

Financial Planning Process

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DIVORCE & PENSIONS

Qualified Domestic Relation Orders (QDRO)

Introduction

More than 48 million private wage and salary workers are currently covered by employer-sponsored pension plans in the United States. For many of these Americans, pension savings represent one of their most significant assets. For this reason, whether and how to divide a participant's interest in a pension plan are often important considerations in separation, divorce, and other domestic relations proceedings.

While the division of marital property generally is governed by state domestic relations law, any assignments of pension interests must also comply with Federal law, namely the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986 (the Code). Under ERISA and the Code, pension interests may be assigned only if the judgment, decree, or order creating or recognizing a spouse's, former spouse's, child's, or other dependent's interest in an individual's pension benefits constitutes a "qualified domestic relations order" or "QDRO."

Qualified Domestic Relations Orders: An Overview

This chapter includes a general overview of the provisions of Federal law governing the assignment of pension benefits in a domestic relations proceeding and the requirements that apply in determining whether a domestic relations order is a QDRO. The following areas are addressed:

- Who can be an "alternate payee"?
- What information must be included in a domestic relations order in order for it to be "qualified"?
- Who determines whether a domestic relations order is a QDRO?

In general, ERISA and the Code do not permit a participant to assign or alienate the participant's interest in a pension plan to another person. These "anti-assignment and alienation" rules are intended to ensure that a participant's pension benefits are actually available to provide financial support during the participant's retirement years. **A limited exception to the anti-assignment and alienation rules is provided for assignments of pension benefits through qualified domestic relations orders (QDROs).**

Under the QDRO exception, a domestic relations order may assign some or all of a participant's pension benefits to a spouse, former spouse, child, or other dependent to satisfy family support or marital property obligations if and only if the order is a "qualified domestic relations order." ERISA requires that each pension plan pay benefits in accordance with the applicable requirements of any "qualified domestic relations order" that has been submitted to the plan administrator. The plan administrator's determinations on whether a domestic relations order is a QDRO, therefore, have significant implications for both the parties to a domestic relations proceeding and the plan. **The following questions and answers are intended to provide an overview of the Federal requirements a domestic relations order must satisfy to be considered a QDRO.**

What is a Qualified Domestic Relations Order?

A "qualified domestic relation order" (QDRO) is:

- A domestic relations order
- That creates or recognizes the existence of an "alternate payee's" right to receive, or assigns to an alternate payee the right to receive, all or a portion of the benefits payable with respect to a participant under a pension plan, and that includes certain information and meets certain other requirements.

What is a "domestic relations order"?

To be recognized as a QDRO, an order must be a "domestic relations order." A domestic relations order is:

- **A judgment, decree, or order (including the approval of a property settlement)**
- **That is made pursuant to state domestic relations law (including community property law)**
- **That relates to the provision of child support, alimony payments, or marital property rights for the benefit of a spouse, former spouse, child, or other dependent of a participant**

A state authority, generally a court, must actually issue a judgment, order, or decree or otherwise formally approve a property settlement agreement before it can be a "domestic relations order" under ERISA. The mere fact that a property settlement is agreed to and signed by the parties will not, in and of itself, cause the agreement to be a domestic relations order.

There is no requirement that both parties to a marital proceeding sign or otherwise endorse or approve an order. It is also not necessary that the pension plan be brought into state court or made a party to a domestic relations proceeding for an order issued in that proceeding to be a "domestic relations order" or a "qualified domestic relations order." Indeed, because state law is generally preempted to the extent that it relates to pension plans, the DOL takes the position that pension plans cannot be joined as a party in a domestic relations proceeding pursuant to state law. Moreover, pension plans are neither permitted nor required to follow the terms of domestic relations orders purporting to assign pension benefits unless they are QDROs.

Reference: ERISA §§ 206(d)(3)(B)(ii), 514(a), 514(b)(7); IRC § 414(p)(1)(B)

Must a "domestic relations order" be issued by a state court?

No. A domestic relations order may be issued by any state agency or instrumentality with the authority to issue judgments, decrees, or orders, or to approve property settlement agreements, pursuant to state domestic relations law (including community property law).

Reference: ERISA § 206(d)(3)(B)(ii); IRC § 414(p)(1)(B)

Who can be an "alternate payee"?

A domestic relations order can be a QDRO only if it creates or recognizes the existence of an alternate payee's right to receive, or assigns to an alternate payee the right to receive, all or a part of a participant's benefits. For purposes of the QDRO provisions, an alternate payee cannot be anyone other than a spouse, former spouse, child, or other dependent of a participant. Reference: ERISA § 206(d)(3)(K), IRC § 414(p)(8)

What information must a domestic relations order contain to qualify as a QDRO under ERISA?

QDROs must contain the following information:

- The name and last known mailing address of the participant and each alternate payee
- The name of each plan to which the order applies
- The dollar amount or percentage (or the method of determining the amount or percentage) of the benefit to be paid to the alternate payee
- The number of payments or time period to which the order applies Reference: ERISA § 206(d)(3)(C)(i)-(iv); IRC § 414(p)(2)(A)-(D)

Are there other requirements that a domestic relations order must meet to be a QDRO?

Yes. There are certain provisions that a QDRO must not contain:

- The order must not require a plan to provide an alternate payee or participant with any type or form of benefit, or any option, not otherwise provided under the plan
- The order must not require a plan to provide for increased benefits (determined on the basis of actuarial value)
- The order must not require a plan to pay benefits to an alternate payee that are required to be paid to another alternate payee under another order previously determined to be a QDRO
- The order must not require a plan to pay benefits to an alternate payee in the form of a qualified joint and survivor annuity for the lives of the alternate payee and his or her subsequent spouse

Reference: ERISA §§ 206(d)(3)(D)(i)-(iii), 206(d)(3)(E)(i)(III); IRC §§ 414(p)(3)(A)-(C), 414(p)(4)(A)(iii)

May a QDRO be part of the divorce decree or property settlement?

Yes. There is nothing in ERISA or the Code that requires that a QDRO (that is, the provisions that create or recognize an alternate payee's interest in a participant's pension benefits) be issued as a separate judgment, decree, or order. Accordingly, a QDRO may be included as part of a divorce decree or court-approved property settlement, or issued as a separate order, without affecting its "qualified" status. The order must satisfy the requirements described above to be a QDRO. Reference: ERISA § 206(d)(3)(B); IRC § 414(p)(1)

Must a domestic relations order be issued as part of a divorce proceeding to be a QDRO?

No. A domestic relations order that provides for child support or recognizes marital property rights may be a QDRO, without regard to the existence of a divorce proceeding. Such an order, however, must be issued pursuant to state domestic relations law and create or recognize the rights of an individual who is an "alternate payee" (spouse, former spouse, child, or other dependent of a participant).

An order issued in a probate proceeding begun after the death of the participant that purports to recognize an interest with respect to pension benefits arising solely under state community property law, but that doesn't relate to the dissolution of a marriage or recognition of support obligations, is not a QDRO because the proceeding does not relate to a legal separation, marital dissolution, or family support obligation. Reference: ERISA § 206(d)(3)(B); IRC § 414(p)(1); Advisory Opinion 90-46A (Appendix A); see *Boggs v. Boggs*, No. 97-79 (S. Ct. June 2, 1997)

May a QDRO provide for payment to the guardian of an alternate payee?

Yes. If an alternate payee is a minor or is legally incompetent, the order can require payment to someone with legal responsibility for the alternate payee (such as a guardian or a party acting in loco parentis in the case of a child, or a trustee as agent for the alternate payee). Reference: See Staff of the Joint Committee on Taxation, *Explanation of Technical Corrections to the Tax Reform Act of 1984 and Other Recent Tax Legislation*, 100th Cong., 1st Sess. (Comm. Print 1987) at 222.

Can a QDRO cover more than one plan?

Yes. A QDRO can assign rights to pension benefits under more than one pension plan of the same or different employers as long as each plan and the assignment of benefit rights under each plan are clearly specified. Reference: ERISA § 206(d)(3)(C)(iv); IRC § 414(p)(2)(D)

Must all QDROs have the same provisions?

No. Although every QDRO must contain certain provisions, such as the names and addresses of the participant and alternate payee(s) and the name of the plan(s), the specific content of the rest of the QDRO will depend, as explained in more detail in Chapter 3, on the type of pension plan, the nature of the participant's pension benefits, the purposes behind issuing the order, and the intent of the drafting parties.

Who determines whether an order is a QDRO?

Under Federal law, the administrator of the pension plan that provides the benefits affected by an order is the individual (or entity) initially responsible for determining whether a domestic relations order is a QDRO. Plan administrators have specific responsibilities and duties with respect to determining whether a domestic relations order is a QDRO. Plan administrators, as plan fiduciaries, are required to discharge their duties prudently and solely in the interest of plan participants and beneficiaries. Among other things, plans must establish reasonable procedures to determine the qualified status of domestic relations orders and to administer distributions pursuant to qualified orders.

Administrators are required to follow the plan's procedures for making QDRO determinations. Administrators also are required to furnish notice to participants and alternate payees of the receipt of a domestic relations order and to furnish a copy of the plan's procedures for determining the qualified status of such orders.

It is the view of the DOL of Labor that a state court (or other state agency or instrumentality with the authority to issue domestic relations orders) does not have jurisdiction to determine whether an issued domestic relations order constitutes a "qualified domestic relations order." In the view of the DOL, jurisdiction to challenge a plan administrator's decision about the qualified status of an order lies exclusively in Federal court. Reference: ERISA §§ 206(d)(3)(G)(i)(II), 404(a), 502(a)(3), 502(e), 514; IRC § 414(p)(6)(A)(ii)

Who is the "administrator" of the plan?

The "administrator" of an employee benefit plan is the individual or entity specifically designated in the plan documents as the administrator. If the plan documents do not designate an administrator, the administrator is the employer maintaining the plan, or, in the case of a plan maintained by more than one employer, the association, committee, joint board of trustees, or similar group representing the parties maintaining the plan.

The name, address, and phone number of the plan administrator is required to be included in the plan's summary plan description. The summary plan description is a document that the administrator is required to furnish to each participant and to each beneficiary receiving benefits. It summarizes the rights and benefits of participants and beneficiaries and the obligations of the plan. Reference: ERISA §§ 3(16), 102(b), 29 CFR § 2520.102-3(f); IRC § 414(g), Treas. Reg. § 1.414(g)-1

Will the DOL of Labor issue advisory opinions on whether a domestic relations order is a QDRO?

No. A determination of whether an order is a QDRO necessarily requires an interpretation of the specific provisions of the plan or plans to which the order applies and the application of those provisions to specific facts, including a determination of the participant's actual pension benefits under the plan(s). The DOL will not issue opinions on such inherently factual matters. Reference: See ERISA Procedure 76-1, 41 Fed. Reg. 36281 (1976)(Appendix B)

Administration of QDROs: Determining Qualified Status and Paying Benefits

This chapter describes the duties of a plan administrator in determining the qualified status of domestic relations orders and administering distributions under QDROs. The following areas are addressed:

- What are the plan administrator's responsibilities in furnishing information to a participant and alternate payee?
- What measures must a plan administrator take to protect the plan participant's benefits upon receipt of a domestic relations order?
- What procedures must a plan administrator follow in determining whether a domestic relations order is a QDRO?

ERISA imposes a number of responsibilities on the plan administrator relating to the handling of domestic relations orders. As a plan fiduciary, the administrator is required to discharge these responsibilities prudently and solely in the interest of the plan's participants and beneficiaries. It is the view of the DOL that the prudent discharge of a fiduciary's responsibilities with respect to the handling of domestic relations orders, like other areas of plan administration, requires plan administrators to take steps to avoid unnecessary and excessive administrative burdens and costs to the plan.

The DOL believes that the adoption of procedures and policies designed to facilitate, rather than impede, the timely processing and perfection of domestic relations orders generally will serve to minimize plan burdens and costs attendant to QDRO determinations.

The following questions and answers are intended to provide guidance on the discharge of administrator's obligations under the QDRO and fiduciary responsibility provisions of ERISA.

What information is an administrator required to provide a prospective alternate payee before the administrator receives a domestic relations order?

Congress conditioned an alternate payee's right to an assignment of a participant's pension benefit on the prospective alternate payee's obtaining a domestic relations order that satisfies specific informational and other requirements. It is the view of the DOL that Congress therefore intended prospective alternate payees -- spouses, former spouses, children, and other dependents of a participant who are involved in a domestic relations proceedings -- to have access to plan and participant benefit information sufficient to prepare a QDRO. Such information might include the summary plan description, relevant plan documents, and a statement of the participant's benefit entitlements.

The DOL believes that Congress did not intend to require prospective alternate payees to submit a domestic relations order to the plan as a prerequisite to establishing the prospective alternate payee's rights to information in connection with a domestic relations proceeding. However, it is the view of the DOL that a plan administrator may condition disclosure of such information on a prospective alternate payee's providing information sufficient to reasonably establish that the disclosure request is being made in connection with a domestic relations proceeding.

It is the DOL's understanding that many domestic relations orders fail initially to qualify when submitted to the plan because they fail to take into account the plan's provisions or the participant's actual benefit entitlements. Affording prospective alternate payees access to plan and participant information in a timely manner will, in the view of the DOL, help drafters avoid making such obvious errors in preparing orders and, thereby, facilitate plan administration. Reference: ERISA §§ 206(d)(3)(A) -(C), 404(a); IRC § 414(p)(1) - (3)

What are the duties of a plan administrator upon receipt of a domestic relations order by the plan?

Upon receipt of a domestic relations order, the plan administrator is required to promptly notify the affected participant and each alternate payee named in the order of the receipt of the order and to provide a copy of the plan's procedures for determining whether a domestic relations order is a QDRO. Notification should be sent to the address included in the domestic relations order.

The administrator is required to determine whether the order is a QDRO within a reasonable period of time after receipt of a domestic relations order and to promptly notify the participant and each alternate payee of such determination. Reference: ERISA § 206(d)(3)(G)(i); IRC § 414(p)(6)(A)

Is a plan required to have procedures for determining whether a domestic relations order is qualified?

Yes. Every pension plan is required to establish written procedures for determining whether domestic relations orders are QDROs and for administering distributions under QDROs. Reference: ERISA § 206(d)(3)(G)(ii); IRC § 414(p)(6)(B)

What requirements must a plan's QDRO procedures meet?

The QDRO procedures must:

- Be in writing
- Be reasonable
- Provide that each person specified in a domestic relations order received by the plan as entitled to payment of benefits under the plan will be notified (at the address specified in the domestic relations order) of the plan's procedures for making QDRO determinations upon receipt of a domestic relations order
- Permit an alternate payee to designate a representative for receipt of copies of notices and plan information that are sent to the alternate payee with respect to a domestic relations orders

[ERISA § 206(d)(3)(G)(ii); IRC § 414(p)(6)]

Are there other matters that should be addressed in a plan's QDRO procedures?

Yes. It is the view of the DOL of Labor that a plan's QDRO procedures should be designed to ensure that QDRO determinations are made in a timely, efficient, and cost-effective manner, consistent with the administrator's fiduciary duties under ERISA. The DOL believes that unnecessary administrative burdens and costs attendant to QDRO determinations and administration can be avoided with clear explanations of the plan's determination process, including:

- An explanation of the information about the plan and benefits that is available to assist prospective alternate payees in preparing QDROs, such as summary plan descriptions, plan documents, individual benefit and account statements, and any model QDROs developed for use by the plan
- A description of any time limits set by the plan administrator for making determinations
- A description of the steps the administrator will take to protect and preserve pension assets or benefits upon receipt of a domestic relations order (for example, a description of when and under what circumstances plan assets will be segregated or benefit payments will be delayed or suspended)
- A description of the process provided under the plan for obtaining a review of the administrator's determination as to whether an order is a QDRO

It is the view of the DOL that the plan administrator's adoption and use of clear QDRO procedures, coupled with the administrator's provision of information about the plan and benefits upon request, will significantly reduce the difficulty and expense of obtaining and administering QDROs by minimizing confusion and uncertainty about the process. Reference: ERISA §§ 206(d)(3)(G), 206(d)(3)(H), 404(a); IRC §§ 414(p)(6), 414(p)(7)

May a plan administrator charge a participant or alternate payee for determining the qualified status of a domestic relations order?

The DOL has taken the position that in the context of a defined contribution plan, an administrator may assess reasonable expenses attributable to a QDRO determination against the individual account of the participant who is a party to the domestic relations order. The document of the plan should be reviewed to determine how plan expenses are allocated.

Reference: ERISA § 404(a); see Field Assistance Bulletin 2003-3 (Appendix A)

May plan administrators provide parties with a model form or forms to assist in the preparation of a QDRO?

Yes. Although they are not required to do so, plan administrators may develop and make available "model" QDRO forms to assist in the preparation of a QDRO. Such model forms may make it easier for the parties to prepare a QDRO and reduce the time and expenses associated with a plan administrator's determination of the qualified status of an order.

Plan administrators are required to honor any domestic relations order that satisfies the requirements to be a QDRO. In the view of the DOL, therefore, a plan may not condition its determinations of QDRO status on the use of any particular form.

In determining the qualified status of a domestic relations order, is the administrator required to determine the validity of the order under state domestic relations law?

No. A plan administrator is generally not required to determine whether the issuing court or agency had jurisdiction to issue an order, whether state law is correctly applied in the order, whether service was properly made on the parties, or whether an individual identified in an order as an alternate payee is in fact a spouse, former spouse, child, or other dependent of the participant under state law. Reference: See Advisory Opinion 92-17A (Appendix A)

Is a plan administrator required to reject a domestic relations order as defective if the order fails to specify factual identifying information that is easily obtainable by the plan administrator?

No. In many cases, an order that is submitted to a plan may clearly describe the identity and rights of the parties, but may be incomplete only with respect to factual identifying information within the plan administrator's knowledge or easily obtained through a simple communication with the alternate payee or the participant. For example, an order may misstate the plan's name or the names of participants or alternate payees, and the plan administrator can clearly determine the correct names, or an order may omit the addresses of participants or alternate payees, and the plan administrator's records include this information.

In such a case, the plan administrator should supplement the order with the appropriate identifying information, rather than rejecting the order as not qualified. Reference: ERISA §§ 206(d)(3)(C), 206(d)(3)(I); IRC § 414(p)(2); see S. Rep. 575, 98th Cong., 2d Sess. at 20

How long may the plan administrator take to determine whether a domestic relations order is a QDRO?

Plan administrators must determine whether a domestic relations order is a QDRO within a reasonable period of time after receiving the order. What is a reasonable period will depend on the specific circumstances. For example, a domestic relations order that is clear and complete when submitted should require less time to review than an order that is incomplete or unclear.

Plans are required to adopt reasonable procedures for determining the qualified status of domestic relations orders. Compliance with such procedures should ensure that determinations of the qualified status of an order take place within a reasonable period of time. Procedures that unduly inhibit or hamper the QDRO determination process will not be considered reasonable procedures. Reference: ERISA § 206(d)(3)(G)(i)(II); IRC § 414(p)(6)(A)(ii)

What must the plan administrator do during the determination process to protect against wrongly paying pension benefits to the participant that would be paid to the alternate payee if the domestic relations order had been determined to be a QDRO?

During any period in which the issue of whether a domestic relations order is a QDRO is being determined (by a plan administrator, by a court of competent jurisdiction, or otherwise), ERISA requires that the plan administrator separately account for the amounts that would be payable to an alternate payee under the terms of the order during such period if the order had been determined to be qualified. These amounts are referred to as "segregated amounts."

During the period in which the status of a domestic relations order is being determined, the plan administrator must take steps to ensure that amounts that would have been payable to the alternate payee, if the order were a QDRO, are not distributed to the participant or any other person.

The plan administrator's duty to separately account for and to preserve the segregated amounts is limited in time. ERISA provides that the plan administrator must preserve the segregated amounts for not longer than the end of an "18-month period." This "18-month period" does not begin until the first date (after the plan receives the order) that the order would require payment to the alternate payee.

It is the view of the DOL that, in order to ensure the availability of a full 18-month protection period, the 18 months cannot begin before the plan receives a domestic relations order. Rather, the "18-month period" will begin on the first date on which a payment would be required to be made under an order following receipt by the plan. Reference: ERISA §§ 206(d)(3)(H), 404(a); IRC § 414(p)(7)

What are an administrator's duties with respect to a domestic relations order received by the plan before the beginning of the "18-month period"?

A plan administrator must determine whether a domestic relations order is a QDRO within a reasonable period following receipt. In the view of the DOL, the "18-month period" during which

a plan administrator must preserve the "segregated amounts" is not the measure of the reasonable period for determining the qualified status of an order and in most cases would be an unreasonably long period of time to take to review an order.

It is further the view of the DOL that, during the determination period, the administrator, as a plan fiduciary, may not permit distributions to the participant or any other person of any amounts that would be payable to the alternate payee if the domestic relations order were determined to be a QDRO. If the domestic relations order is determined to be a QDRO before the first date on which benefits are payable to the alternate payee, the plan administrator has a continuing duty to account for and to protect the alternate payee's interest in the plan to the same extent that the plan administrator is obliged to account for and to protect the interests of the plan's participants. The plan administrator also has a fiduciary duty to pay out benefits in accordance with the terms of the QDRO.

The DOL understands that orders that are initially rejected by the plan administrator as not qualified are frequently revised and resubmitted within a short period of time. The DOL also recognizes that in some instances plan administrators who reject an order may receive requests from participants for immediate distribution of benefits under circumstances that suggest that the rejected order is being revised and will shortly be resubmitted to the plan. In such circumstances, the plan administrator may be subject to conflicting claims for either paying the benefit or failing to pay the benefit.

The DOL suggests that plan administrators may wish to consider the establishment of a process for providing preliminary or interim review of orders, and postponing final determinations for limited periods, to permit parties to correct defects within the 18-month segregation period. Such a process would reduce the likelihood of conflicting claims. Reference: ERISA §§ 206(d)(3)(H), 404(a)

What are an administrator's duties with respect to a domestic relations order received on or after the date on which benefits would be payable to an alternate payee under the order?

Upon receipt of a domestic relations order, the administrator must separately account for and preserve the amounts that would be payable to an alternate payee until a determination is made with respect to the status of the order. Refer to questions 2-11, 2-12. If, within the "18-month period" --beginning with the date (after receipt of the order by the plan) on which the first payment would be required to be made to an alternate payee under the order -- the plan administrator determines that the order is a QDRO, the plan administrator must pay the segregated amounts to the alternate payee in accordance with the terms of the QDRO.

If, however, the plan administrator determines within the "18-month period" that the order is not a QDRO, or if the status of the order is not resolved by the end of the "18-month period," the plan administrator must pay out the segregated amounts to the person or persons who would have been entitled to such amounts if there had been no order. If the order is later determined to be a QDRO, the order will apply only prospectively; that is, the alternate payee will be entitled only to amounts payable under the order after the subsequent determination. Reference: ERISA §§ 206(d)(3)(H), 404(a); IRC § 414(p)(7); but see H.R. Conf. Rep. No. 841, 99th Cong., 2d Sess. II-858 (describing 1986 amendments to the Retirement Equity Act of 1984, including

clarification of the procedures to be followed during the 18-month segregation period for QDRO determinations)

What kind of notice is required to be provided by a plan administrator following a QDRO determination?

The plan administrator is required to notify the participant and each alternate payee of the administrator's determination as to whether the order constitutes a QDRO. This notice should be in writing and furnished promptly following a determination.

In the case of a determination that an order is not qualified, the notice should include the reasons for the rejection. It is the view of the DOL that, in most instances where there has been a reasonable good faith effort to prepare a qualified domestic relations order, the parties will attempt to correct any deficiencies in the order and resubmit a corrected order for the plan administrator to review. The DOL believes that, where a reasonable good faith effort has been made to draft a QDRO, prudent plan administration requires the plan administrator to furnish to the parties the information, advice, and guidance that is reasonably required to understand the reasons for a rejection, either as part of the notification process or otherwise, if such information, advice, and guidance could serve to reduce multiple submissions of deficient orders and therefore the burdens and costs to plans attendant on review of such orders.

The notice of the plan administrator's determination should be written in a manner that can be understood by the parties. Multiple submissions and unnecessary expenses may be avoided by clearly communicating in the rejection notice:

- The reasons why the order is not a QDRO;
- References to the plan provisions on which the plan administrator's determination is based;
- An explanation of any time limits that apply to rights available to the parties under the plan (such as the duration of any protective actions the plan administrator will take); and
- A description of any additional material, information, or modifications necessary for the order to be a QDRO and an explanation of why such material, information, or modifications are necessary.

Reference: ERISA §§ 206(d)(3)(G)(i)(II), 206(d)(3)(I); IRC § 414(p)(6)(A)(ii)

What effect does an order that a plan administrator has determined to be a QDRO have on the administration of the plan?

The plan administrator must act in accordance with the provisions of the QDRO as if it were a part of the plan. In particular, if, under a plan, a participant has the right to elect the form in which benefits will be paid, and the QDRO gives the alternate payee that right, the plan administrator must permit the alternate payee to exercise that right under the circumstances and in accordance with the terms that would apply to the participant, as if the alternate payee were the participant. Reference: ERISA §§ 206(d)(3)(A), 206(d)(3)(E)(i)(III); IRC §§ 401(a)(13)(B), 414(p)(4)(A)(iii)

What disclosure rights does an alternate payee have under a QDRO?

ERISA provides that a person who is an alternate payee under a QDRO generally shall be considered a beneficiary under the plan for purposes of ERISA. Accordingly, the alternate payee must be furnished, upon written request, copies of a variety of documents, including the latest summary plan description, the latest annual report, any final annual report, and the bargaining agreement, trust agreement, contract, or other instrument under which the plan is established or operated.

The administrator may impose a reasonable charge to cover the cost of furnishing such copies. It is the view of the DOL that, at such time as benefit payments to the alternate payee commence under the QDRO, the alternate payee must be treated as a "beneficiary receiving benefits under the plan" and automatically furnished the summary plan description, summaries of material plan changes, and the plan's summary annual report. Reference: ERISA §§ 104, 105, 206(d)(3)(J), 404(a); 29 CFR § 2520.104b-1 et seq.

What happens to the rights created by a QDRO if the plan to which the QDRO applies is amended, merged into another plan, or is maintained by a successor employer?

The rights of an alternate payee under a QDRO are protected in the event of plan amendments, a plan merger, or a change in the sponsor of the plan to the same extent that rights of participants or beneficiaries are protected with respect to benefits accrued as of the date of the event. Reference: ERISA §§ 204(g), 206(d)(3)(A), 403(c)(1); IRC §§ 401(a)(13)(B), 411(d)(6).

What happens to the rights created by a QDRO if a plan is terminated?

In the view of the DOL, the rights granted by a QDRO must be taken into account in the termination of a plan as if the terms of the QDRO were part of the plan. To the extent that the QDRO grants the alternate payee part of the participant's benefits, the plan administrator, in terminating the plan, must provide the alternate payee with the notification, consent, payment, or other rights that it would have provided to the participant with respect to that portion of the participant's benefits. Reference: ERISA §§ 206(d)(3)(A), 403(d)

What happens to the rights created by a QDRO if a defined benefit plan is terminated and the Pension Benefit Guaranty Corporation becomes trustee of the Plan?

The Pension Benefit Guaranty Corporation (PBGC) is a Federal agency that insures pension benefits in most private-sector defined benefit pension plans. It is important to note that not all plans are insured by PBGC and not all plans that terminate become trustee by PBGC. For example, defined contribution plans (including 401(k) plans) are generally not covered by PBGC's insurance. In addition, most defined benefit plans that terminate have sufficient assets to pay all benefits. PBGC does not trustee these plans.

When an insured plan terminates without enough money to pay all guaranteed benefits, PBGC becomes trustee of the terminating plan and pays the plan benefits subject to certain limits on amount and form. For instance, PBGC does not pay certain death and supplemental benefits. In addition, benefit amounts paid by PBGC are limited by ERISA, and the forms of benefit PBGC pays are also limited.

PBGC has special rules that apply to payment of benefits under QDROs. For example, if a QDRO is issued prior to plan termination, PBGC will not modify the form of benefit payable to an alternate payee specified in the QDRO. If, in contrast, a QDRO is issued after plan termination, PBGC will generally limit the form of benefit that PBGC will pay under the QDRO to the form permitted by PBGC in other circumstances (generally a single life annuity). There are other special rules that apply to the administration by PBGC of QDROs.

Drafting QDROs

- What are the most common and useful ways of dividing pension benefits?
- What are survivor benefits, and why are they important?
- When can an alternate payee receive the benefits assigned by a QDRO?
- In what form will the alternate payee receive the assigned benefits?

Although domestic relations orders that involve pension plans are issued under and governed by state law, Federal law (ERISA and the Code) and the terms of the relevant pension plan determine whether these orders can be QDROs. This chapter discusses how to draft orders that will qualify as QDROs while accomplishing the purposes for which the pension benefits are being divided.

This chapter also discusses the most common methods of dividing pension benefits under the two separate types of pension plans: defined benefit plans and defined contribution plans. The following questions and answers emphasize the importance of understanding the nature of a participant's pension benefits and of making decisions about the assignment of any survivor benefits payable under the pension plan.

What is the best way to divide a participant's pension benefits in a QDRO?

There is no single "best" way to divide pension benefits in a QDRO. What will be "best" in a specific case will depend on many factors, including the type of pension plan, the nature of the participant's pension benefits, and why the parties are seeking to divide those benefits.

In deciding how to divide a participant's pension benefits in a QDRO, it is also important to consider two aspects of a participant's pension benefits: the benefit payable under the plan directly to the participant for retirement purposes (referred to here as the "retirement benefit"), and any benefit that is payable under the plan on behalf of the participant to someone else after the participant dies (referred to here as the "survivor benefit"). These two aspects of a participant's pension benefits are discussed separately in this booklet only in order to emphasize the importance of considering how best to divide pension benefits.

How much can be given to an alternate payee through a QDRO?

A QDRO can give an alternate payee any part or all of the pension benefits payable with respect to a participant under a pension plan. However, the QDRO cannot require the plan to provide increased benefits (determined on the basis of actuarial value); nor can a QDRO require a plan to provide a type or form of benefit, or any option, not otherwise provided under the plan. The QDRO also cannot require the payment of benefits to an alternate payee that are required to be paid to another alternate payee under another QDRO already recognized by the plan.

Reference: ERISA §§ 206(d)(3)(B)(i)(I), 206(d)(3)(D), 206(d)(3)(E); IRC §§ 414(p)(1)(A)(i), 414(p)(3), 414(p)(4)

Why are the reasons for dividing the pension benefits important?

Generally, QDROs are used either to provide support payments (temporary or permanent) to the alternate payee (who may be the spouse, former spouse or a child or other dependent of the participant) or to divide marital property in the course of dissolving a marriage. These differing goals often result in different choices in drafting a QDRO. This answer describes two common different approaches in drafting QDROs for these two different purposes.

One approach that is used in some orders is to "split" the actual benefit payments made with respect to a participant under the plan to give the alternate payee part of each payment. This approach to dividing retirement benefits is often called the "shared payment" approach. Under this approach, the alternate payee will not receive any payments unless the participant receives a payment or is already in pay status. This approach is often used when a support order is being drafted after a participant has already begun to receive a stream of payments from the plan (such as a life annuity).

An order providing for shared payments, like any other QDRO, must specify the amount or percentage of the participant's benefit payments that is assigned to the alternate payee (or the manner in which such amount or percentage is to be determined). It must also specify the number of payments or period to which it applies. This is particularly important in the shared payment QDRO, which must specify when the alternate payee's right to share the payments begins and ends. For example, when a state authority seeks to provide support to a child of a participant, an order might require payments to the alternate payee to begin as soon as possible after the order is determined to be a QDRO and to continue until the alternate payee reaches maturity.

Alternatively, when support is being provided to a former spouse, the order might state that payments to the alternate payee will end when the former spouse remarries. If payments are to end upon the occurrence of an event, notice and reasonable substantiation that the event has occurred must be provided for the plan to be able to comply with the terms of the QDRO.

Orders that seek to divide a pension as part of the marital property upon divorce or legal separation often take a different approach to dividing the retirement benefit. These orders usually divide the participant's retirement benefit (rather than just the payments) into two separate portions with the intent of giving the alternate payee a separate right to receive a portion of the retirement benefit to be paid at a time and in a form different from that chosen by the participant. This approach to dividing a retirement benefit is often called the "separate interest" approach.

An order that provides for a separate interest for the alternate payee must specify the amount or percentage of the participant's retirement benefit to be assigned to the alternate payee (or the manner in which such amount or percentage is to be determined). The order must also specify the number of payments or period to which it applies, and such orders often satisfy this requirement simply by giving the alternate payee the right that the participant would have had under the plan to elect the form of benefit payment and the time at which the separate interest will be paid. Such an order would satisfy the requirements to be a QDRO.

Federal law does not require the use of either approach for any specific domestic relations purpose, and it is up to the drafters of any order to determine how best to achieve the purposes for which pension benefits are being divided. Further, the shared payment approach and the separate interest approach can each be used for either defined benefit or defined contribution plans. However, it is important in drafting any order to understand and follow the terms of the plan. An order that would require a plan to provide increased benefits (determined on an actuarial basis) or to provide a type or form of benefit, or an option, not otherwise available under the plan cannot be a QDRO.

In addition to determining whether or how to divide the retirement benefit, it is important to consider whether or not to give the alternate payee a right to survivor benefits or any other benefits payable under the plan. Reference: ERISA § 206(d)(3)(C)(ii) - (iv); IRC § 414(p)(2)(B) - (D)

In deciding how to divide the participant's pension benefits, why is understanding the type of pension plan important?

Understanding the type of pension plan is important because the order cannot be a QDRO unless its assignment of rights or division of pension benefits complies with the terms of the plan. Parties drafting a QDRO should read the plan's summary plan description and other plan documents to understand what pension benefits are provided under the plan.

Pension plans may be divided generally into two types:

- Defined benefit plans
- Defined contribution plans

A defined benefit plan promises to pay each participant a specific benefit at retirement. This basic retirement benefit is usually based on a formula that takes into account factors like the number of years a participant works for the employer and the participant's salary. The basic retirement benefit is generally provided in the form of periodic payments for the participant's life beginning at what the plan calls "normal retirement age." This stream of periodic payments is generally known as an "annuity."

A participant's basic retirement benefit under a defined benefit plan may increase over time, either before or after the participant begins receiving benefits, due to a variety of circumstances, such as increases in salary or the crediting of additional years of service with the employer (which are taken into account under the plan's benefit formula), or through amendment to the plan's provisions, including some amendments to provide cost of living adjustments.

Defined benefit plans may promise to pay benefits at various times, under certain circumstances, or in alternative forms. Benefits paid at those times or in those forms may have a greater actuarial value than the basic retirement benefit payable by the plan at the participant's normal retirement age. When one form of benefit has a greater actuarial value than another form, the difference in value is often called a "subsidy."

A defined contribution plan, by contrast, is a type of pension plan that provides for an individual account for each participant. The participant's benefits are based solely on the amount contributed to the participant's account and any income, expenses, gains or losses, and any

forfeiture of accounts of other participants that may be allocated to such participant's account. **Examples of defined contribution plans include profit-sharing plans (like "401(k)" plans), employee stock ownership plans ("ESOPs"), and money purchase plans. A participant's basic retirement benefit in a defined contribution plan is the amount in his or her account at any given time. This is generally known as the participant's "account balance."**

Defined contribution plans commonly provide for retirement benefits to be paid in the form of a lump sum payment of the participant's entire account balance. Defined contribution plans by their nature do not offer subsidies.

It should be noted, however, that some defined benefit plans provide for lump sum payments, and some defined contribution plans provide for annuities. Reference: IRS Notice 97-11, 1997-2 IRB 49 (Jan. 13, 1997)

What are "survivor benefits," and why should a QDRO take them into account?

Federal law requires all pension plans, whether they are defined benefit plans or defined contribution plans, to provide benefits in a way that includes a survivor benefit for the participant's spouse. The provisions creating these protections are contained in section 205 of ERISA and sections 401(a)(11) and 417 of the Code.

The type of survivor benefit that is required by Federal law depends on the type of pension plan. Plans also may provide for survivor (or "death") benefits that are in addition to those required by Federal law. Participants and alternate payees drafting a QDRO should read the plan's summary plan description and other plan documents to understand the survivor benefits available under the plan.

Federal law generally requires that defined benefit plans and certain defined contribution plans pay retirement benefits to participants who were married on the participant's "annuity starting date" (this is the first day of the first period for which an amount is payable to the participant) in a special form called a "qualified joint and survivor annuity" (QJSA) unless the participant elects a different form and the spouse consents to that election. When benefits are paid as a QJSA, the participant receives a periodic payment (usually monthly) during his or her life, and the surviving spouse of the participant receives a periodic payment for the rest of the surviving spouse's life upon the participant's death.

Federal law also generally requires that, if a married participant with a non-forfeitable benefit under one of these types of plans dies before his or her "annuity starting date," the plan must pay the surviving spouse of the participant a monthly survivor benefit. This benefit is called a "qualified preretirement survivor annuity" (QPSA). Appendix C also describes the QPSA.

Those defined contribution plans that are not required to pay pension benefits to married participants in the form of a QJSA or QPSA (like most 401(k) plans) are required by Federal law to pay any balance remaining in the participant's account after the participant dies to the participant's surviving spouse. If the spouse gives written consent, the participant can direct that upon the participant's death any balance remaining in the account will be paid to a beneficiary other than the spouse, for example, the couple's children. Under these defined contribution plans, Federal law does not require a spouse's consent to a participant's decision to withdraw any portion (or all) of his or her account balance during the participant's life.

If a participant and his or her spouse become divorced before the participant's annuity starting date, the divorced spouse loses all right to the survivor benefit protections that Federal law requires be provided to a participant's spouse. If the divorced participant remarries, the participant's new spouse may acquire a right to the Federally mandated survivor benefits. A QDRO, however, may change that result.

To the extent that a QDRO requires that a former spouse be treated as the participant's surviving spouse for all or any part of the survivor benefits payable after the death of the participant, any subsequent spouse of the participant cannot be treated as the participant's surviving spouse. For example, if a QDRO awards all of the survivor benefit rights to a former spouse, and the participant remarries, the participant's new spouse will not receive any survivor benefit upon the participant's death.

If such a QDRO requires that a defined benefit plan, or a defined contribution plan subject to the QJSA and QPSA requirements, treat a former spouse of a participant as the participant's surviving spouse, the plan must pay the participant's benefit in the form of a QJSA or QPSA unless the former spouse who was named as surviving spouse in the QDRO consents to the participant's election of a different form of payment.

It should also be noted that some pension plans provide that a spouse of a participant will not be treated as married unless he or she has been married to the participant for at least a year. If the pension plan to which the QDRO relates contains such a one-year marriage requirement, then the QDRO cannot treat the alternate payee as a surviving spouse if the marriage lasted for less than one year.

In addition, it is important to note that some pension plans may provide for survivor benefits in addition to those required by Federal law for the benefit of the surviving spouse. Generally, however, the only way to establish a former spouse's right to survivor benefits such as a QJSA or QPSA is through a QDRO. A QDRO may provide that a part or all of such other survivor benefits shall be paid to an alternate payee rather than to the person who would otherwise be entitled to receive such death benefits under the plan.

As discussed above, a spouse or former spouse can also receive a right to receive (as a separate interest or as shared payments) part of the participant's retirement benefit as well as a survivor's benefit. Reference: ERISA §§ 205, 206(d)(3)(F); IRC §§ 401(a)(11), 414(p)(5), 417

How may the participant's retirement benefit be divided if the pension plan is a defined contribution plan?

An order dividing a retirement benefit under a defined contribution plan may adopt either a "separate interest" approach or a "shared payment" approach (or some combination of these approaches).

Orders that provide the alternate payee with a separate interest, either by assigning to the alternate payee a percentage or a dollar amount of the account balance as of a certain date, often also provide that the separate interest will be held in a separate account under the plan with respect to which the alternate payee is entitled to exercise the rights of a participant. Provided that the order does not assign a right or option to an alternate payee that is not

otherwise available under the plan, an order that creates a separate account for the alternate payee may qualify as a QDRO.

Orders that provide for shared payments from a defined contribution plan should clearly establish the amount or percentage of the participant's payments that will be allocated to the alternate payee and the number of payments or period of time during which the allocation to the alternate payee is to be made. A QDRO can specify that any or all payments made to the participant are to be shared between the participant and the alternate payee.

In drafting orders dividing benefits under defined contribution plans, parties should also consider addressing the possibility of contingencies occurring that may affect the account balance (and therefore the alternate payee's share) during the determination period. For example, parties might be well advised to specify the source of the alternate payee's share of a participant's account that is invested in multiple investments because there may be different methods of determining how to derive the alternate payee's share that would affect the value of that share.

The parties should also consider how to allocate any income or losses attributable to the participant's account that may accrue during the determination period. If an order allocates a specific dollar amount rather than a percentage to an alternate payee as a shared payment, the order should address the possibility that the participant's account balance or individual payments might be less than the specified dollar amount when actually paid out. Reference: ERISA §§ 206(d)(3)(C); IRC § 414(p)(2)

How may the participant's retirement benefit be divided if the pension plan is a defined benefit plan?

As indicated earlier, an order may adopt either the shared payment or the separate interest approach (or a combination of the two) in dividing pension benefits in a defined benefit plan. If shared payments are desired, the order should specify the amount of each shared payment allocated to the alternate payee either by percentage or by dollar amount. If the order describes the alternate payee's share as a dollar amount, care should be taken to establish that the payments to the participant will be sufficient to satisfy the allocation, and the order should indicate what is to happen in the event a payment is insufficient to satisfy the allocation.

The order must also describe the number of payments or period of time during which the allocation to the alternate payee is to be made. This is usually done by specifying a beginning date and an ending date (or an event that will cause the allocation to begin and/or end). If an order specifies a triggering event that may occur outside the plan's knowledge, notice of its occurrence must be given to the plan before the plan is required to act in accordance with the order. If the intent is that all payments made under the plan are to be shared between the participant and the alternate payee, the order may so specify.

A defined benefit plan may provide for subsidies under certain circumstances and may also provide increased benefits or additional benefits either earned through additional service or provided by way of plan amendment. A QDRO that uses the "shared payment" method to give the alternate payee a percentage of each payment may be structured to take into account any such future increases in the benefits paid to the participant. Such a QDRO does not need to address the treatment of future subsidies or other benefit increases, because the alternate payee will automatically receive a share of any subsidy or other benefit increases that are paid to the participant. If the parties do not wish to provide for the sharing of such subsidies or

increases, the order should so specify.

If a separate interest is desired for the alternate payee, it is important that the order be based on adequate information from the plan administrator and the plan documents concerning the participant's retirement benefit and the rights, options, and features provided under the plan. In particular, the drafters of a QDRO should consider any subsidies or future benefit increases that might be available with respect to the participant's retirement benefit. The order may specify whether, and to what extent, an alternate payee is to receive such subsidies or future benefit increases. Reference: ERISA §§ 206(d)(3)(C), 206(d)(3)(D); IRC §§ 414(p)(2), 414(p)(3)

May the QDRO specify the form in which the alternate payee's benefits will be paid?

A QDRO that provides for a separate interest may specify the form in which the alternate payee's benefits will be paid subject to the following limitations:

- The order may not provide the alternate payee with a type or form of payment, or any option, not otherwise provided under the plan
- The order may not provide any subsequent spouse of an alternate payee with the survivor benefit rights that Federal law requires be provided to spouses of participants under section 205 of ERISA
- For any tax-qualified pension plan, the payment of the alternate payee's benefits must satisfy the requirements of section 401(a)(9) of the Code respecting the timing and duration of payment of benefits. In determining the form of payment for an alternate payee, an order may substitute the alternate payee's life for the life of the participant to the extent that the form of payment is based on the duration of an individual's life. However, the timing and forms of benefit available to an alternate payee under a tax-qualified plan may be limited by section 401(a)(9) of the Code.

Alternatively, a QDRO may (subject to the limitations described above) give the alternate payee the right that the participant would have had under the plan to elect the form of benefit payment. For example, if a participant would have the right to elect a life annuity, the alternate payee may exercise that right and choose to have the assigned benefit paid over the alternate payee's life. However, the QDRO must permit the plan to determine the amount payable to the alternate payee under any form of payment in a manner that does not require the plan to pay increased benefits (determined on an actuarial basis).

A plan may by its own terms provide alternate payees with additional types or forms of benefit, or options, not otherwise provided to participants, such as a lump-sum payment option, but the plan cannot prevent a QDRO from assigning to an alternate payee any type or form of benefit, or option, provided generally under the plan to the participant. Reference: ERISA §§ 206(d)(3)(A), 206(d)(3)(D), 206(d)(3)(E)(i)(III); IRC §§ 401(a)(9), 401(a)(13)(B), 414(p)(3), 414(p)(4)(A)(iii)

When can the alternate payee get the benefits assigned under a QDRO?

A QDRO that provides for shared payments must specify the date on which the alternate payee will begin to share the participant's payments. Such a date, however, cannot be earlier than the

date on which the plan receives the order. With respect to a separate interest, an order may either specify the time (after the order is received by the plan) at which the alternate payee will receive the separate interest or assign to the alternate payee the same right the participant would have had under the plan with regard to the timing of payment. In either case, a QDRO cannot provide that an alternate payee will receive a benefit earlier than the date on which the participant reaches his or her "earliest retirement age," unless the plan permits payments at an earlier date.

The plan itself may contain provisions permitting alternate payees to receive separate interests awarded under a QDRO at an earlier time or under different circumstances than the participant could receive the benefit. For example, a plan may provide that alternate payees may elect to receive a lump sum payment of a separate interest at any time. Section 401(a)(9) of the Code may affect when benefits must be paid under tax-qualified pension plans. Reference: ERISA §§ 206(d)(3)(C), 206(d)(3)(D), 206(d)(3)(E); IRC §§ 401(a)(9), 414(p)(2), 414(p)(3), 414(p)(4)

What is "earliest retirement age," and why is it important?

For QDROs, Federal law provides a very specific definition of "earliest retirement age," which is the earliest date as of which a QDRO can order payment to an alternate payee (unless the plan permits payments at an earlier date). The "earliest retirement age" applicable to a QDRO depends on the terms of the pension plan and the participant's age. "Earliest retirement age" is the earlier of two dates:

- The date on which the participant is entitled to receive a distribution under the plan, or
- The later of either
- The date the participant reaches age 50, or
- The earliest date on which the participant could begin receiving benefits under the plan if the participant separated from service with the employer.

Drafters of QDROs should consult the plan administrator and the plan documents for information on the plan's "earliest retirement age." The following examples illustrate the concept of "earliest retirement age."

Example 1 -The pension plan is a defined contribution plan that permits a participant to make withdrawals only when he or she reaches age 59½ or terminates from service. The "earliest retirement age" for a QDRO under this plan is the earlier of:

- When the participant actually terminates employment or reaches age 59½, or
- The later of the date the participant reaches age 50 or the date the participant could receive the account balance if the participant terminated employment.

Since the participant could terminate employment at any time and thereby be able to receive the account balance under the plan's terms, the later of the two dates described above is "age 50." The "earliest retirement age" formula for this plan can be simplified to read the earlier of:

- Actually reaching age 59½ or terminating employment or
- Age 50. Since age 50 is earlier than age 59½, the "earliest retirement age" for this plan will be the earlier of age 50 or the date the participant actually terminates from service.

Example 2 -The pension plan is a defined benefit plan that permits retirement benefits to be paid beginning when the participant reaches age 65 and terminates employment. It does not permit earlier payments. The "earliest retirement age" for this plan is the earlier of:

- The date on which the participant actually reaches age 65 and terminates employment, or
- The later of age 50 or the date on which the participant reaches age 65 (whether he or she terminates employment or not).

Because age 65 is later than age 50, the second part of the formula can be simplified to read "age 65" so that the formula reads as follows: the "earliest retirement age" is the earlier of:

- The date on which the participant reaches age 65 and actually terminates or
- The date the participant reaches age 65. Under this plan, therefore, the "earliest retirement age" will be the date on which the participant reaches age 65.

Reference: ERISA § 206(d)(3)(E); IRC § 414(p)(4)

COMMON QDRO ISSUES IN LITIGATION

State Law vs Federal Law

Boggs v Boggs, 520 US 833 (1997)

I. Background

Isaac Boggs worked for South Central Bell from 1949 until his retirement in 1985. Isaac and Dorothy, his first wife, were married when he began working for the company, and they remained husband and wife until Dorothy's death in 1979. They had three sons. Within a year of Dorothy's death, Isaac married Sandra, and they remained married until his death in 1989.

Upon retirement, Isaac received various benefits from his employer's retirement plans. One was a lump-sum distribution from the Bell System Savings Plan for Salaried Employees (Savings Plan) of \$151,628.94, which he rolled over into an Individual Retirement Account (IRA). He made no withdrawals and the account was worth \$180,778.05 when he died. He also received 96 shares of AT & T stock from the Bell South Employee Stock Ownership Plan (ESOP). In addition, Isaac enjoyed a monthly annuity payment during his retirement of \$1,777.67 from the Bell South Service Retirement Program.

The instant dispute over ownership of the benefits is between Sandra (the surviving wife) and the sons of the first marriage. The sons' claim to a portion of the benefits is based on Dorothy's will. Dorothy bequeathed to Isaac one-third of her estate, and a lifetime usufruct in the remaining two-thirds. A lifetime usufruct is the rough equivalent of a common-law life estate. She bequeathed to her sons the naked ownership in the remaining two-thirds, subject to Isaac's usufruct. All agree that, absent pre-emption, Louisiana law controls and that under it Dorothy's will would dispose of her community property interest in Isaac's undistributed pension plan benefits. A Louisiana state court, in a 1980 order entitled "Judgment of Possession," ascribed to Dorothy's estate a community property interest in Isaac's Savings Plan account valued at the time at \$21,194.29.

Sandra contested the validity of Dorothy's 1980 testamentary transfer, basing her claim to those benefits on her interest under Isaac's will and 29 U.S.C. § 1055. Isaac bequeathed to Sandra outright certain real property including the family home. His will also gave Sandra a lifetime usufruct in the remainder of his estate, with the naked ownership interest being held by the sons. Sandra argues that the sons' competing claim, since it is based on Dorothy's 1980 purported testamentary transfer of her community property interest in undistributed pension plan benefits, is pre-empted by ERISA. The Bell South Service Retirement Program monthly annuity is now paid to Sandra as the surviving spouse.

After Isaac's death, two of the sons filed an action in state court requesting the appointment of an expert to compute the percentage of the retirement benefits they would be entitled to as a result of Dorothy's attempted testamentary transfer. They further sought a judgment awarding them a portion of: the IRA; the ESOP shares of AT & T stock; the monthly annuity payments received by Isaac during his retirement; and Sandra's survivor annuity payments, both received and payable.

In response, Sandra Boggs filed a complaint in the United States District Court for the Eastern District of Louisiana, seeking a declaratory judgment that ERISA pre-empts the application of Louisiana's community property and succession laws to the extent they recognize the sons' claim to an interest in the disputed retirement benefits. The District Court granted summary judgment against Sandra Boggs. It found that, under Louisiana community property law, Dorothy had an ownership interest in her husband's pension plan benefits built up during their marriage. The creation of this interest, the court explained, does not violate 29 U.S.C. § 1056(d)(1), which prohibits pension plan benefits from being "assigned" or "alienated," since Congress did not intend to alter traditional familial and support obligations. In the court's view, there was no assignment or alienation because Dorothy's rights in the benefits were acquired by operation of community property law and not by transfer from Isaac. Turning to Dorothy's testamentary transfer, the court found it effective because "[ERISA] does not display any particular interest in preserving maximum benefits to any particular beneficiary."

A divided panel of the Fifth Circuit affirmed and stressed that Louisiana law affects only what a plan participant may do with his or her benefits after they are received and not the relationship between the pension plan administrator and the plan beneficiary. For the reasons given by the District Court, it found ERISA's pension plan anti-alienation provision, inapplicable to Louisiana's creation of Dorothy Boggs' community property interest in the pension plan benefits. It concluded that the transfer of the interest from Dorothy to her sons was not a prohibited assignment or alienation, as this transfer was "two steps removed from the disbursement of benefits."

II. Analysis

Part I

This case lies at the intersection of ERISA pension law and state community property law. None can dispute the central role community property laws play in the nine community property States. It is more than a property regime. It is a commitment to the equality of husband and wife and reflects the real partnership inherent in the marital relationship. State community property laws, many of ancient lineage, "must have continued to exist through such lengths of time

because of their manifold excellences and are not lightly to be abrogated or tossed aside."

The community property regime in Louisiana dates from 1808 when the territorial legislature of Orleans drafted a civil code which adopted Spanish principles of community property. Louisiana's community property laws, and the community property regimes enacted in other States, implement policies and values lying within the traditional domain of the States. These considerations inform our pre-emption analysis.

ERISA's express pre-emption clause states that the Act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" We can begin, and in this case end, the analysis by simply asking if state law conflicts with the provisions of ERISA or operates to frustrate its objects. We hold that there is a conflict, which suffices to resolve the case. We need not inquire whether the statutory phrase "relate to" provides further and additional support for the pre-emption claim. Nor need we consider the applicability of field pre-emption.

The annuity at issue is a qualified joint and survivor annuity mandated by ERISA. Section 1055(a) provides:

"Each pension plan to which this section applies shall provide that -(1) in the case of a vested participant who does not die before the annuity starting date, the accrued benefit payable to such participant shall be provided in the form of a qualified joint and survivor annuity."

ERISA requires that every qualified joint and survivor annuity include an annuity payable to a nonparticipant surviving spouse. The survivor's annuity may not be less than 50% of the amount of the annuity which is payable during the joint lives of the participant and spouse. Provision of the survivor's annuity may not be waived by the participant, absent certain limited circumstances, unless the spouse consents in writing to the designation of another beneficiary, which designation also cannot be changed without further spousal consent, witnessed by a plan representative or notary public. Sandra Boggs, as the surviving spouse, is entitled to a survivor's annuity under these provisions. She has not waived her right to the survivor's annuity, let alone consented to having the sons designated as the beneficiaries.

Respondents say their state-law claims are consistent with these provisions. Their claims, they argue, affect only the disposition of plan proceeds after they have been disbursed by the Bell South Service Retirement Program, and thus nothing is required of the plan. ERISA's concern for securing national uniformity in the administration of employee benefit plans, in their view, is not implicated. They argue Sandra's community property obligations, after she receives the survivor annuity payments, "fai[l] to implicate the regulatory concerns of ERISA."

We disagree. The statutory object of the qualified joint and survivor annuity provisions, along with the rest of § 1055, is to ensure a stream of income to surviving spouses. Section 1055 mandates a survivor's annuity not only where a participant dies after the annuity starting date but also guarantees one if the participant dies before then. These provisions, enacted as part of the Retirement Equity Act of 1984 (REA), enlarged ERISA's protection of surviving spouses in significant respects. Before REA, ERISA only required that pension plans, if they provided for the payment of benefits in the form of an annuity, offer a qualified joint and survivor annuity as an option entirely within a participant's discretion.

REA modified ERISA to permit participants to designate a beneficiary for the survivor's annuity, other than the nonparticipant spouse, only when the spouse agrees. Congress' concern for surviving spouses is also evident from the expansive coverage of § 1055, as amended by REA. Section 1055's requirements, as a general matter, apply to all "individual account plans" and "defined benefit plans." The terms are defined, so that all pension plans fall within those two categories. While some individual account plans escape § 1055's surviving spouse annuity requirements under certain conditions, Congress still protects the interests of the surviving spouse by requiring those plans to pay the spouse the non-forfeitable accrued benefits, reduced by certain security interests, in a lump-sum payment.

ERISA's solicitude for the economic security of surviving spouses would be undermined by allowing a predeceasing spouse's heirs and legatees to have a community property interest in the survivor's annuity. Even a plan participant cannot defeat a nonparticipant surviving spouse's statutory entitlement to an annuity. It would be odd, to say the least, if Congress permitted a predeceasing nonparticipant spouse to do so. Nothing in the language of ERISA supports concluding that Congress made such an inexplicable decision. Testamentary transfers could reduce a surviving spouse's guaranteed annuity below the minimum set by ERISA (defined as 50% of the annuity payable during the joint lives of the participant and spouse). In this case, Sandra's annuity would be reduced by approximately 20%, according to the calculations contained in the sons' state-court filings. There is no reason why testamentary transfers could not reduce a survivor's annuity by an even greater amount. Perhaps even more troubling, the recipient of the testamentary transfer need not be a family member. For instance, a surviving spouse's annuity might be substantially reduced so that funds could be diverted to support an unrelated stranger.

In the face of this direct clash between state law and the provisions and objectives of ERISA, the state law cannot stand. Conventional conflict pre-emption principles require pre-emption "where compliance with both federal and state regulations is a physical impossibility, ... or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."

It would undermine the purpose of ERISA's mandated survivor's annuity to allow Dorothy, the predeceasing spouse, by her testamentary transfer to defeat in part Sandra's entitlement to the guarantees her as the surviving spouse. This cannot be. States are not free to change ERISA's structure and balance. Louisiana law, to the extent it provides the sons with a right to a portion of Sandra Boggs' survivor's annuity, is pre-empted.

Post Death QDROs

Patton v Denver Post, 326 F.3d 1148 (10th Cir. 2003)

I. Background

The marriage of Mr. Phipers and Ms. Patton was dissolved on February 10, 1988. During the mediation related to the dissolution of their marriage, the parties voluntarily produced financial information. In this regard, Mr. Phipers wrote to request information from his employer, the Denver Post, regarding his retirement benefits. In response to his inquiry, the plan administrator informed him of only one plan, the Newspaper Guild International Pension Plan, although in fact at that point he had two plans.

There is no indication of an attempt on anyone's part to conceal the existence of the second plan, but the Denver Post Pension Plan was nevertheless inadvertently omitted from the parties' division of marital assets. The parties divided the one disclosed plan in a QDRO, in which Ms. Patton was designated as surviving spouse in the event of Mr. Phipers' death. Ms. Patton's interest in the disclosed plan was one half of the plan's value attributable to the thirteen years of the parties' marriage.

Mr. Phipers died in 1999 at the age of 58. He died before retirement age and while still employed at the Denver Post. Under these circumstances, ERISA provides that retirement plan benefits can only be paid to a surviving spouse. Mr. Phipers had not remarried, so at the time of his death only Ms. Patton qualified as his surviving spouse under ERISA. Ms. Patton filed with the plan administrator her QDRO covering the disclosed plan and received a lump sum payout, which appeared to her to be very low considering Mr. Phiper's twenty-seven years of service. When she inquired about this, she learned of the undisclosed plan.

The plan administrator refused to divide the undisclosed plan according to the terms established in the QDRO for the disclosed plan, even though the plans had since merged into one. Believing the nondisclosure of the second plan to have been inadvertent, Ms. Patton requested the state court to issue a *nunc pro tunc* domestic relations order for the undisclosed plan. She asked that the second plan be divided in the same way as the disclosed plan had been. The state court entered the *nunc pro tunc* order, effective on the date of the dissolution of the parties' marriage.

A domestic relations order must be qualified by the plan administrator in order to become a QDRO and in order for the benefits to be distributed according to the terms of the QDRO. When Ms. Patton presented the *nunc pro tunc* order to the plan administrator, however, the plan administrator rejected it. Ms. Patton then filed for a declaratory judgment in federal district court, requesting enforcement of the order and distribution of the benefits. The Denver Post appeals the district court's grant of summary judgment in favor of Ms. Patton.

II Analysis

We note at the outset that counsel for the two parties made conflicting representations at oral argument as to whether ERISA requires that notice of the entry of a QDRO be given to the plan administrator (i.e., whether the QDRO itself must be in the plan file) prior to the death of the participant. Neither side, either in the briefs or at oral argument, provided any specific citation to support its assertion. Nor have we been able to discover any part of the statute itself or any interpretation of the statute in case law or secondary scholarly materials demonstrating to us that the statute requires such notice to be given.

The Denver Post asks us to infer a notice requirement, asserting the policy interests of ease of administration, predictability, and actuarial accounting. We decline to infer such a requirement. First, the plan summary does not indicate that notice is required prior to the death of a participant, either concerning a change in marital status or concerning the existence of a domestic relations order relevant to the plan.

Second, the Denver Post concedes the plan allows for post hoc determinations of whether the domestic relations order is qualified (this much is explicitly allowed by the statute, as well as post-death notification of the existence of an actual surviving spouse. That is, if there were an

actual surviving spouse of which it had no notice prior to the death of the participant, failure to notify the Denver Post of the spouse's existence in advance would not prevent the surviving spouse from receiving benefits. There is thus no difference to the Denver Post in terms of predictability of its liability if there is no requirement that the parties inform the plan of any change prior to the death of the participant.

Because the statute and the plan itself both clearly contemplate making decisions regarding benefits after the death of the participant, the Denver Post's arguments about predictability and actuarial calculations lack weight.

The domestic relations order in this case is a qualified domestic relations order because it fits within the requirements of ERISA. ERISA requires that in order to be "qualified," a domestic relations order may not provide a type or form of benefit or an option not otherwise provided by the plan, require the plan to provide increased benefits, or divest a beneficiary under an earlier established QDRO. Neither side argues that the domestic relations order in this case divests any other beneficiary so we look to the other two requirements. While this case only purports to raise an argument regarding provision of increased benefits, analysis of the "not otherwise provided" requirement is also pertinent.

Under the interpretation of this section of the statute in Payne v. GM/UAW Pension Plan Adm'r, No. Civ.A. 95-CV-73554DT, 1996 WL 943424 (E.D.Mich. May 7, 1996), which we find persuasive, there is no increase in liability or benefits. In *Payne*, the former wife sought pension benefits pursuant to the terms of a divorce granting her a forty-five percent interest in her former husband's plan. The divorce decree stated that a QDRO would issue within thirty days, but the husband died before the entry of the QDRO. The plan rejected the posthumously entered order as a QDRO because it maintained that no provision of the plan allowed for establishment of surviving spouse after the death of the participant.

It argued that allowing for such would provide a benefit not otherwise provided in the plan, in violation of ERISA. The court noted that the plan could not point to a provision requiring notice to the administrator prior to death, and provided no authority for its proposition that a post-death amendment is invalid. Because the order was amended *nunc pro tunc*, the court held it was to be considered entered before the death of the participant and thus did not provide a benefit not otherwise provided.

Payne's analysis recognizes the validity of the state court's use of the *nunc pro tunc* doctrine to amend a QDRO. We are persuaded that if that is true for § 1056(d)(3)(D)(i), it is true as well for § 1056(d)(3)(D)(iii). Because the *nunc pro tunc* order in the present case must be considered to have been entered before the death of the participant, it does not increase the benefits to be paid.

Our conclusion that the domestic relations order in this case did not confer different or increased benefits as prohibited by § 1056(d)(3)(D)(i)-(iii) is supported by solid case law and secondary materials. For example, benefits of a type or form not otherwise provided is best understood as referring to a lump sum payout rather than regular payments over a period of years.

As to the meaning of an increase, case law similarly confirms that the increase must be real rather than conceptual. In *Bailey*, a former spouse sought a portion of her former husband's

benefits (half of which were already being distributed to his subsequent wife). The court determined that while it was theoretically possible that the benefits would have been greater in such a situation, in fact, due to the life expectancies of the two women, the benefits would be lessened with the addition of the former wife and the domestic relations order would therefore not be disqualified. Here, Ms. Patton has not asked to receive funds in any manner different from that allowed for in the plan. Nor will she receive more benefits than she would have received if the second plan had been included in the original order.

Other cases allow for the post-death entry of an order, noting that such entry occurred within the eighteen months prescribed by the statute for determining whether a plan is qualified. In Hogan v. Raytheon, Co., 302 F.3d 854, 857 (8th Cir.2002), the court held that a domestic relations order can be qualified posthumously. While *Hogan* noted that the plan had notice a QDRO might issue, such notice was not essential to its determination of the order's validity. Instead, the court held "[t]he fact that Mr. Hogan died prior to the entry of the ... Order is irrelevant."

The Denver Post acknowledges that *nunc pro tunc* orders have a legitimate place in state law, but it maintains they cannot be used to rewrite historical facts. The *nunc pro tunc* order here does not attempt to rewrite historical facts. Rather, it is more akin to the correction of a clerical error, which is an accepted use for *nunc pro tunc* orders. All that occurred in this case is that the state court and the parties previously lacked full information as to the assets to be distributed in the divorce settlement. When those assets were finally discovered, the court simply allotted them as it had intended under the original plan, i.e., as it would have done had it been aware of their existence at the time.

The historical facts were not changed--two pension plans existed on the date of the divorce as well as the date of death. That is, once discovered, the second plan simply was added to the list of assets and apportioned so as to achieve the same equitable division of marital assets originally intended by the domestic relations court. No other person's vested interest was upset by this action.

Moreover, as to the Denver Post's argument that the domestic relations order did not exist before the date of the participant's death, the very point of a *nunc pro tunc* order is the creation of a legal fiction that the order *did* exist as of the date to which it is made effective. That fiction is one which has been accepted in Colorado as a basic doctrine of law, such that its fictional quality does not diminish its binding effect.

The Denver Post advocates the position taken by the majority of a Third Circuit panel in Samaroo v. Samaroo, 193 F.3d 185 (3d Cir.1999). The court held that a beneficiary's entitlement had to be established as of the day the participant died. It reasoned that a *nunc pro tunc* order entered after that date, even though back-dated to a date prior to death, was an attempt to obtain increased benefits and therefore could not be a QDRO. Based on our earlier analysis, we disagree. The holding in *Samaroo* "work[s] an unwarranted interference with the states' ability to administer their domestic relations law and to effectuate equitable divisions of marital assets." In dissent, Judge Mansmann noted, as we have, that the holding in *Samaroo* was not compelled by statute or case law, nor was there a policy argument sufficiently weighty to overcome the propriety of using the *nunc pro tunc* doctrine in these types of cases.

We are further persuaded of the correctness of our decision by an article from the periodical of the ABA's Family Law Section, written by Gary Shulman, author of the *Qualified Domestic*

Relations Order Handbook. Mr. Shulman writes:

Nunc pro tunc QDROs are desperately needed in the domestic relations arena. There must be a way to secure a former spouse's property rights to a pension that could suddenly disappear as a result of a technicality or a family law attorney's inexperience in drafting QDROs.

In sum, this is precisely the type of situation, particularly in the domestic relations arena, for which the *nunc pro tunc* doctrine is appropriate. Courts in domestic relations contexts must have the power to effect equitable settlements by responding to newly acquired information or to changes in circumstances. If necessary changes once effected by the state court are not then recognized by plan administrators or by federal courts adjudicating disputes, state courts are effectively stripped of their ability to equitably distribute marital assets in a divorce. Accordingly, we AFFIRM the district court's grant of summary judgment in favor of Ms. Patton.

MILITARY PENSIONS IN DIVORCE

I HISTORY

The Uniformed Services Former Spouses' Protection Act (USFSPA) was passed by Congress in 1982. **The USFSPA gives a State court the authority to treat military retired pay as marital property and divide it between the spouses.** Congress' passage of the USFSPA was prompted by the United States Supreme Court's decision in *McCarty v. McCarty* in 1981.

The *McCarty* decision effectively precluded state courts from dividing military retired pay as an asset of the marriage. Justice Blackmun, writing for the majority, stated that allowing a state to divide retired pay would threaten "grave harm to 'clear and substantial' federal interests."

Accordingly, the Supremacy Clause of Article VI preempted the State's attempt to divide military retired pay. Congress, by enacting the USFSPA, clarified its intent that State courts have the power to divide what can be the largest asset of a marriage.

With the passage of the USFSPA, Congress took the opportunity to set forth various requirements to govern the division of military retired pay. Congress sought to make a fair system for military members, considering that their situation often exposes them to difficulties with civil litigation. **Therefore, if a member is divorced while on active duty, the requirements of the Soldiers' and Sailors' Civil Relief Act (SSCRA) must be met before an award dividing military retired pay can be enforced under the USFSPA. The USFSPA contains its own jurisdictional requirement.**

It limits the amount of the member's retired pay which can be paid to a former spouse to 50% of the member's disposable retired pay (gross retired pay less authorized deductions). It requires that the parties must have been married for at least 10 years while the member performed at least 10 years of active duty service before a division of retired pay is enforceable under the USFSPA. It specifies how an award of military retired pay must be expressed.

II DOCUMENTS NEEDED TO DIVIDE MILITARY RETIRED PAY.

The USFSPA defines a “court order” dividing military retired pay enforceable under the Act as a “final decree of divorce, dissolution, annulment, or legal separation issued by a court, or a court ordered, ratified, or approved property settlement incident to such a decree.” This also includes an order modifying a previously issued “court order.”

Since military retired pay is a Federal entitlement, and not a qualified pension plan, there is no requirement that a Qualified Domestic Relations Order (QDRO) be used. As long as the award is set forth in the divorce decree or other court order in an acceptable manner, that is sufficient. It is also not necessary to judicially join the “member’s plan” as a part of the divorce proceeding. There is no Federal statutory authority for this. The award may also be set forth in a court ratified or approved separation agreement, or other court order issued incident to the divorce.

In order to submit an application for payments under the USFSPA, a former spouse needs to submit a copy of the applicable court order certified by the clerk of court within 90 days immediately preceding its service on the designated agent, along with a completed application form (DD Form 2293). Instructions, including designated agent names and addresses, are on the back of the DD Form 2293. The Defense Finance and Accounting Service (DFAS) is the designated agent for all uniformed military services.

III REQUIREMENTS FOR ENFORCEABILITY UNDER USFSPA

Soldiers’ and Sailors’ Civil Relief Act

The provision of the SSCRA that has primary application to the USFSPA and the division of military retired pay is the section concerning default judgments against active duty service members. This section requires that if an active duty defendant fails to make an appearance in a legal proceeding, the plaintiff must file an affidavit with the court informing the court of the member’s military status.

The court shall appoint an attorney to represent the interests of the absent defendant. Since a member has 90 days after separation from active duty service to apply to a court rendering a judgment to re-open a case on SSCRA grounds, the SSCRA is not a USFSPA issue where a member has been retired for more than 90 days.

The 10/10 requirement

This is a “killer” requirement. **For a division of retired pay as property award to be enforceable under the USFSPA, the former spouse must have been married to the member for a period of 10 years or more during which the member performed at least 10 years of service creditable towards retirement eligibility.** This requirement does not apply to the Court’s authority to divide military retired pay, but only to the ability of the former spouse to get direct payments from DFAS. This is a statutory requirement, and not a personal right of the member that can be waived.

Although this requirement was probably included in the USFSPA to protect members, we have had more complaints about it from members than from former spouses. Assuming that a

member intends to meet his or her legal obligations, the member would much rather have us pay the former spouse directly rather than have to write a check each month. It would lessen contact with the former spouse, and the former spouse would receive her or his own IRS Form 1099, instead of the member being taxed on the entire amount of military retired pay.

If we cannot determine from the court order whether the 10/10 requirement has been met, we may ask the former spouse to provide a copy of the parties' marriage certificate. A recitation in the court order such as, "The parties were married for 10 years or more while the member performed 10 years or more of military service creditable for retirement purposes" will satisfy the 10/10 requirement.

USFSPA Jurisdiction

The USFSPA's jurisdictional requirement is found in 10 U.S.C. § 1408(c)(4). This is another "killer" requirement. If it is not met, the former spouse's application for retired pay as property payments under the USFSPA will be rejected. For a court to have the authority to divide military retired pay, the USFSPA requires that the court have "C-4" jurisdiction over the military member in one of three ways. One way is for the member to consent to the jurisdiction of the court. The member indicates his or her consent to the court's jurisdiction by taking some affirmative action with regard to the legal proceeding, such as filing any responsive pleading in the case. Simply receiving notice of filing of the divorce complaint or petition is not sufficient. Consent is the most common way for a court to have "C-4" jurisdiction over a member.

The other ways for the court to have C-4 jurisdiction is for the member to be a resident of the State other than because of his or her military assignment, or for the court to find that the member was domiciled in the particular State. Now, the key with regard to domicile is that it should be the court making this determination, and it should be noted in the divorce decree.

MILITARY PENSION CASES

Forgie v. Forgie, 2005 WL 1125316 (KY CA, 2005)

I. Background

Pursuant to the terms of an amended property settlement agreement, the domestic relations commissioner of the Hardin Circuit Court undertook a division of appellant's military retirement benefits. **Based upon an application of the Poe formula**, as provided for in the amended agreement, the commissioner concluded that appellee was entitled to 39.6% of those benefits. Appellant filed objections to that determination alleging that the calculation was based upon an erroneous number of months of military service and that the award failed to take into consideration the second part of the *Poe* formula. The circuit court order overruling those objections precipitated this appeal.

II. Analysis

Disposable military retirement pay is now subjected to state law regarding division of marital assets in a dissolution proceeding by virtue of the federal Uniformed Services

Former Spouses Protection Act. Courts of this Commonwealth adhere to a utilization of the formula prescribed in *Poe* in calculating a spouse's share of military retirement pay. In this case, the parties entered into an amended separation agreement which contained the following provision as to the division of the military retirement pay:

“4. *MILITARY RETIREMENT*: WIFE will be entitled to 50% of HUSBAND's retirement benefits. Both parties agree that based upon *Poe v. Poe, Ky.App., 711 S.W.2d 849 (1986)*, WIFE's share of HUSBAND's benefits shall be computed as follows:

<u>months (duration of marriage)</u>	X	50% of future monthly retirement payments total months of military service which were earned during the marriage.
50% of future monthly retirement payments earned during the marriage	1/2 OF HUSBAND'S disposable retired or retainer pay (as defined in 10 U.S.C. Section 1408(c)(1)),	that portion of any post-retirement cost-of living increase (10 U.S.C. Section 140(a)) which are proportional to [the non-military spouse's] interest in the disposable retired or retainer pay computed as of the date of retirement.
X	OR	X
	1/2 of the disposable retired or retainer pay which would be payable to HUSBAND if he retired at the same rank and basic pay rate which he had attained as of (date of judgment)	
	<i>WHICHEVER IS LESS</i>	

The order dissolving the parties' marriage was entered on September 9, 1997 and appellant retired from the military on October 31, 2002. Appellee thereafter moved the circuit court for entry of an order awarding her 50% of appellant's retirement benefits under the terms of the parties' separation agreement.

Because at the time of the motion neither party resided in Kentucky, the matter was submitted to the commissioner on stipulated information submitted by the parties without apparent argument. The supplied information which consisted of appellant's certificate of discharge from active duty and what appears to be a current pay statement.

The commissioner subsequently entered a report finding that the amended separation agreement had not been incorporated into the dissolution decree, but it was nevertheless enforceable as a contract between the parties; that the parties had been married for almost exactly nineteen years or 228 months; that it appeared from the supplied documentation that appellant retired with 24 years of military service or 288 months. Applying the cited formula to these findings, the commissioner concluded that dividing the months of marriage by the months of service equaled 79% and that appellee was entitled to 50% of that amount, or 39.6%. She then noted that because appellant was an E-8 both at the time of divorce and at the time of retirement, appellee was entitled to 39.6% of appellant's presently payable benefits, but that a specific dollar amount had not been provided.

Appellant filed objections to the report alleging that the commissioner did not properly apply the *Poe* formula in that she failed to take into account the difference in appellant's pay rate from the amount owing at the time of the decree to the amount as of the date of retirement. Appellant also contended that the commissioner erroneously omitted four months from the total months of military service. The trial judge, after a brief hearing on the objections, entered orders overruling appellant's objections and awarding appellee 39.6% of appellant's divisible military retirement benefits.

Appellee's motion, supported by her affidavit, simply stated that pursuant to the parties' separation agreement, which had been incorporated into the dissolution decree, she was entitled to 50% of appellant's military retirement benefits. In her report, the commissioner stated that the matter was submitted to her on January 7, 2003 and that she utilized documentation supplied by appellee's counsel on that date in reaching her recommendation on appellee's motion. That documentation consisted of two items: appellant's certificate of release or discharge from active duty and an earnings statement for the period ending October 31, 2002. The number 25 was supplied in the block for years of service on the earnings statement and appellant's discharge from active duty contained a service record total of twenty-four years and four months in one section and a slightly bolder statement of 24 years, 0 months service as an armor senior sergeant in another section.

Relying upon this documentation and the parties' separation agreement, the commissioner concluded that appellee was entitled to 50% of the benefits accrued during the marriage. The commissioner arrived at that amount of benefits accrued during the marriage by dividing 24 years or 288 months of military service by the 228 months of marriage, which equaled 79% under the *Poe* calculation. The commissioner then divided the 79% figure by 50% pursuant to the parties' agreement, for an award of 39.6%. The commissioner then noted that because appellant was an E-8 at the time of divorce and that he was an E8 when he retired, appellee was entitled to 39.6% of his present payable benefits.

Finally, we do not agree with appellant's argument concerning the proper method of applying *Poe* to the facts. Appellant's most persuasive argument is that the commissioner should have used a denominator of 292 months in the initial *Poe* equation, rather than 288 months. As noted previously, the finding of 288 was reasonable based upon the information supplied the commissioner. Furthermore, even if we were to agree that 292 is the correct denominator, the result would be a difference of only .6 percent, an amount we find to be de minimus under the facts presented. Thus, we agree with the trial judge that the commissioner's findings and conclusions comport with the information presented to her prior to issuance of the report. Accordingly, the judgment overruling appellant's objections to that report is affirmed.

WILLS

MAKING A WILL

A will is a revocable transfer to take effect on death. Wills have been with us since the first days of recorded history. Archaeologists have found 4500-year-old hieroglyphics leaving property to others in Egyptian tombs. Bible readers recall that Jacob left Joseph a larger inheritance than his brothers received, and the trouble that caused. Whether in ancient Egypt or modern America, all wills are different. What you put in yours depends on what property you have, whom you want it to go to, the dynamics of your family, and so on.

THE SEVEN ESSENTIALS OF A VALID WILL

To be valid, your will doesn't have to conform to a specific formula. For example, in states that recognize handwritten wills (not Kentucky), some wills scrawled on the back of an envelope have stood up in court. However, there are certain elements that usually must be present.

1. You must be of legal age to make a will. This is 18 in most states, but may be several years older or younger in some places --check with a lawyer if you need to know.
2. You must be of sound mind, which means that you should know you're executing a will, know the general nature and extent of your property, and know the objects of your bounty, i.e. your spouse, descendants and other relatives that would ordinarily be expected to share in your estate. Although you do not have to be found mentally incompetent by a court for your will to be challenged on the grounds of incompetence, the law presumes that a testator was of sound mind, and the standard for proving otherwise is very high--much more than mere absent-mindedness or forgetfulness. Because disgruntled relatives who want to challenge a will occasionally use this sound-mind requirement to attack the testator's mental capacity, in special cases the execution of a will is sometimes videotaped and kept on file, so if someone raises a question after the testator dies, the videotape can be good evidence of testamentary capacity.
3. The will must have a substantive provision that disposes of property, and it must indicate your intent to make the document your final word on what happens to your property--that is, that you really intended it to be a will.
4. The will must be voluntarily signed by the testator, unless illness or accident or illiteracy prevents it, in which case you can direct that your lawyer or one of the witnesses sign for you. This requires a lawyer's guidance, or at least knowledge of your state's law, since an invalid signature could void a will.
5. Although oral wills are permitted in limited circumstances in some states, wills must usually be written and witnessed. The will scrawled on an envelope won't work in these states. To be safe, don't handwrite a will if you can avoid it.
6. Though some states do allow informal oral and written wills in certain circumstances, all states have standards for formal wills. Writing a formal will and following these standards helps assure that your wishes will be followed after your death. In almost all states, the signing of a formal will must be witnessed by at least two adults who understand what they are witnessing and are competent to testify in court. There have to be three in Vermont and New Hampshire, three plus a notary in Puerto Rico. In most states the witnesses have to be disinterested (i.e., not getting anything in your will). If they aren't, you run the risk of voiding certain provisions in the will, opening it to challenge, or invalidating the entire will.
7. A formal will must be properly executed, which means that it contains a statement at the end attesting that it is your will, the date and place of signing, and the fact that you signed it before witnesses, who then also signed it in your presence--and watched each other signing it. Most states allow so-called self-proving affidavits, which eliminate the necessity of having the witnesses testify that they witnessed the signing; the affidavit is proof enough. In other states, if the witnesses are dead or unavailable, the court may have to get someone else to verify the legitimacy of their signatures.

If your will doesn't meet these conditions, it might be disallowed by a court, and your estate would then be distributed according to a previous will or under your state's intestacy laws.

WHO CAN WRITE A WILL

Legally, you don't have to use a lawyer to write your will. If it meets the legal requirements in your state, it is valid whether or not you wrote it with a lawyer's help. Nonetheless, studies show that more than 85% of Americans who have wills used a lawyer's help in preparing them.

Below are your alternatives and considerations to take into account in deciding which to use.

Doing it yourself

Several alternatives are absolutely free but not often used. For example, oral wills are permissible in less than half the states, sometimes under very limited circumstances, such as when they are uttered in your final illness. Also, oral wills often apply only to personal property.

Handwritten, unwitnessed wills are valid in about half the states and effective to dispose of more kinds of property. Nonetheless, they're not recommended. Since they rarely follow legal formalities, it's sometimes hard to prove that they are intended to be wills, or intended to be your last will, and they are vulnerable to fraud and they often don't cover all the testator's assets.

Soldiers' and seamen's wills are permitted by about half the states. They allow people actually serving in the armed forces to dispose of their wages and personal property orally or in an informal written document. Often they're only valid during wartime, when the willmaker is in a hostile zone, and they usually cease to be valid after a certain time that varies by state.

Statutory wills are another free alternative available in a few states. A statutory will is a form that has been created by a state statute. Since the statutory will includes all the formalities, all you have to do is get a copy at a stationery store, fill it out, have it witnessed, and you have a valid will. Unfortunately, these wills are very limited. They assume you want to leave everything to your spouse and children and provide for few other gifts. And you must follow the form--they can't legally be changed.

In recent years, a number of books and computerized will kits have come on the market which claim to enable you to make your own will. The cost of a book may run \$20 or more, the cost of a kit \$70 or more. For simple estates--involving little money and other assets, and in which everything is to go to few people--they might be a viable alternative. However, make sure that a given book or kit is up-to-date and thorough, especially since probate laws vary from state to state. The kits are easier than the books to fit into your estate plan--they typically take you through a will with computer prompts that enable you to alter the document to fill typical needs.

Doing it this way may not be easy. Do-it-yourself books and kits, some lawyers say, have caused more work for lawyers (and bills for clients) than they have avoided. There's a famous case about one man who thought he'd get two wills for the price of one will kit. He made a form will for himself, then took that and substituted his wife's name for his own in the signature clause and the introductory clause. But he failed to change the name of the beneficiaries--meaning that when his wife died, she left all her property to herself! This one, of course, ended up in court, at

a substantial cost to the surviving husband.

Once you begin totaling up all your assets, you may be surprised to find that your estate is larger than you thought. At the same time, family relationships are becoming more complicated. Today, a do-it-yourself will might not do the job.

Using a lawyer

The cost of having a will drawn up professionally depends on the size and complexity of your estate, the going rates for lawyers in your area, your lawyer's experience, and so on.

About 74 million Americans belong to group legal service plans. These plans enable members to get legal services either free or at reduced cost. In many programs simple wills are either free or cost far less than the going rate. More comprehensive estate planning and preparation of other documents are available from lawyers at a reduced hourly rate. About 90% of plans are available to members of certain organizations (like AARP, the military or a union), or to workers in certain industries as a result of collective bargaining agreements. Some of these plans have no fee at all to the participant; others may have a modest fee. About 10% of plans are available to individuals, including one through the Signature Group of Montgomery Ward's.

Legal clinics are another low-cost alternative. They can prepare your will for modest amounts because legal assistants do much of the work under a lawyer's guidance. That work often consists of adapting standard computerized forms to fit the needs of the client. If you have a small, simple estate, the cost may be modest, and you may have the benefit of professional advice and reassurance that your will meets the standards for validity in your state.

If you want to use a private lawyer, many will give you the first consultation free. Ask one to give you a price or range of prices for preparing a will or estate plan; it might be cheaper than you think. Often, lawyers have a written fee schedule for various kinds of wills. If yours doesn't, before you give the final go-ahead to draw up your will, ask the estimated cost (or at least a range of likely costs).

You should most certainly use a lawyer if you own a business, if your estate exceeds \$1 million (making tax planning a factor under current law), or if you anticipate a challenge to the will from a disgruntled relative or anyone else.

As noted in chapter one, a skillfully drawn will generally saves you money in the long run. By giving the executor (the person you choose to administer your estate after you die) authority to act efficiently, by saying that a surety bond will not be required and by directing that the involvement of the probate court be kept to a minimum, you can save your family money.

WRITING A WILL

Freedom of disposition

After your lawyer has a good idea of what you want and what your assets are, he or she will probably suggest various options to help you achieve those objectives. In general, you can pick whom you want your property to go to and leave it in whatever proportions you want.

There are exceptions, however. For example, a surviving husband or wife may be entitled to a statutory share of the estate regardless of the will. This is a percentage set by state law. (You or your spouse can voluntarily give up this legal protection in a prenuptial agreement.) Otherwise, you can disinherit anyone, but if you're disinheriting a family member, you should do so specifically, not by omission. In some states surviving spouses are entitled by law to the family home as a homestead right. Though your spouse can try to give it to someone else in the will, you have to approve or the property is yours.

And some states limit how much you can leave to a charity if you have a surviving spouse or children, or if you died soon after making the provision (under the assumption someone exerted undue influence on you).

Most states impose some restrictions on conditions listed in wills that are bizarre, illegal or against public policy of the state. For example, if you wanted to set up an institute to promote terrorism and violent overthrow of the government, the probate court would probably throw out the bequest.

Some people try to make their influence felt beyond the grave by attaching conditions to a gift made in the will (as opposed to the purely advisory language in a letter of intent). Most lawyers advise against this; courts don't like such conditions, and you're inviting a will contest if you try to tie them to a gift. You can't require your daughter to divorce her no-account husband to claim her inheritance from you; nor can your husband make your inheritance contingent on a promise you'll never remarry; nor can you force that secular humanist son-in-law to go to church every Sunday. For the most part, though, it's your call.

CLAUSE-BY-CLAUSE

There's no set formula for what goes into a will. There are some things you might want to think about if you fall into certain categories--younger couples, older couples, single people, divorced people, and so on. Chapters six and seven discuss some of the needs and options different people might have in planning their estates.

Below are the more common clauses of a basic will, following the order of clauses of the sample will in this chapter, to illustrate some typical will contents. Funeral expenses and payment of debts

Your debts don't die with you; your estate is still liable for them, and your executor needs no authority to pay them off.

If your debts exceed your assets, your state law will prescribe the order in which the debts must be paid by category. Funeral expenses and expenses of administration usually get first priority. Family allowances, taxes, and last illness expenses will also appear near the top of the list. If you want certain creditors to be paid off first, ask your lawyer how to ensure this will happen in light of your state's particular law.

As for funeral directions, while you can put them in your will, be aware that the will might not be found until after you're buried. It's best to put these in a separate document.

You can also forgive any debts someone owes you by saying so in your will.

Gifts of personal property

It's important to carefully identify all recipients of your largesse, including their address and relationship to you. There are too many cases of people leaving property to "my cousin John," not realizing that more than one person might fit that description. Or you leave something to "my sister's husband," and she later divorces him and remarries--who gets the gift? A court might have to decide.

If you have several children or other relatives in the same category (cousins, siblings, etc.), and you want them to divide your estate or some portion of it equally, you should state that you are giving the gift to the class ("my cousins") not to them as individuals ("Mutt and Jeff"). That way, if one of them dies, the others would take the whole gift. Otherwise, the dead cousin's heirs would take his share of the gift. On the other hand, if you definitely do want a beneficiary's children to take a gift if he predeceases you, you would use language that indicates this, typically "to my cousins, A, B, and C and their issue, per stirpes." This is technical territory, but the main thing to remember about gifts to a class is this: if you have several beneficiaries, use language that will account for the possibility of one of the class members dying before you do. For similar reasons, you should usually be specific about the gifts you are making. Don't just leave "household property" to someone, because that category is vague enough to spark a dispute in court, or at least in the family. Spell out the items ("stereo equipment, clothing, books, cash"), or just omit any mention at all and let them pass through the residuary clause (discussed below).

On the other hand, in cases where the specific item of property might change between the time you write the will and the time you die, you might want to be more general in your phrasing—leaving your son not "my 1986 Yugo" but "the car I own when I die." The same applies to stocks or bank accounts; the bank may be taken over by another bank; the stock may be sold. Better to include a general description or leave a dollar amount or fractional share.

Make sure the language you use in giving the gift is unambiguous: "I give..." "I direct that..." and so on. Wishy-washy terms like "It is my wish that..." might be taken to be merely an expression of hope, not an order. At the very least, such precatory language could invite a court challenge.

In general, it's simpler for your executor if you leave your property to people in broad but specific categories ("all my furniture") rather than passing it on it piece-by-piece ("my kitchen table") to many different people. If you want specific gifts of sentimental value to go to certain people, consider giving them to those people before you die, so you can witness their pleasure (and, if your estate is large, lower estate taxes). Or, some attorneys advise leaving most items to one or two people, and then writing a letter of intent that advises those people about how you want them to spend that money or distribute those items. Some states have laws providing for these letters but some do not. That means **LETTERS OF INTENT MAY NOT BE LEGALLY BINDING**. Use them only with people you can trust. (One way to handle specific bequests of personal property is through a tangible personal property memorandum or TPPM).

Remember also that personal property can include intangible assets like insurance policies (for instance, if you own a policy on your spouse's life, that policy and cash value of the premiums paid into it can be passed on through your will), bank accounts, certain employee benefits, and stock options.

Finally, if you have multiple beneficiaries you want to share in a gift, be careful to specify what percentage of ownership each will have. If you don't, the court will probably presume that you intended the beneficiaries to share equally. Most lawyers counsel against shared gifts, because it means several people have to agree on use of the property, and one co-owner may be able to force a sale. But there are some indivisible assets--a house, typically--where you may have little choice but to let more than one person share in the gift. If so, talk to the beneficiaries first and make sure they agree on how they'll jointly use and manage the gift. And be sure to designate alternative beneficiaries (usually the others who will share in the gift) in case one of them dies before you do.

You can save on taxes by using gifts wisely. This section of your will can be used to give gifts to institutions and charities as well as to people.

Gifts of real estate

Most people prefer that their spouses receive the family home. If the home is not held in joint tenancy (survivorship), you should have instructions about what will happen to it in your will.

It is possible to give what lawyers call a life estate. This is giving something to a person, to use for as long as he or she lives but that reverts to your estate or passes to someone else after he or she dies (see chapter two for more on this). It's a way of assuring, for example, that your husband will have the use of your house while he lives, but that it will pass to the children of your first marriage after he dies. The rules governing such transfers, or any transfers different from a fee simple outright transfer of ownership, are so complicated that you must use a lawyer to make such a gift properly.

If you die before you've paid off the mortgage on your house, your estate will normally have to pay it off. If you're afraid this will drain the estate too much, or if you want the recipient of the house to keep paying on the mortgage, you must specify that in your will. If you haven't paid off the family house, and you're afraid your survivors can't afford to, you may be able to buy mortgage-canceling insurance to pay it off.

Executors

It helps to spell out certain powers the executor (or, as he or she is called under the laws of some states, the personal representative) can have in dealing with your estate: to buy, lease, sell and mortgage real estate; to borrow and lend money; to exercise various tax options. Giving the executor this kind of flexibility can save months of delay and many dollars by allowing him or her to cope with unanticipated situations. If you run a business, be sure to give your executor specific power to continue the business-or enter into new business arrangements. If you don't, the law may require that the business be liquidated or sold.

Residuary clause

This is one of the most crucial parts of a will, covering all assets not specifically disposed of by the will. You will probably accumulate assets after you write your will, and if you haven't specifically given an asset to someone, it won't pass through the will--unless you have a residuary clause that, as Lyndon Johnson used to say of grandmother's nightdress, covers everything. (If your will omits a residuary clause, the assets not left specifically to anyone would pass on through the intestate succession laws, after long delays and extensive court

involvement.) No matter how small your residuary estate seems at the time you write your will, you should almost always leave it to the person you most care about.

The residuary clause distributes assets that you mightn't have anticipated owning. For example, normally anything you own in joint tenancy would pass automatically to the other tenant at your death, and so you wouldn't include it in your will. But what if the joint tenant has died before you? Your estate now probably owns the entire asset, and your residuary clause would ensure that it goes to someone you care about.

Testamentary Trusts

As we'll see in the next chapter, you can set up a testamentary trust in your will, or have your will direct funds from your estate into a trust you had previously established (your will would then be a pour-over will). You would normally do so in a separate clause in your will.

AFTER THE WILL IS WRITTEN

Executing the will

After you've drawn up your will, there remains one step: the formal legal procedure called executing the will. This requires witnesses to your signing the will. In all states, the testimony of at least two witnesses is needed as proof of the will's validity. In some states, the witnesses must actually show up in court to attest to this, but in a growing number of states, a will which is formally executed with the signatures notarized (and a self-proving affidavit attached) is considered to be self-proved and may be used without testimony of witnesses or other proof.

Who should you pick to be your witnesses? The witnesses should have no potential conflict of interest-which means they should absolutely not be people who receive any gifts under the will, or who might benefit from your death. You needn't bring them with you to your lawyer's office; typically, some employees of your lawyer will witness the signing. You should sign every page of the original. The witnesses will watch you sign the will and then sign a statement attesting to this.

Where to keep your will

It's not a bad idea to make a few unsigned copies of your will and have them available for ready reference, but to avoid confusion; you should sign only one original. This--and only this--is your legally valid will. Keep it in a safe place, such as your safe deposit box or your lawyer's office. Some jurisdictions will permit you to lodge the will with the probate court for a nominal fee, but in some places, that makes the will a public record. If privacy is paramount for you, you should ask your lawyer or the probate office how best to accomplish this.

You should also keep a record of other estate planning documents with your will, such as a trust agreement, IRAs, insurance policies, income savings plans such as 401(k) plans, government savings bonds (if payable to another person), and retirement plans.

What if you lose your will? Have your lawyer draw up a new will as soon as possible, and execute it with all the necessary formalities. If your family situation, state of residence, or income hasn't changed, your lawyer should be able to use copies of your lost will as a guide.

While many people keep their wills in their safe deposit boxes at a bank, in some jurisdictions the law requires those boxes to be sealed immediately after death, until the estate is sorted out.

Needless to say, if your will is inside that box--or your cemetery deeds and burial instructions—sorting things out might get pretty complicated. If you do keep it in a safe deposit box, make sure to provide that someone else (and certainly the executor you name) can get at the will when you die. Tell your executor and your beneficiaries where the will is located, and make sure your executor, or someone you trust, has authority (and a key!) to open the box after your death. Many estates have gone through long probate delays because the bank didn't have permission to let anyone open the safe deposit box except the person who had just died. If you name a bank as executor or co-executor, deliver the original will to the bank for safekeeping.

It's OK to store copies of the will in your home. Personal papers such as your birth certificate, citizenship records, marriage certificate, coin collections, jewelry, heirlooms, medals and so on may be kept in your safe deposit box. Financial records, like securities, mortgage documents, contracts, leases and deeds are also safe to store.

What about a trust agreement? Unlike a will, a trust may have more than one original, in which case, there will be language saying something like, "This trust is executed in four counterparts, each of which has the force of an original." Your trustee, successor trustee, and lawyer should each have a copy. And every time you amend the trust, be sure to have the amendment in a separate copy so indicated and signed by you. Unless the amendment is a complete restatement of the trust (i.e., a complete reworking of the trust), attach an executed copy to each signed copy of the trust, if possible.

KINDS OF WILLS

Here's a brief glossary of terms used in the law for various kinds of wills:

Simple Will: A will that just provides for the outright distribution of assets for an uncomplicated estate.

Testamentary Trust Will: A will that sets up one or more trusts for some of your estate assets to go to after you die.

Pourover Will: A will that leaves some of your assets in a trust that you had already established before your death.

Holographic Will: A will that is unwitnessed and in the testator's handwriting. About 20 states recognize the validity of such wills.

Oral Will (also called nuncupative will): A will that is spoken not written down. A few states permit these.

Joint Will: One document that covers both a husband and wife (or any two people). These are often a big mistake and are especially inadvisable for estates larger than \$675,000.

Living Will: Not really a will at all--since it has force while you are still alive and doesn't dispose of property--but often executed at the same time you make your will. Tells doctors and hospitals whether you wish life support in the event you are terminally ill or as a result of accident or illness cannot be restored to consciousness.

TRUSTS

Like a will, a trust is a very useful instrument in the estate-planning arsenal. Estates can be as diverse as people, and the flexibility of a trust makes it useful for many different needs. A trust can do a number of things a will can't do as well, including:

- manage assets efficiently if you should die and your beneficiaries are minor children or others not up to the responsibility of handling the estate;
- protect your privacy (unlike a will, a trust is confidential);
- depending on how it is written, and on state law, a trust can protect your assets by reducing taxes;
- if it is a living trust, the trustee can manage property for you while you're alive, providing a way to care for you if you should become disabled. A living trust also avoids probate, lowers estate administration costs, and speeds transfer of your assets to beneficiaries after your death.

Should you have a trust? It depends on the size of your estate and the purpose of the trust. For example, if you mainly want a living trust to protect assets from taxes and probate, but your estate is under the current federal tax floor and small enough to qualify for quick and inexpensive probate in your state, some lawyers would tell you it isn't worth the cost. If, however, you want to avoid a court hearing if you become incompetent or unable to provide for yourself or you want to provide for grandchildren, minor children, or relatives with a disability that makes it difficult for them to manage money, a trust has many advantages.

WHAT IS A TRUST?

A trust is a legal relationship in which one person (or qualified trust company) (trustee) holds property for the benefit of another (beneficiary). The property can be any kind of real or personal property--money, real estate, stocks, bonds, collections, business interests, personal possessions and automobiles. It is often established by one person for the benefit himself or of another. In those cases, it generally involves at least three people: the grantor (the person who creates the trust, also known as the settler or donor), the trustee (who holds and manages the property for the benefit of the grantor and others), and one or more beneficiaries (who are entitled to the benefits).

It may be helpful to think of a trust as a contract between the grantor and the trustee. The grantor makes certain property available to the trustee, for certain purposes. The trustee (who often receives a fee) agrees to manage the property in the way specified.

Putting property in trust transfers it from your personal ownership to the trustee who holds the property for you. The trustee has legal title to the trust property. For most purposes, the law looks at these assets as if they were now owned by the trustee. For example, many trusts have separate taxpayer identification numbers. But trustees are not the full owners of the property. Trustees have a legal duty to use the property as provided in the trust agreement and permitted

by law. The beneficiaries retain what is known as equitable title, the right to benefit from the property as specified in the trust.

The donor may retain control of the property. If you set up a revocable living trust with yourself as trustee, you retain the rights of ownership you'd have if the assets were still in your name. You can buy anything and add it to the trust, sell anything out of the trust, and give trust property to whomever you wish.

If you set up the trust by your will to take effect at your death--a testamentary trust--you retain the title to the property during your lifetime, and on your death it passes to the trustee to be distributed to your beneficiaries as you designate.

We speak of putting assets "in" a trust, but they don't actually change location. Think of a trust instead as an imaginary container. It's not a geographical place that protects your car, but a form of ownership that holds it for your benefit. On your car title, the owner blank would simply read "the Richard Petty trust." It's common to put whole bank and brokerage accounts, as well as homes and other real estate, into a trust.

After your trust comes into being, your assets will probably still be in the same place they were before you set it up--the car in the garage, the money in the bank, the land where it always was--but it will have a different owner: the Richard Petty trust, not Richard Petty.

HOW DO TRUSTS OPERATE?

There is no such thing as a standard trust, just as there's no standard will. You can include any provision you want, as long as it doesn't conflict with state law. The provisions of a written trust instrument govern how the trustee holds and manages the property. That varies greatly depending on why the trust was set up in the first place.

In a living trust, the grantor may be the trustee and the beneficiary. In trusts set up in your will, the trustee is often one or more persons or, for larger estates where investment expertise is required, a corporate trust company or bank.

Trusts can be revocable (that is, you can legally change the terms and end the trust) or irrevocable. Later chapters, particularly chapter five, discuss the practical effects of each. **Here it's enough to say that a revocable trust gives the donor great flexibility but no tax advantages.** If the trust is revocable and you are the trustee, you will have to report the income from the trust on your personal income tax return, instead of on a separate income tax statement for the trust. The theory is that by retaining the right to terminate the trust, you have kept enough control of the property in it to treat it for tax purposes as if you owned it in your name.

Irrevocable trusts are the other side of the coin--far less flexibility but possible tax benefits. The trustee must file a separate tax return.

Trusts can be very simple, intended for limited purposes, or they can be quite complex, spanning two or more generations, providing tax benefits and protection from creditors of the beneficiary, and displacing a will as the primary estate planning vehicle.

WHO NEEDS A TRUST?

Parents with young children

If you have young children, want to assure a good education for them, and will have enough assets to do so after death (including life insurance proceeds), you should consider setting up a trust. The trustee manages the property in the trust for the benefit of your children during their lifetime or until they reach the ages that you designate. Then any remaining property in the trust may be divided among the children. This type of arrangement has an obvious advantage over an inflexible division of property among children of different ages without regard to their respective ages or needs.

Trusts are more flexible than giving outright gifts to minors in your will (which requires a guardian) or a gift under the Uniform Transfer to Minors Act, which requires appointment of a custodian and transfers of property to the child at age 18. Issues to consider when setting up a trust for the benefit of your children:

One Trust or Many?

Most people will set up one trust that all the children can draw on, until they've completed their educations (or reached an age by which they should have done so).

Then the remaining principal is divided among them equally. This permits the trustee greater flexibility to distribute ("sprinkle") the money unequally according to need; for example, one child may choose to pursue an advanced degree at an expensive private university, while another may drop out of community college after a semester. Obviously, they will have different educational expenses. Where very young children are involved, it's especially important to build in some flexibility; who knows if a two-year-old may turn out to need special counseling or education by the time he turns five or six?

There are two philosophies about what to do if there's a disparity in ages among the children. One theory is that the older children have already received the benefit of the parents' spending before they died, so the trustee should have authority to make unequal distributions in favor of the younger children to compensate. The other camp, by contrast, thinks it better to establish separate trusts, so that the older children don't have to wait until they're well into adulthood before the trust assets are distributed (which usually happens when the youngest child reaches majority age). You'll have to decide which course is best for your family's circumstances.

Generally speaking, the less money you have to distribute, the more likely you would put it all in one trust. Since there is a limited amount of money, you want to pool it to be sure that it goes for the greatest need. On the other hand, if equality is your primary consideration and there's plenty of money available to take care of each child's likely needs, then you may want to set up separate trusts for each child, to assure that each gets an equal share.

What should the assets be used for?

You can specify that the trust pay for education, health care, food, rent, and other basic support. Given life's unpredictability, however, it's often better to write a vague standard (e.g., "for the support of my children") into the document and allow the trustee the discretion to decide if an expenditure is legitimate. Such a provision also gives the trustee flexibility.

For example, if one of your children has an unanticipated expenditure, like a serious illness, the trustee could give him more money that year than the other children.

When should the assets be distributed?

Some parents pick the age of majority (18) or the age when a child will be out of college (22 or so). If all the assets are in one trust that serves several children, you would usually have the assets distributed when the youngest child reaches the target age. If you have separate trusts and a pretty good idea about each child's level of maturity, you can pick the age that seems appropriate for each one to receive his or her windfall.

If you don't know when each child will be capable of handling money, you can leave the age of distribution up to the trustee (and risk friction between the trustee and the children), have the trustee distribute the assets at different times (say, half when the first child turns 25 and the rest when the youngest does so), or just pick an age for each child, such as 30.

Like any trust, a children's trust costs money to set up: lawyers' fees for creating the trust, fees for preparing and filing the separate tax returns required, and so on. For families of limited assets, it might be best to give the money via a custodial account under the Uniform Gift to Minors Act or the Uniform Transfers to Minors Act.

People with beneficiaries who need help Trusts are especially popular among people with beneficiaries who aren't able to manage property well. This includes elderly beneficiaries with special needs or a relative who may be untrustworthy with money. For example, if you have a granddaughter who has been in a juvenile detention center, it may be a good idea to require her to obtain the money at intervals from a trustee instead of giving her a gift outright in your will. A discretionary trust gives the trustee leeway to give the beneficiary as much or as little he or she thinks appropriate.

Another type of trust is for improvident beneficiaries a spendthrift trust. It's simply a trust in which your instructions to the trustee carefully control how much money is released from the trust and at what intervals, so you can keep an irresponsible beneficiary from the temptation of getting thousands of dollars in one stroke. You can stipulate that the trustee will pay only certain expenses for the beneficiary--those you (or the trustee) consider legitimate, such as rent and utility bills. In a spendthrift trust the beneficiary cannot assign his or her interest in the trust, and creditors of the beneficiary can't get at the principal in a trust, but can make a claim (if it's otherwise legal) on whatever income the beneficiary receives. Spendthrift provisions raise a number of tricky questions and should be used cautiously—your lawyer can tell you whether such a trust is right for your situation.

People who own property that is hard to divide

Trusts help you transfer property that's not easy to divide evenly among several beneficiaries.

Suppose you have a little vacation cottage on the Cape, and four children who each want to use it. You can pass it to them in a trust that sets out each child's right to use the property, establishes procedures to prevent conflicts, requires that when the property is sold the trustee divide the proceeds evenly (or unevenly, if some children aren't as well off as others), and sets up a procedure by which any child may buy out another's interest in the cottage. People who want to control their property because of family dynamics.

Through a trust, you can maintain more control over a gift than you can through a will. Some people use trusts to pass money to a relative when they have doubts about that person's spouse. For example, you love your son, but don't trust his wife, Livia. You're afraid she'll spend the money you give him on astrologers and shoes. Leave the money in trust for your son instead of making a direct gift to him, and you can direct that he get only the income, so neither he nor his wife can squander the principal. In many states, if you leave money in trust to your son, Livia can not get at the assets if they divorce. Moreover, he can choose how much, if any, of the trust income or principal to leave Livia; if she hasn't been a good and faithful companion, he can leave the whole thing to whomever he desires.

People concerned about estate taxes

Trusts are very useful to people with substantial assets, because they can help avoid or reduce estate taxes. For example, by establishing a trust for their benefit, you can make tax-free gifts (up to the limit allowed by law) each year to your children or grandchildren during your lifetime, even if they're minors. This will reduce your taxable estate and save taxes upon your death. A properly drawn trust may also reduce estate taxes by utilizing the marital deduction or avoiding the generation skipping tax.

SETTING UP A TRUST

If you establish one in your will, the trust provisions are contained in that document. If you create a trust during your lifetime, its provisions are contained in the trust agreement or trust declaration. The provisions of that trust document (not your will or state law) will determine what happens to the property in the trust upon your death. With any type of trust, one of the most important issues is choosing the trustee.

Funding the trust

A testamentary trust is funded after your death, with assets that you've specified in your will and through beneficiary designations of your life insurance, IRA, and so on. Such trusts generally receive most of the estate assets, such as the proceeds from the sale of a house. Or you could set up an "unfunded" standby trust. This is a trust that could be called "minimally" funded to avoid confusion. It may have a nominal sum of money in it--\$100 or so--to get it started while you're alive (and thus make it a living trust), but it only receives substantial assets when you die. Your pour-over will would direct that many or all of your assets be transferred from your estate to the trust at your death.

Life insurance payable to the trust, as well as designating the trust as the beneficiary of IRAs, profit-sharing plans, and so on, will pass these assets directly to the trust outside of probate. However, other assets not already owned by the trust when you die will have to go through probate. This is why many lawyers shy away from unfunded trusts, unless probate avoidance isn't the primary goal (see chapter eleven for some reasons why you might not want to avoid probate).

If your estate--with life insurance benefits included--will add up to more than \$1 million, you can save taxes by removing the life insurance proceeds from your estate and establishing an irrevocable life insurance trust that owns the policy; all incidents of ownership in the policy

belong to the trust. When you die, the proceeds are paid into the trust, escaping estate taxation and creditors in so far as the insurance policy is concerned.

Trusts and taxes

Chapter eight discusses death and taxes, and trusts are a major part of that discussion. However, there are a few basic principles worth mentioning here. While gifts under the \$1 million level (in a trust or in a will) escape federal estate taxation, the recipients of the trust income will still have to pay income tax when they receive income from the trust. They would not have to pay tax on the principal in the trust when they collected it (unless their state has an inheritance tax).

The trustee pays, out of the principal, the taxes on income from the trust that's reinvested or put back into the principal. Capital gains from the sale of stock, real estate, and the like are generally added to the principal unless you specify otherwise.

The choice of trustee can affect the tax the trust owes. If the beneficiary is made the only trustee, some of the tax advantages of the trust can be lost. Similarly, the more powers the grantor retains, the more likely the assets in the trust will be taxable, either during the grantor's life as income tax or after death as estate tax. Consult your attorney or a tax advisor before setting up any trust for tax purposes.

Terminating a trust

Only charitable trusts can last indefinitely. Since trusts of this sort are established to accomplish a substantial benefit to the public, it is entirely appropriate that Rhodes scholarships, Pulitzer and Nobel prizes, and thousands of other awards and grants be funded by trusts that are expected to endure.

Private trusts--set up to benefit private beneficiaries --cannot last forever. The rule against perpetuities, which is embodied in state law and may vary somewhat from state to state, is designed to limit the time a trust may be operative. Usually it specifies that a trust can last no longer than the life of a person alive at the time the trust is created, plus 21 years. So if you set up a trust to benefit your infant granddaughter and any children she may eventually have, and she has a long life, your trust may extend 100 years, but not much more.

Your trust agreement should contain a clause that provides how it can be terminated. A good trust drawn up by a lawyer will certainly have such a clause.

A trust often terminates when the principal is distributed to the beneficiaries, at the time stated in the trust agreement. For example, you might provide that a trust for the benefit of your children would end when the youngest child reaches a certain age. At that time, the trustee would distribute the assets to the beneficiaries according to your instructions. The law generally allows a "windup phase" to complete administration of trust duties (e.g., filing tax returns) after the trust has officially terminated.

You can also give your trustees the discretion to distribute the trust assets and terminate the trust when they think it's a good idea, or place some restrictions on their ability to do so. For example, you could allow the trustees to terminate the trust in their discretion, provided that your daughter has completed her education.

Your trust should have a termination provision even it is an irrevocable trust. "Irrevocability" means that you, the donor, can't change your mind about how you want the trust to terminate. It doesn't mean that you can't set up termination procedures in the first place. If you have an irrevocable trust and don't have a termination provision, it can usually terminate only if all beneficiaries consent and no material purpose of the trust is defeated.

However, an irrevocable trust can also be terminated if there was fraud, duress, undue influence or other problems when the trust was set up; if the trustee and the beneficiary become the same person; if the operation of the trust becomes impracticable or illegal; or if the period of time specified in state law expires. We're obviously into technical territory here, so the basic rule is, don't set up an irrevocable trust unless you're prepared to live--and die--by its terms.

CONSUMER TIP

When you approach a lawyer to help you set up a trust, make sure he or she is willing to work with you to tailor the trust to your particular needs; otherwise the primary benefit of trusts--their flexibility--is wasted.

It's another reason to avoid those prefabricated, all-purpose trusts you see in self-help books and at seminars. A good lawyer will provide you with a financial analysis to show how much you might save over time by structuring your trust in certain ways.

Make sure you choose a lawyer who's familiar with estate planning, trusts, and, if your trust is used for saving taxes, tax law. IRS regulations governing trusts change often, and the agency has always given trusts special scrutiny.

WHAT LAW APPLIES IF I SET UP A TRUST AND THEN MOVE TO ANOTHER STATE?

State law governs trusts. If the trust involves real estate, the law of the state where the property is located applies. If it's personal property, like a car or money, or most other things, the law of the state where the grantor created the trust will probably control. If you have residences in more than one state, you can provide in your trust which of those states' laws will control the disposition of your real property.

KINDS OF TRUSTS

Charitable trusts are created to support some charitable purpose. Often these trusts will make an annual gift to a worthy cause of your choosing, simultaneously helping good causes and reducing the taxes on your estate.

Discretionary Trusts permit the trustee to distribute income and principal among various beneficiaries or to control the disbursements to a single beneficiary, as he or she sees fit.

Insurance Trusts are tax-saving trusts in which trust assets are used to buy a life insurance policy whose proceeds benefit the settlor's beneficiaries.

Living Trusts enable you to put your assets in a trust while still alive. You can wear all the hats--donor, trustee, and beneficiary--or have someone else be trustee and have other beneficiaries.

Medicaid qualifying trusts are trusts that may help you qualify for federal Medicaid benefits by placing certain property in a trust, sometimes limiting your assets for Medicaid purposes. This device is mostly used when family members are concerned with paying the costs of nursing home care. It is dealt with in chapter twelve.

Revocable trusts are simply ones that can be changed, or even terminated, at any time by the donor. (Though most living trusts are revocable, a living trust and a revocable trust are not synonymous).

Irrevocable trusts cannot be changed or terminated before the time specified in the trust, but the loss of flexibility may be offset by savings in taxes.

Spendthrift trusts can be set up for people whom the grantor believes wouldn't be able to manage their own affairs--like an extravagant relative, or someone who's mentally incompetent. They may also be useful for beneficiaries who need protection from creditors.

Support trusts direct the trustee to spend only as much income and principal as may be needed for the education and support of the beneficiary.

Testamentary trusts are set up in wills.

Totten trusts are not really trusts at all. They're simply bank accounts that pass to a beneficiary immediately upon your death.

Wealth trusts are tax-saving trusts that benefit several generations of your descendants.

FIVE OTHER REASONS TO HAVE A TRUST

- 1. Trusts are generally more difficult to contest than wills.**
2. Trusts can be flexible; you can authorize that payments fluctuate with the cost of living, allow extra withdrawals in case of emergency, or even set a standard figure for payment each year; if the income doesn't meet that amount, the difference can be made up out of the principal.
3. Or you can use them to impose discipline on the beneficiary. You could require the beneficiary to live within a set figure, getting a certain amount of income each year, regardless of inflation, need, or the stock market's effect on the principal.
- 4. Trusts are sometimes set up in divorce, for example to provide for the education of the couple's children.**
- 5. Trusts can also be helpful if you want to make a major charitable gift but wish to retain some use of the property.**

KY STATUTES

391.010 Descent of real estate.

When a person having right or title to any real estate of inheritance dies intestate as to such estate, it shall descend in common to his kindred, male and female, in the following order, except as otherwise provided in this chapter:

- (1) To his children and their descendants; if there are none, then
- (2) To his father and mother, if both are living, one (1) moiety each; but if the father is dead, the mother, if living, shall take the whole estate; if the mother is dead, the whole estate shall pass to the father; if there is no father or mother, then
- (3) To his brothers and sisters and their descendants; if there are none, then
- (4) To the husband or wife of the intestate; if there are none surviving, then
- (5) One (1) moiety of the estate shall pass to the paternal and the other to the maternal kindred, in the following order:
 - (a) The grandfather and grandmother equally, if both are living; but if one is dead, the entire moiety shall go to the survivor; if there is no grandfather or grandmother, then
 - (b) To the uncles and aunts and their descendants; if there are none, then
 - (c) To the great-grandfathers and great-grandmothers, in the same manner prescribed for grandfather and grandmother by subsection (a); if there are none, then
 - (d) To the brothers and sisters of the grandfathers and grandmothers and their descendants; and so on in other cases without end, passing to the nearest lineal ancestors and their descendants.
- (6) If there is no such kindred to one of the parents as is described in subsection (5), the whole to go to the kindred of the other. If there is neither paternal nor maternal kindred, the whole shall go to the kindred of the husband or wife, as if he or she had survived the intestate and died entitled to the estate.

391.030 Descent of personal property --Exemption for surviving spouse and children -- Withdrawal of money from bank by surviving spouse.

- (1) Except as otherwise provided in this chapter, where any person dies intestate as to his or her personal estate, or any part thereof, the surplus, after payment of funeral expenses, charges of administration, and debts, shall pass and be distributed among the same persons, and in the proportions, to whom and in which real estate is directed to descend, except as follows:
 - (a) The personal estate of an infant shall be distributed as if he or she had died after full age;
 - (b) An alien may be distributee as though he or she were a citizen; and
 - (c) Personal property or money on hand or in a bank or other depository to the amount of fifteen thousand dollars (\$15,000) shall be exempt from distribution and sale and shall be set apart by the District Court having jurisdiction over the estate on application to the surviving spouse, or, if there is no surviving spouse, to the surviving children.**
- (2) The surviving spouse may, at any time before the property or money is set apart by the court, procure on petition from the Judge of the District Court having jurisdiction over

administration of the estate, an order authorizing the surviving spouse to withdraw from any bank or other depository not exceeding one thousand dollars (\$1,000) belonging to the estate of the deceased. Upon presentation of the order, the bank or depository shall permit the surviving spouse to withdraw the sum and shall lodge the order, endorsing thereon the amount withdrawn, with the circuit clerk who shall retain it in his or her files to be considered in connection with further proceedings in the estate and the withdrawal shall be treated as a charge against the property of the estate exempt from distribution.

(3) In the application for the setting apart of property or money under subsection (1) of this section, the surviving spouse or, if there is no surviving spouse, the surviving children may make their selection out of the personal property of the estate to the extent that the value of the property selected does not exceed the amount of fifteen thousand dollars (\$15,000).

(4) The exemption provided in this section applies where the husband or wife dies testate.

391.040 Descendants of distributees take per stirpes.

When any or all of a class first entitled to inherit are dead, leaving descendants, such descendants shall take per stirpes the share of their respective deceased parents.

DEFINITION: Per Stirpes – A method of determining who inherits property when a joint beneficiary has died before the willmaker, leaving living children of his or her own. For example, Fred leaves his house jointly to his son Alan and his daughter Julie. But Alan dies before Fred, leaving two young children. If Fred's will states that heirs of a deceased beneficiary are to receive the property "per stirpes," Julie will receive one-half of the property, and Alan's two children will share his half in equal shares (through Alan by right of representation).

393.020 Property subject to escheat

If any property having a situs in this state has been devised or bequeathed to any person and is not claimed by that person or by his heirs, distributees, or devisees within three (3) years after the death of the testator, or if the owner of any property having a situs in this state dies without heirs or distributees entitled to it and without disposing of it by will, it shall vest in the state, subject to all legal and equitable demands.

Any property abandoned by the owner, except a perfect title to a corporeal hereditament, shall vest in the state, subject to all legal and equitable demands. Any property that vests in the state under this section shall be liquidated, and the proceeds, less costs, fees, and expenses incidental to all legal proceedings of the liquidation shall be paid to the department.

394.020 Persons competent to make - What may be disposed of.

Any person of sound mind and eighteen (18) years of age or over may by will dispose of any estate, right, or interest in real or personal estate that he may be entitled to at his death, which would otherwise descend to his heirs or pass to his personal representatives, even though he becomes so entitled after the execution of his will.

394.040 Requisites of a valid will.

No will is valid unless it is in writing with the name of the testator subscribed thereto by himself, or by some other person in his presence and by his direction. If the will is not wholly written by the testator, the subscription shall be made or the will acknowledged by him in the presence of at least two (2) credible witnesses, who shall subscribe the will with their names in the presence of the testator, and in the presence of each other.

394.080 Revocation of will -- How effected.

No will or codicil, or any part thereof, shall be revoked, except:

- (1) By subsequent will or codicil;
- (2) By some writing declaring an intention to revoke the will or codicil, and executed in the manner in which a will is required to be executed; or
- (3) By the person who made the will, or some person in his presence and by his direction, cutting, tearing, burning, obliterating, canceling, or destroying the will or codicil, or the signature thereto, with the intent to revoke.

394.210 Attesting witness -- Effect of subsequent incompetency of or devise to.

- (1) If any person who attests the execution of a will shall, after its execution, become incompetent to be admitted as a witness to prove its execution, the will shall not, on that account, be invalid.
- (2) If a will is attested by a person to whom, or to whose wife or husband, any beneficial interest in the estate is devised or bequeathed, and the will cannot otherwise be proved, such person shall be deemed a competent witness; but such devise or bequest shall be void, unless such witness would be entitled to a share of the estate of the testator if the will were not established, in which case he shall receive so much of his share as does not exceed the value of that devised or bequeathed.
- (3) A will may be proved by the testimony of one (1) of the subscribing witnesses without regard to the availability or competency of the other witnesses, provided said will was acknowledged or subscribed by the testator in the presence of two (2) witnesses at the same time.

WILLS & TRUSTS CASES

Bye v Mattingly, 975 SW2d. 451 (KY 1998)

Background

The testator, William Louis McQuady, and Alberta Beavin McQuady were married for forty-five years prior to Ms. McQuady's death on March 23, 1989. In October of 1988, the McQuadys executed identical wills which left the surviving spouse in possession of the entire estate. In the event that there was no surviving spouse, all realty was to pass to Richard Keith McQuady, a second cousin once removed to William McQuady, and all personalty was to pass to Samuel Thomas Beavin, brother of Alberta Beavin McQuady. Accordingly, on Ms. McQuady's death, the

entire estate passed to Mr. McQuady.

Following his wife's death, Mr. McQuady retained Mary Ruth Bye, appellant in this matter, to act as his housekeeper. Mr. McQuady was unable to see and required assistance to overcome this disability. During their marriage, Ms. McQuady had performed all tasks related to maintaining the household and Ms. Bye was to perform these tasks as part of her duties. Ms. Bye assumed her position as housekeeper in May of 1989.

On July 17, 1989, Mr. McQuady, accompanied by Ms. Bye, visited Herbert O'Reilly of Hardinsburg who had drafted the 1988 wills the McQuadys had executed. Mr. McQuady executed a new will that left his entire estate, save a hundred dollar bequest to St. Mary of the Woods Church, to Ms. Bye.

Subsequent to the execution of the 1989 will, Ms. Bye arranged for a garage to be constructed on Mr. McQuady's property. Following completion of the garage Mr. McQuady's car was never actually stored in the garage. However, at trial Ms. Bye testified that her car was periodically parked inside the garage. The relevance of this event was that it sparked concern in Mr. Beavin and Mr. Richard McQuady with regard to the use of Mr. William McQuady's money by Ms. Bye. The construction of the garage concerned Mr. Beavin and Richard McQuady as the McQuadys had lived in a frugal fashion during their forty-five year relationship and Mr. McQuady possessed an older automobile which had never been garaged in the past.

On May 18, 1990, the petition of Mr. Beavin and Mr. Richard McQuady to appoint a guardian/conservator for William McQuady was heard. As a result of that hearing the Breckinridge District Court appointed Mr. Beavin as a Limited Conservator and Limited Guardian for Mr. McQuady. Following the hearing, Mr. McQuady's health declined and he was admitted to the hospital on September 21, 1990. Mr. McQuady was diagnosed as suffering from Alzheimer's disease. It should be noted that the effects of Alzheimer's disease can be accentuated by poor health and/or poor treatment.

After Mr. McQuady was diagnosed with Alzheimer's disease, a petition seeking to permit Mr. McQuady to marry Ms. Bye was filed with the Breckinridge District Court. On May 17, 1991, a hearing was held in Breckinridge District Court to determine whether the petition of William McQuady to marry Ms. Bye should be granted. At that hearing Mr. McQuady testified that although he had signed the petition, he was misled in regard to the nature of the document. Mr. McQuady stated that he was told by the Byes not to worry about it and just sign it. The document was prepared by Ellen Bye, daughter of appellant.

During the course of this hearing, Mr. McQuady emphatically stated that he did not want to get married to Ms. Bye. He also stated that he was afraid of Ms. Bye. The court denied the petition to marry. Ms. Bye's services as housekeeper were subsequently terminated.

Five months after the hearing on the petition to marry, Mr. McQuady executed a new will. The net effect of the will executed October 29, 1991, was to re-enact the will he had executed in 1988, in effect leaving his personalty to Mr. Beavin and his realty to Mr. Richard McQuady. The 1991 will was drafted by Alton Cannon and was executed in his office. Richard McQuady drove William McQuady to Mr. Cannon's Law Offices, but Richard McQuady never participated in any discussion or activities regarding the will.

William McQuady and Mr. Cannon privately discussed the will that Mr. McQuady desired. When the will was actually executed Mr. Cannon, Mrs. Sheila Cannon and William McQuady were the

only three persons present.

On August 7, 1992, William McQuady died. Mr. Beavin was appointed executor of McQuady's estate. Appellant then brought the instant action, challenging the validity of the 1991 will on grounds of undue influence and lack of testamentary capacity. Mr. Beavin died on October 5, 1993 and Sylvia Mattingly, Mr. Beavin's daughter, was appointed by the Breckinridge Circuit Court to serve as a party-defendant in place of Mr. Beavin in his capacity as executor.

Following a five day trial, a jury returned a unanimous verdict for appellees. During the course of the trial Judge Samuel Monarch, a sitting judge on the Breckinridge Circuit Court, was called by appellees to testify as a witness. Judge Monarch had not been listed by appellees on their witness list. Judge Monarch testified as to the honesty and veracity of his former partner in legal practice, Alton Cannon. Appellants appealed the verdict to the Court of Appeals. A divided panel upheld the trial court.

II Analysis

A. Lucid Interval

On July 9, 1990, William McQuady was adjudged partially disabled in the Breckinridge District Court. Appellants urge this Court to rule that the effect of such judgment was to remove McQuady's capacity to draft a will or in the alternative that a presumption against testamentary capacity was created by the judgment. We decline to make either such ruling.

In Kentucky there is a strong presumption in favor of a testator possessing adequate testamentary capacity. This presumption can only be rebutted by the strongest showing of incapacity. Testamentary capacity is only relevant at the time of execution of a will. Thus any order purporting to render a person per se unable to dispose of property by will is void *ab initio*, as such a ruling on testamentary capacity would be premature. This is not to say that such an order is irrelevant, but rather it is not dispositive of the issue of testamentary capacity.

"Kentucky is committed to the doctrine of testatorial absolutism ." The practical effect of this doctrine is that the privilege of the citizens of the Commonwealth to draft wills to dispose of their property is zealously guarded by the courts and will not be disturbed based on remote or speculative evidence. The degree of mental capacity required to make a will is minimal. The minimum level of mental capacity required to make a will is less than that necessary to make a deed, or a contract.

To validly execute a will, a testator must: (1) know the natural objects of her bounty; (2) know her obligations to them; (3) know the character and value of her estate; and (4) dispose of her estate according to her own fixed purpose. Merely being an older person, possessing a failing memory, momentary forgetfulness, weakness of mental powers or lack of strict coherence in conversation does not render one incapable of validly executing a will. "Every man possessing the requisite mental powers may dispose of his property by will in any way he may desire, and a jury will not be permitted to overthrow it, and to make a will for him to accord with their ideas of justice and propriety."

In the instant case Mr. McQuady executed wills in 1988, 1989 and 1991. Appellant seeks to have the 1991 will declared invalid as it was executed following the 1990 adjudgment of partial incapacity. While a ruling of total or partial disability certainly is evidence of a lack of

testamentary capacity, it is certainly not dispositive of the issue. This Court has upheld the rights of those afflicted with a variety of illnesses to execute valid wills.

We have not disturbed the testatorial privileges of those who believed in witchcraft, spiritualism or atheism. While none of these cases absolutely parallels the instant case, we recite them here to demonstrate how this Court has always taken the broadest possible view of who may execute a will no matter what their infirmity.

When a testator is suffering from a mental illness which ebbs and flows in terms of its effect on the testator's mental competence, it is presumed that the testator was mentally fit when the will was executed. This is commonly referred to as the lucid interval doctrine. Alzheimer's is a disease that is variable in its effect on a person over time. It is precisely this type of illness with which the lucid interval doctrine was designed to deal. By employing this doctrine, citizens of the Commonwealth who suffer from a debilitating mental condition are still able to dispose of their property.

The lucid interval doctrine is only implicated when there is evidence that a testator is suffering from a mental illness; otherwise the normal presumption in favor of testamentary capacity is operating. The burden is placed upon those who seek to overturn the will to demonstrate the lack of capacity. The presumption created is a rebuttable one, so that evidence which demonstrates conclusively that the testator lacked testamentary capacity at the time of the execution of the will results in nullifying that will.

In the present case there is no question that Mr. McQuady suffered from Alzheimers disease. However, under the doctrine he is presumed to have been experiencing a lucid interval during the execution of the will. The wisdom of this doctrine is demonstrated by Mr. McQuady's testimony during the hearing on the petition for marriage in Breckinridge District court. During that hearing Mr. McQuady was very lucid and demonstrated a complete grasp of the circumstances in which he found himself. Appellant has failed to offer this Court evidence which demonstrates that the testator did not have a lucid interval during which he executed the 1991 will. In sum, let it suffice to say that in the instant case a presumption of a lucid interval of testamentary capacity was appropriate.

Given this Court's consistent attitude toward the virtually absolute right of the citizens of the Commonwealth to make wills, it would be incongruous for us now to announce a new rule of law which restricted these rights which we have held in such high regard for so long. While the clear policy of the Commonwealth is that our citizens who are no longer able to fully care for themselves must be protected from the various societal predators, we will restrict their testamentary rights only when it is absolutely necessary and even then only to the degree required to defend their interests.

B. Undue Influence

Undue influence is a level of persuasion which destroys the testator's free will and replaces it with the desires of the influencer. In discerning whether influence on a given testator is "undue", courts must examine both the nature and the extent of the influence. First, the influence must be of a type which is inappropriate. Influence from acts of kindness, appeals to feeling, or arguments addressed to the understanding of the testator are permissible. Influence from threats, coercion and the like are improper and not permitted by the law.

Second, the influence must be of a level that vitiates the testator's own free will so that the testator is disposing of her property in a manner that she would otherwise refuse to do. The essence of this inquiry is whether the testator is exercising her own judgment.

In addition to demonstrating that undue influence was exercised upon the testator, a contestant must also show influence prior to or during the execution of the will. Undue influence exercised after the execution of the will has no bearing whatsoever upon whether the testator disposed of her property according to her own wishes.

The influence must operate upon the testator at the execution of the will. If the influence did not affect the testator, then such conduct is irrelevant. However, even if the influence occurred many years prior to the execution of the will, but operates upon the testator at the time of execution, it is improper and will render the will null and void.

To determine whether a will reflects the wishes of the testator, the court must examine the indicia or badges of undue influence. Such badges include a physically weak and mentally impaired testator, a will which is unnatural in its provisions, a recently developed and comparatively short period of close relationship between the testator and principal beneficiary, participation by the principal beneficiary in the preparation of the will, possession of the will by the principal beneficiary after it was reduced to writing, efforts by the principal beneficiary to restrict contacts between the testator and the natural objects of his bounty, and absolute control of testator's business affairs.

Applying these badges to the 1991 will, it is clear that no undue influence was present. Given the fact that a partial disability order was in place when the will was executed, there is no question that the testator was physically and mentally weak. Similarly, since a disability order was in place, Mr. Beavin had complete control of the testator's business affairs. However, none of the other badges are present with respect to the 1991 will.

When a contestant seeks to claim that undue influence was employed upon a testator, the burden is upon the contestant to demonstrate the existence and effect of the influence. Merely demonstrating that the opportunity to exert such influence is not sufficient to sustain the burden of proof. When undue influence and a mentally impaired testator are both alleged and the mental impairment of the testator is proven, the level of undue influence which must be shown is less than would normally be required since the testator is in a weakened state.

In Kentucky no presumption of undue influence arises from a bequest by a testator who has a confidential relationship with the beneficiary. There is no question when a testator who has a confidential relationship with one who receives a benefit under a will, such a transaction should certainly be examined and placed into evidence before the jury, but no presumption of wrongdoing is created. In fact, it is not uncommon or inappropriate for a testator to make such a bequest to one who has provided comfort and support to the testator.

We wish to note that in making this ruling we are not disturbing the well-settled rule that a contract between a guardian and ward does indeed create a presumption against the transaction which must be rebutted by the guardian with clear and convincing evidence. The distinction between a bequest in a will and a transaction between two parties is that a will gift does not involve conflicting interests. However, in a transaction, the parties are placed in an adversarial relationship in which each party is attempting to maximize his or her own benefit without regard to the other. Accordingly, all contracts between a ward and guardian are due a

much higher level of scrutiny and thus the presumption against them is created.

Accordingly, since no presumption against the validity of the 1991 will exists, the burden was on the appellant to show that the 1991 will was procured through undue influence. A jury unanimously found that the 1991 will was not procured by undue influence. Nothing appellant has offered this Court even comes close to rising to the level necessary to set the jury's verdict aside. This Court is particularly disinclined to set aside a jury's decision in which it has found a will to be valid.

Appellant's argument, based on the idea that because the testator had been adjudicated as mentally infirm, he was more susceptible to undue influence, is indeed an interesting one. However, for some reason appellant urges this Court not to examine the 1989 will, procured under suspicious circumstances (under which she benefitted) but rather only apply its undue influence analysis to the 1991 will. We decline her invitation to do so. If testator was in a mentally feeble condition in July of 1990, then it is certainly possible--in fact likely--that he was in a similar condition one year earlier when he willed his entire estate to appellant. We find appellant's argument unpersuasive. However, as we find no undue influence in the execution of the 1991 will, we have no occasion to fully review the circumstances surrounding the enactment of the 1989 will.

There is a presumption which has some potential application to the instant case. In those instances in which a will is grossly unreasonable and the principal beneficiary actively participated in its execution, a presumption of undue influence arises. If the contestant can offer evidence of such activities, then the burden of persuasion shifts to the proponents of the will, but it does not relieve the contestants of the continuing burden of proof.

The executions of the 1989 and 1991 wills are virtually identical in their facts. In 1989, Ms. Bye drove the testator to a lawyer and Ms. Bye was not privy to the drafting nor execution of the will. Following the execution ritual, Ms. Bye drove the testator home. In 1991, the same circumstance was repeated with Mr. Beavin driving testator to and from the lawyer's offices. Under neither of these circumstances can we say that Ms. Bye nor Mr. Beavin actively participated in the execution of the respective wills. Accordingly, this presumption does not apply in the instant case.

New v Creamer, 275 SW.2d 918 (KY 1955)

This is a will contest. The testator died at the age of 79, having executed a will one year prior thereto leaving an estate of approximately \$8,500. He devised and bequeathed all of his property to his only son and left nothing to his only daughter. The jury found against the will, and the significant issue on this appeal is whether or not there was sufficient evidence of the lack of mental capacity to submit the question.

It was and is the contention of the contestant that the unnatural disposition made by the will, certain statements of the testator, some seemingly unusual conduct, his antipathy toward his son-in-law, and other circumstances constituted substantial evidence of the mental incapacity of the testator at the time he made his will.

The apparent unnatural disposition of all of his property to his son with the consequent disinheriting of his daughter is clearly explained by the record. The testator had an extreme aversion to his daughter's husband. The latter had from time to time been involved in several

kinds of trouble, the testator had disapproved of the marriage, and he envisioned that any property left to his daughter would be dissipated by his son-in-law. Whether or not the testator should have taken a more kindly attitude toward his son-in-law or whether or not his property would have been dissipated, it was established beyond question that in making his will the testator had a very definite purpose which had no semblance of irrationality. His antipathy toward his son-in-law was not of that baseless and extravagant character which would suggest an insane delusion.

A person has a free choice in determining the objects of his bounty, and mere inequality of disposition alone does not prove anything. Since the apparent unnaturalness of this will is so fully explained and justified, the nature of the disposition is no evidence at all of the lack of mental capacity.

It is next contended by the contestant that because the testator had told his daughter he was leaving property to her and because the will was inconsistent with such expressed intention, there is an indication of irrationality. It appears to us perfectly normal for a person to change his mind or even to do at a later date something contrary to his earlier expressed intention. The proof on this point does not show lack of mental capacity.

The strongest proof of what may be termed unusual conduct on the part of the testator related to his general debility in the declining year of his life. The testator's wife died four months before he made the will, and he passed on about a year after it was executed. The testimony of his daughter, who of course is the interested party, indicates that from the time of her mother's death until her father's death he progressively showed the signs of old age. He lived by himself and became slovenly in his habits with respect to keeping house, preparing his meals and keeping up his personal appearance. Whereas earlier in life he had always been neat and clean, it became difficult to persuade him to change his clothes, to take baths and to do other things which might normally be expected of him. Apparently he did not use his bathroom in the proper manner and was very careless about his personal habits. He burned things on the stove, and at one time thought someone was trying to steal his property. He became forgetful and on occasion did not recognize his daughter or close neighbors.

There are two reasons why this proof has little or no force with respect to the testator's mental capacity. In the first place, the contestant's witnesses, including herself, did not fix the times when the events occurred or the actions were observed *with relation to the time the will was executed*. In the second place, the facts shown do not indicate an abnormal course of conduct but rather a lack of stability which generally comes with old age. The fact that a person grows old, his habits change, or he is unable to administer to his wants in the best manner without the help of a wife who has cared for him most of his life does not constitute substantial evidence of the lack of mental capacity.

The contestant undertook to prove over the objection of the contestees that the testator attempted to make an oral arrangement with his son whereby his daughter would eventually share in his estate. The contestant claims that this proposed arrangement, inconsistent with the will, showed lack of mental capacity. As we view this evidence it tended to prove quite the contrary. It indicated the testator still recognized his daughter as a natural object of his bounty, though he remained firm in his purpose not to leave property to her under the will which might come into the hands of her husband.

The right of a person to make a will disposing of his property in accordance with his own wishes is one carefully guarded by the courts. This right would be of little value if it could be exercised only in accordance with a court's or a jury's notion of what would be the just and proper thing to do. The presumption is that a testator possesses sufficient mental capacity to make a will, and the burden is upon a contestant to establish by substantial evidence the lack of it. We think the proof in this case falls short of showing lack of mental capacity, and a verdict should have been directed upholding the will. .

Teater v Newman, 472 SW.2d 696 (KY 1971)

Background

Mrs. Owens was an elderly widow who resided in her home on South Upper Street, in Lexington. For many years, Mrs. Owens had been addicted to the use of narcotics which she received legally by prescription from her physician. Over the course of years, the decedent became a friend of her physician's office assistant, Mrs. Rebecca Ross. At Mrs. Owens' request, Mrs. Ross contacted her son, Paul, who is an attorney, for the purpose of assisting her in the preparation of a will.

Paul Ross contacted Mrs. Owens, but she was so wary of anyone knowing about her intentions that she refused to give him the information necessary to prepare a will. Instead, Paul Ross left with Mrs. Owens a typewritten skeleton or form that she was to use in writing her own will. This skeleton was typed on two pages of legal sized paper (8 1/2 by 13).

On September 14, 1965, Paul Ross and his father returned to Mrs. Owens' home for the purpose of witnessing a will. Mrs. Owens had several sheets of paper, but Paul Ross saw only a single page which contained a place for Mrs. Owens' signature and a typewritten attestation clause. The paper was then duly executed.

Mrs. Owens subsequently broke her hip, which resulted in her becoming an invalid. In late August or early September, 1967, Mrs. Owens employed Mrs. Nora Yarber as a companion. The two women did not know each other before this time. Mrs. Yarber received \$12.50 per week, plus room and board. During October, Mrs. Owens told Mrs. Yarber that she was providing for Mrs. Yarber in her will. On one occasion Mrs. Yarber saw Mrs. Owens sign her name to a sheet of paper which the decedent identified as being a part of her will although Mrs. Yarber never saw any of the contents.

In early November, 1967, Mrs. Owens was admitted to the hospital. While there, Mrs. Owens told Mrs. Yarber to go to a desk in her house where she would find her will. Mrs. Yarber found a sealed envelope in the desk which she delivered to a neighbor, Mrs. Faye Teater, for safekeeping. Shortly before Mrs. Owens died, Mrs. Teater delivered the sealed envelope to Paul Ross.

When Ross opened the envelope to examine the contents, he found a total of eight pages. Some of the pages were folded together, others were not, so as to form three separate sets of papers. Ross did not know the order in which the sets were found when he removed them from the envelope. For convenience, the Court will refer to them as Set A, Set B and Set C, without intending to indicate their sequence within the envelope.

Set A consisted of the two typewritten pages which Paul Ross had prepared as a will outline or skeleton for Mrs. Owens in August, 1965. These two pages were folded together separately from the others.

Set B consisted of the page which was signed by Mrs. Owens on September 14, 1965, and witnessed by Paul Ross and his father. This page was a sheet of plain white paper approximately 8 1/2 inches by 11 inches. Mrs. Owens' signature appears on a typewritten line approximately 3 3/4 inches from the top. Beneath the signature is a typewritten attestation clause which recites:

“Signed and acknowledged by Addie Owens to be her last will and testament .”

The original typewritten date in the attestation clause was '10 day of March 1959.' With a ballpoint pen Mrs. Owens had inserted the numerals '62' in the year. However, all the date had been blocked out with a blue ballpoint pen, and Mrs. Owens had written the date '14 September 1965', also with a blue ballpoint pen. Mrs. Owens' signature and that of Paul Ross and his father were all written in black ink with a fountain pen. According to Paul Ross, this attestation page (Set B) was folded in half vertically from top to bottom and folded roughly into thirds by two horizontal folds. As thus folded, it measured roughly 5 inches by 3 3/4 inches.

Set C consisted of five sheets of ruled, loose leaf, notebook paper which measured approximately 8 inches by 10 1/2 inches. According to Ross, the five sheets of Set C had been folded together by first making a horizontal fold into halves and then again horizontally into quarters. An thus folded, Set C measured 8 inches by 3 3/4 inches.

The five pages are entirely in the handwriting of Addie Owens. The first page is not numbered but it is apparent that it precedes the others. The other pages are numbered at the top 2, 3, 4 and 5. The first page commences with the date 'September 14, 1965' and is followed by an introductory paragraph which recites that it is the decedent's will. This is followed by paragraphs numbered 2, 3, 4 and 5. On page two appears paragraphs numbered 6 and 7. Paragraphs numbered 8 and 9 appear on page three and a paragraph numbered 10 appears on page 4. The paragraphs on page five are unnumbered.

The five pages of Set C are unusual in a number of ways. The first page contains no dispositive clauses at all but repeats some of the clauses contained in the will form furnished by Paul Ross (Set A). Yet, page two commences with a testimonium clause which is also dated September 14, 1965. Immediately beneath the testimonium clause, paragraph 6 provided that Rebecca Ross, Faye Teater and Nora Yarber are to make her funeral arrangements. Since Addie Owens did not know Mrs. Yarber until August or September of 1967, it is obvious that the remainder of the five pages was written long after September 14, 1965. The next pages contain a number of specific bequests. It should be noted that on page three, she divides her accounts in the Second National Bank amount Rebecca Ross, Faye Teater and Nora Yarber. On page five, she bequeaths her jewelry to Rebecca Ross and her home to Nora Yarber.

On page one, all but the last two lines are filled by writing. Page two is signed by Mrs. Owens at the bottom, her signature being separated by seven lines from the last writing on the page. Pages three and four are also signed at the bottom by the decedent and the signatures are separated from the writing above by only a single line. However, page five is not signed and ten blank lines separate the last writing from the bottom of the page.

One further feature of the pages in question must be disposed of. On the attestation page (Set B) the typewritten numbers '666' appear immediately above the decedent's signature at the top of the page. Paul Ross testified that it was his recollection that he also prepared this page on his typewriter. In order to make a line on this typewriter, he stated that it was necessary to use the upper case of the 6 key. He accounted for the '666' by his failure to shift to the upper case. Therefore, the '666' at the top of the attestation page has no significance from the point of view of pagination.

On page two, Mrs. Owens wrote:

"This will is all rite as I have written this will with my own hands"

II Analysis

It is our opinion that the trial judge correctly held that the purported will was not executed in conformity with the statutory requirements, particularly the requirement of that the signature be 'subscribed at the end or close of the writing.

This court has said that the purpose of the requirement that the testator's signature be at the end or close of the will is 'to indicate that his testamentary dispositions had been fully and completely expressed. The purpose of such a requirement is 'to do away with the necessity of inquiring into the actual intention of the testator in writing his name in the body of the will, and to avoid inquiry as to whether the instrument in question is intended as a preliminary draft or as a final and complete instrument.'

It appears clear that the statute admits of no substitute for the proper placing of the signature as evidence of the completion of the testator's testamentary expression. The fact that the intention of the testator of making a completed testamentary disposition may be clear from other evidence, such as oral declarations or the placing of the signature on the outside of a sealed envelope containing the testamentary papers, is of no avail. Accordingly, the statement of Mrs. Owens, to Mrs. Yarber, that her will was in a desk in her house (where Mrs. Yarber found the envelope containing the purported will), cannot supply a deficiency in compliance with the statutory requirement as to the position of the signature.

The controlling question is whether the signature of Mrs. Owens was in fact at the end or close of the will. Her intent that it be there supplies nothing if the signature never in fact was there. The question has to do with actual presence at the time of execution .

There is no direct evidence in the record before us that the sheet bearing the signature ever was placed at the end or close of the will. The sheet was in the same envelope with the pages bearing dispositive provisions but it was folded separately, was on a different kind of paper, and gave indication, by a series of changed dates noted upon it (the last of which clearly preceded the writing of some of the dispositive provisions), that the testatrix several times had changed her mind about her testamentary dispositions.

The only basis on which it could be maintained that the sheet bearing the signature was in fact at the end or close of the will would be that the fact could be inferred from the mere presence of the sheet in the envelope, the inference being justified on the ground that logically there would be no reason for the testatrix to have put the signature sheet in the envelope unless she intended it to evidence a completion of her testamentary expression. One fallacy in that

proposition is that it rests on inferred intent rather than the statutory required direct evidence of intent from actual position of the signature.

Furthermore, we think that it is equally as probable that the signature sheet was placed or left in the envelope simply as one of Mrs. Owens' working papers, the same as the two-page outline prepared for her by Paul Ross. (Mrs. Owens' statement to Mrs. Yarber that her will was in the desk is no evidence that the signature sheet was ever made a part of the will, any more than was the two-page outline.) With two equal probabilities, neither one can rise to the force of an inference; both become mere possibilities.

Obviously, the signature in question was not written at the time the rest of the purported will was written. Nor was it affixed or appended to a final testamentary document on the last date entered on the sheet, because some of the dispositive provisions were written after that date. Therefore, in order for there to be a valid will, the signature sheet would have to have been affixed or appended at the end or close of the testamentary document at some unidentified time. It is our opinion that an inference that such affixing or appending was done would require a much stronger basis than would be required in a case where the separated or disconnected signature obviously was written simultaneously with the testamentary dispositions.

Sonner v Nall, 413 SW2d 334 (KY 1967)

I. Background

Mrs. J. T. Nall, who was the same person as Verna Nall, died on or about December 8, 1963, a resident of McLean County, Kentucky.

Several numbered handwritten sheets of tablet paper, the first of which bears the date October 10, 1960, and subscribed 'Mrs. J. T. Nall', were offered for probate in the McLean County Court, and were admitted to probate as the will of Mrs. J. T. Nall on December 21, 1963.

After the purported will of decedent was admitted to probate, appellants, Eura Nall Sonner and J. C. Nall, children of decedent, filed this action in the McLean Circuit Court against Eugene Nall, Gates Nall, Emogene Nall Atherton, also children of decedent, Marvin Eugene Carter, an infant and grandchild of decedent, and Gates Nall, the executor named in the purported will, seeking a judgment declaring the purported will null and void and of no effect because 'it is so ambiguous and indefinite that it fails to disclose a meaning or the intentions of the testator in any realistic sense.'

The parties to the action are all named as beneficiaries in the purported will, and we assume are all the heirs at law of the decedent.

By agreed order, the case was submitted to the court upon the record, and briefs of counsel. The circuit court entered judgment on March 29, 1966, adjudging 'that the paper offered for probate in the McLean County Court as the holographic will with codicils of Mrs. J. T. Nall, deceased, was properly admitted to probate by said court.' From this judgment, appellants have prosecuted this appeal.

II. Analysis

From reading the record, it appears that there is some misconception upon the question of when a purported will may or may not be admitted to probate. The rule as to admissibility of a writing to probate is thus stated in Moss et al. v. Hodges et al., 294 Ky. 677, 172 S.W.2d 584:

'Any writing executed with the formalities of a will, no matter in what form, if intended as a will, and not to take effect until the maker's death, may be construed as testamentary and admitted to probate, if revocable at any time at the pleasure of the maker.'

Matters of construction or interpretation of the instrument, as well as the validity of particular devises, are not to be considered by the probate court in determining whether an instrument should be admitted to probate.

The writing is admittedly wholly in the handwriting of decedent. It was intended by Mrs. Nall to be her will, for at its beginning she states, 'This is my last will'. The document is subscribed as required by statute, except as to some writing on the back of page 3. It is clear from a reading of the instrument that it is not intended to take effect until Mrs. Nall's death, and it is revocable at any time. It follows, therefore, that the writing was properly admitted to probate.

But the admission of the instrument to probate does not preclude an attack upon its validity by an action filed in the circuit court. Whether the purported will should be held void in toto because it is so uncertain, vague, ambiguous or illegible that the intention of decedent cannot be ascertained without resort to guesswork or speculation, or because one or more of its provisions violates the rule against perpetuities, or because one or more of its provisions are invalid for any reason, is the real question to be determined upon this appeal.

The original of the purported will is filed with the record. The court has read the several pages which are written in pencil, and while the instrument is by no means a model of penmanship, punctuation or grammar, the court does not find the document illegible. It is true, as contended by appellants, that where the entire purported will is so vague and indefinite that the decedent's intent as to all of the bequests and devises attempted to be made cannot be ascertained from the instrument itself without resort to speculation, then the court will declare the entire instrument void. But there are many wills which the courts have decided are partially valid and partially invalid.

Where a will contains both valid and invalid provisions, the will is never held null and void in its entirety, but is adjudged to be the will of testator, and is executed as to all of the provisions which are valid. In 57 Am.Jur., Wills, paragraph 38, it is said:

'The failure of one part of a will for invalidity or other cause does not affect those portions of it which are valid. Clearly, where a will has at least one valid clause bequeathing a plain and definite legacy, it may be entitled to probate notwithstanding the invalidity of the other provisions.'

At three places in the purported will, Mrs. Nall undertakes to devise a life estate in all her property to appellee, Eugene Nall. At page 1, she writes: 'I want Eugene Nall to have everything his lifetime.' At page 3, she states: 'Eugene is to have everything his lifetime.' And on the back of page 3: 'The land all goes to Eugene Nall his lifetime.'

It is thus made abundantly clear that the paramount concern of Mrs. Nall was the welfare of Eugene Nall, and the court finds no difficulty in holding that the above-quoted writings constitute a valid and binding devise of a life estate to Eugene Nall.

This is not an action seeking a construction of the purported will, but is an action to have the whole instrument declared void for uncertainty. Since a portion of the purported will is valid, and without determining the validity or invalidity of the remaining provisions of the instrument, we hold that the purported will under discussion is the true last will of Mrs. J. T. Nall.

Henderson v Thomas, 129 SW3d 853 (KY CA 2004)

I. Background

Ralph and Ruth Henderson were married to each other for about four years; but they were living separately when Ruth died on October 25, 1999. Several months before her death, Ruth confronted Henderson about his admitted marital infidelity. Henderson claims that following that confrontation, Ruth, knowing of her terminal medical condition and aided by her daughter Deanna, systematically disposed of personal property to defeat Ralph's spousal interest in it. Specifically, Henderson alleges that Ruth replaced his name with Deanna's as a joint owner with her of their mobile home, traded their jointly owned automobile, cashed their jointly owned certificate of deposit, and drained their joint checking account.

FN1. One of the issues looming for the trial of this case was the voluntariness of Henderson's leaving the marital home to live with another woman. KRS 392.090(2) provides that if either spouse voluntarily leaves the other and lives in adultery, the "offending party" forfeits the spousal share.

Ruth's will was probated and Deanna was appointed executrix in an order entered November 24, 1999. Ruth's will nominated Deanna as executrix and divided all of Ruth's property equally between her daughters, Deanna, and Mona Reynolds. Ruth left Henderson nothing by will. It is undisputed that Henderson did not attempt to renounce the will in the manner required by KRS 392.080(1). Instead, he filed suit in the Knox Circuit Court on April 4, 2000, demanding that Ruth's will be set aside and that the property she transferred be restored to her estate so that he could ultimately take his share of her property as her surviving spouse. He also demanded damages for fraud from Ruth's estate and from Deanna.

On the morning of the jury trial, the court granted Deanna's renewed motion to dismiss Henderson's complaint in its entirety. The sole basis stated by the court for the dismissal was Ralph's failure to renounce the will. This appeal eventually followed. In considering the propriety of the court's order terminating the litigation on a motion to dismiss, we must bear in mind that the moving party is not entitled to judgment unless it appears beyond doubt that the nonmoving party cannot prove any set of facts that would entitle him to relief.

II. Analysis

The crux of Henderson's suit is his entitlement to the surviving spouse's statutory share in the decedent's property created by KRS Chapter 392. In that chapter, the legislature has provided the surviving spouse with a "dower" or "curtesy" interest in the decedent's estate which he or she can assert, if there is a will, only by renouncing the will and releasing what is given to him or

her under the will, if anything. The circuit court's dismissal in the instant case rests upon Henderson's failure to follow, substantially or otherwise, the renunciation steps outlined in KRS 392.080(1), which states, in relevant part, that:

When a husband or wife dies testate, the surviving spouse may, though under full age, release what is given to him or her by will, if any, and receive his or her share under KRS 392.020 [surviving spouse's interest section] as if no will had been made.... Such relinquishment shall be made within six (6) months after the probate.... If, within those six (6) months, an action contesting the will is brought, the surviving spouse need not make such relinquishment until within six (6) months succeeding the time when the action is disposed of.

Contrary to Henderson's arguments, Kentucky cases hold that the surviving spouse's failure to renounce the will results in the loss of the right to claim the statutory share in the decedent's estate. This is true even when the will makes no provision for the surviving spouse. The further effect of Henderson's failure to renounce the will is the loss of standing to claim that the alleged fraudulent transfers Ruth made before she died deprived him of his statutory share.

Henderson raises an alternative theory that he did not present for consideration by the trial court: the filing of the complaint in circuit court within six months following the appointment of the personal representative tolled the running of the renunciation period until the circuit court action is concluded. Specifically, Henderson now asserts that words in the *ad damnum* paragraph of his complaint to the effect that Ruth's will should be set aside is sufficient to make this "an action contesting the will" to interrupt the running of the six months' time for renunciation.

We will not consider a theory of the case that is not preserved for appellate review. However, even if the issue were properly preserved, we would hold that it lacks merit. When a husband or wife dies testate, the renunciation process outlined in KRS 392.080(1) is the exclusive remedy by which the surviving spouse may make a claim to the statutory share. Since the relief Henderson is seeking here is his elective share, he cannot contest the will to get it.

TAXES

Pre-Retirement Taxes

Conventional wisdom holds that it's almost always better to invest in a tax-deferred vehicle like a 401(k) plan or IRA than in an after-tax investment. This holds that even if the initial investment itself is made with money that's already been taxed, the earnings accumulate untaxed, and this adds immeasurably to the positive power of compounding. Because your earnings (and often the contribution) are untaxed until you begin withdrawing money in retirement, the government is in effect providing you leverage in the investment. This allows you to amass far more money for retirement than you could in a taxable alternative. Additionally, you control when it gets taxed, and at what rate, by deciding on the amount of the withdrawal and when to take it. By contrast, in conventional investments, you are taxed on all money going in and on all dividends and gains in the year they are received.

History of Income Taxes

The federal, state, and local tax systems in the United States have been marked by significant changes over the years in response to changing circumstances and changes in the role of government. The types of taxes collected, their relative proportions, and the magnitudes of the revenues collected are all far different than they were 50 or 100 years ago. Some of these changes are traceable to specific historical events, such as a war or the passage of the 16th Amendment to the Constitution that granted the Congress the power to levy a tax on personal income. Other changes were more gradual, responding to changes in society, in our economy, and in the roles and responsibilities that government has taken unto itself.

Colonial Times

For most of our nation's history, individual taxpayers rarely had any significant contact with Federal tax authorities as most of the Federal government's tax revenues were derived from excise taxes, tariffs, and customs duties. Before the Revolutionary War, the colonial government had only a limited need for revenue, while each of the colonies had greater responsibilities and thus greater revenue needs, which they met with different types of taxes. For example, the southern colonies primarily taxed imports and exports, the middle colonies at times imposed a property tax and a "head" or poll tax levied on each adult male, and the New England colonies raised revenue primarily through general real estate taxes, excises taxes, and taxes based on occupation.

England's need for revenues to pay for its wars against France led it to impose a series of taxes on the American colonies. In 1765, the English Parliament passed the Stamp Act, which was the first tax imposed directly on the American colonies, and then Parliament imposed a tax on tea. Even though colonists were forced to pay these taxes, they lacked representation in the English Parliament. This led to the rallying cry of the American Revolution that "taxation without representation is tyranny" and established a persistent wariness regarding taxation as part of the American culture.

The Post-Revolutionary Era

The Articles of Confederation, adopted in 1781, reflected the American fear of a strong central government and so retained much of the political power in the States. The national government had few responsibilities and no nationwide tax system, relying on donations from the States for its revenue. Under the Articles, each State was a sovereign entity and could levy tax as it pleased.

When the Constitution was adopted in 1789, the Founding Fathers recognized that no government could function if it relied entirely on other governments for its resources, thus the Federal Government was granted the authority to raise taxes. The Constitution endowed the Congress with the power to "...lay and collect taxes, duties, imposts, and excises, pay the Debts and provide for the common Defense and general Welfare of the United States." Ever on guard against the power of the central government to eclipse that of the states, the collection of the taxes was left as the responsibility of the State governments.

To pay the debts of the Revolutionary War, Congress levied excise taxes on distilled spirits, tobacco and snuff, refined sugar, carriages, property sold at auctions, and various legal documents. Even in the early days of the Republic, however, social purposes influenced what was taxed. For example, Pennsylvania imposed an excise tax on liquor sales partly "to restrain persons in low circumstances from an immoderate use thereof." Additional support for such a targeted tax came from property owners, who hoped thereby to keep their property tax rates low, providing an early example of the political tensions often underlying tax policy decisions.

Though social policies sometimes governed the course of tax policy even in the early days of the Republic, the nature of these policies did not extend either to the collection of taxes so as to equalize incomes and wealth, or for the purpose of redistributing income or wealth. As Thomas Jefferson once wrote regarding the "general Welfare" clause:

To take from one, because it is thought his own industry and that of his father has acquired too much, in order to spare to others who (or whose fathers) have not exercised equal industry and skill, is to violate arbitrarily the first principle of association, "to guarantee to everyone a free exercise of his industry and the fruits acquired by it."

With the establishment of the new nation, the citizens of the various colonies now had proper democratic representation, yet many Americans still opposed and resisted taxes they deemed unfair or improper. In 1794, a group of farmers in southwestern Pennsylvania physically opposed the tax on whiskey, forcing President Washington to send Federal troops to suppress the Whiskey Rebellion, establishing the important precedent that the Federal government was determined to enforce its revenue laws. The Whiskey Rebellion also confirmed, however, that the resistance to unfair or high taxes that led to the Declaration of Independence did not evaporate with the forming of a new, representative government.

During the confrontation with France in the late 1790's, the Federal Government imposed the first direct taxes on the owners of houses, land, slaves, and estates. These taxes are called direct taxes because they are a recurring tax paid directly by the taxpayer to the government based on the value of the item that is the basis for the tax. The issue of direct taxes as opposed to indirect taxes played a crucial role in the evolution of Federal tax policy in the following years. When Thomas Jefferson was elected President in 1802, direct taxes were abolished and for the next 10 years there were no internal revenue taxes other than excises.

To raise money for the War of 1812, Congress imposed additional excise taxes, raised certain customs duties, and raised money by issuing Treasury notes. In 1817 Congress repealed these taxes, and for the next 44 years the Federal Government collected no internal revenue. Instead, the Government received most of its revenue from high customs duties and through the sale of public land.

The Civil War

When the Civil War erupted, the Congress passed the Revenue Act of 1861, which restored earlier excises taxes and imposed a tax on personal incomes. **The income tax was levied at 3 percent on all incomes higher than \$800 a year.** This tax on personal income was a new direction for a Federal tax system based mainly on excise taxes and customs duties. Certain inadequacies of the income tax were quickly acknowledged by Congress and thus none was

collected until the following year.

By the spring of 1862 it was clear the war would not end quickly and with the Union's debt growing at the rate of \$2 million daily it was equally clear the Federal government would need additional revenues. On July 1, 1862 the Congress passed new excise taxes on such items as playing cards, gunpowder, feathers, telegrams, iron, leather, pianos, yachts, billiard tables, drugs, patent medicines, and whiskey. Many legal documents were also taxed and license fees were collected for almost all professions and trades.

The 1862 law also made important reforms to the Federal income tax that presaged important features of the current tax. For example, a two-tiered rate structure was enacted, with taxable incomes up to \$10,000 taxed at a 3 percent rate and higher incomes taxed at 5 percent. A standard deduction of \$600 was enacted and a variety of deductions were permitted for such things as rental housing, repairs, losses, and other taxes paid. In addition, to assure timely collection, taxes were "withheld at the source" by employers.

The need for Federal revenue declined sharply after the war and most taxes were repealed. By 1868, the main source of Government revenue derived from liquor and tobacco taxes. The income tax was abolished in 1872. From 1868 to 1913, almost 90 percent of all revenue was collected from the remaining excises.

The 16th Amendment

Under the Constitution, Congress could impose direct taxes only if they were levied in proportion to each State's population. Thus, when a flat rate Federal income tax was enacted in 1894, it was quickly challenged and in 1895 the U.S. Supreme Court ruled it unconstitutional because it was a direct tax not apportioned according to the population of each state.

Lacking the revenue from an income tax and with all other forms of internal taxes facing stiff resistance, from 1896 until 1910 the Federal government relied heavily on high tariffs for its revenues. The War Revenue Act of 1899 sought to raise funds for the Spanish-American War through the sale of bonds, taxes on recreational facilities used by workers, and doubled taxes on beer and tobacco. A tax was even imposed on chewing gum. The Act expired in 1902, so that Federal receipts fell from 1.7 percent of Gross Domestic Product to 1.3 percent.

While the War Revenue Act returned to traditional revenue sources following the Supreme Court's 1895 ruling on the income tax, debate on alternative revenue sources remained lively. The nation was becoming increasingly aware that high tariffs and excise taxes were not sound economic policy and often fell disproportionately on the less affluent. Proposals to reinstate the income tax were introduced by Congressmen from agricultural areas whose constituents feared a Federal tax on property, especially on land, as a replacement for the excises.

Eventually, the income tax debate pitted southern and western Members of Congress representing more agricultural and rural areas against the industrial northeast. The debate resulted in an agreement calling for a tax, called an excise tax, to be imposed on business income, and a Constitutional amendment to allow the Federal government to impose tax on

individuals' lawful incomes without regard to the population of each State.

By 1913, 36 States had ratified the 16th Amendment to the Constitution. In October, Congress passed a new income tax law with rates beginning at 1 percent and rising to 7 percent for taxpayers with income in excess of \$500,000. Less than 1 percent of the population paid income tax at the time. Form 1040 was introduced as the standard tax reporting form and, though changed in many ways over the years, remains in use today.

One of the problems with the new income tax law was how to define "lawful" income. Congress addressed this problem by amending the law in 1916 by deleting the word "lawful" from the definition of income. As a result, all income became subject to tax, even if it was earned by illegal means. Several years later, the Supreme Court declared the Fifth Amendment could not be used by bootleggers and others who earned income through illegal activities to avoid paying taxes. Consequently, many who broke various laws associated with illegal activities and were able to escape justice for these crimes were incarcerated on tax evasion charges.

Prior to the enactment of the income tax, most citizens were able to pursue their private economic affairs without the direct knowledge of the government. Individuals earned their wages, businesses earned their profits, and wealth was accumulated and dispensed with little or no interaction with government entities. The income tax fundamentally changed this relationship, giving the government the right and the need to know about all manner of an individual or business' economic life. Congress recognized the inherent invasiveness of the income tax into the taxpayer's personal affairs and so in 1916 it provided citizens with some degree of protection by requiring that information from tax returns be kept confidential.

World War I and the 1920's

The entry of the United States into World War I greatly increased the need for revenue and Congress responded by passing the 1916 Revenue Act. The 1916 Act raised the lowest tax rate from 1 percent to 2 percent and raised the top rate to 15 percent on taxpayers with incomes in excess of \$1.5 million. The 1916 Act also imposed taxes on estates and excess business profits.

Driven by the war and largely funded by the new income tax, by 1917 the Federal budget was almost equal to the total budget for all the years between 1791 and 1916. Needing still more tax revenue, the War Revenue Act of 1917 lowered exemptions and greatly increased tax rates. In 1916, a taxpayer needed \$1.5 million in taxable income to face a 15 percent rate. By 1917 a taxpayer with only \$40,000 faced a 16 percent rate and the individual with \$1.5 million faced a tax rate of 67 percent.

Another revenue act was passed in 1918, which hiked tax rates once again, this time raising the bottom rate to 6 percent and the top rate to 77 percent. These changes increased revenue from \$761 million in 1916 to \$3.6 billion in 1918, which represented about 25 percent of Gross Domestic Product (GDP). **Even in 1918, however, only 5 percent of the population paid income taxes and yet the income tax funded one-third of the cost of the war.**

The economy boomed during the 1920s and increasing revenues from the income tax followed. This allowed Congress to cut taxes five times, ultimately returning the bottom tax rate to 1 percent and the top rate down to 25 percent and reducing the Federal tax burden as a share of GDP to 13 percent. As tax rates and tax collections declined, the economy was strengthened further.

In October of 1929 the stock market crash marked the beginning of the Great Depression. As the economy shrank, government receipts also fell. In 1932, the Federal government collected only \$1.9 billion, compared to \$6.6 billion in 1920. In the face of rising budget deficits which reached \$2.7 billion in 1931, Congress followed the prevailing economic wisdom at the time and passed the Tax Act of 1932 which dramatically increased tax rates once again. This was followed by another tax increase in 1936 that further improved the government's finances while further weakening the economy. By 1936 the lowest tax rate had reached 4 percent and the top rate was up to 79 percent. In 1939, Congress systematically codified the tax laws so that all subsequent tax legislation until 1954 amended this basic code. The combination of a shrunken economy and the repeated tax increases raised the Federal government's tax burden to 6.8 percent of GDP by 1940.

The Social Security Tax

The state of the economy during the Great Depression led to passage of the Social Security Act in 1935. This law provided payments known as "unemployment compensation" to workers who lost their jobs. Other sections of the Act gave public aid to the aged, the needy, the handicapped, and to certain minors. **These programs were financed by a 2 percent tax, one half of which was subtracted directly from an employee's paycheck and one half collected from employers on the employee's behalf. The tax was levied on the first \$3,000 of the employee's salary or wage.**

World War II

Even before the United States entered the Second World War, increasing defense spending and the need for monies to support the opponents of Axis aggression led to the passage in 1940 of two tax laws that increased individual and corporate taxes, which were followed by another tax hike in 1941. By the end of the war the nature of the income tax had been fundamentally altered. Reductions in exemption levels meant that taxpayers with taxable incomes of only \$500 faced a bottom tax rate of 23 percent, while taxpayers with incomes over \$1 million faced a top rate of 94 percent. These tax changes increased federal receipts from \$8.7 billion in 1941 to \$45.2 billion in 1945. Even with an economy stimulated by war-time production, federal taxes as a share of GDP grew from 7.6 percent in 1941 to 20.4 percent in 1945. Beyond the rates and revenues, however, another aspect about the income tax that changed was the increase in the number of income taxpayers from 4 million in 1939 to 43 million in 1945.

Another important feature of the income tax that changed was the return to income tax withholding as had been done during the Civil War. This greatly eased the collection of the tax for both the taxpayer and the Bureau of Internal Revenue. However, it also greatly reduced the taxpayer's awareness of the amount of tax being collected, i.e. it reduced the transparency of the tax, which made it easier to raise taxes in the future.

Developments after World War II

Tax cuts following the war reduced the Federal tax burden as a share of GDP from its wartime high of 20.9 percent in 1944 to 14.4 percent in 1950. However, the Korean War created a need for additional revenues which, combined with the extension of Social Security coverage to self-employed persons, meant that by 1952 the tax burden had returned to 19.0 percent of GDP.

In 1953 the Bureau of Internal Revenue was renamed the Internal Revenue Service (IRS), following a reorganization of its function. The new name was chosen to stress the service aspect of its work. By 1959, the IRS had become the world's largest accounting, collection, and forms-processing organization. Computers were introduced to automate and streamline its work and to improve service to taxpayers. In 1961, Congress passed a law requiring individual taxpayers to use their Social Security number as a means of tax form identification. By 1967, all business and personal tax returns were handled by computer systems, and by the late 1960s, the IRS had developed a computerized method for selecting tax returns to be examined. This made the selection of returns for audit fairer to the taxpayer and allowed the IRS to focus its audit resources on those returns most likely to require an audit.

Throughout the 1950s tax policy was increasingly seen as a tool for raising revenue and for changing the incentives in the economy, but also as a tool for stabilizing macroeconomic activity. The economy remained subject to frequent boom and bust cycles and many policymakers readily accepted the new economic policy of raising or lowering taxes and spending to adjust aggregate demand and thereby smooth the business cycle. Even so, however, the maximum tax rate in 1954 remained at 87 percent of taxable income. While the income tax underwent some manner of revision or amendment almost every year since the major reorganization of 1954, certain years marked especially significant changes. For example, the Tax Reform Act of 1969 reduced income tax rates for individuals and private foundations.

Beginning in the late 1960s and continuing through the 1970s the United States experienced persistent and rising inflation rates, ultimately reaching 13.3 percent in 1979. Inflation has a deleterious effect on many aspects of an economy, but it also can play havoc with an income tax system unless appropriate precautions are taken. Specifically, unless the tax system's Parameters, i.e. its brackets and its fixed exemptions, deductions, and credits, are indexed for inflation, a rising price level will steadily shift taxpayers into ever higher tax brackets by reducing the value of those exemptions and deductions.

During this time, the income tax was not indexed for inflation and so, driven by a rising inflation, and despite repeated legislated tax cuts, the tax burden rose from 19.4 percent of GDP to 20.8 percent of GDP. **Combined with high marginal tax rates, rising inflation, and a heavy regulatory burden, this high tax burden caused the economy to under-perform badly, all of which laid the groundwork for the Regan Tax Cut, also known as the Economy Recovery Tax Act of 1981.**

The Regan Tax Cut

The Economic Recovery Tax Act of 1981, which enjoyed strong bi-partisan support in the Congress, represented a fundamental shift in the course of federal income tax policy. Champion in principle for many years by then-Congressman Jack Kemp (R-NY) and then

Senator Bill Roth (R-DE), it featured a 25 percent reduction in individual tax brackets phased in over 3 years, and indexed for inflation thereafter. This brought the top tax bracket down to 50 percent.

The 1981 Act also featured a dramatic departure in the treatment of business outlays for plant and equipment, i.e. capital cost recovery, or tax depreciation. Heretofore, capital cost recovery had attempted roughly to follow a concept known as economic depreciation, which refers to the decline in the market value of a producing asset over a specified period of time. The 1981 Act explicitly displaced the notion of economic depreciation, instituting instead the Accelerated Cost Recovery System which greatly reduced the disincentive facing business investment and ultimately prepared the way for the subsequent boom in capital formation. In addition to accelerated cost recovery, the 1981 Act also instituted a 10 percent Investment Tax Credit to spur additional capital formation.

Prior to, and in any circles even after the 1981 tax cut, the prevailing view was that tax policy is most effective in modulating aggregate demand whenever demand and supply become mismatched, i.e. whenever the economy went in to recession or became “over-heated”. The 1981 tax cut represented a new way of looking at tax policy, **though it was in fact a return to a more traditional or neoclassical economic perspective. The essential idea was that taxes have their first and primary effect on the economic incentives facing individuals and businesses. Thus, the tax rate on the last dollar earned, i.e. the marginal dollar, is much more important to economic activity than the tax rate facing the first dollar earned or than the average tax rate. By reducing marginal tax rates it was believed the natural forces of economic growth would be less restrained.** The most productive individuals would then shift more of their energies to productive activities rather than leisure and businesses would take advantage of many more now profitable opportunities. It was also thought that reducing marginal tax rates would significantly expand the tax base as individuals shifted more of their income and activities into taxable forms and out of tax-exempt forms.

The 1981 tax cut actually represented two departures from previous tax policy philosophies, one explicit and intended and the second by implication. The first change was the new focus on marginal tax rates and incentives as the key factors in how the tax system affects economic activity. The second policy departure was the de facto shift away from income taxation and toward taxing consumption. Accelerated cost recovery was one manifestation of this shift on the business side, but the individual side also saw a significant shift in the enactment of various provisions to reduce the multiple taxation of individual saving. The Individual Retirement Account, for example, was enacted in 1981.

Simultaneously with the enactment of the tax cuts in 1981, the Federal Reserve Board, with the full support of the Reagan Administration, altered monetary policy so as to bring inflation under control. The Federal Reserve’s actions brought inflation down faster and further than was anticipated at the time and one consequence was that the economy fell into a deep recession in 1982. Another consequence of the collapse in inflation was that federal spending levels, which had been predicated on a high level of expected inflation, were suddenly much higher in inflation-adjusted terms. The combination of the tax cuts, the recession, and the one-time increase in inflation-adjusted federal spending produced historically high budget deficits which, in turn, led to a tax increase in 1984 that pared back some of the tax cuts enacted in 1981, especially on the business side.

As inflation came down and as more and more of the tax cuts from the 1981 Act went into effect, the economic began a strong and sustained pattern of growth. Though the painful medicine of disinflation slowed and initially hid the process, the beneficial effects of marginal rate cuts and reduction in the disincentives to invest took hold as promised.

The Evolution of Social Security and Medicare

The Social Security system remained essentially unchanged from its enactment until 1956. However, beginning in 1956 Social Security began an almost steady evolution as more and more benefits were added, beginning with the addition of Disability Insurance benefits. In 1958, benefits were extended to dependents of disabled workers. In 1967, disability benefits were extended to widows and widowers. The 1972 amendments provided for automatic cost-of-living benefits.

In 1965, Congress enacted the Medicare program, providing for the medical needs of persons aged 65 or older, regardless of income. The 1965 Social Security Amendments also created the Medicaid programs, that provides medical assistance for persons with low incomes and resources.

Of course, the expansions of Social Security and the creation of Medicare and Medicaid required additional tax revenues, and thus the basic payroll tax was repeatedly increased over the years. Between 1949 and 1962 the payroll tax rate climbed steadily from its initial rate of 2 percent to 6 percent. The expansions in 1965 led to further rate increases, with the combined payroll tax rate climbing to 12.3 percent in 1980. Thus, in 31 years the maximum Social Security tax burden rose from a mere \$60 in 1949 to \$3,175 in 1980.

Despite the increased payroll tax burden, the benefit expansions Congress enacted in previous years led the Social Security program to an acute funding crisis in the early 1980s. Eventually, Congress legislated some minor programmatic changes in Social Security benefits, along with an increase in the payroll tax rate to 15.3 percent by 1990. Between 1980 and 1990, the maximum Social Security payroll tax burden more than doubled to \$7,849.

The Tax Reform Act of 1986

Following the enactment of the 1981, 1982, and 1984 tax changes there was a growing sense that the income tax was in need of a more fundamental overhaul. The economic boom following the 1982 recession convinced many political leaders of both parties that lower marginal tax rates were essential to a strong economy, while the constant changing of the law instilled in policy makers an appreciation for the complexity of the tax system. Further, the debates during this period led to a general understanding of the distortions imposed on the economy, and the lost jobs and wages, arising from the many peculiarities in the definition of the tax base. A new and broadly held philosophy of tax policy developed that the income tax would be greatly improved by repealing these various special provisions and lowering tax rates further. Thus, in his 1984 State of the Union speech President Reagan called for a sweeping reform of the income tax so it would have a broader base and lower rates and would be fairer, simpler, and more consistent with economic efficiency.

The culmination of this effort was the Tax Reform Act of 1986, which brought the top statutory tax rate down from 50 percent to 28 percent while the corporate tax rate was reduced from 50 percent to 35 percent. The number of tax brackets was reduced and the personal exemption and standard deduction amounts were increased and indexed for inflation, thereby relieving millions of taxpayers of any Federal income tax burden. However, the Act also created new personal and corporate Alternative Minimum Taxes, which proved to be overly complicated, unnecessary, and economically harmful.

The 1986 Tax Reform Act was roughly revenue neutral, that is, it was not intended to raise or lower taxes, but it shifted some of the tax burden from individuals to businesses. Much of the increase in the tax on business was the result of an increase in the tax on business capital formation. It achieved some simplifications for individuals through the elimination of such things as income averaging, the deduction for consumer interest, and the deduction for state and local sales taxes. But in many respects the Act greatly added to the complexity of business taxation, especially in the area of international taxation. Some of the over-reaching provisions of the Act also led to a downturn in the real estate markets which played a significant role in the subsequent collapse of the Savings and Loan industry.

Seen in a broader picture, the 1986 tax act represented the penultimate installment of an extraordinary process of tax rate reductions. Over the 22 year period from 1964 to 1986 the top individual tax rate was reduced from 91 to 28 percent. However, because upper-income taxpayers increasingly chose to receive their income in taxable form, and because of the broadening of the tax base, the progressivity of the tax system actually rose during this period.

The 1986 tax act also represented a temporary reversal in the evolution of the tax system. Though called an income tax, the Federal tax system had for many years actually been a hybrid income and consumption tax, with the balance shifting toward or away from a consumption tax with many of the major tax acts. The 1986 tax act shifted the balance once again toward the income tax. Of greatest importance in this regard was the return to references to economic depreciation in the formulation of the capital cost recovery system and the significant new restrictions on the use of Individual Retirement Accounts.

Between 1986 and 1990 the Federal tax burden rose as a share of GDP from 17.5 to 18 percent. Despite this increase in the overall tax burden, persistent budget deficits due to even higher levels of government spending created near constant pressure to increase taxes. Thus, in 1990 the Congress enacted a significant tax increase featuring an increase in the top tax rate to 31 percent. Shortly after his election, President Clinton insisted on and the Congress enacted a second major tax increase in 1993 in which the top tax rate was raised to 36 percent and a 10 percent surcharge was added, leaving the effective top tax rate at 39.6 percent. Clearly, the trend toward lower marginal tax rates had been reversed, but, as it turns out, only temporarily.

The Taxpayer Relief Act of 1997 made additional changes to the tax code providing a modest tax cut. The centerpiece of the 1997 Act was a significant new tax benefit to certain families with children through the Per Child Tax credit. The truly significant feature of this tax relief, however, was that the credit was refundable for many lower-income families. That is, in many cases the family paid a "negative" income tax, or received a credit in excess of their pre-credit tax liability. Though the tax system had provided for individual tax credits before, such as the Earned Income Tax credit, the Per Child

Tax credit began a new trend in federal tax policy. Previously tax relief was generally given in the form of lower tax rates or increased deductions or exemptions. The 1997 Act really launched the modern proliferation of individual tax credits and especially refundable credits that are in essence spending programs operating through the tax system.

The years immediately following the 1993 tax increase also saw another trend continue, which was to once again shift the balance of the hybrid income tax-consumption tax toward the consumption tax. The movement in this case was entirely on the individual side in the form of a proliferation of tax vehicles to promote purpose-specific saving. For example, Medical Savings Accounts were enacted to facilitate saving for medical expenses. An Education IRA and the Section 529 Qualified Tuition Program was enacted to help taxpayers pay for future education expenses. In addition, a new form of saving vehicle was enacted, called the Roth IRA, which differed from other retirement savings vehicles like the traditional IRA and employer-based 401(k) plans in that contributions were made in after-tax dollars and distributions were tax free.

Despite the higher tax rates, other economic fundamentals such as low inflation and low interest rates, an improved international picture with the collapse of the Soviet Union, and the advent of a qualitatively and quantitatively new information technologies led to a strong economic performance throughout the 1990s. This, in turn, led to an extraordinary increase in the aggregate tax burden, with Federal taxes as a share of GDP reaching a postwar high of 20.8 percent in 2000.

The Bush Tax Cut

By 2001, the total tax take had produced a projected unified budget surplus of \$281 billion, with a cumulative 10 year projected surplus of \$5.6 trillion. Much of this surplus reflected a rising tax burden as a share of GDP due to the interaction of rising real incomes and a progressive tax rate structure. Consequently, under President George W. Bush's leadership the Congress halted the projected future increases in the tax burden by passing the Economic Growth and Tax Relief and Reconciliation Act of 2001. The centerpiece of the 2001 tax cut was to regain some of the ground lost in the 1990s in terms of lower marginal tax rates. Though the rate reductions are to be phased in over many years, ultimately the top tax rate will fall from 39.6 percent to 33 percent.

The 2001 tax cut represented a resumption of a number of other trends in tax policy. For example, it expanded the Per Child Tax credit from \$500 to \$1000 per child. It also increased the Dependent Child Tax credit. The 2001 tax cut also continued the move toward a consumption tax by expanding a variety of savings incentives. Another feature of the 2001 tax cut that is particularly noteworthy is that it put the estate, gift, and generation-skipping taxes on course for eventual repeal, which is also another step toward a consumption tax. One novel feature of the 2001 tax cut compared to most large tax bills is that it was almost devoid of business tax provisions.

The 2001 tax cut will provide additional strength to the economy in the coming years as more and more of its provisions are phased in, and indeed one argument for its enactment had always been as a form of insurance against an economic downturn. However, unbeknownst to the Bush Administration and the Congress, the economy was already in a downturn as the Act was being debated. Thankfully, the downturn was brief and shallow, but it is already clear that

the tax cuts that were enacted and went into effect in 2001 played a significant role in supporting the economy, shortening the duration of the downturn, and preparing the economy for a robust recovery.

One lesson from the economic slowdown was the danger of ever taking a strong economy for granted. The strong growth of the 1990s led to talk of a "new" economy that many assumed was virtually recession proof. The popularity of this assumption was easy to understand when one considers that there had only been one very mild recession in the previous 18 years.

Taking this lesson to heart, and despite the increasing benefits of the 2001 tax cut and the early signs of a recovery, President Bush called for and the Congress eventually enacted an economic stimulus bill. The bill included an extension of unemployment benefits to assist those workers and families under financial stress due to the downturn. The bill also included a provision to providing a temporary but significant acceleration of depreciation allowances for business investment, thereby assuring that the recovery and expansion will be strong and balanced. Interestingly, the depreciation provision also means that the Federal tax on business has resumed its evolution toward a consumption tax, once again paralleling the trend in individual taxation.

Federal Income Tax

Federal income taxes are not based on age. Your tax burden does not go down simply because you turn a particular age (of course you may be eligible for an additional deduction). Instead, federal income taxes are bracketed based on your adjusted gross income. **Effective with the 2003 Tax Act, the brackets have been reduced from a high of 38.56% to 35% (with each respective lower bracket reduced accordingly).** This translates to a lower tax bill for you. Also, dividends (until 2010) are now taxed at a lower rate than ordinary income.

In determining a retiree's federal income tax, the end result (in many cases) is a lower tax bill. Again, this is not because of age or even lower income. Instead, it is a result of a change in classification of income. Social Security still represents a significant portion of many retirees income. As such, it is not subject to federal income tax (until the retiree's adjusted gross income exceeds certain levels).

Another item of note is that most retirees (unless they are without medical insurance) will no longer file Schedule A (itemize) with their return. Rather, they will be electing the standard deduction. This results from the shift of income from payroll (subject to state and local income tax) to retirement income (from pensions, IRAs, and Social Security).

Once you determine your expected annual income, you should determine your expected income tax bill. Do not wait until April 15th to pay your tax bill; otherwise you may be subjected to additional taxes and penalties for late payment. Instead, either pay the expected tax bill quarterly, or better yet, have it deducted from your pension or IRA payments. You can also have income tax withheld from your Social Security check.

2004 Federal Personal Income Tax Rates
Ordinary taxable income for use in filing returns due April 15, 2005

TAX RATE	SINGLE FILERS	MARRIED FILING JOINTLY OR QUALIFYING WIDOW/WIDOWER	MARRIED FILING SEPARATELY	HEAD OF HOUSEHOLD
10%	Up to \$7,150	Up to \$14,300	Up to \$7,150	Up to \$10,200
15%	\$7,151 - \$29,050	\$14,301 - \$58,100	\$7,151 - \$19,050	\$10,201 - \$38,900
25%	\$29,051 - \$70,350	\$58,101 - \$117,250	\$29,051 - \$58,625	\$38,901 - 100,500
28%	\$70,351-\$146,750	\$117,251 - \$178,650	\$58,626 - \$89,325	\$100,501 - \$162,700
33%	\$146,751 - \$319,100	\$178,651 - \$319,100	\$89,326 - 159,550	\$162,701 - \$319,100
35%	\$319,101 or more	\$319,101 or more	\$159,551 or more	\$319,101 or more

State (Kentucky) Income Tax

Individual Income Tax is due on all income earned by Kentucky residents and all income earned by nonresidents from Kentucky sources.

Kentucky's Individual Income Tax Law is based on the Internal Revenue Code in effect as of December 31, 2001. The tax has graduated rates from 2% - 6% and allows itemized deductions and certain income reducing deductions as defined in KRS 141.010. A full-year resident of Kentucky files Form 740 or Form 740-EZ and a person that moves into or out of Kentucky during the year or is a full-year nonresident files on Form 740-NP. Individual Income Tax Laws are found in Chapter 141 of the Kentucky Revised Statutes.

Even if your federal income tax is reduced or eliminated, depending on your resident state you may still owe state income tax. Currently, there are 22 states that allow some form of income tax break to retirees; Kentucky is one such state.

The pension exclusion is 100 percent or \$40,200, whichever is less. Retirees of previously exempt retirement systems of the federal government, Commonwealth of Kentucky, or any Kentucky local government must compute the amount of pension income attributable to service credit earned after December 31, 1997.

All pension and retirement income paid under a written retirement plan is eligible for exclusion. This includes pensions, annuities, IRA accounts, 401(k) and similar deferred compensation plans, death benefits, and other similar accounts or plans.

SOCIAL SECURITY TAX

There are 3 taxes you should be aware of regarding Social Security: payroll, income and penalty.

Payroll Tax

The payroll tax, more commonly referred to as FICA, is assessed on all earned income (typically W-2 income). **The current rate is 4.2% for the employee and 6.2% for the employer.** If you happen to be self-employed, you pay both for a 13.3% total (you do get to deduct the tax as a business expense thereby reducing your cost).

Also, Medicare assesses a payroll tax of 1.45% for the employee and 1.45% for the employer. Similar to FICA, this is assessed only on earned income.

Typically, most retirees (unless they are working) do not pay anymore payroll tax. Therefore, when calculating budgets and cash flow, remember that you will have 6.2% (7.65% including Medicare) additional cash flow.

Income Tax

The income tax is assessed at two levels: 50% and 85%. Generally, up to 50% of your benefits will be taxable. However, up to 85% of your benefits can be taxable if either of the following situations apply to you:

- (1) The total of one-half of your benefits and all of your other income is more than \$34,000 (\$44,000) if you are married filing jointly), or
- (2) You are married filing separately and lived with your spouse at any time during 2002.

Note: The tax rate is not 50% or 85%. These percentages only apply to the amount of Social Security you would have to include in your taxable income. Therefore, it is important to keep in mind your taxable income when taking distributions from retirement accounts. While you may be aware of the federal income tax on the distributions, you may unknowingly subject your Social Security to taxes as well. This is especially true with required minimum distributions (age 70 ½).

Penalty (Working While Receiving Social Security Benefits)

You can get Social Security retirement or survivors benefits and work at the same time. However, under the law, your benefits could be reduced if you earn more than certain amounts.

How much can you earn and still get benefits?

If you work and are full retirement age (age 65 and 6 months in 2005) or older, you may keep all of your benefits, no matter how much you earn. If you are younger than age 65 and 6 months all year, there is a limit to how much you can earn and still receive full Social Security benefits. If you are younger than age 65 and 6 months in all of 2005, we must deduct \$1 from your benefits for each \$2 you earned above \$12,000.

If you turn 65 and 6 months during 2005, we must deduct \$1 from your benefits for each \$3 you earned above \$31,800 until the month you turn 65 and 6 months.

These examples show how the rules would affect you:

Let us say that you begin receiving Social Security benefits at age 62 in January 2005 and your payment is \$600 per month (\$7,200 for the year). During the year, you work and earn \$20,000 (\$8,000 above the \$12,000 limit). Social Security would withhold \$4,000 of your Social Security

benefits (\$1 for every \$2 you earn over the limit), but you would still receive \$3,200 in benefits.

Or, let us say you were age 64 at the beginning of the year, but reach full retirement age (currently 65 and 6 months) in August 2005. You earned \$33,000 in the seven months from January through July. During this period, we would withhold \$400 (\$1 for every \$3 you earned above the \$31,800 limit). You would still receive \$3,800 of your Social Security benefits. And, starting in August (when you reach 65 and 6 months), you would begin receiving your full benefits, no matter how much you earn.

What income counts?

If you work for someone else, only your wages count toward Social Security's earnings limits. If you are self-employed, we count only your net earnings from self-employment. Social Security does not count income such as other government benefits, investment earnings, interest, pensions, annuities and capital gains.

If you work for wages, income counts when it is earned, not when it is paid. If you have income that you earned in one year, but the payment was made in the following year, it should not be counted as earnings for the year you receive it. Some examples are accumulated sick or vacation pay and bonuses.

If you are self-employed, income counts when you receive it--not when you earn it--unless it is paid in a year after you become entitled to Social Security and earned before you became entitled.

Special rules for the first year you retire

Sometimes people who retire in mid-year already have earned more than the yearly earnings limit. That is why there are special rules that apply to earnings for one year, usually the first year of retirement. **Under these rules, you can get a full Social Security check for any whole month you are retired, regardless of your yearly earnings.**

In 2005, a person under full retirement age (age 65 and 6 months) is considered retired if monthly earnings are \$1,000 or less. For example, John Smith retires at age 62 on August 30, 2005. He will make \$45,000 through August. He takes a part-time job beginning in September, earning \$500 per month. Although his earnings for the year substantially exceed the 2005 limit (\$12,000), he will receive a Social Security payment for September through December. This is because his earnings in those months are less than \$1,000, the special "first year of retirement" monthly limit for people younger than full retirement age. If Mr. Smith earns more than \$1,000 in any of those months (September through December), he will not receive a benefit for that month.

Beginning in 2006, only the yearly limits will apply to him because he will be beyond his first year of retirement.

Also, if you are self-employed, we consider how much work you do in your business to determine whether you are retired. One way is by looking at the amount of time that you spend working. **In general, if you work more than 45 hours a month in self-employment, you are not retired; if you work less than 15 hours a month, you are retired.** If you work between 15

and 45 hours a month, you will not be considered retired if it is in a job that requires a lot of skill or you are managing a sizable business.

Reporting changes in your earnings

Social Security adjusts the amount of your Social Security benefits in 2005 based on what you reported you would earn that year.

If other family members get benefits based on your work, your earnings after you start getting retirement benefits could reduce their benefits, too. However, if your spouse and children get benefits as family members, their earnings affect only their own benefits.

Will my extra earnings increase my benefits?

Your original Social Security benefit was based on your highest years of earnings. But each year, Social Security reviews the records for all Social Security recipients who work. If your latest year of earnings turns out to be one of your highest years, we refigure your benefits and pay you any increase due. This is an automatic process and is usually completed by October of the following year. For example, by October 2005, you should get an increase for your 2004 earnings if those earnings raised your benefit. The increase would be retroactive to January 2005.

CAPITAL GAINS & DIVIDENDS

Capital Gains

The 2003 Act reduces the previous 20% and 18% rates on net capital gains to 15% and the previous 10% and 8% rates to 5% (0%, in 2008). The lower rates apply to assets held for more than one year.

The lower rates apply to taxable years ending on or after May 6, 2003, and beginning before January 1, 2009. For taxable years that include May 6, 2003, special transitional rules apply for computing the tax. While these transitional rules are complex, their general effect is to apply the lower rates to gain from the sale of capital assets sold or exchanged on or after May 6, 2003. The lower capital gains rates apply for purposes of both the regular and alternative minimum tax.

Dividends

Dividends are distributions of money, stock, or other property paid to you by a corporation. You also may receive dividends through a partnership, an estate, a trust, or an association that is taxed as a corporation. However, some amounts you receive that are called dividends are actually interest income.

The most common kinds of distributions are:

- Ordinary dividends,
- Capital gain distributions, and
- Non-dividend distributions.

Most distributions are paid in cash (check). However, distributions can consist of more stock, stock rights, other property, or services.

Form 1099-DIV. Most corporations use Form 1099-DIV, Dividends and Distributions, to show you the distributions you received from them during the year. Keep this form with your records. You do not have to attach it to your tax return. Even if you do not receive Form 1099-DIV, you must still report all of your taxable dividend income. For example, you may receive distributive shares of dividends from partnerships or subchapter S corporations. These dividends are reported to you on Schedule K-1 (Form 1065) and Schedule K-1 (Form 1120S).

Dividends on stock sold. If stock is sold, exchanged, or otherwise disposed of after a dividend is declared, but before it is paid, the owner of record (usually the payee shown on the dividend check) must include the dividend in income.

Dividends received in January. If a regulated investment company (mutual fund) or real estate investment trust (REIT) declares a dividend (including any exempt-interest dividend or capital gain distribution) in October, November, or December payable to shareholders of record on a date in one of those months but actually pays the dividend during January of the next calendar year, you are considered to have received the dividend on December 31. You report the dividend in the year it was declared.

Ordinary Dividends are the most common type of distribution from a corporation. They are paid out of the earnings and profits of a corporation and are ordinary income to you. This means they are not capital gains. You can assume that any dividend you receive on common or preferred stock is an ordinary dividend unless the paying corporation tells you otherwise. Ordinary dividends will be shown in box 1a of the Form 1099-DIV you receive.

Qualified Dividends

Qualified dividends are the ordinary dividends that are subject to the same 5% or 15% maximum tax rate that applies to net capital gain. They should be shown in box 1b of the Form 1099-DIV you receive.

Qualified dividends are subject to the 15% rate if the regular tax rate that would apply is 25% or higher. If the regular tax rate that would apply is lower than 25%, qualified dividends are subject to the 5% rate.

To qualify for the 5% or 15% maximum rate, all of the following requirements must be met.

- (1) The dividends must have been paid by a U.S. corporation or a qualified foreign corporation.
- (2) The dividends are not of the type listed later under *Dividends that are not qualified dividends*.
- (3) You meet the holding period.

Holding period. You must have held the stock for more than 60 days during the 121-day period that begins 60 days before the ex-dividend date. The ex-dividend date is the first date following the declaration of a dividend on which the buyer of a stock will not receive the next dividend

payment. When counting the number of days you held the stock, include the day you disposed of the stock, but not the day you acquired it.

Exception for preferred stock. In the case of preferred stock, you must have held the stock more than 90 days during the 181-day period that begins 90 days before the ex-dividend date if the dividends are due to periods totaling more than 366 days. If the preferred dividends are due to periods totaling less than 367 days, the holding period in the preceding paragraph applies.

Example 1: You bought 5,000 shares of XYZ Corp. common stock on July 1, 2004. XYZ Corp. paid a cash dividend of 10 cents per share. The ex-dividend date was July 9, 2004. Your Form 1099-DIV from XYZ Corp. shows \$500 in box 1a (ordinary dividends) and in box 1b (qualified dividends). However, you sold the 5,000 shares on August 4, 2004. You held your shares of XYZ Corp. for only 34 days of the 121-day period (from July 2, 2004, through August 4, 2004). The 121-day period began on May 10, 2004 (60 days before the ex-dividend date), and ended on September 7, 2004. You have no qualified dividends from XYZ Corp. because you did not hold the XYZ stock for more than 60 days.

Example 2: Assume the same facts as in *Example 1* except that you bought the stock on July 8, 2004 (the day before the ex-dividend date), and you sold the stock on September 9, 2004. You held the stock for 63 days (from July 9, 2004, through September 9, 2004). The \$500 of qualified dividends shown in box 1b of your Form 1099-DIV are all qualified dividends because you held the stock for 61 days of the 121-day period (from July 9, 2004, through September 7, 2004).

Example 3: You bought 10,000 shares of ABC Mutual Fund common stock on July 1, 2004. ABC Mutual Fund paid a cash dividend of 10 cents per share. The ex-dividend date was July 9, 2004. The ABC Mutual Fund advises you that the portion of the dividend eligible to be treated as qualified dividends equals 2 cents per share. Your Form 1099-DIV from ABC Mutual Fund shows total ordinary dividends of \$1,000 and qualified dividends of \$200. However, you sold the 10,000 shares on August 4, 2004. You have no qualified dividends from ABC Mutual Fund because you did not hold the ABC Mutual Fund stock for more than 60 days.

Holding period reduced where risk of loss is diminished. When determining whether you met the minimum holding period discussed earlier, you cannot count any day during which you meet any of the following conditions.

1. You had an option to sell, were under a contractual obligation to sell, or had made (and not closed) a short sale of substantially identical stock or securities.
2. You were grantor (writer) of an option to buy substantially identical stock or securities.
3. Your risk of loss is diminished by holding one or more other positions in substantially similar or related property.

Qualified Foreign Corporation. A foreign corporation is a qualified foreign corporation if it meets any of the following conditions.

1. The corporation is incorporated in a U.S. possession.
2. The corporation is eligible for the benefits of a comprehensive income tax treaty with the United States that the Treasury Department determines is satisfactory for this purpose and that includes an exchange of information program. For a list of those treaties.

3. The corporation does not meet (1) or (2) above, but the stock for which the dividend is paid is readily tradable on an established securities market in the United States.

A corporation is not a qualified foreign corporation if it is a foreign personal holding company, foreign investment company, or a passive foreign investment company during its tax year in which the dividends are paid or during its previous tax year.

Readily tradable stock: Any stock (such as common, ordinary, or preferred stock), or an American depositary receipt in respect of that stock, is considered to satisfy requirement (3) if it is listed on one of the following securities markets: the New York Stock Exchange, the NASDAQ Stock Market, the American Stock Exchange, the Boston Stock Exchange, the Cincinnati Stock Exchange, the Chicago Stock Exchange, the Philadelphia Stock Exchange, or the Pacific Exchange, Inc.

Dividends that are not qualified dividends. The following dividends are not qualified dividends. They are not qualified dividends even if they are shown in box 1b of Form 1099-DIV.

- Capital gain distributions.
- Dividends paid on deposits with mutual savings banks, cooperative banks, credit unions, U.S. building and loan associations, U.S. savings and loan associations, federal savings and loan associations, and similar financial institutions. (Report these amounts as interest income.)
- Dividends from a corporation that is a tax-exempt organization or farmer's cooperative during the corporation's tax year in which the dividends were paid or during the corporation's previous tax year.
- Dividends paid by a corporation on employer securities which are held on the date of record by an employee stock ownership plan (ESOP) maintained by that corporation.
- Dividends on any share of stock to the extent that you are obligated (whether under a short sale or otherwise) to make related payments for positions in substantially similar or related property.
- Payments in lieu of dividends, but only if you know or have reason to know that the payments are not qualified dividends.
- Payments shown in Form 1099-DIV, box 1b, from a foreign corporation to the extent you know or have reason to know the payments are not qualified dividends.

Dividends Used To Buy More Stock

The corporation in which you own stock may have a dividend reinvestment plan. This plan lets you choose to use your dividends to buy (through an agent) more shares of stock in the corporation instead of receiving the dividends in cash. If you are a member of this type of plan and you use your dividends to buy more stock at a price equal to its fair market value, you still must report the dividends as income.

If you are a member of a dividend reinvestment plan that lets you buy more stock at a price less than its fair market value, you must report as dividend income the fair market value of the additional stock on the dividend payment date.

You also must report as dividend income any service charge subtracted from your cash dividends before the dividends are used to buy the additional stock. But you may be able to deduct the service charge.

In some dividend reinvestment plans, you can invest more cash to buy shares of stock at a price less than fair market value. If you choose to do this, you must report as dividend income the difference between the cash you invest and the fair market value of the stock you buy. When figuring this amount, use the fair market value of the stock on the dividend payment date.

Money Market Funds

Report amounts you receive from money market funds as dividend income. Money market funds are a type of mutual fund and should not be confused with bank money market accounts that pay interest.

Taxable Stock Dividends and Stock Rights. Distributions of stock dividends and stock rights are taxable to you if any of the following apply.

1. You or any other shareholder has the choice to receive cash or other property instead of stock or stock rights.
2. The distribution gives cash or other property to some shareholders and an increase in the percentage interest in the corporation's assets or earnings and profits to other shareholders.
3. The distribution is in convertible preferred stock and has the same result as in (2).
4. The distribution gives preferred stock to some common stock shareholders and common stock to other common stock shareholders.
5. The distribution is on preferred stock. (The distribution, however, is not taxable if it is an increase in the conversion ratio of convertible preferred stock made solely to take into account a stock dividend, stock split, or similar event that would otherwise result in reducing the conversion right.)

The term "stock" includes rights to acquire stock, and the term "shareholder" includes a holder of rights or convertible securities. If you receive taxable stock dividends or stock rights, include their fair market value at the time of the distribution in your income.

Dividends on insurance policies. Insurance policy dividends that the insurer keeps and uses to pay your premiums are not taxable. However, you must report as taxable interest income the interest that is paid or credited on dividends left with the insurance company.

If dividends on an insurance contract (other than a modified endowment contract) are distributed to you, they are a partial return of the premiums you paid. Do not include them in your gross income until they are more than the total of all net premiums you paid for the contract.

TAX PENALTIES IN RETIREMENT PLANS

Pre 59 ½ - Early Distributions

You must include early distributions of taxable amounts from your traditional IRA in your gross income. Early distributions are also subject to an additional 10% tax. Early distributions generally are amounts distributed from your traditional IRA account or annuity before you are

age 59½, or amounts you receive when you cash in retirement bonds before you are age 59½.

Age 59½ Rule

Generally, if you are under age 59½, you must pay a 10% additional tax on the distribution of any assets (money or other property) from your traditional IRA. Distributions before you are age 59½ are called early distributions. The 10% additional tax applies to the part of the distribution that you have to include in gross income. It is in addition to any regular income tax on that amount.

NOTE: You may have to pay a 25%, rather than 10%, additional tax if you receive distributions from a SIMPLE IRA before you are age 59½.

Exceptions

There are several exceptions to the age 59½ rule. Even if you receive a distribution before you are age 59½, you may not have to pay the 10% additional tax if you are in one of the following situations:

- You have unreimbursed medical expenses that are more than 7.5% of your adjusted gross income.
- **The distributions are not more than the cost of your medical insurance.**
- You are disabled.
- **You are the beneficiary of a deceased IRA owner.**
- You are receiving distributions in the form of an annuity.
- The distributions are not more than your qualified higher education expenses.
- You use the distributions to buy, build, or rebuild a first home.
- The distribution is due to an IRS levy of the qualified plan.

Distributions that are timely and properly rolled over, as discussed earlier, are not subject to either regular income tax or the 10% additional tax. Certain withdrawals of excess contributions after the due date of your return are also tax free and therefore not subject to the 10% additional tax.

Unreimbursed medical expenses. Even if you are under age 59½, you do not have to pay the 10% additional tax on distributions that are not more than:

- The amount you paid for unreimbursed medical expenses during the year of the distribution, minus
- 7.5% of your adjusted gross income (defined later) for the year of the distribution.

You can only take into account unreimbursed medical expenses that you would be able to include in figuring a deduction for medical expenses on Schedule A, Form 1040. You do not have to itemize your deductions to take advantage of this exception to the 10% additional tax.

Medical Insurance. Even if you are under age 59½, you may not have to pay the 10% additional tax on distributions during the year that are not more than the amount you paid during the year for medical insurance for yourself, your spouse, and your dependents. You will not have to pay the tax on these amounts if all of the following conditions apply.

- You lost your job.
- You received unemployment compensation paid under any federal or state law for 12 consecutive weeks because you lost your job.
- You receive the distributions during either the year you received the unemployment compensation or the following year.
- You receive the distributions no later than 60 days after you have been reemployed.

Disabled. If you become disabled before you reach age 59½, any distributions from your traditional IRA because of your disability are not subject to the 10% additional tax. You are considered disabled if you can furnish proof that you cannot do any substantial gainful activity because of your physical or mental condition. A physician must determine that your condition can be expected to result in death or to be of long, continued, and indefinite duration.

Beneficiary. If you die before reaching age 59½, the assets in your traditional IRA can be distributed to your beneficiary or to your estate without either having to pay the 10% additional tax.

However, if you inherit a traditional IRA from your deceased spouse and elect to treat it as your own, any distribution you later receive before you reach age 59½ may be subject to the 10% additional tax.

Annuity. You can receive distributions from your traditional IRA that are part of a series of substantially equal payments over your life (or your life expectancy), or over the lives (or the joint life expectancies) of you and your beneficiary, without having to pay the 10% additional tax, even if you receive such distributions before you are age 59½. You must use an IRS-approved distribution method and you must take at least one distribution annually for this exception to apply. The “required minimum distribution method,” when used for this purpose, results in the exact amount required to be distributed, not the minimum amount.

There are two other IRS -approved distribution methods that you can use. They are generally referred to as the “fixed amortization method” and the “fixed annuitization method.” These two methods are not discussed in this publication because they are more complex and generally require professional assistance.

The payments under this exception must generally continue until at least 5 years after the date of the first payment, or until you reach age 59½, whichever is later. If a change from an approved distribution method is made before the end of the appropriate period, any payments you receive before you reach age 59½ will be subject to the 10% additional tax. This is true even if the change is made after you reach age 59½. The payments will not be subject to the 10% additional tax if another exception applies or if the change is made because of your death or disability.

One-time switch. If you are receiving a series of substantially equal periodic payments, you can make a one-time switch to the required minimum distribution method at any time

without incurring the additional tax. Once a change is made, you must follow the required minimum distribution method in all subsequent years.

Higher Education Expenses. Even if you are under age 59½, if you paid expenses for higher education during the year, part (or all) of any distribution may not be subject to the 10% additional tax. The part not subject to the tax is generally the amount that is not more than the qualified higher education expenses for the year for education furnished at an eligible educational institution. The education must be for you, your spouse, or the children or grandchildren of you or your spouse.

When determining the amount of the distribution that is not subject to the 10% additional tax, include qualified higher education expenses paid with any of the following funds.

- Payment for services, such as wages.
- A loan.
- A gift.
- An inheritance given to either the student or the individual making the withdrawal.
- A withdrawal from personal savings (including savings from a qualified tuition program).

Do not include expenses paid with any of the following funds.

- Tax-free distributions from a Coverdell education savings account.
- Tax-free part of scholarships and fellowships.
- Pell grants.
- Employer-provided educational assistance.
- Veterans' educational assistance.
- Any other tax-free payment (other than a gift or inheritance) received as educational assistance.

Qualified higher education expenses. Qualified higher education expenses are tuition, fees, books, supplies, and equipment required for the enrollment or attendance of a student at an eligible educational institution. They also include expenses for special needs services incurred by or for special needs students in connection with their enrollment or attendance. In addition, if the individual is at least a half-time student, room and board are qualified higher education expenses.

Eligible educational institution. This is any college, university, vocational school, or other postsecondary educational institution eligible to participate in the student aid programs administered by the Department of Education. It includes virtually all accredited, public, nonprofit, and proprietary (privately owned profit-making) postsecondary institutions. The educational institution should be able to tell you if it is an eligible educational institution.

First home. Even if you are under age 59½, you do not have to pay the 10% additional tax on distributions you receive to buy, build, or rebuild a first home. To qualify for treatment as a first-time homebuyer distribution, the distribution must meet all the following requirements.

1. It must be used to pay qualified acquisition costs (defined later) before the close of the 120th day after the day you received it.

2. It must be used to pay qualified acquisition costs for the main home of a first-time homebuyer (defined later) who is any of the following.
 - a. Yourself.
 - b. Your spouse.
 - c. Your or your spouse's child.
 - d. Your or your spouse's grandchild.
 - e. Your or your spouse's parent or other ancestor.
3. When added to all your prior qualified first-time homebuyer distributions, if any, the total distributions cannot be more than \$10,000.

If both you and your spouse are first-time homebuyers (defined later), each of you can receive distributions up to \$10,000 for a first home without having to pay the 10% additional tax.

Qualified acquisition costs. Qualified acquisition costs include the following items.

- Costs of buying, building, or rebuilding a home.
- Any usual or reasonable settlement, financing, or other closing costs.

First-time homebuyer. Generally, you are a first-time homebuyer if you had no present interest in a main home during the 2-year period ending on the date of acquisition of the home which the distribution is being used to buy, build, or rebuild. If you are married, your spouse must also meet this no-ownership requirement.

Date of acquisition. The date of acquisition is the date that:

- You enter into a binding contract to buy the main home for which the distribution is being used, or
- The building or rebuilding of the main home for which the distribution is being used begins.

Additional 10% tax

The additional tax on early distributions is 10% of the amount of the early distribution that you must include in your gross income. This tax is in addition to any regular income tax resulting from including the distribution in income.

Example: Tom Jones, who is 35 years old, receives a \$3,000 distribution from his traditional IRA account. Tom does not meet any of the exceptions to the 10% additional tax, so the \$3,000 is an early distribution. Tom never made any nondeductible contributions to his IRA. He must include the \$3,000 in his gross income for the year of the distribution and pay income tax on it. Tom must also pay an additional tax of \$300 (10% × \$3,000).

Age 70 ½ Required Minimum Distributions (RMD)

You cannot keep funds in a traditional IRA indefinitely. Eventually they must be distributed. If there are no distributions, or if the distributions are not large enough, you may have to pay a 50% excise tax on the amount not distributed as required. The requirements for distributing IRA

funds differ, depending on whether you are the IRA owner or the beneficiary of a decedent's IRA.

Required minimum distribution. The amount that must be distributed each year is referred to as the required minimum distribution.

Distributions not eligible for rollover. Amounts that must be distributed (required minimum distributions) during a particular year are not eligible for rollover treatment.

IRA Owners

If you are the owner of a traditional IRA, you must start receiving distributions from your IRA by April 1 of the year following the year in which you reach age 70½. April 1 of the year following the year in which you reach age 70½ is referred to as the required beginning date.

You must receive at least a minimum amount for each year starting with the year you reach age 70½ (your 70½ year). If you do not (or did not) receive that minimum amount in your 70½ year, then you must receive distributions for your 70½ year by April 1 of the next year. If an IRA owner dies after reaching age 70½, but before April 1 of the next year, no minimum distribution is required because death occurred before the required beginning date.

Even if you begin receiving distributions before you reach age 70½, you must begin calculating and receiving required minimum distributions by your required beginning date.

More than minimum received. If, in any year, you receive more than the required minimum distribution for that year, you will not receive credit for the additional amount when determining the minimum required distributions for future years. This does not mean that you do not reduce your IRA account balance. It means that if you receive more than your required minimum distribution in one year, you cannot treat the excess (the amount that is more than the required minimum distribution) as part of your required minimum distribution for any later year. However, any amount distributed in your 70½ year will be credited toward the amount that must be distributed by April 1 of the following year.

The required minimum distribution for any year after the year you turn 70½ must be made by December 31 of that later year.

Example: You reach age 70½ on August 20, 2004. For 2004, you must receive the required minimum distribution from your IRA by April 1, 2005. You must receive the required minimum distribution for 2005 by December 31, 2005.

If you do not receive your required minimum distribution for 2004 until 2005, both your 2004 and your 2005 distributions will be includible on your 2005 return.

Distributions from individual retirement account. If you are the owner of a traditional IRA that is an individual retirement account, you or your trustee must figure the required minimum distribution for each year.

Distributions from individual retirement annuities. If your traditional IRA is an individual retirement annuity, special rules apply to figuring the required minimum distribution. For more information on rules for annuities, see Regulations section 1.401(a)(9)-6.

Change in marital status. For purposes of figuring your required minimum distribution, your marital status is determined as of January 1 of each year. If you are married on January 1, but get divorced or your spouse dies during the year, your spouse as of January 1 remains your sole beneficiary for that year. For purposes of determining your distribution period, a change in beneficiary is effective in the year following the year of death or divorce.

Change of beneficiary. If your spouse is the sole beneficiary of your IRA, and he or she dies before you, your spouse will not fail to be your sole beneficiary for the year that he or she died solely because someone other than your spouse is named a beneficiary for the rest of that year. However, if you get divorced during the year and change the beneficiary designation on the IRA during that same year, your former spouse will not be treated as the sole beneficiary for that year.

Figuring the Owner's Required Minimum Distribution

Figure your required minimum distribution for each year by dividing the IRA account balance (defined next) as of the close of business on December 31 of the preceding year by the applicable distribution period or life expectancy.

IRA account balance. The IRA account balance is the amount in the IRA at the end of the year preceding the year for which the required minimum distribution is being figured.

Contributions. Contributions increase the account balance in the year they are made. If a contribution for last year is not made until after December 31 of last year, it increases the account balance for this year, but not for last year. Disregard contributions made after December 31 of last year in determining your required minimum distribution for this year.

Outstanding rollovers and re-characterizations. The IRA account balance is adjusted by outstanding rollovers and re-characterizations of Roth IRA conversions that are not in any account at the end of the preceding year.

For a rollover from a qualified plan or another IRA that was not in any account at the end of the preceding year, increase the account balance of the receiving IRA by the rollover amount valued as of the date of receipt.

If a conversion contribution or failed conversion contribution is contributed to a Roth IRA and that amount (plus net income allocable to it) is transferred to another IRA in a subsequent year as a re-characterized contribution, increase the account balance of the receiving IRA by the re-characterized contribution (plus allocable net income) for the year in which the conversion or failed conversion occurred.

Distributions. Distributions reduce the account balance in the year they are made. If a distribution for last year is not made until after December 31 of last year, it reduces the account balance for this year, but not for last year. Disregard distributions made after December 31 of last year in determining your required minimum distribution for this year.

Example 1: Laura was born on October 1, 1934. She is an unmarried participant in a qualified defined contribution plan. She reaches age 70½ in 2005. Her required beginning date is April 1, 2006. As of December 31, 2004, her account balance was \$26,500. No rollover or re-characterization amounts were outstanding. Using Table III in Appendix C, the applicable distribution period for someone her age (71) is 26.5 years. Her required minimum distribution for 2005 is \$1,000 ($\$26,500 \div 26.5$). That amount is distributed to her on April 1, 2006.

Example 2: Joe, born October 1, 1933, reached 70½ in 2004. His wife (his beneficiary) turned 56 in September 2004. He must begin receiving distributions by April 1, 2005. Joe's IRA account balance as of December 31, 2003, is \$30,100. Because Joe's wife is more than 10 years younger than Joe and is the sole beneficiary of his IRA, Joe uses Table II in Appendix C. Based on their ages at year end (December 31, 2004), the joint life expectancy for Joe (age 71) and his wife (age 56) is 30.1 years. The required minimum distribution for 2004, Joe's first distribution year (his 70½ year), is \$1,000 ($\$30,100 \div 30.1$). This amount is distributed to Joe on April 1, 2005.

Distribution period. This is the maximum number of years over which you are allowed to take distributions from the IRA. The period to use for 2004 is listed next to your age as of your birthday in 2004 in Table III or IRA Pub. 590.

Life expectancy. If you must use Table I, your life expectancy for 2005 is listed in the table next to your age as of your birthday in 2005. If you use Table II, your life expectancy is listed where the row or column containing your age as of your birthday in 2005 intersects with the row or column containing your spouse's age as of his or her birthday in 2005. Both Table I and Table II are in IRS Pub. 590.

Distributions during your lifetime. Required minimum distributions during your lifetime are based on a distribution period that generally is determined using Table III (Uniform Lifetime) in IRS Pub. 590. To figure the required minimum distribution for 2005, divide your account balance at the end of 2004 by the distribution period from the table. This is the distribution period listed next to your age (as of your birthday in 2005) in Table III in IRS Pub. 590, unless the sole beneficiary of your IRA is your spouse who is more than 10 years younger than you.

Example: You own a traditional IRA. Your account balance at the end of 2004 was \$100,000. You are married and your spouse, who is the sole beneficiary of your IRA, is 6 years younger than you. You turn 75 years old in 2005. You use Table III. Your distribution period is 22.9. Your required minimum distribution for 2005 is \$4,367 ($\$100,000 \div 22.9$).

Sole beneficiary spouse who is more than 10 years younger. If the sole beneficiary of your IRA is your spouse and your spouse is more than 10 years younger than you, use the life expectancy from Table II (Joint Life and Last Survivor Expectancy). The life expectancy to use is the joint life and last survivor expectancy listed where the row or column containing your age as of your birthday in 2005 intersects with the row or column containing your spouse's age as of his or her birthday in 2005. You figure your required minimum distribution for 2005 by dividing your account balance at the end of 2004 by the life expectancy from Table II (Joint Life and Last Survivor Expectancy) in IRS Pub. 590.

Example: You own a traditional IRA. Your account balance at the end of 2004 was \$100,000. You are married and your spouse, who is the sole beneficiary of your IRA, is 11 years younger

than you. You turn 75 in 2005 and your spouse turns 64. You use Table II. Your joint life and last survivor expectancy is 23.6. Your required minimum distribution for 2005 is \$4,237 ($\$100,000 \div 23.6$).

Distributions in the year of the owner's death. The required minimum distribution for the year of the owner's death depends on whether the owner died before the required beginning date. If the owner died before his or her required beginning date, base required minimum distributions for years after the year of the owner's death generally on your single life expectancy.

If the owner died on or after the required beginning date, the required minimum distribution for the year of death generally is based on Table III (Uniform Lifetime) in IRS Pub. 590. However, if the sole beneficiary of the IRA is the owner's spouse who is more than 10 years younger than the owner, use the life expectancy from Table II (Joint Life and Last Survivor Expectancy). You figure the required minimum distribution for the year in which an IRA owner dies as if the owner lived for the entire year.

IRA Beneficiaries

The rules for determining required minimum distributions for beneficiaries depend on whether the beneficiary is an individual. The rules for individuals are explained below.

Surviving spouse. If you are a surviving spouse who is the sole beneficiary of your deceased spouse's IRA, you may elect to be treated as the owner and not as the beneficiary. If you elect to be treated as the owner, you determine the required minimum distribution (if any) as if you were the owner beginning with the year you elect or are deemed to be the owner. However, if you become the owner in the year your deceased spouse died, you are not required to determine the required minimum distribution for that year using your life; rather, you can take the deceased owner's required minimum distribution for that year (to the extent it was not already distributed to the owner before his or her death).

Taking balance within 5 years. A beneficiary who is an individual may be required to take the entire account by the end of the fifth year following the year of the owner's death. If this rule applies, no distribution is required for any year before that fifth year.

Owner Died On or After Required Beginning Date

If the owner died on or after his or her required beginning date, and you are the designated beneficiary, you generally must base required minimum distributions for years after the year of the owner's death on the longer of:

- Your single life expectancy as shown on Table I, or
- The owner's life expectancy as determined under *Death on or after required beginning date*, under *Beneficiary not an individual*.

Owner Died Before Required Beginning Date

If the owner died before his or her required beginning date, base required minimum distributions for years after the year of the owner's death generally on your single life expectancy. If the owner's beneficiary is not an individual (for example, if the beneficiary is the owner's estate), see *Beneficiary not an individual*, later.

Date the designated beneficiary is determined. Generally, the designated beneficiary is determined on September 30 of the calendar year following the calendar year of the IRA owner's death. In order to be a designated beneficiary, an individual must be a beneficiary as of the date of death. Any person who was a beneficiary on the date of the owner's death, but is not a beneficiary on September 30 of the calendar year following the calendar year of the owner's death (because, for example, he or she disclaimed entitlement or received his or her entire benefit), will not be taken into account in determining the designated beneficiary.

Death of a beneficiary. If a person who is a beneficiary as of the owner's date of death dies before September 30 of the year following the year of the owner's death without disclaiming entitlement to benefits, that individual, rather than his or her successor beneficiary, continues to be treated as a beneficiary for determining the distribution period.

Death of surviving spouse. If the designated beneficiary is the owner's surviving spouse, and he or she dies before he or she was required to begin receiving distributions, the surviving spouse will be treated as if he or she were the owner of the IRA. However, this rule does not apply to the surviving spouse of a surviving spouse.

More than one beneficiary. If an IRA has more than one beneficiary or a trust is named as beneficiary, see *Miscellaneous Rules for Required Minimum Distributions*, later.

Figuring the Beneficiary's Required Minimum Distribution

How you figure the required minimum distribution depends on whether the beneficiary is an individual or some other entity, such as a trust or estate.

Beneficiary an individual. If the beneficiary is an individual, to figure the required minimum distribution for 2005, divide the account balance at the end of 2004 by the appropriate life expectancy from Table I (Single Life Expectancy) in IRS Pub 590. Determine the appropriate life expectancy as follows.

- Spouse as sole designated beneficiary. Use the life expectancy listed in the table next to the spouse's age (as of the spouse's birthday in 2005). If the owner died before the year in which he or she reached age 70½, distributions to the spouse do not need to begin until the year in which the owner would have reached age 70½.
- Other designated beneficiary. Use the life expectancy listed in the table next to the beneficiary's age as of his or her birthday in the year following the year of the owner's death, reduced by one for each year since the year following the owner's death.

Example: Your father died in 2004. You are the designated beneficiary of your father's traditional IRA. You are 53 years old in 2005. You use Table I and see that your life expectancy in 2005 is 31.4. If the IRA was worth \$100,000 at the end of 2004, your required minimum distribution for 2005 is \$3,185 ($\$100,000 \div 31.4$). If the value of the IRA at the end of 2005 was again \$100,000, your required minimum distribution for 2006 would be \$3,289 ($\$100,000 \div 30.4$). Instead of taking yearly distributions, you could choose to take the entire distribution in 2009 or earlier.

Beneficiary not an Individual. If the beneficiary is not an individual, determine the required minimum distribution for 2004 as follows.

- Death on or after required beginning date. Divide the account balance at the end of 2003 by the appropriate life expectancy from Table I (Single Life Expectancy) in IRS Pub 590. Use the life expectancy listed next to the owner's age as of his or her birthday in the year of death, reduced by one for each year since the year of death.
- Death before required beginning date. The entire account must be distributed by the end of the fifth year following the year of the owner's death. No distribution is required for any year before that fifth year.

Example: The owner died in 2004 at the age of 80. The owner's traditional IRA went to his estate. The account balance at the end of 2004 was \$100,000. In 2005, the required minimum distribution was \$10,870 ($\$100,000 \div 9.2$). (The owner's life expectancy in the year of death, 10.2, reduced by one.) If the owner had died in 2004 at the age of 70, the entire account would have to be distributed by the end of 2009.

Which Table Do You Use To Determine Your Required Minimum Distribution?

There are three different tables. You use only one of them to determine your required minimum distribution for each traditional IRA. Determine which one to use as follows.

In using the tables for lifetime distributions, marital status is determined as of January 1 each year. Divorce or death after January 1 is generally disregarded until the next year. However, if you divorce and change the beneficiary designation in the same year, your former spouse cannot be considered your sole beneficiary for that year.

Table I (Single Life Expectancy). Use Table I for years after the year of the owner's death if either of the following apply.

- You are an individual and a designated beneficiary, but not both the owner's surviving spouse and sole designated beneficiary.
- You are not an individual and the owner died on or after the required beginning date.

Surviving spouse. If you are the owner's surviving spouse and sole designated beneficiary, and the owner had not reached age 70½ when he or she died, and you do not elect to be treated as the owner of the IRA, you do not have to take distributions (and use *Table I*) until the year in which the owner would have reached age 70½.

Table II (Joint Life and Last Survivor Expectancy). Use Table II if you are the IRA owner and your spouse is both your sole designated beneficiary and more than 10 years younger than you. Use this table in the year of the owner's death if the owner died after the required beginning date and this is the table that would have been used had he or she not died.

Table III (Uniform Lifetime). Use Table III if you are the IRA owner and your spouse is not both the sole designated beneficiary of your IRA and more than 10 years younger than you. Use this table in the year of the owner's death if the owner died after the required beginning date and this is the table that would have been used had he or she not died.

No table. Do not use any of the tables if the designated beneficiary is not an individual and the owner died before the required beginning date. In this case, the entire distribution must be made by the end of the fifth year following the year of the IRA owner's death. This rule also applies if there is no designated beneficiary named by September 30 of the year following the year of the IRA owner's death.

5-year rule: If you are an individual, you can elect to take the entire account by the end of the fifth year following the year of the owner's death. If you make this election, do not use a table.

What Age(s) Do You Use With the Table(s)?

Table I (Single Life Expectancy). If you are a designated beneficiary figuring your first distribution, use your age as of your birthday in the year distributions must begin. This is usually the calendar year immediately following the calendar year of the owner's death. If you are the owner's surviving spouse and the sole designated beneficiary, this is the year in which the owner would have reached age 70½. After the first distribution year, reduce your life expectancy by one for each subsequent year.

Example: You are the owner's designated beneficiary figuring your first required minimum distribution. Distributions must begin in 2005. You become 57 years old in 2005. You use Table I. Your distribution period for 2005 is 27.9 years. Your distribution period for 2006 is 26.9 (27.9 - 1). Your distribution period for 2007 is 25.9 (27.9 - 2).

No designated beneficiary. In some cases, you need to use the owner's life expectancy. You need to use it when the owner dies on or after the required beginning date and there is no designated beneficiary as of September 30 of the year following the year of the owner's death. In this case, use the owner's life expectancy for his or her age as of the owner's birthday in the year of death and reduce it by one for each subsequent year.

Table II (Joint Life and Last Survivor Expectancy). For your first distribution by the required beginning date, use your age and the age of your designated beneficiary as of your birthdays in the year you become age 70½. Your combined life expectancy is at the intersection of your ages. If you are figuring your required minimum distribution for 2005, use your ages as of your birthdays in 2005. For each subsequent year, use your and your spouse's ages as of your birthdays in the subsequent year.

Table III (Uniform Lifetime). For your first distribution by your required beginning date, use your age as of your birthday in the year you become age 70½. If you are figuring your required minimum distribution for 2005, use your age as of your birthday in 2005. For each subsequent year, use your age as of your birthday in the subsequent year.

Miscellaneous Rules for Required Minimum Distributions

Installments allowed. The yearly required minimum distribution can be taken in a series of installments (monthly, quarterly, etc.) as long as the total distributions for the year are at least as much as the minimum required amount.

More than one IRA. If you have more than one traditional IRA, you must determine a separate required minimum distribution for each IRA. However, you can total these minimum amounts and take the total from any one or more of the IRAs.

Example: Sara, born August 1, 1933, became 70½ on February 1, 2004. She has two traditional IRAs. She must begin receiving her IRA distributions by April 1, 2005. On December 31, 2003, Sara's account balance from IRA A was \$10,000; her account balance from IRA B was \$20,000. Sara's brother, age 64 as of his birthday in 2004, is the beneficiary of IRA A. Her husband, age 78 as of his birthday in 2004, is the beneficiary of IRA B.

Sara's required minimum distribution from IRA A is \$377 ($\$10,000 \div 26.5$ (the distribution period for age 71 per Table III)). The amount of the required minimum distribution from IRA B is \$755 ($\$20,000 \div 26.5$). The amount that must be withdrawn by Sara from her IRA accounts by April 1, 2005, is \$1,132 ($\$377 + \755).

More than minimum received. If, in any year, you receive more than the required minimum amount for that year, you will not receive credit for the additional amount when determining the minimum required amounts for future years. This does not mean that you do not reduce your IRA account balance. It means that if you receive more than your required minimum distribution in one year, you cannot treat the excess (the amount that is more than the required minimum distribution) as part of your required minimum distribution for any later year. However, any amount distributed in your 70½ year will be credited toward the amount that must be distributed by April 1 of the following year.

Example: Justin became 70½ on December 15, 2004. Justin's IRA account balance on December 31, 2003, was \$38,400. He figured his required minimum distribution for 2004 was \$1,401 ($\$38,400 \div 27.4$). By December 31, 2004, he had actually received distributions totaling \$3,600, \$2,199 more than was required. Justin cannot use that \$2,199 to reduce the amount he is required to withdraw for 2005, but his IRA account balance is reduced by the full \$3,600 to figure his required minimum distribution for 2005. Justin's reduced IRA account balance on December 31, 2004, was \$34,800. Justin figured his required minimum distribution for 2005 is \$1,313 ($\$34,800 \div 26.5$). During 2005, he must receive distributions of at least that amount.

Multiple individual beneficiaries. If as of September 30 of the year following the year in which the owner dies there is more than one beneficiary, the beneficiary with the shortest life expectancy will be the designated beneficiary if both of the following apply.

- All of the beneficiaries are individuals, and
- The account or benefit has not been divided into separate accounts or shares for each beneficiary.

Separate accounts. Separate accounts with separate beneficiaries can be set up at any time, either before or after the owner's required beginning date. If separate accounts with separate beneficiaries are set up, the separate accounts are not combined for required minimum distribution purposes until the year after the separate accounts are established, or if later, the date of death. As a general rule, the required minimum distribution rules separately apply to each account.

However, the distribution period for an account is separately determined (disregarding beneficiaries of the other account(s)) only if the account was set up by the end of the year

following the year of the owner's death. The separate account rules cannot be used by beneficiaries of a trust.

Trust as beneficiary. A trust cannot be a designated beneficiary even if it is a named beneficiary. However, the beneficiaries of a trust will be treated as having been designated as beneficiaries if all of the following are true.

1. The trust is a valid trust under state law, or would be but for the fact that there is no corpus.
2. The trust is irrevocable or will, by its terms, become irrevocable upon the death of the owner.
3. The beneficiaries of the trust who are beneficiaries with respect to the trust's interest in the owner's benefit are identifiable from the trust instrument.
4. The IRA trustee, custodian, or issuer has been provided with either a copy of the trust instrument with the agreement that if the trust instrument is amended, the administrator will be provided with a copy of the amendment within a reasonable time, or all of the following.
 - a. A list of all of the beneficiaries of the trust (including contingent and remaindermen beneficiaries with a description of the conditions on their entitlement).
 - b. Certification that, to the best of the owner's knowledge, the list is correct and complete and that the requirements of (1), (2), and (3) above, are met.
 - c. An agreement that, if the trust instrument is amended at any time in the future, the owner will, within a reasonable time, provide to the IRA trustee, custodian, or issuer corrected certifications to the extent that the amendment changes any information previously certified.
 - d. An agreement to provide a copy of the trust instrument to the IRA trustee, custodian, or issuer upon demand.

The deadline for providing the beneficiary documentation to the IRA trustee, custodian, or issuer is October 31 of the year following the year of the owner's death. If the beneficiary of the trust is another trust and the above requirements for both trusts are met, the beneficiaries of the other trust will be treated as having been designated as beneficiaries for purposes of determining the distribution period. The separate account rules cannot be used by beneficiaries of a trust.

PROPERTY TAX

All property, unless specifically exempted by the Kentucky Constitution, is taxable. The Kentucky Constitution expressly prohibits exemption of any property or persons except those allowed by the Kentucky Constitution itself. Therefore, taxation is the rule and exemption the exception.

Currently, examples of such exceptions are the Homestead Exemption for age 65 and older and the Disability Exemption for 100% totally disabled persons. The Homestead Exemption (based on age or disability status) allows taxpayers who are at least 65 years of age or who are totally disabled to receive an exemption. The current exemption for 2005-2006 is \$29,400.

The following requirements must be met in order to claim the disability homestead exemption:

- The taxpayer must both own and maintain the property as his or her personal residence as of January 1st;

- The taxpayer must have been classified as totally disabled under a program authorized or administered by an agency of the United States Government, the Railroad Retirement System or any retirement system either within or outside the state of Kentucky on January 1st for the year in which the application is made and maintain the disability classification through December 31st;
- The taxpayer must be receiving disability payments pursuant to that disability classification; and
- An application for the disability exemption must be made on an annual basis.

The most common government agency under which a taxpayer can obtain a totally disabled classification is Social Security / SSI. Other programs include the Tennessee Valley Authority, the Veterans Administration and the Teacher's retirement System. Not included is Worker's Compensation due to the fact that this program is authorized and administered by the State of Kentucky not the Federal Government.

An application must be completed and filed in the Property Valuation Office along with documentation verifying age. Appropriate documentation might include Medicare cards issued by Social Security, birth certificates, and driver's license. When applying for the disability homestead, the same form will apply. However, documentation verifying total disability and that payments have been issued throughout the entire year must follow. Because of this, a taxpayer needs to provide proof of his or her disability status in the month of December.

HEALTH INSURANCE ISSUES

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to provide notice.

Introduction

Health insurance programs help workers and their families take care of their essential medical needs. These programs can be one of the most important benefits provided by an employer.

There was a time when employer-provided group health coverage was at risk if an employee was fired, changed jobs, or got divorced. That substantially changed in 1986 with the passage

of the health benefit provisions in the Consolidated Omnibus Budget Reconciliation Act (COBRA). Now, many employees and their families who would lose group health coverage because of serious life events are able to continue their coverage under the employer's group health plan, at least for limited periods of time.

What is COBRA Continuation Coverage?

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act to require most group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated.

COBRA requires continuation coverage to be offered to covered employees, their spouses, their former spouses, and their dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce, or legal separation from a covered employee, a covered employee's becoming entitled to Medicare, and a child's loss of dependent status (and therefore coverage) under the plan.

Employers may require individuals who elect continuation coverage to pay the full cost of the coverage, plus a 2 percent administrative charge. The required payment for continuation coverage is often more expensive than the amount that active employees are required to pay for group health coverage, since the employer usually pays part of the cost of employees' coverage and all of that cost can be charged to the individuals receiving continuation coverage. The COBRA payment is ordinarily less expensive, though, than individual health coverage.

While COBRA continuation coverage must be offered, it lasts only for a limited period of time. COBRA generally applies to all group health plans maintained by private-sector employers (with at least 20 employees) or by state and local governments. The law does not apply, however, to plans sponsored by the Federal government or by churches and certain church-related organizations.

Under COBRA, a group health plan is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance, by a health maintenance organization, out of the employer's assets on a pay-as-you-go basis, or otherwise. "Medical care" for this purpose includes:

- Inpatient and outpatient hospital care;
- Physician care;
- Surgery and other major medical benefits;
- Prescription drugs;
- Dental and vision care.

Life insurance is not considered "medical care," nor are disability benefits; and COBRA does not cover plans that provide only life insurance or disability benefits.

Group health plans covered by COBRA that are sponsored by private sector employers generally are governed by ERISA. ERISA does not require employers to establish plans or to provide any particular type or level of benefits, but it does require plans to comply with ERISA's rules, and ERISA gives participants and beneficiaries rights that are enforceable in court.

Alternatives to COBRA Continuation Coverage

If you become entitled to elect COBRA continuation coverage when you otherwise would lose group health coverage under a group health plan, you should consider all options you may have to get other health coverage before you make your decision. One option may be “special enrollment” into other group health coverage.

Under the Health Insurance Portability and Accountability Act (HIPAA), if you or your dependents are losing eligibility for group health coverage, including eligibility for continuation coverage, you may have a right to special enroll (enroll without waiting until the next open season for enrollment) in other group health coverage. For example, an employee losing eligibility for group health coverage may be able to elect special enrollment in a spouse's plan.

A dependent losing eligibility for group health coverage may be able to enroll in a different parent's group health plan. To have a special enrollment opportunity, you or your dependent must have had other health coverage when you previously declined coverage in the plan in which you now want to enroll. To special enroll, you or your dependent must request special enrollment with 30 days of the loss of other coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of special enrollment, you will have another opportunity to request special enrollment once you have exhausted your continuation coverage. In order to exhaust COBRA continuation coverage, you or your dependent must receive the maximum period of continuation coverage available without early termination. You must request special enrollment within 30 days of the loss of continuation coverage.

Another option may be to buy an individual health insurance policy. HIPAA gives individuals who are losing group health coverage and who have at least 18 months of creditable coverage without a break in coverage of 63 days or more the right to buy individual health insurance coverage that does not impose a preexisting condition exclusion period.

For this purpose, most health coverage, including COBRA continuation coverage, is creditable coverage. These special rights may not be available to you if you do not elect and receive COBRA continuation coverage. For more information on your right to buy individual health insurance coverage, contact your state department of insurance.

In addition to these options, individuals in a family may be eligible for health insurance coverage through various state programs. For more information contact your state department of insurance.

Who is Entitled to Continuation Coverage?

There are three basic requirements that must be met in order for you to be entitled to elect COBRA continuation coverage:

- Your group health plan must be covered by COBRA;
- A qualifying event must occur; and
- You must be a qualified beneficiary for that event.

Plan Coverage

COBRA covers group health plans sponsored by an employer (private sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.

Qualifying Events

“Qualifying events” are events that cause an individual to lose his or her group health coverage. The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage.

A plan may always choose to provide longer periods of continuation coverage.

The following are qualifying events for a covered employee if they cause the covered employee to lose coverage:

- Termination of the employee’s employment for any reason other than “gross misconduct”; or
- Reduction in the employee’s hours of employment.

The following are qualifying events for the spouse and dependent child of a covered employee if they cause the spouse or dependent child to lose coverage:

- Termination of the covered employee’s employment for any reason other than “gross misconduct”;
- Reduction in the hours worked by the covered employee;
- Covered employee becomes entitled to Medicare;
- Divorce or legal separation of the spouse from the covered employee; or
- Death of the covered employee.

In addition to the above, the following is a qualifying event for a dependent child of a

covered employee if it causes the child to lose coverage:

- Loss of “dependent child” status under the plan rules.

Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. Only certain individuals can become qualified beneficiaries due to a qualifying event, and the type of qualifying event determines who can become a qualified beneficiary when it happens.

A qualified beneficiary must be a covered employee, the employee’s spouse or former spouse, or the employee’s dependent child. In certain cases involving the bankruptcy of the employer sponsoring the plan, a retired employee, the retired employee’s spouse (or former spouse), and the retired employee’s dependent children may be qualified beneficiaries.

In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Your COBRA Rights and Responsibilities: Notice & Election Procedures

Under COBRA, group health plans must provide covered employees and their families with certain notices explaining their COBRA rights. They must also have rules for how COBRA continuation coverage is offered, how qualified beneficiaries may elect continuation coverage, and when it can be terminated.

Summary Plan Description

The COBRA rights provided under the plan must be described in the plan’s summary plan description (SPD). The SPD is a written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works.

ERISA requires group health plans to give you an SPD within 90 days after you first become a participant in a plan (or within 120 days after the plan is first subject to the reporting and disclosure provisions of ERISA). In addition, if there are material changes to the plan, the plan must give you a summary of material modifications (SMM) not later than 210 days after the end of the plan year in which the changes become effective; if the change is a material reduction in covered services or benefits, the SMM must be furnished not later than 60 days after the reduction is adopted. A participant or beneficiary covered under the plan may request a copy of the SPD and any SMMs (as well as any other plan documents), which must be provided within 30 days of a written request.

COBRA General Notice

Group health plans must give each employee and each spouse who becomes covered under the plan a general notice describing COBRA rights. The general notice must be provided within the first 90 days of coverage. Group health plans can satisfy this requirement by giving you the plan’s SPD within this time period, as long as it contains

the general notice information.

The general notice should contain the information that you need to know in order to protect your COBRA rights when you first become covered under the plan, including the name of the plan and someone you can contact for more information, a general description of the continuation coverage provided under the plan, and an explanation of any notices you must give the plan to protect your COBRA rights.

COBRA Qualifying Event Notices

Before a group health plan must offer continuation coverage, a qualifying event must occur, and the group health plan must be notified of the qualifying event. Who must give notice of the qualifying event depends on the type of qualifying event.

The employer must notify the plan if the qualifying event is:

- Termination or reduction in hours of employment of the covered employee;
- Death of the covered employee;
- Covered employee's becoming entitled to Medicare; or
- Bankruptcy of the employer.

You (the covered employee or one of the qualified beneficiaries) must notify the plan if the qualifying event is:

- Divorce;
- Legal separation; or
- A child's loss of dependent status under the plan.

You should understand your plan's rules for how to provide notice if one of these qualifying events occur. The plan must have procedures for how to give notice of the qualifying event, and the procedures should be described in both the general notice and the plan's SPD.

The plan must allow at least 60 days after the date on which the qualifying event occurs for the qualified beneficiary or employee to give this notice.

If your plan does not have reasonable procedures for how to give notice of a qualifying event, you can give notice by contacting the person or unit that handles your employer's employee benefits matters. If your plan is a multiemployer plan, notice can also be given to the joint board of trustees, and, if the plan is administered by an insurance company (or the benefits are provided through insurance), notice can be given to the insurance company.

COBRA Election Notice

When the plan receives a notice of a qualifying event, the plan must give the qualified beneficiaries an election notice, which describes their rights to continuation coverage and how to make an election.

The notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event. The election notice should contain all of the information you will need to understand continuation coverage and make an informed

decision whether or not to elect continuation coverage. It should also give you the name of the plan's COBRA administrator and tell you how to get more information.

COBRA Notice of Unavailability of Continuation Coverage

Group health plans may sometimes deny a request for continuation coverage or for an extension of continuation coverage. If you or any member of your family requests continuation coverage and the plan determines that you or your family member is not entitled to the requested continuation coverage for any reason, the plan must give the person who requested it a notice of unavailability of continuation coverage. The notice must be provided within 14 days after the request is received, and the notice must explain the reason for denying the request.

COBRA Notice of Early Termination of Continuation Coverage

Continuation coverage must generally be made available for a maximum period (18, 29, or 36 months). The group health plan may terminate continuation coverage earlier, however, for any of a number of specific reasons.

When a group health plan decides to terminate continuation coverage early for any of these reasons, the plan must give the qualified beneficiary a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy.

Special Rules for Multiemployer Plans

Multiemployer plans are allowed to adopt some special rules for COBRA notices. First, a multiemployer plan may adopt its own uniform time limits for the qualifying event notice or the election notice. A multiemployer plan also may choose not to require employers to provide qualifying event notices, and instead to have the plan administrator determine when a qualifying event has occurred. Any special multiemployer plan rules must be set out in the plan's documents (and SPD).

Election Procedures

If you become entitled to elect COBRA continuation coverage, you must be given an election period of at least 60 days (starting on the later of the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage.

Each of the qualified beneficiaries for a qualifying event may independently elect continuation coverage. This means that if both you and your spouse are entitled to elect continuation coverage, you each may decide separately whether to do so. The covered employee or the spouse must be allowed, however, to elect on behalf of any dependent children or on behalf of all of the qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child.

If you waive continuation coverage during the election period, you must be permitted later to revoke your waiver of coverage and to elect continuation coverage as long as you do so during the election period. Under those circumstances, the plan need only provide continuation

coverage beginning on the date you revoke the waiver.

Benefits Under Continuation Coverage

If you elect continuation coverage, the coverage you are given must be identical to the coverage that is currently available under the plan to similarly situated active employees and their families (generally, this is the same coverage that you had immediately before the qualifying event). You will also be entitled, while receiving continuation coverage, to the same benefits, choices, and services that a similarly situated participant or beneficiary is currently receiving under the plan, such as the right during an open enrollment season to choose among available coverage options.

You will also be subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

Any changes made to the plan's terms that apply to similarly situated active employees and their families will also apply to qualified beneficiaries receiving COBRA continuation coverage. If a child is born to or adopted by a covered employee during a period of continuation coverage, the child is automatically considered to be a qualified beneficiary receiving continuation coverage. You should consult your plan for the rules that apply for adding your child to continuation coverage under those circumstances.

Duration of Continuation Coverage

COBRA requires that continuation coverage be made available for a limited period of time of 18 or 36 months. The length of time for which continuation coverage must be made available (the "maximum period" of continuation coverage) depends on the type of qualifying event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

When the qualifying event is the covered employee's termination of employment or reduction in hours of employment, qualified beneficiaries are entitled to a maximum of 18 months of continuation coverage.

For all other qualifying events, qualified beneficiaries are entitled to a maximum of 36 months of continuation coverage.

Early Termination

A group health plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis;
- The employer ceases to maintain any group health plan;
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage, as long as that plan doesn't impose an exclusion or limitation affecting a preexisting condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or

- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice.

Extension of an 18-month Period of Continuation Coverage

If you are entitled to an 18-month maximum period of continuation coverage, you may become eligible for an extension of the maximum time period in two circumstances. The first is when a qualified beneficiary (either you or a family member) is disabled; the second is when a second qualifying event occurs.

Disability

If any one of the qualified beneficiaries in your family is disabled and meets certain requirements, all of the qualified beneficiaries receiving continuation coverage due to a single qualifying event are entitled to an 11-month extension of the maximum period of continuation coverage (for a total maximum period of 29 months of continuation coverage). The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11-month disability extension.

The requirements are, first, that the disabled qualified beneficiary must be determined by the Social Security Administration (SSA) to be disabled at some point during the first 60 days of continuation coverage, and, second, that the disability must continue during the rest of the 18-month period of continuation coverage.

The disabled qualified beneficiary or another person on his or her behalf must also notify the plan of the SSA determination. The plan can set a time limit for providing this notice of disability, but the time limit cannot be shorter than 60 days, starting from the latest of: (1) the date on which SSA issues the disability determination; (2) the date on which the qualifying event occurs; or (3) the date on which the qualified beneficiary receives the COBRA general notice.

The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The plan can require qualified beneficiaries receiving the disability extension to notify it if the SSA makes such a determination, although the plan must give the qualified beneficiaries at least 30 days after the SSA determination to do so.

The rules for how to give a disability notice and a notice of no longer being disabled should be described in the plan's SPD (and in the election notice if you are offered an 18-month maximum period of continuation coverage).

Second Qualifying Event

If you are receiving an 18-month maximum period of continuation coverage, you may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event that is the death of a covered employee, the divorce or legal separation of a covered employee and spouse, a covered employee's becoming entitled to Medicare, or a loss of dependent child status under the plan. The second

event can be a second qualifying event only if it would have caused you to lose coverage under the plan in the absence of the first qualifying event. If a second qualifying event occurs, you will need to notify the plan. The rules, for how to give notice of a second qualifying event, should be described in the plan's SPD (and in the election notice if you are offered an 18-month maximum period of continuation coverage).

Conversion Options

If your group health plan gives participants and beneficiaries whose coverage under the plan terminates the option to convert from group health coverage to an individual policy, the plan must give you the same option when your maximum period of continuation coverage ends. The conversion option must be offered not later than 180 days before your continuation coverage ends. The premium for an individual conversion policy may be more expensive than the premium of a group plan, and the conversion policy may provide a lower level of coverage. You are not entitled to the conversion option, however, if your continuation coverage is terminated before the end of the maximum period for which it was made available.

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered, based on the type of qualifying event. Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.

<u>QUALIFYING EVENT</u>	<u>QUALIFIED BENEFICIARIES</u>	<u>MAXIMUM PERIOD OF CONTINUATION COVERAGE</u>
Termination (for reasons other than gross misconduct)	Employee Spouse Dependent Child	18 months
Employee enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

Note: *In certain circumstances, qualified beneficiaries entitled to 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months) or an extension of an additional 18 months due to the occurrence of a second qualifying event (for a total maximum of 36 months)*

PAYING FOR CONTINUATION COVERAGE

Your group health plan can require you to pay for COBRA continuation coverage. The amount charged to qualified beneficiaries cannot exceed 102 percent of the cost to the plan for similarly situated individuals covered under the plan who have not incurred a qualifying event. In determining COBRA premiums, the plan can include the costs paid by employees and the employer, plus an additional 2 percent for administrative costs.

For qualified beneficiaries receiving the 11-month disability extension, the COBRA premium for those additional months may be increased to 150 percent of the plan's total cost of coverage for similarly situated individuals.

COBRA charges to qualified beneficiaries may be increased if the cost to the plan increases, but generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay the required premiums on a monthly basis if you ask to do so, and the plan may allow you to make payments at other intervals (for example, weekly or quarterly). The election notice should contain all of the information you need to understand the COBRA premiums you will have to pay, when they are due, and the consequences of late payment or nonpayment.

When you elect continuation coverage, you cannot be required to send any payment with your election form. You can be required, however, to make an initial premium payment within 45 days after the date of your COBRA election (that is the date you mail in your election form, if you use first-class mail). Failure to make any payment within that period of time could cause you to lose all COBRA rights. The plan can set premium due dates for successive periods of coverage (after your initial payment), but it must give you the option to make monthly payments, and it must give you a 30-day grace period for payment of any premium.

You should be aware that if you do not pay a premium by the first day of a period of coverage, but pay the premium within the grace period for that period of coverage, the plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Failure to make payment in full before the end of a grace period could cause you to lose all COBRA rights.

If the amount of a payment made to the plan is wrong, but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices.

COORDINATION WITH OTHER FEDERAL BENEFIT LAWS

Premium Tax Credit

Certain individuals may be eligible for a Federal income tax credit that can alleviate the financial burden of monthly COBRA premium payments. The Trade Adjustment Assistance Reform Act of 2002 (Trade Act of 2002) created the Health Coverage Tax Credit (HCTC), an advanceable, refundable tax credit for up to 65 percent of the premiums paid for specified types of health insurance coverage (including COBRA continuation coverage). The HCTC is available to certain workers who lose their jobs due to the effects of international trade and who qualify for trade adjustment assistance (TAA), as well as to certain individuals who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Individuals who are eligible for the HCTC may choose to have the amount of the credit paid on a monthly basis to their health coverage provider as it becomes due, or may claim the tax credit on their income tax returns at the end of the year.

FMLA

The Family and Medical Leave Act (FMLA) requires an employer to maintain coverage under any "group health plan" for an employee on FMLA leave under the same conditions coverage

would have been provided if the employee had continued working. Group health coverage that is provided under the FMLA during a family or medical leave is not COBRA continuation coverage, and taking FMLA leave is not a qualifying event under COBRA.

A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee taking FMLA leave decides not to return to work and notifies an employer of his or her intent not to return to work.

HIPAA

In considering whether to elect continuation coverage, you should take into account that maintaining group health coverage affects your future rights to protections provided under HIPAA. HIPAA limits the length of any preexisting condition exclusion that a group health plan may impose and generally requires any exclusion period to be reduced by an individual's number of days of creditable coverage that occurred without a break in coverage of 63 days or more. For this purpose, most health coverage, including COBRA coverage, is creditable coverage. Electing COBRA may help you avoid a 63-day break in coverage and, therefore, help you eliminate or shorten any future preexisting condition exclusion period that may be applied by a future group health plan, health insurance company, or HMO.

To take advantage of some of HIPAA's protections, individuals must show evidence of prior creditable coverage. The primary way individuals can evidence prior creditable coverage to reduce a preexisting condition exclusion period (or to gain other access to individual health coverage) is with a certificate of creditable coverage.

HIPAA requires group health plans, health insurance companies, and HMOs to furnish a certificate of creditable coverage to an individual upon cessation of coverage. A certificate of creditable coverage must be provided automatically to individuals entitled to elect COBRA continuation coverage, no later than when a notice is required to be provided for a qualifying event under COBRA, and to individuals who elected COBRA coverage, either within a reasonable time after learning that the COBRA coverage has ceased, or, within a reasonable time after the end of the grace period for payment of COBRA premiums.

If you do not receive or lose your certificate and cannot obtain another, you can still show prior coverage using other evidence of prior health coverage (for example, pay stubs, copies of premium payments, or other evidence of health care coverage).

Government Authority

COBRA continuation coverage laws are administered by several agencies. The Departments of Labor and Treasury have jurisdiction over private-sector group health plans. The Department of Health and Human Services administers the continuation coverage law as it affects public-sector health plans.

The Labor Department's interpretive responsibility for COBRA is limited to the disclosure and notification requirements of COBRA. The Labor Department has issued regulations on the COBRA notice provisions. The Treasury Department has interpretive responsibility to define the required continuation coverage. The Internal Revenue Service, Department of the Treasury, has issued regulations on COBRA provisions relating to eligibility, coverage and payment. The

Departments of Labor and Treasury share jurisdiction for enforcement of these provisions.

COBRA CASES

McDowell v Krawchison, 125 F.3d 954 (6th Cir. 1997)

I. BACKGROUND

At the times relevant to this case, Krawchison held an ownership interest in and operated several chiropractic clinics in Ohio, Kentucky, and Indiana. He owned half of the shares in each of three clinics, and owned all of the shares in the others, including Winton Road Chiropractic Center, Inc. Most of the clinics, including Winton Road, were separately incorporated. Krawchison also wholly owned Michiana Corporation, which provided management services for all of his clinics, such as paying bills (using the separate clinics' own funds), and provided patient transportation for the Indiana clinics. Krawchison followed corporate formalities with respect to each incorporated clinic and did not commingle their funds.

The clinics provided health insurance to their employees through Medical Benefits Mutual Life Insurance Company; the plan under which employees of all the separate clinics were covered was obtained under the name "John R. Krawchison Corporation" (that name appeared on the employees' insurance cards). Krawchison obtained the insurance under a single plan for all the clinics in order to receive a lower rate (by aggregating the numbers of employees); there was no actual John R. Krawchison Corporation.

In late 1991, Krawchison asked McDowell to work for him at the Winton Road clinic in Cincinnati. McDowell accepted and began work in early January 1992. In September 1992, Dr. Dennis Anderson, who had previously worked at the Winton Road clinic, returned to buy the clinic from Krawchison. He terminated McDowell's employment, effective two days later. McDowell, whose wife, Sidovar, had breast cancer, wanted to continue his and Sidovar's health insurance. Although McDowell claimed that Anderson had assured him that "we" would take care of the insurance, Krawchison disputed Anderson's authority to act on behalf of either Krawchison or the Winton Road corporation at that point. McDowell later asked Susan Porter, the office manager for the Winton Road clinic, if he could continue on the health insurance plan. Porter told him that she believed it was possible, but that she would check with Krawchison, which she did. .

On McDowell's last day of employment, Porter told him that his health insurance would be continued; the parties dispute whether Porter told McDowell that he would have to pay the premiums. Porter stated in her deposition that she had so told him, and that she also had told him that he should contact Trisha Kincer, an employee of Michiana Corporation who handled the health insurance plan, to find out the amount of the premiums. McDowell never contacted Kincer.

Porter also gave McDowell a release to sign, waiving all claims related to his employment against Winton Road Chiropractic Center, Inc. or Krawchison individually. After consulting with counsel, McDowell signed the release.

Neither McDowell nor Sidovar sought coverage for any medical treatment from September 1992 until early June 1993. At that time, Sidovar sought pre-approval for medical treatment and

learned that she had no insurance coverage. McDowell and Sidovar filed suit against Krawchison in early 1994 alleging violation of COBRA in addition to several state claims; they later added the Winton Road corporation as a defendant. In July 1995, the district court issued an order denying Krawchison's motion for summary judgment with regard to his individual liability on the COBRA claim, denying the corporation's motion for summary judgment based on its contention that it was exempt from COBRA requirements, denying the defendants' motion for summary judgment based on the signed release, granting the plaintiffs' motion for partial summary judgment based on failure to provide notice of COBRA rights, and granting the defendants' motion for summary judgment as to the allegation of an oral promise to provide continued benefits and as to the state law claims. After a hearing and stipulations, the court issued a final order in March 1996 entering judgment for the plaintiffs against both defendants. On appeal, the defendants base their challenge on the issues of COBRA notice, Krawchison's liability, and the effect of the release.

II. ANALYSIS

COBRA imposes a statutory requirement that a plan administrator notify "any qualified beneficiary" of his or her right to continue health insurance coverage for up to eighteen months after a "qualifying event" (here, McDowell's termination). "Providing appropriate notice is a key requirement under COBRA.... If the administrator fails to provide that notice [of triggering of COBRA rights] to the qualified beneficiary, it may be bound to provide coverage to her." Both plaintiffs in this case were qualified beneficiaries as defined by COBRA.

It was undisputed that McDowell and Sidovar received no written notice of their COBRA rights. McDowell claimed that he was not informed of his rights; Susan Porter stated in her deposition that she did inform him that he would have to pay his own premiums to continue coverage. Because the defendants produced no other evidence to support Porter's version, the district court stated that the evidence was "in equipoise," and that the issue must be resolved against the party bearing the burden of proof—the defendants.

COBRA rights include the option to continue health insurance coverage equivalent to other qualified beneficiaries for at least eighteen months, at a cost of no more than 102 percent of the premium; the beneficiary must elect coverage within sixty days after the qualifying event, and may not be required to make the first premium payment before forty-five days after election. The statute itself does not prescribe the contents of the required notice. Nevertheless, the notice given must be sufficient to allow the qualified beneficiary to make an informed decision whether to elect coverage.

Although the defendants contend that oral notice should be deemed sufficient, we need not decide that issue in this case. Even if the notice to McDowell by way of his conversation with Porter was legally sufficient, it did not meet the statutory requirement as to Sidovar. She was entitled by statute to *her own notice* of her rights. The statute explicitly requires notice to be given to any qualified beneficiary, and defines a covered spouse to be a qualified beneficiary. A covered spouse has his or her own rights under COBRA, which are *not* dependent on the covered employee's rights. For example, a covered spouse might choose to elect coverage while the covered employee does not, or they might choose different plans.

The covered spouse often may be a qualified beneficiary where the covered employee is not: a covered spouse is specifically defined as a qualified beneficiary; a covered employee, on the

other hand, is a qualified beneficiary only when he or she is terminated other than for gross misconduct or experiences a reduction in hours. In fact, the definition of “qualifying event” focuses largely on the resulting loss of coverage to other family members; COBRA coverage for qualified beneficiaries is triggered not only when the covered employee is terminated, but also when he or she dies or becomes covered by Medicare, when the covered spouse is divorced or legally separated from the covered employee, when a dependent child ceases to be a dependent child, or when an employer from whom the covered employee retired files for bankruptcy.

Other COBRA provisions belie the defendants' contention that notice to the covered employee satisfies the administrator's obligation as to a covered spouse. For instance, states that notification by the administrator “to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.” In other words, the administrator is not required to notify each covered dependent child living at home, provided that the nonemployee parent, the spouse of the covered employee, is notified. If the statute eliminates the need to notify certain qualified beneficiaries, but does *not* explicitly except notification of the spouse-and, in fact, relies upon such notification to provide notice to covered dependents-then we cannot read the statute to eliminate the need to notify a covered spouse.

The statute also provides that “any election of continuation coverage by a qualified beneficiary ... shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event. If there is a choice among types of coverage under the plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage.” Perhaps significantly, this provision acts only to preserve coverage for other qualified beneficiaries; it does not, for instance, treat one beneficiary's decision not to continue coverage as eliminating the other beneficiaries' option to elect, and in fact it allows beneficiaries to elect different types of coverage.

This election provision is useful as an analogy-it allows one beneficiary to be deemed to have acted on others' behalf only in order to maintain coverage, and it explicitly provides for a separate election by each beneficiary; it does not allow beneficiaries to be treated as a unit for purposes of denying coverage. Similarly, we do not interpret the statute's notice provisions as treating the covered employee and his or her spouse as a unit for notice purposes, such that the plan administrator is absolved of its duty to notify the spouse.

Taken together, §§ 1165(2) and 1166(c) indicate that qualified beneficiaries are to be treated separately for COBRA purposes except in these specifically-defined exceptions, both of which operate in favor of coverage. Moreover, these two provisions strongly suggest that had Congress intended notice to a covered employee to serve as notice to that employee's covered spouse as well, it would have so provided. Therefore, we hold that the plan administrator was required to provide Sidovar with sufficient notice of her rights, and that failure to do so violated COBRA.

We note that case law from other courts also supports our conclusion that notice to a covered employee does not fulfill the statutory requirement of notice to a covered spouse. The Seventh Circuit has held that because the duty to notify does not depend on the employee's knowledge, “[l]ikewise, an employee's knowledge cannot affect his spouse's right to notification or election.”

Cases cited by the defendants do not support a different conclusion. In *Lincoln General Hospital*, the Eighth Circuit held that the plan administrator had satisfied the notification requirement *not* because the employer gave the COBRA notice form to the covered employee to deliver to his ex-wife (the finalization of the divorce was the qualifying event, triggering the ex-wife's COBRA rights), but because the insurer sent an identification card, premium statement, and benefits information to the ex-wife herself.

The Eleventh Circuit's holding in *Meadows* does not support the defendants' argument; although the court held sufficient a notice that was mailed to the covered employee not at her last known address, but at her husband's last known address, in that case the employee was in a persistent vegetative state, her last known address was the medical facility in which she was hospitalized, and it was clear that her husband was handling her insurance coverage on her behalf.

Though the court did not explain its reasoning for holding the notice satisfactory despite its mailing to an address other than the beneficiary's last known address (as required by the plan in that case), the factual situation suggests that the court considered the beneficiary's inability to make an informed decision, and her spouse's need to make the decision for her. Nothing in *Meadows* suggests that notice to the spouse of a qualified beneficiary, as is claimed in this case (i.e., notice to McDowell), is a satisfactory substitute for notice to the beneficiary herself (Sidovar).

The defendants argue that if McDowell did in fact communicate the information given to him to Sidovar, Sidovar should be deemed to have been notified. Even if the information given to McDowell was sufficient to provide him with the required notice, this argument fails. As the Seventh Circuit stated in *Misna*, “[a]n employee's knowledge of his COBRA rights does not relieve the plan administrator of its notification duties.... [T]he statute does not make the duty to notify dependent upon an employee's knowledge....” Likewise, any qualified beneficiary's knowledge of his or her rights does not affect the statutory duty to notify that beneficiary. The defendants ask this court to hold that McDowell's purported understanding of his rights relieved the plan administrator of its statutory obligation to notify Sidovar of her rights as well. Defendants urge this court that to require actual notice to Sidovar would turn COBRA into “a technical labyrinth”; to the contrary, we believe that the clear language of the statute not only mandates actual notice, but establishes a simple requirement that will not mire plan administrators and courts in fact-specific inquiries as to whether a covered employee actually notified the covered spouse, whether that notification adequately informed the spouse of his or her rights, and so on.

B. Krawchison's Liability

The district court denied Krawchison's motion for summary judgment as to his individual liability; the court held that under ERISA's definition of “employer,” Krawchison was McDowell's employer for COBRA purposes, and that deference to the corporate form was unwarranted in light of the purposes of ERISA and COBRA, particularly since Krawchison did not hold corporate meetings and obtained the health insurance coverage in his own name. In the final order, the court entered judgment against both the Winton Road Chiropractic Center, Inc. and Krawchison individually. Krawchison contends that the district court erred in imposing individual liability.

The district court analyzed the issue of liability incorrectly, basing its imposition of personal liability largely on its holding that Krawchison was McDowell's employer. We note that Krawchison is incorrect in contending that "employer" is not defined for COBRA purposes and must be afforded its ordinary meaning. Though Krawchison points out that "employer" is not defined "in COBRA," he overlooks the fact that COBRA was merely an amendment to ERISA. "Employer" is defined in ERISA, and the definition applies to the entire subchapter, which includes COBRA. Though COBRA contains its own definitions, applicable only to that part, it is also part of ERISA and subject to the definitions in § 1002. Therefore, the district court stated the correct definition of "employer": "any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan...." Nevertheless, the district court misapplied the definition.

Krawchison did meet the ERISA definition of an employer. Even assuming that he did not act directly as an employer, he clearly did act "indirectly in the interest of" the Winton Road corporation with regard to the health plan. He obtained the insurance plan for the clinic, along with the other clinics-not merely as an officer performing an administrative function, but clearly as a figure central to all of the clinics. The fact that Porter consulted him about McDowell's COBRA coverage, rather than asking someone at the insurance company or at Michiana also shows that he made decisions regarding the plan on behalf of (and in the interest of) the Winton Road corporation. Krawchison therefore acted in the interest of the Winton Road corporation with regard to the health plan to an extent that met the ERISA definition of "employer."

The fact that Krawchison could be considered the employer in his actions regarding the plan, however, does not justify imposition of individual liability. In Miller v. Maxwell's Int'l Inc., 991 F.2d 583, 587-88 (9th Cir.1993), the court held that definitions of "employer" for purposes of Title VII and *962 the ADEA that included agents were intended to impose respondeat superior liability on employers, not to hold those acting on behalf of employers personally liable. This circuit recently came to the same conclusion regarding Title VII.

The definition of "employer" under ERISA is worded such that it appears to have the same intended purpose. A broader interpretation might allow a court to hold an individual employee who merely processes health insurance questions and paperwork personally liable for a plaintiff's medical costs under COBRA; Congress most likely did not intend such a result. Holding Krawchison individually liable on the basis of the ERISA definition, therefore, was error.

Nevertheless, the district court reached the correct result as to Krawchison's liability. COBRA clearly places the burden of providing notice on the "administrator." "Administrator" is defined for ERISA purposes as (i) the person specifically designated as the administrator by the terms of the plan instrument; (ii) if the instrument does not designate an administrator, the plan sponsor; or (iii) if no administrator is designated and a plan sponsor cannot be identified, a person prescribed by the Secretary in regulations.

A "plan sponsor," in turn, is the employer, in the case of a plan established or maintained by a single employer, or "the association, committee, joint board of trustees, or other similar group of representatives" of the parties who establish or maintain a plan jointly. In this case, there is no evidence in the record, and neither party has contended, that Medical Benefits Mutual Life Insurance Company was designated the plan administrator. In fact, defendants' counsel conceded at oral argument that no plan administrator was designated in the plan documents. Moreover, all parties appear to have assumed that the responsibility for providing notice, and

the liability for any failure to provide notice, rested on McDowell's employer, with no suggestion that Medical Benefits Mutual Life Insurance Company was in any way responsible. Under 29 U.S.C. § 1002(16)(A)(ii), therefore, in the absence of a designated administrator, the plan sponsor was the plan administrator for purposes of ERISA and COBRA.

The evidence indicates that Krawchison himself was the plan sponsor. If the plan had been established and maintained solely by the Winton Road corporation for its employees, the Winton Road corporation would be the plan sponsor. The medical benefits plan at issue, however, was not established or maintained by the Winton Road corporation, and its coverage was not limited to employees of that corporation. Rather, the separate clinics owned by Krawchison shared a common health plan; by definition, the plan sponsor of such a plan is the committee or similar group of representatives of the member employers.

In this case, Krawchison is the only entity that could reasonably be deemed the plan sponsor under the statutory definition. He was the sole owner and officer of most of the clinics, and the single common link among all of the clinics. In addition, rather than obtaining insurance separately for each clinic, he decided to aggregate the clinics' work forces in the interest of obtaining a cheaper rate. Significantly, he established the plan under his own name; although the plan was in the name of the "John R. Krawchison Corporation," Krawchison conceded that no such corporation existed. In fact, his own statements indicated that he did not seek to use a corporate name to obtain the policy; he simply wanted to aggregate the number of employees, and someone else created the corporate variation of his name. (Krawchison signed his own name (without "Corporation") as the "Employer's Legal Name" on the employer application to obtain a health insurance plan). The very fact that he chose to cover the employees at all of his separately-incorporated clinics on a single policy, and that the policy was put under his own name, rather than any clinic-employer's name, justifies holding him to be the plan sponsor. Moreover, Krawchison's own evidence suggested that he made decisions with regard to the administration of the plan. When McDowell asked whether he could continue coverage, Porter, the office manager for the Winton Road clinic, did not turn to Medical Benefits Mutual Life Insurance Company for the answer, or even to the Michiana Corporation, which handled premium payments and other administrative functions for the separate clinics. Instead, Porter told McDowell that she would ask Krawchison; she did in fact ask Krawchison, who told her that McDowell could maintain coverage if he paid his own premiums, and Porter relayed that information to McDowell.

For the above reasons, we hold that Krawchison is liable as the plan sponsor and thus as the administrator responsible for the failure to notify Sidovar of her COBRA rights, and therefore that the district court properly held him individually liable. Because there was no evidence that the Winton Road corporation established or maintained the benefits plan, it cannot be deemed the plan sponsor under the statute, despite the fact that it was McDowell's employer; the Winton Road corporation therefore cannot be held liable for the failure to provide COBRA notice.

C. The Effect of the Release

The defendants contend that the plaintiffs' COBRA claims are barred by the release that McDowell signed, which waived all claims against the Winton Road corporation and Krawchison "directly or indirectly relating" to his employment. We need not decide that issue, however, because we hold that the release signed by McDowell could not have waived Sidovar's COBRA rights. The defendants argue that the release barred Sidovar's COBRA claim as well as

McDowell's, since her right to coverage was dependent on his right to coverage, because there was no "qualifying event" as to Sidovar. A simple reading of the statute shows that the defendants are clearly mistaken. A rule by which the spouse's COBRA rights would derive from the employee's rights could apply, if at all, only to cases where the covered employee himself or herself was a qualified beneficiary. For that reason, the defendants' reading of the statute is nonsensical; it would eradicate all COBRA coverage for nonemployees (i.e., spouses and families) triggered by the qualifying events listed in 29 U.S.C. § 1163(1), (3)-(5) -all but § 1163(2) and (6).

Under the clear language of the statute, Sidovar, as a spouse of an employee, and as a beneficiary under the plan as of the day before the qualifying event of McDowell's termination, was a qualified beneficiary entitled to COBRA coverage. Her rights were in no way contingent on McDowell's. Therefore, even if McDowell did waive his COBRA rights, he did not-and could not-waive Sidovar's.

III. CONCLUSION

For the reasons discussed above, we AFFIRM the judgment of the district court awarding damages to the plaintiffs against Defendant Krawchison, and REVERSE the judgment against Defendant Winton Road Chiropractic Center, Inc. We REMAND to the district court for further proceedings consistent with this opinion.

Geissal v. Moorer Medical Corp., 524 U.S. 74 (1998)

(Souter, J., delivered the opinion for a unanimous Court.)

The Employee Retirement Income Security Act of 1974 (ERISA), as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), authorizes a qualified beneficiary of an employer's group health plan to obtain continued coverage under the plan when he might otherwise lose that benefit for certain reasons, such as the termination of employment. The issue in this case is whether 29 U.S.C. § 1162(2)(D)(i) allows an employer to deny COBRA continuation coverage to a qualified beneficiary who is covered under another group health plan at the time he makes his COBRA election. We hold that it does not.

I BACKGROUND

On July 16, 1993, respondent Moore Medical Corporation fired James Geissal, who was suffering from cancer. While employed, Geissal was covered under Moore's group health plan as well as the health plan provided by his wife's employer, Trans World Airlines (TWA), through Aetna Life Insurance Company.

According to Geissal, soon after he lost his job, Moore told him that he had a right under COBRA to elect to continue coverage under Moore's plan. Geissal so elected, and made the necessary premium payments for six months. On January 27, 1994, however, Moore informed Geissal it had been mistaken: he was not actually entitled to COBRA benefits because on the date of his election he was already covered by another group health plan, through his wife's employer.

Geissal then brought this suit against Moore, the Group Benefit Plan of Moore Medical Group, Herbert Walker (an administrator of the plan), and Sedgwick Lowndes (another administrator)

(collectively, Moore). Geissal charged Moore with violating COBRA by renouncing an obligation to provide continuing health benefits coverage (Count I); he further claimed that Moore was estopped to deny him continuation coverage because it had misled him to think that he was entitled to COBRA coverage (Count II), that Moore's misrepresentation amounted to a waiver of any right to assert a reading of the plan provisions that would deprive him of continuation coverage (Count III), and, finally, that Walker had violated COBRA by failing to provide him with certain plan documents (Count IV).

After limited discovery, Geissal moved for partial summary judgment on Counts I and II of the complaint. He argued that Moore's reliance upon 29 U.S.C. § 1162(2)(D)(i) as authority to deny him COBRA continuation coverage was misplaced. Although that subsection provides that an employer may cancel COBRA continuation coverage as of "[t]he date on which the qualified beneficiary first becomes, after the date of the election ... covered under any other group health plan (as an employee or otherwise)," Geissal was first covered under the TWA plan before he elected COBRA continuation coverage, not after. In any event, Geissal maintained, Moore was estopped to deny him health benefits, because he had detrimentally relied upon its assurances that he was entitled to them. While the summary judgment motion was pending, Geissal died of cancer, and petitioner Bonnie Geissal, his wife and personal representative of his estate, replaced him as plaintiff.

The Magistrate Judge hearing the case first rejected Moore's arguments that Geissal lacked standing and that Aetna was a necessary party under Federal Rule of Civil Procedure 19(a). The Magistrate concluded that even if Moore was correct that Geissal had no claim for compensatory damages because Aetna paid all of the medical bills, Geissal could seek statutory damages under 29 U.S.C. § 1132(a)(1). The Magistrate held that Aetna was not a necessary party to the suit, since complete relief could be granted between Moore and Geissal without joining Aetna, a verdict in Geissal's favor would not subject Moore to the risk of inconsistent or double obligations, and Aetna's joinder was not necessary to determine primacy as between the two plans.

The Magistrate denied summary judgment for Geissal, however, and instead *sua sponte* granted partial summary judgment on Counts I and II in favor of Moore, concluding that an employee with coverage under another group health plan as of the date he elects COBRA continuation coverage is ineligible for COBRA coverage under § 1162(2)(D)(i), and that James Geissal presented insufficient evidence of detrimental reliance on Moore's representation that he was entitled to benefits under COBRA. The Magistrate also found that there was no significant difference between the terms of coverage under Aetna's plan and Moore's; they differed only in the amount of their respective deductibles, and there was no evidence that Aetna's plan excluded or limited coverage for James Geissal's condition.

The Magistrate then granted Geissal's unopposed motion under Federal Rule of Civil Procedure 54(b) for the entry of final judgment on Counts I and II, and so enabled Geissal to seek immediate review of the Magistrate's decision. The Court of Appeals for the Eighth Circuit affirmed and we granted certiorari to resolve a conflict among the Circuits on whether an employer may deny COBRA continuation coverage under its health plan to an otherwise eligible beneficiary covered under another group health plan at the time he elects coverage under COBRA.

II DISCUSSION

A COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 amended the Employee Retirement Income Security Act, among other statutes. The amendments to ERISA require an employer who sponsors a group health plan to give the plan's "qualified beneficiaries" the opportunity to elect "continuation coverage" under the plan when the beneficiaries might otherwise lose coverage upon the occurrence of certain "qualifying events," including the death of the covered employee, the termination of the covered employee's employment (except in cases of gross misconduct), and divorce or legal separation from the covered employee. Thus, a "qualified beneficiary" entitled to make a COBRA election may be a "covered employee" (someone covered by the employer's plan because of his own employment), or a covered employee's spouse or dependent child who was covered by the plan prior to the occurrence of the "qualifying event." § 1167(3).

COBRA demands that the continuation coverage offered to qualified beneficiaries be identical to what the plan provides to plan beneficiaries who have not suffered a qualifying event. The statute requires plans to advise beneficiaries of their rights under COBRA both at the commencement of coverage and within 14 days of learning of a qualifying event, § 1166(a), after which qualified beneficiaries have 60 days to elect continuation coverage, § 1165(1). If a qualified beneficiary makes a COBRA election, continuation coverage dates from the qualifying event, and when the event is termination or reduced hours, the maximum period of coverage is generally 18 months; in other cases, it is generally 36.

The beneficiary who makes the election must pay for what he gets, however, up to 102 percent of the "applicable premium" for the first 18 months of continuation coverage, and up to 150 percent thereafter. The "applicable premium" is usually the cost to the plan of providing continuation coverage, regardless of who usually pays for the insurance benefit. § 1164. Benefits may cease if the qualified beneficiary fails to pay the premiums, and an employer may terminate it for certain other reasons, such as discontinuance of the group health plan entirely. COBRA coverage may also cease on

"[t]he date on which the qualified beneficiary first becomes, after the date of the election-
"(i) covered under any other group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary, or
"(ii) entitled to benefits under title XVIII of the Social Security Act."

B ANALYSIS

Moore, like the Magistrate, believes that James Geissal's coverage under the TWA plan defeats the claim for COBRA coverage after his election to receive it. As Moore reads § 1162(2)(D)(i), it is not relevant when a qualified beneficiary first obtains other health insurance coverage; instead, Moore submits, all that matters is whether, at any time after the date of election, the beneficiary is covered by another group health plan. In any event, Moore claims, James Geissal first became covered under the TWA plan only after his COBRA election, because it was only at that moment that his TWA coverage became primary.

Moore's reading; however, will not square with the text. Section 1162(2)(D)(i) does not provide that the employer is excused if the beneficiary "is" covered or "remains" covered on or after the date of the election. Nothing in § 1162(2)(D)(i) says anything about the hierarchy of policy obligations, or otherwise suggests that it might matter whether the coverage of another group health plan is primary. So far as this case is concerned, what is crucial is that § 1162(2)(D)(i) does not speak in terms of "coverage" that might exist or continue; it speaks in terms of an event, the event of "becom[ing] covered." This event is significant only if it occurs, and "first" occurs, at a time "after the date of the election." It is undisputed that both before and after James Geissal elected COBRA continuation coverage he was continuously a beneficiary of TWA's group health plan. Because he was thus covered before he made his COBRA election, and so did not "first become" covered under the TWA plan after the date of election, Moore could not cut off his COBRA coverage under the plain meaning of § 1162(2)(D)(i).

Moore argues, to the contrary, that there is a reasonable sense in which a beneficiary does "first becom[e]" covered under a pre-existing plan "after the date of the election," even when prior coverage can be said to persist after the election date: the first moment of coverage on the day following the election is the moment of first being covered after the date of the election. But that reading ignores the condition that the beneficiary must "first becom[e]" covered after election, robbing the modifier "first" of any consequence, thereby equating "first becomes ... covered" with "remains covered." It transforms the novelty of becoming covered for the first time into the continuity of remaining covered over time.

Moore argues, further, that even if our reading of the statute is more faithful to its plain language, Congress could not have meant to give a qualified beneficiary something more than the right to preserve the status quo as of the date of the qualifying event. Moore points out that if the phrase "first becomes covered ... after" the date of election does not apply to any coverage predating election, then the beneficiary is quite free to claim continuation coverage even if he has obtained entirely new group coverage between the qualifying event and the election; in that case, on our reading, COBRA would not be preserving the circumstances as of the date of the qualifying event.

That the plain reading does not confine COBRA strictly to guardianship of the status quo is, of course, perfectly true, though it is much less certain whether this fact should count against the plain reading (even assuming that the obvious reading would be vulnerable to such an objection. The statute is neither cast expressly in terms of the status quo, nor does it speak to the status quo on the date of the qualifying event except with reference to the coverage subject to election. Nor does a beneficiary's decision to take advantage of another group policy not previously in effect carry any indicia of the sort of windfall Congress presumably would have disapproved. Since the beneficiary has to pay for whatever COBRA coverage he obtains, there is no reason to assume that he will make an election for coverage he does not need, whether he is covered by another policy in place before the qualifying event or one obtained after it but before his election.

Still, it is true that if during the interim between the qualifying event and election a beneficiary gets a new job, say, with health coverage (having no exclusion or limitation for his condition), he will have the benefit of COBRA, whereas he will not have it if his new job and coverage come after the election date. Do we classify this as an anomaly or merely a necessary consequence of the need to draw a line somewhere? For the sake of argument we might call it an anomaly, but that would only balance it against the anomaly of Moore's own position, which defies not

only normal language usage but the expectations of common sense: since an election to continue coverage is retroactive to the date of the qualifying event, under Moore's reading of § 1162(2)(D)(i) an election that is ineffective to bring about continuation coverage for the roughly 18 (or 36) month statutory period would nonetheless have the surprising effect of providing continuation coverage for the period of weeks, or even days, between the event and the election. One wonders why Congress would have wanted to create such a strange scheme. Thus, assuming that our reading of § 1162(2)(D)(i) produces an anomaly, so does Moore's.

But this is not all, for the anomalous consequences of Moore's position are not exhausted without a look at the interpretative morass to which it has led in practice. To support its thesis that Congress meant individuals situated like James Geissal to be ineligible for COBRA benefits, Moore points to a statement in the House Reports on the original COBRA bill, that "[t]he Committee [on Ways and Means] is concerned with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay."

Of course, if this concern (expressed in one House Committee Report) were thought to be a legitimate limit on the meaning of the statute as enacted, there would be no COBRA coverage for any beneficiary who had "any health insurance" on the date of election, or obtained "any" thereafter. But neither Moore nor any court rejecting the plain reading has gone quite so far. Instead, that draconian alternative has been averted by a nontextual compromise.

The compromise apparently alludes to the proviso that § 1162(2)(D)(i) applies so as to authorize termination of COBRA coverage only if the coverage provided by the other group health plan "does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary." Moore urges us to hold, as some Courts of Appeals have done, that although Congress generally intended to deny COBRA coverage to individuals with other group insurance on the election date, there will still be COBRA eligibility in such cases if there is a "significant gap" between the coverage offered by the employer's plan and that offered by the beneficiary's other group health plan. When there is such a gap, some courts have explained, it cannot be said that the employee is truly "covered" by his pre-existing insurance coverage.

This "significant gap" approach to § 1162(2)(D)(i) is plagued with difficulties, however, beginning with the sheer absence of any statutory support for it. Section 1162(2)(D)(i) makes no mention of what to do when a person's other coverage is generally inadequate or inferior; instead, it provides merely that coverage under a later acquired group health plan will not terminate COBRA rights when that plan limits or excludes coverage for a pre-existing condition of the beneficiary. The proviso applies not when there is a "gap" or difference between the respective coverages of the two policies, but when the later acquired group coverage excludes or limits coverage specific to the beneficiary's pre-existing condition. It is this "gap" between different coverage provisions of the non-COBRA plan, not a gap between the coverage provisions of the COBRA plan and the non-COBRA plan, that Congress was legislating about.

But even leaving textual inadequacy aside, there is further trouble under the "significant gap" approach. Needless to say, when the proviso (as written) arguably does apply, its applicability is easy to determine. Once the beneficiary's pre-existing condition is identified, a court need only look among the terms of the later policy for an exclusion or limitation peculiar to that condition. If either is found, COBRA continuation coverage is left undisturbed; if neither is found, the consequence of obtaining this later insurance is automatic. Applying the significant gap rule, on

the other hand, requires a very different kind of determination, essentially one of social policy. Once a gap is found, the court must then make a judgment about the adequacy of medical insurance under the later group policy, for this is the essence of any decision about whether the gap between the two regimes of coverage is "significant" enough. This is a powerful point against the gap interpretation for two reasons. First, the required judgment is so far unsuitable for courts that we would expect a clear mandate before inferring that Congress meant to foist it on the judiciary.

What is even more strange, however, is that Congress would have meant to inject the courts into the policy arena, evaluating the adequacy of non-COBRA coverage that happened to be in place prior to the COBRA election, while at the same time intending to limit the judicial intrusion, and leave the beneficiary to the unmediated legal consequences of the terms of the non-COBRA coverage that happened to become effective after the election. One just cannot credibly attribute such oddity to congressional intent.

In sum, there is no justification for disparaging the clarity of § 1162(2)(D)(i). The judgment of the Court of Appeals is vacated, and the case is remanded for further proceedings consistent with this opinion.

RETIREE HEALTH BENEFITS

Can the Retiree Health Benefits Provided By Your Employer Be Cut?

Background

Providing for health care is an important part of retirement. Some employees are fortunate: they belong to employer-provided health care plans that carry over to retirement. However, an important question arises for employees and retirees: How secure are my health care benefits after retirement? Under what circumstances can the company reduce or terminate my health benefits?

Employees and retirees should know that private-sector employers are not required to promise retiree health benefits. Furthermore, when employers do offer retiree health benefits, nothing in federal law prevents them from cutting or eliminating those benefits--unless they have made a specific promise to maintain the benefits.

The key to understanding your retiree health benefits lies in the documents governing your plan.

Review Your Plan Documents

To understand the terms of employer-provided retiree health benefits, you should first review your plan documents. The Summary Plan Description (SPD) is a summary of the terms of the plan. Employers are required to provide a copy to you within 90 days after you become a participant in the plan.

For retirees, the SPD that was in effect when you retired may be the controlling document. You should save a copy of it. You also should save any SPD changes affecting your benefits after you retire. In addition, there may be formal written documents that outline how your health plan is operated. These may include a collective bargaining agreement or an insurance contract.

You Should Know-Coverage Can Change

If your employer has reserved the right in the SPD and controlling plan document to change the terms of the plan, you may lose coverage at any time during your retirement. If your employer made a clear promise that you will have specific health care benefits for a definite period of time or for life, and did not reserve the right to change the plan, you should be covered.

What to Look for in Plan Documents

Check all your plan documents with the following questions in mind:

Do the SPD or other plan documents promise that health benefits after retirement will continue at a specified level for a certain period of time?

If there is no specific language describing retiree health benefits in your plan documents, it is unlikely that you have coverage. If there is such language, how specific is it?

Sometimes language covering retiree health benefits is included in the documents, but it is too vague to stand up to a test in the courts. Conversely, there is language on employee health benefits that has held up in court. Here is an example:

"Basic health care coverages will be provided at the company's expense for your lifetime."

Even if a specific promise is made, is there also language that gives your former employer the right to change or terminate that specific promise or to amend or terminate the entire plan?

Typical language giving the employer that right might read:

"The company reserves the right to modify, revoke, suspend, terminate, or change the program, in whole or in part, at any time."

This is an actual example, but other similar language may be found anywhere in the plan documents.

If you are an employee reviewing the current plan, it is important to remember that it can change in the future. The documents in effect when you retire are the ones that will determine your health benefits, if any, in your retirement. However, court rulings in these matters have not been uniform.

What if the Language is Conflicting or Ambiguous?

Benefit plan documents are often not easy to interpret, and the language, described above, providing an employer's right to change benefits may be contained in any part of the documents.

Some courts may not enforce what seems like clear "promise" language if the plan document contains general language reserving the employer's right to amend or terminate the plan.

On the other hand some courts have enforced clear promise language in an SPD, even in cases where the plan document contained a right by the employer to amend the promise. You need to check all documents.

Review Any Employer Communications on Retiree Health Benefits

You should obtain whatever information is available indicating the intentions of your former employer with respect to retiree health care benefits.

Has your employer sent any correspondence--letters, brochures, medical plan booklets, employee handbooks or other written materials--containing promises concerning the duration of retiree health benefits?

Are there records of meetings where your employer made such promises?

You should know that some courts may take into account any informal communications that you have had with your employer concerning retiree health care benefits, at least where the plan document and SPD are ambiguous.

If You Retire Early, Review any Agreements or Correspondence from Your Employer Concerning Your Early Retirement

If you retire early and have a special agreement with your employer, carefully consider the materials you have received concerning the terms of your early retirement.

Do any of these documents contain language regarding the duration of your retiree health benefits?

Are there any records of meetings that your employer may have had with you concerning an early retirement offer?

You should know that some courts have permitted plans to change promises made with respect to early retirement offers even if the formal plan document, collective bargaining agreement or SPD contain language allowing the employer to terminate or amend the plan.

If you are considering an early retirement, you may wish to protect yourself by negotiating a written contract with your employer that includes the specific terms of health care benefits and the circumstances, if any, under which they can be changed.

Given the uncertainty of the law in this area, you may wish to seek legal advice in negotiating such arrangements with your employer.

Get Help in Clarifying Documents and Promises

This brief was prepared to help you understand the terms governing your health benefits after retirement. If there are questions or disputes about your individual retirement benefits or about the possibility of changes and cuts for you and other employees or retirees, you should consult your union representative or an attorney who is familiar with employee benefits.

Legal action can help interpret or enforce retirement health care promises.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Protecting Your Health Insurance Coverage

Life is filled with a variety of events that may affect the health insurance coverage you need or that you have available to you. Each year millions of Americans face life events, which can vary from the birth of a baby, the onset of a chronic condition or disabling disease, to divorce, changing jobs or a business closing, cutting back on staff or reducing the number of hours you work.

You need to know how these and other life events affect your health insurance coverage. Your ability to get and keep health insurance coverage may be of special concern if you or your family members have a history of medical problems.

Recent changes in Federal law now give additional – though limited – protections to you and your family members when you need to buy, change, or continue your health insurance. These important laws can affect the health benefits of millions of working Americans and their families. Understanding these new protections, as well as laws in your State, can help you make a more informed choice if you need to make a change in health coverage. It also can help you better understand the health coverage protections you have under the law.

HIPAA Helps You Get and Keep Health Insurance Coverage

Overview

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, includes important new – but limited – protections for millions of working Americans and their families.

HIPAA may:

- Increase your ability to get health coverage for yourself and your dependents if you start a new job;
- Lower your chance of losing existing health care coverage, whether you have that coverage through a job, or through individual health insurance;
- Help you maintain continuous health coverage for yourself and your dependents when you change jobs; and
- Help you buy health insurance coverage on your own if you lose coverage under an employer's group health plan and have no other health coverage available.

Among its specific protections, HIPAA:

- Limits the use of pre-existing condition exclusions;
- Prohibits group health plans from discriminating by denying you coverage or charging you extra for coverage based on your or your family member's past or present poor health;
- Guarantees certain small employers, and certain individuals who lose job-related coverage, the right to purchase health insurance; and
- Guarantees, in most cases, that employers or individuals who purchase health insurance

can renew the coverage regardless of any health conditions of individuals covered under the insurance policy.

In short, HIPAA may lower your chance of losing existing coverage, ease your ability to switch health plans and/or help you buy coverage on your own if you lose your employer's plan and have no other coverage available.

MISUNDERSTANDINGS ABOUT HIPAA

Although HIPAA helps protect you and your family in many ways, you should understand what it does NOT do.

- HIPAA does NOT require employers to offer or pay for health coverage for employees or family coverage for their spouses and dependents;
- HIPAA does NOT guarantee health coverage for all workers;
- HIPAA does NOT control the amount an insurer may charge for coverage;
- HIPAA does NOT require group health plans to offer specific benefits;
- HIPAA does NOT permit people to keep the same health coverage they had in their old job when they move to a new job;
- HIPAA does NOT eliminate all use of pre-existing condition exclusions; and
- HIPAA does NOT replace the State as the primary regulator of health insurance.

4 Steps to Understanding How HIPAA May Affect You

To understand if and how HIPAA may help you, there are five steps you should take. These steps generally mean you need to:

1. Understand the different types of health insurance and group health plan coverage that are affected by HIPAA;
2. Evaluate the impact of a pre-existing condition that you have which may trigger the need for HIPAA's limited protections;
3. Determine how much – if any – creditable coverage you have;
4. Understand the other HIPAA coverage protections you have; and

Step 1: Understand the Various Types of Health Coverage

Before you can understand how HIPAA may help protect your health coverage, you must understand what the various types of health coverage are. This is important because the law provides different protections depending on the type of health coverage you have or wish to apply for.

Types of Coverage

HIPAA generally applies to the following three types of coverage:

- **Group Health Plans.** A group health plan is health coverage sponsored by an employer or union for a group of employees, and possibly for dependents and retirees as well. To understand your rights, you will need to know the following things about your group health plan.

- Does a State or local governmental employer sponsor the plan?
 - Does a church or group of churches sponsor the plan?
 - Does the plan cover fewer than two current employees?
 - Does a small employer or a large employer sponsor the plan?
 - Is the plan an insured plan that purchases health insurance coverage from an HMO or other health insurance issuer, or is it a self – insured plan?
- **Individual Health Insurance.** Individual health insurance coverage is insurance coverage that is sold by HMOs or other health insurance issuers to individuals who are not part of a group health plan. Even though health coverage might be provided through an association or other group, such as groups of college students or self-employed individuals, it is still considered to be "individual" health insurance if it is not provided through a group health plan.
 - **Comparable Coverage through a High-risk Pool.** Some States have set up high-risk pools to provide health coverage for people who cannot otherwise obtain health insurance coverage in the individual Market.

Eligibility for HIPAA Protections

If you are not currently covered by a particular type of plan or insurance, you need to determine what you may be eligible for. Your eligibility to enroll in a group health plan is determined by the rules of the group health plan and the contract terms of any insurance purchased by an insured plan.

Your eligibility to have HIPAA guarantee you the right to purchase individual health insurance coverage (which, in some States, will be through a high-risk pool) depends on your ability to meet ALL of the following requirements:

- You have at least 18 months of creditable coverage without a significant break in coverage – a period of 63 or more days during all of which you had no coverage. If you get coverage by midnight of the 63rd day, you have not incurred a significant break;
- Your most recent coverage must have been through a group health plan (through your or a family member's employer or union);
- You are not eligible for coverage under any other group health plan;
- You are not eligible for Medicare or Medicaid;
- You do not have other health insurance;
- You did not lose your insurance for not paying the premiums or for committing fraud; and
- You accepted and used up your COBRA continuation coverage or similar State coverage if it was offered to you.

If you meet these requirements, then you become a HIPAA eligible individual.

Once you know what kind of health care coverage you have, or would like to apply for, you can begin to understand how HIPAA may protect you and your family.

When You Get a New Job

If you find a new job that offers a group health plan, or, if you are eligible under another family member's group health plan, you first need to determine whether HIPAA applies to the group health plan. For example, if the job is with a church, or with a State or local governmental employer, or with a very small employer, HIPAA protections may be more limited.

If HIPAA does apply to your group health plan, then generally it:

- Limits the length of pre-existing condition exclusions that can keep you and your dependents from getting full coverage;
- Generally prohibits the health plan from denying coverage, or charging higher rates based on your or your dependents' current health or health history; and
- May give you a special enrollment period for enrolling in the group health plan when you lose other coverage if you chose not to join the health plan when you were first eligible or when you have a new dependent.

When You Leave a Job or Otherwise Lose Group Health Plan Coverage

If you are a HIPAA eligible individual, and you apply for individual health coverage within 63 days after losing group health plan coverage, HIPAA:

- Guarantees that you will have a choice of at least two coverage options;
- Guarantees that you will be eligible, regardless of any medical conditions you may have, to purchase some type of individual coverage, whether from a health insurance issuer, high-risk pool, or other source designated by your State; and
- Guarantees that you will not be subject to any preexisting condition exclusions.

HIPAA does **NOT** limit the amount you can be charged for the policy. However, State law may set limits. Also, if your coverage is through a network plan, HIPAA does not guarantee that your policy will be renewed if you move outside the area served by providers under contract with your insurer. In addition, if your coverage is through a high-risk pool, and you move out of the State, HIPAA does not guarantee that your coverage will be renewed.

Step 2: Determine The Impact of Any Pre-existing Condition

Traditionally, many employer-sponsored group health plans and health insurance issuers in both the group and individual markets limited or denied coverage of health conditions that an individual had prior to the person's enrollment in the plan. These types of exclusions are known as pre-existing condition exclusions.

Although such exclusions were problematic for those trying to secure health coverage in the past, HIPAA and other recent Federal laws bring some relief to this problem in certain situations. To best understand the protections provided by the law, you need to remember two things. First, HIPAA establishes requirements and limits under which a pre-existing condition exclusion can apply. Second, if you have a pre-existing condition, HIPAA helps minimize the impact of that exclusion on your access to health coverage.

If you are a HIPAA eligible individual in the individual market, no pre-existing condition exclusion can be applied to your coverage.

Limits for Pre-Existing Condition Exclusions in the Group Market

Even if your family member had a medical condition in the past, it is possible that the group health plan cannot use it as the basis for a pre-existing condition exclusion. HIPAA limits pre-existing condition exclusions to those medical conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period before your enrollment date — your first day of coverage or, if there is a waiting period, the first day of your waiting period.

This is typically your date of hire. This 6-month period is often called a “look-back” period. Some State laws shorten this look-back period if your group health plan is an insured plan.

Minimizing the Impact of Exclusions

In many instances, HIPAA can reduce the impact of a pre-existing condition exclusion. HIPAA does this in two principal ways.

First, the law limits the time over which an exclusion can keep you from getting coverage; and second, HIPAA generally allows your previous health insurance coverage to reduce the amount of time the exclusion can apply, or, in some cases, can totally eliminate such exclusions. In addition, no pre-existing condition exclusion is permitted for newborn and adopted children, who are enrolled within 30 days, or for pregnancy.

The Exclusion Period Begins

The exclusion period must begin on your enrollment date. It can generally last no longer than 12 months. If you do not enroll when you are first eligible and do not enroll when you have special enrollment rights, the plan can refuse to cover pre-existing conditions for up to 18 months after you enter the plan.

Notice Requirements

Before a pre-existing condition exclusion can be applied to your coverage, the plan's consumer materials must tell you if the plan imposes pre-existing condition exclusions. Your group health plan must send you a written notice that an exclusion will be imposed on you. The notice should describe the length of the exclusion period because you do not have enough creditable coverage. The notice also should describe how you can demonstrate how much creditable coverage you have.

Step 3: Determine If You Can Minimize the Length of the Exclusion

Once you understand that you have a pre-existing condition that is subject to an exclusion, it is important to remember that your previous health insurance coverage might reduce or eliminate the length of the pre-existing condition exclusion.

Under HIPAA's group market rules, creditable coverage can be used to reduce or eliminate pre-existing condition exclusions that might be applied to you under a future plan or policy. In general, if you had other health coverage – for example, under another group health plan or under an individual health insurance policy, Medicare, Medicaid, an HMO, or a State high-risk pool – your new plan's pre-existing condition exclusion period must be reduced by the period of

your other coverage. This earned credit for previous coverage that can help you reduce your exclusion period is called creditable coverage.

The exclusion period must be shortened by one day for each day of creditable coverage that you have. If the amount of creditable coverage you have is equal to or longer than the exclusion period, no exclusion period can be imposed on you. When figuring out how much creditable coverage you have, however, you receive no credit for previous coverage that has been followed by a significant break in coverage – a period of 63 or more full days in a row during which you had no creditable coverage.

Two examples help illustrate these points.

Case 1: If you were covered by your old employer's plan for 4 months and your new employer's plan has a 12-month pre-existing condition exclusion, your new employer's plan cannot exclude coverage for you for any pre-existing condition for more than 8 months.

Case 2: John was covered under his employer's group health plan from January 1, 1998 until March 1, 1999, a period of 14 months. He then dropped that coverage. When he resumed coverage under his employer's plan on July 1, 1999, he had incurred a break of 122 days. From July 1, to August 1 of 1999, John had only 31 days of creditable coverage. His earlier coverage (from January 1, 1998 until March 1, 1999) was followed by a significant break in coverage. As a result, the earlier coverage is not counted as creditable coverage.

Know Your State's Law on Coverage

If you are in an insured plan, your State law may let you have a longer break in coverage. If so, you may be able to count creditable coverage even if it is followed by a break of 63 days or more in a row. Your State also may require a shorter exclusion period, or shorter look-back period. State law requirements for pre-existing condition exclusions do not affect those imposed by self-insured plans. For more information contact your State insurance department.

Group health plans and health insurance issuers are required to furnish you a certificate of creditable coverage. The certificate describes how much creditable coverage you have and the date the coverage ended. Most group health plans and insurance issuers are required to issue certificates automatically shortly after your coverage ends.

You also can request a certificate describing particular coverage at any time while the coverage is in effect and within 24 months of the time the coverage ends. Finally, your new health plan can simply call your old plan to inquire about your creditable coverage. If the two plans agree, the plans can exchange the information by telephone.

When you receive a certificate from a former employer, you should make sure the information is accurate. Contact the plan administrator of your former health plan or the health insurance issuer if any of the information is wrong.

If you do not receive a certificate from your previous plan or health insurance issuer, your new health plan must accept other documentation that shows you had prior creditable coverage

Step 4: Understand Your Other Coverage Protections

Understanding how you can best protect your health coverage is not easy. It is complicated because the rules are different depending on your special situation. The fourth step in understanding HIPAA and your protections under the law involves knowing some general information about:

- Special enrollment rights to other group coverage;
- How your health status can affect your access to care;
- Other coverage choices that may help you take advantage of HIPAA protections; and
- Your rights to renew group and individual coverage.

Special Enrollment Rights to Other Group Coverage

Group health plans and health insurance issuers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll. Importantly, individuals will be able to enroll without having to wait until the plan's next open enrollment period, but in most situations you must request a special enrollment within 30 days.

A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption. Special enrollment is NOT late enrollment, which can trigger an 18-month pre-existing condition exclusion period.

How Your Health Status Can Affect Access to Care

If you are in a group health plan, you cannot be denied coverage based on your health status. A group health plan cannot refuse to enroll you just because of:

- Your health status;
- Physical or mental condition;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability; or
- Disability.

But employers can establish limits or restrictions on benefits or coverage for similarly situated individuals under a group health plan, or charge a higher premium or contribution for similarly situated individuals. In addition, employers may change your plan benefits or covered services if they give you proper notification.

If you are no longer in a group health plan, and you meet the requirements to be a HIPAA eligible individual, you cannot be denied individual health coverage. However, the choices available to you will depend on the approach your State has taken to make health coverage available to you.

If you are not an eligible individual, State law rather than HIPAA will determine whether you can be denied coverage. Depending on your State's laws, insurers and HMOs offering individual health insurance may be able to deny coverage based on your health status. Federal laws other than HIPAA and some State laws may ensure that certain people who have lost group coverage are guaranteed access to health coverage, at least temporarily, regardless of their health status.

Other Coverage Choices That May Help You Take Advantage of HIPAA Protections

Some key HIPAA protections help you avoid pre-existing condition exclusions on your access to coverage. One Federal law that may help you take advantage of those and other HIPAA protections is the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage gives employees and their dependents who leave an employer's group health plan the opportunity to purchase and maintain the same group health coverage for a period of time (generally, 18, 29 or 36 months) under certain conditions. Workers in companies with 20 or more employees generally qualify for COBRA. You may have this right if you lose your job or have your working hours reduced.

You also may have this right if you are covered under your spouse's plan and your spouse dies or you get divorced. Children who are born, adopted, or placed for adoption with the covered employee while he or she is on COBRA also will be entitled to coverage.

COBRA May Help When You Change Jobs

If you are between jobs, COBRA continuation coverage or similar State-mandated continuation coverage can help you avoid a significant break in coverage. That, in turn, may allow you to maximize your creditable coverage that can be used to shorten or eliminate your pre-existing condition exclusion period under a new plan.

If you are going to a new job immediately, your new employer might impose a waiting period before you can start getting benefits under the health plan. While days spent in the waiting period will not be counted as a break in coverage, you still will not have health coverage during the waiting period unless you can obtain it from another source. For many people, COBRA may be that source. Taking COBRA from your old plan until coverage under your new plan starts can provide you with continued health coverage.

When you lose eligibility for coverage under one group health plan, you also may be able to special enroll into another group health plan, such as a spouse's plan, under which you originally declined coverage because you already had coverage under your plan. You may want to do this as a temporary measure during a waiting period imposed by an employer plan or as a permanent change. If both COBRA continuation coverage and special enrollment under another plan are available to you, you have two opportunities to request special enrollment:

- When you lose coverage under your old plan; and
- If you elect to take COBRA continuation coverage, when you have exhausted your COBRA coverage.

If you elect COBRA coverage when you lose group health coverage, you will have to exhaust the COBRA coverage before you will be entitled to special enrollment into the other plan. You may need to carefully evaluate whether it is more to your advantage to special enroll into the

other plan immediately or to first take COBRA continuation coverage from your old plan.

COBRA as a Bridge into the Individual Market

In addition to helping you avoid a significant break in coverage when you are between jobs or helping you maintain coverage while you are in a waiting period, COBRA can help you – if you want – to buy individual health insurance, which is not connected to a job. Normally, your decision to buy COBRA coverage – if available to you – is voluntary. However, if you want to protect your right to coverage in the individual market as a HIPAA eligible individual, you must take and exhaust COBRA or similar State continuation coverage that is offered to you.

Exhausting COBRA

Sometimes there may be a clear advantage to paying insurance premiums for the entire period until COBRA continuation coverage is no longer available to you. (This is called “exhausting” your COBRA coverage.) Continuation coverage is creditable coverage for HIPAA purposes. If you accept continuation coverage, it could help you avoid a significant break in coverage. In turn, that could reduce or eliminate a pre-existing condition exclusion if you later have access to another group health plan. If you reach the end of your COBRA coverage without having access to another group health plan, exhausting COBRA will help you qualify for portability into the individual market as an eligible individual.

There are certain situations in which you may lose COBRA coverage earlier than the end of the usual period. Two examples help illustrate the point.

Example 1: Your coverage is under a network plan, such as an HMO, you move out of the plan’s service area, and there are no other options for continuing COBRA benefits. In this first example, your COBRA continuation coverage is considered to be exhausted.

Example 2: Your former employer is permitted to terminate continuation coverage in certain situations when you become covered under another group health plan. However, if you have a preexisting condition, the former employer cannot terminate your COBRA continuation coverage if the new group health plan limits or excludes coverage for your pre-existing condition.

Consider Conversion Options Carefully

Conversion coverage is individual health coverage that might be offered to you when you lose group health plan coverage. Conversion coverage is sometimes offered by a group health plan at the end of COBRA continuation coverage. It also may be offered in place of COBRA or similar State-mandated continuation coverage. Some States require issuers of group health insurance coverage to offer conversion coverage. A few States also have chosen to use conversion policies as their approach to guaranteeing availability of coverage in the individual market to HIPAA eligible individuals.

If you accept conversion coverage, at the end of coverage under a group health plan or at the end of COBRA or similar State continuation coverage, you might give up some HIPAA protections. These include the ability to qualify as a HIPAA eligible individual. To retain that guarantee, your most recent coverage must have been group health plan coverage.

For HIPAA purposes, conversion coverage is NOT group coverage. Therefore, you can lose your rights as a HIPAA eligible individual if you choose conversion coverage.

Your Rights to Renew Group and Individual Coverage

HIPAA generally gives you the right to renew your group and individual health insurance. But that right varies considerably between group and individual plans based on certain events. When the group health plan buys a group insurance policy, coverage generally must be renewed for as long as the employer wants it to be. If your group health plan buys an individual policy for you, it generally must be renewed so long as you want to do so.

Your group coverage is NOT guaranteed to be renewable, however, if the group health plan has:

- Failed to pay premiums for the coverage;
- Committed fraud against the issuer providing the coverage;
- Violated participation or contribution rules that apply to the coverage;
- Terminated the coverage;
- Ended membership in an association (if the coverage is available only to members of the association); or
- If the coverage is a network plan (such as an HMO), the issuer also may terminate or refuse to renew the coverage if all members of the group move outside of the plan's service area.

If you have individual health insurance, generally, your coverage is renewable regardless of whether you are a HIPAA eligible individual. Your coverage may be discontinued or non-renewed by your insurance company, only if you:

- Fail to pay your premiums;
- Commit fraud against the issuer;
- Terminate the policy;
- Move outside the service area (if in a network plan);
- Move outside a State (if in a State high-risk pool); or
- End your membership in an association (if the coverage is available only to members of the association).

Frequently Asked Questions and Answers about HIPAA

Pre-Existing Condition Exclusions

Q: Are there any situations in which exclusions are completely prohibited?

A: Under HIPAA's group market rules, there can be no pre-existing condition exclusion for pregnancy, no matter when pregnancy began and whether medical advice, diagnosis, care or treatment was recommended or received for the pregnancy. An exclusion cannot be applied to you even if your previous health plan did not cover pregnancy.

An exclusion cannot be applied just because there is genetic information suggesting that you may have a particular condition.

An exclusion cannot be applied at all to a child who was covered by creditable coverage no later than 30 days after birth or after being adopted or placed for adoption with you.

Q: I had a pre-existing condition exclusion period at my prior employment. Can another exclusion period be applied by my new group health plan?

A: It depends on how much creditable coverage you have. If you were subject to a pre-existing condition exclusion period in the past, it does not itself prevent you from having another one applied now. If you only have a little creditable coverage, a pre-existing exclusion period may still apply to your new coverage.

Q: I am changing from one type of coverage to another, but staying within the same employer's group health plan. Can a pre-existing condition exclusion be applied to my new coverage?

A: It depends on how long you have been in the group health plan. If you sign up at the first opportunity, a pre-existing condition exclusion cannot extend more than 12 months after your enrollment date. Your enrollment date is the first day on which you are able to receive benefits under a group health plan or, if your plan imposes a waiting period, the enrollment date is the first day of your waiting period — typically your date of hire.

If less than 12 months have passed, a pre-existing condition exclusion might be applied, but the exclusion cannot last beyond the one-year anniversary of your enrollment date (a total of 12 months).

Example: Nancy began work on June 1, 1999. She signed up for her employer's group health plan on the same day, as soon as she was eligible to do so. Her employer has no waiting period, so she was able to receive benefits as soon as she signed up. As a result, June 1, 1999 is her enrollment date. On May 1, 2000, Jane changed from one coverage option available under the plan to another. Because 12 months had not passed since her enrollment date, a pre-existing condition exclusion might be applied to her new coverage option. The exclusion can only be effective, however, until June 1, 2000.

If an exclusion is applied, it will be reduced one day for each day of creditable coverage that you have as of your enrollment date.

Example: Betty began work on June 1, 1999 and signed up for her employer's group health plan at the first opportunity. She has no waiting period. As of her enrollment date (June 1, 1999) she has a total of 60 days of creditable coverage from a previous employer. On May 1, 2000, at the first opportunity to do so, Betty changes from one coverage option available under the plan to another. Without taking her creditable coverage into account, the pre-existing condition exclusion period would end on June 1, 2000 (with 30 days remaining). Her 60 days of creditable coverage are enough to eliminate the entire remaining exclusion period. As a result, no exclusion can be applied to her new coverage option.

If more than 12 months have passed since your enrollment date, a pre-existing condition exclusion cannot be applied to your new coverage.

Example: Dan began work for his current employer on March 1, 1999. He signed up for his employer's group health plan on the same day, as soon as he was eligible to do so. He has no waiting period. As a result, March 1, 1999 is his enrollment date. On April 10, 2000, Dan changed from one coverage option available under the plan to another. Because more than 12 months have passed since his enrollment date, no pre-existing condition exclusion can be applied.

Q: I've lost my job but I haven't found a new one yet. What can I do to retain my protections under HIPAA?

A: Be careful to avoid a significant break in coverage (63 or more full days in a row without any coverage). If offered, decide whether you should accept COBRA continuation coverage. If you had group health plan coverage at your last job, you probably will be offered COBRA continuation coverage (or similar continuation coverage that must be offered to you under State law).

If you are eligible for such continuation coverage, it counts as creditable coverage. In addition, you must accept and exhaust COBRA benefits before you can obtain coverage in the individual market as a HIPAA eligible individual. (You may also have to satisfy other requirements to obtain the coverage.)

About Special Enrollment

Q: What events trigger a special enrollment period?

A: Special enrollment is required in two situations.

- You or your dependent lose other health coverage; and
- You get a new dependent through marriage, birth, adoption, or placement for adoption with you.

You or your dependent lose other health coverage

To get a special enrollment opportunity in this situation, the employee or dependent must earlier have turned down coverage available through the group health plan because he or she had other coverage.

If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA coverage is exhausted. If the other coverage was NOT COBRA continuation coverage, the individual can request special enrollment when his/her other coverage ends because the individual is no longer eligible for it.

A special enrollment period also must be given if the employer sponsoring the group health plan stops paying its share of the premiums. You get a new dependent through marriage, birth, adoption, or placement for adoption with you.

If the triggering event is a birth, adoption or placement for adoption, the child, the employee, and the employee's spouse are entitled to special enrollment, either individually or in any combination.

Q: When do I request special enrollment?

A: If a special enrollment period is triggered when an employee or his/her dependent loses other health coverage, the employee must request the special enrollment(s) within 30 days of the loss of coverage. If a special enrollment period is triggered when a new dependent is added, the individual must request the special enrollment(s) within 30 days of the triggering event.

Q: How are pre-existing condition exclusions applied to special enrollees?

A: For each triggering event, a special enrollee is regarded as a regular enrollee and not a late enrollee. Therefore, the maximum pre-existing condition exclusion period that may be applied to a special enrollee is 12 months. The 12 months are reduced, day for day, by the special enrollee's creditable coverage. In addition, a newborn, adopted child or child placed for adoption cannot be subject to a preexisting condition exclusion period if the child is enrolled within 30 days after birth, adoption or placement for adoption and has no subsequent significant break in coverage after that time.

Q: Are plans and issuers required to notify individuals of their special enrollment rights?

A: Yes. A notice of special enrollment rights must be provided to employees on or before the time they are offered the opportunity to enroll in the group health plan.

Q: When will the new coverage start?

A: When the individual loses other coverage, the new coverage must begin no later than the first day of the first calendar month beginning after the date the employee requests special enrollment. In the case of marriage, enrollment must be effective not later than the first day of the first calendar month that begins after the date the group health plan receives the completed request for enrollment.

In the case of birth, adoption, or placement for adoption, enrollment is required to be effective not later than on the date of such birth, adoption, or placement for adoption.

About Creditable Coverage

Q: What if I don't receive a certificate, or lose one that I received?

A: In most cases, your first step should be to contact the plan administrator of your prior group plan. Ask for a copy of the certificate; it should be free of charge. If you do not automatically receive a certificate of coverage or receive one before you need it, you should:

- Contact the plan administrator if you have been in a group plan;
- Contact the health insurance issuer if you have had individual coverage.

Because some people have had creditable coverage through multiple sources, you should always check with all sources to be sure you get the credit you deserve.

If you lose your certificate, you can go back and request another one, free of charge. In most cases, even if you do not receive a certificate, you can use other evidence to prove creditable coverage. These include:

- Pay stubs that reflect a premium deduction;
- Explanation of benefit forms;
- A benefit termination notice from Medicare or Medicaid; and
- Verification by a doctor or your former health care benefits provider that you had prior health coverage.

You also can request a certificate describing your coverage under a particular group health plan, policy or contract (free of charge) at any time while you are still covered or up to 24 months after the coverage has ended. Each certificate that you request should describe the creditable coverage you have received for the prior 24 months.

About Portability

Q: What are the circumstances in which I will have portability?

A: HIPAA provides for portability rights in three circumstances:

- When you leave a job where you had group health plan coverage, and move to another job with group health plan coverage. (This also applies if you are covered as a dependent of the person who changes jobs.)
- You lose group health plan coverage, you meet the definition of a HIPAA eligible individual and you wish to purchase individual health insurance coverage.
- You have individual health insurance coverage or any other type of creditable coverage, and you enroll in a new group health plan.

Q: What does portability **NOT** do?

A: There are 4 things that portability does NOT do.

- Portability does NOT let you keep your current plan or benefits when you change or lose your job or get a new job.
- It does NOT require your new employer or union to provide health coverage
- It does NOT guarantee that if you move from one plan or policy to another, the benefits you receive will be the same as those that were available to you under your old plan or policy. Coverage under the new plan could be less (or more) generous, and premiums and cost-sharing arrangements (such as deductibles and copayments) may differ.
- HIPAA does NOT provide for portability rights when you have individual health insurance coverage and you move to other individual health insurance coverage. However, State law might provide portability rights in this situation.

About Access to Other Coverage Options

Q: I've lost my job, and I am worried about health insurance. Is there any help for me?

A: You may have rights to certain health coverage even if you lose your job. If your company

provided a group health plan, you may be entitled to continued health benefits for a period of time under COBRA or a State law. You may also have rights under HIPAA to buy individual health insurance.

Q: If I had health coverage under my or my spouse's old job but I lost that coverage and do not have access to group coverage through my new job, can HIPAA help me as an individual?

A: If you meet the requirements to be a HIPAA eligible individual, you must get a choice of individual coverage with no pre-existing condition exclusion, either through a health insurance issuer or a State's high-risk pool.

Q: Can I keep my doctor?

A: If you are changing from one health plan to another, or from one policy to another, you may have to change doctors. It depends on the benefits offered by your new plan or policy. Your need to change doctors is especially true if you join a managed care plan. Check with your plan to understand the extent your choice of doctors may be restricted.

General HIPAA Questions

Q: Do HIPAA's group market protections apply to all group health plans?

A: No, HIPAA's group market protections do not automatically apply to all employment -related group health plans. The following situations trigger some exceptions:

1. Very small plans. In most cases, if you are in a group health plan that only covers one current employee, State law will determine whether you have HIPAA group market protections.
2. Non-federal governmental plans. If your eligibility for your group health plan is based on your or someone else's employment with a State or local government agency, HIPAA protections should apply to you unless your plan has notified you that it is exempt from some or all HIPAA requirements. However, even if the plan is exempt from other requirements, it must always provide you with a certificate of creditable coverage when your coverage ends. You also can ask your plan administrator if you are not sure which protections apply, or you can check the HIPAA website (<http://hipaa.hcfa.gov>) for a list of non-federal governmental plans.
3. Federal governmental plans. If your eligibility for your group health plan is based on your or someone else's employment with a Federal government agency, HIPAA itself does not apply directly, but the government affords similar protections.
4. Church plans. If your eligibility for your group health plan is based on your or someone else's employment with a church or group of churches, you should check with your plan administrator to find out whether HIPAA's group market protections apply to you.

Q: Does HIPAA limit my health insurance premiums?

A: HIPAA generally does not limit premiums. However, when a plan or issuer provides group health plan coverage, HIPAA does not allow the plan or issuer to charge one individual a higher premium based on that individual's health status. For example, individuals with diabetes cannot be charged a higher premium because of that medical condition. An individual must be charged the same premium that is charged to similarly situated individuals for the same coverage.

Similarly situated individuals are, for example, other individuals who are in the same employee category, or in the same geographic location. Employee categories may include, for example, full-time employees (or part-time employees), all employees with the same length of service, and current employees (or former employees). Employees' dependents are grouped into categories that are based on the categories used for the employees themselves. For example, if employees are categorized by location, as full-time or part-time, all dependents of part-time employees are similarly situated individuals.

CONTINUATION & CONVERSION COVERAGE IN KY

What rights to continuation of coverage are provided by Kentucky law?

As a safeguard for Kentucky residents whose fully insured health insurance plans do not fall under COBRA protection, the state enacted legislation that provides a similar opportunity for continuation of group coverage. You may be eligible under the provisions of this law if your employer has fewer than 20 employees and your group has a fully insured plan. Your employer can let you know if your group's plan is self-funded or fully insured.

How long would my continued coverage be in effect?

If you qualify for state continuation, you and your dependents can extend your group health insurance for 18 months after the date on which the coverage would have ended because you were no longer a group member. When the 18-month period for continuation ends, you have a right to convert to individual coverage that provides benefits substantially similar to your group plan.

HOW CAN I KEEP MY HEALTH INSURANCE COVERAGE?

What are the conditions for state continuation of coverage?

You and any dependents who are insured under your group policy have the right to continuation of coverage if you meet certain conditions.

- The first condition is that you, the group member, must have been covered by the group policy or any group policy it replaced for at least three months.
- Second, you must notify the insurer and pay the premium at the group rate within 31 days after you receive a notice of your right to continue coverage.

Who notifies the insurance company that I am leaving the group, and who tells me about my eligibility?

The employer usually lets the insurance company know you are leaving the group, but you should make certain that your employer has properly reported your status change. The insurer then is required to give you written notice of your right to elect continuation of coverage. The insurance company is considered to have given the required notification when a notice is mailed or delivered to your last known address.

It is your responsibility to be sure that the insurance company has your correct address, and you must notify the insurer in writing that you are choosing continuation benefits. An insurance company is not required to provide continuation benefits if you do not elect coverage and pay

the required premium within 90 days after termination of your group coverage. If you do not receive your notification, be sure to contact the insurance company well before the 90-day period has expired.

Who do I pay for my continued coverage?

Premium payments will be made directly to the insurance company. If you fail to make timely premium payments, your coverage terminates at the end of the last period for which the premium was paid.

What happens if my former employer changes insurance companies?

If the group through which you have continuation coverage changes to another insurer, you will remain with your original insurance company rather than switch to a new company along with the group.

How is my coverage affected if the health insurance plan is terminated for the entire group?

If the group policy is terminated and is not replaced with another group policy within 31 days, the insurance company will end your continued group health coverage in the same way that they end coverage for active employees. However, you will then have a right to convert to individual coverage.

Who, in addition to the group member, is eligible for state continuation?

The right to extend group health insurance coverage is also available to certain dependents of the group member.

- A surviving spouse and children whose coverage under the group policy would end at the death of the group member are eligible under the state law.
- A child who has been covered as a dependent under the plan has a right to continuation coverage upon reaching the plan's age limit for dependent status.
- A former spouse and the children in his or her custody are eligible for continuation benefits when their status as dependents of the group member ends. This status change would result from a court order dissolving the marriage.

Remember that state continuation provides Kentucky residents with protections similar to those offered by COBRA, but does not mirror COBRA provisions.

What rights to conversion coverage does Kentucky law provide?

If you are a group member with a fully insured plan and you have been covered under any group health insurance policy for at least three months, you have the right to a conversion health insurance policy. The policy must provide benefits that are substantially similar to the coverage you had at the time that your membership in the group was terminated for any reason. For instance, in a situation where the group coverage ends completely or the group no longer exists, you as an individual employee are eligible for conversion coverage.

Keep in mind that when the 18-month period for continuation coverage ends, you have a right to convert to an individual policy with substantially similar benefits. There is no time limit on how long you can keep your conversion coverage. Be aware that although the law requires that you be offered benefits substantially similar to your group coverage, there are no restrictions to keep premium costs in line with the group rate you were previously paying.

What are the terms of conversion health insurance coverage?

- Conversion health insurance coverage must be made available to you without evidence of insurability and with no pre-existing condition limitations under most circumstances.
- The conversion health insurance policy will cover you and any eligible dependents that were covered by the group policy on the date the group coverage ended.
- The effective date of the conversion health insurance policy will be the date your group coverage ended.
- The conversion health insurance policy must provide benefits substantially similar to those offered by your group policy, but not less than minimum standards according to Kentucky laws and regulations.

RIGHTS TO CONVERSION COVERAGE UNDER KENTUCKY LAW

How is conversion different from continuation?

Continuation allows you to keep the same group health plan you had as an employee. Both COBRA and state continuation provide this opportunity for you to extend your group health insurance coverage for a specified period of time. There may be circumstances, however, in which you will not be eligible for continued group coverage, making it necessary for you to obtain insurance on your own. That is where conversion comes in.

The conversion provision in Kentucky law gives you the right to convert the group plan you will be losing to an individual policy offering benefits that are substantially similar to those you had through group coverage.

Are there exceptions to this eligibility?

The following are situations in which continuation of your group health benefits need not be granted:

- If you are or could be covered by Medicare
- If you are or could be covered by other group coverage.

What can I do if I am not notified of my right to continued group health benefits or conversion health insurance coverage?

If you become eligible for continued health insurance or conversion health benefits and you are not given written notice of your rights, an additional limited time period must be granted for you to apply for the continuation or conversion coverage for which you are eligible.

The insurance company must give you the required notice as soon as possible after being informed of its failure to provide notification. The additional period will end 60 days after you receive the written notice. If you make application and pay the required premium within this time period, the effective date of your continued coverage or conversion health coverage will be the date your group membership ended. However, the insurance company is not required to provide continuation or conversion coverage if you do not elect coverage and pay the required premium within 90 days after termination of your group coverage.

Who do I contact for help or information on state continuation and conversion?

The full text of the statute on state continuation coverage, KRS 304.18-110, and the statute on conversion coverage, KRS 304.18-114, is available from the Kentucky Office of Insurance Web site, <http://doi.ppr.ky.gov/kentucky>.

ASSISTANCE AND INFORMATION

Who, in addition to the group member, is eligible for conversion under state law?

A conversion health insurance policy will cover any eligible dependents who were covered by the group policy on the date coverage under the group policy ended.

Are there exceptions to this eligibility?

The following are situations in which conversion health coverage need not be granted:

- If you are or could be covered by Medicare
If you are or could be covered by other group coverage, or if you have obtained