Disability Insurance — A Primer to Understanding the Provisions

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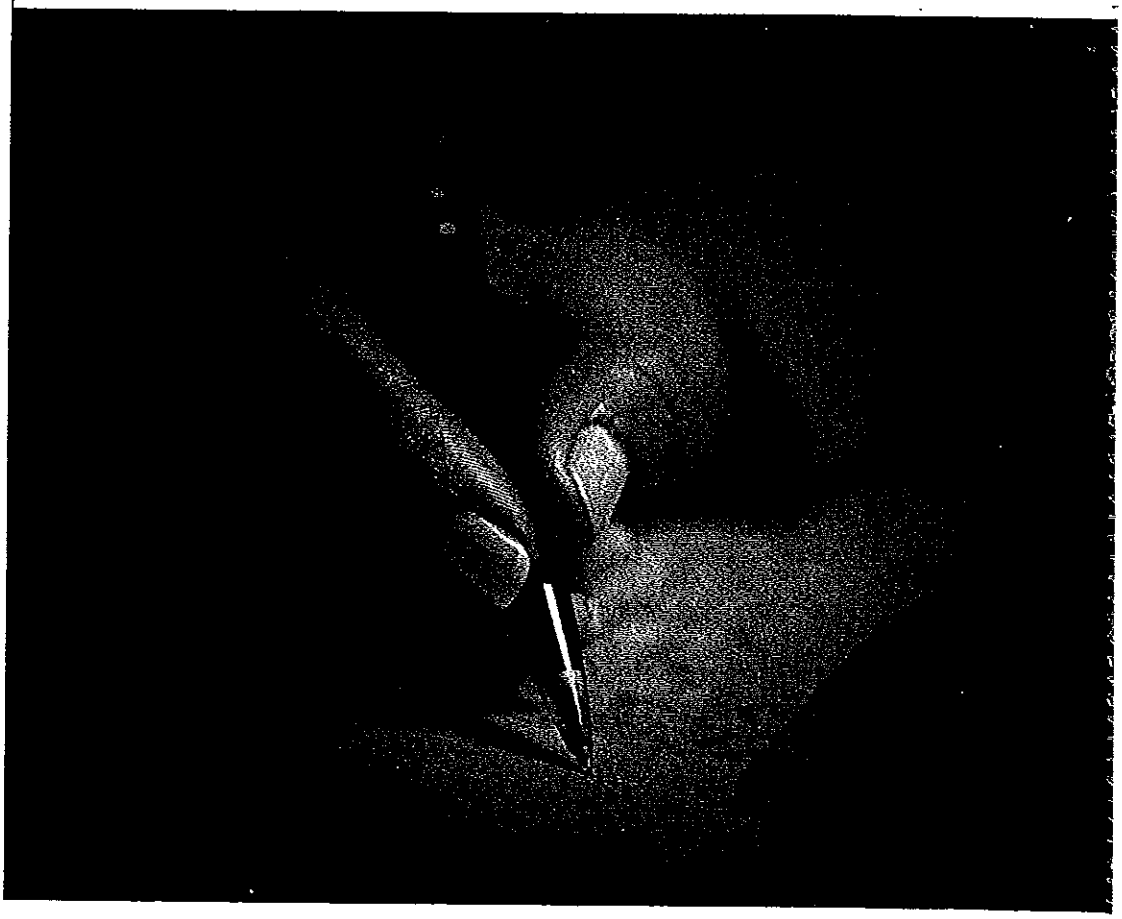
Protecting your income, financial planners say, is the cornerstone of all financial planning. When many young, healthy people start their career, they don't even consider adding disability insurance into their tight budget. This should not be overlooked, however, because as your career grows and your life changes, you have much more to protect — a strong client base, a mortgage, a 401K plan and other individuals who may depend on your income.

Your income and ability to work are your most valuable assets, no matter what career phase you are in. Protecting your potential earnings (which could be as much as $2 million for a 45-year-old earning $75,000 to $100,000 a

Women, in particular, have been hard hit with the introduction of sex-distinct rates that have replaced unisex rates, resulting in premiums that are approximately 30 percent higher than for men.



year, projected to age 65) should be high on your list of priorities. This article will help you sift through the maze of different words and phrases used in disability contracts options.

The Factors of an Ideal Disability Policy

If every company offering a disability-insurance policy had the same wording, terms and conditions, then consumers' decision would be easy — all they would have to think about would be simple things, like whether or not they liked the company's logo or spokesperson.

Unfortunately, evaluating different contracts is not so easy. A contract can be comprised of 30 or more considerations, terms, definitions, etc., each affecting benefits and how much, how long and under what conditions and circumstances a claim will be paid. Most companies offer similarities in about 15 or 20 of these components; however, there are differences in many others.

Let's look at seven of the most important differences, roughly in the same order in which they appear in most contracts.

1. Guarantees

One of the most dramatic changes the industry has made in the past several years is that some carriers have taken away non-cancelable ("non-can") provisions, which guarantee premiums to age 65, and have introduced policies that are only guaranteed renewable. This change enables the carrier to raise classification rates (the category that rates the liability for individual professions) and thus raise your premiums.

You should try, however, to get a non-cancelable and guaranteed-renewable policy. Most companies that deal with white-collar workers still offer the "non-can" and guaranteed-renewable combination. Other carriers have removed their "non-can" policies from the market or use this feature only with a loss-of-earnings policy (see Residual/ Proportionate, below).

2. Definitions

When comparing contracts, notice whether the definition for sickness says "when first manifested itself" rather than "when first contracted." The difference between the two is significant, especially if the disability is caused by cancer, for example. Under the first definition, if cancer existed when the policy was issued, but it had not yet produced symptoms nor caused a prudent person to seek medical attention, it *would* be covered. Under the second definition, it *would not* be covered if it could be proven to have existed *prior* to the policy's effective date.

Another way that disability policies differ is in their definition of total disability. The best definition for total disability is "own occupation" or "own-occ." Although this definition is available for many occupations (but not all), it is not always necessary, nor is it always available for the full benefit period.

Under the own-occ definition, you will be considered totally disabled if you are unable to perform the substantial duties (quantitative measure) and, most importantly, the material duties (e.g., produces the most income) of your occupation at the time of claim and not when the application was originally negotiated. This is important to consider as your duties and skills change over your career. Potentially the best reason you should look for own-occ in a disability policy is because it is easier to prove vs. loss of income, and by comparison it is relatively "hassle-free" at claim time.

The policy's definition of own-occ might be especially necessary for someone whose skills could be (conceivably) transferred to another occupation. For example, consider a surgeon who developed unsteadiness in his or hands. Without an own-occ definition, he or she could be expected to teach.

Or, consider the QRC who loses his or her ability to hear. Such a professional might be expected to find an occupation related to the research field (such as writing) that would not involve a need for hearing. As a result, the QRC might not be considered totally disabled and, instead, might be paid under a residual (proportionate) benefits provision.

The three common own-occ definitions reflect a particular carrier's claims experience for a particular occupation. They are from most liberal to least liberal, as follows:

- Own occupation / *full* benefit period — This definition pays even if you are working elsewhere (in another occupation). Some carriers even offer an own-occ specialty definition, which is especially important if you are a highly specialized QRC.

- Own occupation / *not* gainfully employed elsewhere — A policy with this definition pays if you can't do the duties of your occupation and are not working elsewhere. Working or not then becomes *your* choice.

- Own occupation / for a period of time, thereafter *unable* to *work/not working* elsewhere — This is a split definition that gives true own-occ (see the first definition above) for a period of time (for example, five years), then changes to *unable to work/not working* elsewhere by reason of education, training and experience (and, in some instances, prior economic status).

It should be noted that some contracts have no own-occ definition. Instead, they have a "loss of earnings" definition, which more carriers have recently chosen to stipulate in lieu of the own-occ definition. Loss of earnings is the same as residual or proportionate benefit (see below).

3. Benefit Period

This represents *how long* you will be paid in the event of a covered disability. Be aware that there may be exclusions due to pre-existing conditions.

Typically, benefit periods are two years, five years or up until age 65. Some carriers offer graded lifetime benefit amounts; you might get *some percentage* of the base benefit paid for lifetime, depending on the disability onset age. Full benefits for your lifetime no longer exist. Give this much consideration if you are planning on working, even part-time, past traditional retirement age.

4. Residual/Proportionate Disability Optional Benefit

The purpose of a residual benefit is to pay you while you are working in your occupation while slowly recovering and building back your income to pre-disability status; therefore, you are paid in a proportional manner based on income, not on hours worked. For example, if during a disability you have a 30 percent loss in income while disabled and under the care of a physician, you will receive 30 percent of the monthly benefit.

Most contracts read alike for this benefit except for some of the following terms and conditions, which can make a difference in how much of the claim will be paid:

- Pre-disability earnings period — Typical contracts state that, as an earnings benchmark, the insurance company will consider the previous twelve months or any two consecutive years within the last five years, whichever is more favorable to you. Obviously, the higher the baseline, the higher the benefit amount (most often, choosing the best two out of last five years is the most advantageous). This combination is ideal for someone whose income possibly varies from year to year or is greatly affected by the health of the economy.

- Pre-disability income included *or* excluded for the calculation of loss/earnings — This can be a significant factor if the claimant is in the service industry (e.g., a QRC, accountant, attorney, etc.) and has some accounts receivable (pre-disability earnings) received *during* a period of disability. If the contract does not allow these to be *excluded*, then the calculation will generate a *lower* loss of income percentage and as a result the payment will be *smaller*.

- Qualification period — This is the number of days you must be *totally* disabled before the residual benefits can be paid. Companies that have this restriction usually require 30 days. Most companies do not impose this qualification period and also allow periods of residual disability to count toward the elimination period.

5. Recovery/Extended Transitional Optional Benefit (usually part of residual)

Basically, this recovery benefit means that a person who no longer is under claim (under a physician's care) will be paid as if he/she still were (even though he/she has returned to work full time and is in the process of rebuilding his/her practice). An example would be a Certified Public Accountant (CPA) who broke a wrist during tax season (when he/she earns 80 percent of his/her annual income) and recovered perfectly *after* April 15 for the remainder of the year. Benefits under this provision would *continue* to be paid, *even* though the accountant was fully recovered, until his/her income reached 80 percent of pre-disability earnings. Again, some companies offer this benefit, but for different time periods (typically, for either 12 months, 24 months or for the full benefit period).

6. Future Purchase Increase Optional Benefit

This benefit allows you to apply for more coverage based on higher earnings without any evidence of insurability (no review of your medical information). This is important for someone who, since the initial policy was negotiated based on good health, has developed diabetes, a heart condition, etc., which otherwise would have prevented issuance of any more benefits without this option.

Most companies offer this option; once again, however, there are these differences to watch out for:

- Cut-off age for having this option *issued* as part of the policy — Most companies will not offer this option after you reach age of 50, although a few companies will issue it up to age 55. In any event, if issued, it drops off at certain ages, with a corresponding reduction in premium.

- Cut-off age for *exercising* — Normally, most companies will not allow it to be exercised past age 55. Most companies, if not all, use a formula as to what percentage can be exercised at any given time, participation tables not

withstanding. A few carriers might allow part of this option to be exercised and paid, along with an existing claim.

7. Cost of Living Adjustment (COLA) Optional Benefit

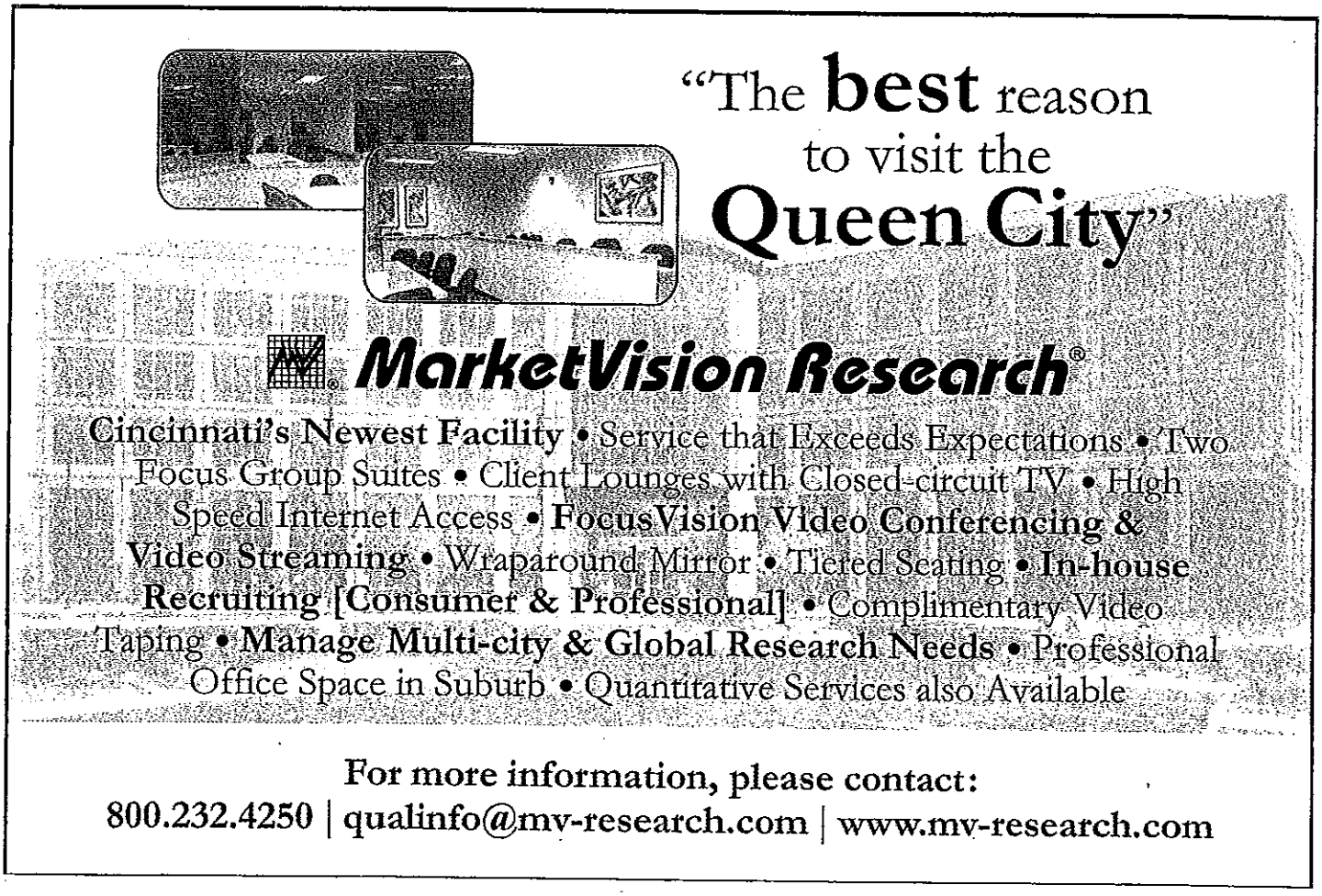
Some differences that exist between companies fall into the following categories:

- Basis for increase that is indexed to some standard, such as the Consumer Price Index (CPI) or guaranteed.
- Conversion of these benefits to the base benefit after returning to work, prior to what age and at what cost, if any. This is especially important if the insured got disabled again and there was no future increase option and the insured wanted the new claim to *begin* with the last benefit amount, which already included the most recent cost of living adjustment(s).

8. Miscellaneous

Although less significant than those mentioned above, a few additional contract components should also be considered. These are:

- Conditionally renewable — Most policies are guaranteed renewable after age 65 and up to age 75, while others are renewable for the insured's lifetime (if you are gainfully employed for a minimum of 30 hours weekly). However, all options/conditions disappear (i.e., COLA, residual benefits, etc.). Generally, your rates will go up after age 65.
- Recurrent disability — Some contracts state that six months must have elapsed before a new claim for the same condition can be considered, while others say twelve. Which is better depends on the length of the benefit period (two years, five years or up to the age of 65). For instance, in the event a disability-condition relapse occurs after a claim has been paid *and* the benefit period has



expired, generally speaking, policies that have a short benefit period (say, two years) are best with a six-month recurrent period. With this particular combination, the relapse will be considered as a new claim and the benefit period would begin again after the elimination (deductible) period (which can vary, usually from 30 to 90 days) was satisfied.

On the other hand, if your policy pays to age 65 and you have a relapse of the same condition, then the longer recurrent period (twelve months) is better. With this combination, during this twelve-month period, there is no requirement that the elimination period must be resatisfied, and the claim payments will begin immediately (assuming the elimination period was initially satisfied).

The key word for both scenarios is *same* claim (i.e., a relapse). If the second claim is unrelated to the first one, the recurrent period doesn't apply.

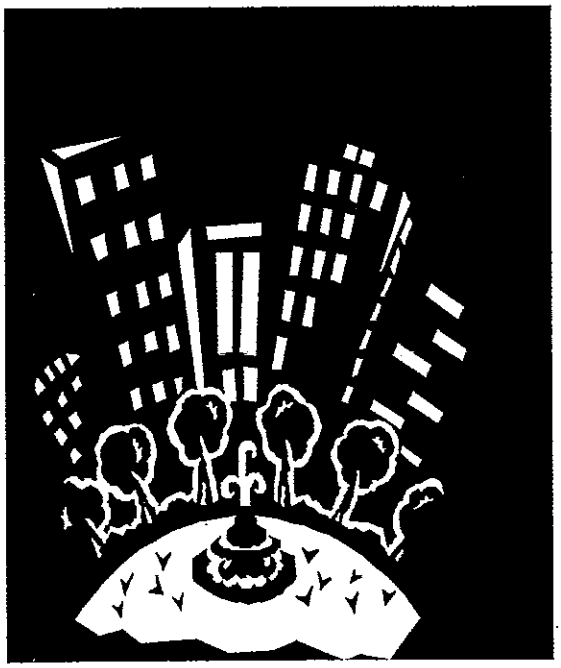
- Loss of income necessary to be deemed totally disabled — Most contracts say 75 percent, while a few use 80 percent. The *lower* the percentage, the better the contract.

Consider Employer-Paid Group Plans Carefully

Scrutinize employer-paid group plans carefully, since the differences can be costly. Most definitions protect the insurance company more than the insured.

The following is a short list of how typical employer-sponsored plans differ from the individual policy:

- Typically, bonuses are not included in your yearly income earnings. So, if a portion of your income is bonus or commissions, these amounts will not be included in the calculation of benefits.
- Coverage is not portable. If you have a pre-existing condition or poor medical history, you may be denied coverage if you change companies or look for an individual policy.
- If your employer pays the policy premium, you will be taxed on the benefit you receive. If you have your own policy, benefits are tax-free.



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- Typically, many offsets (such as social security and/or workman's compensation) can reduce your benefit payment. These are not applicable in an individual policy.

- Mental or nervous conditions, such as stress and depression, are typically only covered for two years, even though the normal benefit period for other conditions may be covered to 65. Some individual policies will treat mental or nervous conditions like any other health condition for the full benefit period.

The Window of Opportunity Is Beginning to Close for Better Contracts

In view of the fact that the disability-insurance industry has experienced some major changes in the past few years, consumers should have their policies reviewed by a specialist. Recently issued policies or even some older ones might contain provisions that will make it more difficult to have a claim paid.

Women, in particular, have been hard hit with the introduction of sex-distinct rates that have replaced unisex rates, resulting in premiums that are approximately 30 percent higher than for men. In some instances, however, it is possible for a woman to get unisex rates.

Spring is a good time to review your existing policy or set a date to talk to your insurance provider or financial planner about disability insurance. It is one of the best ways to protect your earnings, now and for the future.