax status of the contract and any penalties that apply to withdrawn values;
- k. the effect of any riders on the contract; and
- l. charges and fees that apply to the contract.

Failure to comply with these requirements is an unfair or deceptive act or practice in the transaction of insurance.

On page 194, insert the following content before “C. Suicide”:

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- C. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)** Many of the basic concepts associated with qualified employer plans can be traced to the Employee Retirement Income Security Act of 1974, commonly called ERISA. The purpose of ERISA is to protect the rights of workers covered under an employer-sponsored plan.
- 1. Participation standards** All qualified employer plans must comply with minimum participation standards designed to determine employee eligibility. In general, employees who have reached age 21 and have completed one year of service must be allowed to enroll in a qualified plan. Or, if the plan provides for 100% vesting upon participation, they may be required to complete two years of service before enrolling.
- D. SPECIAL OPTIONS** To individual members covered by a group life or group health insurance plan, the function the insurance serves is identical to an individual plan. In the case of group life, should the covered member die, his beneficiary (usually a spouse or children) will receive a stated amount in death proceeds from the group term policy. Thus, the purpose of group life plans is the same as individual life plans.

- 1. Indemnity** As in the case of an individual life insurance policy, a group life insurance policy is a valued contract that pays a stated sum, regardless of the actual loss incurred, when the contingency insured against occurs.
- 2. Accidental Death and Dismemberment** AD&D coverage pays an additional amount when covered employees die or are severely injured by accident. Benefits are stated as a percentage of a principal sum. For example, death caused by a common carrier (such as a scheduled airline) may result in payment of three times the principal sum. For other accidental causes of death, the policy may pay twice the principal sum.
- 3. Waiver of premiums** As in the case of an individual life insurance policy, a group plan may allow its members, for an additional premium, to add a rider that will waive premium payments if members are disabled and unable to pay the group premium.

On page 204, add the following citation to “b. Rules governing replacement of accident and health policies”: [Sec. 10-16-202].

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On page 205, replace the citation for “4. Sale to self-employed individuals” with the following: [Secs. 10-16-102, 105.2(1)(c)(I)(A) to (D), (II), (III); Regs. 4-2-19, 4-6-5].

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On page 205, add the following content after paragraph “c” in “4. Sale to self-employed individuals”:

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- d. Business group of one** A business group of one is an individual, a sole proprietor, or a single full-time employee of a subchapter S or C corporation, nonprofit corporation, limited liability company, or partnership who is permanently employed for at least 24 hours per week and who has engaged in significant business activity for at least one year before applying for coverage. A substantial part of that person’s gross income must have been earned through those business activities for at least the last three consecutive years. A “business group of one” also includes a permanent, full-time household employee who works at least 24 hours per week and whose gross income in the last three consecutive years came mostly from such employment if the employer employed at least one household employee on at least half of the days in a normal work week during the preceding calendar year.
- e. Small employer** A small employer is a person or business that, on at least 50% of the working days in the preceding calendar year, employed no more than 50 persons, most of whom were employed in Colorado.

- f. Basic plan** There are three plan design options available to consumers. At least one option must be used in Colorado's small employer group market and as conversion coverage. The other two options must be high-deductible, Health Savings Account qualified plans. If the insurer offers more than one basic health plan, it must offer all of its basic plan options to every small employer who is interested in the basic health plan or to those persons buying a basic conversion plan.
- g. Standard plan** The standard health benefit plan must also be used in Colorado's small employer group market and for use as conversion coverage.

On page 206, add the following content after paragraph "k.":

- l. Required provisions in individual accident and sickness policies** If an individual converts coverage from a group policy to individual coverage, the new coverage must include the provisions required for all individual accident and sickness policies issued in Colorado:
- entire contract;
  - time limit on certain defenses (incontestability after two years from policy's issue date);
  - grace period of at least 10 days for monthly premium policies and 31 days for all other policies;
  - reinstatement;
  - notice of claim (given to insurer within 20 days after occurrence or beginning of loss);
  - claim forms (given to insured within 15 days of notice of claim);
  - proof of loss (given to insurer within 90 days of loss);
  - time payment of claims (paid upon written proof of loss);
  - physical examination and autopsy;
  - legal actions (cannot be started within 60 days of written proof of loss or after three years have passed since written proof of loss was provided); and
  - change of beneficiary.
- m. Conversion and Medicare [Sec. 10-16-108]** An insurer is not required to issue a converted policy to anyone who is covered by Medicare. Also, an insurer is not required to issue a converted policy to anyone who has or is eligible for similar coverage under another hospital, surgical, medical, major medical expense, or other such policy.

On page 215, add the following content before “2. Long-term care”:

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- h. Penalties [Sec. 10-18-109]** In addition to other applicable penalties for violations of the insurance rules, the Commissioner can order violators to cease marketing any Medicare supplement policies or certificates in Colorado. He can also order violators to comply with the law.

On page 225, replace “r. Continuing education requirement” with the following:

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- r. Continuing education requirement [Sec. 10-19-113.6]** No one may sell or transact long-term care insurance without being licensed as an insurance producer for accident, health, sickness, or life insurance. Furthermore, the producer must complete a one-time training course on or before January 1, 2009, with continuing education every 24 months thereafter. The one-time training course must be at least 16 hours of classroom education, eight of which must focus on long-term care in general, and the other eight on long-term care partnership plans. The continuing education course must consist of at least five hours of classroom education. Topics are to cover long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs.

On page 228, add the following content to “4. Benefit description plan”:

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- c.** If a small employer carrier offers a health benefit plan with a deductible of at least \$1,500, the carrier must disclose to each covered person the amount of the deductible and any copayments, deductibles, and cost-sharing arrangements. [Sec. 10-16-105]
- d.** A small employer carrier cannot alter an employer’s or employee’s basic or standard health benefit plan through a rider, endorsement, or other means if the effect of the modification is to limit or exclude coverage for certain diseases or medical conditions that the plan otherwise covers. [Sec. 10-16-105]

On page 229, add the following content to “G. CoverColorado”:

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- 8. Preexisting Conditions [Sec. 10-8-516]** Coverage under the CoverColorado program can exclude expenses incurred during the first six months of coverage for any preexisting condition that is defined not more restrictively than an injury, sickness, or pregnancy for which a person incurred expenses, received medical treatment, sought health care services, or took prescription drugs within the six months immediately preceding the effective date of coverage. Credit must be given for the time a person had qualifying previous coverage for the preexisting condition that was continuous to a date not more than 90 days before the effective date of enrollment in the program.

Similarly, the program cannot exclude coverage for a preexisting condition if the person had coverage for at least a three-month continuous period not more than 90 days before enrolling in the program.

- 9. Adverse Underwriting Decisions and Notice to Persons Affected [Reg. 4-6-3]** If an insurance company rejects an application for insurance, it is required to notify the applicant or insured that he may be eligible for coverage under CoverColorado. Dependents are also eligible for coverage under the program. Adverse underwriting decisions that trigger this notice are:
- rejection of the application due to the applicant's medical condition or history;
  - acceptance of the application but at a premium that exceeds the rate available through CoverColorado; or
  - acceptance of the application but only with reduced, limited, or restrictive riders or exclusion of coverage for a preexisting condition for longer than six months.
- 10. Penalties for Unfair or Deceptive Acts and Practices [Sec. 10-3-1108]** If the Commissioner, after due notice and hearing, finds that an insurer has violated the insurance code or engaged in an unfair practice or deceptive method of competition while engaged in the CoverColorado program, the Commissioner may:
- issue an order to cease and desist;
  - impose a fine of up to \$3,000 for each act or violation, not to exceed a total of \$30,000;
  - impose a fine of up to \$30,000 for each willful act or violation, not to exceed a total of \$750,000 for the year;
  - suspend or revoke the insurer's certificate of authority for a willful violation;
  - order payment of a contractual claim to an insured or beneficiary if the violation was the reason why the claim was not paid; or
  - order any combination of the above penalties.

## Part II

### Changes to Questions

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There are no new questions at this time.

On page 168, replace the answer and rationale for question number 38 with the following:

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- 38. D.** Under a disability income policy purchased and paid for by an employer on a key employee, the latter being the recipient of the benefits, the premiums are tax deductible by the employer, and the employee's benefits are subject to income tax.

On page 154, replace the last sentence of “2. Taxation of medical expense insurance” with the following:

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A self-employed individual may deduct premiums paid for medical insurance, limited to the net earnings from self-employment in the business for which the plan coverage was established.

To submit comments or suggestions, please send an email to [errata@kaplan.com](mailto:errata@kaplan.com).



[www.kaplanfinancial.com](http://www.kaplanfinancial.com)  
1905 Palace Street, La Crosse, WI 54603  
800-824-8742