

Accelerated Benefits

by Gary D. Chartier

Introduction – Chapter 1

Insurance began to be a part of our civilized lifestyle in the 17th century. The first insurance policies were issued in order to cover ships at sea against the chance of them not returning to their port. Since that early form of insurance coverage, insurance has developed to the point that it is now possible to insure every object and every living being on earth all the way from Jimmy Durante's nose and Liberace's fingers, down to the legs of Brooke Shields, Tina Turner, and Mary Hart. Though insurance has such a long history, just in the last 50 years, the concept of insurance has even further changed from being a luxury to the current status of being a true necessity. 245 million Americans today own some form of life insurance.

With modern medical technology, persons are now living longer. In 1970, the median age of the United States' population was 28 years. By the year 2000, the median age exceeded 35 years. At the same time of these changes, the death rate of people who are 50 to 70 years old, has been steadily decreasing due to many factors, including the population's overall awareness of good health practices, and, more importantly, the multitude of drastic improvements in medical services, care, and knowledge. However, this medical technology is costly. Therefore, insurance for protection against long-term illness and/or disability is important to maintain an appropriate lifestyle.

The purpose of this article is to document the development in the early 1980s of a specific type of insurance coverage. It is a hybrid plan drawing both from the traditional life insurance and health insurance

coverage. It is informally called a 'dread disease' policy, or an accelerated benefit policy.

Benefit and Design – Chapter 2

Dread disease benefits are payments made to life insurance policyholders under certain and additional circumstances other than, but including, death. The benefit payments reduce or eliminate the face value of the policy that otherwise would have been payable to the policyholder's beneficiaries. These benefits come in the form of a complete life insurance policy, or as a rider, added to a base life insurance policy. The accelerated benefit is then available to the insured under conditions such as the following:

1. Terminal illness with a limited and specified life expectancy.
2. Confinement to a long-term care facility.
3. The diagnosis of a certain catastrophic and specified dread disease.
(this benefit is also known or referred to as a pre-death, accelerated, dread disease or living, benefit).

Implementation of the Accelerated Benefit – Chapter 3

This part will address one of the above three conditions. Upon the diagnosis of one of a policy provision's defined diseases, the insurance company pays a lump sum benefit to the insured. The amount, pre-calculated in the policy's application and provisions at issue, is almost always 10% to 100% of the policy's face value. The National Association of Insurance Commissioners (NAIC) initially released guidelines as of January, 1991, which suggests limiting the maximum percentages available to 50%. The NAIC amended those guidelines and removed any maximum percentage of the policy's face amount. The NAIC is headquartered in Kansas City, Missouri and is the association

that sets guidelines for insurance companies nationwide. Not all NAIC guidelines or regulations, however, are adopted by all states.

Over 70 life insurance companies in the United States have introduced this unique coverage in policy form or as a supplementary part of a policy (a rider). The face amount of the insurance coverage, representing 100% of the insured's life coverage, is reduced by a dread disease claim percentage amount upon the policy's call for diagnosis of a specific disease. The most popular numerical amount is 25%. The life coverage then continues after the accelerated part is paid and the remaining benefit will be paid to the policy beneficiary whenever death occurs. Many of the policies providing this benefit waive premiums as well as reduce the plan's provisions by the same percentage as the accelerated benefit payment. A simple example would be a 25% benefit payment of \$25,000 from a base life insurance policy of \$100,000. After the benefit is paid, the \$10.00 monthly premium, if not waived entirely, would likely or normally be reduced to \$7.50.

Unlike regular life or health indemnity insurance, dread disease coverage does not have to meet any expense amount or specific hospitalized dates to be honored. Dread disease insurance pays the benefit upon the diagnosis of the policy's defined disease, regardless of the future outcome of the insured's health. The claim's lump sum amount is designed to actually be used for special medical equipment, prolonged convalescence, early retirement, organ transplant, or unpaid medical expenses. However, the benefit can be used for any reason the insured selects. With today's advancing and improving medical practices, extending and increasing survival rates, there is a clear need for financial assistance for individuals during and after what might be termed a 'lifetime health crisis', while they still live.

Medical technology has decreased our mortality rates resulting from certain diseases. However, these same conditions will and do often require some additional care and treatment as our population continues to age.

Early History – Chapter 4

In the year 1900 there were only one in twenty-five United States residents that were aged 65 or older. In 1980, one in nine people were 65 or older and in the year 2030, twenty per-cent of our population, or one out of every five people, will be in the over 65-age category. Many within this number will suffer life-threatening diseases and because of the disease's related costs for recovery and more, they and their families could and will incur heavy financial burdens. A response to this growing need is possibly the accelerated benefit.

Recent History – Chapter 5

The very first true life insurance dread disease benefit policy was introduced and sold in 1983 by Crusader Life Insurance Company of Johannesburg, South Africa. Crusader Life had just been purchased by a group of South Africans. This new owner group, because of their small capital base, felt that they needed a revolutionary and exciting product. The Crusader Life product was viewed as an improved version of the cancer plan and paid a lump sum payment, referred hereafter, as an accelerated benefit, in the event that one of three dread diseases was diagnosed. These initial diseases were myocardial infarction, coronary artery surgery, and stroke. Some of this plan's success was because South Africa was the first country to have a heart transplant. Also, South African laws did not allow life insurers to offer any kind of benefit reimbursement of medical treatment expenses. Crusader Life had great success with the product and many, many reproductions were born. Crusader's initial policy's definitions were written and defined by Dr. Marius Barnard, a popular and well-respected surgeon of that time, which impressed the public as well as the reinsurers (companies that share in a life or health risk that exceeds certain pre-set amounts or guidelines), competitors, and the media. Dr. Barnard's brother, Christian Barnard, was the primary surgeon on the world's first successful heart transplant in 1967.

The 1980s saw considerable plans with dread disease accelerated benefits start in the Caribbean, Australian, and United States markets. Jackson National of Lansing, Michigan, was the first United States company to launch the plan in February, 1988. Their initial covered diseases were myocardial infarction, cancer, renal failure, stroke, and coronary artery surgery. As of December 31, 1990, Jackson National Life had approximately 9,000 policies in force providing their version of the accelerated benefit. More than 70 companies, with more adding the coverage daily, now offer some form of the dread disease benefit.

Coverage Objectives – Chapter 6

The number-one objective of the dread disease accelerated benefit is to provide financial support at a time when the insured's life may be in danger and to ease the stress caused by monetary concerns.

In spite of this benefit and its ability to meet real needs and the excitement surrounding the concept of the benefit, it was met with resistance by consumers, state insurance officials, and life and health insurance agents.

A recent Gallup Poll of 1,000 consumers showed that 940 of the polled people agreed that policyholders should be allowed to collect a portion of their life insurance policy early, while they are still alive, in the form of a cash benefit due to a serious or terminal illness. The Gallup Poll results are listed as follows:

Are you interested in a policy with living benefits?

Very interested	9%
Somewhat interested	37%
Not at all interested	52%
Don't know	2%

Should policyholders be allowed to collect part of their death benefit if they are very sick or unable to care for themselves?

Yes	94%
No	5%
Don't know	1%

Should a policyholder be allowed to collect living benefits under the following circumstances?

<u>Circumstance</u>	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
A terminal illness	91%	7%	2%
Need for long-term care	90%	8%	2%
A serious illness	87%	11%	2%

If you were a beneficiary of a policy, what would you regard as a justifiable reason for the policyholder to collect living benefits?

<u>Reason</u>	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>
To pay medical bills	93%	6%	1%
To receive the best possible care in the most convenient setting	82%	15%	1%
To improve the quality of daily life	40%	57%	3%
To fulfill a long-held dream	25%	73%	2%

The Tax Issue – Chapter 7

Tax questions seem to be the major area currently causing insecurity and much caution from consumers as well as the insurers and agents selling the product. State insurance departments' refusal to quickly endorse the accelerated benefit product reflects their concern for clear tax issues as well as no regulatory precedents at that time. The NAIC guidelines are only that, and are not necessarily adopted by all state insurance regulators. The NAIC's Accelerated Benefits Model Regulations were available in January 1991 and later amended in October 1996.

Life agents are hesitant to include the dread disease accelerated benefit in their portfolios. This is caused by the same lack of familiarity with the new product as the consumer. Both the insurance industry and government leaders predict a 'long learning curve' for all parties: consumers, agents and companies alike.

The progress of the dread disease accelerated benefits is experiencing 'birth pangs' similar to those of the universal life concept of the early 1980s. A universal life plan is one that allows all premiums that exceed the insured's mortality to participate in either the company's earnings or a special investment fund made directly with such funds. A careful and slow evaluation of the accelerated benefit's early performance can provide an important opportunity for feedback, re-education and re-design. The delicate study of many factors over time including regulations, rates, reinsurance, distribution, agent training, illustration software, and promotional ideas and materials are all necessary, before the product can truly evolve.

No sales statistics are yet available which would allow all to follow the progress of the dread disease benefit from a sales point of view in the successful South African market, or, for that matter, in any market. For

Crusader Life, though, 70% of their policies being issued contain the dread disease benefit today.

Dread disease benefits do address a definite need in the market, which is protection against the financial implications of a lengthy illness due to serious disease. The benefit can be used for all sorts of different purposes such as medical bills, organ transplants, replacement income, nursing or rehabilitation care. The most important factor of this unique and new coverage is that it can reduce the worry associated with a health threatening illness at least from the financial aspect, and can allow the insured to concentrate solely on his or her recovery. This was and remains the primary and first goal or use, of the dread disease accelerated benefit.

Tax Benefits – Chapter 8

As mentioned earlier, the still unanswered questions regarding the Government's taxation of the dread disease accelerated benefit results from the reality that these benefits are not true death benefits, health benefits, or disability benefits. It is this hybrid quality that causes the absence of a definitive statement on their tax status. The issue to most is not how they fit into the internal revenue code, but whether the tax code should be revised to accommodate these new benefits. To date, the Internal Revenue Service has not issued a clarification as to whether accelerated benefits constitute taxable income. Pending this clarification, accelerated benefits are viewed as life insurance benefits and therefore, are not taxable. One side of this tax issue maintains that accelerated benefits are not keeping with the original intent of life insurance benefits and therefore should not receive the same benefits. The other argument is that they should be neutral since in their absence, the benefit would eventually be paid out as tax-free death benefits.

The features of the many dread disease products all differ, and yet are also similar. To assist state officials responsible for their sales in various states, the NAIC has developed a preliminary set of guidelines to be used

by those decision makers. The guidelines point out the many regulatory and disclosure issues concerning all insurance policies offering the accelerated benefits. The NAIC is an administrative agency that collects information for the various state insurance departments to utilize. Model legislation is put together by the NAIC but drafted for use and approval by the state insurance departments.

NAIC Guidelines – Chapter 9

Applicable NAIC guidelines for the accelerated benefit plans are as follows:

“Accelerated benefits” means benefits are payable under a life insurance contract:

1. To a policyholder or certificate holder, during the lifetime of the insured, in anticipation of death or upon the occurrence of specific life threatening or catastrophic conditions as defined by the policy or the rider, or
2. Which reduce the death benefit otherwise payable under the life insurance contract, and,
3. Which are payable upon the occurrence of a single qualifying event, which results in the payment of a benefit amount fixed at the time of acceleration.

The NAIC defines a qualifying event as one or more of the following:

1. A medical condition which could result in a drastically limited life span as specified in the contract (for example, 24 months or less),
2. A medical condition that has required or requires extraordinary medical intervention such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die,
3. Any condition which usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life,
4. A medical condition, which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, one or more of the following:
 - a. Coronary artery disease resulting in an acute infarction or requiring surgery,
 - b. Permanent neurological deficit resulting from a cerebral vascular accident,
 - c. End-stage renal failure,
 - d. Other medical conditions which the Commissioner shall approve for any particular filing.
5. Other qualifying events, which the Commissioner shall approve for any particular filing.

Policy and Coverage Design – Chapter 10

Insurance products that provide living benefits can be structured either as complete policies (stand alone) or as riders attached to existing life insurance policies, most frequently, but not necessarily, permanent life policies. Aside from the constraints relating to state insurance department approval of the sale of particular living benefit products, the

limited but growing number of living benefit riders offered by insurers is frequently not compatible with existing universal or whole life insurance policies. In these instances, the sale of the rider often involves the replacement of an otherwise functional life insurance policy in order to get rider coverage. Presently, one major insurer offers a freestanding rider that can be added to any carrier's policy. Another joint effort between an insurer and an employee benefits consulting firm offers a living benefits rider that can be added to any employer's group universal life (GUL) program.

The substantial variation in terms and conditions among living benefit policies/riders translate into the exceedingly difficult task of evaluating a product on its own terms from a benefit versus cost standpoint, as well as comparing products with one another. The following are the major structural elements of living benefit products:

1. Whether it is a policy or a rider and, if a rider, what type of policy it can be attached to.
2. Lower and upper age limits on purchase.
3. Events triggering the accelerated benefit.
4. Whether there is a waiver of premium once benefits are triggered.
5. Percentage of the face amount that is to be paid out.
6. Maximum payout in dollars.
7. Whether there is a waiting period following enforcement of the policy or rider and, if so, how long.
8. How the benefit is paid out; lump sum, or over a period of time.
9. Whether there are restrictions on how benefit distribution is spent.
10. Whether there are pre-existing conditions clauses and, if so, what limits or restrictions they contain.
11. Number of times the benefit can be collected.
12. States in which the sale of the product is permitted.
13. Cost of the benefit to the consumer.

The specific parameters of each of the above categories may impose serious limitations on the attractiveness of the policy/rider for any

particular consumer. The ability of these products to meet real needs is contingent upon an objective understanding of what these parameters entail relative to what the buying consumer expects. In this respect, the task assumed by the NAIC with regard to living benefits is two-fold: (1) to reveal any product design that may be inherently unsound; and (2) to facilitate disclosure of product design that has integrity but may be easily misunderstood by the uninformed but normal consumer. Again, the ultimate responsibility for approval of living benefit products on an insurer-by-insurer basis rests with each state insurance department.

A weakness of the accelerated product is the consumer's misunderstanding, of course, but there are other specific problems. Waiting periods, which may severely limit actual benefit payments, are one problem. Another is that a catastrophic illness policy/rider is of little value to a policyholder diagnosed with an illness other than one of those listed in the plan of coverage. An additional weakness may be the public's overall view of the act of paying a part of a policy's face amount to a dying individual. To some, that equates or looks like a vulture sitting on a fence or circling overhead, just waiting for the 'final' event. Viatical companies experience those very same thoughts. Viatical companies buy life insurance policies from terminally-ill people at a discount of the face amount. They then own the policy and keep them in force by paying the premiums. Their profits are made after the insured expires and the death benefit is paid to the viatical company. They might get a benefit of \$100,000 after they gave the insured person \$65,000 and paid six months of premiums that totaled \$240.

Two additional areas of coverage for the acceleration of a life insurance policy's face amount, not addressed in detail in this publication are the terminal illness benefit and the long-term care benefit. These basically work as follows:

The terminal illness benefit works very similar to the dread disease benefit excepting that the benefit is paid only if life expectancy is predictable and usually less than twelve (12) months. The benefit,

referred to simply as “terminal illness coverage”, has been added to credit insurance plans nationwide, and completely pays off a covered loan in the event of a diagnosis of pending death, in accordance with the policy’s definition, again, usually, within a year. The benefit is paid in the full amount of the face amount.

Long-term care coverage basically pays a benefit of 1 to 2% of the policy’s face amount after the insured has become a patient of a long-term care facility. The definition of the facility is one of the policy’s most important provisions and should be addressed strongly at the time of application. This benefit will reduce the face amount by the percentage mentioned above, and will be paid on a monthly basis. Many differences in waiting periods, claim payment due dates, as well as other provisions, still do exist.

Cost to the Insureds – Chapter 11

The pricing process of the accelerated benefit products has three components: (1) to determine the incidence rates of the covered diseases, (2) to determine the survival rates of covered diseases, and (3) to determine proper pricing through the proportions of deaths directly attributable to the covered diseases, added to the death rate.

Tables 1, 2 and 3 depict the ratios for the three primary diseases (heart attack, cancer, and heart surgery):

TABLE 1
Primary Diseases: Heart Attack
Farmington Heart Attack Study, USA
(Per 1,000, includes sudden deaths)

AGE	MALE	FEMALE
15-24	0.012	0.001
25-34	0.194	0.022
35-44	1.58	0.174
45-54	3.79	0.730
55-64	8.71	1.60
65-74	8.76	3.48
75-up	8.84	3.51

TABLE 2
Primary Diseases: Cancer
1987 Annual Cancer Statistics Review (Per 1,000)

AGE	MALE	FEMALE
20-24	0.305	0.275
25-29	0.409	0.520
30-34	0.595	0.912
35-39	0.861	1.559
40-44	1.434	2.523
45-49	2.510	3.926
50-54	4.547	5.418
55-59	8.094	7.531
60-64	12.593	10.057
65-69	18.416	12.300
70-74	24.893	14.576
75-79	30.643	16.307
80-84	35.804	18.326
85-up	36.356	18.631

TABLE 3
Primary Diseases: Heart Surgery (per 1,000)
Rochester, Minnesota Study

AGE	MALE	FEMALE
15-24	0.03	0.01
25-34	0.06	0.04
35-44	0.21	0.12
45-54	0.83	0.31
55-64	2.79	2.19
65-74	7.17	4.25
75-84	14.04	10.28
85-up	19.62	13.96

Further statistics suggest that as many as 33% of men and 49% of women who are diagnosed with cancer will be alive five years later, and following a heart attack, 81% of men and 86% of women between the ages of 45-65 will survive for that same five-year period. Fewer and fewer people die immediately after these diseases are diagnosed.

Additional diseases or conditions that have been added to the original four (myocardial infarction, cancer, stroke, and coronary artery surgery) are: kidney failure, paralysis, major organ transplant, total and permanent disability, Alzheimer's disease and multiple sclerosis. The addition of these diseases makes the coverage appear more comprehensive without affecting the pricing due to the small incidence of the latter diseases. Cancer and heart disease account for 75% of the total cost of the coverage from the original four diseases. Specimen definitions of the primary diseases are listed herein.

Myocardial infarction – the death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis is usually

based upon (a) typical chest pain, (b) electrocardiographic changes, or (c) elevation of cardiac enzymes.

Coronary artery surgery – heart surgery to correct narrow or blocked coronary arteries (usually two or more), with bypass grafts. Non-surgical procedures such as angioplasty or laser repair of an obstruction are almost always excluded.

Stroke – A cerebrovascular incident that produces a neurological sequelae that lasts more than 24 hours and includes the infarction of brain tissue, hemorrhage, or an embolism. Permanent neurological evidence must usually be present for a period of thirty (30) days, or more.

Cancer – a malignant tumor characterized by the uncontrolled growth or spread of malignant cells and the invasion of tissue. Leukemia, Hodgkin’s disease and malignant melanoma are normally included. Non-invasive cancers, lymphocytic leukemia, human immunodeficiency virus cancers, and skin cancers are excluded.

The maximum amount available to insureds for the accelerated benefit appears to have been set at \$250,000.00 in the United States. NAIC guidelines do not call for any maximum benefit as of this date.

Entry and expiry ages differ per company and product. Almost all companies impose a limitation on the age at issue. Ages 55-60 are the most popular maximum ages for issuing the accelerated benefit policies. The ages for the benefit payment to expire also differ, but more from country to country than from company to company. South Africa, Europe and other countries have basically stopped or limited the dread disease benefit at or about age 65, while the coverage in the United States lasts throughout the insured’s lifetime.

The accelerated benefit percentages that are payable in the event of a claim, differ also from company to company and product to product. Twenty-five percent (25%) is the sum that has been selected or chosen by

the majority of companies. One advantage of having the accelerated coverage in the lower sums is that the benefit does not cost much more than the base policy. Also, the higher the percentage used for the dread disease accelerated benefit claim, the less face amount would remain available for the insured's beneficiaries or dependents after the insured's death.

Underwriting – Chapter 12

Rating classifications, other than the premium differences between male and female, or smokers and non-smokers, have not been used as they are in life-only cases. These rating classifications are used for insureds that have additional risks or impairments. Premiums are increased for life insurance underwriting only, over the regularly scheduled premium in numbers of tables (25% increase per table). The accelerated benefit practice to date has been to simply either accept or deny the risk at the time of underwriting. Should any additional table of risk be present, the accelerated coverage is simply not available to a proposed insured.

Underwriting, which is the evaluation of whether a risk on a particular individual is accepted or denied, is much more strict for accelerated benefits than in the practice on a life-only plan. Family history is the most important aspect of underwriting the accelerated product and must be reviewed and evaluated carefully. A family history of cancer, heart disease, general bad health or early death, could and does cause the accelerated benefit applicant to be turned down in the application stage. In short, underwriting for accelerated benefits and life only plans, differ greatly.

Premium Comparison – Chapter 13

Tables 4 and 5 below show a sampling of annual gross price comparisons for mortality alone, versus mortality plus a 100% accelerated benefit.

The majority of companies offering the product have set the ratio or benefit percentage used by insurance companies for the accelerated benefit at 25%.

TABLE 4
1980 Commissioner's Standard Ordinary Table
Of Mortality Cost with 100% Dread Disease Accelerated Benefit
(Annual Premiums per \$1,000 of Coverage)

AGE	Mortality Only*	Mortality Plus 100% Accelerated Benefits
25	\$ 1.75	\$ 2.27
35	2.17	3.91
45	4.73	9.16
55	10.96	21.40
65	26.62	49.70

TABLE 5
Comparison Table of Mortality Cost
With 25% Dread Disease Accelerated Benefit
(Annual Premium Per \$1,000 of Coverage)

AGE	Premium
25	\$ 1.88
35	2.60
45	5.83
55	13.57
65	32.39

Conclusions – Chapter 14

Notwithstanding the many concerns that surround their use, accelerated benefits are a true contribution toward the solution of serious and long-standing social welfare problems. In some respects, meeting the

financial demands of death, disability and old age through the private sector is the age-old standard that most Americans try to follow.

Many challenges await the future development of the accelerated benefits. Those challenges are in legal, actuarial, ethical, social and administrative areas. The now-pending areas of regulatory, pricing, underwriting and especially, tax issues, will determine the depth of the future of accelerated benefits.

As the population gets older, we become accustomed to a lifestyle that can quite naturally be taken for granted. Maintaining this lifestyle will generally depend solely on earnings – paying the home's mortgage, supporting the family, and providing all those extra items that add to the general quality of life.

What happens if a serious illness strikes? How does a family maintain its lifestyle and pay all of the outstanding bills when the family income is suddenly threatened? Most conventional insurance policies do not cover this situation and of course, life insurance is only payable upon death of the insured. Private health insurance does not cover chronic and/or incurable illnesses, or is very limited at the best.

Serious illnesses today are less inclined to result in death. The fact remains, however, that many survivors must still find a way to support their families. At this stage, considerable amounts of extra money are often needed to pay for special equipment and physical aids to help recovery and assist people in coping with various disabilities caused by dread diseases.

The facts about such illnesses are frightening, but fortunately, because of today's advancement in medical science, more people are surviving. The presence of a dread disease policy can help people maintain a better quality of life that would otherwise have been impossible.

Life insurance has been defined and described as a “study of needs”. Many refinements are continually being introduced to life and health insurance policies to ensure that appropriate and relevant coverage is available. With a direct emphasis upon death, life products have to overcome an individual’s natural reluctance to consider their own demise.

Dread disease coverage, with benefits paid upon a diagnosis, represents a comparatively straightforward prospect, combining the more acceptable aspects of life coverage together with health coverage. Public imagination, fear, and the likelihood or knowledge that an acquaintance has suffered from cancer, stroke, heart attack or heart surgery are, and will continue to be, powerful aids in the sales of this plan.

Accelerated benefit products, whether in a rider or base plan form, present a great opportunity for the life and health insurance industry. Optimism from the insurers comes from the belief that the benefit will increase persistency of the permanent products. Consumers like the product as it can fulfill certain needs throughout their lives. The life insurance industry seems to always be looking for a cure-all, such as retired lives reserves, Section 79, Universal Life, Second to Die, and now, this awesome plan, the Accelerated Benefit. While none are cure-alls, the Accelerated Benefit coverage is certainly a nice and interesting addition.

The most important benefit of a life insurance policy not too long ago was the assurance that family members were provided for in the event of death, and death only. With the introduction of this coverage, life insurance policies can finally live up to their name, and provide true benefits, **for life.**