A STATE-WIDE CONFERENCE OF LEGAL ISSUES RELATING TO HIV-INFECTED INDIVIDUALS.

AIDS Law

1990

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The conference has two objectives: one is to enable attorneys to provide service and assistance to HIV-infected individuals in substantive legal matters. The second is to promote discussion among the legal community and interested others about the issues involving HIV-infection and the law. Areas to be covered include employment discrimination, wills and durable powers of attorney, government benefits, bankruptcy and collection, insurance and employee benefits, and family law. We'll also look at such topics as criminal issues and mandatory testing, access to medical care, patient confidentiality, suicide, and other ethical concerns.

In addition, one of the workshops will address the how-to's of running a legal services program for HIV-infected people: fund-raising, administration, and attorney recruitment will be discussed.

The fee for the day-long event includes lunch as well as a comprehensive 450-page AIDSLaw manual that contains chapters on each of the substantive issues listed above. People with AIDS, students, and other low-income individuals are encouraged to take advantage of the special rate available to them.

*Santa Clara County Bar Association Law Foundation, Inc.

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SSA RELEASES NEW HIV REGULATIONS

Irwin E. Keller
Benefits Program Director
AIDS Legal Referral Panel of the San Francisco Bay Area
(415) 291-5454

Last month the Social Security Administration issued new regulations for evaluating HIV-related disability. Effective immediately, the new regulations will be used for assessing both SSDI and SSI disability claims, and have replaced the Interim Regulations which were in use since December, 1991.

Under these new regulations, an applicant may qualify as disabled by HIV in one of two ways:

(1) S/he has been diagnosed with any one of 41 "stand-alone" illnesses (e.g. toxoplasmosis, PCP pneumonia, etc.); or

(2) His/her HIV disability is manifested in a series of chronic illnesses whose severity is not as extreme as the stand-alone illnesses and s/he experiences a marked level of functional impairment.

The new regulations focus on actual symptoms and functionality, and not on more abstract markers of immune function. So T-cell counts are no longer taken into consideration in the disability evaluation. This means that not all official AIDS diagnoses will necessarily produce a disability finding. Instead, the exact terms of the Listings still must be met. What follows is a more detailed discussion of the two alternative means by which the Listings can be satisfied.

A. Opportunistic and Indicator Diseases ("Stand-alone")

Under the interim regulations that were in effect from December, 1991 until now, 37 HIV conditions automatically qualified an applicant as disabled. (These were the diagnoses listed in Block D of the old Form 4814.) In the new listings, some previously "stand-alone" conditions have been consolidated, some conditions that previously required additional showings (e.g. resistance to therapy, found in combination, functional impairment) have been promoted to "stand-alone" status. Some conditions not previously listed for HIV have been added as stand-alones.

---


2 They include some additional manifestations of HIV found most often or exclusively in women, such as pelvic inflammatory disease and condyloma caused by human papillomavirus (HPV).
Perhaps in compensation for this expansion of the stand-alone categories, the 41 conditions in that list are defined more restrictively than before. It is therefore important that a benefits advocate work closely with an applicant's physician to ensure that the exact language of the particular Listing is met in any physician's statement filed.

B. Repeated Manifestations of HIV Disease plus Functional Impairment

If the applicant does not meet the exact definition for any of the 41 "stand-alone" indicator diseases, s/he has a second opportunity to demonstrate disability by listing other repeated manifestations of HIV infection and providing evidence of functional impairment.

Under the first prong of this analysis, the applicant must provide evidence of repeated manifestations of HIV infection. To be sufficient, the manifestations must meet one of the following tests of severity:

1. At least three episodes within one year, each episode lasting at least two weeks;

2. Substantially more than three episodes within one year, each episode lasting less than two weeks; or

3. Less than three episodes within one year, each episode lasting substantially more than two weeks.

The manifestations discussed in this section can include diseases which are listed in the "stand-alone" section but whose exact stand-alone requirements are not met, or any other disease or HIV condition which results in significant, documented symptoms. The POMS issued to Social Security disability analysts suggests that the three episodes required need not reflect the same particular manifestation. So, for instance, two episodes of diarrhea each lasting two weeks and one episode of a bacterial infection lasting two weeks should satisfy this prong of the test. As a matter of practice, however, the client's physician should be encouraged to list as many manifestations of HIV disease as possible.

The second prong of the analysis is the test of functional limitations. This requirement has been relaxed in the new regulations. The client now only has to demonstrate marked impairment in one of three categories: activities of daily living, social functioning, or ability to complete tasks.

Perhaps more significant than the relaxation of the functional impairment test is the rephrasing of the functional impairment question in the Medical Report form. The old Form 4814 asked the physician to assess the level of impairment through a choice of boxes ranging from "none" to "extreme", where the middle box was "moderate", the selection of which would not support a disability finding. In contrast, the new Form 4814-F5 asks the doctor, for each category, if the applicant has exhibited "marked" functional impairment. The doctor may choose to check the box or not. Given a choice between indicating "marked"
impairment and indicating nothing at all, a physician will be more likely to respond favorably.

C. New Regulations for Children with HIV Infection

The new regulations also include listings relevant to children with HIV. The formula for achieving a disability determination is similar to that of adults. A child can qualify either by meeting the specific requirements of any one of 47 "stand-alone" conditions, or by having any other manifestation of HIV along with sufficient functional impairment. The nature of the functional impairment requirement varies according to the child's age.

D. Presumptive Disability

The new regulations form the basis of Presumptive Disability (PD) determinations as well. A satisfactorily completed Form 4814-F5 (for adults) or Form 4815-F6 (for children) will result in a finding of presumptive disability, allowing the applicant to receive SSI payments while the full disability evaluation is taking place. The forms are available through Social Security field offices, and also provide a useful roadmap to the new HIV regulatory scheme as a whole.

E. Effect of New HIV Listings on Pending SSDI and SSI Claims

The new regulations went into effect on July 3, 1993, and will be used for all pending disability evaluations, regardless of the original filing date. Since the SSA disability analysts are not yet fluent in them, it is recommended that advocates submit supplemental briefs or memos in support of the client's claim, relating the client's condition to the new regulations.

It is also advisable to have the client's physician fill out a new Form 4814-F5. Although the new regulations will also be applied to the old Form 4814, it is clear that the new Form 4814-F5 is designed to elicit a much more favorable response from the physician. If it appears that under the new regulations your client would have qualified as disabled as of his/her originally claimed onset date, advise the physician to fill out the form with the original onset date in mind, so your client can receive the appropriate retroactive payment when approved.
February 14, 1992

Gwendolyn King
Commissioner Of Social Security
Department of Health and Human Services
P.O. Box 1585
Baltimore, Maryland 21203

Office of Regulations
Social Security Administration
3-B-4
Operations Building
6401 Security Boulevard
Baltimore, Maryland 21235

Dear Commissioner King:

Enclosed are comments to the recently proposed Social Security regulations regarding HIV disease.

Thank you for your consideration.

Sincerely,

[Signature]
Paul A. Di Donato
ALRP Director of Policy
COMMENTS OF THE BAY AREA AIDS LEGAL REFERRAL PANEL

TO PROPOSED SOCIAL SECURITY REGULATIONS

REGARDING HIV-RELATED SOCIAL SECURITY CLAIMS

Submitted February 14, 1992
San Francisco, California

ALRP CO-CHAIRS:
R. Paul Richard
Gail Dekreon

ALRP EXECUTIVE DIRECTOR
Clint Hockenberry

Prepared By:
Paul A. Di Donato
ALRP DIRECTOR OF POLICY
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>i</td>
</tr>
<tr>
<td>I. GENERAL COMMENTS</td>
<td>1</td>
</tr>
<tr>
<td>II. MEDICAL DOCUMENTATION AND OTHER EVIDENTIARY REQUIREMENTS OF THE PROPOSED REGULATIONS</td>
<td>4</td>
</tr>
<tr>
<td>III. LISTING AND CATEGORIZATION OF MEDICAL CONDITIONS IN PROPOSED REGULATIONS</td>
<td>6</td>
</tr>
<tr>
<td>IV. FUNCTIONAL TEST IN PROPOSED REGULATIONS</td>
<td>14</td>
</tr>
<tr>
<td>V. PROPOSED REGULATIONS REGARDING PRESUMPTIVE DISABILITY CLAIMS</td>
<td>17</td>
</tr>
</tbody>
</table>
INTRODUCTION

These public comments are submitted by the Bay Area AIDS Legal Referral Panel (ALRP). These comments apply to the proposed rules published by the Social Security Administration of the Department of Health and Human Services (SSA) regarding the new Listing section called "Immune System," see 56 Fed. Reg. No. 243, pp. 65702-65714 (December 18, 1992), and proposed changes in presumptive disability claims processing. See 56 Fed. Reg. No. 243, pp. 65714-65716 (December 18, 1992).

These comments are also applicable in content to the Secretary's Evaluation of Human Immunodeficiency Virus Infection, Ruling 91-8P, 56 Fed. Reg. No. 242, pp. 65498-65505 (December 17, 1992). We request that SSA employees responsible for authorship and revision of Ruling 91-8P review these comments as well.

These comments do not address those portions of the proposed regulations and the notice of ruling regarding HIV disease and children. ALRP is nevertheless very concerned about this issue and urges SSA to consider in a serious fashion all public comments received in response to the proposed regulations and notice of ruling on this crucial HIV issue.

ALRP has a great interest in SSA's treatment of HIV disease which stems from ALRP's years of experience on this issue. Our expertise on social security benefits for persons with HIV disease in the Bay Area is quite extensive on all three levels of the issue: basic claims processing, legal requirements and parameters, and public policy.

ALRP was formed in 1983 by Bay Area Lawyers For Individual Freedom (BALIF), the Bay Area's local lesbian and gay bar association, in response to the growing AIDS crisis faced by the gay community at that time. Since then, ALRP has also joined forces with the San Francisco Bar Association's Volunteer Legal Services Program in our efforts to respond to the legal needs of Bay Area residents impacted by HIV disease. We achieve this mission by providing free or low cost legal services to such individuals. Such services are crucial, especially to the many poor and low-income clients we serve in the Bay Area.

ALRP is the largest AIDS legal organization in California, where we are the lead organization in the state-wide coalition of State Aids Legal Services Association (SALSA), as well as in the United States. The ALRP Board of Directors, staff, Advisory Board, and panel of over 400 volunteer attorneys form one of the largest and most organized pools of AIDS legal and policy expertise in the nation. Our experience and expertise are especially relevant to and reflective of the HIV epidemic in the Bay Area.
Since our inception, ALRP has responded to the legal needs of clients involved in the pursuit of public benefits for their HIV disease. Our staff and panel attorneys have consistently served clients involved in the social security claims process. In 1990, we created a special program, the Employee Benefits and Insurance Program, to address exclusively our clients' needs regarding access to public and private benefits. We estimate that since 1983 we have referred or directly served well over 2,000 callers and clients in dealing with HIV-related social security matters. Many of our clients are poor or low-income individuals with HIV disease, and a growing number of our clients represent the changing populations involved in the HIV epidemic, including women, people of color, and intravenous drug users (IDUs).

ALRP is also the publisher of a nationally acclaimed AIDS Law Manual, which includes an extensive chapter on HIV and social security. We have also published several brochures on social security and other benefits issues relating to HIV. ALRP regularly conducts AIDS law seminars and conferences and participates in many other such events, including, for example, the International AIDS Conference held in San Francisco in 1990.

The ALRP Public Policy program was established in 1991 to address in a comprehensive fashion all policy aspects of access to benefits for persons with HIV disease. ALRP designated SSA's HIV procedures as a major focus of the Policy Project. In preparing these comments, the ALRP Policy Project has had contact with or been informed by not only the ALRP Board, staff and volunteer attorneys, but also by a large number of other individuals, both in the Bay Area and nationally, with wide-ranging expertise in areas such as HIV disease, other disabling conditions, social security benefits and/or other public benefits issues. ALRP would like to thank these individuals who assisted us in our research and analysis of this issue, including Kristin Chambers, Constance Hiatt and Hannah Schwarzchild of ALRP as well as the staff and officers named on our cover, and:

Jeffrey Levi and Belinda Rochelle, AIDS Action Council; John Yarling and Susan Williams, AIDS Benefits Counselors; Elizabeth Cooper, American Civil Liberties Union; Doctors Leonard Simpson and Robert Scott, Bay Area Physicians for Human Rights; Jeffrey Selbin, Berkeley Community Law Center; Rhoda Shaponik, Homeless Advocacy Project; Vyrtice Carter, Marin Aids Project; Terry McGovern, MFY HIV Project; Rene Durazzo and Carol Fiul, San Francisco AIDS Foundation; Herman Levias, San Francisco AIDS Office; Rosa Nanez-Cedillo, Tri-City Health Center; and Steve Morin, Office of Congresswoman Nancy Pelosi.
Our experience with HIV disease and HIV legal and policy issues, especially social security matters, as well as our extensive contacts with experts in these areas specifically for purposes of preparing these comments form the basis for the following comments.

Finally, we want to commend SSA for its reconsideration of the previous regulations and rulings applicable to HIV-related claims. Although the comments below contain a comprehensive critique of the proposed regulations and the notice of ruling, they are made in the dual beliefs that SSA will consider seriously all comments, and that our goal is a shared one of increasing speedy access to reasonable levels of SSA benefits for those disabled from HIV. We welcome all SSA efforts to improve the HIV disability claims system, and stand ready to assist in whatever way we can in that effort.

I. GENERAL COMMENTS

A. The Formal Creation of an Updated Listing Level Category for Immune System Disorders, Including HIV Disease, and the Call for Dialogue with the HIV community and Other HIV Experts Is a Positive Step.

The former SSA disability rulings applicable to HIV-related SSA claims were originally promulgated in 1985. See 50 Fed. Reg. 5573 (Feb. 11, 1985)(adopting 20 C.F.R. sec. 416.934(k)). Although this initial ruling was set to expire in three years, SSA extended it in 1988 to run to the end of 1989. See 53 Fed. Reg. 3739 (Feb. 9, 1988). The regulation was unchanged by the end of 1989, and later extended again to the end of 1991, without notice or comment procedures. See 54 Fed. Reg. 53605 (Dec. 29, 1989). See also POMS, section DI 24525.001-24525.035.

As the AIDS community has recognized for quite some time, the former SSA disability rulings applicable to HIV did not reflect many of the disabling, HIV-related medical and mental conditions experienced by HIV-positive individuals, especially women, people of color, poor and low-income individuals and IDUs. Indeed, those previous rulings were quickly outpaced by the developing HIV epidemic. Despite this fact, and the medical establishment's acknowledgement that AIDS is a rapidly changing epidemic, the previous rulings remained in effect until the epidemic's tenth year anniversary in this country.

We commend SSA for its efforts to update the relevant regulations at this juncture. The history described above, however, suggests valuable lessons for the future. Public notice and comment on SSA's HIV regulations and rulings is crucial. Without adequate comment and input from the public and careful scrutiny of such input by SSA, not only are Administrative Procedures Act problems
raised, but most importantly, the validity and usefulness of the regulations and policies in question can be undermined, as became the case with the previous SSA HIV-related regulations. Thus, we hope and trust that SSA will follow its pledge to solicit and accept suggestions for improvement in the SSA HIV Immune Systems Listing of Impairments on a regular basis, consistent with Administrative Procedures Act requirements. See 56 Fed. Reg. 65704 (December 18, 1992).

On this point, there is one other issue that must be raised. In preparing these proposed regulations, SSA states that it consulted with several groups experienced in HIV disease. See 56 Fed. Reg. 65703 (December 18, 1992). Yet, as the critique of the proposed regulations which follows demonstrates, and as other individuals and organizations have noted, there is a serious question as to whether SSA sought advice from individuals and organizations fully knowledgeable about the clinical manifestations of HIV disease in general, and manifestations of HIV disease in populations of women, poor and low-income people, people of color and IDUs in particular. Such experts and professional organizations should be included in efforts by SSA to revise all HIV-related regulations, as is called for by the changing nature and impact of the HIV epidemic.

If SSA follows through with the commitment to solicit and accept such advice on an ongoing basis from knowledgeable individuals and groups, as stated in the preamble to the proposed regulations, the five year duration date of the proposed regulations should not be problematic. See 56 Fed. Reg. 65703 (Dec. 18, 1992). Such a long duration date, however, in the case of AIDS and HIV disease would otherwise raise concerns. The rapidly changing nature of HIV disease and the course of the epidemic will require revisions in the SSA regulations more often than once every five years.

B. SSA's Stated Decoupling from the Centers for Disease Control Definition of AIDS Requires Careful Consideration and Further Planning.

In the preamble to the proposed regulations, SSA details the historical connection that has existed to date between the CDC definition of AIDS and the SSA criteria regarding HIV-related claims for disability benefits. See 56 Fed. Reg. 65703-704. The preamble also contains a rationale for the "decoupling" of the CDC and SSA definitions of AIDS due to the differing missions of each agency with regard to the disease. Although we understand and agree with the different roles each agency plays with regard to the HIV epidemic, the decoupling notion should not be carried too far.

In particular, close coordination between both agencies seems essential in order for each to carry out their respective missions with regard to HIV disease. For instance, the CDC conducts or funds
a significant percentage of the research on natural histories of HIV disease, developing clinical manifestations of HIV-related conditions, and trends in the epidemic. Although many criticisms have been leveled against the CDC regarding omissions of certain HIV-impacted populations, SSA should certainly be aware of the information CDC produces in these areas for purposes of reviewing the "rapidly evolving nature of the HIV disease complex." See 56 Fed. Reg. 65704.

We applaud SSA for expanding its definition of disabling HIV conditions beyond the CDC definition of AIDS at previous points in time. Indeed, such actions were crucial to reflect realities in the epidemic's course that the CDC was unable or unwilling to track or acknowledge. For instance, CDC studies to date have been so exclusively focused on gay, white men -- the first community devastated by AIDS -- that CDC information did not and still does not accurately reflect manifestations of the epidemic among women, people of color, poor and low-income people and IDUs. As a result, CDC and SSA have been the targets of litigation, Congressional pressure and complaints from relevant advocacy groups and communities on these errors. We encourage SSA to pay close attention to this particular problem so that its regulations do not blindly repeat the same omissions now or in the future.

Of course, flexibility must be maintained on the part of both agencies with regard to coordination of HIV policies. For instance, if the pending revision of the CDC definition of AIDS increases the CD4 cell level which qualifies a person for a CDC AIDS diagnosis, it would be wholly appropriate for SSA to revisit the CD4 cell count level used in section 14.08(M) of the proposed regulations. See Section III below. Similarly, we hope that CDC's new definition of AIDS will capture the overwhelming percentage of individuals technically eligible for SSA benefits under the proposed SSA regulations. (If this were not the case, one would seriously question whether CDC's new AIDS definition measured accurately the morbidity and mortality associated with the HIV epidemic).

Finally, on this point, the coordination in which we are encouraging SSA to participate must include coordination on public education and education of health care providers. Considerable confusion exists within the HIV community, the health care provider community, and no doubt the general public, as a result of CDC's and SSA's near simultaneous actions to drastically revise established definitions and criteria regarding AIDS, while further decoupling the historic link between the two agencies' definitions. We believe that a coordinated effort in this area should have been made, and such an effort is still possible to reduce any confusion in the mind of the public.
II. MEDICAL DOCUMENTATION AND OTHER EVIDENTIARY REQUIREMENTS OF THE PROPOSED REGULATIONS

A. The Provisions Regarding HIV Status Documentation Require Clarification and Revision to Address Possible Confusion and Overly Restrictive Standards.

Section 14.00 (D) of the proposed regulations sets forth the following requirement:

"The medical evidence should include documentation of HIV infection... ."

Section 14.00 (D)(4), however, also states that diagnosis of HIV infection can be established based on "clinical history, physical examination, exclusion of other causes for clinical abnormalities and treating source opinion." We agree with this dual approach; however, some clarifications and some changes are in order.

The flexibility to determine disability without requiring evidence of HIV test results must be more clearly stated in the final regulations. Such a clarification simply bolsters what is already rightfully and appropriately allowed in the regulations; however, we believe that this is necessary to clarify any possible confusion and conflict that the current language may leave. SSA should clarify as well that adjudicating agencies (DDS or SSA offices) should not order HIV testing, if the test results are not otherwise readily available, due to logistics, costs or other reasons. Our reasoning is as follows:

1) Current regulations permit a medically determinable impairment to be established even in the absence of specific laboratory test results. This approach is based on sound medical and clinical knowledge and practice, as long as such clinical findings are well-reasoned and documented. HIV disease and HIV-related conditions can be accurately diagnosed through clinical as well as laboratory means.

Indeed, in the proposed regulations, neither a positive nor a negative HIV test result should alter the outcome of the disability determination process in light of the manner in which the proposed regulations are written. For example, if a person meets the criteria in the proposed Listing, or the altered criteria we recommend herein, and documentation of HIV infection by clinical means is possible (as listed in section 14.00 (D)), an HIV test would be medically unnecessary. Even a negative HIV test result under these circumstances should not alter the disability determination. In fact, this approach actually helps address the problem of false-negative results in HIV laboratory tests.

2) HIV testing is too expensive for some. For example, the ready availability of such testing in San Francisco, due to the Bay
Area's comparatively high standard of care on this matter, is not indicative of availability in other cities. Also, since HIV testing is a complex process in which adequate testing protocol calls for some degree of pre- and post-test counseling, the cost of testing programs is greater than the cost of the actual test itself. Therefore, without specific provisions to ensure payment for such testing, some applicants' claims could be delayed or denied for monetary reasons alone, if care providers or SSA adjudicators believed that such documentation is essential.

We also propose a further language change in section 14.00 (D)(4) to facilitate SSA's intent in these proposed regulations. Presently, this section reads in part:

"If HIV infection is not documented by the above laboratory evidence, a diagnosis of HIV infection can still be accepted if the individual has a disease predictive of a defect in cell-mediated immunity ... ."

This should be changed to read:

"If HIV infection is not documented by the above laboratory evidence, the existence of a medically determinable impairment (i.e., a diagnosis of HIV infection) can still be considered to exist if the individual has a disease predictive of a defect in cell-mediated immunity ... ."

The reason for this change is that SSA frequently makes a distinction between a diagnosis and a medically determinable impairment. In this case, to avoid confusion to adjudicators and others in the adjudication process, it should be clear that the diagnosis of HIV infection does establish a medically determinable impairment.

B. Requirements Regarding Specific Laboratory Evidence of Listing or Listing Equivalent Conditions Are Confusing and Potentially Overly Restrictive.

As with the issue of HIV test results discussed above, the proposed regulations' requirements regarding other medical evidence, found in section 14.00 (D), appear to be contradictory and could prove overly stringent if misinterpreted.

We favor SSA's proposal to permit opportunistic infections to be diagnosed based upon clinical impressions and responses to treatment, assuming, as SSA does, that sound medical judgement is exercised when using such means of diagnosis and adequate documentation exists. See section 14.00 (D)(4). As currently drafted, however, the proposed regulations also suggest that definitive laboratory results are needed for some HIV-related disability determinations to be made. Compare sections 14.08 (A) -
For instance, one could read the proposed regulations to allow presumptive diagnosis for pneumocystis carinii pneumonia (PCP), esophageal thrush, cytomegalovirus and toxoplasmosis, but not for other conditions. The confusion is compounded by the introduction of the "equals" concept in the discussion of non-laboratory based diagnosis in section 14.00 (D)(4).

SSA should clarify that, for all listed medical conditions, medical histories and clinical impressions can serve as substitutes for definitive laboratory-based diagnoses. This can be done with clarifying language in section 14.00 (D)(4) and/or section 14.08 (A) - (M). Of course, sound medical judgment is necessary in such instances as is appropriate documentation to support such medical histories and clinical findings.

If this is not the current intent of SSA, we oppose the notion that diagnoses cannot be based upon appropriately documented clinical impressions and findings for all of the reasons stated above.

III. LISTING AND CATEGORIZATION OF MEDICAL CONDITIONS IN PROPOSED REGULATIONS

A. A Comprehensive Listing of all HIV-Related Conditions Known or Strongly Indicative of Disability in Sections 14.08 (A) - (L) is Crucial if the New SSA Regulations Are to Achieve Their Intended Result.

Sections 14.00 (A) - (L) establish those medical conditions which will per se qualify an individual for a disability determination based upon medical evidence and findings alone. (Future references to "per se" listings refer to these sections in the proposed regulations). These sections basically track the CDC definition of AIDS as established in 1987, see 56 Fed. Reg. 65703-65704, and SSA's Ruling 86-20, which until recently was the SSA's major ruling on HIV-related, qualifying disability conditions. Several medical conditions have been added in the proposed listing. Karposi's sarcoma has been removed to that part of the HIV Listing that is not a per se listing, see section 14.08(M)(2)(h).

We commend SSA for creating a formal Listing level for AIDS in general, as opposed to relying on rulings and Program Circulars to establish Listing level equivalency. We also commend SSA for adding the new conditions contained in the proposed regulations and not found in previous SSA rulings and Program Circulars. We further commend SSA for consolidating the previous listing level equivalents found in Ruling 86-20 with other relevant HIV-related conditions, which were until now found in other listings for other body systems. The use of the categorization scheme in sections
14.08 (A) - (L), (e.g. viral, fungal, bacterial, protozoan, etc.), is also an excellent improvement in organization.

We believe that problems do exist with the language and scope of sections 14.08 (A) - (L). These problems stem from the specific nature of HIV disease as well as the populations experiencing the epidemic.

The per se sections of the HIV Listing, sections 14.08 (A) - (L), are critical to disabled, HIV-positive SSA claimants and lie at the very core of SSA's mission to capture systematically all disabling, HIV-related conditions in a streamlined claims process. SSA estimates that 75% of those found eligible for its disability benefits are found eligible at the Listing stage of the SSA disability process. This is also the easiest phase of the process for SSA, health care providers and claimants, as this stage relies almost exclusively on relatively objective medical evidence and findings. Other parts of the SSA sequential disability process involve more difficult and more time consuming assessments of such things as: general functional capacity, residual functional capacity ("RFC") and job availability in the national economy.

Indeed, the whole purpose of the SSA Listing structure is to predetermine what conditions are sufficiently indicative of inability to engage in substantial gainful activity so that a costly and time consuming case-by-case assessment is not necessary. Thus, the government and the claimants have an interest in seeing a comprehensive listing for all disabling conditions. A major impetus for this drastic overhaul of the SSA HIV-related regulations is to correct the serious problems of burdensome delay and exclusion which have existed to date due to the absence of a comprehensive listing of disabling HIV conditions based solely on medical evidence and findings.

The need for a comprehensive HIV Listing is especially crucial given the HIV population. HIV claimants are overwhelmingly "younger" individuals in SSA parlance. If an HIV claimant does not meet the Listing and the grids of the sequential process are applied, these claimants are often found not disabled because of their young age (unless, of course, they can show that the grids are inapplicable to them). Also, HIV claimants' health prognoses are universally poor. Therefore, if the per se Listing is not expansive, the result will be unnecessary hearings and sequential evaluations for individuals who, in nearly 100% of the cases, will eventually meet SSA criteria.
B. Sections 14.08 (A) through (L) are Not as Inclusive and Comprehensive as Necessary to Capture Disabling HIV-Related Conditions, Especially with Regard to Those Conditions Which Primarily or Exclusively Effect Women, Poor People and Intravenous Drug Users.

As noted above, earlier versions of SSA's HIV-related regulations and rulings were based largely on CDC definitions of AIDS. CDC definitions were, in turn, based on studies of AIDS and HIV disease conducted mainly on gay, white, middle-class men, the group first acknowledged and understood to be affected seriously by HIV in the United States. Unfortunately, CDC studies and many other studies of HIV disease continue to focus almost exclusively on this group of individuals despite the dramatic growth of the HIV epidemic among women, the poor, people of color, and IDUs.

As the preamble to SSA's proposed regulations states, women with HIV disease manifest specific gynecological impairments which have traditionally not been recognized as associated with HIV infection, but which are, in fact, associated in a severe and debilitating form with immunocompromised systems. Specifically, SSA cites vulvovaginal candidiasis, genital herpes and pelvic inflammatory disease. See 56 Fed. Reg. 65704. In fact, the preamble to the regulations discusses in some detail the difficulty HIV-infected women have had in qualifying for disability benefits, the clinical manifestations which occur in women and the need for adjudicators to scrutinize the medical evidence for these conditions specific to women.

Unfortunately, the preamble to the proposed regulations is not the legal or regulatory equivalent of the Listing. The actual Listing of conditions requiring medical evidence or clinical findings alone for proof of disability, section 14.08 (A) - (L), omit all of these specifically mentioned conditions but one -- invasive carcinoma of the cervix in its most advanced stage. See 14.08 (A) - (L).

Moreover, neither the preamble nor the proposed regulations themselves acknowledge or address the changing nature and growing problem of HIV disease in poor people, people of color and IDUs. We need only read the newspapers with regard to the tuberculosis epidemic among poor, HIV-positive individuals in large urban centers to realize some of the severe problems among these populations.

The socio-economic factors discussed here are especially important in addressing HIV disease. Providers of health care have long recognized that an affluent individual with access to quality health care and with a CD4 count of 200 will almost invariably be healthier, suffer fewer, and perhaps different opportunistic infections than a low-income person with little access to health care and a similar CD4 count. This problem is worsened if the low-
The income person is an IDU and/or homeless. Thus, the \textit{per se} part of the proposed HIV Listing, sections 14.08 (A) - (L), must be sensitive to this issue. And, as noted elsewhere in these comments, these socio-economic and medical realities of the HIV epidemic must also be factored into both the evidentiary issues involved in the proposed regulations, see Section II above, and the functional test issues involved, see Section IV below.

We propose the following with regard to sections 14.08 (A) - (L) of the proposed Listing to address these problems specific to women, other special populations and other gaps in the current proposal. In most cases where we believe conditions listed in sections 14.08 (M) should be of Listing level in sections 14.08 (A) - (L), we have included comments to that effect in this section of our comments. Our comments below must be read in close conjunction with our comments regarding sections 14.08 (M), as we are proposing a serious and extensive re-evaluation of the entire proposed five-part structure found in SSA's proposed regulations, sections 14.08 (A) - (L), and 14.08 (M)(1), (M)(2), (M)(3) and (M)(4).

1) The \textit{per se} Listing should and does contain cervical cancer when related to HIV disease; however, the standard presently proposed is too strict. The Listing contains a Stage II level for cervical cancer. Stage II cancer extends beyond the cervix into the vagina or uterus. The appropriate standard for invasive cervical cancer is FIGO Stage IB. Cancer of the cervix alone certainly is a serious enough impairment to be predictive of disability.

2) The \textit{per se} Listing should contain anal-genital squamous cell carcinomas for similar reasons outlined above.

3) The \textit{per se} Listing should contain pancytopenia, a severe form of anemia. The current proposed regulations list anemia only in section 14.08 (M)(3)(a) without separating out more severe forms of anemia and listing them appropriately.

There are several other problems associated with the proposed Listing which we believe require serious investigation and re-evaluation by SSA. In reference to suggestions which follow, we believe that SSA must review carefully all of the comments to these proposed regulations on these particular areas, especially comments from clinicians and other advocates very familiar with the special problems of women with HIV disease. After such a thorough review, it may well be that ample evidence exists to add many conditions to the Listing at the \textit{per se} level, 14.08 (A) - (L), or at the revised 14.08 (M) levels which we propose. As noted in Section IV below, such an analysis must take note of the fact that HIV-related impairments of the type listed in these proposed regulations are the only physical conditions in SSA's entire Adult Listings which have such a functional test attached.
Even if SSA does not alter the current proposal in finalizing the regulations, it is imperative that SSA conduct further inquiries into these particular conditions. SSA cannot wait for the expiration of the full five year duration of the final regulations to revisit the issue of the Listing placement of these particular conditions. SSA should follow this same approach if it does not follow our proposal (and those of others) regarding all of the specific conditions and items discussed in Section III above.

1) The HIV Listing should contain Chronic Pelvic Inflammatory Disease ("PID") in some section. SSA has recognized HIV-related PID as a potentially disabling impairment in both the March 1991 Program Circular on HIV and in the preamble to the proposed Listing. See 14.08 (D)(4)(3). There is medical evidence showing that PID is exacerbated in the presence of HIV. Of course, as PID occurs in the non-HIV population, the Listing version of PID for these purposes should conform with the contours of the disabling condition as manifested in the HIV affected population. Hence, we propose the following Listing for PID:

PID with three or more episodes; or one episode which is refractory to treatment and which requires hospitalization; or one episode which requires pelvic surgery; or one episode which results in a documented chronic pain syndrome.

2) The Listing should include recurrent genital herpes with lesions which have been documented to last for four weeks, or recur more often than every eight weeks, or which are incompletely suppressed despite continuous maintenance therapy. Currently, the proposal lists herpes three times: in sections 14.08 (A)(5), (E)(2) and (M)(3)(h). It is possible that the (M)(3)(h) listing could remain if the suggested listing here were added to the (M)(1) or (M)(2) category, as we suggest those categories be revised in these comments.

3) The Listing should contain chronic genital ulcers caused by a sexually transmitted disease which fail to respond to treatment and persist for more than four weeks.

4) The Listing should contain neurosyphilis, syphilis and certain types of abscesses of internal organs or body cavities.

5) The Listing does contain vulvovaginal candidiasis; however, SSA should investigate moving it from the 14.08 (M) category to the 14.08 (A) - (L) categories. Those familiar with clinical manifestation of HIV disease in women have noted that this specific condition can be disabling and is associated in its severest forms with women with HIV.
6) SSA should investigate the appropriateness of moving the 14.08(M)(3)(a) listing for anemia to the (M)(2) or (A) - (L) categories, if defined as persistent hemoglobin of less than 10.0; or hematocrit of less than 30.0 (regardless of AZT) intake; or the need for a blood transfusion due to anemia more often than twice yearly.

Finally, a comment on section 14.08 (A) in particular. The language of this section appears less definitive and detailed in certain places as compared to other places in section 14.08. This gives the mistaken impression that the criteria for section 14.08 (A) are less stringent, for example, than for section 14.08 (E). For instance. Listing 14.08 (A)(5) reads simply:

"Herpes Simplex virus infection causing a mucocutaneous ulcer that persists longer than one month."

By contrast, Listing 14.08 (E)(2) reads:

"Herpes simplex virus, causing chronic, continuous (longer than one month) mucocutaneous infection or infection of the pulmonary or gastrointestinal tracts or encephalitis or disseminated infection demonstrated by culture, histology, or cytology."

We suggest that the language of Listing 14.08(A) be revisited and revised in the instance above, and all relevant instances, to be consistent with the wording of the comparable criteria in 14.08 (B) - (L).

C. Section 14.08 (M) Must be Altered to Correct Some Problems With This Section of the Listing

We believe that section 14.08 (M) should be drastically revised for several reasons. The Listing is more stringent than comparable listings in other body systems on several levels. Moreover, those diseases most associated with or particular to women, poor people and IDUs are listed in these sections, thus continuing the unnecessarily rigid and overly restrictive treatment of these groups of HIV-positive individuals in the SSA disability process. See Section III-B above.

1). Section 14.08(M)(1)

Section 14.08 (M)(1) is a problematic entry in light of the linkage to the proposed functional test in section 14.08 (M)(4), given the stringency of that functional test. We recommend that SSA link any proposed CD4 level with the more rational and appropriate functional test we recommend below in Section IV.

SSA should carefully review the comments it receives on these proposed regulations to assess if there is ample evidence to alter
further its proposed CD4 level and that level's connection to any functional test. Again, if this is not the case at present, this specific idea should be one that SSA investigates further immediately, rather than waiting for the end of the five year duration of the final regulations to revisit this issue.

There are several reasons for such an inquiry. A CD4 count of less than or equal to 200 cells (or 14% of total lymphocytes) could very well be too stringent for disability determination, unless it is used as a sole criterion, i.e., all individuals with such counts might be allowed on the basis of poor prognosis, if they are otherwise eligible for benefits. This criterion would then fit with that portion of the general disability definition which refers to conditions which may or will result in death.

SSA should investigate if a CD4 count linked to a functional test could remove the need to set a ceiling at 200 CD4 level. When attached to an appropriate functional test, there is arguably a safeguard that any particular CD4 count will "catch" healthy, able individuals in the system. For example, if a claimant meets an appropriate functional test and has been diagnosed appropriately with HIV disease, that claimant is disabled regardless of whether the CD4 count is 100 or 500. Some rather odd adjudication problems can arise if the CD4 level used is too low or too rigid. For instance, if an individual had a CD4 count of 225, then the adjudicator would be compelled to attempt to find another laboratory test or condition to replace the "missing" finding (200 CD4 count or less). This may or may not be possible. It creates, however, additional work which is time consuming and costly for both the government and the applicant, when the claimant might be clearly unable to perform substantial gainful activity.

2) Section 14.08(M)(2) and (M)(3)

Sections 14.08 (M)(2) and (M)(3) are problematic because, in some cases, the conditions listed are quite severe, hence connection to another condition, or to the proposed functional test appears unnecessarily rigid. In most cases, the actual items listed reflect a marked degree of impairment and are considerably more severe than the comparable criteria found in the mental listings, from which the proposed HIV functional test is borrowed. After SSA reviews all of the comments to these proposed regulations, it may well be that ample evidence exists to sever completely the connection between most of the section 14.08(M)(2) and (M)(3) conditions and the functional test. Perhaps additional, relevant modifiers on duration, resistance to treatment and other factors would need to be added to many of the conditions in question do so.

If such a move is not supportable now for the entire, proposed section 14.08 (M)(2) and (M)(3) Listing, or particular conditions in those sections, SSA should conduct further inquiries immediately and not wait the full five year duration of the final regulations.
to revisit this matter. SSA should follow this same approach if it does not follow our proposal and those of others regarding all items in Section III.

We make the following additional observations and suggest the following changes in section 14.08(M)(3):

1) Some of the criteria listed in section 14.00 (M) are of such severity that the claimant would already have an AIDS diagnosis which would fulfill criteria in other sections of the regulation. Other criteria are such that a claimant would be so impaired that death would be imminent, e.g., bacterial or fungal sepsis persistent and/or resistant to therapy would likely be incompatible with life. To require that a person have a persistent and/or resistant meningitis or septic arthritis or septic endocarditis and two of the four functional tests is excessive. These specific conditions cited here should not be connected to the functional test. And, consistent with our comments in Section III above, the most severe conditions listed in section 14.08(M) should be re-evaluated immediately to assess if they belong in the per se categories of 14.08(A) - (L).

2) We also have concern that the criteria listed in section 14.08 (M)(3) potentially represent very different levels of functional impairment. The same would be true of many combinations of two of them. For example, persistent fever and weight loss as described in (M)(3) would create far greater functional limitations than a two-month history of eczema with radiologically demonstrated sinusitis. This suggests that the section is internally inequitable, and should be revisited to separate serious conditions from less serious ones.

3) When the re-evaluation and separation of conditions called for in Section III-C- above occurs, we suspect that evidence will show that the (M)(2) conditions, of which only one is and should be required to meet the Listing, should be much longer and more comprehensive than at present, and probably contain a significant number of those conditions listed now under (M)(3). As repeatedly noted above, with an appropriate functional test connected to the (M)(2) listings and the requirements for medical evidence or findings proposed in the regulations (and commented on herein), there is no compelling basis for requiring two rather than one of the enumerated conditions existing over a two month period for many of these conditions.
IV. FUNCTIONAL TEST IN PROPOSED REGULATIONS

A. The Proposed Functional Test Must be Drastically Revised To Correct the Overly Stringent and Insupportable Elements of the Current Proposal.

Since at least February of 1990, SSA has utilized a functional test for the evaluation of HIV-related disability which required that an individual with the specified medical conditions meet one of two functional criteria:

Interference with activities of daily living resulting in:

Marked restriction of activities of daily living such that the individual needs help with most activity including climbing stairs, shopping, cooking, housework; or,

Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere).

POMS, Section DI 24525.001-24525-035

The proposed regulations contain a drastically changed test. We have been unable to uncover any SSA reports, statements or other evidence that this standard created problems regarding awarding of unjustified benefits, or problems regarding fraud. In the preamble to the proposed regulations, SSA does not give any reason for the change. Therefore, we are faced with a significant change in the functional standard for reasons which are unstated, and frankly insupportable given the nature of symptomatic HIV as an impairment. The new test is much more restrictive than the previous SSA test, and, if implemented, will make it extremely difficult for disabled claimants not suffering from an AIDS defining disease to meet the proposed HIV Listing.

The functional criteria SSA proposes here are virtually identical to those used by SSA to determine functional limitations of people with mental disorders. See 20 C.F.R. Ch. 111, Part 404, Subpart P, App. 1, Section 1200. There is one major exception, as proposed in these regulations, these same functional tests are more stringent than they appear and are applied in the mental Listings, due to their connection to proven medical conditions.

Although such borrowing may be tempting for a variety of reasons, the inappropriateness of transposing mental disorder functional criteria onto HIV SSA applicants is obvious upon analysis. The mental disorder Listings clearly state that the "purpose of including the criteria is to describe the functional
limitations associated with mental disorder which are incompatible with ability to work." 20 C.F.R. Ch. 111, Part 404, Subpart P, App. 1, Section 1200 at 377. As applied to HIV-related claims, this same set of functional criteria bear little rational relationship to the disease at issue.

This problem is especially obvious when one realizes that the proposed HIV Listing, if adopted, would be the only body Listing with such a functional test requirement and requirements of medical conditions in conjunction with the functional test. This is especially problematic and puzzling given the fact that health care providers are now accustomed to the current standard. Any change will create confusion for both providers and SSA, but an unjustified, inexplicable change is hardly worth such confusion.

As alluded to above, the addition of a functional test to SSA regulations, particularly such a burdensome one as proposed here, defeats the general purpose of the SSA Listing system. The Listings exist to provide objective medical criteria on which SSA can rely to make timely disability determinations without the need for a complex and time-consuming assessment of the person’s ability to work. For those who need benefits speedily -- because they are terminally ill and they need to maintain their environment and nutrition so as to keep infection at a minimum -- it serves no legitimate purpose to add a functional test.

This problem is exacerbated for poorer individuals who lack a single primary health care provider to assess the application of the functional test on that particular patient. Many women with HIV disease fall into this category. The proposed standard will, for example, no doubt result in even heavier reliance on Third-Party ADL forms. Such reliance will again disproportionately discriminate against low-income individuals, homeless or otherwise "marginalized" claimants who generally have a much more limited support structure than that which is necessary to respond to such evidentiary requests. Hence, the proposed functional tests, like other problematic elements of these proposed regulations, hit hardest on those populations least accounted for in the current SSA HIV regulations.

B. SSA Should Not Require That Two of Four of the Proposed Functional Tests Be Met Nor Should SSA Require the Proposed "Marked" Level of Restriction.

Setting aside for the moment the other problems with the proposed functional test, individuals should certainly not be required to meet two of the proposed tests versus one, especially given the definition of the "marked" level of restriction necessary. Any one test currently proposed by SSA, if met by a claimant, would meet the only applicable and legal standard necessary -- inability to engage in substantial gainful activity. Moreover, even in this case, an applicant would still have to
exhibit one of the medical conditions listed in the section 14.08 (M) categories (as revised in our proposals).

A recitation of one possible case is particularly telling. Under the current proposal, if a person has bacterial pneumonia, she must prove first that the condition is persistent or resistant to treatment. Next, she must prove that the condition results in two of the functional problems listed. For example, she must prove not only that most of the time she needs help with activities of daily living, but also that she cannot function socially, cannot complete tasks in a timely manner, or that she has had three bouts of deterioration each of which lasted two weeks. Such a person would likely be not only disabled, but in serious danger of death at that point.

The use of the "marked" level of restriction is much too severe as well. "Marked" is defined as more than moderate but less than extreme; a degree of limitation which "seriously interferes with the ability to function independently, appropriately, and effectively." See section 14.00 (D). If an individual is unable to perform activities, or engage in the other categories of functions listed, most of the time, then the individual should be by definition disabled. An individual who cannot perform such functions most of the time cannot engage in substantial gainful activity.

For instance, as defined in the proposal, marked restriction of activities of daily living describes close to a nursing home level of dysfunction. An individual does not need to be bed-ridden or homebound to meet the general SSA rule of inability to engage in substantial gainful activity. Similarly, in the case of marked difficulty in completing tasks in a timely manner due to deficiencies in concentration, persistence or pace, such a severe breakdown of mental functions is not necessary to be disabled.

C. The Proposed Functional Test on Social Functioning is Inappropriate and Should Be Removed Completely From the Final Regulations.

The proposed regulations define this element of the functional test as "most of the time the individual is unable to sustain interaction and communication." This test is entirely inappropriate for the evaluation of HIV-related disability.

Many gravely ill individuals with HIV-related impairments are able to maintain close social relations with family, companions and friends, even when confined to bed or hospital. Thus, this test is an inappropriate marker for inability to engage in substantial gainful activity. It is also an irrelevant marker for such an evaluation, as it bears little if any relation to ability to work as SSA has traditionally defined the concept. Moreover, the terms used to define this test are themselves rather vague. In an extreme
interpretation, they could be read to equal comatose levels of mental/physical ability to interact with others.

D. The Proposed Functional Test Regarding Decompensation Must Be Seriously Revised or Deleted.

The proposed regulations define repeated elements of decompensation as "averaging three times a year or once every four months, lasting two or more weeks each, which cause the individual to deteriorate." The frequency and durational requirements appear rather severe and unnecessary for a functional criteria that, again, is intended to measure inability to engage in substantial gainful activity. The standard should be revised so that it reflects the reality of the exacerbations and remissions in HIV-related physical conditions and the need to be absent from work for treatment.

E. SSA Should Return to the Previous Functional Test Used to Judge HIV-Related Disability

Section 14.08 (M)(4) should use a functional standard similar to or the same as the current standard found in the February 1990 POMS, Section DI 24525.001 - 24525.035, namely the meeting of a single part of a two-part test. In addition, adjudicators should be instructed explicitly to ensure that claimants can meet any functional test each and every day. Although HIV is generally unrelenting, the nature of the disease is that those infected have better and worse days. Short-term improvements should not result in short-term denial of benefits in a way that leads the same applicant to reapply for much needed benefits within a short period of time after further, serious deterioration. Such denial of borderline cases creates unnecessary costs for the system, not to mention the hardship wrought on the individual.

V. PROPOSED REGULATIONS REGARDING PRESumptIVE DISABILITY CLAIMS

We believe that the proposed regulations regarding the revised process for presumptive disability require alteration. See 56 Fed. Reg. 65714-65716 (December 18, 1991)(adopting 20 C.F.R. Part 416, Regulations No. 16). SSA has unduly complicated the process of presumptive disability in cases of HIV infection. SSA proposes a checklist (Form SSA-4814 (12/91)) to be sent to physicians by SSA and returned by them to SSA, which parallels the proposed listings for HIV. See 56 Fed. Reg. 65702-65741. This checklist basically reflects the criteria proposed for the HIV Listing. Therefore, we feel the presumptive disability criteria carry all the same faults discussed in our comments above. Thus, at minimum, we recommend that the form used by SSA for the proposed presumptive disability process should conform to our recommendations regarding the proposed HIV Listing above.
There are other difficulties we see with the presumptive disability proposal. The checklist to be sent to physicians is unwieldy and confusing. Due to the complicated nature of the proposed HIV Listing, the form in question does not capture many of the nuances of the new system. The problem in this is that the form could mislead treating physicians as to tests and conditions required for presumptive disability and/or permanent SSA disability benefits. This in turn could lead to delays and outright denials of benefits -- the opposite of the result SSA is trying to achieve with all of these HIV proposals.

Some illustrative examples of these problems are:

1) Items (A) and (B) might suggest that an HIV test is necessary. (See discussion in Section II above.)

2) Items (D), (E), (F) and (G) do not conform fully with the proposed Listing, and there is no explanation in the proposed regulations on presumptive disability as to why this is the case. Hence, confusion could arise, especially for adjudicators assessing both the completed form and obliged to follow the regulations. As a general rule, that part of the form drafted to follow the proposed Listing should not contain verbiage not found in the Listing, and certainly should not exclude key language necessary for the provider completing the form to understand the form.

3) We question the use of the term "mild" in item (G), as we do not believe that this term is one of common usage in SSA regulations or in POMS language on HIV functional tests. Introduction of such a new term on a poorly explained form may prove very confusing, especially as it is not defined in the preamble to the proposed HIV Listing. Moreover, this term could have unfortunate legal implications given its lack of definition, especially in the appeals part of any claim process.

4) Item (G) as a whole raises serious concerns when included on a one-page form with no explanation of guidance. We wonder whether standardization of usage can be achieved by treating providers to the degree necessary to make the information in question useful to SSA. We are especially concerned that a misguided check of a less than "marked" category will prove detrimental to a claimant when an independent SSA analyst reviews the file for permanent disability determination.
Dated: February 14, 1992

Respectfully Submitted,

Paul A. Di Donato
ALRP Director of Policy
May 7, 1993

To whom it may concern.

Thanks for the information you sent me. I am enclosing all the necessary information for you to process my application.

As I told you on the phone, my insurance policy is from Mexico.

I am looking forward to hear from you about this matter as soon as possible.

Sincerely

[Signature]
INDICE

POLIZA DE VIDA
CONDICIONES GENERALES  2

COBERTURAS Y VALORES GARANTIZADOS  5

BENEFICIO MATRIMONIAL  8

BENEFICIOS POR ACCIDENTE  9

BENEFICIOS DE INCAPACIDAD TOTAL
Y PERMANENTE  11

CLAUSULA DE AUMENTO DE SUMA ASIGURADA  12
POLIZA DE VIDA
CONDICIONES GENERALES

OBJETO.-La Compañía se obliga a brindar al Asegurado la protección por los beneficios amparados en esta póliza mediante el pago de la prima convenida.

INDISPUTABILIDAD.-Esta póliza no será disputable después de dos años de su emisión o de su rehabilitación, por omisiones o inexactas declaraciones, contenidas en la solicitud de seguro y/o en el cuestionario del examen médico.

PRIMAS.-El importe de la prima deberá pagarse a la Compañía el primer día de plazo de un año de vigencia del seguro, mediante un solo pago, o bien semestral, trimestral o mensualmente. En los tres últimos casos cubriendo la Compañía los recargos autorizados por la Comisión Nacional Bancaria y de Seguros.

Los pagos deben efectuarse en las oficinas de la Compañía contra entrega del recibo correspondiente.

Si no hubiere sido pagada la prima o la fracción pactada, dentro de los treinta días naturales siguientes a la fecha de su vencimiento y solo se hubieren cubierto menos del número de primas anuales necesarias para tener derecho a los valores garantizados de los planes del seguro contratado, los efectos del contrato de seguro cesarán automáticamente a las 12 horas del último día de este plazo y por consiguiente la Compañía no estará obligada a pagar la indemnización en caso de siniestro.

En caso de que al ocurrir el siniestro no hubiere sido pagada la prima anual completa, de la liquidación correspondiente, la Compañía tiene derecho a deducir el importe faltante de la prima anual y cualquier otro adeudo derivado de esta póliza.

El Asegurado gozará de un período de espera de 30 días naturales para liquidar el total de la prima pendiente de pago o de cada una de las fracciones convenidas.

MONEDA.-Todos los pagos relativos a este contrato, por parte del Asegurado o la Compañía deberán efectuarse en moneda nacional, conforme a la Ley Monetaria vigente en la fecha de pago.

REHABILITACION.-En caso de que este seguro hubiere cesado en sus efectos por falta de pago de las primas, el Asegurado podrá rehabilitarlo en cualquier época mediante el cumplimiento de los siguientes requisitos:

a) Presentar a la Compañía una solicitud por escrito firmada por el mismo.

b) Comprobar a satisfacción de la Compañía que reúne las condiciones necesarias de salud y de rehabilitabilidad en general a la fecha de su solicitud:

c) Cubrir el importe de la prima por el periodo de seguro rehabilitado, conforme a las bases autorizadas por la Comisión Nacional Bancaria y de Seguros.

CAMBIO DE PLAN.-A solicitud del Asegurado, el plan de este seguro podrá ser cambiado en cualquier tiempo a otro de los que emita la Compañía, siempre que esta póliza se encuentre en vigor.

En su caso el importe del cambio que quede a cargo del Asegurado se determinará conforme a las bases autorizadas por la Comisión Nacional Bancaria y de Seguros.

SUICIDIO.-En caso de muerte por suicidio del Asegurado ocurrido dentro de los dos primeros años de la vigencia de este contrato, cualquiera que haya sido la causa y el estado mental o físico del Asegurado, la Compañía solamente cubrirá el importe de la reserva matemática, que corresponda a la fecha que ocurra el fallecimiento.

En caso de rehabilitación, el periodo de dos años a que se refiere el párrafo anterior, correrá a partir de la fecha en que se rehabilitó.

BENEFICIARIOS.-El Asegurado tendrá derecho a designar libremente a los beneficiarios del seguro y podrá revocar tal designación mediante notificación por escrito a la Compañía siempre y cuando no hubiere renunciado a este derecho. La renuncia se hará constar forzosamente en esta póliza y será el único medio de prueba.

Cuando no exista beneficiario designado, el importe del
seguro formará parte de la sucesión del Asegurado.

La misma regla se observará en caso de que el beneficiario muera antes que el Asegurado y éste no hubiere hecho nueva designación.

Cuando existan varios beneficiarios, al fallecer alguno de ellos su porción acrecerá por partes iguales a la de los demás, a menos que el Asegurado haya dispuesto otra cosa.

COMPROBACIÓN DEL SINIESTRO.-La Compañía tiene derecho de solicitar al Asegurado o beneficiario toda clase de información o documentos relacionados con el siniestro.

PAGO DEL SEGURO.-El importe del seguro se pagará previa la comprobación de la muerte, supervivencia, incapacidad o pérdidas orgánicas del Asegurado deduciendo de la suma asegurada el valor de los préstamos en el momento de la liquidación final de la póliza o aumentando el saldo de la cuenta de Dividendos y Dividendos en Administración correspondiente a la póliza.

Las sumas aseguradas por muerte se pagarán a los beneficiarios designados. Las sumas aseguradas por supervivencia, incapacidad o pérdidas orgánicas al propio Asegurado.

La Compañía estará obligada a pagar el importe del seguro dentro de los treinta días siguientes a la fecha en que la Compañía haya recibido los documentos e información que le permitan conocer el fondo de la reclamación.

INTERÉS MORATORIO.-En caso de que la Compañía no hubiera recibido los documentos e información que le permita conocer el fondo de la reclamación que haya sido presentada, no cumplirá con la obligación de pagar indemnización, capital o renta en los términos del Artículo 71 de la Ley Sobre el Contrato de Seguro, en vez del interés legal, quedará convencionalmente obligada a pagar al Asegurado, beneficiario o tercero dañado un interés moratorio anual equivalente a la media aritmética de las tasas de rendimiento brutos correspondientes a las series de Certificados de la Tesorería de la Federación (CETES) emitidas durante el lapso de mora.

En defecto de los CETES se aplicará la tasa de rendimiento de los depósitos bancarios de dinero al plazo de noventa días para el cálculo del interés moratorio convencional.

CONTENIDO DE LA POLIZA (Artículo 25 de la Ley Sobre el Contrato de Seguro).-"Si el contenido de la póliza o sus modificaciones no concordaren con la oferta, el Asegurado podrá pedir la rectificación correspondiente dentro de los treinta días que sigan al día en que recibía la póliza. Transcurrido este plazo se considerarán aceptadas las estipulaciones de la póliza o de sus modificaciones."
EDAD.-La edad declarada por el Asegurado en la presente póliza se deberá comprobar fiablemente cuando así lo juzgue necesario la Compañía.

Para efectos de este contrato se considera como edad real del Asegurado la más cercana al aniversario de la póliza.

Una vez que el Asegurado haya comprobado su edad a la Compañía, ésta hará la anotación correspondiente en la propia póliza y no tendrá derecho alguno para exigir nuevas pruebas.

Cuando de la comprobación de la edad resulte,

1.-Que la edad verdadera del Asegurado se encuentra dentro de los límites de admisión autorizados a la Compañía.

a) Si es mayor a la declarada, el importe del seguro se reducirá en la proporción que exista entre la prima pagada y la que corresponda a la tarifa correspondiente a la edad real en la fecha de celebración del Contrato.

b) Si es menor a la declarada, la suma asegurada no se modificará y la Compañía tendrá obligación de reembolsar la diferencia que haya entre la reserva existente y la que corresponda a la edad real del Asegurado, en el momento de la celebración del contrato. Las primas ulteriores deberán reducirse de acuerdo con esta edad.

c) Cuando con posterioridad a la muerte del Asegurado, de la comprobación de la edad resulte que fue incorrecta a la manifestada en la solicitud, pero que la edad real se encuentra dentro de los límites de admisión autorizados, la Compañía pagará la suma asegurada que las primas cubiertas hubieren podido pagar de acuerdo con la edad real que se calculará de acuerdo con las tarifas que hayan estado en vigor en el momento de la celebración del Contrato.

d) Si la edad real es menor de doce años se procederá de acuerdo a lo establecido en la cláusula de MENORES, de la presente póliza.

2.-Que la edad real del Asegurado se encuentre fuera de los límites de admisión autorizados a la Compañía:

En este caso la póliza quedará rescindida y la Compañía lo comunicará por escrito al Asegurado, reduciéndose su obligación a pagar el importe de la reserva matemática que corresponda a la presente póliza en la fecha de rescisión, calculada según las reglas aprobadas por la Comisión Nacional Bancaria y de Seguros.

LIMITES DE EDAD DE CONTRATACION.-El límite máximo de admisión autorizado a la Compañía aparece en la carátula de la póliza.

MUJERES.-Conforme a los procedimientos autorizados por la Comisión Nacional Bancaria y de Seguros, se considera que la edad de la Asegurada, para efectos de determinación de Primas y Valores Garantizados es la edad equivalente registrada en la carátula.

MENORES (CONTRASEGURO).-Las condiciones de contratación y cláusulas se modifican para Asegurados menores de doce años de edad, en los siguientes términos:

1) La prima y valores de rescate habrán sido calculados considerando al Asegurado como si tuviera doce años de edad.

2) En caso de fallecimiento del Asegurado antes de cumplir los doce años de edad, la Compañía pagará a los beneficiarios designados al importe de las primas cubiertas o el valor de rescate, lo que resulte ser mayor.

3) Hasta la fecha en que el Asegurado cumpla los doce años de edad queda sin efecto legal la Cláusula de conversión a Seguro Saldado o Seguro Prorrogado.

4) A partir de los doce años de edad en caso de que el Asegurado eligiera el Seguro Saldado o Seguro Prorrogado, la Compañía calculará los valores a que tenga derecho, de acuerdo a los procedimientos aprobados por la Comisión Nacional Bancaria y de Seguros, ya que los valores que se muestren en la Tabla no corresponderán a la edad alcanzada de acuerdo al plazo transcurrido.
COBERTURAS Y VALORES GARANTIZADOS

ORDINARIO DE VIDA Y VIDA PAGOS LIMITADOS.-La Compañía pagará la suma asegurada de esta cobertura, al ocurrir el fallecimiento del Asegurado.

TEMPORAL.-La Compañía pagará la suma asegurada de esta Cobertura si el Asegurado fallece dentro del plazo del plan.

TOTAL.-La Compañía pagará la suma asegurada en caso de que el fallecimiento del Asegurado ocurra dentro del plazo del plan o al término del mismo, si se encuentra con vida.

MANCOMUNADOS.-1. La Compañía pagará la suma asegurada por fallecimiento a los beneficiarios del primero de los Asegurados que fallezca de acuerdo al tipo de cobertura escogido en los incisos anteriores.

2.-En caso de fallecimiento simultáneo la suma asegurada de las coberturas por fallecimiento se distribuirá a los beneficiarios respectivos por partes iguales.

3.-La suma asegurada que deba cubrirse en caso de supervivencia se pagará solamente si los Asegurados sobreviven al período de seguro estipulado y se distribuirá por partes iguales.

4.-El pago de primas cesará al ocurrir el primer fallecimiento, o al término del período de pago de primas contratado, lo que ocurra primero.

VALORES GARANTIZADOS.-Después de que el Asegurado haya cubierto las primas correspondientes y que haya transcurrido el número de años mínimo indicados en la tabla de valores garantizados respectiva, el Asegurado podrá hacer uso de algunos de los derechos que se describen posteriormente.

Si en la fecha de solicitud del valor garantizado escogido, la póliza se encuentra gravada con alguna deuda, ésta deberá ser liquidada a la Compañía, o bien se reducirá el importe de la opción al que pudiera pagarse con la diferencia entre el préstamo máximo y el adeudo derivado de esta póliza.

a) Seguro Saldado.-El seguro saldado mantiene este plan en vigor, sin más pago de primas, por la suma asegurada vigente a la fecha de conversión durante el período de tiempo que marca la tabla de valores garantizados correspondiente, de acuerdo a la edad de ingreso al plan y al número de años que el plan haya estado en vigor.

b) Seguro Prorrogado.-El seguro prorrogado mantiene a este plan en vigor sin más pago de primas, por la suma asegurada vigente a la fecha de conversión durante un período de tiempo que marca la tabla de valores garantizados respectiva de acuerdo a la edad de ingreso al plan y al número de años que el plan haya estado en vigor.

Si en la tabla de valores garantizados aparece alguna cantidad en efectivo, ésta será pagada al propio Asegurado en caso de supervivencia dentro del período del seguro prorrogado.

c) Rescate.-El Asegurado podrá obtener como valor en efectivo de este plan la cantidad que aparece en la tabla de valores garantizados correspondiente, de acuerdo a la edad de ingreso al seguro y al número de años que el plan haya estado en vigor. Para conceder el rescate en una fecha que no coincida con el aniversario de la póliza, el valor se determinará deduciendo a la cantidad correspondiente el número de primas anuales pagadas, intereses sobre dicha cantidad a razón del 6% anual desde la fecha en que se solicite el rescate hasta el vencimiento de la siguiente prima.

El Asegurado podrá obtener como rescate del seguro saldado o del seguro prorrogado el 80% de la reserva matemática correspondiente.
OPCION DE PRESTAMO.-Como aparece en la cláusula de la póliza el asegurado eligió entre tener derecho a préstamo bajo las bases que se mencionan en la cláusula de préstamo a no tener derecho a préstamo y obtener un dividendo por los excedentes de la inversión que la Compañía obtenga al invertir por cuenta de éste el valor de rescate bajo las bases que se mencionan en la cláusula de dividendo.

Independientemente de la opción elegida, o si el asegurado no indica el derecho que desea usar, esta póliza se atendrá a lo mencionado en las cláusulas de préstamo automático de primas y préstamo.

DIVIDENDOS.-Mensualmente se estimarán los excedentes que se produzcan derivados de la operación de la cartera a la que pertenece esta póliza. La Compañía conforme a los procedimientos aprobados por la CNBS determinará qué parte de dichos excedentes se acreditará en forma de dividendos a cada póliza. La información sobre los dividendos realmente acreditados cada mes estará contenida en el estado de cuenta anual, en caso de presentarse algún movimiento extraordinario antes de finalizar dicho ejercicio se podrá considerar el dividendo estimado para efectos del rescate correspondiente.

DIVIDENDOS EN ADMINISTRACIÓN.-Salvo estipulación en contrario entre el Asegurado y la Compañía mediante acuerdo a esta póliza, los dividendos correspondientes se administrarán y calcularán por la Compañía de acuerdo a las disposiciones aprobadas por la Comisión Nacional Bancaria y de Seguros.

Por cada póliza se llevará una cuenta de dividendos en administración y mensualmente se afectuará el proceso de todos los movimientos que afecten la misma.

Una vez al año, en el aniversario de la póliza, se le enviará al asegurado un estado de cuenta indicando todos los movimientos operados en el año precedente, así como su saldo al valor de rescate y de dividendos en administración.

En cualquier momento durante la vigencia de la póliza el asegurado podrá solicitar con un mínimo de sesenta días de anticipación el retiro total o parcial de su fondo de dividendos en administración.

La Compañía invertirá los dividendos generados en valores de renta y a plazos fijos de los emitidos por Instituciones de Crédito y por el Gobierno Federal, o en cualquier otro tipo de valores autorizados para inversiones que permitan obtener el mejor rendimiento posible dentro de la máxima seguridad pero siempre con la liquidez necesaria.

La Compañía buscará el mayor rendimiento posible en las inversiones de los dividendos generados, sin que esto signifique que se está garantizando un rendimiento predeterminado debido a las fluctuaciones del mercado.

Si el Asegurado deja de cobrar una prima dentro de los treinta días del período de espera, esta se pagará del saldo de la cuenta de los Dividendos en Administración siempre que éste así lo permita y sí no fuera el caso, se aplicará lo establecido en la Cláusula de Préstamo Automático, salvo estipulación en contrario por parte del Asegurado, mediante endoso a esta póliza.

PRESTAMO AUTOMÁTICO DE PRIMAS.-Adquirida la facultad de usar estos derechos, si el Asegurado dejase de cobrar una prima dentro de los 30 días del periodo de espera otorgado para su pago, la Compañía prestará sin necesidad de solicitud del Asegurado y sujeto a la cláusula de préstamo, el importe de dicha prima, siempre que los préstamos existentes, la prima aplicada a préstamo y los intereses correspondientes no excedan el préstamo máximo a que tuviera derecho el Asegurado.

Cuando el préstamo máximo sea menor al total del adeudo, esta póliza continuará en vigor por tantos días cuantos resulten multiplicando los días del periodo que cubra la prima (90, 180 o 360) por el resultado que dé el importe del préstamo máximo, menos las deudas derivadas de la póliza y dividiendo el producto entre la prima correspondiente.
Si transcurrió el número de días a que se refiere el párrafo anterior, que nunca será menor de 30, el Asegurado no paga la prima, cesarán los efectos de este contrato así como las obligaciones que la Compañía haya contraído con él.

Las deudas contraídas por préstamo automático de primas podrán ser pagadas por el Asegurado en cualquier tiempo, ya sea en un solo pago o en pagos parciales, siempre que la póliza esté en vigor.

En el momento en que las deudas del Asegurado más los intereses sean igual al préstamo máximo, esta póliza cesará en sus efectos y la Compañía deberá notificarlo por escrito al Asegurado.

Para la aplicación de esta cláusula, se sumarán al préstamo máximo de la póliza, las reservas de las adiciones salidas y toda cantidad que por dividendo o por otro concepto adeude la Compañía al Asegurado.

Todas las deudas contraídas en virtud de esta cláusula, serán deducidas por la Compañía en el momento de la liquidación final de esta póliza.

Préstamo.-Con la sola garantía de la reserva de la póliza, el Asegurado podrá obtener préstamos en cantidades que no excedan a las que se especifican en la tabla de valores garantizados correspondiente, de acuerdo a la edad de ingreso al seguro y al número de años en que el plan haya estado en vigor. Estos préstamos devengarán un interés que fijará la Compañía de acuerdo con la tasa autorizada en esa fecha por la C.N.B.S., debiendo cubrirse, al obtener el préstamo, los intereses de este hasta la fecha de aniversario siguiente, así como cualquier otro adeudo derivado de este contrato. En lo sucesivo, los intereses vencerán en cada año en la fecha de aniversario de esta póliza.

En caso de falta de pago de una prima, éste no afectará la vigencia del seguro mientras el adeudo total sea inferior al importe del préstamo máximo a que tenga derecho el Asegurado de acuerdo al número de primas anuales pagadas. Si el adeudo llegare a ser igual al préstamo máximo, el presente contrato cesará en sus efectos y no tendrá valor alguno, no requiriéndose declaración por parte de la Compañía.

Todas las deudas contraídas en virtud de esta cláusula, serán deducidas por la Compañía en el momento de la liquidación final de esta póliza.
BENEFICIO MATRIMONIAL

VIGENCIA.- Los beneficios de esta cláusula estarán en vigor hasta la fecha en que el Asegurado cumpla o hubiese cumplido los 65 años de edad o al finalizar el plazo de pago de primes, lo que ocurra primero.

Si el cónyuge muere antes que el Asegurado, éste recibirá el 10% de la suma asegurada contratada para este beneficio.

BENEFICIO.- Si el Asegurado muere antes que su cónyuge, este quedará asegurado por la suma que aparece en la caraleta de esta póliza para este beneficio sin más pago de primes.

En caso de que el fallecimiento de Asegurado y el cónyuge fuera simultáneo, se considerará que el fallecimiento del cónyuge fue posterior aí del Asegurado.
BENEFICIOS POR ACCIDENTE

VIGENCIA.-Los beneficios adicionales en caso de Accidente, estarán en vigor mientras el Asegurado no alcance la edad indicada en la carátula. Estos beneficios se cancelarán en caso de que proceda el pago de alguno de los beneficios adicionales de Incapacidad Total y Permanente.

ACCIDENTE.-Para los efectos de estos beneficios se define como accidente aquel acontecimiento proveniente de una causa externa, súbita y violenta, que produzca la muerte o lesiones en la persona del Asegurado. No se considerarán accidentes las lesiones corporales o la muerte provocadas intencionalmente por el Asegurado.

BENEFICIO DE MUERTE ACCIDENTAL (DI).- La Compañía pagará en caso de muerte accidental la suma indicada en la carátula de esta póliza para este beneficio siempre que la muerte ocurra dentro de los 90 días siguientes a la fecha del accidente, adicionalmente a la suma asegurada contratada para este seguro.

BENEFICIO DE PERDIDAS ORGANICAS (PO).-La Compañía pagará las indemnizaciones que se detallan a continuación cuando las pérdidas orgánicas ocurran dentro de los 90 días siguientes a la fecha del accidente. Cuando sean varias las pérdidas orgánicas, en uno o varios accidentes, la suma de las indemnizaciones por este beneficio y el beneficio de muerte accidental, en ningún caso será superior a la suma asegurada contratada.

A. Por la pérdida de ambas manos, de ambos pies o de la vista en ambos ojos, una cantidad igual al cien por ciento de la suma asegurada contratada.

B. Por la de una mano y un pie, una cantidad igual al cien por ciento de la suma asegurada contratada.

C. Por la pérdida de una mano o un pie: conjuntamente con la vista de un ojo, una cantidad igual al cien por ciento de la suma asegurada contratada.

D. Por la pérdida de una mano o un pie, una cantidad igual al cincuenta por ciento de la suma asegurada contratada.

E. Por la pérdida de la vista en un ojo, una cantidad igual al treinta por ciento de la suma asegurada contratada.

F. Por la pérdida del dedo pulgar de una mano, una cantidad igual al quince por ciento de la suma asegurada contratada.

G. Por la pérdida del dedo índice de una mano, una cantidad igual al diez por ciento de la suma asegurada contratada.

Para efectos de este beneficio se entiende por pérdida de una mano, su separación completa desde la articulación del puño o arriba de ella; por la pérdida de un pie, su separación completa desde la articulación del tobillo o arriba de ella; por pérdida de la vista de un ojo, la desaparición completa e irreparable de esta función en ese ojo, por pérdida del pulgar o índice la separación de dos falanges completas en cada dedo.

BENEFICIO DE ACCIDENTE EN LUGARES PÚBLICOS (TI).- La Compañía en caso de accidente en lugares públicos pagará la suma indicada en la carátula de la póliza para este beneficio si el asegurado fallece y en caso de Perdidas Orgánicas la cantidad que resulte de aplicar la tabla de indemnizaciones del Beneficio de Pérdidas Orgánicas, en adición a la suma asegurada contratada para este seguro.

Se entenderá por accidente en lugares públicos, el que ocurra:

a) Mientras el asegurado viaje como pasajero a bordo de cualquier vehículo de transporte público, que no sea aéreo, autorizado legalmente, sobre una ruta establecida para servicio de pasajeros y sujeto a itinerarios regulares, o

b) Mientras el asegurado viaje como pasajero en un ascensor que opere para servicio de pasajeros: con exclusión de ascensores usados en minas, o

c) A causa de incendio en cualquier teatro, hotel u otro edificio público en el cual se encuentre el Asegurado al iniciarse el incendio.
EXCLUSIONES.- Estos beneficios no se concludrán si la muerte del Asegurado o las pérdidas orgánicas que sufra son debidas directamente, total o parcialmente a:

1. Enfermedades, padecimientos u operaciones quirúrgicas de cualquier naturaleza, que no sean ocasionadas directamente por los accidentes a que se refiere este capítulo.

2. Envenenamiento de cualquier naturaleza e inhalación de gases de cualquier clase, excepto cuan do se deriven de un accidente.

3. Suicidio o intento de él, cualesquiera que sean las causas o circunstancias que lo provoquen.

4. Lesiones u homicidios ocasionados en riña al Asegurado por cualquier persona, únicamente cuando el Asegurado haya sido el provocador.

5. Lesiones sufridas al prestar servicio militar o naval en tiempo de guerra, revolución o actos de insurrección.

6. La participación en cualquier forma de navegación aérea, excepto que, al ocurrir un accidente, el Asegurado viajare como pasajero en un avión de una compañía comercial de aviación debidamente autorizada para transportar pasajeros, salvo para el beneficio de accidente en lugares públicos.

7. La participación en cualquier forma de navegación submarina.

8. Lesiones o muerte sufridas mientras el Asegurado se encuentre en cualquier vehículo tomando parte en carreras, pruebas o contiendas de seguridad, resistencia o velocidad.

9. La participación en eventos de paracaidismo y motociclismo.

10. Accidentes que sufra el Asegurado encontrándose este bajo los efectos del alcohol, drogas o enervantes que le causen perturbación mental o pérdida del conocimiento, excepto cuando hayan sido prescritas por un médico.
**BENEFICIOS DE INCAPACIDAD TOTAL Y PERMANENTE**

**VIGENCIA.** Los beneficios de Incapacidad Total y Permanente estarán en vigor mientras el Asegurado no haya alcanzado la edad indicada en la carátula de la póliza.

**INCAPACIDAD.** Para los efectos de estos beneficios se define como Incapacidad Total y Permanente el hecho que el Asegurado sufra lesiones corporales o padezca una enfermedad que lo imposibilite para el desempeño de todas sus labores diarias propias de su ocupación u otra apropiada a sus conocimientos, aptitudes y compatibles con su posición social, que pudiera producirle remuneración o utilidad durante un periodo continuo de 6 meses. También se considerará Incapacidad Total y Permanente la pérdida completa e irremediable de la vista de ambos ojos, la pérdida de ambos pies o de ambos manos o la pérdida conjunta de toda la mano y todo un pie.

Para los efectos de este beneficio se entiende por pérdida de una mano su sección absoluta de la articulación de la muñeca o arriba de ella, por pérdida de un pie y su sección absoluta de la articulación del tobillo o arriba de él.

El Asegurado deberá acreditar ante la Compañía su estado de incapacidad.

**BENEFICIO DE EXENCIÓN DE PAGO DE PRIMAS (EPP).** Después de haber pagado la totalidad de las primas del primer año si el Asegurado se incapacita total y permanentemente, la Compañía conviene en pagar por él las primas que vengan, inmediatamente después de transcurrido el periodo continuo de 6 meses citado en la definición de incapacidad. La póliza quedará de este modo vigente y el Asegurado tendrá sobre la misma los derechos que sus condiciones le conceden.

**BENEFICIO DE PAGO ADICIONAL (SIPA).** La Compañía le pagará al Asegurado la suma asegurada, que aparece en la carátula de la póliza, inmediatamente después de transcurrido el periodo continuo de seis meses citado en la definición de incapacidad.

**BENEFICIO RENTA VITALICIA (RVI).** La Compañía conviene en otorgarle al Asegurado, mientras subsista la incapacidad, el siguiente beneficio: Le pagará la renta mensual que aparece en la carátula de la póliza.

La renta comenzará a pagarse inmediatamente después de transcurrido el periodo continuo de 6 meses citado en la definición de incapacidad y la seguirá pagando mensualmente durante toda la vida del mismo.

**RECUERACIÓN DE LA INCAPACIDAD.** La Compañía podrá cuando lo estime necesario, pero no más de una vez al año, exigir que se compruebe de manera acertada que continúa el estado de incapacidad del Asegurado. Si este se niega a hacerlo, o aparece que ya está dedicado a cualquier ocupación que la produzca remuneración, cesará el goce de los beneficios contrataados, debiendo el Asegurado reanudar el pago de primas a partir de la que venza inmediatamente después de que esto ocurra.

**EXCLUSIONES.** El goce de estos beneficios no se concederá si la incapacidad es a consecuencia de:

a) Lesiones o enfermedades que se provoquen deliberadamente el propio Asegurado;

b) Guerra o rebelión, o insurrecciones;

c) Accidentes ocurridos mientras el Asegurado esté viajando en aviones que no sean de líneas aéreas legalmente autorizadas para el transporte de pasajeros.
CLAUSULA DE AUMENTO DE SUMA ASEGURADA

SUMA ASEGURADA.- La Suma Asegurada del Plan Básico y de los Beneficios Adicionales por Accidente e Incapacidad, se aumentarán en la proporción eléctrica por el Asegurado y hasta los límites máximos de suma asegurada mencionados en la carátula de la póliza, reservándose la Compañía el derecho de aumentarlos. Los aumentos se harán anualmente en la fecha de aniversario del inicio de vigencia de la póliza.

Para estos efectos la Compañía expedirá sin necesidad de examen médico el Encargo de Aumento de Suma Asegurada respectivo junto con el recibo de cobro correspondiente por el aumento, en donde se indicará la nueva prima, suma asegurada y en su caso también enviará los nuevos valores garantizados. Si el asegurado no pagara la prima por el aumento de suma asegurada dentro de los treinta días siguientes a la fecha de su vencimiento, la suma asegurada anterior se mantendrá igual. Si el Asegurado falleciera durante los treinta días sin haber pagado la prima correspondiente a dicho aumento, se descontará esta de la Suma Asegurada que hubiere alcanzado.

Si el aumento depende del Índice de Precios al Consumidor o del Índice de Crecimiento al Salario Mínimo General en el Distrito Federal, este se determinará al primero de enero de cada año o al que se tenga conocimiento dentro de los tres meses anteriores y corresponda a 12 meses.

CANCELACIÓN - Esta cláusula se cancelará:

a) Cuando el Asegurado haya cumplido 66 años de edad.

b) Si el Asegurado opta por los beneficios de Seguro Saldado o de Seguro Prorrogado en los términos de la póliza contratada o se acogiere el Beneficio de Incapacidad en los términos de las cláusulas respectivas.

c) En cualquier momento a petición del Asegurado.

REINSTALACIÓN - En caso de que hubiere cesado los derechos del Asegurado sobre esta cláusula de aumento de suma asegurada, esta podrá reinstalarse mediante el cumplimiento de los siguientes requisitos:

a) Presentar a la Compañía una solicitud de la reinstalación por escrito;

b) Comprobar a su costa y a satisfacción de la Compañía que reúne las condiciones necesarias de salud y asegurabilidad en general.
PÓLIZA DE SEGURO DE VIDA INDIVIDUAL

SEGUROS AMÉRICA S.A. A.V. REVOLUCIÓN NÚM. 11020 MÉXICO, D.F.
NOMBRE DEL ASEGURADO: [REDACTED]

DOMICILIO: [REDACTED]
FECHA DE NACIMIENTO DEL ASEGURADO: [REDACTED]
FECHA DE VIGENCIA: 28/10/88
FORMA DE PAGO: TRIMESTRAL

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<th>COBERTURAS CONTRATADAS</th>
<th>TIPO DE COBERTURA</th>
<th>SUMA ASEGURADA O RENTA</th>
<th>PRIMA ANUAL</th>
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<td>BÁSICA</td>
<td>$150 - 300 - 00 - 00</td>
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PRIMA Y EXTRA PRIMA ANUAL: $775.852.00
RECARGO POR PAGO FRACCIONADO: $150 - 515.30
GASTOS DE EXPEDICIÓN DE POLIZA: $50.00
PAGO TOTAL: $926.868.20

COBERTURA: TEMPORAL
TIPO: BÁSICA
LÍMITE MÁXIMO DE SUMA ASEGURADA: $5
ALCANCE: HASTA EL LÍMITE PERMITIDO POR LOS CONTRATOS DE REASEGURADO DE LA COMPAÑÍA.

NOTA IMPORTANTE: El asegurado debe designar beneficiarios de forma clara y precisa, para evitar cualquier incertidumbre sobre el particular. La designación de beneficiarios atribuye a la persona de cuyo favor se hace un derecho propio al crédito derivado del seguro de manera que son inflosos las designaciones para que una persona sobre la suma asegurada y la entregue a otra, por ejemplo, "a los hijos menores del Asegurado" y no "a quien conozca".

NOMBRE DE LOS BENEFICIARIOS

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<th>BENEFICIARIO</th>
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Seguros América, S.A. (en adelante denominada la compañía) se obliga a pagar las sumas aseguradas correspondientes a los planes de seguro y beneficios adicionales contratados que aparezcan declarados, de conformidad con la solicitud y las demás declaraciones del Asegurado y con sujeción a las condiciones generales, específicas y cláusulas contenidas en esta póliza, siempre y cuando la misma se encuentre en vigor.

NOMBRE Y CÉDULA DEL AGENTE: TELALMATZIN ACOSTA ROBERTO
LOM-923394
DIVISIÓN-REGIONAL: CONDES
LUGAR Y FECHA: MÉXICO D.F., 28 DE OCTUBRE DE 1988

AUT C.M.B.E. OF. NUM. 37235 EXP. 7323 (5-3) DEL 21 DE JULIO DE 1988. REG. FED. CONT. SAM-846000 CED. EMP. L.V. 1043567
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TO:  Ergin Keller (AIDS Legal Funeral Panel)

SENT TO FAX #:  921-5853

FROM:  Erik Duban

SENDER'S PHONE #: (415) 864-5855 ext. 2528

DATE:  5/3/93

NUMBER OF PAGES (INCLUDING COVER):  7

RESPONSE REQUESTED:  YES X NO
Viatical Settlements: New Planning Tool for the Seriously Ill

By John Darragh


Viatical settlements allow a terminally ill person to convert a non-cash asset into cash. Judicious use of viatical settlements may alleviate financial burdens placed on the terminally ill and their families. In 1989 the first life insurance policy was viaticated for a terminally ill client. Since then the concept of viatical settlements has gained wide acceptance among terminally ill policy holders and third-party entrepreneurial firms. In exchange for an immediate cash payment to the policy holder (in an amount less than the policy death benefit), third-party firms take assignment of the life insurance policy as owner and beneficiary. NOTE: Viatical settlements should not be confused with settlements that occur for a pre-death payment by insurers. For many clients it locates a knowledgeable, insightful planner.

Planners must be prepared to discuss the alternatives to a viatical settlement. Alternatives include loans from family members or friends (loans are non-taxable) or an accelerated benefits provision within their existing policy.

A client is receiving or plans to receive means-based entitlements such as Medicaid or Supplemental Security Income, the receipt of a viatical settlement usually will disqualify the client from eligibility in the month received. Fortunately, planning techniques are available that can prevent long-term disqualification from these entitlements. It is critical that planners become familiar with federal and state entitlement provisions.

The seller of a life insurance policy is required to declare as taxable ordinary income the viatical received, less the sum total of all premiums paid, all dividends received, and any outstanding policy loans. In March 1993 the IRS will conduct hearings on the taxability of accelerated benefits. Viatical settlement advocates are scheduled to address the hearing and attempt to have viatical settlements treated as income tax-free life insurance death benefits.

Viatical Settlements

The Process

The viatication process is a relatively simple and private business transaction between a buyer and a seller. Typically, if a client's life expectancy is 24 months or less, the buyer will offer to purchase a life policy for 50 to 80 percent of its face value.

Selling a life insurance policy is a major financial decision. It is strongly recommended that individuals wanting to viaticate their life policies seek the advice of a qualified professional. An obstacle for many clients is locating a knowledgeable, insightful planner.

Planners must be prepared to discuss the alternatives to a viatical settlement. Alternatives include loans from family members or friends (loans are non-taxable) or an accelerated benefits provision within their existing policy.

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Service Options

Planning professionals have options for providing optimal service to their clients. They can: refer clients to another planner who has experience in the viatical settlement process; refer clients to knowledgeable benefits counselors at community-based organizations; or assume the role of primary planner. Building a local network of specialized professionals can be invaluable.

Planners who specialize in addressing the financial planning needs of the terminally ill typically contract with their clients on an hourly fee basis. Fee-based services assure the client that the planner makes no specific financial gain from the potential policy sale. One must remember that helping a client with the viatical settlement process is only a small part of the overall plan.

To be a working participant with a client, the planner must perform due diligence on viatical settlement companies. Among the questions that need to be addressed are:

- Is the company acting as a principal or broker?
- How are they compensated?
- When did they purchase their first policy?
- How do they insure client confidentiality?
- How do they determine settlement amounts in relation to life expectancy projections?

John Darragh has been a practicing financial planner since 1977. He was diagnosed with AIDS in June 1988. Currently he lectures around the country and counsels individuals, professionals, and organizations on financial planning for those facing life-threatening illnesses.

ARE THESE YOUR ANNUITIES?? ARE THESE YOUR RESULTS??

<table>
<thead>
<tr>
<th>All viatical settlement companies:</th>
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<tbody>
<tr>
<td>• Require that the insurance company be a quality carrier with a good reputation for paying death claims;</td>
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<tr>
<td>• Require that all persons having an ownership or beneficiary interest release their interest and waive future rights;</td>
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<tr>
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<td>• Require applicants to release medical records for review;</td>
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<td>• Require applicants to make a designation of irrevocable beneficiary in favor of the purchaser;</td>
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<td>• Require the policy be past the period specified in the contestability clause and suicide exclusion;</td>
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<tr>
<td>• Suggest that the applicant secure the advice and counsel of a financial planner, insurance professional, attorney and/or tax accountant before viaticking a policy;</td>
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<tr>
<td>• Have panels of medical experts to review the applicant's medical records and to make independent estimates of life expectancy;</td>
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<tr>
<td>• Promise the maximum confidentiality consistent with what the companies need to disclose to do their jobs; and</td>
</tr>
<tr>
<td>• Specify a time period after settlement within which the seller has the right to undo the entire transaction.</td>
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**ARE THESE YOUR ANNUITIES?? ARE THESE YOUR RESULTS??**

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<th>BUY &amp; HOLD*</th>
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<tr>
<td>WESTERN RESERVE WRL SERIES SUB ACCOUNT GROWTH</td>
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* Total returns for 1992
1800-229-7131

“Not All Timing Services Were Created Equal”
1-800-229-7131

THE JUPITER GROUP
6619 South Dixie Hwy., Box 229, Miami, FL 33143

**Buy & Hold vs. Jupiter**
GETTING MONEY FROM YOUR LIFE INSURANCE: SOME THINGS YOU NEED TO KNOW

How can I turn my life insurance into cash that I can use?

There are several ways of doing this.

1. You can ask the person you've named as the beneficiary of the policy if they will loan you money now. They will be paid back after you die when the policy is paid out.

2. You can ask the insurance company itself if it offers an "accelerated benefit" or "living benefit." If so, it may pay you the value of your policy, or some portion of it, if your health condition warrants it.

3. The last method is through a "viatical settlement." In a viatical settlement, you irrevocably name a third party investment company as your beneficiary. In exchange, the company will pay you a percentage of the death benefit of the policy. The percentage will vary depending on your health condition and your bargaining skills.

Is selling my life insurance policy to a viatical settlement company a good idea?

The answer depends on your situation. Doing a viatical settlement should be part of an overall financial planning strategy. The process takes time, so if you want it as a quick fix, think again.

If you are thinking of doing it because you can’t pay your bills, you should talk with a lawyer about declaring bankruptcy or finding other means of handling your creditors. You may already be "judgment-proof," meaning that your income and assets are low enough that you are shielded from your creditors. Getting a large sum of money through a viatical settlement may expose you to a greater threat from your creditors than you have now.

How much money will I get through a viatical settlement?

It depends on several factors, including your health and prognosis, the rating of your insurance company, how long you've had the insurance, market factors, and your own negotiating skills. Usually, viatical settlements range from 50% to 80% of the death benefit of the policy.
How can I be sure to get a higher amount for my policy?

You must think in business terms. Remember, that no matter how sympathetic a viatical company's advertisements or telephone marketing agents, they are running a business, not a service agency. They want your business, and will respond to your advocacy and to competition.

We suggest that you complete applications with at least five companies. That means you should ask your doctor for at least five complete sets of medical records right from the start. Choose a variety of companies: different sizes, different locations. Using companies that are licensed or have applied for licenses in California gives you some additional protection through the California Insurance Commission.

Once you've received offers from the five companies, you can inform them of the higher bids, and let them bid against each other. This may be hard work. Perhaps a friend can help you with the process.

Will the money I receive be taxable?

Despite the fact that viatical settlement companies are not currently required by law to issue 1099 forms, the money you receive is taxable on your federal tax return. Under California law, however, it is not considered part of your gross income on your California tax return.

Will my disability or health benefits be affected by receiving money from a viatical settlement?

Need-based benefits such as Supplemental Security Income (SSI), Medi-Cal, General Assistance (GA), Food Stamps and Aid to Families with Dependent Children (AFDC) will be affected. In order not to lose your benefits, you should consult with an attorney or benefits counselor before completing a transaction like this.

Benefits that are not based on financial need, such as Social Security Disability Insurance (SSDI), State Disability Insurance (SDI) and private disability insurance policies, are not affected by your receipt of this money.

What if I agree to a viatical settlement, but then change my mind?

Under California law, you have fifteen days after you sign a viatical settlement agreement to change your mind.

Where can I get help if I have questions?

You can speak with an attorney through the AIDS Legal Referral Panel by calling (415) 291-5454. If you have a complaint about a viatical settlement company, you should call the California Insurance Commission's viatical settlement licensing unit at (415) 904-5694.
Q. What is the definition of "terminally ill" or facing a "life threatening illness"?

A. Having a life expectancy of twenty-four (24) months or less.

Q. What are the necessary requirements to be eligible for an advance benefits program?

A. 1. The maximum life expectancy should be twenty-four (24) months or less, however most viatical companies consider each case individually.
   2. The policy should be individually owned, rather than a group policy, however most group policy's can be converted or, under some circumstances, processed satisfactorily.
   3. The policy must have been in-force for a minimum of two years.
   4. The policy should have been issued by an A or A+ rated insurance company, as determined by the A.M. Best Company. Policies from companies rated less than A or A+ are considered on an individual basis.

Q. How is a person determined to have a life expectancy of twenty-four (24) months or less.

A. This must have been determined by a medical doctor.

Q. Based upon the face value of the life insurance policy, what amount may I expect to receive through an advance cash benefits program?

A. As a general rule, up to eighty percent (80%) of the face value of the policy is paid. The shorter the life expectancy, the more a benefactor can pay; with a longer life expectancy, less can be obtained. Another important factor in determining the purchase price is market rate available on similar investment. The annual premium, type of policy and rating of the insurance company will also affect the amount paid for a policy.

Q. What types of life insurance policies are acceptable for an advance benefits program?

A. All types of individually owned and most group policies can be purchased.

Q. What size policies are considered for purchase?

A. Viatical settlement companies will help anyone facing life threatening illness to obtain the funds to improve their quality of life, no matter how small the policy. All policies with face amounts up to one million ($1,000,000) are considered for purchase automatically. Policies with face amounts in excess of one million are considered on an individual basis only.
Q. How does the insured know that he will receive his monies while the transfer and recording of instruments is in process at the insurance company?

A. Viatical settlement companies process no transaction expect under strict escrow agreement with a third party trust agent. While processing takes place one hundred (100%) of the insured's funds rest safely at escrow. Benefactor and client each pay half of the trust agent's fee, (approximately $200 each), for this service. The clients portion of this fee will be deducted from his proceeds at closing.

Q. Is it necessary for the policy holder to continue to pay premiums after he has sold the policy?

A. Most group policies and some individual policies offer a disability waiver of premium, where the insurance company or the employer pay the premiums on proof of disability. If the insured is currently paying the premiums, he should see if these options are available to him and act on them immediately. If no third party is liable to pay the premiums of the policy, two years annual premium is deducted from proceeds to the insured at closing, After that, the insured will not pay additional premiums ever.

Q. Does the insured need an attorney to represent his interests in this transaction?

A. Viatical settlement companies strongly suggests that all of its insured clients have legal counsel and provides that the benefactor will pay half of the insured's attorney fees. In the case where insured's attorney represents him pro bono, the viatical settlement company provides contributions equivalent to reasonable attorney's fees to any organization or entity designated by the insured.

Q. Does the insured pay any fee to the viatical settlement companies?

A. The insured never pays any fees whatsoever to the viatical settlement companies. No expenses associated with this transaction, be they medical, express mail, processing, copying, legal or otherwise are ever paid by the insured client.

Q. What happens to the interest of the existing beneficiaries listed on the policy?

A. Each person having a beneficial interest in the policy must sign a "Consent to Transfer Policy and Waiver of Interest" form waiving all their interest in the policy before the transaction can be finalized. If the estate is the beneficiary of the policy, a copy of the will and any codicils is required. Heirs or assigns of the estate may be required to sign the same waiver, viatical settlement companies accept no clients unless the existing beneficiary of the Policy willfully and joyfully joins in the sale with the client insured.

Q. How does the insured know that his medical information is handled confidentially?

A. The law protects the insured. Viatical settlement companies never disclose medical information except as lawfully provided for in the Welfare and Institutions Code of the State of California under Article 6.6 (commencing with section 791) of Chapter 1 of Part 2 of Division 1, concerning confidentially of medical information.
Q. What if the policy has lapsed and has been reinstated? Does this affect the original two year waiting period?

A. If the policy has lapsed for a period of sixty (60) days or more, the two year waiting period starts over again from the date it was reinstated. If the lapsed time was less than sixty days, it does not affect the original two year waiting time.

Q. How is payment made?

A. Payment is made in a lump sum through bank wire transfer or with a certified check, or, at the insured client's option checks of various amounts can be made to any party or entity designated by the insured.

Q. What other options may be available to the insured other than an advance cash benefits program.

A. Viatical settlement companies encourages early professional financial planning, tax, estate planning and legal advice by those facing life threatening illness. Some insurance policies may offer accelerated benefits options and viatical settlement companies inquire into these options and fully inform the insured of any such alternatives. They seek maximization of benefits to the insured whether through an advance cash benefits program or any other option.

Q. What tax consequences need to be considered by participants in an advance cash benefits program?

A. Viatical settlement companies cannot and will not offer tax advice. Competent professional counsel must be obtained by the insured to review these matters as they may pertain to his personal situation and the current interpretation of the law by Federal and State authorities. Under the law, no records of this transaction are provided to taxing authorities.

Q. What are the possible consequences for the participant in an advance benefits program with regard to public assistance?

A. The law concerning these questions is in development and regulations are under review by various Federal and State agencies. Competent professional counsel should be obtained to review these matters as they pertain to the personal situation of the insured. Because income and resources are used by many agencies to determine eligibility for assistance, receipt of these funds could impact the eligibility of the insured.
Q. For what reasons would a terminally ill person want to participate in an advance cash benefits program?

A. 1. To continue the insured's health care at the highest quality;  
2. To retain the insured's independence and dignity by being financially able to select and pay for choices available;  
3. To be able to personally distribute the proceeds of their life insurance to friends, life partners, loved ones, ministries, charitable institutions, schools, hospitals, and organizations;  
4. To retire a debt.  
5. To take a memorable trip.  
6. To have the peace of knowing that the insured's insurance proceeds were distributed according to his wishes;  
7. To be able to share the joy with those receiving gifts. There are many other reasons for this decision. Whether it be as simple as a new car or a cellular phone each individual has a right to enjoy life to the fullest while he can. Viatical settlement companies exists to facilitate this goal.

Q. What is the procedure to determine if a policy can be purchased.

A. To determine if a policy and medical situation fall within acceptable guidelines, a questionnaire, medical authorization, and policy authorization must be completed, once received at the viatical settlement company, all medical records pertinent to the illness are gathered as well as confirming information about the policy. Once all records are received, a panel of physicians expert in the appropriate field review the records and then render an evaluation. Based on these options, a purchase price is calculated and the client is notified of the amount.

Q. What is the next step should the client decide that the purchase price is acceptable?

A. The purchase agreement is immediately forwarded to the client. Matters progress smoothly and rapidly from this point. Once the purchase agreement has been returned, signed by the insured, the trust, or escrow agent forwards the closing documents to the client insured's attorney. These documents consist of an explanatory cover letter, the Escrow Agreement, Statement of Sale, Viator's Statement, Special Power of Attorney, Consent to Transfer Policy and Waiver of Interest for the existing beneficiary to sign, and a Settlement Statement. Also included are the form provided by the insurance company to change the ownership and beneficiary of the policy to any party or entity designated by the viatical settlement companies. All signed forms are returned to the trust agent, who then forwards beneficiary and ownership change form to the insurance company to be recorded and filed. Once the endorsed changes are received by the trust agent from the insurance company, a certified check is delivered, usually by express mail.

Q. What is the average length of time to accomplish the sale of a life insurance policy?

A. It depends upon how soon the medical records and policy confirmation are received. Normally, it takes approximately six (6) to eight (8) weeks from beginning to end.
October 16, 1992

To: Viatical Settlement File

A client with whom Wayne Morris and I consulted two days ago called back with the following information:

1. The four viatical settlement companies with whom he's been dealing insist they are under no obligation to report the sale to the IRS and they do not.

2. The Bradley bill making life insurance sale proceeds tax exempt federally is on George Bush's desk now. (Client claims to have gotten this information from Millie, the most literate member of the Bush household. I find that dubious.)

3. SSA does have access to whatever info the IRS has, including the existence of bank accounts and deposits made therein.

Medi-Cal not & not income

SSJ lose one month of benefits

Kokkinis [Hayes Keeler
398.4363
Luxury Trust Keeler Trust]
VIATICAL SETTLEMENTS
LIVING BENEFITS CONTRACTS
STATE OF CALIFORNIA
AN OVERVIEW - FEBRUARY, 1992

VIATICAL SETTLEMENTS (vei, æ.tikal). Historical: A supply of money or other necessaries for a journey; a sum given or taken to cover traveling expenses. Oxford Dictionary

Viatical settlements have opened a financial door where one did not previously exist. Now a terminally ill person can turn a non-cash asset into cash when it is most needed.

Since 1989, when the first life insurance policy was viaticated for a terminally ill client, the concept of living benefits or viatical settlements has been gaining wide acceptance among insurers, terminally ill policyholders and third-party entrepreneurial firms. In exchange for an immediate cash payment to the policyholder, in an amount less than the policy death benefit, third-party firms take assignment of the life insurance policy as owner and beneficiary.

Until recently this new industry has largely been unregulated. The intent of this overview is to provide assistance in understanding a new piece of important consumer legislation and its affect on the terminally ill in California.

California legislation introduced by Assemblyman Steve Peace (D-San Diego) and approved by the Governor, expressly permits living benefits contracts between insureds and third parties transacting business in California. Prior law did not regulate transactions between the owner of a life insurance policy and a person or business wishing to enter into a living benefits contract.

According to the Senate Insurance, Claims and Corporations Committee analysis, the legislation alleviates some of the extreme financial burdens and economic duress placed on the terminally ill and their families.

The law requires that every person entering into or soliciting living benefits contracts be licensed by the California Department of Insurance (CDOI).

In addition the law makes the following provisions:
- Exempts from gross income the proceeds from a living benefits plan contract entered into with a third party.
- Exempts from gross income the proceeds from a living benefit program received from an insurance company.
- Excludes living benefit plan proceeds from the requirement for the withholding of tax.
- Specifies, within the definition of a living benefits contract, that such contracts do not include assignment of a life insurance policy to a licensed lending institution or credit union for a loan.
- Specifies that a living benefits contract shall not include a provision for payment of cash surrender values, loans or other benefits made by an insurer in accordance with the policy provisions.

The Code requires that before a living benefits contract or viatical settlement is entered into or executed, the person entering into a living benefits contract with the person with the catastrophic illness must first obtain the following:
- A written statement from the insured's attending physician that the person is of sound mind and under no constraint or undue influence.
- A duly witnessed signed document whereby the insured consents to the living benefits contract, acknowledges the catastrophic or life-threatening illness, represents that he

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723 Humboldt St., Santa Rosa, CA 95404 (707) 579-5303 1
or she has a full and complete understanding of the living benefits contract, represents that he or she has a full and complete understanding of the benefits of the life insurance policy, allows release of his or her medical records, and acknowledges that he or she has entered into the contract freely and voluntarily.

Living benefits licensees shall be required to disclose or advise any applicant for a living benefits contract, at the time of solicitation, of all of the following:

a) Possible alternatives to living benefits contracts, including, but not limited to, accelerated benefits options that may be offered by the life insurer.

b) Tax consequences that may result from entering into a living benefits contract.

c) Consequences for interruption of public assistance as provided by information provided by the State Department of Health Services and the State Department of Social Services under Section 11022 of the Welfare and Institutions Code.

The law provides that certain public assistance shall not be affected or reduced by reason of a failure to exercise an option to receive benefits under a living benefits provision or accelerated death benefit.

All medical information solicited or obtained by any person soliciting or entering into a living benefits contract shall be subject to California law concerning confidentiality of medical information.

Any person who enters into a living benefits contract shall have the absolute right to rescind the contract within 15 days of execution of the contract.


Sections 10113.1 and 10113.2 are added to the Insurance Code. The former defines the definition of a living benefits contract; the later applies to any person entering into or soliciting living benefits contracts.

Accordingly, on December 31, 1991, the CDOI issued a notice to all interested parties that in order to engage in the business of living benefits contracts in California as defined in CIC Sections 10113.1 and 10113.2 they must apply for a license by February 28, 1992.

Within the CDOI guidelines several issues are being dealt with. The licensing procedure and information required from viatical settlement companies includes: their organization and structure; financial statements; past experience; methods of obtaining medical information; viator's statement; copies of all forms used; disclosure and advice forms and the viator's rescission agreement.

The CDOI requires that the applicant describe their experience for the past three years on each case vitiacated. The data required is: policy face amount, amount paid, expected life expectancy at date of contract (in months), duration from date of contract to date of death (in days), date and amount of payment(s) to viator, date of death, age at death, cause of death and viator's state of residence.

Currently all information gathered by the CDOI is considered confidential and is not available to the public. The author of the legislation has indicated that past experiences should be made public to guide the consumer and will take action to make this information available.

For clients, the disclosure and advice section is one of the most important sections. It is vital that clients and benefits counselors understand the effects of receiving a negotiated settlement.

ALTERNATIVES: The persons entering into a living benefits contract must be informed of other options available to them before entering into a living benefits contract. It is the responsibility of the living benefits company to provide written information to a prospective client, at the time of contact, as to alternatives to a living benefits contract.

Among the options to a living benefits contract are:

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723 Humboldt St., Santa Rosa, CA 95404 (707) 579-5303
1. A loan from family or friends secured by the client's life insurance contract. Loans are not taxable income and cannot exceed usury fee regulations.

2. Accelerated benefit options available within the existing life insurance contract. If life expectancy is too long to meet the parameters of the insurance companies' accelerated benefits provision or the company does not have such a provision, then and only then, should a living benefits contract be considered. The viatical settlement company must take the responsibility to inform the client as to any accelerated benefit provision within their existing life insurance contract.

TAXATION: Section 17131.5 is added to the California Revenue and Taxation Code. Beginning on or after January 1, 1991, gross income does not include any amounts received by a person who enters into a living benefits contract.

Until legislation is passed, negotiated settlements should be treated as ordinary income for federal taxation purposes. The taxable amount would be the proceeds received less all premiums paid and dividends received plus the balance due on outstanding policy loans.

ENTITLEMENTS: Living benefits contracts have no effect on the eligibility for non-means based entitlements such as Social Security Disability, statutory short-term disability benefits and Medicare.

If the viator is receiving or plans to receive means-based entitlements such as Medi-Cal (Medicaid) Supplemental Security Income, or Needy Veterans Disability Pensions, receipt of a living benefit will disqualify the viator from eligibility until he meets the program's property reserve limits.

The intent of the bill's author is that proceeds received from a negotiated settlement should not be included in property reserve limits for state means-based entitlement programs. To date, federal legislation has not dealt with this issue. Until federal legislation is passed, property reserve limits still apply.

The State Department of Health Services and the State Department of Social Services are to prepare information on the impact of the receipt of funds under a living benefits contract as to eligibility to receive or continue to receive aid, assistance, or benefits from all federal, state, or other relevant assistance programs. This information is not yet available.

In order to understand the effects of current regulations, the receipt of living benefits proceeds and its effects on Medi-Cal, SSI and Needy Veterans Disability Pensions one must become familiar with each agency's property reserve limits and certain reporting requirements.

Property limitations vary from agency to agency and distinguish assets as exempt and non-exempt. Exempt assets usually include real property used as a home, life insurance policies, designated burial funds ($1,500 to qualify for SSI and Medi-Cal) and certain personal property. All agencies require that they be notified, in a timely manner, of any changes in an individual's financial status (for Medi-Cal, the time period is 10 days).

An individual may keep a certain amount of personal property, such as a checking/savings account or insurance policies, and still be eligible for Medi-Cal and SSI. Other personal property such as cash, stocks, bonds, cash surrender value of life insurance, etc., in excess of the property reserve limit, are considered nonexempt assets and are subject to the limits. The property reserve limits are $2,000 for one person and $3,000 for a couple.

The receipt of a negotiated settlement will increase property reserve limits. In order to maintain eligibility an individual may reduce his or her nonexempt property to within the specified limits in any way he or she chooses. It will be necessary to document expenditures that reduce property limits.

Medi-Cal recipients who maintain excess property reserve balances will have an increased share of cost in the months that the reserve exceeds the limits. It is possible with Medi-Cal to still continue to receive benefits even in the same month of receipt of a settlement. To qualify,
an individual's monthly average property reserve balance cannot exceed property reserve limits.

Supplemental Security Income (SSI) is based not just on a verifiable disability but also on a lack of income and resources. A negotiated settlement will disqualify the individual from receiving payments until reserve limits are met.

A viatical settlement exceeds the Needy Veterans Disability Pension property limits and is considered as "countable" income. Therefore the veterans benefits will be stopped. When assets have been spent down to meet the VA pension limits, the veteran must re-apply for his pension and will be subjected to a new 12 month waiting period to qualify for reinstatement of his pension (income received is annualized over a twelve month period). If a veteran renounces his pension in the month prior to receiving a settlement, receives and spends down the settlement the next month, they can then reapply to the VA with only a two to three month interruption of their pension. As of November, 1990, all veterans who receive benefits based on age only, become ineligible to renew their pension unless they can demonstrate that they now also have a disability.

Section 11021 is added to the Welfare and Institutions Code to state that as a condition of eligibility for or of continuing to receive aid, assistance, or benefits: a) the individual is not required to make an election to receive funds and b) by failure to make such an election, will not reduce the amount of aid, assistance, or benefits and individual receives, unless that individual would thereby exceed federal liability limits.

The passage of California's living benefits legislation has left many unanswered questions as to overlapping federal and state programs. Currently clients and counsellors must use their best judgement based on existing federal and state regulations.

BIBLIOGRAPHY

You May Be Able to Get SSI. US Dept. of Health and Human Services, Social Security Administration, SSA Publication No. 05-11069, April, 1990.
Accel. Benefits Clarification May Ride On Election Returns

BY STEVEN BROSTOFF
WASHINGTON—Insurance companies and agents are hopeful that legislation clarifying the tax status of accelerated death benefits will be on the Congressional agenda again next year.

"Both the Senate Finance Committee and the House Ways and Means Committee have indicated that they will work with us on the legislation in the next Congress," according to Janel Patterson, a representative of the American Council of Life Insurance.

Michael Kerley, vice president of federal affairs with the National Association of Life Underwriters, cautioned, however, that it will be difficult to determine the prospects for the legislation until after the November elections.

Many experts predict that more than 100 new faces will be elected to Congress this year.

A provision in the tax bill sponsored by Sen. Bill Bradley, D-N.J., would have clarified that accelerated death benefits are tax-free. However, Mr. Kerley noted, the provision was dropped from the tax bill when House and Senate conferees were unable to find a revenue offset to make up for any loss in tax revenue arising from the provision.

Sen. Bradley's proposal would apply retroactively to life insurance policies currently in force.

In the House, Rep. Barbara Kennelly, D-Conn., is backing an accelerated death benefits plan that would only apply prospectively to policies sold as of a certain date.

Both ACLI and NALU said they prefer Senator Bradley's approach that applies retroactively.

ACLI, NALU Favor Sen. Bradley's Retroactive Approach

Cont'd from Page 1

Cont'd on Page 27
David Petersen is 49 years old, retired and is terminally ill with AIDS. Formerly vice president of Peregrine Partners, Inc., he practiced as a fee-based personal financial planner specializing in planning for the terminally ill. He has counseled many clients with AIDS and one of his clients was the first person to viaticate his life insurance policy. He is Chair of the Gay and Lesbian Financial Planners Association and financial seminar leader for Body Positive, a support organization for people with HIV disease. He is a member of the IAFA and the Foundation for Thanatology, an organization dedicated to promoting grace and dignity in dying. Earlier, David was a tax accountant with Arthur Andersen & Co. He was educated in financial planning and economics at Claremont McKenna College, New York University and the London School of Economics. David can be reached at 212-371-4740, 429 East 52nd Street #4G, New York, NY 10022-6431.

Definitions

VIATICATE—to sell a life insurance policy to a third party (historically, to furnish with the things necessary for a journey).

VIATICUM—(plural, viaticas; pronounced vi-at-i-ka) Also called “viatical settlement,” the proceeds from the sale of a life insurance policy to a third party by a terminally ill individual. (Historically, an allowance for travelling expenses or provision for a journey).

VIATOR—the terminally ill seller of a life insurance policy to a third party (not the insurance company), a traveler, wayfarer.

VIATIONAL SETTLEMENTS—sale of a life insurance policy to a third party—should be distinguished from accelerated benefits wherein the policyholder receives early death benefits directly from the second party (the insurance company). (See JoAnn Canning’s article on accelerated benefits in this issue). Living benefits is used in this article to mean both accelerated benefits and viatical settlements.

Starting in 1989, the “viatical settlements” industry emerged. Companies in the industry pay cash (typically 60-80% of face amount) for life insurance policies of the terminally ill. Generally, the shorter the life expectancy, the more they pay. There are now eight operating firms in the new small viatical settlements industry.

• Affirmative Lifestyles, Inc
  1100 NW Loop 410, Suite 207
  San Antonio, Texas 78213
  800-876-2991
  President: Peggy Wallace, CFP

• American Life Resources Corp.
  2977 McFarlane Road
  Coconut Grove, Florida 33133
  800-633-9407
  President: Steven Simon

• American National Investors Corp.
  7612 Queensferry Lane
  Dallas, Texas 75248
  800-594-2168
  President: George Kimeldorf

• Life Benefits Corporation
  3490 South Dixie Drive #120
  Dayton, Ohio 4543
  800-367-1792
  President: Thomas Holtz

• Life Benefits, Inc.
  P. O. Box 161652
  Irving, Texas 75016
  800-969-6000
  President: W. Eddie Speed

• Medical Escrow Society, Inc.
  800 East Lakeview Avenue
  Eustis, Florida 32726
  800-422-1314
  Acting President: David Reed

• Southeastern Financial Management, Inc.
  220 Third Avenue
  Eastman, Georgia 31023
  800-537-1487 (GA only)
  912-374-2355
  President: Wendell W. McCranie

There has been an advertisement in the Village Voice for Lifeline (212-766-4549), but the person who answered the telephone refused to be interviewed for this article. I would suggest proceeding with Lifeline only with extreme caution.

Requirements

All the companies:

1. require that the insurance company be a quality carrier with a good reputation for paying death claims;

2. require that all persons having an ownership or beneficiary interest release their interest and waive future rights;

3. require applicants to release medical records for review;

4. require applicants to make a designation of irrevocable beneficiary in favor of the purchaser;

5. require that the policy be past the period specified in the contestability clause;

6. suggest that the applicant secure the advice and counsel of a financial planner, insurance professional, attorney and/or tax accountant before viaticating a policy;

7. have panels of medical experts to review the applicant’s medical records and to make independent estimates of life expectancy;

continued on page 19
Petersen, cont. from page 17

8. promise the maximum confidentiality consistent with what the companies need to disclose to do their job, and

9. specify a time period after settlement within which the seller has the right to undo the entire transaction.

Clients are sometimes unaware that if they have allowed a life insurance policy to lapse by not paying the premium, but have then applied for and been granted policy reinstatement, the contestable period starts all over again.

Life Benefits Corporation prefers policyholders with life expectancies of more than 20 months and has entered into transactions with viators with estimated life expectancies of as long as ten years.

The companies may require a statement from a psychotherapist that the seller is of sound mind and under no constraint or undue influence.

The companies prefer policies with face amounts of between $50,000 and $500,000, but will deal with other sources of cash should be investigated for the policy. Abast from a psychotherapist that the seller is of sound mind and under no constraint or undue influence.

As a practical matter, the most important variables used in calculating offering prices are:

1. Face amount of the policy;
2. Months of life expectancy;
3. Prime rate, and
4. Future premiums (if any).

No table of life expectancies by symptom pattern exists yet, but all the companies are working on the project (see chart on page 25). They hope to increase the viaticum percentage to the policyholder as time goes by.

If a person named as beneficiary refuses to release his/her interest and to waive future rights, the designation of beneficiary could possibly be changed by the policyowner to his/her estate, thus eliminating the beneficiaries' direct interest and rights to the policy. After a suitable time period she/he could then proceed with the sale of the policy. Be sure to check with the purchasing company before embarking on such a maneuver, though.

Some of the viatical settlement companies act as principals buying contracts for their own account; some act primarily as brokers. Depending on the availability of funds, the principals may, at times, act as brokers. Most of the viatical settlement companies are concerned that transactions be completed quickly for the seller. They feel that a viator should not have to wait until their investment funds arrive.

The administrative process involved in the sale of a life insurance policy is lengthy and complex; assume it will take three or four months from the first contact until the receipt of a check even if maximum use is made of fax and express mail.

Some insurance companies are slow to answer viatical settlement company questionnaires on the status of life insurance policies. The viatcating process may be further slowed down by insurance companies not respecting the insured's release. Information is sent directly to the insured instead of to the viatical settlement company.

There may be a period during the transaction after one has signed a designation of irrecoverable beneficiary naming the buying company and one has sold the policy giving up all the incidents of ownership, but one has not yet received the cash. Check to make sure that there is an escrow or trust arrangement.

Mechanics

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Appropriateness

I know you have clients to whom you have made strong recommendations for disability insurance, but who just would not make the decision to buy. With the client now terminally disabled, viatcating a life insurance policy is a particularly useful strategy when the client has life insurance and little or no long-term dis-

ability insurance.

The mere prospect of viating a life insurance policy may encourage beneficiaries with financial resources to consider making the terminally ill insured a loan secured by an irrecoverable beneficiary designation. The possibilities of such a transaction, as an alternative to viation, should be explored with each prospective seller.

Group Insurance

With most of the viatical settlement companies, group insurance coverage can become eligible once the applicant has converted it to an individual policy. For American Life Resources and Life Benefits Corp. to buy a group life policy, the group must be stable and the viatical settlement company must receive the conversion rights.

Group insurance has a number of people (insurance company, administrator, employer/association and insured) involved in the insuring process; each may make some unilateral decisions affecting the ability to viate a policy. Potential replacement of group insurance policies presents extra risks to the viatical settlement companies. Viatical settlement companies must secure a mechanism for receiving notification when a viator leaves a group so the viatical settlement company can exercise the conversion rights.

Some relatively minor provisions in group life insurance may present insoluable or, at least, major problems for viation. Some group policies are not subject to conversion until a participant has been in the group for five years. Some group policies—usually life-medical combined—can be assigned only as a gift but not assigned for value, thereby precluding viation. Yet other group insurance policies are not assignable to a corporation but assignment to an individual is permitted. Employer-funded life insurance under ERISA regularly has problems with assignability. One viatical settlement company estimates that a group life insurance viatical settlement is worth 5-7% less to the buyer than an individual life insurance policy because of the additional problems and risks.

In one particularly thorny case, the terminally ill person was, nevertheless, still working. The prospective viator's association group policy required that he leave the group in order to convert the life insurance to an individual policy which he could then viate. Leaving the

continued on page 21
group, however, also meant disqualification for retaining his association group disability insurance—Catch 22.

Taxes

Generally, the seller will be required to declare as taxable income the viaticum less all premiums previously paid plus all dividends received plus the amount of any outstanding loans at the time of sale. Life Benefits Corp. says it usually structures the transaction so that some portion of the death proceeds, even if small, are paid to the current beneficiary thereby not creating a total sale of the policy. LBC says that it is relying on the written opinion of counsel that its transactions are loans and, therefore, not taxable income to the seller. A viator should have his/her own tax counsel review the opinion. The IRS has not, yet, required viatical settlement companies to report purchase distributions.

Income taxes of viatical settlements may not be an issue for some viators. Terminally ill people probably have inordinately large medical deductions (unreimbursed medical expenses, deductible, co-insurance and medical insurance premiums) even when they have very good medical insurance. Viatical settlement proceeds and the medical expense deduction are netted on the income tax return before the tax is calculated. Each seller’s income tax projections must be reviewed as a part of the decision to viaticate a policy.

In some cases, particularly those involving small face amounts, the tax bite could be reduced by arranging an installment sale to spread the receipt of the viaticum over more than one tax year to take advantage of having the viaticum taxed in the lower brackets. This maneuver would, however, make the prospective solvency of the viatical settlement company an important issue.

For an insured who has a prospective taxable estate (more than $600,000) and the estate will include life insurance, it may not make much difference if the insured viaticates the life policy and pays the income tax instead of having the life insurance proceeds taxed in the estate.

Congresswoman Barbara Kennelly (D-CT) has introduced a bill (HR 134) to make pre-death proceeds directly from the insurance company (accelerated benefits) not subject to income tax for those with a life expectancy of 12 months or less.

Senator William Bradley (D-NJ) has introduced a similar bill in the Senate. Viatical settlements were not included in the original wording of the bills. If the bill is passed, it will probably not be until it is merged with many other tax related matters and addressed by Congress as an omnibus tax bill late in 1991. The viatical settlement companies have requested that viatical settlements be included in the proposed legislation.

Bankruptcy

Bankruptcy preceding the sale of a life insurance policy may cause the viator some problems. In some states the receipt of the “proceeds of life insurance” within, for instance, 180 days of the bankruptcy discharge are subject to the claims of creditors.

Entitlements

If a policyholder is receiving or plans to receive means-based entitlements such as Medicaid or Supplementary Security Income, receipt of a capital sum from the sale of a life insurance policy will disqualify the policyholder from eligibility. It is not clear yet whether such a person could retain eligibility for means-based entitlements if the policy were placed in a “luxury” trust which then sold the policy and proceeded to make distributions to the original owner for luxuries; the trust being prohibited from making distributions for necessities—food, rent, medical expenses. The unexercised option to sell a life insurance policy has no effect on eligibility for means-based entitlements. Selling an insurance policy has no effect on the eligibility for non-means-based entitlements such as Social Security Disability, statutory short-term disability benefits and Medicare.

Life Expectancy

The first step in investigating the feasibility of the sale of a life insurance policy is a frank and candid discussion about life expectancy with the primary care physician. The client should be encouraged to be brave about discussing the subject; there is a lot of money at stake. The physician’s sensibilities do not need to be protected; Medicare has, for years, paid for hospice care only on certification by the primary care physician that life expectancy was six months or less. Physicians are more used to dealing with life expectancy estimates than you might think. In order to start the process, viatical settlement companies will need to know life expectancy in the form of specific number of months or years, without modifying adjectives and no ranges. No “up to 12 months” or “from 2 to 5 years.” The physician will probably not be familiar with the concept of the sale of a life insurance policy, so the doctor will need to be briefed on the nature of the transaction and the irony (to medical ears) that the shorter the life expectancy, the more money the patient will receive. A vague or sugarcoated physician’s estimate of life expectancy will only slow down or derail the process of selling the policy. Of course, the physician’s estimate should be as accurate as possible; the applicant’s medical records will be reviewed by independent physicians retained (and paid for) by the viatical settlement companies. Affirmative Lifestyles has designed its program to obviate this discussion on estimated life expectancies by simply requiring a diagnosis of AIDS for those with HIV disease.

Reservations

Upon hearing for the first time about viatical settlements, some laymen are aghast at the “ghoulishness” of the concept. But, when I was in practice and advising seriously ill clients, I saw nothing but joy and rejoicing. “At last, someone out there understands what we are facing financially,” said one of my terminally ill clients. The viaticum meant removal of acute frustration with cashlessness, a concomitant lowering of immune-system-damaging stress and, in my opinion, a consequent lengthening of life itself. For other cases, viatica meant saving a home, the opportunity for memorable trip, the ability to keep a child in college. In short, the terminally ill find the possibility of viatication to be a godsend.

Indiana University Professor Joseph M. Belth (the self-appointed conscience of the insurance industry) points out that viatical settlement companies have no insurable interest which does, indeed, raise some moral issues. A number of people have wondered what would happen to this new industry and the viators if “hit men” were to enter the business. Caveat vendor! Of course, for centuries the insurance industry has itself no interest in life continuing for those receiving a disability income benefit or a life annuity. The insurance industry has not, however, made it a practice to “bump off”...
Petersen. cont. from page 21

those income recipients.

Belth also objected to what he perceived to be an inadequately low level of viatical settlement payout. However, in his calculations he made no allowance for the enormous risks these companies face—the prolongation of payment of interest and premiums for exceptional patients and, more importantly, the unknowable and immeasurable risk of projecting into an environment of rapidly developing life-extending treatments. Although a cure for some terminal illnesses may not be likely in the near future, a surprise medical research breakthrough would decimate these companies.

Viatical settlement companies also face a “litigation” risk—the possibility that a disgruntled ex-beneficiary will claim the death benefits even though the ex-beneficiary released his/her interests and waived right in the policy at the time it was viaticated.

The viatical settlement companies face the risk that interest rates will rise, thereby increasing their carrying costs. Of course, they will benefit if interest rates go down. This is a risk, of course, that can be hedged.

The offering price from a viatical settlement company is calculated to include these risks of a medical technological development, litigation and interest rate fluctuations along with the costs of future premiums, processing, independent medical review, collection (estimated), taxes and a reasonable profit.

That these companies make a reasonable profit is important in order for them to be able to attract additional capital into the business and buy yet more policies from the terminally ill.

Regulation

Living Benefits is regulated by the New Mexico Insurance Department under legislation passed in April, 1989. Except for New Mexico, the viatical settlement companies are unregulated. Indeed, they are not insurance companies.

Viatical settlements are legal in New York State. General advertising is permitted, but the viatical settlement companies are enjoined from direct solicitation in person, by telephone or by mail. The NYS Insurance Department has been monitoring the activities of the viatical settlements industry on an informal basis.

There appears to be some interest in viatical settlement legislation in Colorado, California, Washington (State) and New York. Aspects that may be covered in future legislation are:

1. Disclosure to prospective viators;
2. Licensure of viatical settlement companies;
3. Taxability of viatia;
4. Time limits for payment of viatical settlements after presentation of completed purchase documents;
5. Financial responsibility and solvency of those who pay viatical settlements over time;
6. Confidentiality;
7. Limits on double indemnity recovery;
8. How viatical settlements will interact with state public assistance programs;
9. Protection of interests of minor children or others dependent on the viator; and
10. Minimum amounts or percentages for settlements.

There is also a concern that living benefits (both accelerated benefits and viatical settlements) not be sold as an alternative or substitute for long-term care insurance.

In November, 1990, the New York State Assembly Standing Committee on Insurance—chaired by Howard Lasher—held hearings on living benefits (both accelerated benefits and viatical settlements) to explore what kind of legislation is appropriate and necessary. Governor Cuomo has encouraged legislation on living benefits.

Legislation will probably be passed only if and when some serious abuses have occurred. The humanitarian manner in which the existing viatical settlement companies have conducted themselves makes serious abuses relatively unlikely. Please contact me (and the NYS Insurance Department) if you encounter any abuses or untoward behavior on the part of any of the viatical settlement companies.

The Future

While viaticating a life insurance policy may be a very useful financial tool for any client with a terminal illness, the most aggressive viatiaors have been people with AIDS. To date, more than 90% of the policies bought by the viatical settlement companies have been from people with AIDS; most of the rest were from people with cancer. This new industry bought about $5 million (face value) of life insurance in 1989 and $40 million in 1990. I estimate that they will buy $100 million in 1991.

What’s In It For You

You, as an insurance professional, are a logical financial advisor for your insureds to turn to when the feasibility of viatication needs exploring and examining.

Until recently, the viatical settlement companies have not been paying commissions for agent referral of the occasional client. Now, however, with their capital financing in place, it seems that they are ready to discuss paying referral fees to agents who can provide a stream of policies for viatication.

If you charge fees for advice, your client will certainly get his/her money's worth for your advice. It is a new kind of strange transaction and your professional help can go a long way in relieving the anxiety that goes with a large non-recurring transaction. You can certainly be instrumental in shopping a policy around for the best offer or assisting your client to do so.

You can provide an extra service to your group life insurance clients if you analyze your proposed offerings for lack of restrictions on assignment of the group insurance and point out how these once-unimportant restrictions could now affect a group member in the future. It may even be worthwhile to review your group life contracts in force for making upgrade proposals.

Restrictions on assignment of group life insurance should now be included in life insurance reviews for individuals. The client may become more appreciative of the need for better individual life coverage.

If you happen to be the person who introduces a financially strapped terminally ill client to the concept of viatical settlements, you will probably be perceived as “walking on water” and you can bet that their friends and family are going to hear about your good deed.

And, of course, the existence of viatical settlements gives you a potent new arrow in your quiver of sales points when selling any life insurance policy. Viatical settlements are going to be available regardless

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<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Buy Pol. From + Direct Pay to SSI/Med. Recips. After Counseling</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Buys individually owned policies</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Buys group life policies</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Eligible policyholders</td>
<td>CDC-defined AIDS diagnosis</td>
<td>18 months or less life expectancy</td>
<td>24 months or less life expectancy (longer—on exception)</td>
<td>Health seriously impaired</td>
<td>24 months or less life expectancy</td>
<td>24 months or less life expectancy</td>
<td>24 months or less life expectancy</td>
<td>24 months or less life expectancy</td>
</tr>
<tr>
<td>Maximum purchase price ever paid as a % of face amount for a policy</td>
<td>73%</td>
<td>80%</td>
<td>70%</td>
<td>50%</td>
<td>65%</td>
<td>77%</td>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>Approx. number of policies bought</td>
<td>20</td>
<td>300</td>
<td>11</td>
<td>16</td>
<td>12</td>
<td>N/A</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Number of policies collected on</td>
<td>N/A</td>
<td>20</td>
<td>2</td>
<td>1</td>
<td>None</td>
<td>28</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>Requires that a disability waiver of premium be in effect</td>
<td>Depends on funding source</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*But typical payout amounts can be much lesser percentages due to legal, medical and administrative costs; interest rates; predictability/length of life expectancy; premium costs; quality and amount of policy; and investor considerations.

Sources: Firms’ responses to January 1991 telephone survey. Prepared by David Petersen and Thomas McCormack. Mr. McCormack is a nationally recognized expert on government entitlements programs and author of The AIDS Benefits Handbook published by Yale University Press.
Accelerated Benefits: The NALU Position

Issue

Accelerated benefit riders and provisions are a relatively new innovation in the use of life insurance. The issue is, what is the proper way to regulate these products in order to encourage continued growth of the market and innovations in the product?

Background

In anticipation of a growing public need that will continue to expand as longevity increases, the life insurance industry has responded by developing an innovative life insurance product option known as accelerated benefits. Accelerated benefit riders or provisions, permit cash advances against the death benefit of a policy under limited conditions related to the health of the insured, and typically allow terminally ill policyholders to access all or part of their death benefit.

While life insurance benefits could theoretically be accelerated for any reason, currently there are only three reasons for acceleration that are recognized and being implemented by the industry: long-term care, specified diseases and terminal illnesses. (Use of accelerated benefits for long-term care is regulated by the NAIC Long-Term Care Model Act and Regulation and is not being included in this discussion).

At its December 1989 meeting, the NAIC adopted accelerated benefits guidelines to assist state insurance departments in approving and regulating these new benefits. In further recognition of the growing use and importance of these products, the NAIC adopted an Accelerated Benefits Model Regulation at its December 1990 meeting. The model regulation is intended to apply to all accelerated benefit provisions of individual and group life insurance policies except for those policy provisions providing accelerated benefits for long-term care purposes, which are regulated under the NAIC's Long-Term Care Model Act and Regulation.

The model regulation permits accelerated benefit provisions to be either written into existing life insurance policies or attached to life policies as riders. Under the new regulation, "accelerated benefits" are defined as benefits payable under a life insurance contract during the lifetime of the insured in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions defined in the policy and which reduce the death benefit otherwise payable under the policy. The model regulation also sets forth the various qualifying events under which accelerated benefits would become payable.

Significantly, the model regulation states the NAIC's position that accelerated benefit riders and life insurance policies with accelerated benefit provisions represent mortality risks rather than morbidity risks. Accelerated benefit riders and provisions are life insurance, not health insurance benefits, and should not be marketed as health insurance. The regulation also contains various disclosure requirements which agents must meet when offering the product to clients. These requirements include disclosures regarding any additional costs for the product and the effect on a policy's cash value of any accelerated benefits payout. The regulation does not impose any restrictions on the use of the proceeds.

NALU Position

NALU feels the model regulation will encourage insurers to enter this market and NALU will continue to work with the NAIC and the life insurance industry to refine the regulation in light of advances that will undoubtedly continue to occur in the marketplace.

For further information, contact Gary A. Sanders, NALU staff, at 202-331-6026.

Petersen, cont. from page 25

of what New York State comes up with in terms of accelerated benefits legislation and regulation. For your uninsurable clients, the possibility of a viatical settlement may make guaranteed issue life insurance worth the premiums.

The new existence of viatical settlements expands the market for life insurance. Investment considerations aside, the traditional need to buy life insurance has related to cases where there were dependents to provide for or as a source of estate liquidity for large estates with few liquid assets. The advent of the viatical settlements industry has made having life insurance a new wise financial planning tool for virtually any healthy (insurable) adult. I hope you will review your client files and make another presentation to those clients who have been putting off their life insurance purchases.

With all the money being pumped into the terminally ill community, viatical settlements are a dynamic new tool in helping clients and, as a terminally ill person myself, I can assure you that viatical settlements are an enormously gratifying source of new funds to deal with a very expensive personal crisis.

Canning, cont. from page 15

difference between life insurance with an accelerated benefit rider and long-term care insurance, noting that his company's "Living Needs Benefit" (sm) was not long term care insurance nor was it being sold as an alternative to it. He noted that there are accelerated benefit products which provide long-term care coverage, but he stated that such products differed "fundamentally in their design from accelerated benefits that can be triggered by permanent confinement to a nursing home."

Therefore, in his opinion, a different regulatory approach might be required for living benefit products that provide long-term care benefits and are sold as such.

In conclusion, in an era when runaway health care costs make the prospect of financial crisis more than a remote possibility for many consumers who thought they were prepared to face any eventualities, the accelerated benefit concept has the potential for solving critical needs. As this product gains acceptance, policy definitions, the separation of policy types, tax issues, and financial planning applications are still unfolding. Regulators, legislators, insurance companies, agents and consumers will all have important roles to play in the future.

What's Inside

Articles on Living Benefits
- Accelerated Death Benefits 13
- Viatical Settlements 17
- Image Builders Campaign 5
- GAMA Gleanings 7
- CLU & ChFC Classes 7
- WLUC Upcoming Events 7

Other Articles
- Day On The Hill 9
- Think About It 33
- Scherago 39
- CLU Case Pointer 45
- One Man's Opinion 49
- MDRT: Panel Answers 49
- What's Happening 53
- Articles Of Interest 54
Affording Care
VIATIONAL SETTLEMENT COMPANIES - 27
SEPTEMBER, 1992

CA Dedicated Resources
Mike Zadoff - President
1650 Elmwood Ave.
Rochester, NY 14620
800/677-5026 716/244-1700
FAX: 1-716-244-4043

CA Estate Trust Co., Inc.
Michael Quinn - President
7400 York Road #300
Baltimore, MD 21204
410/828-1171
FAX: 1-410-296-2144

CA Financial Life Line, Inc.
Benjamin Samuels - President
21936 Nordhoff St.
Chatsworth, CA 91311
CA800/882-7936 818/882-7936
FAX: 1-818-882-7930

CA American Life Resources Corp.
CA Affirmative Lifestyles, Inc.
CA Living Benefits, Inc.
CA Lifetime Options, Inc.
CA National Funds for Life
Leon Chartalsky
415 N. Hoy 101
Solana Beach, CA 92075
CA800/339-9221 619/792-6125
FAX: 1-619-792-6124

CA Neuma, Inc.
David Binter - David Tepper
1007 Church St #314
Evanston, IL 60201
800/457-7828 708/866-1150
FAX: 1-708-866-1145

CA Independence Life The Access Program
Ansel Sisone - President
1875 Century Park East, Suite 2738
Los Angeles, CA 90067
800/235-6411
FAX: 1-310-556-7782

CA Affirmative Lifestyles, Inc.
Peggy Wallace, CFP - President
1100 Executive Park Dr., #311
Cincinnati, OH 45241
800/969-5740 513/769-5740
FAX: 1-513-769-5741

CA Legacy Benefits Corp.
Meir Elia - President
25 W. 34th St #1605
New York, NY 10122
800/453-4229 212/643-1190
FAX: 1-212-643-1180

CA Life Benefits Inc.
Eddie Speed - President
P.O. Box 161652
Irving, TX 75016
800/969-6000 214/869-2239
FAX: 1-214-556-1566

CA Q-Foil (formerly Life Benefits Corp.)
Thomas Holtz - President
3400 South Dixie Dr., Suite 120
Dayton, OH 45439
800/367-1792 513/294-7081
FAX: 1-513-299-7107

CA Assured Lifetime Benefits
Milton Heching - President
3420 West Arthur Ave.
Lincolnwood, IL 60645
708/675-8856
FAX: 1-708-675-6444

CA Life Today
Rick Perry - 2401 Fountain View #910
Houston, TX 77057
800/554-2104 713/977-5433
FAX:

CA LifeAID
Alan Kassnn, Esq. - President
15915 Ventura Blvd., #300
Encino, CA 91346
818/981-8812
FAX: 1-818-981-6681

CA Lifestyle Resources Corp.
Fran Welcom - President
P.O. Box 1665, Station C
Worcester, MA 01607-0665
800/835-2006 508/865-3002
FAX:

CA Viatical Funding Company, Inc.
Kenneth Klein, JD - President
220 Third Avenue
Eastman, GA 31023
800/537-1487 912/374-2535
FAX: 1-912-374-0173

CA American National Investors Corp.
George Kimeldorf - President
7612 Queensferry Lane
Dallas, TX 75248
800/594-2168 214/594-2168
FAX: 1-800-594-2168 Press 99

CA Viatical Settlemcnt Companies - 27
SEPTEMBER, 1992

CA American Life Resources Corp.
Steve Simon - President
930 Washington Ave
Miami Beach, FL 33139
800/633-0407 305/534-0101
FAX: 305/534-1020

CA Q-Foil (formerly Life Benefits Corp.)
Thomas Holtz - President
3400 South Dixie Dr., Suite 120
Dayton, OH 45439
800/367-1792 513/294-7081
FAX: 1-513-299-7107

CA Affirmative Lifestyles, Inc.
Peggy Wallace, CFP - President
1100 NW Loop 410, Suite 207
San Antonio, TX 78213
800/876-2991 512/341-2855
FAX: 1-512-341-0956

CA Aid for AIDS also VS, Inc.
Bill Crust - President
P.O. Box 15683
Kansas City, MO 64106-0683
800/786-7183 816/472-8383
FAX:

CA Assured Lifetime Benefits
Milton Heching - President
3420 West Arthur Ave.
Lincolnwood, IL 60645
708/675-8856
FAX: 1-708-675-6444

CA Assured Lifetime Benefits
Milton Heching - President
3420 West Arthur Ave.
Lincolnwood, IL 60645
708/675-8856
FAX: 1-708-675-6444

CA Conservative Life Benefits, Inc.
Alan Sternberg - Nancy Cane
1646 No. California Blvd. #220
Wnut Creek, CA 94596
510/932-3200
FAX: 1-510-932-5614

CA Lifestyle Options, Inc.
Craig Fishman - Vice-President
2700 South Quincy St., #540
Arlington, VA 22206
800/999-5419
FAX: 1-703-998-5470

CA Lifestyle Options, Inc.
Craig Fishman - Vice-President
2700 South Quincy St., #540
Arlington, VA 22206
800/999-5419
FAX: 1-703-998-5470

CA Life Today
Rick Perry - 2401 Fountain View #910
Houston, TX 77057
800/554-2104 713/977-5433
FAX:

CA Living Benefits, Inc.
Rob Worley, Jr - President
6100 Seagull Lane, Suite 108
Albuquerque, NM 87109
800/485-8790 505/883-4799
FAX: 1-505/883-4799

CA Medical Escrow Society
David Reed - Director
800 East Lakeview Ave.
Eustis, FL 32726
800/422-1314
FAX: 1-904-483-1505

CA National Funds for Life
Leon Chartalsky
415 N. Hoy 101
Solana Beach, CA 92075
CA800/339-9221 619/792-6125
FAX: 1-619-792-6124

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Leon Chartalsky
415 N. Hoy 101
Solana Beach, CA 92075
CA800/339-9221 619/792-6125
FAX: 1-619-792-6124

CA Notes:
The initials "CA" before a company's name indicates that they have applied to the California Commissioner of Insurance to be licensed to solicit or enter into living benefits contracts. The review of applicants and names is still in process and are subject to change. No licenses have been issued to date.

Inclusion on this list is in no way an endorsement. Names have been added solely by request of the individual company. The company may be in formation or may only be "brokering" (rather than buying policies for their own account). Securing multiple bids is recommended.

See your financial advisor -- personal financial planner, attorney, accountant or insurance broker -- for advice on choosing a viatical settlement company or companies, review of offers, income and estate tax consequences and the effect on means-based entitlements (Medicaid and SSI -- not SSDI and Medicare).

For additional information write to
Affording Care
365 West 52nd Street Suite 4B
New York, NY 10019
or call
John Darragh
(707) 579-5303
David Petersen
(212) 371-4741

CA Medical Escrow Society
David Reed - Director
800 East Lakeview Ave.
Eustis, FL 32726
800/422-1314
FAX: 1-904-483-1505

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FAX: 1-513-299-7107

CA Viatical Funding Company, Inc.
Kenneth Klein, JD - President
220 Third Avenue
Eastman, GA 31023
800/537-1487 912/374-2535
FAX: 1-912-374-0173
AFFORDING CARE

Providing financial education and information for the seriously ill and their financial advisors

SOURCES OF INSURANCE FOR UNINSURABLES

From The Irreversible Decline of Eddie Socket, a novel by John Weir, page 99:

Eddie thought of his clinician as Dr. Fillgrave. His clinic was listed in the "Where to Find It" section of the Village Voice. Prices were on a sliding scale, and confidentiality was assured. And it was conveniently located, too, in a low brick building in the West Village not far from the piers, and the trucks, and the old Mineshaft -- an easy commute, Eddie thought. But Dr. Fillgrave had a fixed bland expression beneath which percolated a bilious loathing, and he treated Eddie as if he were just another cadaver. "You'll last a good two weeks, don't worry, two years, maybe six years if you're lucky," he offered, helpfully, when all the blood had rushed out of Eddie's face and he thought he was going to faint, "unless of course you don't have health insurance, in which case, the quicker the better, eh?"

While the title is Insurance, we are also dealing with government entitlements and employer benefits. In fact, financial help can come from any or all the following:

1. Commercial insurance companies
2. Prepaid medical plans
3. Health maintenance organizations
4. Self-insuring employers
5. Government -- agencies and mandates

An insurance broker or agent is probably not the best advisor on securing insurance for uninsurables. Brokers/agents work on commission and their business is geared to selling insurance to insurables only. Brokers/agents know little or nothing about many of the ways to get insurance listed on the next page. Fee-based personal financial planners are the only type of counsellors who have the breadth of knowledge to deal with all the combinations and permutations.
<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>Disability</th>
<th>Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Individual insurance through a private carrier or prepaid medical plan</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>2.</td>
<td>Employer group insurance</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>3.</td>
<td>Group insurance through school</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Health maintenance organization</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Group insurance through associations, for example, professional, fraternal, alumni or union</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>6.</td>
<td>High risk insurance from over twenty state mandated high risk pools</td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
| 7. | Guaranteed Issue insurance  
   Medical plan -- Blue Cross Blue Shield  
   Life Insurance | x | x | |
| 8. | Hospital indemnity plan | x | | |
| 9. | Change residence to a country with a national medical insurance program | x | | |
| 10. | Spouse secures dependent medical coverage through spouse’s employment | x | | |
| 11. | Marriage to someone who, as a spouse, can qualify you for medical coverage | x | | |
| 12. | Adoption | x | | |
| 13. | Employee leasing company | x | x | x |
| 14. | Medicare (after 29 months of disability or after age 65) | x | | |
| 15. | Veterans Administration | x | x | |
| 16. | Social Security Disability | x | x | |
| 17. | Supplementary Security Income | x | | |
| 18. | Medicaid | x | | |
| 19. | Credit insurance | x | x | |
| 20. | State mandated short term disability | x | | |

MMFile: dsourcin 2
Brochure on Viatical Settlements (possible areas of discussion):

1. Business aspect of it. Comment on marketers that sound like Mom. Cold, hard business. You need to be equipped to deal.

2. If you can, get offers from at least five. Let them compete against each other for your business.

3. Not a quick fix. Takes time to go through the process.

4. Why do you want a viatical settlement? If it's to pay bills, attend the credit/bankruptcy clinic to see if you have other options for alleviating the financial stress. Maybe you're judgment proof. Or talk to consumer credit counselors. You may wish to file bankruptcy and clear your slate instead of viaticating and losing it all immediately to creditors.

5. Have you looked into other options? What about accelerated benefit? What about getting a loan from a friend or relative for a higher percentage? Start by talking to the beneficiary.


7. Get five sets of medical records right off the bat.

8. Taxation.


10. Qs and As to ask the companies.

11. Advice to make this part of more comprehensive financial planning.

12. Call ALRP or Garimendi with complaints.

13. What California law requires of VS companies.
What reason would a terminally ill person have for selling his or her life insurance policy?

Many interested individuals give the following reasons: to continue receiving quality health care; to ease financial strain; to afford the basic comforts of life and to meet daily living expenses; to distribute gifts to family, friends, or other special purposes; to take a special vacation; to live with financial independence.

Is there a special way to maintain selected benefits for a primary beneficiary and still sell a portion of my policy?

Yes. Viatical settlement companies should be familiar with this procedure. You make an irrevocable beneficiary designation for a portion of the proceeds designated to your beneficiary(s) of choice. The benefit will be paid by the life insurance company directly to your named beneficiary. You will receive copies of this documentation.

What are the requirements for viatical settlement companies to purchase a policy?

- Companies usually require that the insurance policy be beyond the contestability period that, in most cases, is two years.
- The insurance company’s rating by A.M. Best is one of the determining factors in a purchase.
- The viator has been diagnosed as having a shortened life expectancy (up to 48 months will be considered).
- The policy has a face value of between $10,000 and $2,000,000 (both lower and higher amounts will be considered).
- Anyone currently having an ownership and/or beneficiary interest in the policy must sign documents releasing their interest.
- If the policy is a group policy, it must have an irrevocable beneficiary, absolute assignment, waiver of premium, and/or convertibility options.

How much will I receive for my policy?

Every application we receive is reviewed individually, and regard is paid to your unique situation. Many factors are considered which include on-going premiums to be paid, life expectancy, interest rates, and the items listed in the previous question. Purchases by the viatical settlement companies are generally between 60-80% of the face amount of the policy, depending upon the factors mentioned. Payment is made by the purchasing company in a lump sum by wire transfer or by bank check whichever you prefer.

Do I have benefits such as this with my own insurance company?

You may. Some carriers offer accelerated benefits or living benefit riders to enable their insureds to convert policies early in the event of a terminal illness. Each insurance company has its own qualification requirements and amount of benefits to be paid. Generally, 6-12 month life expectancy, home health care or nursing home care is required, and total disability. Consider reviewing this directly with your carrier or through your financial planner, advisor, or insurance agent. The questionnaire we send to your insurance company also addresses this issue so that you have full-disclosure, thereby enabling you to make an informed decision.
Do I need to speak to an attorney or financial consultant?
Our Questionnaire and Application, Disclosure and other forms are straightforward. However, we recommend that you consult with your attorney, CPA, or financial planner about this transaction, as well as review your financial situation with your family and friends.

Will I have a tax liability on the proceeds I receive?
Under current Federal and many State tax laws, the sale of a life insurance policy may be taxable. Generally, tax is payable on the proceeds of the sale less total premiums paid. Prior to the presidential elections of 1992, there was a bill pending in Congress to make the proceeds tax-exempt. We look forward to the same opportunity with the new administration. We are not required to issue any notices of the transactions to tax authorities.

Will the sale of my life insurance policy result in an interruption of any public assistance I receive?
Yes, if the benefits are "means-based" (food stamps, Medicaid, SSI). This is an area where proper planning can be very helpful and we recommend you consult with an experienced financial advisor. Some transactions may be structured to prevent loss of means-based benefits. We recommend that you obtain information from the State Department of Health Services and State Department of Social Services.

Do you work with companies that purchase group insurance policies?
We do, provided that the policy can be irrevocably assigned and can be converted to an individually owned policy. A few companies will consider assignments of benefits even if the policies are not individually convertible or absolute assignment is not available. An irrevocable beneficiary designation and/or waiver of premium is required.

What if my policy has lapsed and been reinstated?
With most policies, if the policy has lapsed for more than 60 days the contestability period begins again as of the date of reinstatement. We would need to inquire how your policy works and determine its qualification.

Will selling my insurance policy affect my major medical insurance benefits?
In most cases, it will not since they are separate policies. We will review your current medical benefits with you if you wish.

Will I be responsible for paying any future premiums on my life insurance policy?
No. The purchaser will pay the premiums on your policy once they purchase the policy.

How will the cash value in my policy affect my settlement?
The cash value is included in the purchase price.

Do I have to be examined by other doctors?
Generally not. We require your medical records from your attending physicians and a short questionnaire and certification. The viatical settlement companies' physicians (specialists knowledgeable about your condition) will make their determinations based on your medical records and your physician's questionnaire.
Will my employer be contacted or notified of my medical condition?
Not without your permission. Included in the application package we send you, there are two forms (requiring your signature) authorizing us to contact your physicians and your insurance company. No one else will be contacted without your written approval. However, if the employer administers the group plan directly, contact with the benefits administrator or its agent may be required.

How much time does it take to complete the sale of the policy?
Generally, the processing time from when we receive your completed application and medical records to closing, is about two to six weeks. We do our best to expedite the matter and to obtain the information in reports from your physicians and insurance company as quickly as possible. We use FAX transmissions and regular telephone contact. We will call you within one day after we have received these reports. Please feel free to check on the status of your application at any time.

What if I change my mind after I have received my money from the viatical settlement company?
You have the right to cancel and rescind the sale within 15 days of signing the purchase agreement. You simply give notice to us and the company that purchased your policy. You return the principal amount paid for the policy within the 15-day period and the transaction is considered canceled. There are no penalties to you, no interest, and no reimbursement for any expenses.

How often am I contacted by the viatical settlement company, after the transaction is completed?
This is an area of much concern and sensitivity for everyone. Therefore, in this collaborative effort, the viatical settlement company and you will tailor this to your needs. You notify the company in the event you change your address and/or phone number. The settlement company will request that your executor, closest friend, and a relative be advised of this transaction, and that you request and authorize that they keep the company informed.

What advantages are there in utilizing the services of Benefit Advocates versus contacting the viatical settlement companies directly?
Every situation is unique. However, it will be a time-consuming process for you to contact the different viatical settlement companies, go through each of their application packages, and then for you to determine the best company with which to negotiate. Some companies have strict life expectancy requirements, minimum/maximum policy face amounts, and some will not purchase group term insurance. We are aware of the companies' specialties and preferences, and we select companies with proven performance in the areas of confidentiality and professionalism and who have applied for a license to comply with the California State Department of Insurance regulations.

We can save you time and unnecessary stress, with no fee paid by you ever!

For further information please contact

BENEFIT ADVOCATES ▼ A Viatical Settlement Advisory Service
(Offered by NCI Insurance Marketing Services, Inc.)
201 Spear Street · Suite 1600 · San Francisco · California · 94105
Phone (415) 435-8886 · (800) 435-8891 · Facsimile (415) 435-8881
April 16, 1993

Mr. Street
San Francisco CA 94109

Re: Policy Number: Insurance Company: 

Dear: 

I am pleased to confirm your acceptance of our offer to purchase your Policy for $ and appreciate your selecting The Access Program. Your satisfaction is important to me and I am committed to making this entire process as easy as possible for you.

The offer is subject to receipt by us of satisfactory verification of our insurance underwriting requirements. You have received an answer to our questionnaire. Please include it with the documents. I have enclosed the necessary closing documents with short instructions on how they are to be completed. The Change Forms should be in your possession. Call me to discuss their signature.

Please mail the signed documents back to me as soon as possible and I will hurry the confirmation of the change of ownership and beneficiary from the Insurance Company. When I have this confirmation in writing, I will rush payment to you. Please complete the Payment Instruction Form as it explains your payment options.

Once again, we thank you for deciding upon The Access Program. We are committed to serving the community, providing our clients with the best service, and recognizing the highest prices possible for policies. We sincerely hope that our dedication to these goals has been evident throughout your dealings with our company.

As always, if you have any questions, please call me.

Sincerely,

Philip Gershater

…Life with Independence, Dignity and Choice
FORMS TO COMPLETE THE SALE

1. Agreement for Sale of Policy - 4 Pages
   Sign this form as Seller and have your signature notarized.

2. Attorney's Certificate - 1 Page
   This is attached to the Agreement of Sale and is to be signed by your attorney.

3. Change of Beneficiary form (for recording with the Insurance Company).


5. Waiver of Claim form for each Beneficiary - 1 Page Each
   Under this form, the beneficiary waives any claims that he or she may have under the Policy.
   Each form is to be signed by the named beneficiary and notarized.

6. Acknowledgement form - 1 Page
   This form is to be signed by your Executor(s), Relative or Friend.

7. Payment Instruction form - 1 Page
   This form provides for the method and place of payment of the purchase price to you and is to be filled out and signed by you.

Remember to mail the above when completed together with the original Policy to:

Independence Life
1875 Century Park East, Suite 2738
Los Angeles, California 90067

...We are committed to being the Leader
AGREEMENT FOR SALE OF POLICY

Between

[Redacted] ("Seller")

and

INDEPENDENCE LIFE ("Buyer")

SALE OF POLICY

1. The Seller hereby sells, transfers and assigns to the Buyer and the Buyer hereby purchases and accepts the transfer and assignment of all the Seller's rights, title and interest in the Policy.

2. The Policy means the Seller's life insurance policy No. [Redacted], issued by [Redacted] (Insurance Company) with current face amount of [Redacted].

3. The purchase price for the Policy is $[Redacted].

4. The purchase price shall be paid immediately upon receipt by the Buyer of written confirmation from the Insurance Company confirming the change of ownership of and beneficiary under the Policy into the name of the Buyer, and nomination of the Buyer as the sole beneficiary under the Policy.

5. The purchase price shall be paid by wire transfer to the Seller's bank account (if provided to Buyer) or by cashier's check.

6. The Buyer shall be responsible for payment of premiums on the Policy from the date of signature of this Agreement.

DOCUMENTS REQUIRED TO COMPLETE SALE

This Agreement and the other forms enclosed need to be signed by the Seller and returned to the Buyer with the original of the Policy. This is a condition of the sale of the Policy and the closing of the transaction.

SELLER'S RIGHT OF CANCELLATION

1. The Seller has the right to cancel this Agreement within 15 days after the date of the Seller's signature hereof. The cancellation shall be effected by the Seller delivering written notice to the Buyer within the 15 day period cancelling the Agreement together with a bank cashier's check payable to Buyer for the full amount of the purchase price paid to the Seller, and any insurance premiums paid by the Buyer, together with interest from date of payment to date of repayment at the rate of 9% per annum.

2. Upon receipt of a the notice and bank cashier's check, the Buyer shall transfer the Policy back to the Seller, waive its claim as Beneficiary of the Policy, and return the original Insurance Policy to the Seller.
4. **ASSURANCES**

The Seller undertakes and represents to the Buyer (and each is material to the Buyer) that:

1. Seller is the owner and has good title to the Policy. Seller has the sole right to sell and assign the Policy free of any restrictions. The Policy is not subject to any loan, claim, or lien (except as expressly stated herein).

2. All premiums payable under the Policy have been paid to date and the Seller is not in default under the Policy.

3. Seller has not done anything or omitted to do anything which might prevent or limit the Buyer from becoming the owner of the Policy, or from receiving the full benefits of the Policy.

4. The Seller is not in bankruptcy and no tax or creditor lien has been filed against the Seller, and the Seller has not made any assignment for the benefit of creditors or other persons.

5. The answers given in the Application submitted by the Seller in connection with this transaction were true and correct on the date made, and are true and correct on the date hereof and there are no material omissions or non-disclosures of facts therein.

6. There are no facts relating to the Policy including its validity, or the Seller’s health, which are or may be material to a purchaser of the Policy, which the Seller has not disclosed in writing to the Buyer.

5. **GENERAL**

1. The Seller undertakes, whenever reasonably requested to do so, and not more often than once per year, to be medically examined by his physician, or if not available, any physician nominated by the Buyer, if so required by the Insurance Company for any proof of disability. The Buyer shall be responsible for any fees charged by the physician.

3. Ownership benefits and risks in the Policy passes to the Buyer upon the execution hereof, provided that the Buyer makes payment of the purchase price.

4. If any death or other benefits under the Policy are paid to the Seller (or Seller’s Estate), Seller (or Seller’s Estate) shall hold them upon trust for the Buyer and shall immediately deliver them to the Buyer in the form in which Seller receives them.

5. This Agreement and the rights and obligations of parties shall be governed by the laws of the State of California.
This Agreement shall inure to the benefit of the Buyer and its successor and assigns, and shall be binding upon the Seller and his executors, administrators, personal representatives, heirs, former beneficiaries and successors in interest.

Any changes to or waiver of any provision of this Agreement shall be in writing signed by the party against whom enforcement of the change or waiver is sought.

The prevailing party shall be entitled to recover from the unsuccessful party all costs, litigation and other expenses and attorneys' fees relating to or arising from the enforcement or interpretation of this Agreement.

If the Buyer fails or delays to exercise any rights, such failure or delay shall not operate as a waiver of such rights. A single or partial exercise of any right shall not preclude any other or further exercise of any such right.

If any provision of this Agreement is held to be invalid or unenforceable, it shall be severable from the rest of this Agreement and the remaining provision shall be valid and enforceable.

All agreements, representations and undertakings made herein shall be deemed to be made as of the date hereof and the date of payment and shall survive the closing of the transaction.

The Seller undertakes to do anything and sign any documents that the Buyer may consider necessary or desirable to give effect to this transaction.

The Policy shall include all right, title, interest, benefits, claims, options, privileges in and under the Policy given to the owner and beneficiaries, including in particular (a) the right to receive the full death benefits under the Policy; (b) the right to assign any and all rights received under this assignment; (c) the right to designate and/or change the beneficiary or beneficiaries under the Policy; (d) the right to exercise any right and privilege to purchase any additional insurance for which I may become eligible under this Policy; (e) the right to any benefits, claims, dividends, options, advantages whether given to the Insured and/or any beneficiary; (f) the right to receive the indemnities and benefits of such insurance; (g) the right to submit the notice of claim, proofs of loss, and proofs of disability required for entitlement to or continuance of such insurance.

Whenever the context so requires in this Agreement, all words used in the singular shall be construed to have been used in the plural (and vice versa), each gender shall be construed to include any other genders, and the word "person" shall be construed to include a natural person, a corporation, a firm, a partnership, a joint venture, a trust, an estate or any other entity.

Seller acknowledges that he has been given the opportunity to obtain independent legal and other counsel with regard to this transaction.
6. [Redacted] authorizes the release to Independence Life or its authorized agents of any information that Independence Life may request from any third party regarding his medical condition and/or his personal, financial or credit affairs, including from his Medical Practitioner(s) and/or his Executor(s). The Seller confirms that [redacted] is the person nominated by him as Executor(s) in his will and that the Executor(s) is/are aware of the nomination. The Seller is entitled at any time to change his Executor.

7. I, [redacted] appoint the President or other Officer for the time being of Independence Life located at Los Angeles, California, as my attorney in fact to act in my place (a) to assign and transfer the ownership and beneficiary interest in my Policy to Independence Life, (b) to establish my disability under the Policy, including without limit to apply for any waiver of premium available due to my disability, to apply to be classified as "disabled", and to require my medical practitioner to complete any forms required for proof of such disability, but not more often than once per year. I grant to my attorney full authority to act in any manner proper and necessary to carry out the foregoing purpose, including the full power of substitution and revocation, and undertake to ratify every act that my attorney may lawfully perform in exercising those powers. I intend this power of attorney to be coupled with that interest. Any expenses shall be paid by the Buyer. I declare this power of attorney to be irrevocable.

8. THE SELLER, AS OWNER OF THE POLICY, HEREBY CONSENTS TO THIS AGREEMENT, AND CONFIRMS, REPRESENTS AND ACKNOWLEDGES THAT HE FULLY UNDERSTANDS THE TERMS OF THIS AGREEMENT AND ITS LEGAL EFFECT AND THE TERMS OF THE POLICY AND THE BENEFITS THEREUNDER, AND THAT HE IS ENTERING INTO THIS AGREEMENT AND IS SELLING THE POLICY/LIFE INSURANCE BENEFITS FREELY AND VOLUNTARILY AND IS NOT UNDER ANY CONSTRAINT OR UNDUE INFLUENCE, AND IS AWARE OF HIS LIFE THREATENING ILLNESS.

_________________________  ________________________________
DATE                        SELLER

_________________________
DATE                        By: ______________________________________

_________________________
DATE                        BUYER: Independence Life

Notary Certificate for Seller's Signature:

STATE OF __________________________ )
) SS:
COUNTY OF __________________________ )

On this day, before me, the undersigned, personally appeared, [redacted], personally known to me, (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he executed it.

Witness my hand and official seal on the ______ day of _______________ 199_.

My Commission Expires: ________________________________

Name and Address: ________________________________

_________________________
[seal]
I, the undersigned hereby certify that:

1. I am an attorney at law duly licensed and admitted to practice in the State of California.

2. I have been consulted by [Name of Client] as a client (Client) in relation to the sale by him of his Life Insurance Policy to Independence Life under an Agreement to which this Certificate is attached. The Life Insurance Policy means Policy No. [Policy Number] issued by [Insurer], on the life of [Insured].

3. I have explained the legal effect of the Agreement to the Client. The Client has acknowledged to me that he understands the legal effect of the Agreement and is willing to enter into the Agreement.

4. In my opinion, the Client is of sound mind and is entering into the Agreement freely and voluntarily.

DATED: ____________________________

Signature of Attorney

Attorney's Name: ____________________________

Address: ____________________________

Telephone No.: ____________________________
I  

WAIVER OF CLAIM  
(Executed by the Beneficiary)

1. I am the named beneficiary under the Policy. The Policy means Policy No., issued by , on the life of .

2. I hereby waive and renounce forever any rights, claims, interest, powers and privileges that I may now have or may at any time in the future possess in, under or arising from the Policy or any proceeds derived therefrom.

3. I consent (insofar as may be necessary) to the owner of the Policy selling the Policy to Independence Life and assigning all rights, title and interest in and to the said Policy to Independence Life.

4. I acknowledge that I have been given the opportunity to consult with independent legal or other counsel with regard to both the form and content of this waiver.

_________________________________________  
Address

_________________________________________  
Telephone Number

STATE OF ) SS:  
COUNTY OF )

On this day, before me, the undersigned, personally appeared , personally known to me, (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he executed it.

Witness my hand and official seal on the ______ day of ___________ 199_.

My Commission Expires:  
_________________________________________

Notary Public in and for the said state

[seal]
I

TO: INDEPENDENCE LIFE

PAYMENT INSTRUCTIONS

I hereby authorize and instruct you to pay the net purchase price of $[ ] for the sale of my Policy to you as follows:

Please indicate

(1) By cashier's check
    Made payable to: [ ]
    Mail to: [ ]
    San Francisco CA 94109

    or

(2) By wire transfer
    to Bank: [ ]
    Address: [ ]
    Account No.: [ ]
    Routing No.: [ ]

    or

(3) As follows: [ ]

Witness Signature: ____________________________
Witness Name (Please Print): ____________________________
Signature: ____________________________
Date: ____________________________
TO: INDEPENDENCE LIFE

Dear Sirs:

I confirm that I have been nominated by [Name] as the Executor in terms of his Will or that I am a relative or close friend of [Name].

I acknowledge that [Name] has sold a life insurance policy to Independence Life and I undertake that in the event of the death of [Name], I will immediately notify Independence Life and provide them with a certified copy of the death certificate within 21 days of the date of death.

Witness Signature

Witness Name (Please Print)

Witness Address

Telephone Number

Date
REQUEST FOR CHANGE OF BENEFICIARY AND/OR OWNER TO

- THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES
- EQUITABLE VARIABLE LIFE INSURANCE COMPANY
- EQUITABLE OF COLORADO

SEPARATE FORMS MUST BE SUBMITTED FOR EQUITABLE, EQUITABLE VARIABLE, AND EQUITABLE OF COLORADO REQUESTS FOR CHANGE OF BENEFICIARY AND/OR OWNER:

DO NOT RETURN THE POLICY WITH THIS REQUEST

BEFORE COMPLETING THIS REQUEST, PLEASE READ THE INSTRUCTIONS ON THE COVER PAGE AND THE PROVISIONS ON THE REVERSE SIDE OF THIS FORM.

POLICY NUMBER(S): ____________________________

INSURED/ANNUITANT'S NAME

CHANGE OF BENEFICIARY: YES ☐ NO ☐

FULL NAME OF NEW BENEFICIARY, RELATIONSHIP TO INSURED/ANNUITANT, ADDRESS OF ALL NAMED BENEFICIARIES, AND SOCIAL SECURITY NUMBER

INDEPENDENCE LIFE

CHANGE OF OWNER: YES ☐ NO ☐

FULL NAME OF NEW OWNER AND RELATIONSHIP TO INSURED/ANNUITANT

INDEPENDENCE LIFE

THIS CHANGE IS SUBJECT TO THE PROVISIONS ON THE REVERSE SIDE

Owner's Address: If applicable, check one and complete.

Address of NEW OWNER is: ☐ Change address of SAME OWNER to:

C/O 1875 CENTURY PARK EAST #2738

Los Angeles CA 90067 Apt./Suite/Bldg.

City State Zip + 4 Code

Signature of Present Owner (if present Owner is not the Insured/Annuitant, see signature requirements on cover page.)

Signature of New Owner

SUBSTITUTE FORM W-9 — FOR NEW INDIVIDUAL OWNER ONLY

Federal Law requires that you provide the following Data (see reverse side for explanation):

PART ONE — Enter your taxpayer identification number in the appropriate box. For most taxpayers, this is the Social Security Number. For most Corporations and Trusts, this is the Employer Identification Number:

Social Security # _______ OR Employer I.D. Number 3408 89 409

PART TWO — Check the box if you are NOT subject to backup withholding under the provisions of section 3406(a)(1)(c) of the Internal Revenue Code.... ☐

CERTIFICATION — Under penalties of perjury, I certify that this information is true, correct and complete.

Signature of New Owner

FOR EQUITABLE/EQUITABLE VARIABLE/EQUITABLE OF COLORADO USE ONLY

The Equitable/EQUITABLE VARIABLE/EQUITABLE of Colorado certifies that this change has been recorded.

Date: _________________________ By: _________________________

IMPORTANT: Please use typewriter or ball point pen. Press firmly since entries must be legible on both parts. Avoid erasures or alterations. When this page and its duplicate are completed, send both completed copies to us. When we have recorded the change, we will return a copy of the form signed by us as evidence of the change.
PROVISIONS

The words "Insured and Annuitant" and "Policy and Contract" are used interchangeably in this form.

Beneficiary

Unless otherwise requested on the reverse side: (a) if two or more persons are named as beneficiaries, those surviving the Insured will share equally; (b) if no stated beneficiary is living when the Insured dies, we will pay the benefits to the children of the Insured who then survive, in equal shares, or if none survive, to the estate of the last to die of the Insured.

Unless otherwise requested on the reverse side, if the beneficiary designation is on a Family Plan Insurance Provision, Retirement Insurance rider on an Additional Insured, or Children’s Term Insurance rider, such designation will apply only to insurance on the life of the Insured.

Unless otherwise provided, installments due after the death of the Insured under an installment type policy or provision will be paid when due to the beneficiaries, if then living, in the order named. A beneficiary who is not a natural person (such as a corporation) or who is a fiduciary will receive payment in one sum.

If a Trustee(s) under a Will is named as beneficiary, and if before payment, the Equitable/EQUITABLE VARIABLE/EQUITABLE of Colorado receives proof satisfactory to it of the admission to probate of a Will creating no such trust, or of the termination of such trust, or of a Will other than the one designated, or of the appointment of a personal representative in intestacy, we will pay the benefits to any succeeding designated beneficiaries if living when payment is due, or should none then be living, to the estate of the last to die of the Insured and the designated beneficiaries.

If any part of the beneficiary change request includes a per stirpes designation, we will pay any benefits under this part equally to the beneficiaries in this designation. However, if any of these beneficiaries dies before the Insured, the deceased beneficiary’s share will be paid equally to his or her surviving children. If there are no surviving children, this share will be paid equally to the other surviving beneficiaries to the per stirpes designation.

If the beneficiary designation includes a Deferral (Common Disaster) Period, we will pay the benefits to the beneficiaries in the order named only if living at the expiration of the stated number of days after the death of the Insured. If no designated beneficiary is living after the number of days stated, we will pay the benefits to the children of the Insured who then survive, in equal shares, or if none survive, to the estate of the Insured.

A change of beneficiary shall revoke any previous beneficiary designation or election of a payment option.

Owner

The owner can exercise all of the rights in the policy while the Insured is living, without the consent of anyone who has only a conditional or future ownership interest in the policy. The term “Owner” shall mean the person in whom “Policy Rights” are vested. Unless otherwise requested on the reverse side: (a) if two or more persons are named as owners, the policy will be owned jointly or by the survivor; (b) if all persons named as owners die before the Insured, the owner will be the estate of the last such person to die.

An owner who is a minor may not exercise ownership rights except as permitted by law.

This change shall be subject to any assignment in effect and on file with us.

Correct Tax Basis — When the ownership of a policy is changed, the Equitable/EQUITABLE VARIABLE/EQUITABLE of Colorado should be furnished with documentation that would allow us to adjust the new owner’s cost basis in the policy. These documents could consist of (1) copies of 1099’s that were filed by the previous owner, (2) copies of documents showing the PSS88 rates that were used each year, (3) photocopies of any checks written by the new owner that were used to purchase the policy from the old owner. Failure to supply the necessary information may subject the new owner to unnecessary tax liability on subsequent financial transactions. (4) If there is a loan on the contract, indicate who received the proceeds.

Important Notice to New Individual Owner(s) Concerning Taxpayer Identification Number

Beginning January 1, 1984, Federal Law requires payers to generally withhold 20% of taxable interest and certain other payments to payees who are subject to backup withholding. As new owner, you may be the payee of future taxable payments and will be subject to backup withholding if:

1. You fail to furnish your taxpayer identification number to the payee. (For most individual taxpayers, the taxpayer identification number is their social security number.)

2. The Internal Revenue Service notifies the payee that you furnished an incorrect taxpayer identification number.

3. You are notified by the Internal Revenue Service that you are subject to backup withholding under section 3406(a)(1)(c) of the Internal Revenue Code because you underreported interest on dividends or you were required to but failed to file a return which would have included a reportable interest or dividend payment.

4. For an interest or dividend earning policy/contract issued after December 31, 1983, you fail to certify to the payer that you are not subject to backup withholding under (3) above.

If two or more individuals are listed as owners, the taxpayer identification number or social security number of the first owner listed should be provided.

In case of a minor, the minor’s social security number must be provided. If the minor does not have a social security number, the natural guardian for the minor owner may obtain one by applying to the social security Administration on Application Form SS-4. If the newly acquired number is not received by Equitable/EQUITABLE VARIABLE/EQUITABLE of Colorado within 60 days, Equitable/EQUITABLE VARIABLE/EQUITABLE of Colorado is required by law to withhold 20% of any taxable interest being credited to the policy/contract.
History

accelerated benefit - viatical settlement

0. V.S. problematic as a quick fix
   look @ credit counseling, bankruptcy
   option.

June 25 UCSF Affording Care Roundtable

ASK RE: non-profit viat consortia?

Recommend 5 bids minimum
Bid them against each other.

LAW

Only NM, CA, KA (1992)

CA - viat. sett. exempt from gross
income
3 pieces of legislation re accelerated benefits.
A new one carried by Barneu.
Frank includes viat settlement,
If so is in holding pattern, pending legislation. But even if they finalize the proposed rega,
it will only include viat settlement.

VS cos don't issue 1099s. Not considered payable income but more like purchase of equiments, contracts, securities.

Entitlements:
If VA non-service connected pension, Resources are viewed over a 12-mo period. So screwed.
Unless assign the pension,
Get the money, spend down, reactivate the pension.

Feedback
ATTENDING VIATICAL SETTLEMENTS FORUM JUNE 8:

Scott Gursky
Emily Doskow
Wayne Morris
Wendy Bolker (Affording Care board)

Keller Young
Roger Gross
Terri Tessicini
John Snipes 472-5551
Denise Rosales 973-6352
Gary Hum
Denina Rios

CAN'T ATTEND, WANTS TAPE OR MATERIALS:

John Rosenzweig
John Darragh

John Darragh has been a practicing comprehensive financial planner since 1977. In 1986 John was informed that he was HIV positive and has been living with AIDS since 1988. Retiring in 1989, he currently lectures nationally and counsels individuals, professionals and organizations on financial planning for those facing life-threatening illnesses. Recognized as a specialist in financial planning and serious illness, he has had numerous articles published and is often quoted in the national media. He is considered to be one of the foremost national authorities on viatical settlements and acts as an advocate for the seriously ill on legislative, insurance and taxation issues.

Mr. Darragh serves on the board of directors of Affording Care, the national financial education and information center for serious illness. Affording Care seeks to empower individuals living with serious illness to make positive financial choices -- enabling them to afford good care and a better quality of life.

Mr. Darragh is a registered principal with Protected Investors of America, a securities broker/dealer and Registered Investment Advisor. He is a past president and a past chairman of the North Bay Chapter, International Association for Financial Planning, and served on the board of directors for six years. He is a former state director of the California Association for Financial Planning, Inc. He has served on the Select Interview Committee for the Registry of Financial Planning Practitioners. John is a member of The Practitioner Division of the IAFP. He is also a member of The American Institute of Life-Threatening Illness & Loss, a division of The Foundation of Thanatology, an organization dedicated to promoting grace and dignity in dying.

John has been a member of the Golden Gate Business Association since 1979. He is a past director of the Russian River Gay Business Association. He was the financial commentator of the internationally syndicated National Gay Network, the program that "broke the silence".
SAN FRANCISCO

State Licenses Companies Offering 'Living Benefits' for Terminally Ill

California became the first state in the nation Monday to license companies that offer terminally ill clients a chance to cash in on their life insurance policies before they die.

Insurance Commissioner John Garamendi said the state issued licenses to three companies in an effort to tighten regulation of the growing "living benefits" field.

Under such arrangements, a company buys a life insurance policy at a discount from a terminally ill client, often an AIDS or cancer patient, who gets a substantial percentage of the policy's benefits. In exchange for managing the policy and paying its premium, the company — which has been named beneficiary — collects the remainder of the benefits once the client dies.

"The terminally ill not only deserve to die with dignity but also deserve to live out their remaining days with some assurance that their financial needs are going to be met," Garamendi said.

Currently there are 46 insurance companies nationwide specializing in viatical settlement contracts, up from only six in 1989. In other states, the companies are regulated but not licensed.

Among the requirements for licensing, Garamendi said, companies must show solid financial resources, keep medical records confidential, have a history of providing sufficient payments and show how the amount of payment is determined.

The three companies receiving a license in California are American Life Resources Corp. of Miami Beach, Fla., Neuma Inc. of Illinois and Living Benefits Inc. of Albuquerque, N.M.

Associated Press
§ 10113

§ 10113. Policy to contain entire contract
Collateral References:
Innocent misrepresentation of physical condition by applicant for life or health insurance. 23 Am Jur Proof of Facts 2d 53.
Doctrine of unconscionability as applied to insurance contracts. 86 ALR3d 862.
3. Coverage
Heart attack following exertion or exercise as within terms of accident provision of insurance policy. 1 ALR4th 1319.

NOTES OF DECISIONS
7. Payment of Premiums
Correspondence between an insurer and insured with issuance of a life insurance policy, in which the parties agreed that the renewal premium would be $6,840 rather than $7,485, was supported by consideration or a legal substitute therefor, where the insurer's agent misrepresented the amount of the renewal premium to the insured as $6,840 and the insured never agreed to pay $7,485 as the annual renewal premium. When plaintiff received the policy and discovered the premium was quoted as $7,485, it was under no legal obligation to accept or retain the policy, but had the legal right to return the policy and demand repayment of the first year's premium, and, after receiving a letter from the insurer promising to accept $6,840 as the annual renewal premium, plaintiff refrained from exercising its legal rights, retained the policy and thereafter paid the specified premium for the remaining term of the policy. Such conduct on the part of the insured, if bargained for, constituted consideration; if not bargained for, it constituted a reasonably expectable and substantial change of position in reliance on the promise of the insurer sufficient to invoke the doctrine of promissory estoppel as a legal substitute for consideration. Homestead Supplies, Inc. v Executive Life Ins. Co. (1978) 81 CA3d 978, 147 Cal Rptr 22.

§ 10113.1. "Living benefits contract"
(a) As used in this section, a "living benefits contract" means an agreement entered into between a person owning a life insurance policy upon the life of a person with a catastrophic or life-threatening illness or condition and another person by which the policy owner receives compensation or anything of value less than the death benefits of the insurance policy in return for an assignment, transfer, sale, devise, or bequest of the death benefits or ownership of the insurance policy, but does not include an assignment of a life insurance policy to a licensed lending institution or credit union as collateral for a loan.
(b) A living benefits contract shall not include a provision for payment of cash surrender values, loans or other benefits made by an insurer in accordance with the policy provisions.
(c) Any person entering into a living benefits contract with any person with a catastrophic or life-threatening illness or condition shall first obtain the following:
(1) A written statement from a licensed medical practitioner attending the person that the person is of sound mind and under no constraint or undue influence.
(2) A duly witnessed signed document in which the person consents to the living benefits contract, acknowledges the catastrophic or life-threatening illness, represents that he or she has a full and complete understanding of the living benefits contract, that he or she has a full and complete understanding of the benefits of the life insurance policy, a release of his or her medical records, and acknowledges that he or she has entered into the contract freely and voluntarily.
(d) No person domiciled, residing or conducting business in California may do any of the following unless he or she has complied with subdivision (c):

§ 10113.2

(1) Enter into a living benefits contract with any person, domiciled or residing in California.
(2) Execute a living benefits contract in whole or in part in this state.
(e) A violation of this section is a misdemeanor.

Note—Stats 1990 ch 1387 provides:
SEC. 7. The Insurance Commissioner shall report to the Legislature, on or before December 1, 1994, on the number of persons doing living benefits business in California; the number of living benefits contracts in California; the fairness of the discount rate in the living benefits contracts; and recommendations for legislative action for consumer protection.

§ 10113.2. Application of section; Licensing requirement; Filing of living benefits contract forms; Disclosures; Alternatives; Investigation; Orders; Penalties
(a) This section applies to any person entering into or soliciting living benefits contracts pursuant to Section 10113.1.
(b) (1) No person may enter into or solicit living benefits contracts pursuant to Section 10113.1 unless that person has been licensed by the commissioner under this section. The person shall file an application for a license in the form prescribed by the commissioner, and the application shall be accompanied by a fee of one thousand dollars ($1,000). The applicant shall provide any information the commissioner may require. The commissioner may issue a license, or deny the application if, in his or her discretion, it is determined that it is contrary to the interests of the public to issue a license to the applicant. The reasons for a denial shall be set forth in writing.
(2) Whenever it appears to the commissioner that it is contrary to the interests of the public for a person licensed pursuant to this section to continue to transact living benefits contracts business, he or she shall issue a notice to the licensee stating the reasons therefor. If, after a hearing, the commissioner concludes that it is contrary to the interests of the public for the licensee to continue to transact living benefits contracts business, he or she may revoke the person's license, or issue an order suspending the license for a period as determined by the commissioner. Any hearing conducted pursuant to this paragraph shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearing may be conducted by administrative law judges chosen pursuant to Section 11502 or appointed by the commissioner, and the commissioner shall have the powers granted therein.
(3) Each licensee shall owe and pay in advance to the commissioner an annual renewal fee of one hundred seventy-seven dollars ($177). This fee shall be for annual periods commencing on July 1 of each year and ending on June 30 of each year, and shall be due on each March 1 and shall be delinquent on and after each April 1.
(4) Any licensee which intends to discontinue transacting living benefits contracts in this state shall so notify the commissioner, and shall surrender its license.
(c) A living benefits licensee shall file with the department a copy of all living benefits contract forms used in this state. No licensee may use any contract in this state unless it has been approved by the commissioner. Any contract form filed with the commissioner shall be deemed approved if it has not been disapproved within 60 days of filing. The commissioner shall disapprove a
§ 10113.2 INSURANCE CODE

contract form if, in his or her discretion, the contract, or provisions contained therein, are contrary to the interests of the public, or otherwise misleading or unfair to the consumer. The commissioner may rescind an approval for any reason or on any basis which would have justified initial disapproval. In the case of disapproval or rescission of approval, the licensee may, within 15 days of notice of the disapproval or rescission, request a hearing before the commissioner or his or her designee, and the hearing shall be held within 30 days of the request.

(d) Living benefits licensees shall be required to disclose or advise any applicant for a living benefits contract, at the time of solicitation for the contract, of all of the following:

(1) Possible alternatives to living benefits contracts for persons with catastrophic or life threatening illness, including, but not limited to, accelerated benefits options that may be offered by the life insurer.

(2) Tax consequences that may result from entering into a living benefits contract.

(3) Consequences for interruption of public assistance as provided by information provided by the State Department of Health Services and the State Department of Social Services under Section 11022 of the Welfare and Institutions Code.

(e) All medical information solicited or obtained by any person soliciting or entering into a living benefits contract shall be subject to Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1, concerning confidentiality of medical information.

(f) The commissioner may adopt rules and regulations reasonably necessary to govern living benefits contracts and transactions. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a death benefit under a life insurance policy.

(g) The commissioner may, whenever he or she deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensee or applicant for a license. The commissioner shall have the authority to order any licensee or applicant to produce any records, books, files, or other information as is reasonably necessary to ascertain whether or not the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(h) The commissioner may investigate the conduct of any licensee, its officers, employees, agents, or any other person involved in the business of the licensee, whenever the commissioner has reason to believe that the licensee may have acted, or may be acting, in violation of the law, or otherwise contrary to the interests of the public. The commissioner may initiate an investigation on his or her own, or upon a complaint filed by any other person.

(i) The commissioner may issue orders to licensees whenever he or she determines that it is reasonably necessary to ensure or obtain compliance with this section, or Section 10113.1. This authority includes, but is not limited to, orders directing a licensee to cease and desist in any practice which is in violation of this section, or Section 10113.1, or otherwise contrary to the interests of the public. Any licensee to which an order pursuant to this subdivision is issued may, within 15 days of receipt of that order, request a hearing at which the licensee may challenge the order.

§ 10113.5 INSURANCE CODE

(j) The commissioner may, after notice and a hearing at which it is determined that a licensee has violated this section or Section 10113.1 or any order issued pursuant to this section order the licensee to pay a monetary penalty of up to ten thousand dollars ($10,000), which may be recovered in a civil action. Any hearing conducted pursuant to this subdivision shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearing may be conducted by administrative law judges chosen pursuant to Section 11502 or appointed by the commissioner, and the commissioner shall have the powers granted therein.

(k) Each licensee shall file with the commissioner on or before March 1 of each year an annual statement in the form prescribed by the commissioner. The information which the commissioner may require in the annual statement shall include, but not be limited to, the data required to satisfy the commissioner's report to the Legislature due on or before December 1, 1994.

(l) No person who is not a resident of California may receive or maintain a license unless a written designation of an agent for service or process is filed and maintained with the commissioner. The provisions of Article 3 (commencing with Section 1600) of Chapter 4 of Part 2 shall apply to living benefits licensees as if they were foreign insurers, their license a certificate of authority, and the living benefits contracts a policy, and the commissioner may modify the agreement set forth in Section 1604 accordingly.

(m) No person licensed pursuant to this section shall engage in any false or misleading advertising, solicitation, or practice. The provisions of Article 6 (commencing with Section 780) and Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 shall apply to living benefits licensees as if they were insurers, their license a certificate of authority or producer's license, and the living benefits contracts a policy, and the commissioner shall liberally construe these provisions so as to protect the interests of the public.

(n) Any person who enters into a living benefits contract with a living benefits licensee shall have the absolute right to rescind the contract within 15 days of execution of the contract, and any waiver or contract language contrary to this subdivision shall be void.

(o) A violation of this section is a misdemeanor.

Added Stats 1990 ch 1387 § 2 (AB 2663).

Editor's Notes—For report to Legislature, see the 1990 note following Ins C § 10113.1.

§ 10113.5. Incontestability clause
Collateral References:
Withkin Summary (9th ed) Contracts § 646.

SUGGESTED FORMS

Complaint by Insurer—Cancellation of Life Insurance Policy Obtained by Intentional Misrepresentation as to Health of Insured

[Title of court and cause]

Plaintiff for cause of action against defendant alleges:

1. Plaintiff is, and at all times herein mentioned was, a corporation organized and existing under the laws of the State of California and doing business as a life insurance company with its principal place of business in the County of , State of California.

2. Defendant is a resident of the County of , State of California.

Beginning in 1992, italic indicate changes or additions. ** indicate omissions.

[Ins C]
housing tenant, any member of the tenant's household, or any guest or other person under the tenant's control, shall be cause for termination of tenancy. For purposes of this section, the term "drug-related criminal activity" means the illegal manufacture, sale, distribution, use, or possession with intent to manufacture, sell, distribute, or use, of a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802)); and

(6) Specify that with respect to any notice of termination of tenancy or eviction, notwithstanding any applicable Tribal or State law, an Indian housing tenant shall be informed of the opportunity, before any hearing or trial, to examine any relevant documents, records, or regulations directly related to the termination or eviction.


Joseph G. Schiff,
Assistant Secretary for Public and Indian Housing.

[FR Doc. 92-30352 Filed 12-14-92; 8:45 am]
BILLING CODE 4210-33-M

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[FI–25–92]

RIN 1545-AQ70

Qualified Accelerated Death Benefits Under Life Insurance Contracts

AGENCY: Internal Revenue Service, Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document provides proposed regulations relating to the definition of a life insurance contract for federal tax purposes and to the federal income tax treatment of amounts received as qualified accelerated death benefits. These proposed regulations are necessary to provide guidance to insurance companies and their policyholders.

DATES: Written comments, requests to speak, and outlines of oral arguments to be presented at the hearing scheduled for March 19, 1993, at 10 a.m. in the Internal Revenue Service Auditorium, must be received by February 26, 1993. See notice of hearing published elsewhere in this issue of the Federal Register.

ADDRESSES: Send submissions to: Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Attention: CC-CORP.T-R (FI–25–92), room 5228, Washington, DC 20004.

FOR FURTHER INFORMATION CONTACT:

SUPPLEMENTARY INFORMATION:

Background

This document sets forth proposed amendments to the Income Tax Regulations (26 CFR part 1) under sections 101, 7702, and 7702A of the Internal Revenue Code (Code). The proposed rules relate to the definition of a life insurance contract under section 7702 of the Internal Revenue Code, to the treatment of a life insurance contract under section 7702A, and to the federal income tax treatment of amounts received as qualified accelerated death benefits under section 101. The proposed regulations reflect the addition 7702 to the Code by section 221(a) of the Tax Reform Act of 1984. Public Law 98–369, and the addition of section 7702A to the Code by section 5012 of the Technical and Miscellaneous Revenue Act of 1988, Public Law 100–647.

Purpose of Regulations

The proposed regulations provide insurers with the standards needed to design and market insurance contracts that provide both death benefits and morbidity benefits without subjecting policyholders to taxation on the inside build-up of the life insurance contracts. In recognition of the needs of individuals who become terminally ill, the proposed regulations also allow the payment of benefits prior to death without any income tax liability to the recipient if death is expected to occur within 12 months.

For insurance contracts that, prior to July 1, 1993, provide for a benefit or loan for terminally ill individuals or a morbidity benefit, the proposed regulations provide transition rules that prevent the benefit or loan from resulting in adverse federal tax consequences to the policyholders and avoid the reporting and withholding requirements that would be imposed upon the insurers if the contracts were to fail to qualify as life insurance contracts. See Rev. Rul. 91–17, 1991–1 C.B. 190.

Summary of Relevant Statutory Provisions

Section 7702 defines a "life insurance contract" as any contract that is a life insurance contract under applicable law, but only if the contract either (1) meets the cash value accumulation test of section 7702(b), or (2) meets the guideline premium requirements of section 7702(c) and fails within the cash value corridor of section 7702(d).

The cash value accumulation test of section 7702(b) requires that, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at that time to fund the future benefits under the contract. "Cash surrender value" for purposes of section 7702 is defined in section 7702(f)(2)(A) as the cash value of the contract determined without regard to any surrender charge, policy loan, or reasonable termination dividends. The "net single premium" must be determined using the assumptions, computational rules, definitions, and special rules contained in section 7702.

The guideline premium limitation of section 7702(c) provides that the premiums paid under the contract at any time must not exceed the greater of the guideline single premium or the sum of the guideline level premiums to that date. Contracts qualifying as life insurance under the guideline premium test also must satisfy the cash value corridor of section 7702(d). The corridor specifies a minimum ratio of death benefits to cash surrender values.

Section 7702(f)(7) provides for adjustments in determinations made under section 7702 if there is a change in the benefits under (or in other terms of) the contract which was not reflected in any previous determination or adjustment. A reduction in death benefits is an adjustment event under section 7702(f)(7). Qualification as a life insurance contract after an adjustment event requires redetermination of values under the contract, including the net single premium, the guideline premium limitation, and the cash value corridor, depending on the test under which the contract qualifies as life insurance.

Section 7702(g) governs the federal income tax treatment of a life insurance contract under applicable law that fails to meet the definition of a life insurance contract under section 7702(a), either at inception or at a later date. In general, under section 7702(g)(1)(A), the "income on the contract" is treated as ordinary income that is received or accrued annually by the policyholder.

Section 7702A(a) defines a modified endowment contract as a life insurance contract meeting the requirements of section 7702 which is entered into on or after June 21, 1988 and which fails to meet the 7-pay test of section 7702A(b) or a life insurance contract which is
received in exchange for a modified endowment contract. Section 7702A(c)(3)(A)(ii) provides that, if there is a "material change" within the meaning of section 7702A(c)(3) to a life insurance contract that is subject to section 7702A, the contract is treated as entered into on the day that the material change takes effect. A material change in the benefits under (or in other terms of the contract) the contract includes an increase in the death benefit under the contract or any increase in, or addition of, a qualified additional benefit under the contract. Section 101(a) provides in part that gross income does not include amounts received (whether in a single sum or otherwise) under a life insurance contract, if the amounts are paid by reason of the death of the insured. Section 72(c)(1) defines investment in the contract for purposes of determining the exclusion ratio for amounts received as an annuity under an annuity, endowment, or life insurance contract. Section 72(e)(6) defines investment in the contract for amounts received under an annuity, endowment, or life insurance contract if the amount is not received as an annuity and no other income tax provision applies. See Rev. Rul. 55-349, 1955-1 C.B. 232, (premiums for supplementary benefits excluded from the investment in the contract). New Insurance Contracts Insurance companies have developed insurance contracts which provide both death benefits and "living benefits" designed to assist policyholders with the rising costs of medical care, particularly medical care in the later years of life. Living benefits generally may be divided into two types of benefits. The first type of living benefit, an "accelerated death benefit," addresses the needs of terminally ill individuals who may incur substantial medical and living expenses prior to death. This benefit allows the policyholder, under a life insurance contract insuring a terminally ill individual, to "accelerate" the death benefit paid under the contract. Generally, the accelerated death benefit is equal to all or a portion of the death benefit discounted for the remaining life expectancy (generally 12 months or less) of the terminally ill individual. The payment of a benefit is conditioned upon the policyholder surrendering all or a portion of the policyholder's rights under the life insurance contract. A second type of living benefit provides accident and health benefits upon the occurrence of certain morbidity risks, for example, a condition requiring a long-term stay in a nursing home or certain dread diseases. The living benefit is a specified amount which is determined by reference to all or a portion of the death benefit otherwise payable. As with accelerated death benefits, the payment of a benefit is conditioned upon the policyholder surrendering all or a portion of the policyholder's rights under the life insurance contract. Explanation of Provisions The proposed regulations are being promulgated to provide guidance concerning the tax treatment to the owners and issuers of insurance contracts that provide living benefits by addressing the application of sections 72, 101, 7702, and 7702A to those insurance contracts. The proposed regulations allow qualified accelerated death benefits under an insurance contract to be treated as amounts paid by reason of the death of the insured for purposes of sections 101(a) and 7702. This proposed treatment allows an insurance contract including these benefits to continue to meet the definition of a life insurance contract under section 7702. The proposed regulations also permit a person who receives a qualified accelerated death benefit to exclude, under section 101(a), the benefit from gross income. A qualified accelerated death benefit is defined in the proposed regulations as a benefit payable under a contract on the life of an insured who becomes terminally ill, where the amount of the death benefit made available cannot be discounted by more than 12 months at the rate of interest specified in the regulations. Under the proposed regulations an individual is terminally ill if the individual has an illness or physical condition that, notwithstanding appropriate medical care, is reasonably expected to result in death within 12 months from the date of payment of the accelerated death benefit. As the 12 month determination is necessarily subjective to some extent, it is expected that the insurer will act prudently in its determination of whether the person is terminally ill. The Service is considering whether to develop further guidance that would create a presumption of terminal illness in certain circumstances. The proposed regulations also address the treatment, under section 7702, of other living benefits that provide payments upon the occurrence of a morbidity risk of an amount determined by reference to all or a portion of the death benefit otherwise payable under an insurance contract. For purposes of section 7702, the benefit could be viewed as an amount paid upon surrender of a contract and accordingly would be included in the cash surrender value of the contract. The impact of this characterization would be to disqualify as life insurance under section 7702 many contracts providing these benefits. Contracts with large cash surrender values would no longer qualify under the cash values accumulation test of section 7702(b) while contracts qualifying under the guideline premium test of section 7702(c) would fail the cash value corridor test of section 7702(d). For example, a policyholder, age 37, might own an insurance contract with a $100,000 face amount, that also provides for a payment of $70,000 upon surrender of the contract if the policyholder is hospitalized for a specified number of days. The $70,000 hospital benefit would result in the failure of the contract to qualify as a life insurance contract under section 7702. To enable policyholders to avoid this result, the proposed regulations adopt an approach which assumes that a life insurance contract and an accident and health insurance contract which could be sold separately should be allowed to be sold together without endangering the qualification of the contract offering both benefits as a life insurance contract under section 7702. To preserve qualification of the contract offering both benefits as a life insurance contract, the proposed regulations exclude amounts payable as additional benefits (other than qualified additional benefits) from cash value if the following conditions are satisfied: (1) The benefits are not required upon the occurrence of a morbidity risk, (2) the charges for the benefits are separately stated and currently imposed by the insurer, and (3) the charges are not included in premiums taken into account in the determination of the investment in the contract under section 72 and are not taken into account in the determination of premiums paid under section 7702(0)(1). If the three conditions are met, the proposed regulations treat a life insurance contract with an additional accident and health benefit as providing both a potential death benefit and a potential living benefit which is paid upon the occurrence of a morbidity risk. The living benefit is treated as being comprised of two elements: (1) A payment upon the partial or full surrender of the life insurance contract for part or all of the cash value, and (2) a payment upon the occurrence of a morbidity event of an additional accident and health benefit equal to the difference between the total payment...
assures the appropriate treatment of conditions specified in proposed generally for contracts issued or entered

The requirement that morbidity risk charges for living benefits be separately stated and currently imposed by the terms of the life insurance contract is necessary if section 7702 is to operate in the manner intended by Congress. Providing for the proper allocation and treatment of charges for these contracts assures the appropriate treatment of amounts paid into the contract and benefits paid.

The approach in the proposed regulations is intended to level the playing field between contracts that provide accident and health benefits in conjunction with life insurance benefits and contracts that provide only accident and health benefits. Thus, the approach of the proposed regulations will allow a contract providing both accident and health and life insurance benefits to continue to qualify as a life insurance contract under section 7702 so long as the contract provides appropriate treatment of the charges for the accident and health benefits.

The proposed regulations also exclude from cash value qualified additional benefits, certain amounts returned upon termination of a credit life insurance contract, and reasonable termination dividend.

The proposed regulations define cash surrender value, net surrender value, and death benefit for purposes of section 7702.

Proposed Effective Dates

The proposed regulations under section 7702, relating to the definition of cash value and the tax treatment of certain benefits, would be effective generally for contracts issued or entered into after June 30, 1993.

Under the proposed regulations, the provision of certain benefits or loans in a life insurance contract before July 1, 1993, does not increase the cash value of the contract. The proposed regulations also provide that the addition to a life insurance contract, before July 1, 1993, of certain benefits or loans has no effect on the date that the contract was issued or entered into for purposes of section 7702 and 7702A, and does not cause a material change in the contract under section 7702A.

The addition of a qualified accelerated death benefit (or an additional benefit satisfying the three conditions specified in proposed § 1.7702-2(f)) to a life insurance contract at any time has no effect on the date that the contract was issued or entered into for purposes of section 7702 and 7702A, and does not cause a material change in the contract under section 7702A.

The section 101 exclusion provided by the proposed regulations for qualified accelerated death benefits would be effective for amounts received on or after the date on which final regulations defining a qualified accelerated death benefit are published in the Federal Register.

Special Analyses

It has been determined that these proposed rules are not major rules as defined in Executive Order 12291. Therefore, a Regulatory Impact Analysis is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) and the Regulatory Flexibility Act (5 U.S.C. chapter 6) do not apply to these regulations, and, therefore, an initial Regulatory Flexibility Analysis is not required. Pursuant to section 7805(f) of the Internal Revenue Code, the proposed regulations will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

Comments and Request for a Public Hearing

Before the adoption of these proposed regulations, consideration will be given to any written comments that are timely submitted (preferably a signed original and eight copies) to the Internal Revenue Service.

Comments are specifically requested on the need for special rules under section 7702(f) for contracts that do not terminate upon payment of a morbid benefit or a qualified accelerated death benefit. Comments are also requested on whether the proposed regulations treat additional benefits, including morbidity benefits that are attached to a life insurance contract in the same fashion as contracts which provide similar benefits that are not attached to a life insurance contract. Finally, comments are requested on whether the regulations should specify how premiums and charges should be allocated among the various benefits provided under a life insurance contract.

All comments will be available for public inspection and copying in their entirety. A public hearing has been scheduled for March 19, 1993. See notice of hearing published elsewhere in this issue of the Federal Register.

Drafting Information

The principal author of these proposed regulations is Ann H. Logan, Office of the Assistant Chief Counsel (Financial Institutions and Products), Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Service and the Treasury Department participated in developing the regulations, in matters of both substance and style.

List of Subjects

26 CFR 1.101-1 through 1.133-1T

Income taxes, Reporting and recordkeeping requirements.

26 CFR 1.7702-0 through 1.7702A-1

Life insurance contract, Taxes.

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 1 is proposed to be amended as follows:

PART 1—INCOME TAX; TAXABLE YEARS BEGINNING AFTER DECEMBER 31, 1993

Paragraph 1. The authority citation for part 1 is amended by adding a citation to read as follows:

Authority: 26 U.S.C. 7805 * * * Section 1.7702-2 also issued under 26 U.S.C. 7702(k) * * *

Par. 2 Section 1.101-8 is added to read as follows:

§ 1.101-8 Amounts paid with respect to terminally ill individuals.

For purposes of section 101(a), a qualified accelerated death benefit (as defined in §1.7702-2(d)), received on or after [date on which final regulations are published in the Federal Register], is treated as an amount paid by reason of the death of the insured.

Par. 3. Section 1.7702-0 is added to read as follows:

§ 1.7702-0 Table of contents.

This section lists the captions that appear in §§ 1.7702-1 and 1.7702-2.

§ 1.7702-1 Mortality charges.

(a) General rule.

(b) Reasonable mortality charges.

(1) Actually expected to be imposed.

(2) Limit on charges.

(c) Safe harbors.

(1) 1980 C.S.O. Basic Mortality Tables.

(2) Unisex tables and smoker/nonsmoker tables.

(3) Certain contracts based on 1958 C.S.O. table.

(d) Definitions.

(1) Prevaling commissioners' standard tables.

(2) Substandard risk.

(3) Nonparticipating contract.
(4) Charge reduction mechanism.
(5) Plan of insurance.
(e) Effective date.
§ 1.7702-2 Definitions.
(a) In general. Paragraphs (b) through
(i) of this section provide definitions and other rules only for purposes of section 7702.
(b) Cash value—(1) In general. Except as otherwise provided in paragraph
(b)(2) of this section, the cash value of a contract is the greater of—
(i) The maximum amount payable under the contract (determined without regard to any surrender charge or policy loan); or
(ii) The maximum amount that the policyholder can borrow under the contract.
(c) Amounts excluded from cash value. The cash value of a contract does not include—
(i) The amount of any death benefit (as defined in paragraph (c) of this section);
(ii) The amount of any qualified additional benefit;
(iii) The amount of any other benefit described in paragraph (f) of this section;
(iv) An amount returned to the insured upon termination of a credit life insurance contract due to a full repayment of the debt covered by the contract; or
(v) A reasonable termination dividend not in excess of $35 for each $1,000 of the face amount of the contract.
(c) Death benefit—(1) In general. A death benefit is the amount payable by reason of the death of the insured (determined without regard to any qualified additional benefits).
(2) Qualified accelerated death benefit treated as death benefit. For purposes of paragraph (b)(2)(i) of this section, the amount payable as a qualified accelerated death benefit as defined in paragraph (d) of this section (but determined without regard to any reduction for discounting) is treated as a death benefit.
(d) Qualified accelerated death benefit—(1) In general. A benefit payable prior to death (accelerated benefit) is a qualified accelerated death benefit if, under the contract, the following conditions are satisfied—
(i) The accelerated benefit is payable only if the insured becomes terminally ill (as defined in paragraph (e) of this section);
(ii) The amount of the accelerated benefit is equal to or more then the present value of the reduction in death benefit otherwise payable in the event of the death of the insured (without regard to any qualified additional benefits); and
(iii) The ratio of the cash surrender value of the contract immediately after the payment of the accelerated benefit to the cash surrender value of the contract immediately before the payment of the accelerated benefit is greater than the ratio of the death benefit immediately after the payment of the accelerated benefit to the death benefit immediately before the payment of the accelerated benefit.
(2) Determination of present value of the reduction in death benefit. For purposes of paragraph (d)(1)(ii) of this section, the present value of the reduction in death benefit occurring upon payment of a qualified accelerated death benefit must be determined by—
(i) Using as the discount rate the greater of—
(A) The applicable federal interest rate determined under section 846(c)(2); or
(B) The interest rate applicable to policy loans under the contract; and
(ii) Assuming that the death benefit (or the portion thereof) would have been paid 12 months after the date of the payment of the accelerated benefit.
(3) Examples. The following examples illustrate the provisions of this paragraph (d).
Example 1. B owns an insurance contract with a death benefit of $100,000 and a cash value of $30,000. In 1994, the insured becomes terminally ill (as defined in paragraph (e) of this section). In 1994, B receives an accelerated benefit equal to forty percent of the death benefit under the contract (discounted in accordance with the rules of paragraph (d)(2) of this section).
As a result of the payment of the accelerated benefit, the amount that B is entitled to receive upon the surrender of the contract is reduced by $12,000 (forty percent of $30,000) to $18,000. The ratio of the cash surrender value of the contract immediately after the payment of the accelerated benefit to the cash surrender value of the contract immediately before the payment of the accelerated benefit (18:30) is equal to the ratio of the death benefit immediately after the payment of the accelerated benefit to the death benefit immediately before the payment of the accelerated benefit (60:100). The accelerated benefit constitutes a qualified accelerated death benefit.
Example 2. C owns an insurance contract with a death benefit of $100,000. In 1994, the insured becomes terminally ill (as defined in paragraph (e) of this section). The policy loan rate specified in the contract is 10 percent and exceeds the federal applicable rate determined under section 846(c). In 1994, C receives an accelerated benefit equal to the entire death benefit of the policy discounted by 10 percent for 12 months from the date of payment and the contract terminates. The accelerated benefit is not a qualified accelerated death benefit.
Example 3. The facts are the same as in Example 2 except that C receives an accelerated benefit equal to the entire death benefit of the policy discounted by 20 percent for 12 months from the date of payment and the contract terminates. The accelerated benefit is a qualified accelerated death benefit.
(e) Terminally ill defined. An individual is terminally ill if the insurer determines that the individual has an illness or physical condition that, notwithstanding appropriate medical care, is reasonably expected to result in death within 12 months from the date of payment of the accelerated death benefit.
(f) Certain other additional benefits—
(1) In general. An additional benefit is described in this paragraph (f) if the following conditions are satisfied—
(i) The benefit is payable solely upon the occurrence of a morbidity risk;
(ii) The charges for the benefit are separately stated and currently imposed by the terms of the contract; and
(iii) The charges for the benefit are not included in premiums taken into account in the determination of the investment in the contract under section 72(c)(1) or 72(e)(6) and are not taken into account in the determination of premiums paid under section 7702(f)(1).
(2) Examples. The following example illustrate the provisions of this paragraph (f):

Example 1. B owns an insurance contract with a death benefit of $100,000 and a cash value of $30,000. In 1994, the insured becomes terminally ill (as defined in paragraph (e) of this section). In 1994, B receives an accelerated benefit equal to forty percent of the death benefit under the contract (discounted in accordance with the rules of paragraph (d)(2) of this section).
As a result of the payment of the accelerated benefit, the amount that B is entitled to receive upon the surrender of the contract is reduced by $12,000 (forty percent of $30,000) to $18,000. The ratio of the cash surrender value of the contract immediately after the payment of the accelerated benefit to the cash surrender value of the contract immediately before the payment of the accelerated benefit (18:30) is equal to the ratio of the death benefit immediately after the payment of the accelerated benefit to the death benefit immediately before the payment of the accelerated benefit (60:100). The accelerated benefit constitutes a qualified accelerated death benefit.

Example 2. C owns an insurance contract with a death benefit of $100,000. In 1994, the insured becomes terminally ill (as defined in paragraph (e) of this section). The policy loan rate specified in the contract is 10 percent and exceeds the federal applicable rate determined under section 846(c). In 1994, C receives an accelerated benefit equal to the entire death benefit of the policy discounted by 10 percent for 12 months from the date of payment and the contract terminates. The accelerated benefit is not a qualified accelerated death benefit.

Example 3. The facts are the same as in Example 2 except that C receives an accelerated benefit equal to the entire death benefit of the policy discounted by 20 percent for 12 months from the date of payment and the contract terminates. The accelerated benefit is a qualified accelerated death benefit.

Example 4. C owns an insurance contract with a death benefit of $100,000. In 1994, the insured becomes terminally ill (as defined in paragraph (e) of this section). The policy loan rate specified in the contract is 10 percent and exceeds the federal applicable rate determined under section 846(c). In 1994, C receives an accelerated benefit equal to the entire death benefit of the policy discounted by 10 percent for 12 months from the date of payment and the contract terminates. The accelerated benefit is not a qualified accelerated death benefit.

Example 5. The facts are the same as in Example 2 except that C receives an accelerated benefit equal to the entire death benefit of the policy discounted by 20 percent for 12 months from the date of payment and the contract terminates. The accelerated benefit is a qualified accelerated death benefit.
Example 1. A owns an insurance contract with a death benefit of $100,000. The contract contains a provision that upon the occurrence of a morbidity risk, the insurer can terminate the contract and pay $30,000 as a morbidity benefit, or add a life insurance benefit of $70,000 payable to A upon the occurrence of the morbidity risk. The $30,000 is treated as cash value payable upon complete surrender of the contract while the remaining $70,000 is treated as a morbid benefit under the contract.

Example 2. The facts are the same as in Example 1 except that the charges for the morbidity benefit are not separately stated and currently imposed. The benefit is not described in this paragraph (f) and consequently the benefit is not excluded from the cash value of the contract. Under paragraph (b)(2)(iii) of this section, the contract's cash value includes the amounts payable by reason of the occurrence of a morbidity risk.

Example 3. The facts are the same as in Example 1 except that the charges for the morbidity benefit are included in premiums taken into account in the determination of the investment in the contract under section 72(c)(1) or 72(e)(6) and are not taken into account in the determination of premiums paid under section 7702(f)(1). The excess of the $70,000 (70 percent of $100,000) payable to A upon the occurrence of the morbidity risk over $40,000 is an additional benefit which is not a qualified additional benefit. The additional benefit is described in this paragraph (f). Under paragraph (b)(2)(iii) of this section, the amount of the additional benefit (the $30,000 payable by reason of the occurrence of a morbidity risk) is not included in the contract's cash value. Accordingly, $40,000 is treated as cash value payable upon complete surrender of the contract while the remaining $30,000 is treated as a morbidity benefit under the contract.

(g) Adjustments under section 7702(f)(7). If a life insurance contract is not terminated upon the payment of a qualified accelerated death benefit or an additional benefit described in paragraph (f) of this section, any change in the benefits under (or in other terms of) the contract is a change not reflected in any previous determination or adjustment under section 7702 and is an adjustment event under section 7702(f)(7).

(h) Cash surrender value—(1) In general. Except as provided in paragraph (b)(2) of this section, cash surrender value of a contract is its cash value, as determined under paragraph (b) of this section.

(2) For purposes of section 7702(f)(7). For purposes of determining the recapture ceiling under section 7702(f)(7), cash surrender value is the amount that would be payable under the contract (determined without regard to any surrender charge, policy loan or reasonable termination dividends) if the contract were terminated immediately prior to the change in the benefits under (or in other terms of) the contract.

(i) Net surrender value. For purposes of section 7702(g), the net surrender value of a contract at any time is the amount that would be payable under the contract (determined with regard to surrender charges but without regard to any policy loan) if the contract were terminated at that time.

(j) Effective date and special rules—(1) In general. Except as otherwise provided in this paragraph (j), this section applies only with respect to contracts issued or entered into after June 30, 1993.

(2) Provision of certain benefits before July 1, 1993—(i) Not treated as cash value. If a benefit or loan payable only in the event the insured becomes terminally ill (as defined in paragraph (e) of this section), or an additional benefit (other than a qualified additional benefit) or loan payable solely upon the occurrence of a morbidity risk, is added to a life insurance contract before July 1, 1993, the addition of the benefit or loan provision has no effect on the date that the contract was issued or entered into for purposes of section 7702.

(ii) No effect on date of issuance. If a benefit or loan provision described in paragraph (a)(1) of this section is added to a life insurance contract before July 1, 1993, the addition of the benefit is not treated as a material change under section 7702A(c)(3).

(3) Special rule for addition of benefit or loan provision after December 15, 1992. This paragraph (a) applies with respect to a benefit or loan provision added to a life insurance contract after December 15, 1992 only if the insurer can demonstrate that the benefit or loan provision was available under a life insurance contract issued within the United States as of December 15, 1992.

(b) Addition of qualified accelerated death benefit. If a qualified accelerated death benefit (as defined in §1.7702-2(d)) is added to a life insurance contract at any time—

(1) The addition of the benefit has no effect on the date that the contract was issued or entered into for purposes of section 7702; and

(2) Paragraph (b)(2) of this section shall apply to the qualified accelerated death benefit.

(c) Addition of other additional benefits. If an additional benefit described in paragraph (f) of this section is added to a life insurance contract at any time—

(1) The addition of the benefit has no effect on the date that the contract was issued or entered into for purposes of section 7702; and

(2) Paragraph (b)(2) of this section shall apply to the additional benefit.
The addition of the benefit is not treated as a material change under section 7702A(c)(3).

Michael P. Dolan,
Acting Commissioner of Internal Revenue.

[FR Doc. 92-29918 Filed 12-14-92; 8:45 am]
BILLING CODE 4830-01-M

26 CFR Part 1
[Fi-25-92]
RIN 1545-AQ70

QUALIFIED ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS:
HEARING

AGENCY: Internal Revenue Service, Treasury.

ACTION: Notice of public hearing on proposed regulations.

SUMMARY: This document provides notice of a public hearing on proposed Income Tax Regulations relating to the definition of a life insurance contract for Federal tax purposes and to the Federal income tax treatment of amounts received as qualified accelerated death benefits.

DATES: The public hearing will be held on Friday, March 19, 1993, beginning at 10 a.m. Requests to speak and outlines of oral comments should be submitted to the Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Attn: CC:CORR:T:R (PS-91-90) room 5228, Washington, DC 20044.

ADDITION: The public hearing will be held in the IRS Auditorium, Seventh Floor, 7400 Corridor, Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC. Requests to speak and outlines of oral comments should be submitted to the Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Attn: CC:CORR:T:R (PS-91-90), room 5228, Washington, DC 20044.

FOR FURTHER INFORMATION CONTACT: Mike Slaughter of the Regulations Unit, Assistant Chief Counsel (Corporate), (202) 622-7190 (not a toll-free number).

SUPPLEMENTARY INFORMATION: The subject of the public hearing is proposed regulations to amend the Income Tax Regulations (26 CFR part 1) under sections 101, 7702, and 7702A of the Internal Revenue Code, to the treatment of life insurance contract under section 7702A, and to the Federal income tax treatment of amounts received as qualified accelerated death benefits under section 101. These proposed regulations appear elsewhere in this issue of the Federal Register.

The rules of §601.601(a)(3) of the "Statement of Procedural Rules" (26 CFR part 601) shall apply with respect to the public hearing. Persons who have submitted written comments within the time period prescribed in the notice of proposed rulemaking and who also desire to present oral comments at the hearing on the proposed regulations should submit not later than Friday, February 26, 1993, an outline of the oral comments/testimony to be presented at the hearing and the time they wish to devote to each subject.

Each speaker (or group of speakers representing a single entity) will be limited to 10 minutes for an oral presentation exclusive of the time consumed by the questions from the panel for the government and answers to these questions.

Because of controlled access restrictions, attendees cannot be admitted beyond the lobby of the Internal Revenue Building until 9:45 a.m.

An agenda showing the scheduling of the speakers will be made after outlines of oral comments are received from the persons testifying. Copies of the agenda will be available free of charge at the hearing.

By direction of the Commissioner of Internal Revenue.

Dale D. Goode,
Federal Register Liaison Officer, Assistant Chief Counsel (Corporate).

[FR Doc. 92-29920 Filed 12-14-92; 8:45 am]
BILLING CODE 4830-01-M

26 CFR Part 1
[PS-91-50]
RIN 1545-APS2

PARTNERSHIP TRANSACTIONS INVOLVING EQUITY INTERESTS OF A PARTNER

AGENCY: Internal Revenue Service, Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: Section 631 of the Tax Reform Act of 1986 was intended to repeal the General Utilities doctrine which, under certain circumstances, permitted a corporation to distribute appreciated assets to its shareholders without recognizing gain. The Service has determined that, in certain circumstances, the acquisition (or mere ownership) by a partnership of stock in one of its corporate partners results in avoidance of the repeal of the General Utilities doctrine. This document contains proposed regulations that prevent a corporate partner from avoiding corporate-level gain through transactions with a partnership involving equity interests of the partner.

The intended effect of these proposed regulations is to provide for gain recognition in such circumstances.

DATES: Written comments and requests to appear, and outlines of oral comments to be presented, at a public hearing scheduled for February 3, 1993 must be received by January 20, 1993. See notice of public hearing on these proposed regulations published elsewhere in this issue of the Federal Register.

ADDITIONS: Send comments, requests to speak at the public hearing, and outline of oral comments to Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Attn: CC:CORR:T:R (PS-91-90) room 5228, Washington, DC 20044.

FOR FURTHER INFORMATION CONTACT: Channing Brackey at (202) 622-3070 or Tom Matragrano at (202) 622-7530 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Introduction

This document contains proposed income tax regulations under section 337(d) of the Internal Revenue Code implementing Notice 89-37, 1989-1 C.B. 679. In the notice, the Internal Revenue Service stated that it would publish regulations to prevent the use of a partnership to circumvent the repeal of the General Utilities doctrine. Section 337(d) provides the Service authority to issue such regulations as may be necessary and appropriate to carry out the purposes of the repeal, “including regulations to ensure that such purpose may not be circumvented through the use of any provision of the law or regulations.”

Prior to the repeal of the General Utilities doctrine, a corporation recognized no gain or loss on certain distributions of property to its shareholders. Following the repeal, a corporation generally recognizes gain on the distribution of appreciated property to a shareholder.

In Notice 89-37, the Service clarified that section 311(b), rather than section 731(a), applies when a partner receives a partnership distribution of its own stock (the distribution rule). Further, the Service stated that the partner recognizes gain when a pre-distribution transaction (or series of transactions) has the economic effect of an exchange by the partner of appreciated property for its stock (the deemed redemption rule). Finally, the Notice indicated that some of the transactions subject to these regulations also may be subject to taxation under the “substance over form” principle or section 707(a)(2)(B), and this continues to be true.
MEMORANDUM

TO: Kristin Chambers
FROM: James Lee
DATE: 9/4/92
RE: Viatical Settlement Agreements

If you are providing legal assistance or financial planning to people with AIDS you should be aware that your clients may be able to collect on life insurance policies during their lifetime. Life insurance is a valuable asset and should be an intricate part of financial planning for the terminally ill. California law allows companies registered with the state to contract to purchase life insurance policies from terminally ill policy holders. These contracts are called viatical settlements.

A viatical settlement agreement is the sale of a life insurance policy of a person with a relatively short life expectancy to a party other than the insurer who originally issued the policy, see Cal. Ins. Code Section 10113.1. The policy holder receives a cash lump-sum payment, usually at a discounted rate of 50% to 80% of the face value, and the ownership and future rights of the policy are then assigned to the third party purchaser.

With the high cost of AIDS treatment, a large sum of immediate cash may be of great help to guarantee the continuation of quality medical care or to simply allow one to maintain a life style with dignity. However, a decision on the part of your client to sell his or her life insurance may have a large and potentially negative effect on other aspects of your client's financial planning. For instance, a large infusion of cash could have significant tax implications and could possibly result in interruptions of government benefits.

The AIDS Legal Referral Panel strongly recommends that you and your client consider all available options and potential consequences of any decision made in regard to the sale of a life insurance policy. Such a sale should only be considered as a last resort after exploring other alternatives.

POSSIBLE ALTERNATIVES TO VIATICATING A POLICY

Your client may be able to receive cash from his or her life insurance policy without actually selling it to a viatical settlement company. Whether these options are available depends on your client's particular insurance policy, the company which issued the policy, and your client's own personal and financial situation. If options are available, they should be carefully
considered because there could be significantly different tax consequences and your client may be able to get a higher rate of return on the face value of the policy. Available options may include:

1. Some life insurance policies accumulate an "investment account" as part of the policy. The value accumulated may be borrowed or withdrawn from the account. Often a simple low interest rate is charged against the value of the withdrawn funds. One advantage of this approach is that the policy stays in force and a death benefit, minus the amount of the loan, is still paid to the beneficiaries. Because this is a loan, it is not treated as a taxable transaction.

2. Some life insurance companies, such as Prudential, John Hancock, and The Travellers currently offer "accelerated benefits". This is a clause within a life insurance policy in which the insurance company will pay a terminally ill policy holder a death benefit prior to their death. This allows the policy holder to avoid a third party viatical settlement company and usually results in a higher rate of return (larger cash payment) on the face value of the policy. Under an accelerated clause, insurance companies often pay up to 95% of the face value as opposed to an average range of 50% to 80% offered by viatical settlement companies.

One potential disadvantage of this option is that most companies require a life expectancy of one year or less, as opposed to viatical settlement companies which often buy policies from holders with a life expectancies of up to two years. Also, some insurance companies only offer accelerated benefits to new policy holders. [The tax implications of selling a policy back to the insurer have not yet been clearly defined by the IRS. However, one should assume, as with viatical settlement agreements, that this will be considered as income for tax purposes.]

3. The most lucrative option is to use the insurance policy as collateral for a loan from a bank, relative or friend. The main advantage of this is that it is not considered taxable income. The disadvantage is that it
may be difficult to secure a loan from a bank or to find friends or relatives with enough liquidity.

SELLING AN INSURANCE POLICY TO A VIATICAL SETTLEMENT COMPANY

If your client decides to sell his or her life insurance policy, you should heavily encourage your client to SHOP AROUND before deciding on any one particular viatical settlement company. A list of companies registered to do business in the state of California may be obtained upon request from ALRP. [This list may not be inclusive and ALRP provides this solely as a service to our clients. We do not intend to endorse or recommend any particular company.]

Be aware that if your client enters into negotiations with a viatical settlement company, according to California law, see Cal. Welf. & Inst. Code Section 11021, the company is required to inform him or her of the following:

1. Alternatives to selling your policy (as discussed above)
2. Tax consequences
3. Possible interruption of government benefits

Also, all contracts are required to allow the seller 15 days to change his or her mind and rescind contract to sell the policy.

Tax Consequences
Cash benefits received by a person entering into a viatical settlement or accelerated benefits agreement are not included as gross income by the state of California. However, for federal tax purposes, both types of transactions should be treated as taxable for income tax purposes.

Tax consequences should be carefully considered. Not only may selling the policy create a substantial tax liability, it may also affect the amount of medical deductions from income taxes available during the year of the settlement.

Effect on Government Benefits
If your client is receiving any needs-base government entitlements such as Supplemental Security Income (SSI) or Medi-Cal (Medicaid), you both should be aware that a large infusion of cash from the sale of life insurance can make your client in-eligible for these programs until he or she again reaches the income limits of each program.

Viatical settlement and accelerated benefits agreements have no effect on non-means based entitlements such as Social Security.
Disability Income (SSDI), short term state disability (SDI) or Medicare.

BASIC REQUIREMENTS AND FEATURES OF VIATICAL SETTLEMENT AGREEMENTS

The first life insurance policy to be viated was to a company in New Mexico in 1989. As of June 1992, there were over 20 viatical settlement companies operating in this country, eight of which applied for licenses to do business in California. For California licensing requirements, see Cal. Ins. Code Section 10113.2. Although the requirements and guidelines to do business with each company vary, some of the general characteristics are:

- A written statement from a physician is required verifying that the policy holder is of sound mind and a signature from the policy holder acknowledging a life-threatening illness and that he or she has a complete understanding of the process.

- The policy holder must release all medical records (all medical information is subject to CA confidentiality laws).

- The insurance company must be a quality carrier with a good reputation for paying claims.

- The policy must meet the two year incontestability period. [If your policy lapsed at any period, the incontestability period may have been reinstated.]

- Presence of spouses, children, or any other dependents may deter a company from buying policy.

- A written release and consent to the transaction must be obtained from formerly named beneficiaries.

- Viatical companies prefer to buy policies with a minimum face value of $50,000; however some firms will act upon compassion on a case by case basis.

- Many companies prefer that seller consults his or her own attorney or financial planner.

- Companies will purchase policies within group
policies, however, they may offer a slightly lower price than individual policies due to the extra parties involved. [If your client is part of a group policy you should also pay particular attention to other factors such as possible restrictions on conversions.]

- The offering price varies and will be affected by factors such as the policy holder's diagnosis, prognosis, symptoms, life expectancy and administration cost such as securing releases from beneficiaries. [Your client's doctor should be aware of why a request of life expectancy is being made. The shorter the estimate, the more cash he or she is likely to receive. The company will have its own medical staff review these records and will make its determinations as to life expectancy.]

- It generally takes three to four months to complete a viatical settlement agreement. Be sure to discuss time frames before entering into a contract.
Dear Irwin

Nancy Doctor is the attorney I spoke to you about - wants to discuss cashing in on life insurance policies. (570) 835-0850.

- Chief

Also, Bill Aseleyne (393-2498) interested in working on ERISA, insurance caps. He'll write your letter.
TERMINALLY ILL INSURANCE POLICYHOLDERS BETTER PROTECTED

Garamendi Issues First “Living Benefits” Licenses In Nation

San Francisco -- Declaring it a new day for the protection and care of terminally ill life insurance policyholders, Insurance Commissioner John Garamendi today announced that he has issued licenses to three companies that specialize in “living benefits” contracts. These are the first such companies anywhere in the country to be licensed and regulated by a governmental agency.

“Living benefits,” also known as viatical settlement contracts, allow the terminally ill to cash-in their life insurance policies so that they may use the proceeds while they are still alive. The companies pay a percentage of the face value of the insurance policy up front, and in return are named as the policy’s beneficiary. The percentage paid may range from 55-90%. A large majority of those taking advantage of the options offered by “living benefit” contracts have tested positive for HIV disease or have already contracted AIDS.

“Regulation of this new industry is vital to ensure that the terminally ill are fully protected and get a good value for their policies,” said Garamendi. “All too often, the terminally ill are relegated to living their final days in destitution because they have no access to their life insurance benefits. These contracts help those who need the cash immediately to live out their lives in dignity and comfort.”

Under California law, terminally ill people can sell their life insurance policies by naming an individual or company as a beneficiary. Regulation of these contracts now falls under the jurisdiction of the Department of Insurance. In January, 1992, Garamendi established strict licensing procedures which must be followed by applicants for licenses. Applicants are now required to provide the department with specific information on their plan of operation, financial status, past experience in viatical settlement contracts, and methods for obtaining information from medical
providers and policyholders. The procedures require that confidentiality of medical records be strictly maintained.

Joining Garamendi to announce the licensings were representatives of AIDS and cancer activist organizations. "This impressive group of activists has supported living benefits contracts and the options they offer, and have worked with us to ensure that the terminally ill are not exploited by unscrupulous operators," said Garamendi. "Our department will continue to closely monitor this relatively new field and protect these most vulnerable consumers."

The three companies to be licensed by the department are American Life Resources Corporation, A Viatical Settlement Company (Florida), Neuma, Inc., A Viatical Settlement Company (Illinois), and Living Benefits, Inc., A Viatical Settlement Company (New Mexico).

Nationally, 45 companies specialize in viatical settlement contracts, however the three licensed today are the first to be licensed. Of those 45, 16 are currently doing business in this state and have applied for licenses: Affirmative Lifestyles (Texas), Slome Capital Corp. d/b/a Independence Life (California), Life Line, Inc. (California), National Funds for Life (California), Lifetime Options, Inc. (Virginia), LifeAid (California), Legacy Benefits Corp. (New York), Dedicated Resources, Inc. (New York), Lifetime Liquidity, L.P. (California), National Viator Representatives, Inc. (New York), Accelerated Benefits of Washington, D.C. (Virginia), Benefit Advocates (California), Beneficial Options, Inc. (California), Assured Lifetime Benefits of Illinois (Illinois), Aid to Life (California), and Dignity Partners, Inc. (Delaware).

Those attending Garamendi's announcement today include:

-- Paul DiDonato of the AIDS Legal Referral Panel;
-- James O'Brien of the California Association of AIDS Agencies;
-- Regina Aragon of the San Francisco AIDS Foundation;
-- George Yamasaki of the American Cancer Society;
-- Dr. Steve Morin, Congresswoman Nancy Pelosi's office;
-- Ben Shatz of Physicians For Human Rights;
-- John Darragh of Affording Care; and
-- Bill Amblin of the Alice B. Toklas Democratic Club

###
"LIVING BENEFITS"
(Viatical Settlements)

LICENSING REQUIREMENTS

California Department of Insurance

-- There will be a filing fee of $2,833;
-- The applicants' status as an individual partnership or corporation must be identified;
-- The applicant must appoint an individual with a California address to transact business;
-- Names must be filed with both the department and, if incorporated, the Secretary of State;
-- Applicants must enclose a plan of operation providing the following information:
  • type of business
  • geographic location
  • business licenses
  • marketing techniques
  • financial resources
  • treatment of insurance policy beneficiaries
  • discount rate (amount of payment to policyholder) and how determined, as well as
    method and installment of payment and factors that may affect the rate
-- Biographical affidavits must be provided on applicants' officers, directors and key personnel;
-- Financial statements by certified public accountants for the past three years must be provided to
  the department, plus the applicants' past financial experience in viatical settlements;
-- The procedure by which applicants obtain medical information on policyholders must be
  submitted;
-- Specific information on how contracts will be negotiated with policyholders must be provided,
  including detailed forms for obtaining information on the illness, the contract, the policy
  benefits, and the release of medical records;
-- Applicant must provide the specific "living benefits" contract forms they plan to use;
-- How applicant will disclose information on alternatives to contracts, tax consequences, and any
  affect on public assistance benefits; and
-- Policyholders must be informed that they have 15 days to rescind the viatical contract.

###
Send UAtt Package when 9/4

Larry White

Janet Cann. office Call him when I get back

Mail ordered to him of Jim's dreams

45 Fremont St.

SF 94105

Send again by 7/27
AIDS Insurance Scheme Facing Action Today

The North Dakota state securities commissioner and the North American Securities Administrators Association will announce an action today against a company that has devised a new investment scheme: preying on people with AIDS.

The company has been hawking beneficiary rights to life insurance policies to “investors” who will buy the policies at a discount from the ailing policyholders. The policyholders, in turn, get a large percentage of the after-death value of the policy before they die.

According to a statement issued yesterday by Glenn Pomeroy, the North Dakota securities commissioner, and the North American Securities Administrators Association, a trade group with headquarters in Virginia, the practice could result in “major, multimillion-dollar losses if now unwary consumers do not learn to avoid” them.

State regulators are concerned by the recent rise of companies promising investors “big bucks” if they cash out at a discount the life insurance policies of people with AIDS and then name the main beneficiary. Typically, an investor is told that he or she can expect to reap $35,000 or more, depending on how long the person with AIDS lives.

These companies differ, however, from legitimate “living benefits” programs offered by major insurance companies and 20 or so smaller companies in the United States. Such companies will directly purchase policies from the terminally ill and do not solicit third parties to buy them.

Neither Pomeroy nor the securities association yesterday would disclose the name of the company alleged to be involved in such practices or the nature of the actions to be taken.

Meet marathon runner, Tony Post, this Friday, Noon-7:00 p.m. at the Grand Opening of our Rockport Concept Shop.

Are your dress shoes comfortable enough to run a marathon in? Probably not, unless they’re Rockport Dressports. You can meet the man who ran both the New York and the London marathons in Dressports and find out just how good they really feel. You can also check out our newly expanded Rockport Conc Shop featuring styles in widths from B-EE. There also be refreshments and music, and with any men’s shoe purchase, you receive a Rockport canvas bag. Men’s Shoes (d. 46 - 56) Macy’s Union Square, E-

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WE'RE A PART OF YOUR LIFE
New Firms Buy Policies of AIDS Patients  
Offering Cash for Insurance Is a Growing Business

By Greg Steinmetz  
Staff Reporter of THE WALL STREET JOURNAL

Companies that buy life insurance policies from people with AIDS are springing up rapidly, spurring calls for regulation.

Such a company buys life insurance policies at a discount, typically 33% off their face value. It makes all subsequent premium payments and, when the person dies, it collects the death benefit as the sole beneficiary. Some companies buy policies from people with cancer, but the vast majority of the business is AIDS-related.

The practice goes by several names, but the most widely accepted is "viatical settlements," a term derived from a Latin word for the purse an emperor gives an emperor as a threat," said Meir Eliav, president of Legacy Benefits Corp. in New York, a viatical settlement company.

Viatical settlement companies maintain they are more flexible. Although their discounts are steep, they are based on the full value of the policy and are available for AIDS patients who are expected to live for more than a year.

Gay-rights advocates voice concern about the lack of regulation, but they concede that viatical settlements are valuable for people who need the money.

"It's an unfortunate index of the deficiencies of our health and welfare system," said Ruth Finkelstein, director of policy for Gay Men's Health Crisis, an advocacy group in New York.

"We thought at first that it was a bit ghoulish and exploitative," said Nicholas Sprayregen, president of Accelerated Benefits of New York, which has bought more than 20 policies. "Then we thought about it and decided no one is forcing a customer to do this."

Some AIDS patients use their life insurance settlements to prevent eviction from their homes, settle debts or pay for medical treatments. Bob Anderson, a 37-year-old former securities analyst with AIDS, used the money to rent a more spacious apartment in Atlanta and hire a maid. He got $17,000 for his life insurance policy with a $25,000 death benefit after he shopped around for the best deal.

"The firms that sound the most passionate are the most ruthless in lowballing the offer," Mr. Anderson said.

'Potential for Abuse'

Only three states--California, Kansas and New Mexico--have laws regulating the industry. New York attorney Mark Scherzer, who advises clients on settlements, said disclosure requirements are essential. Companies should tell people that their payments will be taxed and that the income could disqualify them from Medicaid and other programs, he said.

"Given the potential for abuse," Mr. Scherzer said, the viatical settlement companies "need to be regulated."

Retired New York financial planner David Petersen, who is working to get regulation in New York, would like safeguards from high-pressure sales tactics. He said consumers are often unaware that settlements are only one alternative. Often, he said, a better option for a consumer is borrowing money from the policy's beneficiary. Beneficiaries don't have to pay taxes on a death benefit.

Idea From a Talk Show

Robert Worley Jr., an Albuquerque, N.M., financial planner, is believed to have started the first viatical settlement company. He says he got the idea to buy policies while listening to a radio talk show. A caller was complaining that his life insurance company refused to buy back his policy even at a 50% discount. Mr. Worley made some inquiries and decided he could fill the need, despite the difficulties in trying to predict when someone will die.

"What we do scares actuaries," said Mr. Worley, whose firm, Living Benefits Inc., is the country's oldest and largest viatical settlement company.

Living Benefits is now part of a Nasdaq-listed company, Delaware-based CAPX Corp. A company financial statement from the end of last year said CAPX has paid $11.4 million for policies with death benefits of $17.3 million and has a further $47 million available to buy policies. CAPX had a loss last year because of high advertising costs and interest expense on its debt.

Each of the companies works differently. Some are no more than brokers, passing on referrals to better-capitalized companies a fee. San Antonio-based Affirmative Lifestyles Inc. pools policies and sells them to limited partners. Life Benefits Corp., based in Dayton, Ohio, only buys policies from people with more than two years to live.

Mr. Sprayregen's company, funded by money from the family real estate business, is among the most aggressive advertisers. In addition to advertising in gay publications, it recently took out its first ad in New York magazine.
By: John Darragh

POSITION STATEMENT:

Affording Care, a 501(c)(3) in the making, is the national education and information center for financial planning for serious illness or injury. Affording Care is dedicated to promoting financial education for all those who are seriously ill or injured. As such, Affording Care endorses strongly the concept of viatical settlements as providing needed funds for the terminally ill.

NASAA HOLD NEWS CONFERENCE

On August 19, 1992, a press conference was held by NASAA (North American Securities Administrators Association) on an offering that appears to be for a viatical settlement funding company. That offering is being judged in violation of compliance with securities registration requirements by the North Dakota Securities Commissioner.

David Petersen was asked to appear as part of the press conference panel. As a PWA and as an advocate for PWAs and the terminally ill, David stressed the urgent need of the terminally ill for viatical settlements.

David, and Affording Care, emphasized that the business of providing viatical settlements is new, and it is a sensible and humane response to the very real needs of the terminally ill. They welcomed the concern of regulators to help shape a young industry in responsible ways. But they hoped that overzealousness or misunderstandings won't stunt the potential for helping the terminally ill. They stressed that the viatical industry is not on trial here; that this is just a correction of a possible abuse. This incident serves to demonstrate that there is yet much education to be done in this area.

The company whose offering is in question apparently revealed names in sales materials to potential investors. Mr. Petersen stressed the seriousness of such breaches of confidentiality but affirmed the safeguards practiced in the industry for confidentiality.

Since the news conference, it is my understanding that lawsuits have been filed and no additional information is available.

CALIFORNIA:

PENDING LEGISLATION:

Assemblyman Steve Peace (D-San Diego) has introduced AB 3530 to make technical clarifications to his "Living Benefits Contracts" legislation. It is my understanding that the bill will change the term now used as "Living Benefits Contracts" to "Viatkical Settlements". In addition, the bill will increase the California filing fee from $1,000 to $2,833.

For additional information, contact: Mr. David Takashima, Chief of Staff, Assemblyman Steve Peace, P.O. Box 9492849, Sacramento, CA 94249.

LICENSING:

As of August, 1992, 13 viatical settlement companies have applied to the California Department of Insurance (CDOI) to be licensed to solicit business in the state. Currently 12 are active companies.

It is my understanding that the Department will be issuing licenses shortly after the passage of AB 3530.

CDOI - NEW ADDRESS:

The division of the CDOI that handles viatical settlement applications has moved. To contact Michelle Rowe, Legal Analyst or Nancy Ayoob, Staff Counsel, mail inquiries to: CDOI, Legal Division, 21st Floor, 45 Fremont Street, San Francisco, CA 94105. Michelle's new telephone number is 415/904-5694.

KANSAS:

The State of Kansas now requires viatical settlement firms to register with their Department of Insurance 90 days prior to viaticating a life insurance policy.

Since the passage of SB 519, Kansas has been in the process of establishing guidelines to regulate the industry and has requested information from the California Department of Insurance on their procedures.

For additional information contact: Mr. Marlyn K. Burch, Life Insurance Supervisor, Kansas Department of Insurance, 420 S. W. 9th, Topeka, Kansas 66612-1678, phone 913/296-3071.

NATIONAL:

BRADLEY BILL INTRODUCED ON SENATE FLOOR:

Just days prior to the congressional recess in August, 1992, Senator Bill Bradley's (D-NJ) legislation S 8202 (formerly S 2222) was introduced on the Senate floor. This action by Bradley was not anticipated in this session of Congress.

S 8202 is similar to Rep. Barbara Kennelly's (D-CT) pending legislation HR 134. Both pieces of legislation pertain to the non-taxation of the receipt of an accelerated benefit or a "qualified terminal illness rider" offered by life insurance companies. "...the term 'terminally ill individual' means an individual who has been certified by a physician, licensed under State law, as having an illness or physical condition which can reasonably be expected to result in death in 12 months or less."

The viatical settlement industry has begun action to have "viatical settlements" included in the legislation.

For more information call the viatical settlement companies.

For Additional Information Contact
John Darragh 707/579-5303 FAX:1-707-575-7526

received aug 3 1992

723 Humboldt st

Santa Rosa a
95404
August 25, 1992

Executive Director
AIDS Legal Referral Panel
114 Sansome St., Ste. 1103
San Francisco, CA 94104

Dear Executive Director,

In this era of escalating health care costs, Neuma is at the forefront of a new industry. For individuals who face a life threatening illness, financial resources can be critical. When health care benefits have been exhausted or are inadequate, the professionals at Neuma provide viable solutions.

The people at Neuma recognize the special needs of people living with HIV. Neuma offers viatical settlements (also known as accelerated living benefits) for individuals who qualify by purchasing all, or part of their life insurance policy. Neuma becomes the irrevocable beneficiary and when appropriate assumes the responsibility for paying the premiums.

Enclosed, please find our descriptive literature. You will also discover an article that was printed in the November 24th issue of the Chicago Sun-Times along with a current issue of Neuma News. Should you or your staff wish to learn more about Neuma, please feel free to contact me at our headquarters in Evanston, Illinois (800) 457-7037.

Kindest Regards,

Michelle R. Jahn
Senior Executive Vice President
Marketing and Sales
September 1, 1992

Director Social Services
AIDS Legal Referral Panel
114 Sansom St #1103
San Francisco, CA 94104

Dear Lady/Sir:

Enclosed are program materials about Lifetime Options, Inc., and our services of financial assistance to persons with life-threatening illnesses such as AIDS and cancer.

I would like you to be aware of Lifetime Options as a financial resource for those you help and care for. Also, I would like you to consider our services for listing in your Resources, Information and Guidance Program Directory.

Please let me know if you want me to send you more brochures for your resource information center or waiting room by calling me at our toll free number (800) 999-5419. Our brochures are available in both English and Spanish, please specify.

We take pride in the quality of the service we provide and look forward to the opportunity to serve you and those in your care. LIFETIME OPTIONS is a wholly owned subsidiary of a publicly owned corporation with the financial strength to meet the needs of those people you help.

Upon request we will gladly send you financial information to give you the comfort you need to know that you are dealing with a highly reputable, financially strong institution.

Thank you for your consideration.

Sincerely,

Stella Martinez
Program Director
It's comforting to know there are financial options when you're facing a life-threatening illness...

LIFETIME OPTIONS, INC.
2700 South Quincy Street, Suite 540
Arlington, Virginia 22206
(800) 999-5419
(703)379-8906

LIFETIME OPTIONS, INC.
IMMEDIATE FINANCIAL ASSISTANCE FOR THE TERMINALLY ILL.
LIFETIME OPTIONS ANSWERS YOUR QUESTIONS.

Who Is Lifetime Options?
LifeTime Options is a wholly owned subsidiary of a publicly owned corporation. It was formed specifically to provide financial options for people facing a life-threatening illness by purchasing their life insurance policies. The cash proceeds from this purchase may then be used in any manner the individual wishes.

Who Qualifies?
The individual covered by the life insurance policy must have been diagnosed by a medical doctor as having a life expectancy which does not exceed two years. The policy itself must be an individual, not a group, policy. However, most group life insurance policies can be converted into individual policies at the time employment is terminated. The policy must be issued by a highly rated life insurance company and must have been in full force for at least two consecutive, uninterrupted years at the time Lifetime Options purchases it.

How Much Will Lifetime Options Pay For My Policy?
Each case is different. The principal factors that Lifetime Options considers are: (A) the amount of the death benefit payable under the policy, (B) the maximum life expectancy of the individual covered by the policy, (C) the amount Lifetime Options anticipates paying in premiums, and (D) the interest cost Lifetime Options anticipates incurring to finance the purchase of the policy.

In general, the purchase price amounts to between 55% and 80% of the death benefit payable under the policy. Upon written request, Lifetime Options will provide you with a written purchase price quotation, based on the information supplied in your application.

After Selling My Policy To Lifetime Options, Do I Have Any Further Obligations?
None whatsoever. After purchasing your policy, Lifetime Options is the record owner of the policy, responsible for all obligations, including the payment of premiums. Likewise, Lifetime Options is the designated beneficiary under the policy. All "irrevocable" beneficiaries, if any, are required to sign documents disclaiming their interest in the policy.

What If I Change My Mind Afterwards?
Following payment of the purchase price, the sale is subject to a 15 day grace period during which you may, if you so desire, "undo" the sale by refunding the full purchase price along with certain fees, expenses, and any premiums paid by Lifetime Options. If you "undo" the sale, ownership will be promptly transferred back to you.

How Do I Proceed?
Step 1: Call our toll-free number: (800) 999-5419. Or in Virginia, call (703) 379-8906. We'll send you an application, together with medical release and insurance company release forms, which we need in order to evaluate your application and determine a possible purchase price.

Step 2: Complete and return the application and the releases. If you have any questions, please feel free to call at any point in the process. Once we receive your materials, we will get back to you as quickly as possible to let you know if we can purchase your policy and, if so, what we will pay for it.

Step 3: When we are in agreement on the purchase of the policy, we will send you a "Purchase and Sale Agreement", along with other forms necessary to transfer ownership of the policy. Once the documents have been signed by both you and Lifetime Options and your insurance company has acknowledged the change of ownership, Lifetime Options will pay you the full agreed-upon purchase price for your policy. The entire process can usually be completed within six to eight weeks after we receive your completed application and release forms.

All medical records and other information are held in the strictest of confidence. In addition, Lifetime Options encourages you to seek legal, financial, and/or tax advice before completing the sale of your life insurance policy. We hope that we can be of service.

For More Information, Please Call Or Write:

LIFETIME OPTIONS, INC.
2700 South Quincy Street, Suite 540
Arlington, VA 22206
(800) 999-5419
(703) 379-8906

Stella A. Martinez
Program Director
‘Win-Win’ Strategies for Wiser Charitable Giving

By JONATHAN PLUTCHOK, JD

Charity is at the cutting edge. Some of today’s most creative and sophisticated planning is being done in the area of planned giving. And a few financial planners still may be surprised to learn that some charitable contribution strategies benefit the donor as much as the charity.

At a presentation at the IAFP’s Conference for Advanced Planning last May, Houston attorney Robert L. Coffey surveyed a number of advanced tax-planning techniques for clients who already possess an inclination toward philanthropy. Let’s review a few of the most useful strategies that Coffey so ably explained.

Pay Now, Deduct Later
Let’s start with one of the simpler ploys. Let’s say you are in charge of your alma mater’s fundraising campaign for a new classroom building. One of your old classmates is primed to donate $1 million to the university, but there’s one hitch: Due to an earlier commitment to his church, he already has exceeded the ceiling on income-tax deductions for charitable contributions, both for this year and for the next three years. (Deductions for cash gifts to colleges and churches generally are limited to 50% of adjusted gross income; excess donations can be carried over and deducted in the five succeeding years.)

Your classmate would prefer to postpone his donation to the university until he can realize some tax benefit. But if he doesn’t put a check on the table during the current campaign, his name won’t appear over the lecture-hall door.

Coffey suggests that the donor lend a million dollars to the university, so the money will be in hand for the building campaign. In four years, when the income-tax charitable deduction becomes available to the donor again, he then can forgive the loan. The forgiveness is the donation, and qualifies for deduction at that time.

Problem: Plunging Income
Planners are accustomed to recommending charitable remainder unitrusts (CRUTs) to clients planning large donations. The donor contributes to a trust that promises him (or another income beneficiary he designates) an income for life or a number of years, after which the charity collects whatever money is left in the trust. The beneficiary’s income is a percentage of the trust’s assets, as appraised from year to year. CRUTs offer flexibility in future contributions and the potential for escalating payouts to the income beneficiary as the portfolio grows in value.

However, for fear of losing money or cutting their payouts to the income beneficiary, many CRUTs seek the ultimate in safety by investing in government bonds or similar fixed-income instruments. They overlook the fact that government bonds and similar instruments are very sensitive to interest rates. So if rates rise, the value of the CRUT’s bonds can plummet ... and when the portfolio is revalued for the year, the beneficiary’s annuity will drop off too.

The solution is a charitable remainder annuity trust (CRAT). The main difference between a CRUT and a CRAT is that the latter distributes a fixed-dollar amount, or a fixed percentage of the initial value of the trust to the income beneficiary each year. (The CRAT also cannot accept later additional contributions, as can the CRUT.)

While the CRAT lacks flexibility and inflation protection, it should be considered when it is important that the income beneficiary’s annuity remain predictable and adequate.

Advantage Planning

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AFFORDING CARE

THE NATIONAL EDUCATION AND INFORMATION CENTER OF FINANCIAL PLANNING FOR SERIOUS ILLNESS OR INJURY

365 West 52nd Street
Suite 4B
New York, NY 10019
(212) 262-9449
FINANCIAL PLANNING CAN REDUCE THE PROBLEMS SERIOUSLY-Ill OR INJURED INDIVIDUALS FACE IN OBTAINING GOOD CARE AND A BETTER QUALITY OF LIFE:

People with serious illness or injury face financial challenges resulting from reduced income, increased medical costs and numerous lifestyle adjustment expenses. Planning ahead financially could greatly assist these people, but financial planning strategies can be difficult to understand and hard to access for the average person.

Cancer, AIDS, heart disease, injuries and numerous other serious conditions strike every sector of our population each year. For these millions of Americans and their families, financial resources have a significant impact on both the "quantity" and "quality" of life:

- Studies indicate a correlation between adequate financial resources and longevity. For example, AIDS patients with private medical insurance live much longer than those who must rely on care provided by the current system of public assistance.
- Adequate finances can help seriously-ill or injured individuals marshal their resources, enabling them to continue living in their homes, to visit distant relatives, or accomplish meaningful personal goals.

AFFORDING CARE IS THE ONLY NATIONAL ORGANIZATION PROVIDING FINANCIAL PLANNING INFORMATION TARGETED TO SERIOUS ILLNESS OR INJURY:

Our mission is unique: Affording Care seeks to empower individuals living with serious illness or injury to make positive financial choices—enabling them to afford good care and a better quality of life. By delivering easy-to-understand financial information through a collaborating network of financial and healthcare professionals, Affording Care serves as the national education and information center of financial planning for serious illness or injury.

Until now, there has been no national center targeting the financial problems arising from serious illness or injury. The result:

1. Complex, often-contradictory, financial information has not been understandable to seriously-ill or injured individuals. Financial options which could enhance the quality of life have not been as easily-accessible or widely-disseminated as they need to be.
2. Financial and healthcare professionals tackling particular problem areas have been unable to use and build upon the progress of others who have worked through similar problems (the phenomenon of "re-inventing the wheel").

3. Rapidly changing policies, regulations and strategies constantly render the very few available financial materials and publications out-of-date. Financial planning information exchange and networking among professionals working with the seriously-ill or injured has been inadequate.

Without the unique services of Affording Care, individuals, professionals and organizations have been fending for themselves. Local services have often been inadequate, uncoordinated or duplicated. Medical, disability and life insurance policies have been lost by individuals just when they need them the most. Financial opportunities that would mean greater peace-of-mind have been missed. Good medical care has been underutilized or simply unavailable.

Affording Care tackles these problems with education and information services that empower seriously-ill or injured individuals to maximize their financial resources. We achieve this by providing two kinds of valuable resources:

1. Comprehensive, up-to-date financial planning information targeted to financial and healthcare professionals, and

2. Easy-to-understand materials which are specifically-designed to be passed on to their clients and patients.

These information resources are delivered through a bimonthly newsletter, an annual journal, a clearinghouse of the latest strategies, research, publications and other media, and an institute providing seminars and public education.

BY LEVERAGING OUR SERVICES THROUGH A COLLABORATING MULTI-DISCIPLINARY NETWORK OF PROFESSIONALS, AFFORDING CARE WILL EXPAND THEIR NATIONAL PROGRAM IMPACT AND MAKE THE MOST OF ITS RESOURCES:

AFFORDING CARE'S PROGRAMS WILL BE IMPLEMENTED IN A CAREFULLY-PLANNED "ROLL-OUT" SEQUENCE AS FUNDING AND STAFFING RESOURCES DEVELOP:

Affording Care Newsletter.
Free bimonthly with 26 pages on high-quality color stock (20 information pages targeted to professionals, 6 "acknowledgement pages" for its corporate sponsors/underwriters). A significant portion of our print run will include "individualized" newsletters with 2-page sections of information specific to a particular disease such as cancer, or to a particular professional group such as social workers. By working with selected collaborating organizations
dedicated to these diseases or professional groups, we will provide information sections specific to their concerns, and these “individualized” newsletter print runs will be distributed through the various organizations’ network of professionals as an added-value member benefit. Each issue also contains a ready-to-photocopy-and-distribute 4-page “pull-out insert” targeted to clients/patients with easy-to-understand information.

The Journal of Financial Planning for Serious Illness or Injury.
An annual journal with over 100 pages of innovative financial planning strategies. Supported by 1-3 underwriters and a low-cost per issue copy price. Targeted to the professional.

Affording Care Clearinghouse.
Publications, original research and a computer bulletin-board database of up-to-date information for professionals; easy-to-understand learning programs (manuals, books, video and cassette tapes, etc.) for individuals.

Affording Care Training Institute.
Seminars for individuals, professionals, organizations and corporations providing training, information exchange and networking. The program’s impact and cost-effectiveness will be multiplied by “piggy-backing” seminars into existing community resources and professional conferences. Through this concept, the Institute will establish mutually-beneficial partnerships with a variety of related financial and healthcare professional groups.

Affording Care will also create greater public awareness of the need for “preventive” financial planning for every individual, regardless of current health status, to avoid future financial problems caused by serious illness or injury.
By working with public relations consultants to secure television, radio, newspaper and magazine exposure, Affording Care will become a national “voice,” encouraging all individuals to plan for the financial challenges that serious-illness or injury creates. Our mission concepts lends itself well to “ask-an-expert” interviews and “case study” feature stories, and their impact will encourage people to consider financial planning strategies which anticipate the possibility of disability, expensive medical treatments or significant lifestyle adjustments.

Affording Care is an organization with well-designed, cost-effective programs enabling seriously-ill or injured individuals to secure good care and a better quality of life through financial planning. Working in partnership with voluntary health organizations and multi-disciplinary professional groups, Affording Care fills the need for a national coordinating center delivering accessible, easy-to-understand financial education and and information services.

We urge you to join us in a nationwide effort to help people living with serious illness or injury afford the care they need.
August 29, 1992

Mr. James Lee
AIDS Legal Referral Panel
114 Sansome Street
Suite 1103
San Francisco, California 94104

Dear Jim:

FUND FOR THE TERMINALLY ILL

I was sorry to learn that you were on vacation during the time I was in San Francisco for the American Bar Association convention. I tried a number of times to connect with Kristin Chambers, but she never returned my calls. I concluded that she was too busy on other convention-related events to get back to me.

My only agenda was to introduce the FUND to ALRP, so that when I have received the necessary backing to begin operations, you would at least have heard of me. Since I was unable to do that in person, I will do the second best thing--introduce the FUND by letter.

I enclose a copy of a memorandum that I use when approaching a company, foundation or other possible donor. I also enclose a copy of an article that appeared in last Sunday's Washington Post about viatical settlements. The last four paragraphs of the article describe the role I hope to have the FUND play in this business.

I hope to be able to be calling you again in the not too distant future with the news that you can add the FUND to your referral list.

If you have any questions about the FUND or suggestions concerning possible donors, please let me know. Thank you for taking an interest in the FUND.

Sincerely,

[Signature]
JOHN FREEMAN BLAKE

enclosures
Fatally Ill Should Be Wary On Sale of Death Benefits

Experts Warn of Scams, Suggest Checking Other Options

By Albert B. Crenshaw
Washington Post Staff Writer

For a person dying of AIDS, cancer or other of today's gruesome killers, life insurance can seem like a cruel joke.

There the policy sits, waiting to make somebody a lot better off, but doing nothing to ease the suffering of its owner, who now may be living in the most abject poverty.

The insurance industry in the past couple of years has begun moving to ease this problem. More than 150 companies now offer what are called "accelerated death benefits" products. These are policies, or riders on existing policies, that allow the insured to tap the death benefit prior to death if certain terms are met.

Such products commonly allow withdrawal of a portion of the death benefit if the policyholder contracts a terminal illness or is in need of long-term care. Some allow such withdrawals for any of certain "dread diseases," whether or not they are terminal.

But many companies still do not offer accelerated benefits, nor do they provide for them on older policies. So an industry has sprung up to buy death benefits from terminally ill policyholders, providing the sick person with cash and the buyer, not incidentally, with a tidy profit.

These companies in effect buy a dying person's life insurance policy and become the beneficiary. Such an arrangement is called a "viatical" settlement.

The buyers pay less than the face value of the death benefit, of course, so that when the policy pays off they come out ahead.

Though often described as ghoulish, the business is generally legal and is regarded by the AIDS community as an important way for many people to obtain desperately needed money. AIDS treatment is enormously expensive, and many AIDS sufferers have very limited means. In fact, a recent survey by the National Association of People With AIDS here found that more than half are living on $12,000 a year or less.

The viatical settlement business is largely unregulated, however, and it appears that scam artists are now invading the field.

Officials of the North American Securities Administrators Association reported last week that some firms are promoting viatical settlements as a hot investment. They are mailing out solicitations to potential investors, offering them a chance to bet on the death of an AIDS sufferer and promising profits of up to 50 percent in one year if the AIDS patient dies soon enough.

A solicitation received by a North Dakota resident included what the state's securities commissioner, Glenn Pomeroy, called "a menu of . . . people who are dying." The list included the victims' insurance company, the amount of the policy, their T-cell count and their life expectancy in months. The AIDS patients' names were not included, but officials worry that they might become public, given all the other details provided.

Pomeroy said the offering amounted to an unregistered security, and offering it for sale was illegal. He said his agency was issuing a cease-and-desist order against the company.

Officials of Florida, Texas and Ohio are also investigating suspicious firms that have surfaced in the viatical settlement market. They cautioned AIDS sufferers and investors to be wary in dealing with any viatical settlement company and to be downright suspicious of unsolicited marketing pitches.

Pomeroy and David Petersen, a New York financial planner who specializes in financial issues facing AIDS sufferers, noted that they are not out to destroy the viatical settlement business. Reputable companies "meet a real need," said Petersen, who estimates that these settlements have now grown into a $100 million-a-year business, involving not only AIDS victims but also sufferers of cancer and other dread diseases.

Names of legitimate viatical settlement companies are available from many AIDS support groups. Petersen has compiled a list of 25, which the District-based National Association of People With AIDS distributes.

But Petersen and others noted that selling one's life insurance should be viewed as a last resort and should be undertaken only after careful consideration. Discounts are often very stiff—30 percent to 40 percent from the face value of the policy, meaning that the owner of, say, a $100,000 policy might realize $60,000 to $70,000 in such a sale.

In addition, the seller would have to pay income tax on the payment.

Another problem arises, said Robert J. Darga of the National Association of People With AIDS, if the policy holder is receiving any sort of public assistance. Because there are income limits on most public programs, the infusion of cash could jeopardize the sick person's eligibility for benefits.

And if the sufferer holds on to the money from the sale, it is also counted as an asset—and that too could disqualify him or her, Darga said.

Both Petersen and Darga suggested that insurance policy owners who need money should first consider borrowing against the policy. Such loans are usually granted at relatively favorable interest rates and are not subject to income tax.

If a loan is not available, the policyholder should seek an accelerated death benefit from the company. Some companies allow policyholders to obtain such benefits for a fee even if the policy did not provide for it originally.

Accelerated death benefits are at the moment taxable, though the tax bill currently pending before the Senate contains a provision that would exempt them from tax. Death benefits paid after death are not subject to income tax, though they can be included in the dead person's taxable estate.

Both loans and accelerated death benefits usually leave some value in the policy. Most companies will not let the policyholder borrow the entire value of the policy nor will they pay 100 percent of the death benefit before the insured person's demise. Thus, both of these approaches leave something for the policyholder's heirs—which presumably was his or her intention in purchasing the policy.

Only if these avenues are not available should a viatical settlement be considered, they said.

A Washington attorney named John Free­man Blake is trying to set up a nonprofit or­ganization to improve the terms of viatical settlements. Blake's Fund for the Terminally Ill hopes to obtain credit guarantees from corporate sponsors that would allow it to pay benefits to sick people for life in return for being assigned their insurance policies.

The problem with normal viatical settle­ments is that the policy owner gets a lump sum. When that is spent, "they are back where they started except without a life insu­rance policy," he said. Under his plan, ben­eficiaries would get a stream of income that would last as long as they live.

Blake figures he needs to raise $1 million—or obtain that much credit—to get go­ing. But if possible, he said, his system would allow policyholders to recover much closer to 100 percent of the face value of their poli­cies.

"The fund can be set up in a fashion so amounts distributed are tax-free, and with the nonprofit orientation, it ought to be able to offer dollars much closer to the face value of the policy," Blake said. He added that his plan would also have a "competitive impact on the for-profit industry," creating pressure on those firms to offer better terms.
MEMORANDUM

TO: Prospective Donors and Guarantors

DATE: August 5, 1992

SUBJECT: Grant Request to Finance Public Charity for the Benefit of the Terminally Ill, known as the Fund for the Terminally Ill.

This memorandum contains a proposal for individuals, foundations, companies and governmental agencies ("Donors"), to make grants (either outright, or by guaranteeing a line of credit) to provide some or all of the seed financing for a public charity to be known as the Fund for the Terminally Ill (the "FUND"), a Delaware non-stock, not-for-profit corporation.

The FUND is exempt from Federal income tax under IRC §501(c)(3), and qualifies as a public charity under IRC §509(a)(1). A copy of the advance ruling received from the Internal Revenue Service dated December 23, 1991, is attached to this memorandum.

Mission Statement for the FUND

The mission of the FUND is to ease the suffering of terminally ill individuals, to lessen the stress associated with terminal illness, to provide financial support to terminally ill persons who are indigent, and to enable terminally ill persons to live their remaining lives in dignity and with financial security. The FUND will accomplish its mission by making grants and interest-free loans to terminally ill persons. Grants will be made to terminally ill persons who are without assets or income. Loans will be made to terminally ill persons who do not have sufficient income to support themselves, but have assets that are not income producing. Loans will be repaid to the FUND after the death of the beneficiary from non-productive assets (normally the proceeds of life insurance policies) which the FUND, in turn, will use to provide new grants and interest-free loans to other terminally ill persons.

Statement of the Problem

Within the past few years a thriving business has developed under which terminally ill persons who own life insurance policies are matched up with "investors" who purchase the policies from the terminally ill for a lump sum payment. The growth of this business
(known as "viatical settlements") has been rapid and strong. It is estimated that $5 million (face amount) in life insurance policies were brokered in 1989, $40 million in 1990, and $100 million in 1991.

Private viatical settlements are controversial, for several reasons:

1. The investment motivation of the purchasers of these life insurance policies is, at best, suspect. Wealthy "investors" are making unconscionable profits at the expense of financially desperate, terminally ill individuals. As a result, the transactions are uniformly described as "ghoulish" in nature.

2. Because of the financial difficulties associated with terminal illness, terminally ill individuals are easy prey to the profiteering of aggressive "investors." Most terminally ill persons receive no more than 65% of the face value of their insurance policies. Many receive no more than 50%.

3. The payment made to the terminally ill insured is reduced even further by substantial income taxes imposed upon the gain (that is, the excess of the sales price over premiums paid).

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1 "Viaticum" (pronounced vi* at* i* cum) is a Latin word referring to the "provisions a traveler carries on his journey," or "a stipend for travel expenses."


3 See, United States Internal Revenue Code of 1986 ("IRC") §101(a). The statement was made to the FUND by a viatical "broker" that the purchase price was "non-taxable" to the terminally ill insured. On further questioning, the broker admitted that this statement meant nothing more than the fact that his company would not file a Form 1099 with the IRS reporting the transaction; moreover, it was volunteered that,
4. A question arises as to whether or not the investor has an insurable interest in the policy, leaving some doubt concerning the obligation of the insurer to pay the proceeds.4

Insurance companies have also begun to make policy proceeds available to the terminally ill before death. Known as "accelerated benefits" or "living benefits," these distributions represent an alternative means of meeting the needs of some insured persons.

Senator William W. Bradley (New Jersey) and Congresswoman Barbara A. Kennelly (Connecticut) have both introduced bills to address tax issues related to accelerated benefit distributions. The Bradley bill (S 284) and the Kennelly bill (HB 143), are nearly identical, and both provide that the proceeds of life insurance policies received before death because of a terminal illness are exempt from income tax. Terminal illness exists if a person is expected to die within one year of the receipt of the proceeds.

Recently, the Bush administration announced its opposition to the Bradley and Kennelly bills, citing loss of revenue as the grounds for its opposition.5 Because of the opposition of the Bush administration, it is not expected that either of these bills will be enacted. Furthermore, even if these bills were enacted, the tax consequences of private viatical settlements would not be affected by the legislation.

Despite the controversial nature of private viatical settlements, the terminally ill have welcomed the settlements because they turn unproductive assets (life insurance policies) into cash. Often, the cash is desperately needed to continue expensive medical care. While viatical settlement transactions may be

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5 Testimony of Kenneth Gideon, Assistant Secretary of the Treasury for Tax Policy, before the Senate Finance Taxation Subcommittee, June 12, 1991.
described as "ghoulish," that adjective is only descriptive of "investors." It is not descriptive of the terminally ill insured, who most likely have no other financial resources available to them.  

On May 31, 1990, the American Broadcasting Company program, Prime Time Live, aired a story on the private viatical settlements industry, entitled "Final Payments," with Diane Sawyer. When the producer began researching the issue, she expected to end up with a story that was sharply critical. However, the compelling needs of the terminally ill that were being met by these transactions, changed the story into one that was cautiously sympathetic to them. A copy of "Final Payments," will be made available on 1/2 inch VHS video tape, if requested by a Donor.

Rationale for the FUND

The business of the FUND is, in short, to intercept private viatical settlements, replacing for-profit transactions with charitable transactions in which the support and care of the terminally ill are the sole motivating factors.

Some states have enacted legislation which will allow insurance companies to pay accelerated benefits. Several insurance companies are advertising accelerated benefits as a new policy feature, which is offered as an optional rider sold for an additional premium. If, despite the Bush administration's opposition, the bills introduced by Senator Bradley and Congresswoman Kennelly are enacted into law, it is likely that many more insurance companies will offer similar riders. However, with only a few notable exceptions, most insurance companies are not offering to paying accelerated benefits to existing policy holders. Rather, accelerated benefit riders are employed to assist in the sale of new policies. Therefore, with few exceptions, currently insured, terminally ill persons do not have access to accelerated

6 For a description of typical business practices of viatical settlement companies, see, David Petersen, "Viatical Settlements, Good News for the Terminally Ill," Insurance Sales (February, 1991).

7 It should be noted that Prime Time Live has expressed interest in doing a follow-up segment about the FUND, once it has become operational.
benefits and must turn to private viatical settlement companies to convert life insurance policies into cash. The FUND gives terminally ill persons the choice to avoid private viatical settlement transactions and to meet their critical needs for immediate cash at the hands of an organization that does not seek to make a profit.

In addition, funds received by terminally ill persons—either as sale proceeds from a private viatical settlement transaction, or as accelerated benefits from an insurance company—must pay income tax on the amounts received. In contrast, the FUND will avoid negative tax consequences by making benefits available as an interest-free loan.8

If, despite the Bush administration’s opposition, the Bradley and Kennelly bills are enacted into law, the FUND would still have an important role in easing the suffering of terminally ill persons. This is because both bills limit their benefits to persons who are believed to be facing death within one year. In contrast, the FUND can establish its own reference for life expectancies, and can vary its definition to tailor it to the specific progressions of each terminal illness.

If the insurance industry could handle all of the accelerated benefit needs of the terminally ill insured, the rationale of the FUND would not be diminished. This is because the insurance industry cannot help terminally ill persons who do not own life insurance. In contrast, the FUND may give support to persons who have other non-income producing assets, such as a principal residence.9 In addition, the FUND has more options for structuring support payments to the terminally ill than does the life insurance industry. For example, instead of making a lump sum settlement, the FUND can make support payments in periodic installments. This

8 Interest free loan may, in some cases, provide a tax benefit to the debtor, in the form of a deduction in the amount of the interest that was waived. See, IRC §7872(a). However, it is expected that few (if any) beneficiaries of the FUND could take advantage of this deduction because the mission of the FUND is to assist persons who are without sufficient income to itemize deductions.

9 IRC §170(f)(3)(B)(i) makes specific reference to the gift of a remainder interest in a principal residence as giving rise to an income tax charitable deduction.
flexibility gives the FUND the ability to assist more people than it could if lump sum payments were made.

The FUND is clearly a more preferable environment than private, for-profit viatical settlements for the following reasons:

1. Uncertainties relating to the insurable interest of the beneficiary of a life insurance policy can be avoided in the charitable environment because the FUND can take an irrevocable beneficiary designation, rather than becoming an owner of the policy.\(^\text{10}\)

2. There need be no facade of fair market value exchange. The FUND can gear payments to identifiable needs, rather than pretending to make an exchange for value. By gearing payments to identifiable needs and making payments in installments, the FUND can meet the needs of many more terminally ill persons than can private viatical settlements.

3. In the charitable environment, the negative income tax consequences, both to the terminally ill beneficiary and to the FUND can be avoided. Moreover, it has long been recognized that a gift of life insurance to a charity can give rise to both income and transfer tax deductions, depending upon the time and manner of the gift.\(^\text{11}\)

\(^\text{10}\) One insurance company representative knowledgeable about viatical settlements told the FUND that the issue of the insurable interest of investors is one that is just beginning to be dealt with by the insurance industry. However, this spokesman also said that, as a matter of policy, most companies would not challenge the insurable interest of a charitable organization. If it became necessary for the FUND to take an assignment of a policy, the FUND could seek a commitment in advance from the carrier that it would not challenge the FUND's interest in the policy when the proceeds became payable.

\(^\text{11}\) See, for example, Treas. Regs. §1.170A-1(c)(1); and, PLR 8714037.
4. Those taking advantage of the FUND's benefits have the satisfaction of knowing that they will be helping others who find themselves in a similar health crisis at a later time.

5. Eventually, the FUND will have a regular flow of funds to enable it to continue meeting the needs of others as more and more people find themselves in a terminal health condition.

Structure and Operations of the Fund

The structure of the FUND is as follows:

1. The FUND has been formed as a Delaware, non-stock, not-for-profit corporation.

2. The board of directors of the FUND currently consists of only two persons. The By-Laws of the FUND provide that the Board of Directors may vote to change the number of Board members from time to time. As soon as the FUND begins operations, it is intended that the Board of the FUND will be increased. In order for the FUND to perform its intended charitable function, it will be necessary for the Board to consist of highly visible and well respected members of the business community and the professions. It is intended that the Board will be expanded to 12 to 15 members possessing these characteristics. It would also be desirable to have a highly placed and recognized name as an Honorary Chair to attract media attention to the FUND.

3. A candidate is qualified as a beneficiary of the FUND by meeting all four of the following conditions:

   (a) The candidate is determined to be terminally ill, in the first instance to by the candidate's own doctor, and in the second instance by a doctor representing the FUND. An estimated life expectancy should be used as an element of the qualification. However, different life expectancies exist for each identified terminal illness. In addition, life expectancy limitations will have to be changed from time to time, in order to take into account the effect of new therapies
and medicines introduced from time to time that extend life expectancies.  

(b) The candidate is determined to be disabled (unable to be gainfully employed) according to an established standard, such as the definition used by the Social Security Disability Insurance program.  

(c) For candidates seeking grants, a determination is made that the candidate is indigent, according to an established standard, such as the definition used by the Federal Supplemental Security Income program.  

(d) For candidates seeking loans, a determination is made that the candidate has some valuable asset (life insurance, real property, or other similar asset) available for transfer to the FUND—either immediately or upon the death of the candidate. The FUND makes a determination that it


13 For purposes of Social Security Disability Insurance, a person is disabled if he or she is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR §404.1505.
is more likely than not that the value of the asset donated (or to be donated) exceeds the support payments expected to be made to the candidate. This determination would be made with the assistance of an actuary serving as an adviser to the FUND. Great care must be exercised in making this determination, so that the FUND is not seen as being "profit minded" in making its payment decisions for particular beneficiaries. However, the unique characteristic of the FUND is its intention to create a revolving fund for the support of the terminally ill. Therefore, candidates have to be reassured that the purpose of making actuarial determinations in measuring the benefits payable to them is to assure that the assets of the FUND will be restored so that the FUND can provide similar benefits to others who become terminally ill at a later time.

4. Once a candidate has been qualified as a beneficiary of the FUND, a plan of support is agreed upon between the FUND and the beneficiary. Benefits offered to each beneficiary are determined on a case by case basis, depending upon the particular needs of the beneficiary. Benefits may be paid for one or all of the following purposes:

(a) Payment of the premiums for health insurance to maintain access to quality health care.

(b) Payment of medical expenses not reimbursed by medical insurance.

(c) Payment of the expenses of experimental medical treatments not covered by insurance.

(d) Payment of special expenses not covered by government or private insurance, such as the difference between the cost of a semi-private and a private hospital room.

(e) Direct payment of the uninsured costs of drugs and drug therapies, which can be particularly costly to the terminally ill.
(f) Payments to maintain the asset that has or will be donated to the FUND (for example, premiums payable on life insurance policies; property taxes and mortgage payments on residential property).

(g) For an indigent beneficiary, a stipend for ordinary living expenses.

(h) Other payments that maintain health, comfort, financial security and a sense of personal dignity.

5. Although financial assets may be a relevant factor in qualifying a candidate as a beneficiary, the actuarial value of financial assets should not operate to limit the time over which payments might be made to the beneficiary. The goal of the FUND is to provide terminally ill persons with financial security and the capacity to live in dignity. A terminally ill person should not be concerned about "running out of benefits." Once a payment plan has been agreed to between the FUND and the beneficiary, the obligation of the FUND to make the agreed-upon payments should continue for the beneficiary's lifetime, even if the beneficiary lives longer than originally estimated.

6. The beneficiary signs an open-ended, interest-free, revolving loan agreement with the FUND. The purpose of making payments in the form of a loan is to eliminate concern that the payments will be treated as taxable income to the beneficiary.

7. To the extent practical, the FUND may wish to control expenses by making payments directly to providers rather than to the beneficiary.

8. Upon the death of a beneficiary, the FUND takes appropriate action to perfect its interest in the decedent's property; for example:

   (a) In circumstances in which the asset donated to the FUND is the proceeds of a life insurance policy, the FUND will file a claim with the insurer.

   (b) In circumstances in which the FUND has a remainder interest in real property owned by the
beneficiary, the FUND would take steps to clear
title to the property.

(c) In appropriate circumstances, the FUND
may file a creditor's claim in the probate estate
of a deceased beneficiary for repayment of the
loans.

9. A certified public accountant will suggest appropriate
checks and balances to make sure that the payments being made by the
FUND are being used for the intended charitable purpose. The books
of the FUND will be audited by a certified public accountant on an
annual basis.

Grant Requested

A Donor is requested to make a commitment to make a grant to
the FUND in an amount that is consistent with the charitable
policies of the Donor. Grants could be made in the form of cash. Grants
could also be made in the form of guaranteeing a portion of
the FUND's line of credit and paying the interest that accrues to
the line. It is the intention of the FUND to secure as many
commitments as necessary to total $1 million before commencing
operations. The sum of $1 million is required to begin operations
because of the actuarial uncertainties associated with the benefits
to be provided by the FUND.14

JOHN FREEMAN BLAKE, ESQ.
1101 Connecticut Avenue, N.W., Suite 900
Washington, D.C. 20036

3977.082

14 It should be noted that, despite the actuarial nature
of the benefits of the FUND, the FUND has received the oral
opinion of the D.C. Insurance Commissioner's office that the
FUND would not be treated as "in the business of insurance"
under D.C. Code §35-202. Similar rulings would be obtained by
the FUND before commencing operations in other jurisdictions.
Dear Applicant:

Based on information you supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3).

Because you are a newly created organization, we are not now making a final determination of your foundation status under section 509(a) of the Code. However, we have determined that you can reasonably expect to be a publicly supported organization described in sections 509(a)(1) and 170(b)(1)(A)(vi).

Accordingly, during an advance ruling period you will be treated as a publicly supported organization and not as a private foundation. This advance ruling period begins and ends on the dates shown above.

Within 90 days after the end of your advance ruling period, you must send us the information needed to determine whether you have met the requirements of the applicable support test during the advance ruling period. If you establish that you have been a publicly supported organization, we will classify you as a section 509(a)(1) or 509(a)(2) organization as long as you continue to meet the requirements of the applicable support test. If you do not meet the public support requirements during the advance ruling period, we will classify you as a private foundation for future periods. Also, if we classify you as a private foundation, we will treat you as a private foundation from your beginning date for purposes of section 507(d) and 4940.

Grantors and contributors may rely on our determination that you are not a private foundation until 90 days after the end of your advance ruling period. If you send us the required information within the 90 days, grantors and contributors may continue to rely on the advance determination until we make a final determination of your foundation status.
FUND FOR THE TERMINALLY ILL

If we publish a notice in the Internal Revenue Bulletin stating that we will no longer treat you as a publicly supported organization, grantors and contributors may not rely on this determination after the date we publish the notice. In addition, if you lose your status as a publicly supported organization, and a grantor or contributor was responsible for, or was aware of, the act or failure to act that resulted in your loss of such status, that person may not rely on this determination from the date of the act or failure to act. Also, if a grantor or contributor learned that we had given notice that you would be removed from classification as a publicly supported organization, then that person may not rely on this determination as of the date he or she acquired such knowledge.

If you change your sources of support, your purposes, character, or method of operation, please let us know so we can consider the effect of the change on your exempt status and foundation status. If you amend your organizational document or bylaws, please send us a copy of the amended document or bylaws. Also, let us know all changes in your name or address.

As of January 1, 1984, you are liable for social securities taxes under the Federal Insurance Contributions Act on amounts of $100 or more you pay to each of your employees during a calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

Organizations that are not private foundations are not subject to the private foundation excise taxes under Chapter 42 of the Internal Revenue Code. However, you are not automatically exempt from other federal excise taxes. If you have any questions about excise, employment, or other federal taxes, please let us know.

Donors may deduct contributions to you as provided in section 170 of the Internal Revenue Code. Bequests, legacies, devises, transfers, or gifts to you or for your use are deductible for Federal estate and gift tax purposes if they meet the applicable provisions of sections 2055, 2106, and 2522 of the Code.

Donors may deduct contributions to you only to the extent that their contributions are gifts, with no consideration received. Ticket purchases and similar payments in conjunction with fundraising events may not necessarily qualify as deductible contributions, depending on the circumstances. Revenue Ruling 67-246, published in Cumulative Bulletin 1967-2, on page 104, gives guidelines regarding when taxpayers may deduct payments for admission to, or other participation in, fundraising activities for charity.

You are not required to file Form 990, Return of Organization Exempt From Income Tax, if your gross receipts each year are normally $25,000 or less. If you receive a Form 990 package in the mail, simply attach the label provided, check the box in the heading to indicate that your annual gross receipts are normally $25,000 or less, and sign the return.

If you are required to file a return you must file it by the 15th day of
FUND FOR THE TERMINALLY ILL

the fifth month after the end of your annual accounting period. We charge a penalty of $10 a day when a return is filed late; unless there is reasonable cause for the delay. However, the maximum penalty we charge cannot exceed $5,000 or 5 percent of your gross receipts for the year, whichever is less. We may also charge this penalty if a return is not complete. So, please be sure your return is complete before you file it.

You are not required to file federal income tax returns unless you are subject to the tax on unrelated business income under section 511 of the Code. If you are subject to this tax, you must file an income tax return on Form 990-T, Exempt Organization Business Income Tax Return. In this letter we are not determining whether any of your present or proposed activities are unrelated trade or business as defined in section 513 of the Code.

You need an employer identification number even if you have no employees. If an employer identification number was not entered on your application, we will assign a number to you and advise you of it. Please use that number on all returns you file and in all correspondence with the Internal Revenue Service.

If we said in the heading of this letter that an addendum applies, the addendum enclosed is an integral part of this letter.

Because this letter could help us resolve any questions about your exempt status and foundation status, you should keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown in the heading of this letter.

Sincerely yours,

Addendum

[Signature]
District Director
You are required to make available for public inspection a copy of your exemption application, and supporting documents, and this exemption letter. If you are required to file an annual information return, you are also required to make a copy of the return available for public inspection for three years after the return is due. Failure to make these documents available for public inspection may subject you to a penalty of $10 per day for each day there is a failure to comply (up to a maximum of $5,000 in the case of an annual return). See Internal Revenue Service Notice 88-120, 1988-2 C.B. 454, for additional information.

Guidelines under which private foundations may rely on this determination, for gifts, grants, and contributions made after March 13, 1989, were liberalized and published in Rev. Proc. 89-23, Cumulative Bulletin 1989-1, page 844.
AIDS LEGAL REFERRAL PANEL
114 Sansome St.
Suite 1129
San Francisco, CA 94104

Dear Irwin:

It was a pleasure talking with you on the phone today. I want to take this opportunity to introduce THE MEDICAL ESCROW SOCIETY by enclosing our brochure describing the basic services we provide.

After fifteen years involved with Hospice, we feel there is a definite need for patient advocacy and today, more than ever, we find there is a tremendous need for the program that we offer. While reviewing many of the letters we've received from former clients that we've helped over the years, one message still rings clear: Their quality of life has been greatly improved. We are privileged that THE MEDICAL ESCROW SOCIETY has been able to play an integral part in helping our clients retain their dignity by being financially able to remain independent.

Any suggestions or input you may have that can help in our common cause to offer aid and comfort to those in need would be greatly appreciated.

Looking forward to a rewarding relationship.

Sincerely yours,

ROBERT DALE HARMs
Director

RDH/jmd

enclosure
The Medical Escrow Society is Different

- We process any size policy.
- We process group, term, whole life, and universal life.
- Our plans let you keep your health insurance and disability income.
- We give you a consistently higher percentage of the face value of your policy.
- You get personal attention. A principal of the company is available 24 hours a day to discuss your needs.
- We are an advocate for the patient and have more than 15 years of hospice experience.
- We represent you, not the buyer.

Call 1•800•422•1314 24 hrs
COMMONLY ASKED QUESTIONS AND ANSWERS

Q. WHAT IS THE MEDICAL ESCROW SOCIETY'S DEFINITION OF "TERMINALLY ILL" OR FACING A "LIFE THREATENING ILLNESS"?

A. Having a life expectancy of twenty-four (24) months or less.

Q. WHAT ARE THE NECESSARY REQUIREMENTS TO BE ELIGIBLE FOR THE ADVANCE CASH BENEFITS PROGRAM?

A. 1. The maximum life expectancy should be twenty-four (24) months or less, however The Medical Escrow Society considers each case individually.
2. The Policy should be individually owned, rather than a group policy, however most group policy's can be converted or, under some circumstances, processed satisfactorily.
3. The Policy must have been in-force for a minimum of two years.
4. The Policy should have been issued by an A or A+ rated insurance company, as determined by the A. M. Best Company. Policies from companies rated less than A or A+ are considered on an individual basis.

Q. HOW IS A PERSON DETERMINED TO HAVE A LIFE EXPECTANCY OF TWENTY-FOUR (24) MONTHS OR LESS?

A. This must have been determined by a medical doctor.

Q. BASED UPON THE FACE VALUE OF THE LIFE INSURANCE POLICY, WHAT AMOUNT MAY I EXPECT TO RECEIVE THROUGH THE ADVANCE CASH BENEFITS PROGRAM?

A. As a general rule, up to eighty percent (80%) of the face value of the Policy is paid. The shorter the life expectancy, the more a benefactor can pay; with a longer life expectancy, less can be obtained. Another important factor in determining the purchase price is market rate available on similar investment. The annual premium, type of policy and rating of the insurance company will also affect the amount paid for a policy.

Q. WHAT TYPES OF LIFE INSURANCE POLICIES ARE ACCEPTABLE FOR THE ADVANCE CASH BENEFITS PROGRAM?

A. All types of individually owned and most group policies can be purchased.
Q. WHAT SIZE POLICIES ARE CONSIDERED FOR PURCHASE?

A. The Medical Escrow Society will help anyone facing life threatening illness to obtain the funds to improve their quality of life, no matter how small the Policy. All policies with face amounts up to One Million ($1,000,000) are considered for purchase automatically. Policies with face amounts in excess of One Million are considered on an individual basis only.

Q. HOW DOES THE INSURED KNOW THAT HE WILL RECEIVE HIS MONIES WHILE THE TRANSFER AND RECORDING OF INSTRUMENTS IS IN PROCESS AT THE INSURANCE COMPANY?

A. The Medical Escrow Society processes no transaction except under strict escrow agreement with a third party trust agent. While processing takes place One Hundred Percent (100%) of the insured's funds rest safely at escrow. Benefactor and client each pay half of the trust agent's fee, (approximately $200 each), for this service. The clients portion of this fee will be deducted from his proceeds at closing.

Q. IS IT NECESSARY FOR THE POLICY HOLDER TO CONTINUE TO PAY PREMIUMS AFTER HE HAS SOLD THE POLICY?

A. Most group policies and some individual policies offer a disability waver of premium, where the insurance company or the employer pay the premiums on proof of disability. If the insured is currently paying the premiums, he should see if these options are available to him and act on them immediately. If no third party is liable to pay the premium of the policy, two years annual premium is deducted from proceeds to the insured at closing. After that, the insured will not pay additional premiums ever.

Q. DOES THE INSURED NEED AN ATTORNEY TO REPRESENT HIS INTERESTS IN THIS TRANSACTION?

A. The Medical Escrow Society insists that all of its insured clients have legal counsel and provides that the benefactor will pay half of the insured's attorney fees. In the case where insured's attorney represents him pro bono, the Medical Escrow Society provides contributions equivalent to reasonable attorney's fees to any organization or entity designated by the insured.

Q. DOES THE INSURED PAY ANY FEE TO THE MEDICAL ESCROW SOCIETY?

A. The insured never pays any fees whatsoever to the Medical Escrow Society. No expenses associated with this transaction, be they medical, federal express, processing, copying, legal or otherwise are ever paid by the insured client.
Q. WHAT HAPPENS TO THE INTEREST OF THE EXISTING BENEFICIARIES LISTED ON THE POLICY?

A. Each person having a beneficial interest in the policy must sign a "Consent to Transfer Policy and Waiver of Interest" form waiving all their interest in the Policy before the transaction can be finalized. If the estate is the beneficiary of the policy, a copy of the will and any codicils is required. Heirs or assigns of the estate may be required to sign the same waiver. The Medical Escrow Society accepts no clients unless the existing beneficiary of the Policy willfully and joyfully joins in the sale with the client insured.

Q. HOW DOES THE INSURED KNOW THAT HIS MEDICAL INFORMATION IS HANDLED CONFIDENTIALLY?

A. The law protects the insured. The Medical Escrow Society never discloses medical information except as lawfully provided for in the Welfare and Institutions Code of the State of California under Article 6.6 (commencing with section 791) of Chapter 1 of Part 2 of Division 1, concerning confidentially of medical information.

Q. WHAT IF THE POLICY HAS LAPPED AND HAS BEEN REINSTATED? DOES THIS AFFECT THE ORIGINAL TWO YEAR WAITING PERIOD?

A. If the Policy has lapsed for a period of sixty (60) days or more, the two year waiting period starts over again from the date it was reinstated. If the lapsed time was less than sixty days, it does not affect the original two year waiting time.

Q. HOW IS THE PAYMENT MADE?

A. Payment is made in a lump sum through bank wire or with a certified check, or, at the insured client’s option checks of various amounts can be made to any party or entity designated by the insured.

Q. WHAT OTHER OPTIONS MAY BE AVAILABLE TO THE INSURED OTHER THAN THE ADVANCE CASH BENEFITS PROGRAM?

A. The Medical Escrow Society always encourages early professional financial planning, tax, estate planning and legal advice by those facing life threatening illness. Some insurance policies may offer accelerated benefits options and The Medical Escrow Society always inquires into these options and fully informs the insured of any such alternatives. We seek maximization of benefits to the insured whether through the Advance Cash Benefits Program or any other option.
Q. WHAT TAX CONSEQUENCES NEED TO BE CONSIDERED BY PARTICIPANTS IN THE ADVANCE CASH BENEFITS PROGRAM?

A. The Medical Escrow Society cannot and will not offer tax advice. Competent professional counsel must be obtained by the insured to review these matters as they may pertain to his personal situation and to the current interpretation of the law by Federal and State authorities. Under the law, no records of this transaction are provided to taxing authorities.

Q. WHAT ARE THE POSSIBLE CONSEQUENCES FOR THE PARTICIPANT IN THE ADVANCE CASH BENEFITS PROGRAM WITH REGARD TO PUBLIC ASSISTANCE?

A. The law concerning these questions is in development and regulations are under review by various Federal and State agencies. Competent professional counsel should be obtained to review these matters as they pertain to the personal situation of the insured. Because income and resources are used by many agencies to determine eligibility for assistance, receipt of these funds could impact the eligibility of the insured.

Q. FOR WHAT REASONS WOULD A TERMINALLY ILL PERSON WANT TO PARTICIPATE IN THE ADVANCE CASH BENEFITS PROGRAM?

A. We have been told the following reasons by past participants:
1. To continue the insured's health care at the highest quality;
2. To retain the insured's independence and dignity by being financially able to select and pay for choices available;
3. To be able to personally distribute the proceeds of their life insurance to friends, life partners, loved ones, ministries, charitable institutions, schools, hospitals, and organizations;
4. To retire a debt.
5. To take a memorable trip.
6. To have the peace of knowing that the insured's insurance proceeds were distributed according to his wishes;
7. To be able to share joy with those receiving gifts.

We are sure that there are many other reasons for this decision. Whether it be as simple as a new car or a cellular phone, each individual has a right to enjoy life to the fullest while he can. The Medical Escrow Society exists to facilitate this goal.
Q. WHAT IS THE PROCEDURE TO DETERMINE IF A POLICY CAN BE PURCHASED?

A. To determine if a policy and medical situation fall within acceptable guidelines, a Questionnaire, Medical Authorization, and Policy Authorization must be completed. Once received at the Medical Escrow Society, all medical records pertinent to the illness are gathered as well as confirming information about the Policy. Once all records are received, a panel of physicians expert in the appropriate field review the records and then render an evaluation. Based on these opinions, a purchase price is calculated and the client is notified of the amount.

Q. WHAT IS THE NEXT STEP SHOULD THE CLIENT DECIDE THAT THE PURCHASE PRICE IS ACCEPTABLE?

A. The Purchase Agreement is immediately forwarded to the client by Federal Express for next day delivery. Matters progress smoothly and rapidly from this point.

Once the Purchase Agreement has been returned, signed by the insured, the trust or escrow agent forwards the closing documents to the client insured's attorney. These documents consist of an explanatory cover letter, the Escrow Agreement, Statement of Sale, Viator's Statement, Special Power of Attorney, Consent to Transfer Policy and Waiver of Interest for the existing beneficiary to sign, and a Settlement Statement. Also included are the forms provided by the insurance company to change the ownership and beneficiary of the policy to any party or entity designated by the Medical Escrow Society. All signed forms are returned to the trust agent, who then forwards beneficiary and ownership change forms to the insurance company to be recorded and filed. Once the endorsed changes are received by the trust agent from the insurance company, a certified check is delivered by Federal Express to the insured client by the trust agent.

Q. WHAT IS THE AVERAGE LENGTH OF TIME TO ACCOMPLISH THE SALE OF A LIFE INSURANCE POLICY?

A. It depends upon how soon the medical records and policy confirmation are received. Normally, it takes approximately six (6) to eight (8) weeks from beginning to end.
QUESTIONNAIRE

The responses that you provide on this form will enable The Medical Escrow Society to determine if you are qualified for the Advance Cash Benefits Program. Please fill out the questionnaire completely.

You will be responsible and bear full liability for any error or omissions in the responses that you provide to The Medical Escrow Society.

After you have completed the questionnaire, return with the Authorization to Release Policy Information and Authorization to Release Medical Records forms to the Medical Escrow Society for consideration.

I. PERSONAL DATA (PLEASE PRINT OR TYPE)
   A. NAME: ____________________________________________
   B. ADDRESS: _________________________________________
   C. BIRTH DATE: ________________________________
   D. PLACE OF BIRTH: ________________________________
      (City) (State)
   E. COUNTY OF DOMICILE: __________________________
   F. SOCIAL SECURITY NUMBER: ________________________
   G. RESIDENCE TELEPHONE: (___) ____________
      BUSINESS TELEPHONE: (___) ____________
   H. CLOSEST RELATIVE, FRIEND OR ASSOCIATE:

       ____________________________________________
       ____________________________________________
       ____________________________________________
       ____________________________________________

I. NAME OF NEXT OF KIN:

       ____________________________________________
       ____________________________________________
       ____________________________________________
       ____________________________________________
J. NAME OF NATURAL PARENTS:

(Mother)

(Address) (City)

(State) (Zip) (Telephone)

(Father)

(Address) (City)

(State) (Zip) (Telephone)

K. WHAT ARE THE NAMES AND AGES OF YOUR SPOUSE, CHILDREN AND GRANDCHILDREN? _______________ 

L. ATTORNEY, C.P.A. OR FINANCIAL PLANNER:

(Title) (Name)

(Address) (City)

(State) (Zip) (Telephone)

II. POLICY INFORMATION

A. INSURANCE COMPANY: ____________________________

B. POLICY NUMBER: ____________________________

C. POLICY FACE AMOUNT: ____________________________

D. WHO IS THE OWNER OF THIS POLICY:

(Name) (Address)

(State) (Zip) (Telephone)

E. HAS POLICY EVER LAPSED: YES ________ NO ________

IF YES, HOW LONG WAS IT LAPSED? ____________________________

F. IS THERE A DISABILITY WAIVER OF PREMIUM RIDER ON YOUR POLICY: YES ____________________________ NO ____________________________

IF YES, ARE THE PREMIUMS CURRENTLY BEING PAID BY THIS RIDER? YES ____________________________ NO ____________________________

PLEASE ATTACH A PHOTOCOPY OF COMPLETE LIFE POLICY INCLUDING ORIGINAL LIFE INSURANCE APPLICATION, ALONG WITH LAST BILLING STATEMENT FROM INSURANCE COMPANY WHEN YOU RETURN THIS QUESTIONNAIRE.
G. IS THIS A GROUP POLICY? ______________________

IF THIS IS PART OF A GROUP POLICY, PLEASE GIVE THE EMPLOYER AND EMPLOYER'S INSURANCE ADMINISTRATOR:

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<th>(Employer Name)</th>
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<td>(Telephone)</td>
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<tr>
<td>(Insurance Administrator Name)</td>
<td>(Direct Telephone)</td>
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H. LIST THE BENEFICIARIES OF THE ABOVE POLICY.

<table>
<thead>
<tr>
<th>(Primary Beneficiary Name)</th>
<th>(Relationship)</th>
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<th>(Contingent Beneficiary)</th>
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I. HAVE YOU MADE A CHANGE OF BENEFICIARY SINCE COVERAGE BEGAN? YES _______ NO ________ INDICATE DATE _______

<table>
<thead>
<tr>
<th>(Prior Beneficiary Name)</th>
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J. IF YOUR ESTATE IS THE BENEFICIARY OF YOUR POLICY, LIST THE BENEFICIARIES OF YOUR ESTATE.

<table>
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K. WHAT IS THE TOTAL AMOUNT OF ANY OTHER INSURANCE POLICIES YOU HAVE IN-FORCE? ____________

L. LIST THE BENEFICIARY OF THE ABOVE OTHER INSURANCE.

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III. FINANCIAL INFORMATION

A. HAVE YOU BEEN OR ARE YOU NOW A PARTY TO A CIVIL SUIT?
   YES __________ NO __________

B. HAVE YOU BEEN OR ARE YOU NOW A PARTY TO BANKRUPTCY?
   YES __________ NO __________ IF YES, EXPLAIN __________

C. DO YOU NOW HAVE ANY JUDGEMENTS? YES _____ NO _____
   IF YES, EXPLAIN __________

D. DO YOU NOW HAVE ANY CREDITOR LIENS? YES _____ NO _____
   IF YES, EXPLAIN __________

E. DO YOU NOW HAVE A TAX LIEN? YES ________ NO ________
   IF YES, EXPLAIN __________

F. ARE YOU CURRENTLY RECEIVING ANY MEANS BASED ENTITLEMENTS SUCH AS MEDICAID, FOOD STAMPS OR SUPPLEMENTAL SECURITY INCOME FROM THE SOCIAL SECURITY ADMINISTRATION?
   YES __________ NO __________ IF YES, EXPLAIN __________

IV. PHYSICAL CONDITION

A. PLEASE GIVE A BRIEF DESCRIPTION OF YOUR PRESENT PHYSICAL CONDITION. ________________

B. WHEN DID YOU FIRST BECOME AWARE OF THIS ILLNESS? DATE FIRST DIAGNOSED HIV POSITIVE: ________________

C. IF HIV DISEASE, DATE DIAGNOSED AIDS? ________________

D. WHAT WERE YOU TOLD YOUR LIFE EXPECTANCY WAS AT THE TIME YOU WERE DIAGNOSED AS BEING TERMINALLY ILL? ________________

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</table>
E. IF YOU HAVE BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING OPPORTUNISTIC INFECTIONS RELATING TO HIV INFECTION, PLEASE INDICATE DATE OF INITIAL OCCURRENCE AND COMMENT, IF ANY.

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<thead>
<tr>
<th>Name of Illness</th>
<th>Date of Initial Occurrence</th>
<th>Comment</th>
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<tr>
<td>PCP</td>
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<td>Toxoplasmosis</td>
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<td>Lymphoid Pneumonia</td>
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<td>Histoplasmosis</td>
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<td>HIV Dementia</td>
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<td>Cocciidioidomycosis</td>
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<tr>
<td>HIV Wasting Syndrome</td>
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<tr>
<td>Other</td>
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F. PLEASE INDICATE MEDICATIONS RELATING TO HIV INFECTION YOU ARE CURRENTLY TAKING.

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10. 

G. PLEASE INDICATE YOUR LAST KNOWN T4 COUNT: 
   DATE: ______________________

H. PLEASE GIVE US THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ATTENDING PHYSICIAN.

(Physician Name)          (Address)

(City)                    (State) (Zip) (Telephone)
**I.** PLEASE LIST THE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL OTHER DOCTORS WHO HAVE EXAMINED YOU CONCERNING THIS ILLNESS.

<table>
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<th>(Physician Name)</th>
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<tr>
<td>(Physician Name)</td>
<td>(Address)</td>
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<td>(City)</td>
<td>(State)</td>
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<td>(Physician Name)</td>
<td>(Address)</td>
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**J.** PLEASE GIVE THE NAMES AND ADDRESS OF EACH HOSPITAL IN WHICH YOU HAVE BEEN TREATED IN THE LAST FIVE (5) YEARS.

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<td>(Hospital Name)</td>
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<td>(Hospital Name)</td>
<td>(Address)</td>
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</table>

**K.** ARE YOU SEEMING NOW OR HAVE YOU SEEN A PSYCHIATRIST OR MENTAL HEALTH SPECIALIST FOR DEMENTIA OR OTHER HIV RELATED MENTAL HEALTH ILLNESS? YES _____ NO _________

IF YES, PLEASE GIVE THE MENTAL HEALTH SPECIALIST NAME, ADDRESS AND TELEPHONE NUMBER.

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V. TERMS AND CONDITIONS

A. The Applicant warrants and represents that all information contained in this questionnaire is true and correct to the best of his/her knowledge.

B. The applicant hereby authorizes The Medical Escrow Society or its agents to obtain a credit report.

C. The Applicant consents to be examined by The Medical Escrow Society or its agents and the re-disclosure of any existing medical records. The Applicant consents to the release to The Medical Escrow Society of any and all information that The Medical Escrow Society may request from the Applicant or any third parties. The Applicant will execute any documents necessary to allow The Medical Escrow Society to conduct such examinations or to acquire such information.

D. The applicant herein includes a photocopy of picture identification and swears and warrants that he/she is in fact that person so identified.

__________________________________________  ______________________________________
Date                                          Applicant's Signature

STATE OF __________________________________

COUNTY OF ________________________________

SUBSCRIBED, SWORN TO AND ACKNOWLEDGED before me this _________

day of _________________________________, 19 ______ by ________________________________

(Applicant Name)

________________________________________
Notary Public

My Commission Expires:
AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize any physician, medical practitioner, hospital or medically related facility, insurance company, The Medical Information Bureau or other institution or person having any records, charts, X-rays, laboratory work, or similar information or knowledge of me or of my health, including but not limited to information relating to AIDS/ARC/HIV, to release such information to The Medical Escrow Society or its authorized representative(s). I understand that information obtained will only be released to The Medical Escrow Society or its authorized representative(s) performing services in connection with my Application or as lawfully required. I agree that this authorization is valid for twenty-four (24) months from the date hereof, that a photocopy or facsimile of it is as valid as the original and that I may request a copy of this authorization.

I acknowledge receipt of the Notice of Disclosure of Information.

Signature

Typed or Printed Name

STATE OF ____________________________ )ss

COUNTY OF __________________________

SUBSCRIBED, SWORN TO AND ACKNOWLEDGED before me this __________

day of __________________________, 19_____, by _____________________________.

(Seller of Policy)

Notary Public

My Commission Expires

______________________________
AUTHORIZATION TO RELEASE POLICY INFORMATION

I hereby authorize ___________________________,
the issuer of that certain Policy Number ___________________________,
owned by ___________________________,
and insuring the life of ___________________________, (the Policy), to release to
the Medical Escrow Society, or its authorized representative(s), a true copy of the Policy, or any
information, forms, riders or amendments concerning the Policy. I agree that this authorization is
valid for twenty-four (24) months from the date hereof, that a photocopy or facsimile is as valid as the
original and that I may request a copy of this authorization.

I acknowledge receipt of the Notice of Disclosure of Information.

________________________________________
Signature

________________________________________
Typed or Printed Name

STATE OF __________________ )
COUNTY OF __________________ )ss

SUBSCRIBED, SWORN TO AND ACKNOWLEDGED before me this ____________
dayof __________________, 19_____, by _____________________________.
(Seller of Policy)

________________________________________
Notary Public

My Commission Expires

________________________________________
THE MEDICAL ESCROW SOCIETY

ADVANCE CASH BENEFITS PROGRAM
The Medical Escrow Society

Recognizing the needs and desires of those facing a life threatening illness, THE MEDICAL ESCROW SOCIETY was established for the sole purpose of providing advance cash benefits for the things in life that are important to you, be it a special gift to a friend or loved one, a donation to a favorite school, church or charitable organization, or to provide for quality health care and the basic needs in life.

Having cash, in advance of your life insurance coverage, allows you the freedom of choice to see that your wishes and desires are fulfilled and allow you to participate in matters that are important to you with independence and dignity.

The Advance Cash Benefit Program provides you with up 80% of the face amount of your life insurance policy, considering your health situation and the type of coverage that you may have. In general, most policies are acceptable to THE MEDICAL ESCROW SOCIETY.

Within 15 days of receiving your cash advance, should you have a change of mind regarding the sale of your insurance policy, simply return the amount paid to you and the ownership of your policy will be completely restored. There are NO other costs.

Advance Cash Benefits Program

Q. How do I go about applying for the Advance Cash Benefits Program?
A. Simply call The Medical Escrow Society and a representative will make an appointment to take your application, and answer any questions that you may have.

Q. What is considered a life threatening illness?
A. Any illness or condition diagnosed by a medical physician rendering a life expectancy of twenty-four (24) months or less.

Q. If I am covered by a group policy, am I still eligible?
A. Yes. Most group policies can be converted into “individually owned” policies.

Q. Will my beneficiary be notified about the change in my policy?
A. Yes. Any person having a beneficial interest in the policy will be required to sign a release and a waiver of claim certificate.

Q. How long will it take for me to receive my cash benefits?
A. Most applications can be fully completed in six (6) to eight (8) weeks.

Cash For Your Life Insurance

FOR FURTHER INFORMATION

1-800-422-1314
VIATICAL SETTLEMENTS:
AN ALRP FORUM

Tuesday
June 8, 1993
5:30 PM

Presented by:
John Darragh
Affording Care
the national financial education
and information center
for the seriously ill

Among the topics to be discussed:

- Introduction/history
- Practice management issues
- Planner psychology
- Client management issues
- What does the law do
- Requirements
- Mechanics
- Estate tax considerations
- Group insurance
- Bankruptcy
- Life expectancy
- Regulations
- Appropriateness
- Alternatives
- Taxation
- Entitlements

Enclosures:

3. Affording Care listing of Viatical Settlement Companies - April 15, 1993
4. Memo A Discussion on the Use of the Term "Living Benefits" by Richard W. Bandfield, CLU, RFP, March 20, 1990
6. Commonly Asked Questions - Draft
Definitions

VIATICATE—to sell a life insurance policy to a third party (historically, to furnish with the things necessary for a journey).

VIATICUM—(plural, viaticae; pronounced vi-ati-cum) Also called "viatical settlement," the proceeds from the sale of a life insurance policy to a third party by a terminally ill individual. (Historically, an allowance for travelling expenses or provision for a journey).

VIATOR—the terminally ill seller of a life insurance policy to a third party (not the insurance company), a traveler, wayfarer.

VIATIONAL SETTLEMENTS—sale of a life insurance policy to a third party—should be distinguished from accelerated benefits wherein the policyholder receives early death benefits directly from the second party (the insurance company). (See JoAnn Canning's article on accelerated benefits in this issue). Living benefits is used in this article to mean both accelerated benefits and viatical settlements.

Starting in 1989, the "viatical settlements" industry emerged. Companies in the industry pay cash (typically 60-80% of face amount) for life insurance policies of the terminally ill. Generally, the shorter the life expectancy, the more they pay. There are now eight operating firms in the new small viatical settlements industry.

Requirements

All the companies:

1. require that the insurance company be a quality carrier with a good reputation for paying death claims;
2. require that all persons having an ownership or beneficiary interest release their interest and waive future rights;
3. require applicants to release medical records for review;
4. require applicants to make a designation of irrevocable beneficiary in favor of the purchaser;
5. require that the policy be past the period specified in the contestability clause;
6. suggest that the applicant secure the advice and counsel of a financial planner, insurance professional, attorney and/or tax accountant before viaticating a policy;
7. have panels of medical experts to review the applicant's medical records and to make independent estimates of life expectancy;

continued on page 19
Petersen, cont. from page 17

8. promise the maximum confidentiality consistent with what the companies need to disclose to do their job, and

9. specify a time period after settlement within which the seller has the right to undo the entire transaction.

Clients are sometimes unaware that if they have allowed a life insurance policy to lapse by not paying the premium, but have then applied for and been granted policy reinstatement, the contestable period starts all over again.

Life Benefits Corporation prefers policyholders with life expectancies of more than 20 months and has entered into transactions with viators with estimated life expectancies of as long as ten years.

The companies may require a statement from a psychotherapist that the seller is of sound mind and under no constraint or undue influence.

The companies prefer policies with face amounts of between $50,000 and $500,000, but will deal with other amounts on a compassionate or exception basis. Life Benefits Corp. prefers policies with a minimum of $250,000 face amount and has no upper limit.

Living Benefits, Life Benefits Corp. and American Life Resources will take policies without a disability waiver of premium clause or rider, but, of course, future premium costs are part of their calculations to determine how much the policyholder is offered for the policy. Absence of future premium costs increases the viatical percentage.

If there is a spouse, minor children, dependent parents or someone else reliant on financial support, the viatical settlement companies may not buy the policy. At the very least, all alternative sources of cash should be investigated before selling one's life insurance.

Mechanics

As a practical matter, the most important variables used in calculating offering prices are:

1. Face amount of the policy;
2. Months of life expectancy;
3. Prime rate, and
4. Future premiums (if any).

No table of life expectancies by syndrome pattern exists yet, but all the companies are working on the project. They hope to increase the viatical percentage to the policyholder as time goes by.

If a person named as beneficiary refuses to release his/her interest and to waive future rights, the designation of beneficiary could possibly be changed by the policyowner to his/her estate, thus eliminating the beneficiaries' direct interest and rights to the policy. After a suitable time period she/he could then proceed with the sale of the policy. Be sure to check with the purchasing company before embarking on such a maneuver, though.

Some of the viatical settlement companies act as principals buying contracts for their own account; some act primarily as brokers. Depending on the availability of funds, the principals may, at times, act as brokers. Most of the viatical settlement companies are concerned that transactions be completed quickly for the seller.

They feel that a viator should not have to wait until their investment funds arrive.

The administrative process involved in the sale of a life insurance policy is lengthy and complex; assume it will take three or four months from the first contact until the receipt of a check even if maximum use is made of fax and express mail.

Some insurance companies are slow to answer viatical settlement company questionnaires on the status of life insurance policies. The viaticating process may be further slowed down by insurance companies not respecting the insured’s release. Information is sent directly to the insured instead of to the viatical settlement company.

There may be a period during the transaction after one has signed a designation of irrevocable beneficiary naming the buying company and one has sold the policy giving up all the incidents of ownership, but one has not yet received the cash. Check to make sure that there is an escrow or trust arrangement.

Appropriateness

I know you have clients to whom you have made strong recommendations for disability insurance, but who just would not make the decision to buy. With the client now terminally disabled, viaticating a life insurance policy is a particularly useful strategy when the client has life insurance and little or no long-term disability insurance.

The mere prospect of viaticating a life insurance policy may encourage beneficiaries with financial resources to consider making the terminally ill insured a loan secured by an irrevocable beneficiary designation. The possibilities of such a transaction, as an alternative to viaticating, should be explored with each prospective seller.

Group Insurance

With most of the viatical settlement companies, group insurance coverage can become eligible once the applicant has converted it to an individual policy. For American Life Resources and Life Benefits Corp. to buy a group life policy, the group must be stable and the viatical settlement company must receive the conversion rights.

Group insurance has a number of people (insurance company, administrator, employer/association and insured) involved in the insuring process; each may make some unilateral decisions affecting the ability to viaticate a policy. Potential replacement of group insurance policies presents extra risks to the viatical settlement companies. Viatical settlement companies must secure a mechanism for receiving notification when a viator leaves a group so the viatical settlement company can exercise the conversion rights.

Some relatively minor provisions in group life insurance may present insoluble or, at least, major problems for viatication. Some group policies are not subject to conversion until a participant has been in the group for five years. Some group policies—usually life-medical combined—can be assigned only as a gift but not assigned for value, thereby precluding viatication. Yet other group insurance policies are not assignable to a corporation but assignment to an individual is permitted. Employer-funded life insurance under ERISA regularly has problems with assignability. One viatical settlement company estimates that a group life insurance viatical settlement is worth 5-7% less to the buyer than an individual life insurance policy because of the additional problems and risks.

In one particularly thorny case, the terminally ill person was, nevertheless, still working. The prospective viator's association group policy required that he leave the group in order to convert the life insurance to an individual policy which he could then viaticate. Leaving the

continued on page 21
group, however, also meant disqualification for retaining his association group disability insurance—Catch 22.

Taxes

Generally, the seller will be required to declare as taxable income the viatical less all premiums previously paid plus all dividends received plus the amount of any outstanding loans at the time of sale. Life Benefits Corp. says it usually structures the transaction so that some portion of the death proceeds, even if small, are paid to the current beneficiary thereby not creating a total sale of the policy. LBC says that it is relying on the written opinion of counsel that its transactions are loans and, therefore, not taxable income to the seller. A viator should have his/her own tax counsel review the opinion. The IRS has not, as yet, required viatical settlement companies to report purchase distributions.

Income taxes of viatical settlements may not be an issue for some viators. Terminally ill people probably have inordinately large medical deductions (unreimbursed medical expenses, deductible, co-insurance and medical insurance premiums) even when they have very good medical insurance. Viatical settlement proceeds and the medical expense deduction are netted on the income tax return before the tax is calculated. Each seller’s income tax projections must be reviewed as a part of the decision to viaticalize a policy.

In some cases, particularly those involving small face amounts, the tax bite could be reduced by arranging an installment sale to spread the receipt of the viatical over more than one tax year to take advantage of having the viatical taxed in the lower brackets. This maneuver would, however, make the prospective solvency of the viatical settlement company an important issue.

For an insured who has a prospective taxable estate (more than $600,000) and the estate will include life insurance, it may not make much difference if the insured viaticates the life policy and pays the income tax instead of having the life insurance proceeds taxed in the estate.

Congresswoman Barbara Kennelly (D-CT) has introduced a bill (HR 134) to make pre-death proceeds directly from the insurance company (accelerated benefits) not subject to income tax for those with a life expectancy of 12 months or less.

Senator William Bradley (D-NJ) has introduced a similar bill in the Senate. Viatical settlements were not included in the original wording of the bills. If the bill is passed, it will probably not be until it is merged with many other tax related matters and addressed by Congress as an omnibus tax bill late in 1991. The viatical settlement companies have requested that viatical settlements be included in the proposed legislation.

Bankruptcy

Bankruptcy preceding the sale of a life insurance policy may cause the viator some problems. In some states the receipt of the “proceeds of life insurance” within, for instance, 180 days of the bankruptcy discharge are subject to the claims of creditors.

Entitlements

If a policyholder is receiving or plans on receiving means-based entitlements such as Medicaid or Supplementary Security Income, receipt of a capital sum from the sale of a life insurance policy will disqualify the policyholder from eligibility. It is not clear yet whether such a person could retain eligibility for means-based entitlements if the policy was placed in a “luxury” trust which then sold the policy and proceeded to make distributions to the original owner for luxuries; the trust being prohibited from making distributions for necessities—food, rent, medical expenses. The unexercised option to sell a life insurance policy has no effect on eligibility for means-based entitlements. Selling an insurance policy has no effect on the eligibility for non-means-based entitlements such as Social Security Disability, statutory short-term disability benefits and Medicare.

Life Expectancy

The first step in investigating the feasibility of the sale of a life insurance policy is a frank and candid discussion about life expectancy with the primary care physician. The client should be encouraged to be brave about discussing the subject; there is a lot of money at stake. The physician’s sensibilities do not need to be protected; Medicare has, for years, paid for hospice care only on certification by the primary care physician that life expectancy was six months or less. Physicians are more used to dealing with life expectancy estimates than you might think. In order to start the process, viatical settle-
Petersen. cont. from page 21

those income recipients.

Bell also objected to what he perceived to be an inadequately low level of viatical settlement payout. However, in his calculations he made no allowance for the enormous risks these companies face—the prolongation of payment of interest and premiums for exceptional patients and, more importantly, the unknowable and immeasurable risk of projecting into an environment of rapidly developing life-extending treatments. Although a cure for some terminal illnesses may not be likely in the near future, a surprise medical research breakthrough would decimate these companies.

Viatical settlement companies also face a “litigation” risk—the possibility that a disgruntled ex-beneficiary will claim the death benefits even though the ex-beneficiary released his/her interests and waived right in the policy at the time it was viatialed.

The viatical settlement companies face the risk that interest rates will rise, thereby increasing their carrying costs. Of course, they will benefit if interest rates go down. This is a risk, of course, that can be hedged.

The offering price from a viatical settlement company is calculated to include these risks of a medical technological development, litigation and interest rate fluctuations along with the costs of future premiums, processing, independent medical review, collection (estimated), taxes and a reasonable profit.

That these companies make a reasonable profit is important in order for them to be able to attract additional capital into the business and buy yet more policies from the terminally ill.

Regulation

Living Benefits is regulated by the New Mexico Insurance Department under legislation passed in April, 1989. Except for New Mexico, the viatical settlement companies are unregulated. Indeed, they are not insurance companies.

Viatical settlements are legal in New York State. General advertising is permitted, but the viatical settlement companies are enjoined from direct solicitation in person, by telephone or by mail. The NYS Insurance Department has been monitoring the activities of the viatical settlements industry on an informal basis.

There appears to be some interest in viatical settlement legislation in Colorado, California, Washington (State) and New York. Aspects that may be covered in future legislation are:

1. Disclosure to prospective viators;
2. Licensure of viatical settlement companies;
3. Taxability of viatia;
4. Time limits for payment of viatical settlements after presentation of completed purchase documents;
5. Financial responsibility and solvency of those who pay viatical settlements over time;
6. Confidentiality;
7. Limits on double indemnity recovery;
8. How viatical settlements will interact with state public assistance programs;
9. Protection of interests of minor children or others dependent on the viator, and
10. Minimum amounts or percentages for settlements.

There is also a concern that living benefits (both accelerated benefits and viatical settlements) not be sold as an alternative or substitute for long-term care insurance.

In November, 1990, the New York State Assembly Standing Committee on Insurance—chaired by Howard Lasher—held hearings on living benefits (both accelerated benefits and viatical settlements) to explore what kind of legislation is appropriate and necessary. Governor Cuomo has encouraged legislation on living benefits.

Legislation will probably be passed only if and when some serious abuses have occurred. The humanitarian manner in which the existing viatical settlement companies have conducted themselves makes serious abuses relatively unlikely. Please contact me (and the NYS Insurance Department) if you encounter any abuses or untoward behavior on the part of any of the viatical settlement companies.

The Future

While viatialed a life insurance policy may be a very useful financial tool for any client with a terminal illness, the most aggressive viatiaors have been people with AIDS. To date, more than 90% of the policies bought by the viatical settlement companies have been from people with AIDS; most of the rest were from people with cancer. This new industry bought about $5 million (face value) of life insurance in 1989 and $40 million in 1990. I estimate that they will buy $100 million in 1991.

What’s In It For You

You, as an insurance professional, are a logical financial advisor for your insureds to turn to when the feasibility of viatical need is exploring and examining.

Until recently, the viatical settlement companies have not been paying commissions for agent referral of the occasional client. Now, however, with their capital financing in place, it seems that they are ready to discuss paying referral fees to agents who can provide a stream of policies for viatical.

If you charge fees for advice, your client will certainly get his/her money’s worth for your advice. It is a new kind of strange transaction and your professional help can go a long way in relieving the anxiety that goes with a large non- recurring transaction. You can certainly be instrumental in shopping a policy around for the best offer or assisting your client to do so.

You can provide an extra service to your group life insurance clients if you analyze your proposed offerings for lack of restrictions on assignment of the group insurance and point out how these once-unimportant restrictions could now affect a group member in the future. It may even be worthwhile to review your group life contracts in force for making upgrade proposals.

Restrictions on assignment of group life insurance should now be included in life insurance reviews for individuals. The client may become more appreciative of the need for better individual life coverage.

If you happen to be the person who introduces a financially strapped terminally ill client to the concept of viatical settlements, you will probably be perceived as “walking on water” and you can bet that their friends and family are going to hear about your good deed.

And, of course, the existence of viatical settlements gives you a potent new arrow in your quiver of sales points when selling any life insurance policy. Viatical settlements are going to be available regardless

continued on page 27
### VIATIONAL SETTLEMENT SURVEY — JANUARY 1991

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<tr>
<td>Counsel on Tax, SSI, Medicaid Impact</td>
<td>No—Insist</td>
<td>Yes—In Detail</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Will Consider</td>
<td>Yes—Strong Warning</td>
<td>Yes</td>
</tr>
<tr>
<td>Buy Policy From 3rd Party After Transfer from Client</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Will Consider</td>
<td>Yes</td>
<td>Will Consider</td>
<td>Will Consider</td>
</tr>
<tr>
<td>Buy Policy from Client's Med./Lux/Esther Trust</td>
<td>Will Consider</td>
<td>Yes</td>
<td>Will Consider</td>
<td>Will Consider</td>
<td>Yes</td>
<td>Yes</td>
<td>Will Consider</td>
<td>Will Consider</td>
</tr>
<tr>
<td>Buy Policy Via 3 Party Contract</td>
<td>Will Consider</td>
<td>Yes</td>
<td>Will Consider</td>
<td>Will Consider</td>
<td>Will Consider</td>
<td>Will Consider</td>
<td>Will Consider</td>
<td>Will Consider</td>
</tr>
<tr>
<td>Structure as Loan</td>
<td>No</td>
<td>No</td>
<td>Probably Not</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Probably Not</td>
</tr>
<tr>
<td>Structure Policy Sale as Sh.t. Tm. Annuity Purchase</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Will Consider</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Issue 1099 for IRS/SSI/Med. Income Verification Access</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Accept Irrevoc. Ben. Des. w/o Assign.</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Buy Pol. From + Direct Pay to SSI/Med. Recips. After Counseling</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Buys individually owned policies</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Buys group life policies</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Eligible policyholders</td>
<td>CDC-Defined AIDS diagnosis</td>
<td>18 months or less life expectancy</td>
<td>24 months or less life expectancy</td>
<td>Health seriously impaired</td>
<td>24 months or less life expectancy</td>
<td>24 months or less life expectancy</td>
<td>24 months or less life expectancy</td>
<td>24 months or less life expectancy</td>
</tr>
<tr>
<td>Maximum purchase price ever paid as a % of face amount for a policy*</td>
<td>73%</td>
<td>80%</td>
<td>70%</td>
<td>50%</td>
<td>65%</td>
<td>77%</td>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>Approx. number of policies bought</td>
<td>20</td>
<td>300</td>
<td>11</td>
<td>16</td>
<td>12</td>
<td>N/A</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>First policy bought</td>
<td>12/89</td>
<td>1/90</td>
<td>9/89</td>
<td>9/89</td>
<td>9/89</td>
<td>4/89</td>
<td>8/90</td>
<td>9/90</td>
</tr>
<tr>
<td>Number of policies collected on</td>
<td>N/A</td>
<td>20</td>
<td>2</td>
<td>1</td>
<td>None</td>
<td>28</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>Requi res that a disability waiver of premium be in effect</td>
<td>Depends on funding source</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*But typical payout amounts can be much lesser percentages due to legal, medical and administrative costs; interest rates; predictability/length of life expectancy; premium costs; quality and amount of policy; and investor considerations.

of what New York State comes up with in terms of accelerated benefits legislation and regulation. For your uninsurable clients, the possibility of a viatical settlement may make guaranteed issue life insurance worth the premiums.

The new existence of viatical settlements expands the market for life insurance. Investment considerations aside, the traditional need to buy life insurance has related to cases where there were dependents to provide for or as a source of estate liquidity for large estates with few liquid assets. The advent of the viatical settlements industry has made having life insurance a new wise financial planning tool for virtually any healthy (insurable) adult. I hope you will review your client files and make another presentation to those clients who have been putting off their life insurance purchases.

March 1991

With all the money being pumped into the terminally ill community, viatical settlements are a dynamic new tool in helping clients and, as a terminally ill person myself, I can assure you that viatical settlements are an enormously gratifying source of new funds to deal with a very expensive personal crisis.
# What's Inside

## Articles on Living Benefits
- Accelerated Death Benefits 13
- Viatical Settlements 17
- NALU Position 27

## Other Articles
- Image Builders Campaign 5
- Day On The Hill 9
- GAMA Gleanings 7
- Think About It 33
- CLU & ChFC Classes 7
- Scherago 39
- WLUC Upcoming Events 7
- CLU Case Pointer 45
- One Man's Opinion 49
- MDRT: Panel Answers 49
- What's Happening 53
- Articles Of Interest 54
On January 1, 1991, California enacted a major piece of consumer legislation. The legislation introduced by Assemblyman Steve Peace (D-San Diego), expressly permits viatical settlement contracts between terminally ill insureds and third parties transacting business in California. The legislation alleviates some of the extreme financial burdens and economic duress placed on the terminally ill and their families.

Viatical settlements have opened a financial door where one did not previously exist. Now a terminally ill person can turn a non-cash asset into cash when it is most needed.

Since 1989, when the first life insurance policy was viaticated for a terminally ill client, the concept of living benefits or viatical settlements has been gaining wide acceptance among insurers, terminally ill policyholders and third-party entrepreneurial firms. In exchange for an immediate cash payment to the policyholder, in an amount less than the policy death benefit, third-party firms take assignment of the life insurance policy as owner and beneficiary.

Selling a life insurance policy is a major financial decision. It is strongly recommended that you seek the advice of a financial professional who is knowledgeable about viatical settlements before you proceed.

The following guideline is provided to give you a better understanding to the legislation and to your rights as a consumer.

The law requires that all viatical settlements firms and their representatives to be licensed by the California Department of Insurance.

In addition the law makes the following provisions for California residents:

- Exempts from state gross income the proceeds from a viatical settlement plan contract entered into with a third party.
- Exempts from state gross income the proceeds from a viatical settlement program received from an insurance company.
- Excludes viatical settlement plan proceeds from the requirement for the withholding of state tax.
- Specifies, within the definition of a viatical settlement, that such contracts do not include assignment of a life insurance policy to a licensed lending institution or credit union for a loan.
- Specifies that a viatical settlement shall not include a provision for payment of cash surrender values, loans or other benefits made by an insurer in accordance with the policy provisions.
- Before your enter into a contract the viatical settlement company must first obtain the following from you:
1. A written statement from your attending physician that you are of sound mind and under no constraint or undue influence.

2. A duly witnessed signed document whereby you consent to the viatical settlement, acknowledge the catastrophic or life-threatening illness, represent that you have a full and complete understanding of the viatical settlement, represent that you have a full and complete understanding of the benefits of the life insurance policy, allow the release of your medical records, and acknowledges that you have entered into the contract freely and voluntarily.

- All medical information solicited or obtained by any person soliciting or entering into a viatical settlement shall be subject to the Welfare and Institutions Code of the State of California under Article 6.6 (commencing with section 791) of Chapter 1 of Part 2 of Division 1, concerning confidentiality of medical information.

- Any person who enters into a viatical settlement shall have the absolute right to rescind the contract within 15 days of execution of the contract.

In compliance with Section 10113.2(d) of the California Insurance Code the following information is provided:

**ALTERNATIVES:**
Before entering into a viatical settlement contract, you may have other options available to you. Among the options to a viatical settlement are:

1. A loan from family or friends secured by your life insurance contract. Loans are not taxable income and cannot exceed usury fee regulations.

2. Your life insurance company may provide an "accelerated benefit" or "living benefit" option within your existing life insurance contract.

In the process of reviewing your life insurance policy we will inquire with your insurer as to any accelerated or living benefits riders available to you or currently in force and will notify you promptly of such options.

If your life expectancy is too long to meet the parameters of the insurance companies accelerated benefits provision or the company does not have such a provision, then a viatical settlement should be considered.

**TAXATION:**
Section 17131.5 is added to the California Revenue and Taxation Code. Beginning on or after January 1, 1991, gross income does not include any amounts received by a person who enters into a viatical settlement.

Until legislation is passed, viatical settlements should be treated as ordinary income for federal taxation purposes. The taxable amount would be the proceeds received less all premiums paid and dividends received plus the balance due on outstanding policy loans.
ENTITLEMENTS:

Viatical settlements have no effect on the eligibility for non-means based entitlements such as Social Security Disability, statutory short-term disability benefits and Medicare.

If the viator is receiving or plans to receive means-based entitlements such as Medi-Cal (Medicaid); Supplemental Security Income/State Supplemental Payments (SSI/SSP); In Home Supportive Services (IHSS); Aid To Families With Dependent Children (AFDC); Food Stamps or Needy Veterans Disability Pensions. Receipt of a viatical settlement will disqualify the viator from eligibility until the programs income and property reserve limits are met.

In order to understand the affects of current regulations, the receipt of a viatical settlements and its effects on Medi-Cal, SSI/SSP, IHSS, AFDC, Food Stamps and Needy Veterans Disability Pensions you must become familiar with each agencies property reserve limits and certain reporting requirements.

Property limitations vary from agency to agency and distinguish assets as exempt and non-exempt. Exempt assets usually include real property used as a home, life insurance policies, designated burial funds ($1,500 to qualify for SSI and Medi-Cal) and certain personal property. All agencies require that they be notified, in a timely manner, of any changes in an individuals financial status (for Medi-Cal, the time period is 10 days).

An individual may keep a certain amount of personal property, such as a checking/savings account or insurance policies, and still be eligible for Medi-Cal and SSI. Other personal property such as cash, stocks, bonds, cash surrender value of life insurance, etc., in excess of the property reserve limit, are considered nonexempt assets and are subject to the limits.

The receipt of a viatical settlement will increase property reserve limits. In order to maintain eligibility an individual may reduce his or her nonexempt property to within the specified limits in any way he or she chooses. It will be necessary to document expenditures that reduce property limits.

The CALIFORNIA DEPARTMENT OF SOCIAL SERVICES has issued the following as a breakdown by program of the specific treatment which would be accorded the receipt of viatical settlement funds.

SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENTS (SSI/SSP)

The maximum resource limit for SSI/SSP is $2,000 per single person and $3,000 per couple. Under SSI/SSP rules, the negotiated settlement would be counted as income in the month received and applied against the recipients SSI/SSP grant for that month. Any balance remaining in future months would be considered a resource and, if the recipients total resources including any remaining settlement proceeds exceed the maximum resource level ($2,000 or $3,000), the recipient would be ineligible for further benefits until his or her resources were again below the maximum.

IN-HOME SUPPORTIVE SERVICES (IHSS)

The IHSS rules are the same as SSI/SSP.
AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

The maximum allowable resource for the AFDC program is $1,000 per family. Under AFDC rules, the negotiated settlement would be counted as a resource in the month received and added to any other resources the family already has. If the payment causes the family’s resources to exceed the $1,000 maximum, the family would be ineligible for aid until total resources were below $1,000.

FOOD STAMPS

The maximum resource limit for the Food Stamp program is $2,000 or $3,000 if at least one member of the household is elderly. The Food Stamp rules require that the viatical settlement be counted as a resource in the month received and added to any other resource the household already has. If receipt of the viatical settlement causes the household’s resources to exceed its maximum resource limits, the household would be ineligible for further benefits until the resources were again below these resource maximums.

NOTE:

Individuals contemplating entering into a viatical settlement contract should also be aware that if their income and resources are used in determining the eligibility of other person for any of these assistance programs, receipt of these funds could also impact the eligibility of these other persons for continued assistance. In addition, continued eligibility for medical benefits under the Medi-Cal program is often linked to AFDC and SSI/SSP beneficiary status. We recommend that you contact the State Department of Human Services, 714 P Street, Sacramento, CA 95814, for a determination of the impact of these funds on continued eligibility for Medi-Cal.

The CALIFORNIA DEPARTMENT OF HUMAN SERVICES issues MC Information Notice 007 (1/92) "Medi-Cal General Property Limitations For All Medi-Cal Applicants".

MEDI-CAL

Medi-Cal recipients may keep a certain amount of personal property (cash, stocks, bonds, cash surrender value of life insurance, etc.) and still be eligible for Medi-Cal. The amount of property which may be kept is referred to as the "property reserve". The property reserve limits are $2,000 for one person and $3,000 for a couple.

The receipt of a viatical settlement is not considered income for Medi-Cal purposes. The proceeds from a viatical settlement will affect property reserve limitations.

The property value must be reduced to an amount at or below the property limit by the end of the month in which eligibility is to be established. A Medi-Cal recipient may reduce his or her nonexempt property to within the specified limits in any way he or she chooses. A transfer of nonexempt property generally will not result in a period of ineligibility unless the recipient becomes and institutionalized individual within 30 months from the date of the transfer.

Medi-Cal cannot be approved for a month until the total value of all nonexempt property, that is, property which is counted when eligibility is determined, has been reduced to or below the appropriate property reserve limit in that month.
A recipient who is not institutionalized will not be ineligible due to a transfer of nonexempt property for less than fair market value unless the individual is institutionalized within 30 months of the date of the transfer.

Other means-based entitlements:

**NEEDY VETERANS DISABILITY PENSION**

A viatical settlement most likely will exceed the Needy Veterans Disability Pension property limits and is considered as "countable" income. Therefore the veterans benefits will be stopped. When assets have been spent down to meet the VA pension limits, the veteran must re-apply for his pension and will be subjected to a new 12 month waiting period to qualify for reinstatement of his pension (income received is annualized over a twelve month period). If a veteran renounces his pension in the month prior to receiving a settlement, receives and spends down the settlement the next month, they can then reapply to the VA with only a two to three month interruption of their pension. As of November, 1990, all veterans who receive benefits based on age only, become ineligible to renew their pension unless they can demonstrate that they now also have a disability.

Section 11021 is added to the Welfare and Institutions Code to state that as a condition of eligibility for or of continuing to receive aid, assistance, or benefits: a) the individual is not required to make an election to receive funds and b) by failure to make such an election, will not reduce the amount of aid, assistance, or benefits an individual receives, unless that individual would thereby exceed federal liability limits.

**BIBLIOGRAPHY**


*DEPT. OF SOCIAL SERVICES.* "The property limitations for aid, benefits and assistance administered by the California Department of Social Services"
Inclusion on this list is in no way an endorsement. Names have been added solely by request of the companies. A company may be in formation or may only be "brokering• (rather than buying policies for their own account). Securing multiple bids is recommended.

See your financial advisor - personal financial planner, attorney, accountant or insurance broker - for advice on choosing a viatical settlement company or companies, review of offers, income and estate tax consequences and the effect on means-based entitlements (Medicaid and SSI - not SSD and Medicare).

For additional information write to Affording Care or call:
John Darragh (707) 579-5303 or David Petersen (212) 371-4741

CA = State of California licensed Viatical Settlement Company
cap = indicates that the company has applied to the California Commissioner of Insurance to be licensed to solicit and/or enter into living benefits contracts. The review of applicants and names is still in process and are subject to change.

Currently, only two states (California and Kansas) require licensing of viatical settlement firms.

VIATIONAL SETTLEMENT COMPANIES (47) - page 1
April 15, 1993

ACCELERATED BENEFITS ASSOCIATED
Charles Boxenbaum - President
9090 Wilshire Blvd #201 - Beverly Hills, CA 90211
310/278-2191 - FAX:

ACCELERATED BENEFITS OF NEW YORK
Nick Sprayregen - President
100 United Nations Plaza #38D - New York, NY 10017
800/666-1232 212/283-3333 - FAX: 212-491-3158

ACCELERATED BENEFITS OF WASHINGTON DC
David Berman, MD - Vice President
977 Seminole Trail #228 - Charlottesville, VA 22901
800/227-8447 - FAX: 804-769-5741

ACCESS BENEFITS CORP.
Harrison Green, JD - President
4100 Executive Park Dr., #311 - Cincinnati, OH 45241
800/969-5740 513/769-5740 - FAX: 513-769-5741

THE ACCESS PROGRAM (a subsidiary of Independence Life)
Ansel Slome - President
1875 Century Park East, Suite 2738 - Los Angeles, CA 90067
800/235-6211 310/556-7781 - FAX: 310-556-7782

ADVANCED BENEFIT RESOURCES, INC.
Alan Rosenberg, Esq. - Brenda Smith
4744 Wallingford Street - Pittsburgh, PA 15213
412/621-7447 - FAX:

AFFIRMATIVE LIFESTYLES, INC.
Peggy Wallace, CFP - President
1100 NW Loop 410, Suite 207 - San Antonio, TX 78213
800/235-6211 310/556-7781 - FAX: 310-556-7782

AID FOR AIDS
Frank Childs - Norman Levin
P.O. Box 273293 - Boca Raton, FL 33427
305/421-7171 - FAX:

AID FOR AIDS ALSO VS, INC.
Bill Crust - President
P.O. Box 15683 - Kansas City, MO 64106-0683
800/766-7183 816/472-8383 - FAX:

AID TO LIFE
Gary Hum, Esq. -
One California St 29th Floor - San Francisco, CA 94111
415/793-5303 - FAX: 415-391-9599

CA AMERICAN LIFE RESOURCES CORP.
Steve Simon - President
930 Washington Ave - Miami Beach, FL 33139
800/603-0470 305/534-0101 - FAX: 305-534-1020

AMERICAN NATIONAL INVESTORS CORP.
George Klmeldorf - President
7612 Queensferry Lane - Dallas, TX 75248

ASSURED LIFETIME BENEFITS OF ILLINOIS
Milton Heching - Isadore Goldberg
3420 West Arthur Ave. - Lincolnwood, IL 60645
708/676-6806 - FAX: 708-675-6444

BENEFICIAL OPTIONS, INC.
Tomi Tianinen -
756 Bay Street - San Francisco, CA 94109
415/885-6054 - FAX:

BENEFIT ADVOCATES (a consulting service)
Nancy Cane - Principal
180 Montgomery St. #180 - San Francisco, CA 94104
800/435-8891 415/380-8880 - FAX: 415-385-8881

CONTEMPORARY LIFE BENEFITS, INC.
Alan Sternberg - Bob Bell
1646 No. California Blvd. #220 - Walnut Creek, CA 94596
800/362-1084 510/332-3200 - FAX: 510-332-3200

DEDICATED RESOURCES, INC.
Mike Zadoff - President
1650 Elmwood Ave. - Rochester, NY 14620
800/677-5026 716/244-1700 - FAX: 716-244-5845

DIGNITY PARTNERS, INC.
Alan B. Purper
889 Alser Ave #200 - Incline Village, NV 89452
702/831-4777

ESTATE TRUST CO., INC.
Michael Quinl - Joseph M. Schwartz
7400 York Road #300 - Baltimore, MD 21204
800/455-5190 410/282-1171 - FAX: 410-234-2114

FINANCIAL LIFE LINE, INC.
Benjamin Samuels - David Pacifico
21936 Nordhoff St. - Chatsworth, CA 94311
CA800/882-7936 818/882-7936 - FAX: 818-882-7930
GREAT WESTERN CREDIT CORP
Rick Reichl -
2505 Enterprise Road - Clearwater, FL 34623
800/892-9537 - FAX:

INDIVIDUAL BENEFITS, INC.
Ramon Vicente - President
P.O. Box 36480 - Greensboro, NC 27416
800/800-3264 919/299-5100 - FAX: 919-292-1331

INSURANCE RESOURCES GROUP, LTD.
Paul Myers - Arnold Cornblatt
4919 Hampden Lane - Bethesda, MD 20814
800/283-2139 301/652-9522 - FAX: 301-652-6091

KELCO, INC.
Bill Holman - President
2365 Harrodsburg Rd #A-200 - Lexington, KY 40504
606/223-3262 - FAX:

LEGACY BENEFITS CORP.
Meir Eliav - President
225 W. 34th St #1605 - New York, NY 10001
800/875-1000 212/643-1190 - FAX: 212-643-1180

LIFEAID
Alan Kassan , Esq. - Jeff Paul
15915 Ventura Blvd., #300 - Encino, CA 91436
800/LIFEAID 818/981-8812 - FAX: 818-981-6681

LIFE BENEFITS INC.
Eddie Speed - President
P.O. Box 161652 - Irving, TX 75016
800/969-6000 214/869-2239 - FAX: 214-556-1566

LIFE FUNDING CORPORATION
Tim Heath - Counselling Associate
8300 Dunwoody Place #220 - Atlanta, GA 30350
800/456-8799 404/518-8830 • FAX: 404-518-9663

LIFELINE - PAGE & ASSOC. INC.
Scott Page - President
5311 Northfield Road #200 - Bedford Heights, OH 44146
800/572-4346 216/581-2577 - FAX: 216-662-3885

LIFE PARTNERS, INC.
Brian Pardo - President
P.O. Box 20034 - Waco, TX 76702
817/751-7797 - FAX: 817-751-1025

LIFESTYLE RESOURCES CORP.
Fran Welcom - President
P.O. Box 1665, Station C - Worcester, MA 01607-0665
800/835-2006 508/635-0065 - FAX:

LIFETIME LIQUIDITY, L.P.
Richard Ballard - General Partner
P.O. Box 371 - Walnut Creek, CA 94598
510/837-4600 - FAX: 510-838-6315

LIFETIME OPTIONS, INC.
Craig Fishman - Vice-President
2700 South Quincy St., #540 - Arlington, VA 22206
800/999-5419 703/379-8906 - FAX: 703-998-5470

LIFE TODAY
Rick Perry -
2401 Fountain View #910 - Houston, TX 77057
800/554-2104 713/977-5433 - FAX:

LIVING BENEFITS, INC.
Cale "Kit" Carson - Vice President
6100 Seagull Lane, Suite 108 - Albuquerque, NM 87109
800/458-8790 505/883-4798 - FAX: 505-883-4799

LIVING LIFE, CORP.
Jim Hayes - President
P.O. Box 14472 - Tampa, FL 33690
800/375-0191 813/876-3622 - FAX:

NATIONAL FUNDS FOR LIFE
Leon Chartarinsky - President
415 N. Hwy 101 - Solana Beach, CA 92075
CA800/339-9221 619/792-6125 - FAX: 619-792-6124

MEDICAL ESCROW SOCIETY
David Reed - Robert Harms
205 North Texas Ave #3 - Tavares, FL 32778
800/422-1314 - FAX: 904-483-1331

NATIONAL VIATOR REPRESENTATIVES, INC.
David Landay - President
353 West 56th St #9N - New York, NY 10019
800/932-0050 212/586-6000 • FAX: 212-246-2319

CA NEUMA, INC.
David Binter - Chairman
1007 Church St #314 - Evanston, IL 60201
800/457-7828 708/792-1150 - FAX: 708-792-1145

Q-FOIL COMPANY
Thomas Holtz - Agent
3490 South Dixie Dr., Suite 120 - Dayton, OH 45439
800/367-1792 513/294-5433 - FAX: 513-294-5470

SAS CONSULT SERV,INC.-HUMAN NEEDS
Stan Slovin - President
214 No. Wyoming Ave - So. Orange, NJ 07079
201/761-1744 - FAX: 201-763-9160

SECURITY TODAY
Gary Holman - President
P.O. Box 275 - Macon, MO 63552
816/385-2692 - FAX:

SOUTHEASTERN FINANCIAL MGMT., INC.
Wendell McCranie - President
220 Third Avenue - Eastman, GA 31023
800/537-1487 912/374-2535 - FAX: 912-374-0173

VIATICAL ASSISTANCE CORP.
Jerry Fadal - President
P.O. Box 23434 - Waco, TX 76702
800/892-1282 817/772-3888 - FAX: 817-772-6626

VIATICAL CLEARING HOUSE, INC.
Deborah Rhodes - President
852 Oak Canyon Drive - Loveland, OH 45140
800/969-0509 513/533-0000 - FAX: 513-583-1478

VIATICAL FUNDING COMPANY, INC.
Kenneth Klein - JD -
110 East 59th Street #3202 - New York, NY 10022
212/750-1000 - FAX: 212-581-4715

TRADE ASSOCIATIONS
NATIONAL ASSOCIATION OF VIATIC SETTLEMENT ORGANIZATIONS (NAVSO)
Steve Simon - President
930 Washington Ave - Miami Beach, FL 33139
305/534-0101 - FAX:

NATIONAL VIATIC ASSOCIATION
Brian Pardo - President
P.O. Box 23434 - Waco, TX 76702-3434
817/772-3888 - FAX:
A Discussion on the Use of the Term "Living Benefits"

The life insurance industry has used the term "living benefits" over the years to describe many different policy provisions which offer some type of benefit during an insured’s lifetime.

Cash values have often been referred to as "living benefits" because they are available for use as emergency or opportunity resources for cash through policy loans. The same holds true for the industry's promotion of cash values to meet education funding objectives and retirement accumulation goals.

The availability of options allowing insureds to annuitize their cash values at retirement so that they receive a monthly retirement income has also been characterized as a "living benefit".

Other policy riders such as Disability Waiver of Premium, the Guaranteed Insurability Option and Policy Exchange Privileges also provide "living benefits" to policyowners.

Insurance companies and their sales representatives have made the availability of "living benefits" to prospective buyers an important part of their sales presentations. Their need to differentiate between death benefits and living benefits is understandable, both from a marketing point of view and as an aid to explaining policy provisions to the public.

When companies were created to purchase life insurance policies of terminally ill clients, it was natural for the service they provided to be described as "living benefits". The conversion of the future death benefit of a life insurance policy into cash to be used in any manner by the seller of the contract could hardly be more aptly described.

The development of "accelerated benefits" provisions by many life insurance companies has brought a serious element of confusion to the scene, however. An accelerated benefits provision typically offers totally disabled or terminally ill insureds the opportunity to request advance payment of death benefits from their insurers to meet certain specified personal expenses, such as long term nursing care.

The exact circumstances under which policyowners will be able to qualify for accelerated benefits will vary depending on the insurance company and the regulations applicable to such arrangements as promulgated by state legislative or regulatory bodies.
The concern of the writer, which led to this discourse on the subject, is that insurance companies, insurance department officials, legislators, politicians and the public press have been and are currently describing accelerated benefits as "living benefits". As a result, the difference between accelerated benefits and the transaction of discounted policy purchases by third parties has become obscured.

It is the writer's opinion that "living benefits" firms acquiring policies from the public are faced with the absolute necessity of identifying their services with a generic descriptive term that will provide a means of differentiating their services from the accelerated benefits concept.

Their failure to do so will seriously handicap them in the future development of their "industry", because it will be an industry without a name. The name "living benefits" has been snatched away from them, and there is absolutely no way that it can be recaptured. It is gone!

A great deal will be written and said in the near future about accelerated benefits and benefits provided through the sale of policies. Pre-death settlements are currently a "hot" topic, not only for the media, but also for legislators, health care providers and all elements of the life insurance industry. If there is no clear way to describe what has previously been called "living benefit settlements", there is bound to be a great deal of confusion.

If there is no existing generic term to describe the discounted pre-death settlement sales, then the industry will have to invent one. Otherwise, the press will probably pin a label on such settlements, and it may not be an attractive one.

Such a term should communicate the pre-death nature of such arrangements, and should not have any pejorative overtones. It should convey the positive purpose of such transactions for the seller, not the buyer. Any label attached by the press or the insurance industry will probably not be positive. One can think of such terms as "speculative purchases", "life insurance pawn brokers", and who knows what!

I would like to propose that consideration be given to a term which I have started to use to describe pre-death discounted purchases. I call these "viatical settlements". While the term is certainly not a household word, I think it could become one. The money received by the seller would be a "viaticum".

Basically, a "viaticum" is an amount of money or provisions for a journey. I think it is especially significant that the term also has historically been applied ecclesiastically to the spiritual sustenance provided to the dying through the tangible elements of the Eucharist.
For your information, I am enclosing definitions of the term, from the Oxford Dictionary which includes historical references to its use and development. I believe you will agree that it includes all the positive implications appropriate to the public service being provided by "living benefits" companies.

Perhaps someone can come up with a better suggestion. If so, it needs to be presented and discussed very quickly, because time is running out.

Richard W. Bandfield, CLU, RFP
March 20, 1990

1641 IMPREACH. Father Phillips x. A iii b, After a Viaticke, hee was dispatched againe for England, with some few small Gifts.

1. Viatic, a. Obs. [ad. L. viaticus (rare), f. via way.] (See quot.)

1656 Blount Glossary. Viatick, pertaining to a journey, or traveling by the way. [Hence in Phillips, Bailey, and later Dictionaries.]

Viatical (v̄i.ā.čtikal), a. and sb. rare. [f. L. viaticus or -tium: see prec. and Viaticum.] a. adj. Of or pertaining to a way or road; relating to a journey. b. sb. pl. Articles for use on a journey. 1835 Landor Imag. Conv. Wks. 1836 II. 450 His back would have been bent, under the weight of armour and viaticals which Titus (Livius) carried with him easily and far. 1863 J. G. Baker N. Yorke, Stud. Bot, etc. 188 Such stations are denominated by the terms paludal, viatical, acratal, sylvstral, and sepulchrarum.

Viaticated, a. rare. [f. L. viaticatus (Plautus), f. viaticum : see next.] (See quot.)

1793 Bailey (vol. I), Viaticated, furnished with Things necessary for a Journey.


1. Eccl. The Eucharist, as administered to or received by one who is dying or in danger of death.

1784 in Cooper Annu. Prov. Mass. (Parker Soc.) 11 Divers Christians ... would be always sure to have their viaticum, as it is termed in the old canons, that is to say, their voyage-provision. 1856 T. Stapleton Forth. Faith 126 Whence the auncient fathers called Viaticum, the viage provision of Christen men departing out of this world, c. 1600 Women Saints 78 After that she had received her holy Viaticum or voyage foodos ... she departed this life. 1876 in Cath. Rec. Soc. Publ. III. 63 Wee durst not give him the holy viaticum, being so farre spent. 1685 Evelyn Mrs. Godolphin 145 As if presaging what was aitt hand, she furnished herselfe with the heavenly Viaticum. 1744 in J. O. Payne Old Eng. Cath. Missions (1866) 28, I administered the viaticum to Will. Sile at E. Witon, hedeyed Sep. 3. 1774 Ann. Reg. 151 Many people were dangerously wounded, 18 of whom had the viaticum administered. 1839 [Wiseman] Lives St. Alph. Ligouri, etc. 225 Her mother fell so dangerously ill, that the Viaticum was brought to her. 1855 Kingsley Westrn. Hist. 57 viaticum, No absolution, no viaticum, nor anything! I die like a dog! 1894 J. T. Fowler Adamsum Intro. p. lv. Having received the holy viaticum at the hands of St. Kevin, he passed away in peace. attrib. 1686 tr. Chardin’s Trav. Persia 101 They make their Viaticum Bread once a year; that is to say, upon Holy Thursday.

2. A supply of money or other necessary for a journey; a sum given or taken to cover travelling expenses.

1682-8 Hist. James VI (1804) 100 This was very acceptable to the Duke, and therfor he gaine him a reasonable viaticum for performance of the saider service. 1679 Parker Hist. Ippecr. 1. ii. A poor viaticum; very good gold, sir; But holy men affect a Letter treasure. 1677-90 Row Hist. Kirk (Wodas Soc.) 23 The Earl of Dumbar dealt many angels of gold pretended to a viaticum; but indeed for votes. 1689 J. E. Taylor Gt. Exemp. i. vi. 102 The smallnesse of their viaticum and accommodation for their voyage ... were so many circumstances of poverty. 1791 Wodas Corp. (164) II. 587 There is L250 of debt on the Church, and the viaticums are stopped. 1792 in Scott Mag. (175) 513 This pannel caused to be sent him his baggage, and a viaticum of money. 1826 T. Taylor Aquelius xi. 85 When a few days had elapsed, I rapidly collected together my viaticum in bundles. 1899 B. Camm Brave Days Old 65 Tbis money had been given to him by the most munificent Pope Gregory XII, for his viaticum or travelling expenses the year before.

b. Without article.

1659 Fuller C. Hist. III. 65 He allowed them only bare viaticum to bear their charges. 1883 Law Reg. 9 Probate Div. i: The Gesta of an authentic favour of the season's claim for viaticum, and it is always the practice to give subsistence money.


1653 Patrick Farab. Pilgr. xviii. It will be a very good Viaticum for you, and in the strength of this Food you may travel many days. 1866 J. Davies Hist. Carthby Isles 239 Afterwards sitting down on the grass, every one fell to what he had brought along with him for his Viaticum. 1792 W. Bartram Carolina 344. I comforted myself with a frugal repast of biscuit and dried beef, which was all the food my viaticum afforded me by this time. 1855 Rawlinson Anc. Mon. Childers 1. 135 In the Childernus sequesters a number of dishes are always ranged round the skeleton, containing the viaticum of the deceased person. 1860 W. G. Blair Levison Livingstone v. 87 Purchasing a leaf and a piece of cheese as viaticum, he started for a college at Oberlin.

3. trans. and fig. (from senses 1 and 2).

1618 Davies Wirtsa Pilgr. Wks. (Grosart) II. 461 And sth thy Pilgrimage is almost past Thou needst the lese Viaticum for it. 1640 Flecknoe Trav. XXXIII. (1667) 103 To ... travel without viaticum for any to ... undertake a voyage without the Language of the Country, where he goes. 1749 J. Fer. Taylor Gt. Exemp. i. 421 The grace of God is our viaticum and entertains us by the way. 1866 Hale Contempl. II. (1677) 186 He ... hath a great freedom from fear of Death, and no small viaticum to attain Tranquillity of mind in his life. 1791 Washington Div. Legat. vi. § 6 The doctrine of a future state ... was their constant viaticum through life. 1775 J. Jerx. Corr. (1804) i. 20 Bunbury's eichings and Sterne's journey are almost as good viaticums in France as the post book. 1853 C. D. Yonge Hist. Leicesters v. 169 Another of his sayings was, that education was the best viaticum for old age. 1901 Farrar Soc., & Present Day Quest. 213 There is all Biography ... to nourish you with the viaticum of good examples.
Insurance

Viatical Settlements: New Planning Tool for the Seriously Ill

By John Darragh


Viatical settlements allow a terminally ill person to convert a non-cash asset into cash. Judicious use of viatical settlements may alleviate financial burdens placed on the terminally ill and their families. In 1989 the first life insurance policy was viaticated for a terminally ill client. Since then the concept of viatical settlements has gained wide acceptance among terminally ill policy holders and third-party entrepreneurial firms. In exchange for an immediate cash payment to the policy holder (in an amount less than the policy death benefit), third-party firms take assignment of the life insurance policy as owner and beneficiary. NOTE: Viatical settlements should not be confused with accelerated benefits, which are discounted pre-death payments by insurers. For many individuals, viatical settlements can mean the difference between impoverishment and maintaining a dignified quality of life.

It is estimated that over $250 million in face amount of life insurance has either been viaticated or accelerated in the past four years. The viatical settlement industry has grown from six firms in 1989 to more than 40 today. Some of the companies act as principals, buying for their own account through private resources. Others function as brokers, acting as the client liaison for one or more funding sources. Compensation varies greatly. Each firm has its own life expectancy payout determination process. Some firms have sales representatives to whom they pay a commission or referral fee.

The Process

The viatication process is a relatively simple and private business transaction between a buyer and a seller. Typically, if a client's life expectancy is 24 months or less, the buyer will offer to purchase a life policy for 50 to 80 percent of its face value. Selling a life insurance policy is a major financial decision. It is strongly recommended that individuals wanting to viaticate their life policies seek the advice of a qualified professional. An obstacle for many clients is locating a knowledgeable, insightful planner. Planners must be prepared to discuss the alternatives to a viatical settlement. Alternatives include loans from family members or friends (loans are non-taxable) or an accelerated benefits provision within their existing policy.

If a client is receiving or plans to receive means-based entitlements such as Medicare or Supplemental Security Income, the viatication of a life insurance policy usually will disqualify the client from eligibility in the month received. Fortunately, planning techniques are available that can prevent long-term disqualification from these entitlements. It is critical that planners become familiar with federal and state entitlement provisions.

The seller of a life insurance policy is required to declare as taxable ordinary income the viaticum received, less the sum total of all premiums paid, all dividends received, and any outstanding policy loans. In March 1993 the IRS will conduct hearings on the taxability of accelerated benefits. Viatical settlement advocates are scheduled to address the hearing and attempt to have viatical settlements treated as income tax-free life insurance death benefits.

Service Options

Planning professionals have options for providing optimal service to their clients. They can:

• refer clients to another planner who has experience in the viatical settlement process; refer clients to knowledgeable benefits counselors at community-based organizations; or assume the role of primary planner. Building a local network of specialized professionals can be invaluable.

Planners who specialize in addressing the financial planning needs of the terminally ill typically contract with their clients on an hourly fee basis. Fee-based services assure the client that the planner makes no specific financial gain from the potential policy sale. One must remember that helping a client with the viatical settlement process is only a small part of the overall plan.

To be a working participant with a client, the planner must perform due diligence on viatical settlement companies. Among the questions that need to be addressed are:

• Is the company acting as a principal or broker?
• How are they compensated?
• When did they purchase their first contract?
• How do they insure client confidentiality?
• How do they determine settlement amounts in relation to life expectancy projections?

• How do they determine life expectancies?
• What types of policies will they purchase?
• What types of contracts will they not purchase?
• What is the source of their funding?

To meet the financial planning needs of individuals with serious illnesses, a new organization has been established. Affording Care is a national, 501(c)(3) non-profit corporation formed in late 1992. Its goal is to empower people with serious illnesses through the dissemination of financial education and information. Additional information on viatical settlements is available by contacting: Affording Care, 133 E. 39th Street, New York NY 10016, or, John Darragh at 723 Humboldt Street, Santa Rosa, CA 95404, (707) 579-5303, FAX (707) 575-7526.

John Darragh has been a practicing financial planner since 1977. He was diagnosed with AIDS in June 1988. Currently he lectures around the country and counsels individuals, professionals and organizations on financial planning for those facing life-threatening illnesses. Darragh is a past president of the North Bay Chapter of I AFP and a member of the I AFP's Practitioners Division. He currently serves on the board of directors of Affording Care.

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<th>BUY &amp; HOLD*</th>
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<td>AMERICAN SCANDIA LIFE ALGER SMALL CAP</td>
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<td>WESTERN RESERVE WRL SERIES SUB ACCOUNT GROWTH</td>
<td>+ 1.10%</td>
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* Total returns for 1992. We offer full disclosure
1 Past Performance is no guarantee of future results
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COMMONLY ASKED QUESTIONS

ALR1. Could I jeopardize keeping any benefits that I am receiving if I sell my life insurance policy?

ALR2. Do I have to report to the IRS the amount of money that I get from selling my life insurance policy, and do I have to pay income taxes on those funds?

ALR3. Is it possible that my life insurance company might be interested in giving me money because I am terminally ill?

ALR4. Should I speak to my friends or my family about buying my life insurance policy?

CLB. Viatical Settlement Program - How It Works

CLB1. What reason would a terminally ill person have for selling his or her life insurance policy?

CLB2. What are the requirements for _________ to purchase a policy?

CLB3. How much will I receive for my policy?

CLB4. Do I need to speak to an attorney or financial consultant?

CLB5. Do I have benefits such as this with my own insurance company?

CLB6. Will I have a tax liability on the proceeds I receive?

CLB7. Will the sale of my life insurance policy result in an interruption of any public assistance I receive?

CLB8. Do you purchase group policies?

CLB9. What if my policy has lapsed and been reinstated?

CLB10. Will selling my insurance policy affect my major medical insurance benefits?

CLB11. Will I be responsible for paying any future premiums on my life insurance policy?

CLB12. How will the cash value in my policy affect my settlement?

CLB13. Do I have to be examined by other doctors?

CLB14. Will my employer be contacted or notified of my medical condition?

CLB15. How much time does it take to complete the sale of a policy?

CLB16. What if I change my mind?

MES1. What is the definition of "terminally ill" or facing a "life threatening illness?"

MES2. What are the necessary requirements to be eligible for a viatical settlement?

MES3. How is a person determined to have a life expectancy of twenty-four (24) months or less?

MES4. Based upon the face value of the life insurance policy, what amount may I expect to receive through a viatical settlement?
MES5. What types of life insurance policies are acceptable for a viatical settlement?

MES6. What size policies are considered for purchase?

MES7. How does the insured know that he will receive his monies while the transfer and recording of instruments is in process at the insurance company?

MES8. Is it necessary for the policy holder to continue to pay premiums after he has sold the policy?

MES9. Does the insured need an attorney to represent his interests in this transaction?

MES10. Does the insured pay any fee to the company?

MES11. What happens to the interest of the existing beneficiaries listed on the policy?

MES12. How does the insured know that his medical information is handled confidentially?

MES13. What if the policy has lapsed and has been reinstated? Does this affect the original two year waiting period?

MES14. How is the payment made?

MES15. What other options may be available to the insured other than a viatical settlement?

MES16. What tax consequences need to be considered by participants in a viatical settlement?

MES17. What are the possible consequences for the participant in a viatical settlement with regard to public assistance?

MES18. For what reason would a terminally ill person want to participate in a viatical settlement?

MES19. What is the procedure to determine if a policy can be purchased?

MES20. What is the next step should the client decide that the purchase price is acceptable?

MES21. What is the average length of time to accomplish the sale of a life insurance policy?
John Darragh

John Darragh has been a practicing comprehensive financial planner since 1977. In 1986 John was informed that he was HIV positive and has been living with AIDS since 1988. Retiring in 1989, he currently lectures nationally and counsels individuals, professionals and organizations on financial planning for those facing life-threatening illnesses. Recognized as a specialist in financial planning and serious illness, he has had numerous articles published and is often quoted in the national media. He is considered to be one of the foremost national authorities on viatical settlements and acts as an advocate for the seriously ill on legislative, insurance and taxation issues.

Mr. Darragh serves on the board of directors of Affording Care, the national financial education and information center for serious illness. Affording Care seeks to empower individuals living with serious illness to make positive financial choices -- enabling them to afford good care and a better quality of life.

Mr. Darragh is a registered principal with Protected Investors of America, a securities broker/dealer and Registered Investment Advisor. He is a past president and a past chairman of the North Bay Chapter, International Association for Financial Planning, and served on the board of directors for six years. He is a former state director of the California Association for Financial Planning, Inc. He has served on the Select Interview Committee for the Registry of Financial Planning Practitioners. John is a member of The Practitioner Division of the IAFP. He is also a member of The American Institute of Life-Threatening Illness & Loss, a division of The Foundation of Thanatology, an organization dedicated to promoting grace and dignity in dying.

John has been a member of the Golden Gate Business Association since 1979. He is a past director of the Russian River Gay Business Association. He was the financial commentator of the internationally syndicated National Gay Network, the program that "broke the silence".
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All viatical settlement companies:

• Require that the insurance company be a quality carrier with a good reputation for paying death claims;
• Require that all persons having an ownership or beneficiary interest release their interest and waive future rights;
• Require applicants to release medical records for review;
• Require applications to make a designation of irrevocable beneficiary in favor of the purchaser;
• Require that the policy be past the period specified in the contestability clause and suicide exclusion;
• Suggest that the applicant secure the advice and counsel of a financial planner, insurance professional, attorney and/or tax accountant before viatiating a policy;
• Have panels of medical experts to review the applicant's medical records and to make independent estimates of life expectancy;
• Promise the maximum confidentiality consistent with what the companies need to disclose to do their jobs; and
• Specify a time period after settlement within which the seller has the right to undo the entire transaction.

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FINANCIAL PLANNING NEWS
M A R C H 1 9 9 3
Dear Friends:

You are invited to attend either of the programs offered.

1. The AIDS Legal Referral Panel (ALRP) program is for professionals. RSVP: Phil Kuttner (415) 291-5454

2. The "Personal Finances & HIV" seminar, hosted by the SFAF is directed to clients.

Dear Panel Attorney,

I am writing to invite you to a special forum that the ALRP is holding for insurance and employee benefits lawyers. The topic is viatical settlements — that is, transactions in which seriously ill people exchange their life insurance policies for cash. The speaker is John Darragh, a consultant for Affording Care. John will look at California regulation of these settlements, tax consequences, effect on public benefits, and everything lawyers need to know to properly advise their clients.

The forum will take place on Tuesday, June 8 at 5:30 pm, at 114 Sansome Street, Suite 512, in San Francisco (near the Montgomery Street BART and Muni station). Participation is free, but we ask that you make a reservation since space is limited. Please call me at (415) 291-5454. I look forward to seeing you.

Sincerely,

Philip Kuttner
Volunteer Coordinator

May 28, 1993
FACT SHEET

What Is The Mission Of National Viator Representatives, Inc.?
NVR's mission is to help People With AIDS and other terminally ill people who desire to sell their life insurance access purchasers efficiently and without stress, with the objective of obtaining the best price for their policy(s). NVR is a private company, not affiliated with any purchaser. NVR will:
- Consult with sellers to determine the best method of obtaining these funds.
- Act as representative if the policyholder decides to sell, minimizing stress and paperwork.
- Strive to obtain the best price for the seller and safeguard the seller's rights.

What Are The Alternatives?
NVR helps clients select the best alternative for accelerating life insurance benefits based on the financial consequences for the individual. The choices include:
- Loans against the policy.
- A "living" or "accelerated" benefit from the life insurance carrier.
- Sale to a viatical settlement company.
Federal and state tax ramifications vary, as does the impact on some Federal and State assistance programs. NVR encourages sellers to consult with an attorney or tax consultant.

How Does NVR Operate?
When a person decides to use NVR to assist in the sale of a policy, we ask our clients to:
- Complete one application questionnaire.
- Sign medical and insurance authorizations.
NVR will then handle all paperwork and proceed to:
- Contact physicians to obtain copies of medical records for the last two years.
- Obtain information concerning the policy to be sold from the insurance carrier.
- Match client profile to appropriate purchasing company(s)
- Engage independent medical advice to use when negotiating with viatical companies.
- Negotiate the sale price based on NVR's market knowledge and legal expertise.
- Ensure that the buyer has cash on hand to proceed with the purchase.
Throughout the process, NVR will keep in close communication with its client:
- When an offer is presented, the client may accept or decline payment.
- When an offer is accepted, the client still has 15 days to reverse the transaction.

How Does NVR Find Buyers?
If a sale of a policy is to be made, NVR consults its database to ensure the best match of seller to purchasing viatical settlement company.

How Long Does It Take To Receive Funds?
The entire process from application to payment is usually complete within four to six weeks.

What Are The Fees?
All NVR services are free-of-charge to the seller of a life insurance policy.
NVR is dedicated to helping people with terminal illnesses maximize the amount of monies they can obtain utilizing their life insurance as a source of funds. NVR is an independent seller’s representative, not owned or affiliated with any purchasing entity. If a policy is to be sold, NVR works on behalf of the seller to maximize the amount received as quickly as possible, with the least stress and work incurred by the seller. NVR utilizes a universal application; obtains medical records and insurance information; engages independent medical advice; negotiates the sale price; ensures the buyer has cash on hand to close the purchase, and acts as a safeguard for the seller’s rights — all at no fee to the seller.

NVR was co-founded by:

David S. Landay, attorney, past President of Williamsburg Life Insurance Company and AIDS activist.

Scott B. Wilbanks, a former Vice President of a Viatical Company with a Masters Degree in Business Administration.

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Scott B. Wilbanks, a former Vice President of a Viatical Company with a Masters Degree in Business Administration.
I have a terminal illness. I have heard that I can use my life insurance policy as a source of funds now, while I am still alive. How can I get the most money for my policy?

Either by using your policy as collateral for a loan or by using “living” or “accelerated” benefits if offered by your insurance carrier. Loan proceeds are not taxable, but you will have continuing interest payments to make. Net “living” or “accelerated” benefits are usually considered income for Federal and State tax purposes. In California such monies are not taxable. The laws are currently being reviewed and should be examined by your tax consultant when you are ready to proceed.

If these alternatives are not available to you or do not provide sufficient cash for your purposes, you may consider “viaticating” your policy: selling it to one of the companies that emerged since 1989 in what is now called the “Viatical Settlement industry.”

Does my life insurance policy qualify for sale?

As a general matter, any life insurance policy can be sold, whether it is whole, universal, or term, and whether it is group or individual.

Are there provisions in my policy that could prevent a sale?

It is very difficult to sell a policy during a contestable period or while a suicide exclusion is in effect.

Do I continue to pay the premiums after the sale?

No. After a sale, your rights and responsibilities in the policy cease. The purchasing company will pay the premiums.

What are the tax consequences of selling my policy?

The net proceeds from a sale are usually considered income for Federal and State tax purposes. Some states, such as California, specifically exclude these monies from tax. Consult your tax advisor or NVR for the latest developments.

Does a sale of my policy affect my other personal or group insurance benefits, such as disability or health?

Generally no, but each situation must be checked carefully.

Will a sale of my policy affect state or federal assistance programs such as Social Security, food stamps, Medicaid, unemployment benefits, or veterans’ disability pension benefits?

If the program imposes a cap on the amount of your income or on your resources, the benefits may be affected or possibly even terminated for a period of time. If the program is available as a result of tax or other payments, the benefits usually remain unaffected.

Do all viatical companies offer the same net proceeds?

No. Offers can vary dramatically as a result of the purchasing company’s assessment of longevity, ratio of premiums to proceeds, insurance criteria, and other factors. Viatical companies also differ as to the clientele served and the insurance specifications required.

If I apply today, when can I expect to receive my money?

The timing depends on the reponsiveness of your primary care physician and insurance carrier, review by the viatical company, and the closing process. The average time to complete a sale is four to six weeks.

What is the best way to sell my policy?

The best method of selling your policy is one that maximizes the amount of money you receive and that eliminates stress, paperwork, follow-up time, and attention. With an independent seller’s advocate, such as NVR, you complete only one application and related forms. NVR uses its expertise and the opinions of independent medical consultants to work on your behalf. We obtain your medical records and pertinent insurance verification, obtain and negotiate a cash offer, and safeguard your rights, all at NO FEE to the seller.

If you prefer to proceed on your own, however, you should contact and complete the separate applications for a minimum of three viatical companies. You should monitor each company during the underwriting process as it contacts your primary care physician to obtain a copy of medical records and opinions and verifies data from your insurance carrier. Upon receipt of offers, you should verify that sufficient funding is available for payment. You can, of course, attempt to negotiate those offers to improve your settlement. Lastly, you should monitor the closing process.

Do I have to accept an offer? If I do, can I change my mind?

You are not obligated to accept any offer at any time. If you do accept an offer, NVR stipulates that the purchasing company give you 15 days after the sale is complete to reverse the transaction. Note for California residents: this right is statutory and may not be waived.

Do I have more questions, how can I find the answers?

Please feel free to call NVR toll free at 1-800-932-0050. All information provided to NVR is held in strict confidence.