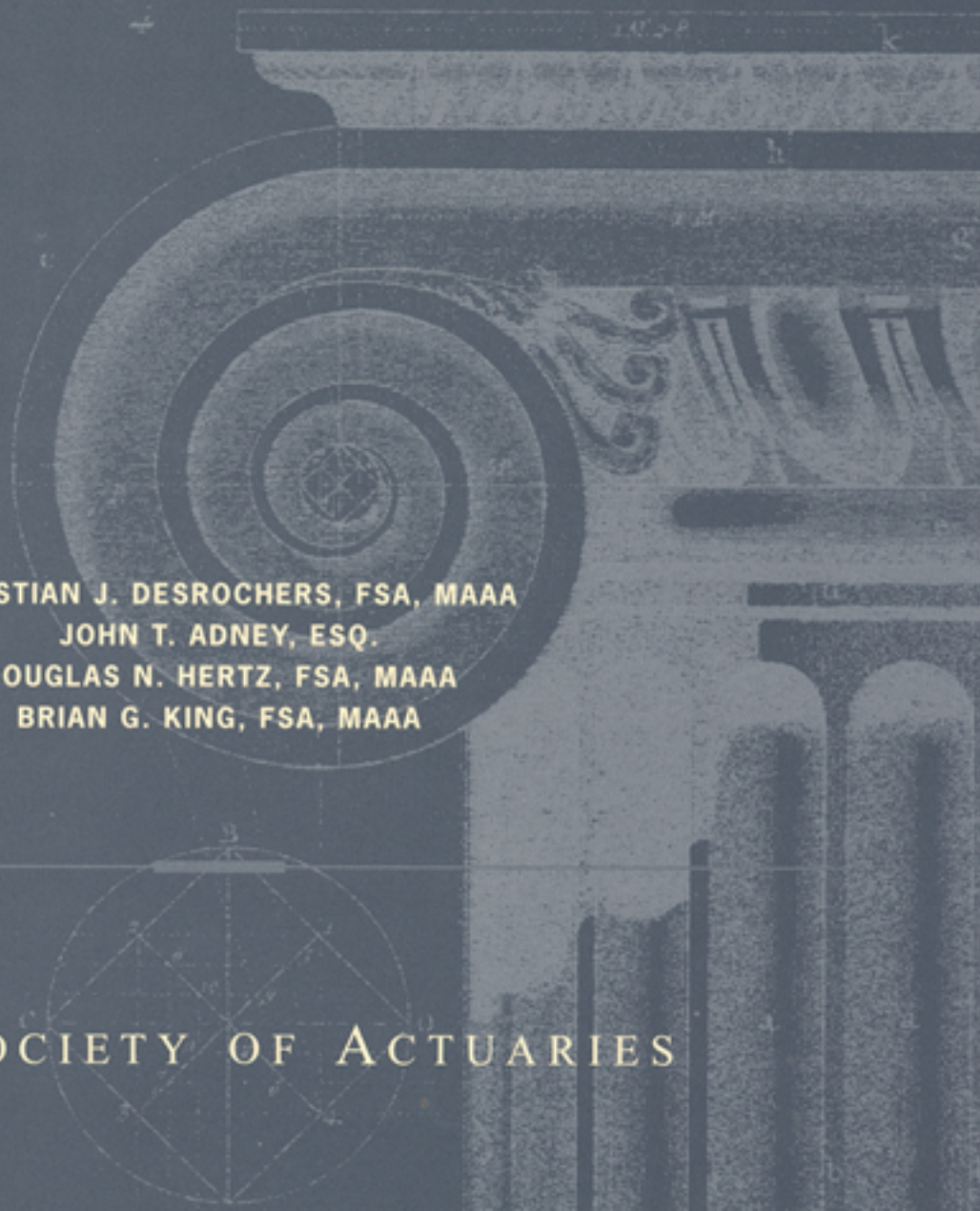
LIFE INSURANCE & MODIFIED ENDOWMENTS

Under Internal Revenue Code Sections 7702 and 7702A



CHRISTIAN J. DESROCHERS, FSA, MAAA
JOHN T. ADNEY, ESQ.
DOUGLAS N. HERTZ, FSA, MAAA
BRIAN G. KING, FSA, MAAA

SOCIETY OF ACTUARIES

TABLE OF CONTENTS

INTRODUCTION

This supplement addresses issues that have arisen since the original publication of our textbook LIFE INSURANCE & MODIFIED ENDOWMENTS in 2004, and it also enhances and clarifies issues that were addressed in the text, adding additional details and discussion where we believe it is needed. It supersedes our 2006 supplement.

Some of the material appearing in this supplement was originally presented in articles that the authors and their colleagues have written and published in *Taxing Times*, the newsletter of the Taxation Section of the Society of Actuaries. The presentation is organized in the order that the discussion would appear in the textbook. It should be noted that certain parts of the discussion in this supplement supplant material that appears in the textbook.

BASIC PRINCIPLES OF SECTIONS 7702 AND 7702A (Chapter II, Page 15)

By their terms, sections 7702 and 7702A[1] apply to all contracts that are treated as life insurance under the "applicable law" (usually the law of the jurisdiction in which the contract was issued) regardless of whether the policyholders are U.S. taxpayers. Hence, if a life insurance contract is issued by an insurer outside of the United States, the two sections technically apply to it, although in most instances the foreign-issued contract's probable non-compliance (or at most accidental compliance) with these sections would not matter to the policyholder, who likely would not be a U.S. taxpayer. However, in cases where a U.S. taxpayer purchases a contract outside of the United States, or a foreign policyholder becomes a U.S. resident and taxpayer, the compliance (or not) of the contract with sections 7702 and 7702A certainly will matter. In such cases, it will be important to test the contract for compliance with the two sections, and to do so from the inception of the contract, although that may not be an easy matter where the issuing insurer is not set up to perform the testing.

Canadian Requirements (Chapter II, Page 15)

Like the United States, Canada imposes restrictions on life insurance policies that receive favorable treatment of the inside buildup. The policyholder tax rules in Canada create two classes of insurance policies: exempt and non-exempt. Exempt policies are considered as providing primarily insurance protection. A life insurance policy is an exempt policy if it satisfies the exempt test found in section 306(1) of the Canadian Income Tax Regulations. The exempt test limits the amount of a policy's cash value relative to its death benefit through a comparison of the cash values (the accumulating fund) of the actual policy to the accumulating fund of one or more standard policies

[1] Unless otherwise indicated, references herein to "section" are to the provisions of the Internal Revenue Code of 1986, as amended (also referred to as "IRC" or the "Code"). Also, capitalized terms and acronyms used and not defined herein have the same meaning as ascribed to them in our textbook.

known as exemption test policies (ETPs). The effect of the exempt test is to limit the amount of income that can be accumulated in a policy on a tax-deferred basis, similar to the CVAT in the United States. If a policy does not satisfy the requirements to be an exempt policy, then it will be a non-exempt policy, and the policyholder will be subject to taxation on the annual income earned under the policy.

APPLICABLE LAW REQUIREMENT

Insurable Interest (Chapter II, Page 17)

Footnote 13 on page 18 is revised to read: "Id. at 821. *Dow* was reversed on other grounds by the U.S. Court of Appeals for the Sixth Circuit. Dow Chem. Co. v. U.S., 435 F.3d 594 (6th Cir. 2006), *rev'g* 250 F. Supp. 2d 748, *cert. denied*, 127 S.Ct. 1251 (2007).

Application of the Test Plan to Term Insurance (Chapter II, Page 24)

Under the computational rules (discussed in detail in Chapter IV), the test plan against which qualification is tested is still an endowment at age 95 even where the policy tested is a term insurance plan that expires before age 95. The definitional limitations, whether guideline premiums or net single premium, are computed under the assumption that benefits are deemed to continue to a date which is no earlier than the day on which the insured attains age 95 and no later than the day on which the insured attains age 100. The DEFRA Blue Book notes, "In applying this rule to contracts that are scheduled to automatically mature or terminate prior to age 95, the benefits should also be deemed to continue to age 95 for purposes of computing both the net single premium and the guideline premium limitations . . . [a] contract written with a termination date before age 95 (*e.g.,* term life insurance to age 65), which otherwise satisfies the requirements of section 7702, will qualify as a life insurance contract for tax purposes."[2] The computational rules apply equally to the 7702A 7-pay test. Thus, in the case of a term policy with a cash value (*e.g.,* a return of premium plan), the test plan standard against which qualification is tested is an endowment at 95, and not a plan that continues only to the end of the term period. This rule also allows a partial endowment before age 95 to qualify as life insurance under section 7702.

CASH VALUE ACCUMULATION TEST

Letter Rulings Defining Cash Surrender Value (Chapter II, Page 27)

Section 7702(f)(2)(A) defines "cash surrender value" as a contract's "cash value determined without regard to any surrender charge, policy loan, or reasonable termination dividends." The statute, however, does not define "cash value." Properly identifying a contract's "cash value" and "cash surrender value" within the meaning of section 7702(f)(2)(A) is of critical importance for purposes of complying with the cash value accumulation test (CVAT), since this test requires that, by a contract's terms, the

[2] DEFRA Blue Book at 652.

cash surrender value must not at any time exceed the net single premium applicable under the contract at that time. This term is similarly important to satisfaction of the cash value corridor, which requires the death benefit under a contract to be at least a certain percentage, varying by age, of the contract's cash surrender value.

In the past few years, the Internal Revenue Service (the Service) has issued several private letter rulings addressing the meaning of the term "cash surrender value" as used in section 7702.[3] The contracts involved in these rulings provided for payment of an amount upon surrender in addition to the generally applicable policy value payable upon surrender. The Service concluded that the additional amount, labeled a "remittance" in the first two of the rulings (chronologically speaking), represented "cash surrender value" within the meaning of section 7702(f)(2)(A), and it further concluded that the failure of the taxpayers to reflect the remittances as cash surrender value was a reasonable error under section 7702(f)(8). In the third ruling, the Service held that an additional amount available upon surrender through a rider was part of the section 7702 cash surrender value.

Facts involved in the first two rulings: The contracts involved in one of the rulings were designed to comply either with the CVAT of section 7702(b) or the guideline premium limitation and cash value corridor tests of section 7702(c) and (d). In the other ruling, the contracts were designed to comply with the CVAT. The contracts provided a policy value that was available upon surrender—referred to in one of the rulings as the "Account Value" and in the other ruling as the "Accumulation Value." The amount in question, styled the "remittance" in the rulings, was not part of this policy value. Rather, it was an additional amount payable upon the early surrender of a contract.[4] In one of the rulings, the remittance was defined as a percentage of premiums paid for the contract, and the specific percentage applicable depended upon when the surrender occurred and how much premium had been paid relative to the target premium for the contract. Part of the remittance was guaranteed from issuance, but the insurance company also paid certain non-guaranteed remittance amounts. In the other ruling, the remittance was defined as a percentage of certain charges assessed and depended upon when the surrender occurred. In both cases, the policyholder could not borrow against the remittance.

The Service's analysis: The rulings began with a discussion of the common meaning of "cash surrender value" and "cash value" as described in certain insurance texts. One such text defined the term "cash surrender value" as "the amount made available contractually, to a withdrawing policyowner who is terminating his or her protection."[5]

---

[3] In chronological order, PLRs 200521009 (Feb. 22, 2005), 200528018 (Apr. 12, 2005), and 200745006 (Aug. 9, 2007).

[4] The rulings do not explain what was meant by "early" surrenders.

[5] KENNETH BLACK, JR. & HAROLD D. SKIPPER, JR., LIFE & HEALTH INSURANCE 46 (13th ed. 2000).

Another cited text defined "cash value" as the "amount available to the policyholder upon the surrender of the life insurance contract."[6] The Service next cited the legislative history of section 7702, which provides that "cash surrender value" is defined in the bill as "the cash value of any contract (*i.e.,* any amount to which the policyholder is entitled upon surrender and against which the policyholder can borrow) determined without regard to any surrender charge, policy loan, or a reasonable termination dividend."[7] Finally, the Service discussed the 1992 proposed income tax regulations (never finalized) defining "cash value," which provide that this term generally equals the greater of (i) the maximum amount payable under the contract (determined without regard to any surrender charge or policy loan), or (ii) the maximum amount that the policyholder can borrow under the contract.[8]

Based on the above considerations, the Service concluded that the remittances constituted part of the cash surrender value of the contracts, thus causing contracts designed to comply with the CVAT to fail this test. In addressing whether the company's error of not treating the remittances as cash value was a waivable error under section 7702(f)(8), the Service noted that, under Notice 93-37,[9] the effective date of the proposed regulations would be no earlier than the date of publication of final regulations in the Federal Register (which has not yet occurred). The Service then observed that the proposed regulations do not contain language that is identical to the definition of cash surrender value in the legislative history of section 7702. For these reasons, the Service concluded that the error was waivable in both of the private letter rulings.

The third ruling: The facts of the third (*i.e.*, most recent) private letter ruling were somewhat sketchy, as the ruling appeared heavily redacted. What the ruling made clear, however, was that an amount could be available for payment upon surrender of the contract and rider involved, by virtue of the rider's presence, which was over and above the cash value of the contract without regard to the rider. In this case, too, following the same analysis as described above, the Service ruled that the additional amount was included in the contract's overall cash surrender value for section 7702 purposes. This ruling, unlike the prior two, did not involve a waiver under section 7702(f)(8).

---

[6] JOHN H. MAGEE, LIFE INSURANCE 599 (3rd ed. 1958).

[7] DEFRA House Report at 1444; DEFRA Senate Report at 573.

[8] *See* 57 Fed. Reg. 59319 (Dec. 15, 1992) and Prop. Treas. Reg. §1.7702-2(b)(2). While not noted by the Service, these proposed regulations further provide that the term "cash value" does not include (1) the amount of any death benefit (as defined in the proposed regulations), (2) the amount of any qualified additional benefit, (3) the amount of certain benefits payable upon the occurrence of a morbidity risk, (4) an amount returned to the insured upon termination of a credit life insurance contract due to a full repayment of the debt covered by the contract, or (5) a reasonable termination dividend not in excess of $35 for each $1,000 of the face amount of the contract.

[9] 1993-2 C.B. 331.

Implications of the rulings: The question remains as to how companies should construe the meaning of "cash surrender value" under current law. Significantly, the holdings of the private rulings appear *not* to follow the official legislative history of section 7702 (as the Service seems to have recognized), and instead appear more in line with the proposed regulations that are not yet effective. In the case of contracts designed to comply with the CVAT especially, given that the terms of the contract must ensure compliance with the test at all times, even minor errors in accurately identifying cash value can result in non-compliance with this test.

In the rulings, the principal focus was on whether the remittances constituted part of the cash surrender value of the contracts. A conclusion that an amount constitutes cash surrender value may have an additional consequence under sections 7702 and 7702A that should be considered as well. Specifically, if an amount constitutes cash value and is provided on a guaranteed basis, does this affect the guarantees under a contract that are taken into account in calculating guideline premiums, net single premiums, and 7-pay premiums under these statutes? The presence of an additional guaranteed cash value arguably could be viewed as resulting in an increased interest rate guarantee in certain circumstances. In addition, if the additional cash value returns to the policyowner certain expenses that have been charged, this may imply that such expenses are so contingent that they should not be taken into account in calculating guideline premiums in the first instance.

Conforming changes permitted: Notice 93-37, which as noted above announced that the effective date of the proposed regulations defining cash value under section 7702 would be no earlier than the date of publication of final regulations in the Federal Register, also outlined a relief provision that was anticipated for the final regulations. Specifically, the Notice states, "[it] is anticipated that insurance companies generally will be allowed a period of time after final regulations are published to bring their policy forms into compliance with any new rules." It is unclear whether this reference to "policy forms" was intended to include in-force policies or the forms that insurers use to issue policies. To the extent that these regulations, if and when finalized, apply to in-force policies, the relief provisions should be construed to encompass both.

Legislative history relating to "cash surrender value" under section 7702A: In connection with explaining certain amendments to section 7702A made in 2002, the Joint Committee on Taxation commented that the definition of "cash surrender value" under the so-called "rollover rule" of section 7702A(c)(3)(ii) was, by cross-reference, the same as that in section 7702. The Joint Committee then stated that, for purposes of applying this rule, "it is intended that the fair market value of the contract be used as the cash surrender value under this provision, if the amount of the putative cash surrender value of the contract is artificially depressed."[10] This legislative history seems to have little relevance for

[10] STAFF OF THE J. COMM. ON TAX'N, 107TH CONG., TECHNICAL EXPLANATION OF THE JOB CREATION AND WORKER ASSISTANCE ACT OF 2002, at 45-46 (Comm. Print 2002).

purposes of generally defining "cash surrender value," since it appears to function solely as an anti-abuse rule directed at limited situations. It is interesting to note, however, that the cited passage refers to a "putative cash surrender value," and this reference arguably is viewing a contract's putative amount, *i.e.*, its policy value, as being the same as its "cash surrender value."

FAIR MARKET VALUE OF A LIFE INSURANCE CONTRACT

The fair market value of a life insurance contract may differ from the stated cash value. While not directly affecting sections 7702 and 7702A, the issue of the applicable cash surrender value that has emerged from the proposed regulations and the recent rulings incorporates elements of fair market value. Further, the issue of fair market value arises in the context of the sale or transfer of a life insurance contract.

Revenue Procedure 2005-25

In April 2005, the Service published Revenue Procedure 2005-25, providing guidance on determining the fair market value of a life insurance contract in the context of distributions from qualified pension plans. Under section 402(a), amounts distributed to a plan participant are taxable in the year in which they are paid to the employee. Regulations provide that the cash value of any retirement income, endowment, or other life insurance contract is includible in gross income at the time of the distribution.[11] Typically, individuals who receive an insurance policy as a distribution from a qualified plan use the stated cash surrender value of the policy as its fair market value for purposes of determining the amount includible in their gross income.

Regulations under section 72 indicate that the reserve accumulation in a life insurance contract constitutes the source of and approximates the amount of such cash value.[12] Moreover, the Service has noted that the use of the cash surrender value may not be appropriate where the policy reserves provide a much more accurate approximation of the fair market value of the policy than does the policy's stated cash surrender value. In recent years, the Service has become increasingly concerned that neither the reserve nor the cash surrender value necessarily represents the correct measure of the fair market value. To this end, the Revenue Procedure addresses, for section 402(a) purposes, the valuation of distributions from qualified retirement plans, including section 412(i) pension plans, under which the plan assets are life insurance or annuity contracts.

While the issue of the fair market value of a life insurance contract has been the subject of litigation and regulation over many years, Revenue Procedure 2005-25, and Revenue Procedure 2004-16, which it superseded, are the first attempts by the Service to introduce a formulaic approach to valuation. The revenue procedure was issued in connection with proposed regulations under section 402(a) of the Code addressing the

[11] Section 1.402(a)-1(a)(2).

[12] Section 1.72-16(c)(2)(ii).

valuation of a life insurance contract distributed from a qualified retirement plan.[13] Under section 402(a), amounts distributed to a plan participant are taxable in the year in which they are paid to the employee. Regulations provide that the cash value of any retirement income, endowment, or other life insurance contract is includible in gross income at the time of the distribution.[14] Typically, individuals who receive an insurance policy as a distribution from a qualified plan use the stated cash surrender value of the policy as its fair market value for purposes of determining the amount includible in their gross income.

Revenue Procedure 2005-25 introduces the concept of a PERC amount, and provides an anti-abuse provision, warning that "the formulas set forth in . . . this revenue procedure must be interpreted in a reasonable manner, consistent with the purpose of identifying the fair market value of a contract." The safe harbor for non-variable contracts defines the fair market value of an insurance contract, retirement income contract, endowment contract, or other contract providing life insurance protection may be measured as the greater of:

(1) the sum of the interpolated terminal reserve and any unearned premiums plus a pro-rata portion of a reasonable estimate of dividends expected to be paid for that policy year based on company experience, and

(2) the product of the PERC amount and the applicable Average Surrender Factor.

The PERC amount is the aggregate of:

a) the premiums paid from the date of issue through the valuation date without reduction for dividends that offset those premiums, plus

b) dividends applied to purchase paid-up insurance prior to the valuation date, plus

c) any amounts credited (or otherwise made available) to the policyholder with respect to premiums, including interest and similar income items (whether credited or made available under the contract or to some other account), but not including dividends used to offset premiums and dividends used to purchase paid-up insurance, minus

d) explicit or implicit reasonable mortality charges and reasonable charges (other than mortality charges), but only if those charges are actually

[13] Amendments to the regulations under IRC §402 were proposed on Feb. 13, 2004 (REG-126967-03, 2004-10 I.R.B. 566) to clarify that the fair market value standard controls when such a contract is distributed. While proposed regulations under IRC §§79 and 83 clarify that the amount includible in income under those sections is based upon the fair market value of the insurance contract rather than its cash surrender value, the proposed regulations do not provide any guidance as to what constitutes fair market value. Thus, the methodology set forth in the revenue procedures applies to determinations under those sections as well.

[14] Treas. Reg. § 1.402(a)-1(a)(2).

charged on or before the valuation date and those charges are not expected to be refunded, rebated, or otherwise reversed at a later date, minus

e) any distributions (including distributions of dividends and dividends held on account), withdrawals, or partial surrenders taken prior to the valuation date.

Historical Valuation Issues

The question of whether the cash surrender value is the proper measure of the value of a life insurance policy is not a new one. More than 60 years ago, in a case involving the valuation of a gift, the United States Supreme Court said:

> Surrender of a policy represents only one of the rights of the insured or beneficiary… But the owner of a fully paid life insurance policy has more than the mere right to surrender it; he has the right to retain it for its investment virtues and to receive the face amount of the policy upon the insured's death. That these latter rights are deemed by purchasers of insurance to have substantial value is clear from the difference between the cost of a single-premium policy and its immediate or early cash-surrender value…[15]

The concept that the policy reserve may be a more appropriate value than the cash surrender value appears in a Tax Court case,[16] as well as Revenue Ruling 59-195, which held:

> Where an employer purchases and pays the premiums on an insurance policy on the life of one of its employees and subsequently sells such policy, on which further premiums must be paid, to the employee, the value of the policy, for computing taxable gain to the employee in the year of purchase, is its interpolated terminal reserve value at the date of the sale, plus the proportionate part of any premium paid by the employer prior to the date of the sale which is applicable to a period subsequent to the date of the sale.[17]

PLR 9433020 (Oct. 28, 1994): In a 1994 private letter ruling, the Service discussed the fair market value of a life insurance contract in connection with a viatical settlement. Noting that an assignment of a life insurance contract for consideration constitutes a sale of property, the Service observed that under section 1001(b), the amount realized is equal to the cash plus the fair market value of any property received in connection with the sale. In this case, the amount realized upon the sale of the life insurance contract would be the consideration received from the viatical settlement company. To determine the

[15] Guggenheim v. Rasquin, 312 U.S. 254 (1941).

[16] Charles Cutler Parsons v. Comm'r, 16 T.C. 256 (1951).

[17] Rev. Ruling 59-195, 1959-1 C.B. 18.

gain on the sale, the amount realized was reduced by the adjusted basis of the contract. The adjusted basis of the contract was set equal to the premiums paid less the sum of:

(i) the cost of insurance (COI) protection provided through the date of sale and

(ii) any amounts (*e.g.,* dividends) received under the contract that have not been included in gross income.

In this context, the Service cited two cases from the 1930s, dealing with the valuation of life insurance policies (for the purpose of deducting losses on sale).[18] In *London Shoe*, the court addressed the value of a life insurance contract. After describing the (predecessor) to the section 72 rules, the court commented:

> The subdivision dealing with the computation of taxable gains somewhat favors the taxpayer at the expense of the government, because it allows the deduction of the full amount of the premiums paid from the total amount received, though the premiums are in excess of what would normally be required for insurance protection, and thus lessens the amount of the taxable gain.[19]

GUIDELINE PREMIUM/CASH VALUE CORRIDOR TEST

Section 7702(d) Cash Value Corridor (Chapter II, Page 29)

The section 772(d) corridor factors apply based on the "attained age" of the insured. In September of 2006, regulations providing guidance on determining an insured's attained age for this and certain other purposes under section 7702 were finalized. (*See* Appendix A—Attained Age Regulation.) The specifics of this guidance, which covers both single and multiple life attained age determinations, are found in Treas. Reg. section 1.7702-2 and are discussed below under the heading "Statutory Limitations on Mortality."

CHOICE OF TESTS

Use of CVAT Factors (Chapter II, Page 34)

A 2004 private letter ruling dealt with the rounding of CVAT "corridor" factors to two decimal places.[20] The policy provided a minimum death benefit equal to the account value multiplied by a cash value accumulation factor, computed as the reciprocal of the net single premium. Thus, when multiplied by the account value, the cash value accumulation factor would yield the death benefit for which the account value is equal to the net single premium.

---

[18] *See* London Shoe v. Comm'r, 80 F.2d 230 (2d Cir. 1935), *cert. denied,* 298 U.S. 663 (1936); Century Wood Preserving Co. v. Comm'r, 69 F.2d 967 (3d Cir. 1934).

[19] London Shoe v. Comm'r, 80 F.2d 230, 232 (2d Cir. 1935).

[20] PLR 200438005 (May 14, 2004).

The cash value accumulation factors rounded, up or down, to the nearest two decimal places were set forth in a contract endorsement for each attained age and underwriting classification. In administering the policy, the insurer relied on its contract administration system, which performed calculations internally to an accuracy of eight decimal places. Despite administrative practices which maintained the policies in compliance, the rulings looked to the "terms of the contract" to determine that the policies failed to meet the CVAT. Under the ruling, the Service waived the potential failure of the policies to meet the CVAT, allowing the insurer to replace the two-decimal place factors with more accurate factors.

TAXATION OF PRE-DEATH DISTRIBUTIONS

Methods of Taxation (Chapter II, Page 37)

Section 72 allocates any "amount received" by the policyholder under a life insurance (or annuity) contract between two categories: income on the contract (gain) or investment in the contract (basis). The sum of these two amounts equals the amount received. The portion allocated to gain is includible in the taxpayer's gross income, while the amount allocated to basis reduces investment in the contract and is not taxable. In general, distributions are taxed in one of three ways:

(1) The first approach is the FIFO (first in, first out) approach and is thought of as the friendly approach, since it defers tax. Under this approach, basis is distributed first, and no distributed amount is taxable until all basis is gone.

(2) The second approach is LIFO (last in, first out), and it does the reverse of FIFO. Under LIFO, gain is distributed first, and no distributed amount is free of tax until all gain is gone from the contract.

(3) Finally, the third (pro-rata) approach compromises between these two extremes and views any distribution as a mix of taxable gain and basis in the same proportion as existed in the contract just before the distribution. (The pro-rata taxation applies to distributions from contracts under qualified plans under section 72(e)(8).)

Investment in the contract as of any date is defined by section 72(e)(6) as the total amount of premium or other consideration paid for the contract before that date less the aggregate amount received by the policyholder from the contract before that date, to the extent the amount received was excludable from gross income for income tax purposes. Income on the contract is effectively defined in section 72(e)(3) as the excess of contract cash value before reduction for any surrender charge over the investment in the contract.[21]

[21] While this discussion speaks of "investment in the contract" and "basis" interchangeably, the concept of basis is a general one under the federal income tax law and technically applies with

Allocation of distributions under section 72 is done one way for modified endowment contracts (MECs), and another way for non-MEC life insurance contracts. For non-MECs, section 72(e)(5) applies, and the amount received is allocated to income on the contract to the extent it exceeds the investment in the contract at the time of distribution. That is, the FIFO method of taxing applies and basis is fully recovered before any income amount is recognized. In addition, for a non-MEC, a policy loan is not treated as a distribution and does not create an amount received by the policyholder.

For a MEC, section 72(e)(10) makes section 72(e)(2)(B) applicable, so that the amount received is allocated to income on the contract to the extent it does not exceed the income on the contract at the time of distribution. That is, the amount received is includible in income to the extent of gain, and only after all gain has been taxed is there any allocation to basis. This is the LIFO method of taxing distributions. However, section 72(e)(5)(E) provides special treatment for full surrender of a contract. That is, the amount received is includible in gross income, but only to the extent it exceeds investment in the contract—the FIFO rule. This rule allows full basis recovery for MECs in circumstances where there is a full surrender in the presence of a surrender charge.

Taxation of Full Surrender	
Basis	800
Gain	200
Cash Value	1,000
Surrender Charge	100
Amount Received on Surrender	900
Taxable Gain	100

To illustrate, assume a MEC with basis of $800 and gain of $200, hence cash value of $1000, is surrendered and that a $100 surrender charge applies. Without this special rule, income on the contract of $200 would be LIFO taxed, and of the $900 amount received only $700 would represent basis recovery. The surrender rule prevents this. Finally, for MECs, policy loans are treated as distributions and create an amount received by the policyholder (under section 72(e)(4)(A)). This applies to loans taken to pay policy loan interest as well as to loans taken as cash or to pay premium.

Policy dividends: A dividend or similar amount that is retained by the insurer as premium or other consideration for the contract is not treated as a distribution and does not create an amount received due to section 72(e)(4)(B). Policy dividends also do not have any effect on investment in the contract (basis). This favorable treatment is not extended to partial surrenders or policy loans applied to pay premium. Thus, partial surrenders or policy loans create distributions for a MEC (or an annuity), which may well be fully or

---

respect to life insurance contracts only in the case of sales, exchanges, or dispositions of contracts other than the surrenders and withdrawals addressed by section 72. Although the basis of a contract is often thought to follow the definition of the investment in the contract, the Service indicated in PLR 9443020 (Oct. 28, 1994) that a contract's basis may be reduced by cost of insurance charges.

partly taxable. Similarly, a dividend applied to reduce a policy loan is treated as a distribution for both MECs and non-MECs. These distributions reduce basis only to the extent they are not taxable.

Charges for LTC riders: Charges assessed against the cash value of a life insurance contract to pay for benefits additional to the basic contract benefits (other than *qualified* additional benefits) are treated as distributions from the contract even though the amounts involved are actually retained by the insurer rather than paid out to the policyholder. This is the treatment, for example, of charges imposed to pay for a long-term-care (LTC) insurance accelerated benefits rider. Hence, if such charges are assessed against the cash value of a MEC, they are includible in gross income on a gain-first basis. However, as discussed further below under the heading ACCELERATED DEATH BENEFITS AND LONG-TERM CARE RIDERS, the Pension Protection Act of 2006[22] enacted new section 72(e)(11), effective after 2009, to exclude from gross income the charges imposed to fund such riders if they provide "qualified" LTC insurance coverage. Instead, those charges will reduce the investment in the contract, whether or not the contract is a MEC. As a result, the premiums paid for the contract, as defined in section 7702(f)(1)(A), will be reduced by such charges.

Policy loans: The taxation of policy loans from MECs requires an adjustment to basis accomplished by the final sentence of section 72(e)(4)(A). The policy loan does not affect the cash value of the contract, and neither will any repayment of the loan. Any taxed portion of the loan is, however, added to the investment in the contract (basis). If a policy loan is applied to pay premium, the basis is increased by any taxed portion of the loan, and further increased by the amount applied as premium (just as any premium payment increases basis). This is illustrated in Table II-5A.

Table II-5A Taxation of a Policy Loan to Pay Premiums

	Value "Before" Withdrawal	Value "After" for MEC LIFO	Value "After" for Non-MEC FIFO
Cash Surrender Value	10,000		
Premiums Paid	7,000		
Section 72(e) Gain	3,000		
Policy Loan	1,000		
Taxable Income		1,000	
Premiums Paid		8,000	7,000
Section 72(e) Gain		2,000	3,000
Premium Payment	1,000		
Cash Surrender Value	11,000		
Premiums Paid		9,000	8,000
Section 72(e) Gain		2,000	3,000

[22] Pub. L. No. 109–280, § 844(a).

Section 7702(f)(1) premiums paid: Under section 72, the investment in the contract is not always the same as premiums paid. At least three differences can be observed:

(1) The first occurs when a contract is issued as an exchange, in which gain is not recognized due to the operation of section 1035. Under section 7702, the entire amount of exchange money counts as premiums paid. However, section 1031(d) intervenes to create a carry-over basis from the old contract to the new one. The effect of this carry-over is to treat income on the old contract not taxed in the exchange as income on the new contract. For completeness we note that if the policyholder in a section 1035 exchange receives money ("boot") in addition to a new contract, the money is taxable to the extent there is gain in the old contract, and any excess of the boot over the prior contract gain will reduce the carry-over basis of the new contract.[23]

(2) The second way basis can differ from premiums paid is through the taxation of policy loans from MECs. As noted above, the taxed portion of the loan increases investment in the contract (basis), but there is no effect on premiums paid.

(3) A third difference is created by a special rule in section 7702(f)(1)(B) allowing amounts taxable under the force-out rule of section 7702(f)(7)(B) and (E) to reduce premiums paid under section 7702. This does not mean that these amounts reduce section 72 investment in the contract.

Section 72 imposes additional tax ("penalty tax") on certain distributions from MECs.[24]

Summary of Taxation of Distributions under IRC Section 72			
	Timing of Tax	**Policy Loans**	**Penalty Tax**
Non-MEC Life Insurance	FIFO	Not Taxed	None
MECs	LIFO	Taxed with basis adjustment	10% with exceptions

Aggregation Rules (Chapter II, Page 39)

Single premium COLI contracts simultaneously purchased in large numbers received some relief from the aggregation rule of section 72(e)(12) by virtue of Rev. Rul. 2007-38.[25] (Section 72(e)(11) was redesignated as section 72(e)(12) by the Pension Protection Act of 2006.) Under the facts of that ruling, a portion of a group of COLI MECs purchased at

[23] IRC § 1031(b) and Treas. Reg. § 1031(d)-1(b).

[24] Section 72(v).

[25] 2007-25 I.R.B. 1420.

the same time from the same carrier was exchanged under section 1035 for new COLI contracts issued by a different carrier (several years later). The ruling held that section 72(e)(12) would not apply to aggregate the new contracts with the contracts that were not exchanged. While this ruling provided some good news for the taxpayers holding COLI contracts, it should be noted that the ruling does not address the situation of an exchange followed by a surrender of some or all of the contracts not exchanged. Such facts could lead to a different result under the tax law's step transaction doctrine.

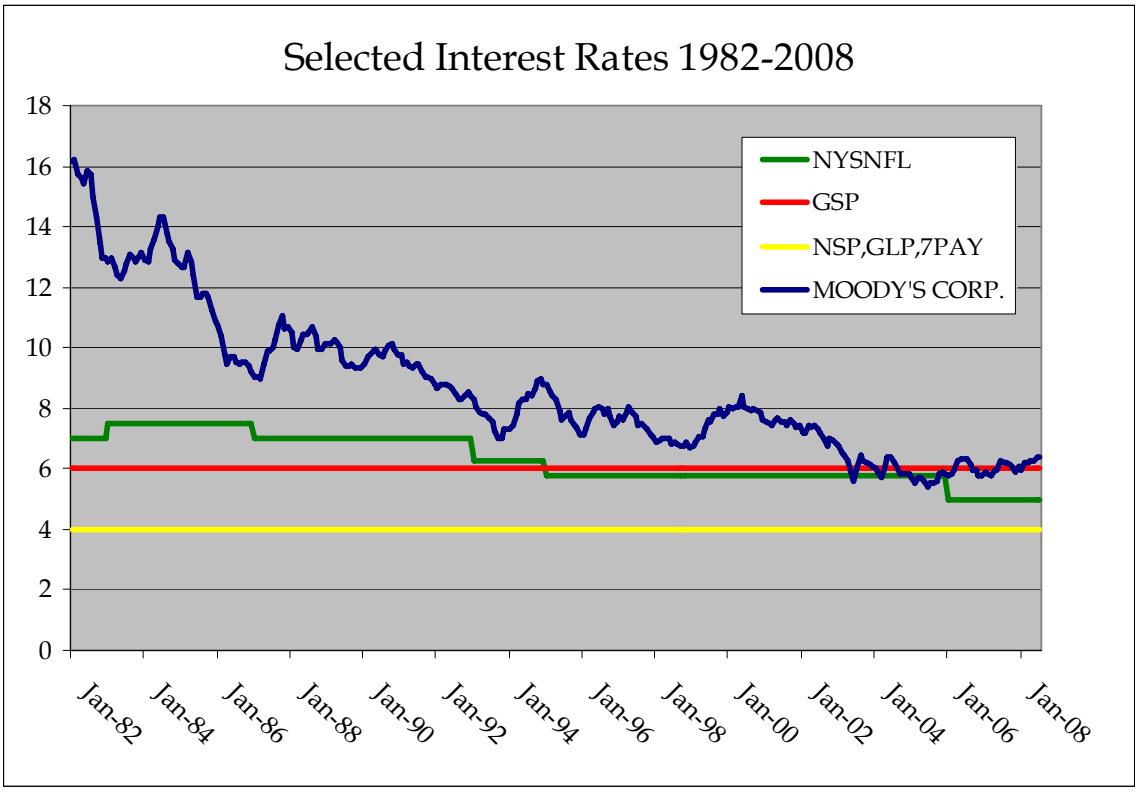
INTEREST

Changes in the Interest Rate Environment (Chapter III, Page 53)

Table III-2 Maximum Nonforfeiture Interest Rates

Years	Nonforfeiture Rates	GSP	GLP, NSP, & 7-Pay
1982	7.00%	6.00%	4.00%
1983-1986	7.50%	6.00%	4.00%
1987-1992	7.00%	6.00%	4.00%
1993-1994	6.25%	6.00%	4.00%
1995-2005	5.75%	6.00%	4.00%
2006-2008	5.00%	6.00%	4.00%

The chart below compares the section 7702 and 7702A interest limitations with maximum rates permitted under the Standard Nonforfeiture Law (for life insurance contracts of durations of 20 or more years) as well as the average of the Moody's Aaa and Baa rates (which is used as a proxy for the general account earnings rate under Revenue Procedure 2001-42).



STATUTORY LIMITS ON MORTALITY

Regulation Section 1.7702-2 (Chapter III, Page 59)

Attained age under section 7702: An insured's attained age is relevant in a number of contexts under both sections 7702 and 7702A. In general, the computation of guideline premiums and net single premiums under section 7702 and 7-pay premiums under section 7702A at any given time requires knowledge of, or an assumption as to, the age(s) of the insured(s) at that time. More particularly, section 7702(e)(1)(B) generally provides that the calculations under section 7702 must assume that a contract's maturity date is no earlier than the day on which the insured attains age 95 and no later than the day on which the insured attains age 100. Also, under section 7702(e)(1)(C), death benefits are deemed to be provided until this maturity date, and under section 7702(e)(1)(D), the amount of any endowment benefit (or sum of endowment benefits, including any cash surrender value on the maturity date) is deemed not to exceed the least amount payable as a death benefit at any time under the contract. As noted previously, the insured's attained age also is pertinent to application of the "cash value corridor" requirement of section 7702(d), which must be satisfied by contracts intended to comply with the guideline premium limitation.

On May 24, 2005, the Treasury Department and the Service proposed regulations explaining how to determine the attained age of an insured for purposes of testing

whether a contract satisfies the requirements of section 7702. Prior to this, the sole official information relating to the determination of attained age was found in the DEFRA legislative history's statement that in applying the cash value corridor, the guideline premium limitation, and the computational rules, "the attained age of the insured means the insured's age determined by reference to contract anniversaries (rather than the individual's actual birthdays), so long as the age assumed under the contract is within 12 months of the actual age." [26] As described below, the proposed regulations elaborated on this rule, and in September of 2006, subject to several changes, they were finalized and now appear as Treas. Reg. section 1.7702-2.

The final regulations, consistent with the proposed regulations, establish a general rule for determining an insured's attained age for purposes of calculating the guideline level premium under section 7702(c)(4), applying the cash value corridor of section 7702(d), and utilizing the computational rules of section 7702(e). Significantly, the preamble to the final regulations states that the regulations do "not, nor are they intended to, endorse or prohibit any methodology for determining reasonable mortality charges under section 7702(c)." This limitation on the scope of the new rules was reiterated, and emphasized, by representatives of the Treasury Department and the Service during discussion of the subject at the Society of Actuaries' (SOA) Product Tax Seminar on Sept. 13, 2006, the day after the final regulations were published. Hence, the new attained age rules apply for limited, specific purposes: (1) determining the level premium payment period under section 7702(c)(4), which refers to payments until age 95, (2) applying the section 7702(d) corridor factors, which are age specific, and (3) making the various calculations in accordance with the endowment or maturity date rules of section 7702(e), which reference ages 95 and 100. The computational rules apply to the section 7702(b) cash value accumulation test as well as the guideline premium test, and they also apply, derivatively, in determining the section 7702A 7-pay premiums.

In addition to addressing contracts covering a single insured's life, the regulations address the permissible attained age assumptions that may be used under joint life insurance contracts, both first-to-die contracts and last-to-die contracts. Specifically, Treas. Reg. section 1.7702-2(b)(1) provides that the attained age of the insured under a contract insuring a single life is either:

(1) the insured's age determined by reference to the individual's actual birthday as of the date of determination (actual age); or

(2) the insured's age determined by reference to contract anniversary (rather than the insured's actual birthday)—sometimes called the "insurance age"—so long as the age assumed under the contract is within 12 months of the actual age.

[26] DEFRA Senate Report at 576; DEFRA Blue Book at 651.

Under these rules, age-last-birthday and age-nearest-birthday assumptions continue to be permitted. This is illustrated in Examples 1 and 2 of Treas. Reg. section 1.7702-2(e), summarized below.

> *Example 1:* An insured born on May 1, 1947 becomes 60 years old on May 1, 2007. On Jan. 1, 2008, the insured purchases an insurance policy on his or her life. January 1 is the contract anniversary date for future years. The insurance company determines the insured's premiums (or cost of insurance) based on an age-last-birthday method. Under this method, the insured has an attained age of 60 for the first contract year, 61 for the second contract year, and so on.
>
> *Example 2:* The facts are the same as under Example 1, except that the insurance company determines the insured's premiums based on an age-nearest-birthday method. Under this method, the insured's nearest birthday to Jan. 1, 2008, is May 1, 2008, when the insured will be 61 years old. Thus, in this example, the insured has an attained age of 61 for the first contract year, 62 for the second contract year, and so on.

This same set of requirements also applies for purposes of determining an insured's attained age in the case of contracts covering multiple lives, although with significant exceptions. In particular, Treas. Reg. section 1.7702-2(c)(1) and (d) provide, respectively, that:

(1) The attained age of the insured under a contract insuring multiple lives on a last-to-die basis—joint and last survivor contracts—is the attained age of the youngest insured; and

(2) The attained age of the insured under a contract insuring multiple lives on a first-to-die basis is the attained age of the oldest insured.

In response to a comment letter on the proposed regulations, the regulations include a rule specifically addressing a last-to-die contract that undergoes a change in both its cash value and its future mortality charges as a result of the death of an insured (*i.e.*, the contract reverts to a single life structure upon the death of an insured). According to Treas. Reg. section 1.7702-2(c)(2), if the youngest insured under such a contract should die, the attained age used for testing after that death is the attained age of the "youngest surviving insured." In this way, the attained age used for federal income tax purposes is consistent with that used under the terms of the contract.

Examples 4, 5, and 6 of Treas. Reg. section 1.7702-2(e) illustrate attained age determinations for multiple life contracts and are summarized below.

Example 4: An insured born on May 1, 1947 becomes 60 years old on May 1, 2007. In addition, a second insured covered by the contract was born on Sept. 1, 1942, and becomes 65 years old on Sept. 1, 2007. On Jan. 1, 2008, the insureds purchase a last-to-die insurance policy. Because the insured born in 1947 is the younger insured, the attained age of 60 must be used for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

Example 5: The facts are the same as under Example 4, except that the younger of the two insureds dies in 2012. After the death of the younger insured, both the cash value and mortality charges of the life insurance contract are adjusted to take into account only the life of the surviving insured. Because of this adjustment, the attained age of the only surviving insured is taken into account (after the younger insured's death) for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

Example 6: An insured born on May 1, 1947 becomes 60 years old on May 1, 2007. In addition, a second insured covered by the contract was born on Sept. 1, 1952, and becomes 55 years old on Sept. 1, 2007. On Jan. 1, 2008, the insureds purchase a first-to-die insurance policy. Because the insured born in 1947 is the older insured, the attained age of 60 must be used for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

The treatment of contracts covering multiple lives is addressed further below under MULTIPLE-LIFE PLANS.

Consistency rule: The regulations contain a consistency requirement. Specifically, Treas. Reg. section 1.7702-2(b)(2) states: " Once determined …, the attained age with respect to an individual insured under a contract changes annually. Moreover, the same attained age must be used for purposes of applying sections 7702(c)(4), 7702(d), and 7702(e), as applicable." While the promulgation of such an anti-whipsaw requirement is understandable, its scope is unclear in a number of respects.

Changes in benefits between policy anniversaries: The consistency requirement of the regulations just quoted provides that the attained age of an insured, "once determined" for purposes of the regulations, "changes annually." Example 3 of Treas. Reg. section 1.7702-2(e), summarized below, details and clarifies the intent of the regulations in dealing with benefit changes off-anniversary.

Example 3: An insured born on May 1, 1947 purchases a contract on Jan. 1, 2008. January 1 is the contract anniversary date for future years. The face amount of the contract is increased on May 15, 2011. During the contract

> year beginning Jan. 1, 2011, the age assumed under the contract on an age-last-birthday basis is 63 years. However, at the time of the face amount increase, the insured's actual age is 64. Treas. Reg. section 1.7702-2(b)(2) provides that, once the attained age is determined, it remains that age until the next policy anniversary. Thus, the insured continues to be 63 years old throughout the contract year beginning Jan. 1, 2011 for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable, even though the insured is age 64 at the time of the increase based on an age-last-birthday determination.

It is important to note that this approach runs contrary to a common insurance industry practice with regard to off-anniversary death benefit increases. Many administrative systems apply a "segment approach" to death benefit increases, where each segment, or layer, of additional death benefit is administered independently from the base contract. Each segment is assigned its own issue date, coverage amount, issue age, etc., and the system calculates, *e.g.*, guideline premiums according to the characteristics assigned to each segment. Under a segment approach, the system would aggregate guideline premiums for each segment to determine the guideline premiums applicable to the contract. A common practice under this approach is to determine issue age for the segment as if the segment were viewed as a newly issued contract. Therefore, if the contract defines age on an age-last-birthday basis, the segment issue age would be determined on an age-last-birthday basis as of the segment issue date; under the facts of Example 3 above, the insured would have a segment issue age of 64 years. Thus, the segment issue age under an age-last-birthday determination would be greater than the attained age permitted under the final regulations, resulting in a potential overstatement of guideline premiums.

This result was deliberate on the part of the Treasury Department and the Service. A comment letter submitted on the proposed regulations characterized the regulations' language as unclear with respect to the attained age that should be used for a death benefit change occurring between policy anniversary dates. The letter requested flexibility in determining which attained age to use in this instance. The final regulations granted the clarification, but in a manner contrary to the request made, determining that the attained age of the insured, once determined, remains constant until the next policy anniversary. Again, however, the new attained age rules apply for the limited purposes of section 7702(c)(4), (d), and (e)—but they do not govern "reasonable" mortality charges, according to the preamble. Off-anniversary changes, then, cannot alter the insured's attained age for purposes of determining the level premium payment period, applying the corridor factors, and making calculations in accordance with the section 7702(e) maturity date rules.

One question that has arisen concerns the application of the final regulations when there is a material change under section 7702A(c)(3)(A)(i). Upon a material change in benefits under a contract which was not reflected in any previous determination under section

7702A, section 7702A(c)(3)(A)(i) requires the contract to be treated as "a new contract entered into on the day on which such material change takes effect." In Example 3, above, if the contract is considered newly entered into on the date of the face amount increase (May 15, 2011), is it then appropriate to determine age as if the contract were newly entered into on that date for purposes of section 7702A(c)(3)(A)? It would seem so, in which case the attained age for the 7-pay premium calculation in the example is 64. While calculations of 7-pay premiums under section 7702A are made, in part, using the computational rules of section 7702(e), section 7702A(c)(3)(A)(i) appears to be the more specific statutory rule governing the date when calculations are made and an insured's age is identified. It would be helpful for this to be clarified in future guidance.

Contractual assumptions: A further question is whether the age assumptions contained within a contract (used, for example, for purposes of determining guaranteed mortality charges) must be used under section 7702, *e.g.*, if a contract sets forth mortality guarantees based on an age-last-birthday assumption, is it permissible to calculate guideline premiums using an age-nearest-birthday assumption? Generally speaking, where section 7702 does not prescribe a particular treatment for an aspect of the calculations, it is appropriate to follow the mechanics of a contract, since such a practice usually will be actuarially reasonable in the circumstance. The statute does not, however, expressly require this, and thus the extent to which variations in practice are permitted is unclear in some respects. We observe that the second example of section 1.7702-2(e) of the proposed regulations describes use of an age-nearest-birthday assumption and notes that "under the contract" premiums were determined on this basis. In addition, the third of the safe harbors with respect to the reasonable mortality charge rule set forth in Notice 2006-95 limits the charges that can be reflected under section 7702 to those guaranteed under the contract, and thus insurers intending to utilize this safe harbor generally will need to reflect contractual age assumptions in their guideline premium calculations. The exact scope of any required consistency between section 7702 and a contract's age assumptions is unclear at present, and there may well be other common practices that could raise questions in this respect.

Effective date: The final regulations are effective Sept. 13, 2006 and apply to policies either (a) issued after Dec. 31, 2008, or (b) issued on or after Oct. 1, 2007 and based on the 2001 CSO tables (discussed below). A taxpayer may choose, however, to apply the final regulations to policies issued prior to Oct. 1, 2007, provided that the taxpayer does not later determine the policies' qualification in a manner that conflicts with the regulations.

Given the prospective application of the regulations' guidance, questions have been asked about the appropriateness of practices, such as joint equal age assumptions and age rate-ups, which insurers have used and continue to use with respect to contracts issued before the above-described effective date. Technically, the regulations do not in any way address such contracts or the appropriateness of any particular practices applied to determine their compliance (apart from the effective date rule permitting a taxpayer to apply the guidance retroactively to such contracts). Thus, the

appropriateness of any particular interpretation of section 7702 and associated practice must be determined based on the requirements as set forth in the statute and other authorities such as legislative histories pertinent to such requirements. They must be judged, in other words, based on the law as it existed without regard to the regulations.

While the regulations thus do not provide any comfort with respect to prior and existing practices (unlike, for example, the relief provided in Rev. Rul. 2005-6 with respect to the treatment of qualified additional benefits), it can fairly be said that the government has been aware of the use of various practices, such as joint equal age assumptions. The preamble to the proposed regulations states that the regulations are "consistent with the existing practice of many (but not all) issuers of both contracts insuring a single life and contracts insuring multiple lives." Thus, the choice of a prospective effective date for the proposed new rules provides some indication that the government is not interested in challenging such practices, as long as they were actuarially reasonable.

THE 2001 CSO MORTALITY TABLE

Notices 2004-61 and 2006-95 (Chapter III, Page 62)

In the fall of 2004 and again in the fall of 2006, the Treasury Department and the Service issued notices in response to the life insurance industry's request for guidance on the transition to the 2001 CSO tables. First, Notice 2004-61[27] provided a set of safe harbor rules intended to enable an orderly transition to the new table. The safe harbors under the Notice addressed both 1980 CSO contracts and 2001 CSO contracts, and it applied to both the definitional limitations under section 7702 and the modified endowment rules under section 7702A. Then, reacting to industry comments concerning certain perceived new restrictions imposed by the 2004 Notice, the government issued Notice 2006-95, [28] (*see* Appendix B) reiterating the prior Notice's safe harbors but removing the troublesome wording. According to its terms, Notice 2006-95 "supplements" Notice 88-128 and "modifies and supersedes" Notice 2004-61.

Safe harbors: Notice 2006-95, like its predecessor, provides three safe harbors with respect to the reasonable mortality charge requirement of section 7702(c)(3)(B)(i), although these are not identical to those of Notice 2004-61.

- The first safe harbor, set forth in section 4.01 of Notice 2006-95, provides that the interim rules described in Notice 88-128 remain in effect "except as otherwise modified by the notice." Notice 88-128 included an "interim" rule allowing use of mortality charges that do not exceed 100% of the applicable mortality charges set forth in the 1980 CSO tables. One modification to the interim rules of the 1988 Notice made by Notice 2006-95 (and previously by Notice 2004-61) results from

[27] 2004-2 C.B. 596.

[28] 2006-45 I.R.B. 848.

the change in the prevailing mortality table to 2001 CSO in 2004.[29] Reflecting this change, and taking account of the transition rules of the National Association of Insurance Commissioners (NAIC) model regulation implementing the new tables, section 2 of Notice 2006-95 observes: "The 1980 CSO tables may still be used in all states for contracts issued in calendar years through 2008. For contracts issued after 2008, use of the 2001 CSO tables will be mandatory." Notice 2004-61 contained a similar statement applicable for contracts issued in states that had adopted the 2001 CSO tables; Notice 2006-95 observes that all states have now adopted the 2001 CSO tables.

- The second safe harbor, set forth in section 4.02 of Notice 2006-95, provides that a mortality charge with respect to a life insurance contract will satisfy the requirements of section 7702(c)(3)(B)(i) so long as (1) the mortality charge does not exceed 100% of the applicable mortality charge set forth in the 1980 CSO tables; (2) the contract is issued in a state that permits or requires the use of the 1980 CSO tables at the time the contract is issued; and (3) the contract is issued before Jan. 1, 2009. It is unclear what situations might satisfy this second safe harbor which would not satisfy the first safe harbor. It may be that this safe harbor simply represents a restatement of the second safe harbor of Notice 2004-61 with a modification—an important one—that removes a requirement added by Notice 2004-61 that the mortality charges assumed in the section 7702 calculations could not exceed the mortality charges specified in the contract at issuance. Section 3 of Notice 2006-95 expressly states that this change was made to ensure that it does not subject 1980 CSO contracts to more stringent standards, retroactively, than applied under Notice 88–128. It may also be that this second safe harbor was intended to implement the "sunset" statement, made in section 2 of Notice 2006-95, that for contracts issued after 2008, use of the 1980 CSO tables will no longer be allowed.

- The third safe harbor, set forth in section 4.03 of Notice 2006-95, provides that a mortality charge with respect to a life insurance contract will satisfy the requirements of section 7702(c)(3)(B)(i) so long as (1) the mortality charge does not exceed 100% of the applicable mortality charge set forth in the 2001 CSO tables; (2) the mortality charge does not exceed the mortality charge specified in the contract at issuance; and (3) either (a) the contract is issued after Dec. 31, 2008, or (b) the contract is issued before Jan. 1, 2009, in a state that permits or requires the use of the 2001 CSO tables at the time the contract is issued. In this manner, the Notice (like its predecessor) follows the adoption dates provided by the NAIC in its Model Regulation adopting the 2001 CSO.[30] The Model

[29] For the special case of burial or pre-need life insurance contracts issued beginning in 2009, *see* the discussion below under the heading SPECIAL PRODUCTS.

[30] *Recognition of the 2001 CSO Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits Model Regulation* (NAIC, December 2002).

> Regulation provides that the 2001 CSO table can be applied at the option of a company until Jan. 1, 2009, by which time all products offered for sale must be 2001 CSO compliant. In following the NAIC Model, the Notices, in effect, adopted the same transition rules for compliance with the definitional limits as the states have provided for contract nonforfeiture values, thus removing any potential conflict between state law and federal tax law requirements.

The importance of meeting one of the safe harbors: The reasonable mortality charge requirement, apart from guidance such as Notice 2006-95 and its predecessors, is tied to the prevailing commissioners' standard tables as defined in section 807(d)(5). Since, as noted above, the 2001 CSO tables became "prevailing" during 2004, the mortality tables' "year of change" within the meaning of the section 807(d)(5)(B) transition rule was 2005, so that under that rule—barring other guidance—the 1980 CSO tables would continue to be permitted to be used as the prevailing tables for "the 3-year period beginning with the first day of the year of change," *i.e.*, only through Dec. 31, 2007. Thus, looking solely at the statutory rules, use of the 2001 CSO tables would be required for contracts covering standard risk insureds issued after Dec. 31, 2007. It is therefore critical that 1980 CSO contracts meet a safe harbor if they are issued during 2008, since it may not otherwise be possible for such designs to comply with the statute.

New role for contract guarantees: As insurers design products with the intention of complying with the third safe harbor of Notice 2006-95, special care should be paid to ensuring that the contract does not in some way guarantee mortality charges less than charges based on 100% of 2001 CSO, such as through a secondary guarantee contained in the contract. If there were a more liberal mortality rate guarantee, it would be necessary to reflect it in the calculations under section 7702 (and 7702A) in order to come within the ambit of this safe harbor.

Rules for smoker-distinct and gender-blended tables: Notice 2004-61 had expressly permitted the use of smoker-distinct and gender-blended mortality tables, but only if a consistency requirement (foreshadowed in the 1991 proposed regulations on reasonable mortality) was met. In particular, if a state permitted the use of 1980 CSO or 2001 CSO unisex tables in determining minimum nonforfeiture values, Notice 2004-61 allowed such tables to be used for female insureds provided the same tables were used for male insureds. Similarly, if a state permitted the use of 1980 CSO or 2001 CSO smoker and non-smoker tables in determining minimum nonforfeiture values, Notice 2004-61 allowed such tables to be used for smoker insureds provided nonsmoker tables were used for nonsmokers. Notice 2006-95 retains these rules, but on its face does so only for purposes of the 2001 CSO tables under the notice's third safe harbor.

Section 3 of Notice 2006-95 describes this change as intended to help ensure that Notice 2006-95 does not subject 1980 CSO contracts to more stringent standards, retroactively, than applied under Notice 88-128. Apparently, the express consistency requirement applicable under Notice 2004-61 for the use of smoker-distinct and gender-blended

tables was considered to be a restriction potentially being applied retroactively. Thus, Notice 2006-95 clarifies that mortality charges deemed reasonable under the safe harbors of Notice 88-128 continue to be considered reasonable without regard to the consistency rule of Notice 2004-61. This particular change made by Notice 2006-95 does not appear intended to broaden the scope of the Notice 88-128 safe harbors, but rather to ensure that they are not curtailed.

One question that has arisen from the changes made by Notice 2006-95 relates to the Notice 88-128 safe harbor rule permitting use of 1980 CSO unisex tables under section 7702 if the state requires use of such tables. Prior to Notice 2004-61, the use of unisex tables in states that permitted, but did not require, the use of such tables seemingly was not encompassed by the Notice 88-128 safe harbor. (This did not mean that this practice ran afoul of the statutory reasonable mortality charge requirement, but rather simply that the safe harbor was unavailable to confirm compliance with the requirement.) One beneficial consequence of Notice 2004-61 was that it confirmed that such permissive uses of unisex 1980 CSO tables were proper in circumstances where unisex tables were consistently used. While the modification of Notice 2004-61 by Notice 2006-95 gives the appearance that such safe harbor treatment is now being withdrawn, such a result seems unintended in view of the rationale for the change set forth in Notice 2006-95. Similar considerations may apply as well with respect to the change relating to the use of smoker-distinct 1980 CSO tables.

Substandard risks: Notice 2006-95 states that neither it nor Notices 88-128 and 2004-61 address the reasonable mortality charge requirement in the case of substandard risks. Thus, reasonable mortality charges for contracts with substandard mortality rate guarantees generally will continue to be governed by the interim rule of section 5011(c)(2) of TAMRA. Under that rule, a contract issued before the effective date of temporary or final regulations will be deemed to satisfy the reasonable mortality charge requirement of section 7702(c)(3)(B)(i) if the mortality charges assumed in the calculations "do not differ materially from the charges actually expected to be imposed by the company (taking into account any relevant characteristic of the insured of which the company is aware)."

Contract changes: The effective date language in section 5.01 of Notice 2006-95 (as well as of Notice 2004-61) uses a contract's issue date to determine whether the 1980 CSO or the 2001 CSO applies where changes are made to a contract after the mandatory Jan. 1, 2009 effective date of the 2001 CSO. In describing the "date on which a contract was issued," Notice 2006-95 refers to the "standards that applied for purposes of the original effective date of section 7702."[31] As described in the legislative history of section 7702, the original

[31] The Notice provided the following citation: "See H.R. Conf. Rep. No. 861, 98th Cong., 2d Sess. 1076 (1984), 1984-3 (Vol. 2) C.B. 330; see also 1 Staff of Senate Comm. on Finance, 98th Cong., 2d Sess., Deficit Reduction Act of 1984, Explanation of Provisions Approved by the Committee on March 21, 1984, at 579 (Comm. Print 1984)."

transition rules followed the principle that "contracts received in exchange for existing contracts are to be considered new contracts issued on the date of the exchange."

While this language would clearly apply to a new 2001 CSO contract that replaces a 1980 CSO contract, it may also sweep in changes made to existing contracts, depending on the nature and the extent of the change. In this regard, both the legislative history and Notice 2006-95 recite that "for these purposes, a change in an existing contract is not considered to result in an exchange if the terms of the resulting contract (that is, the amount and pattern of death benefit, the premium pattern, the rate or rates guaranteed on issuance of the contract, and mortality and expense charges) are the same as the terms of the contract prior to the change."

Notice 2006-95 goes on to provide guidance regarding changes that, even though material, also will not cause a contract to be newly issued for purposes of applying the reasonable mortality charge requirement. In particular, section 5.02 of Notice 2006-95 states that if a life insurance contract satisfied the 1980 CSO safe harbor when originally issued, a change from previous tables to the 2001 CSO tables is not required if:

(1) the change, modification, or exercise of a right to modify, add, or delete benefits is pursuant to the terms of the contract;

(2) the state in which the contract is issued does not require use of the 2001 CSO tables for that contract under its standard valuation and minimum nonforfeiture laws; and

(3) the contract continues upon the same policy form or blank.

Notice 2006-95 further states, in section 5.03, that:

> The changes, modifications, or exercises of contractual provisions referred to in section 5.02 include (1) the addition or removal of a rider; (2) the addition or removal of a qualified additional benefit (QAB); (3) an increase or decrease in death benefit (whether or not the change is underwritten); (4) a change in death benefit option (such as a change from an option 1 to option 2 contract or vice versa); (5) reinstatement of a policy within 90 days after its lapse; and (6) reconsideration of ratings based on rated condition, lifestyle or activity (such as a change from smoker to nonsmoker status).

In describing the changes being made to the rules of Notice 2004-61 with respect to the identification of the issue date of a contract, Notice 2006-95 provided three comments which should be noted.

- First, referring to the change made to an earlier reference to underwriting in the third example (formerly the second example) of section 5.03, Notice 2006-95 observes that "the rule for determining the issue date of a contract that undergoes an increase or decrease in death benefit is simplified by eliminating the concept of 'underwriting.' This change broadens the grandfather rule of Notice 2004-61 to encompass many routine transactions, but does not wholly defer to an issuer's administrative practices and procedures."

- Second, referring to the addition of the third, fifth, and sixth examples to the list in section 5.03, Notice 2006-95 states that "additional examples are provided of changes, modifications, or exercises of contractual provisions that will not require a change from previous tables to the 2001 CSO tables." Interestingly, while seemingly intended as a liberalization, the inclusion of the fifth example—relating to reinstatement of a policy within 90 days after its lapse, apparently modeled on the rule of section 7702A(c)(2)(B)—could be read as an indirect form of restriction. Since a right to reinstate typically applies under a contract for a period considerably longer than 90 days, should reinstatements beyond 90 days result in a loss of grandfathered status? In such a case, it would seem that the general rule of section 5.02 would apply, and the fact that a reinstatement is not specifically identified in the list of examples in section 5.03 should not alter this result.

- Third, Notice 2006-95 provides the reminder that "[e]xcept as described above, this notice does not modify the definition of 'issue date' that was provided in Notice 2004-61."

Effective date: Notice 2006-95 is effective Oct. 12, 2006. The Notice states, however, that its provisions will not be applied adversely to taxpayers who issued, changed, or modified contracts in compliance with Notice 2004-61 (without regard to the modifications to Notice 2004-61 made by Notice 2006-95).

Mortality Rates beyond Age 100 (Chapter III, Page 62)

None of the guidance issued to date by the Treasury Department and the Service on the 2001 CSO transition has commented on one aspect of the 2001 CSO tables—the relationship between (1) the requirement of section 7702(e)(1)(B) that a deemed maturity date between age 95 and 100 must be used in the section 7702 calculations and (2) the fact that the new tables extend to age 121. The "maturity problem" is created by the interaction of §7702(e)(1)(B) (deeming the contract to mature no later than the insured's attaining age 100 for computational purposes) and the new 2001 CSO Mortality Tables (which continue through age 120, with no survivors at age 121).

As a point of clarification, it should be noted that the net single premium (and guideline premiums) for an endowment at age 100 are generally greater than the corresponding values for a whole life plan to age 121 (the exception is the guideline level premium for

an option 2 death benefit). Thus, from a computational viewpoint, the use of whole life to age 121 values should not present any particular problems. The "maturity problem" arises because precisely what happens under section 7702 after age 100 remains unclear. One view is that the requirements cease after age 100, and that no minimum net amount at risk is required. In effect, this is the position of the SOA task force discussed below. This practice follows the Canadian approach, which permits the death benefit and cash value of an "exempt" life insurance policy to be equal after age 85. Another view is that the Congressional intent, as reflected in the legislative history, is that the statutory limitation of age 100 should be interpreted as referring to the end of the mortality table, which, in the case of the 2001 CSO, is age 121. The two interpretations are discussed in more detail below. However, until the Service provides guidance clarifying the "maturity problem," it will remain unresolved.

The SOA task force report: As noted in the report of the 2001 CSO Maturity Age Task Force of the Taxation Section of the Society of Actuaries, "[t]he insurance industry has requested guidance from the Treasury Department and the Internal Revenue Service on the proper application of the current computational rules [of section 7702] to the 2001 CSO Mortality Table but, to date, such guidance has not been provided."[32] Accordingly, the SOA's Taxation Section established the task force "to propose methodologies that would be actuarially acceptable under sections 7702 and 7702A of the Code for calculations under contracts that do not provide for actual maturity before age 100." The report of the task force made the following recommendations:

- Calculations [under sections 7702 and 7702A] will assume that all contracts will pay out in some form by age 100, as presently required by the Code, rather than by age 121 as would occur "naturally" under the 2001 CSO.
- The net single premium used in the cash value accumulation test corridor factors, of section 7702(b) of the Code, and the necessary premium calculations, of section 7702A(c)(3)(B)(i) of the Code, will be for an endowment at age 100.
- The guideline level premium present value of future premium calculations, of section 7702(c)(4) of the Code, will assume premium payments through attained age 99.
- The sum of guideline level premiums, of section 7702(c)(2)(B) of the Code, will continue to increase through attained age 99. Thereafter, premium payments will be allowed and will be tested against this limit, but the sum of guideline level premiums will not increase. If the guideline level premium is negative, the sum of guideline level premiums will also not decrease after age 99.
- In the case of contracts issued or materially changed near to the insured's age 100, the MEC present value of future premium calculations will assume premium payments for the lesser of seven years or through age 99. This is the

[32] *2001 CSO Implementation Under IRC Sections 7702 and 7702A*, published in the February 2006 issue of *Taxing Times*.

case because the computational rules of section 7702A(c)(1) provide: "Except as provided in this subsection, the determination under subsection (b) of the 7 level annual premiums shall be made … by applying the rules … of section 7702(e)", suggesting a need for a new 7-pay premium. However, since section 7702(e)(1)(B) requires a maturity date of no later than the insured's attained age 100, it arguably overrides the computational rules of section 7702A(c)(1) and thus the calculations would end at age 100. Given the lack of guidance, reasonable alternative interpretations may also be available on this point.

- If the MEC present value of future premium calculations assumes premium payments through age 99 because this is less than seven years, the sum of the MEC premiums will continue to increase through attained age 99. Thereafter, premium payments will be allowed and will be tested against this limit for the remainder of the 7-year period, but the sum of MEC premiums will not increase after age 99.
- In the case of contracts issued or materially changed near to the insured's age 100, followed by a reduction in benefits, the MEC reduction rule, of section 7702A(c)(2), will apply for seven years from the date of issue or the date of the material change for a single life contract. For contracts insuring more than one life, the MEC reduction rule, of section 7702A(c)(6), will apply until the youngest insured attains age 121.
- Adjustments that occur on or after attained age 100 will not necessitate a material change for MEC testing purposes or an adjustment event for guideline premium purposes.
- Necessary premium/deemed cash value testing, of section 7702A(c)(3)(B)(i) of the Code, will cease at attained age 100.
- Policies can remain in force after age 100 with a death benefit greater than or equal to the cash value.

The "adjusted maturity date" approach: The legislative history accompanying section 7702 addressed the choice of a maturity date, noting: " . . . the maturity date (including the date on which any endowment benefit is payable) shall be deemed to be no earlier than the day on which the insured attains age 95 and no later than the day on which the insured attains age 100. Thus, the deemed maturity date is generally the termination date set forth in the contract or the end of the mortality table."[33] The House Report had no such comment on an upper limit on maturity date for computational purposes, probably because the House Bill had the lower limit at age 95, but no upper limit. In discussing the lower limit, however, the House Report says, "For these purposes, the

[33] Senate Report at page 576.

term maturity date generally means the termination date set forth in the contract or the end of the mortality table."[34]

The DEFRA Blue Book similarly states, "irrespective of the maturity date actually set forth in the contract, the maturity date (including the date on which any endowment benefit is payable) is deemed to be no earlier than the day on which the insured attains age 95 and no later than the day on which the insured attains age 100. Thus, the deemed maturity date generally is the termination date set forth in the contract or the end of the mortality table."[35] At the end of the paragraph, the DEFRA Blue Book returns to the subject saying, "an actual contract maturity date later than age 100 (*e.g.*, in the case of a contract issued on a mortality basis that employs an age setback for females insureds) will qualify with application of this computational rule."[36]

Under the adjusted maturity date approach, the statutory requirements would be interpreted as ending at age 121 for the 2001 CSO. Thus, rather than eliminating the requirements at age 100, this interpretation would extend them to age 121. In general, this does not change the values materially, with the notable exception of Option 2, which would see a significant increase in permissible values of the guideline level premium.

SECTION 7702(e)(2)(A) and (B) ALTERNATIVE DEATH BENEFIT RULES

Application of the Net Level Reserve Test (Chapter IV, Page 78)

Section 7702(e)(2)(B) allows for death benefit increases that do not increase the net amount at risk to be reflected under the requirements of the cash value accumulation test (CVAT) if the contract satisfies the test using a net level premium reserve (rather than an NSP) as the basis for qualification. Specifically, section 7702(e)(2)(B) permits the increase described in section 7702(e)(2)(A) (*i.e.,* an increase in the death benefit which is provided in the contract may be taken into account, but only to the extent necessary to prevent a decrease in the excess of the death benefit over the cash surrender value of the contract) to be recognized "assuming that the net level reserve (determined as if level

[34] House Report at page 1447.

[35] DEFRA Blue Book at page 652.

[36] A bit of context may help here. In the early 1980s the 1958 CSO Table was the industry standard for life insurance contracts. Female mortality was allowed for by the use of an "age setback"; that is, by acting as if the insured were three or five years younger than her actual age. This is the age setback referred to in the Blue Book. (NAIC allowed a three-year setback for some issue years and then liberalized the rule to five years as it became more evident that female mortality was substantially better than male.) Where such a setback was used, the actual age of the insured at the end of the table was three or five years higher than the age at the end of the 1958 CSO Table, *i.e.,* 103 or 105.

annual premiums were paid for the contract over a period not ending before the insured attains age 95) is substituted for the net single premium."

In his article on section 7702, Professor Andrew D. Pike, who served in the Office of Tax Legislative Counsel of the Treasury Department during the development of section 7702, points out that the term "net level reserve" is not defined in section 7702, nor does the legislative history discuss how the net level premium is to be computed. He also notes that it is possible to take advantage of this rule [the NLR test] even if the contract provides for a pattern of death benefit increases that differs from that produced in the return of cash value policy design. In that case, only the increase that occurs in the return of cash value contract is reflected in the net level reserve.[37]

The NLR test appears to have been intended to permit certain increasing face amount policies to continue to qualify under section 7702, recognizing that they often would be financed by policy loans. It can be argued that section 7702(e)(2)(B) realistically applies only to fixed premium contracts, as the concept of a net level premium reserve makes little sense for flexible premium forms, and a level net premium is needed in order to compute a net level premium reserve.

The DEFRA Blue Book notes that the special rules of section 7702(e)(2) allow contracts "using the guideline premium/cash value corridor test to have a higher internal rate of return than would otherwise be allowed…"[38] It further notes that the relief provided in section 7702(e)(2)(B) for cash-value-accumulation-tested contracts does not provide a comparable expansion. Footnote 55 discusses this discrepancy between the treatment of flexible premium contracts (presumed to be tested under the guideline premium test) and traditional life insurance products (presumed to be tested under the CVAT), essentially rationalizing the harsher treatment accorded fixed premium products:

> The discrepancy between the tax treatment of flexible premium contracts and that of the more traditional life insurance products (which is embodied in the differences between the cash value corridor and the cash value accumulation test) reflect the general concern over the investment orientation of certain life insurance contracts and recognition of the fact that for an investment oriented purchase of traditional life insurance products, the after-tax rate of return can be boosted through the use of the policy loan provisions. Whereas, flexible premium contracts might have slightly more generous limitations under the new definitional provisions, it is generally understood that the owner of such a contract is not able

[37] Andrew D. Pike, *Reflections on the Meaning of Life: An Analysis of Section 7702 and the Taxation of Cash Value Life Insurance*, 43 TAX L. REV. 491, 547 (1989).

[38] DEFRA Blue Book at 653.

to leverage his investment in the contract, and boost his after-tax rate of return, through the use of policyholder loans.[39]

The point being made is that, just as the implicit corridor of the CVAT is more stringent than the cash value corridor under the guideline premium test, the NLR test in section 7702(e)(2)(B) allows less investment orientation than the test in section 7702(e)(2)(A). The introduction of the MEC rules, which treat policy loans as distributions, as well as the expanded limitations on interest deductions on individual and corporate borrowing that arose after the enactment of section 7702, largely eliminated the concern expressed about leveraging in footnote 55, but the constraints placed on traditional contracts persist.

The NLR test was the subject of a series of private letter rulings in 1988.[40] Under the contract form involved in the rulings, the scheduled death benefit for the first contract year was $1,000 per unit of insurance, increasing each contract year by 6% of the prior year's death benefit. Using actuarial calculations submitted by the taxpayer demonstrating that cash values were based on the standard nonforfeiture method (assuming the 1980 CSO and 7% interest), the Service held that the contract qualified as a life insurance contract under section 7702, ruling that since it provided for increasing death benefits the provisions of section 7702(e)(2)(B) governed the application of the CVAT to the contract. Accordingly, the increasing net death benefit was taken into account and the net level reserve substituted for the net single premium. In its ruling the Service applied a two-part test: (1) the amount of the increase may be used only to the extent that it is provided in the contract, and (2) the amount to be recognized is limited to the amount necessary to prevent a decrease in the excess of the death benefit over the cash surrender value.

APPLICATION OF REASONABLE MORTALITY AND EXPENSE LIMITATIONS TO QABs

Revenue Ruling 2005-6 (Chapter IV, Page 88)

On Jan. 19, 2005, the Service provided guidance on the treatment of qualified additional benefits (QABs) under sections 7702 and 7702A through the release of Revenue Ruling 2005-6.[41] (*See* Appendix C for Revenue Ruling 2005-6.) The ruling provides two important pieces of guidance:

(1) First, it confirms the position that the Service had taken in private letter rulings that charges for QABs are subject to the "reasonable expense charge rule" of section 7702(c)(3)(B)(ii), and not the "reasonable mortality charge rule" of section

[39] *Id.* n. 55.

[40] *See* PLRs 8839021 (June 29, 1988), 8839022 (June 29, 1988), 8839028 (June 29, 1988), 8839030 (June 29, 1988), 8839032 (June 29, 1988), and 8839033 (June 29, 1988).

[41] 2005-6 I.R.B. 471.

7702(c)(3)(B)(i), for purposes of determining whether a contract qualifies as a life insurance contract under section 7702 or constitutes a modified endowment contract under section 7702A (MEC).

(2) Second, in response to the concerns that companies had expressed to the Treasury Department and the Service, the ruling provides special transition relief—both generous and without precedent under the statutes affected—for issuers whose compliance systems have not properly accounted for QABs.

The filing procedures under the ruling are discussed in detail below under the heading "REVENUE RULING 2005-6."

ADJUSTMENT EVENTS DEFINED

Section 7702 (Chapter V, Page 93)

Under a guideline-premium-tested contract, a change in the expenses being charged should not be treated in itself as an adjustment event. Rather, it is recognized if and when an actual adjustment event occurs.

ADJUSTMENTS UNDER THE CASH VALUE ACCUMULATION TEST

Application of the Basic CVAT (Chapter V, Page 94)

The legislative history of the 1984 Act[42] discusses the adjustments to be made to a contract's definitional limits if the contract's benefits change in a way not reflected in any previous determination of those limits. The Senate Report notes:

> In the event of an increase in current or future benefits, the limitations under the cash value accumulation test must be computed treating the date of change, in effect, as a new date of issue for determining whether the changed contract continues to qualify as life insurance under the definition prescribed in the bill. Thus, if a future benefit is increased because of a scheduled change in death benefit or because of the purchase of a paid-up addition (or its equivalent), such a change will require an adjustment and new computation of the net single premium definitional limitation.[43]

In advice to the field, attorneys for the Service addressed the treatment of adjustments under the CVAT, and specifically the application of the "least endowment rule" under section 7702(e)(1)(D).[44] In addition, the field service advice also considered whether the

[42] DEFRA House Report at 1448; DEFRA Senate Report at 577.

[43] DEFRA Senate Report at 577.

[44] 1991 IRS NSAR 9594, 1991 WL 11239482 (IRS NSAR), 1991 IRS NSAR 9594 Non-Docketed Service Advice Review Issue: Nov. 27, 1991.

computational assumption in section 7702(e)(1)(A) continued to apply without change unless the death benefit increase results from one of the occurrences specifically listed in the legislative history. If so, a scheduled increase in death benefit or the purchase of paid-up additions would constitute an adjustment event under section 7702(f)(7), but other types of increases would not. Accordingly, the reason for the increase would determine whether the death benefit limit on endowment benefits under section 7702(e)(1)(D) would relate back to the initial death benefit or to the newly increased death benefit instead.

The analysis concluded that section 7702(f)(7)(A), by its terms, as supported by the legislative history, applies to all changes in terms or benefits that affect computations under section 7702. According to the analysis, the broad reach of this provision includes all increases in death benefits without regard to the mechanism causing the increase:

> The plain meaning of the statute, as supported by the legislative history, indicates that an increase in death benefit is an adjustment event, however caused. All increases in death benefits, even those that are scheduled or anticipated, are disregarded in the initial computations of allowable values under section 7702 of the Code, by reason of the computational rule of section 7702(e)(1)(A). Accordingly, any increase in death benefits is a change in benefits that was not reflected in any previous determination or adjustment and is an adjustment event under section 7702(f)(7)(A). If the contract is subject to the cash value accumulation test of section 7702(b), the entire contract is treated as newly issued at the time of the change, and the computational rules of section 7702(e)(1) are applied using the death benefit then in effect as the assumed level death benefit. Accordingly, if the trigger in the contract causes an increase in death benefits, the increase causes a deemed reissuance of the entire contract and a determination of compliance with section 7702 using the new death benefit as the assumed future death benefit under section 7702(e)(1)(A).

ADJUSTMENTS UNDER SECTION 7702A

Material Changes (Chapter V, Page 104)

Where a non-MEC life insurance contract has gone into lapse status for non-payment of premiums during the term of a 7-pay test, and is reinstated at a time more than 90 days after the lapse, there is no guidance specifically addressing the section 7702A status of the reinstated contract. As a practical matter, companies often seem to apply one of two rules. Some take the view that the reinstated contract is a MEC, applying the reduction rule. Others, apparently believing that a complete lack of funding in a contract is no reason to make it a MEC, treat the reinstatement as a material change and start a new 7-pay test at the time of reinstatement. While the latter view appeals to common sense, the former reading appears to be more faithful to the words of the statute.

NECESSARY PREMIUMS

Alternate Treatment of Material Changes (Chapter V, Page 108)

The operation of the necessary premium rule implies that an insurer has a choice of treating benefit increases (including the purchase of paid-up additions with dividends) as material changes at the time they occur or deferring the recognition of such increases until such time as unnecessary premiums are paid into the contract. The choice of methods may create different results for similarly situated policyholders and may result in a contract becoming a MEC under one method and not another. The necessary premium rule is administratively complex, and may be costly to implement. Notably, the application of the necessary premium rule with respect to a sequence of policy changes is subject to interpretation.[45] At the same time, however, continuous application of the material change rule may result in a reduction of the 7-pay limit over time as a result of the application of the rollover rule, or the reduction in benefits rule, which would continue to apply past the initial seven-year period (*i.e.*, it would apply for seven years since the last material change), potentially causing a contract to become a MEC in circumstances where the use of the necessary premium rule would prevent it.

GRANDFATHERING, EXCHANGES, AND CONTRACT MODIFICATIONS

Effective Dates and "Grandfathering" (Chapter V, Page 122)

For detailed discussions of the federal tax law's handling of statutory effective dates and material changes generally, and of the Service's interpretation of the section 7702 grandfather rules in particular, see the discussions in the textbook and below, respectively, under the headings "Cottage Savings and 'Materially Different'" and "The Service's Reading of the Section 7702 Grandfather Rules."

Section 1035 Exchanges (Chapter V, Page 123)

The general rule that an exchange of an existing contract for a new contract gives rise to a new issue date for section 7702 and 7702A purposes does not apply, it appears, where the new contract is issued in connection with a partition or division of the existing contract. In a 2006 private letter ruling, [46] the Service addressed a proposal to partition a group COLI contract and the certificates issued thereunder in a circumstance involving the reorganization of a bank holding company following certain acquisitions and mergers and then the spin-off of one of the banks to the parent organization's public shareholders. Since the spun-off bank held ownership interests in the group contract and certificates along with the other banks in the organization with which it was no longer affiliated, it was proposed to partition the group contract and certificates between the spun-off bank and the others in a pro-rata manner, so that after the partition the former

[45] *See* the discussion in the textbook on pages 108–111.

[46] PLR 200651023 (Sept. 21, 2006).

would own a newly issued group contract and new certificates based on its proportionate interest in the prior contract and certificates, while the latter would own a new contract and certificates reflecting the remaining interest in the prior arrangement. The Service held on these facts that for purposes of sections 7702 and 7702A, the new contracts and certificates would succeed to the original issue dates of the contract and certificates that they replaced. The Service further held that the partition would not give rise to an adjustment event or a material change within the meaning of, respectively, section 7702(f)(7)(A) and section 7702A(c)(3).

The Service's Reading of the Section 7702 Grandfather Rules (Chapter V, Page 127)

As mentioned a number of times before, section 101(f) was added to the tax code in 1982 by TEFRA to require "flexible premium life insurance contracts"—universal life insurance and certain other contracts—to satisfy one of two alternative tests in order to be afforded the favorable tax treatment that accompanies life insurance characterization. Section 101(f) applies only to flexible premium life insurance contracts "issued" before Jan. 1, 1985.[47] Then, in sequence, section 7702 was added to the Code in 1984 by DEFRA, imposing its definition of a "life insurance contract" for all purposes of the Code effective for contracts "issued" after Dec. 31, 1984; the statute was amended in 1988 by TAMRA to limit the mortality and expense charges that could be taken into account in applying the definitional tests (the "Reasonable M&E Rules"), effective for contracts "entered into" after Oct. 20, 1988; and TAMRA also introduced the MEC rules, effective for contracts "entered into" after June 20, 1988 as well as contracts undergoing certain changes specifically defined in section 5012 (e) of TAMRA.

While these effective date and grandfathering rules may appear straightforward, the deemed exchange concept under the *Cottage Savings* case discussed in the textbook, renders their application anything but simple. Perhaps adding to the uncertainty, the courts have not ventured into the territory of these rules, and the Service has issued little guidance,[48] leaving taxpayers largely on their own since 1982 to make sense of them in

[47] Originally, section 101(f) applied to flexible premium life insurance contracts entered into before Jan. 1, 1984. Section 221(b)(2), the Deficit Reduction Act of 1984, Pub. L. No. 98-369 (1984), amended section 101(f) to make it applicable to contracts issued before Jan. 1, 1985.

[48] As noted elsewhere, some guidance has been issued with respect to the transition from one prevailing mortality table to another under the reasonable mortality and expense charge rules of section 7702(c)(3)(B)(i). *See, e.g.*, Notice 2006-95, 2006-45 I.R.B. 848. Other guidance from the Service has appeared in the form of private letter rulings that address only a handful of situations: (1) modifications to a life insurance contract to provide that policy loan interest is payable in arrears, rather than in advance (s*ee, e.g.*, PLR 9737007 (June 11, 1997)); (2) contract changes resulting from an assumption reinsurance transaction, reorganization, and/or demutualization (*see, e.g.*, PLR 200002010 (Sept. 30, 1999)); (3) the assignment of a life insurance contract to a trust and subsequent return of the contract to the taxpayer (PLR 9033023 (May 18, 1990)); (4) an amendment to a contract to allow additional investment options (PLR 8648018 (Aug. 27, 1986)); and (5) the addition of a rider to a life insurance contract that offered an option 2 death benefit that was not available, under the express terms of the contract, as originally issued

specific instances. Recently, however, a "chief counsel advice" memorandum was released to the public that provided insight into the Service's thinking on certain aspects of the grandfather rules.[49] In CCA 200805022 (Aug. 17, 2007) (CCA), the Service essentially concluded that a common occurrence under a universal life insurance contract—the addition of a QAB rider that was not pursuant to the exercise of an option or right granted under the contract—will cause a loss of grandfathering under the DEFRA effective date provisions governing the applicability of section 7702 to a pre-1985 contract and under the TAMRA effective date provisions relating to the Reasonable M&E Rules. The CCA came to the same conclusion where a death benefit pattern was changed in the absence of a right granted under the contract; such a change is not typical of universal life, but is not unprecedented, either. [50]

As discussed in the CCA, a life insurance company had requested rulings that a change from an increasing pattern of death benefit to a level pattern or the addition of a QAB rider would not cause a loss of grandfathering under the DEFRA and TAMRA effective date rules. The CCA recorded that the contracts as originally issued provided only for an increasing death benefit pattern, with no ability for the policyholders to obtain a level death benefit, and also that the express terms of the contracts did not address QAB riders, although the taxpayer had a practice of allowing policyholders to add such riders with evidence of insurability.

(PLR 9853033 (Sept. 30, 1998)). *See also* Rev. Proc. 92-57, 1992-2 C.B. 410, providing that certain modifications and restructurings of life insurance contracts issued by a financially troubled insurance company do not upset grandfathers under section 7702.

[49] "Chief Counsel Advice" is written advice or instruction, under whatever name or designation, prepared by any National Office component of the Service's Office of Chief Counsel that is issued to field or service center employees of the Service (or regional or district employees of the Office of Chief Counsel) and conveys (1) any legal interpretation of a revenue provision, (2) any position or policy of the Service or of the Office of Chief Counsel concerning a revenue provision, or (3) any legal interpretation of federal, state, or foreign law relating to the assessment or collection of any liability under a revenue provision. Section 6110(i). Chief Counsel Advice generally may not be used or cited as precedent. *See* section 6110(k) and section 6110(b)(1)(A).

[50] *See* PLR 9853033, summarized *supra*.

In rejecting the company's arguments supporting its requested rulings, [51] the Service pointed to the deemed exchange rule in the DEFRA effective date's legislative history, *i.e.*, the double-negative statement that a change to a pre-1985 contract would *not* be treated as an exchange (and hence as a newly issued contract for purposes of the effective date) if it did *not* alter the amount or pattern of death benefit, the premium payment pattern, the interest rate(s) guaranteed on issuance of the contract, or the mortality and expense charges. The Service reasoned that this history established, by "negative inference," that a death benefit pattern change or the addition of a QAB rider, with no option or right under the contract for the policyholder to obtain it, would cause a loss of grandfathering under DEFRA. With regard to the TAMRA effective date, the Service cited to a statement in the House Ways and Means Committee report that referred to contracts "issued" or "materially changed" on or after July 13, 1988 (the then proposed effective date), concluding that this "material change" language "will cause a life insurance contract to be entered into anew (for purposes of [the Reasonable M&E Rules]) if there is an increase in future benefits." Demonstrating the motivation behind these conclusions, the Service said that to conclude otherwise "would virtually eliminate the ability to lose grandfathered status except in the clearest of circumstances (new contracts actually issued after the effective date or tax avoidance) and does not follow the intent of Congress."

The CCA's conclusion and reasoning are questionable. The CCA's analysis is elliptical, omitting several key points supporting the contrary conclusion, and it fails to address either (1) the interaction between the relevant effective date provisions and the adjustment rules of sections 101(f) and 7702 or (2) the absence of a material change rule in the context of the TAMRA effective date. Thus, for example, the DEFRA legislative history says that "section 7702 will not become applicable to a contract that was issued before January 1, 1985 [*e.g.*, a section 101(f) contract], because a reduction of the contracts [sic] future benefits resulted in the application of [the] adjustment provision."[52] The

[51] The revenue procedure governing private letter ruling requests states that "[i]f a taxpayer withdraws a letter ruling request …, the Associate office generally will notify, by memorandum, the appropriate Service official in the operating division that has examination jurisdiction of the taxpayer's tax return and may give its views on the issues in the request to the Service official to consider in any later examination of the return.… If the memorandum to the Service official … provides more than the fact that the request was withdrawn and the Associate office was tentatively adverse, or that the Associate office declines to issue a letter ruling, the memorandum may constitute Chief Counsel Advice, as defined in § 6110(i)(1), and may be subject to disclosure under § 6110." Section 7.07 of Rev. Proc. 2007-1, 2007-1 I.R.B. 1 (which applied at the time the CCA was issued). *See also* Rev. Proc. 2008-1, 2008-1 I.R.B. 1 (which includes an identical provision with respect to ruling requests filed in 2008).

[52] DEFRA Blue Book at 654. *See also* STAFF OF THE J. COMM. ON TAX'N, 99TH CONG., EXPLANATION OF THE TECHNICAL CORRECTIONS TO THE TAX REFORM ACT OF 1984 AND OTHER RECENT TAX LEGISLATION, at 107 (Comm. Print 1987) (commenting on the 1986 technical correction mentioned in the following footnote, the legislative history of that correction noted that "[t]he provision that certain changes in future benefits be treated as exchanges … only applies with respect to such changes in contracts issued after December 31, 1984."

DEFRA grandfather rule, in other words, coordinated with the adjustment rule, and since the adjustment rule was available to address the change in the CCA case, there was no reason to forfeit grandfathering. Moreover, the adjustment rules, which represent a more specific form of deemed exchange rule (such as the effective date rule), [53] should be used in such a case, for under principles of statutory construction the specific rule usually is considered to control over the more general one.[54] Further, the TAMRA legislative history relating the Reasonable M&E Rules shows that Congress rejected a previously proposed "material change" rule as part of the TAMRA effective date. Under the House version of TAMRA, the Reasonable M&E Rules were to be effective for contracts "issued" on or after July 13, 1988, and a contract that was materially changed (within the meaning of then new section 7702A(c)(3)) on or after that date was to be treated as newly issued. However, under TAMRA as enacted, the effective date rule was changed simply to "contracts entered into" on or after Oct. 21, 1988; the rule that "material changes" would trigger a loss of grandfathering was dropped.[55]

At minimum, these deficiencies in the CCA's analysis call into question the soundness of its conclusions, leaving open the possibility that other reasonable conclusions may be drawn. Unless the Service issues guidance in a form that is more definitive than a chief counsel advice memorandum, which carries no precedential weight, the grandfathering issues likely will continue to be the subject of debate.

MULTIPLE-LIFE PLANS

Determining Age under Regulation Section 1.7702-2 (Chapter VI, Page 133)

As previously noted, the regulations concerning attained age under sections 7702 and 7702A (*i.e.*, Treas. Reg. section 1.7702-2(c)(1) and (d)) provide that:

---

[53] *See* DEFRA Blue Book at 654, noting that the event triggering the application of the adjustment rule (the benefit reduction) was treated as an exchange for federal income tax purposes generally, thereby invoking the section 1031(d) "boot" rule with respect to amounts distributed in connection with the deemed exchange. (The boot treatment subsequently was altered by the 1986 technical corrections of section 7702, creating the provisions now appearing in section 7702(f)(7)(B)–(E).)

[54] *See* Morales v. Trans World Airlines, Inc., 504 U.S. 374, 384-85 (1992) ("it is a commonplace of statutory construction that the specific governs the general") (*citing* Crawford Fitting Co. v. J. T. Gibbons, Inc., 482 U.S. 437, 445 (1987)); NORMAN J. SINGER, STATUTES AND STATUTORY CONSTRUCTION, Vol. 3A § 66.03, at 17 (5th ed. 1992) ("[w]here there is a conflict in taxing statutes, the specific controls the general") (*citing* State v. Franco Novelty Co., Inc., 299 So. 2d 737 (Ala. 1974)).

[55] Here again, under principles of statutory construction, where Congress includes limiting language in an earlier version of a bill but deletes it prior to enactment, it may be presumed that the limitation was not intended. Russello v. United States, 464 U.S. 16, 23-24 (1983).

(1) The attained age of the insured under a contract insuring multiple lives on a last-to-die basis—joint and last survivor contracts—is the attained age of the youngest insured; and

(2) The attained age of the insured under a contract insuring multiple lives on a first-to-die basis is the attained age of the oldest insured.

These rules for joint life contracts, as recognized by the government in the preamble to the regulations, are without legal precedent and may well run counter to the practices adopted by many insurers. In the case of last-to-die contracts, some insurers have been following rule (i) for a considerable period of time, while others have made use of a joint equal age methodology (discussed below). In the case of first-to-die contracts, it is doubtful that any insurer has followed rule (ii), although application of the rule may not present a problem as a practical matter. If the guideline published by the NAIC (Actuarial Guideline XX) for determining the joint equal age for such contracts is adhered to, it appears that only a very limited group of contracts (depending upon the gender and age relationship of the insureds) would fall on the wrong side of rule (ii). These rules apply regardless of the gender of the insureds or the presence of any smoker or substandard rating applicable to one of them.

Interestingly, as previously noted, the preamble to the regulations disclaims any relationship between the new rules for multiple life contracts and the so-called "reasonable mortality charge" requirement of section 7702(c)(3)(B)(i) introduced by TAMRA in 1988. Hence, while the regulations preclude the use of joint equal age assumptions with respect to deemed maturity dates for purposes of section 7702(e), the government seemingly indicates a desire not to address in these rules the appropriateness of mortality charges based on joint equal age assumptions under section 7702(c)(3)(B)(i).

What is unclear, however, is whether the practical effect of the regulations will be to preclude the use of joint equal age mortality for contracts to which the regulations apply. Consider, for example, a second-to-die life insurance contract under which the joint equal age of the insureds at issue is 60, but the age of the younger insured at that time is 53. In this case, the regulations require use of a deemed maturity date (assuming the younger insured's age 100 is used) in the 47th policy year. In contrast, the use of mortality based on a joint equal age assumption would place the contract's deemed maturity date—when the joint equal age is 100 years—on the 40th policy anniversary, when the younger insured in the example is only 93 years of age. Thus, the use of joint equal age mortality would seem to have the effect of assuming a maturity date prior to the time permitted by the regulations. It also is unclear what adjustments to a joint-equal-age-based mortality assumption might be appropriate to eliminate this apparent problem. As a result of the regulations, insurers may find it difficult, or even impossible, to apply a joint equal age mortality assumption (at least for certain combinations of insureds) for contracts which the regulations govern.

INTEREST SENSITIVE WHOLE LIFE AND FIXED PREMIUM UNIVERSAL LIFE

Application of DEFRA Blue Book Footnote 53 (Chapter VI, Page 139)

Over the past few years, the Service has issued two private letter rulings waiving the failure of certain "fixed-premium universal life insurance" (FPUL) contracts to satisfy the guideline premium test.[56] More specifically, the Service concluded that the errors that caused such contracts to fail were reasonable errors, which is part of the standard that must be satisfied in order for errors to be waivable under section 7702(f)(8). The complexity of the cash value structure under FPUL contracts, particularly as it relates to the determination of the interest and expenses that must be reflected in guideline premiums, appears to have been the root of the problem that resulted in the inadvertent failure of the FPUL contracts in the rulings.

FPUL contracts, sometimes called interest sensitive whole life contracts, are hybrid contracts, combining features of both universal life insurance and whole life insurance. Similar to whole life insurance, FPUL contracts require the payment of fixed premiums and provide guaranteed minimum cash values (or "tabular cash values") based on Standard Nonforfeiture Law (SNFL) requirements. In addition, these types of contracts provide for a universal life insurance type accumulation account, which reflects current assumptions for interest, mortality, and expenses. The cash value structure of this type of contract design creates what has been referred to as a dual or secondary cash value guarantee, whereby the contract cash value is based on the greater of the accumulation account value or the tabular cash value. On a guaranteed basis, the accumulation account value and the tabular cash value of FPUL contracts are generally derived using different assumptions for interest, mortality, and expense.

Treatment of secondary guarantees in calculating guideline premiums: As FPUL plans generally have fixed annual premiums, it is important that the guideline level premium (GLP) for a given policy be no less than the corresponding gross annual premium. To calculate the GLP, a determination first must be made as to the rate or rates guaranteed on issuance of the contract with respect to interest, mortality, and expenses. Because of the dual cash value guarantees, should one look to the accumulation account guarantees, the tabular cash value guarantees, or some combination of the two? The DEFRA Blue Book provides guidance, saying in particular that so-called secondary guarantees must be taken into account in calculating guideline premiums (and net single premiums):

> Also, if the contract's nonforfeiture values for any duration are determined by a formula that uses the highest value produced by alternative combinations of guaranteed interest rate or rates and specified mortality (and other) charges, the combination of such factors used, on a guaranteed basis, in the highest cash

[56] *See* PLR 200328027 (Apr. 10, 2003) and PLR 200230037 (Apr. 30, 2002).

> surrender value for such duration should be used for such duration in determining either the net single premium or the guideline premium limitation. [57]

Significantly, the DEFRA Blue Book then expands upon this comment in footnote 53 (FN 53), which is appended to the text just quoted, and states:

> For example, under a so-called fixed premium universal life contract, if the cash surrender value on a guaranteed basis (ignoring nonguaranteed factors such as excess interest) is not determined by the guaranteed interest rate and the specified mortality and expense charges used to determine the policy value for some duration, but is instead determined by a secondary guarantee using the guaranteed interest rate and specified mortality and expense charges associated with an alternate State law minimum nonforfeiture value for such duration, the guaranteed interest rate and the mortality and expense charges for the secondary guarantee are to be used with respect to such duration in determining either the net single premium or the guideline premium limitation.[58]

By following the FN 53 approach, it appears possible to design a FPUL contract so that, by its terms, it complies with the guideline premium test. In this regard, such a contract is able to comply with section 7702 in a manner similar to that of life insurance contracts that are designed to comply with the CVAT. In reality, even under this FN 53 approach, it still is generally necessary to monitor premiums because of the possibility that premiums received and credited to the accumulation account value before an anniversary may cause "premiums paid" to exceed the sum of guideline level premiums then applicable. The fact that such premium would be permitted if paid on the upcoming anniversary does not prevent the early premium from causing the contract to fail under the GPT.

In order to apply the FN 53 logic to the calculation of a guideline premium, the guaranteed accumulation account value resulting from the payment of the gross premium must be projected using the guarantees applicable to such accumulation account value. Such guaranteed accumulation account values then must be compared with the contract's guaranteed tabular values on a duration-by-duration basis. Typically, based on this comparison at the issuance of a contract, the accumulation account values will be prevailing for some initial period of time, and the tabular values will become the prevailing cash value at some point (the "cross-over point") and thereafter until the contract's maturity date. In this circumstance, the contract guarantees relating to interest, mortality and expenses pertinent to the prevailing cash value form the basis for determining the appropriate actuarial assumptions to use in the determination of guideline premiums under the FN 53 methodology. Thus, in calculating the guideline premiums at issue, in the typical case it is necessary to take into account guarantees

[57] DEFRA Blue Book at 649.

[58] *Id.*

applicable to the accumulation account value for those durations when the accumulation account value is prevailing on the guarantees, and it is necessary to take into account the guarantees applicable to the tabular value for those durations after the cross-over point when the tabular value is prevailing on the guarantees. (If, on the other hand, the contract premiums were set at a level that matured the contract and provided a guaranteed accumulation account value that was the prevailing cash value for all durations, the tabular values would be irrelevant to the calculation of guideline premiums.)

Identification of the appropriate guarantees is at the heart of the FN 53 process. This process can best be illustrated by way of examples.

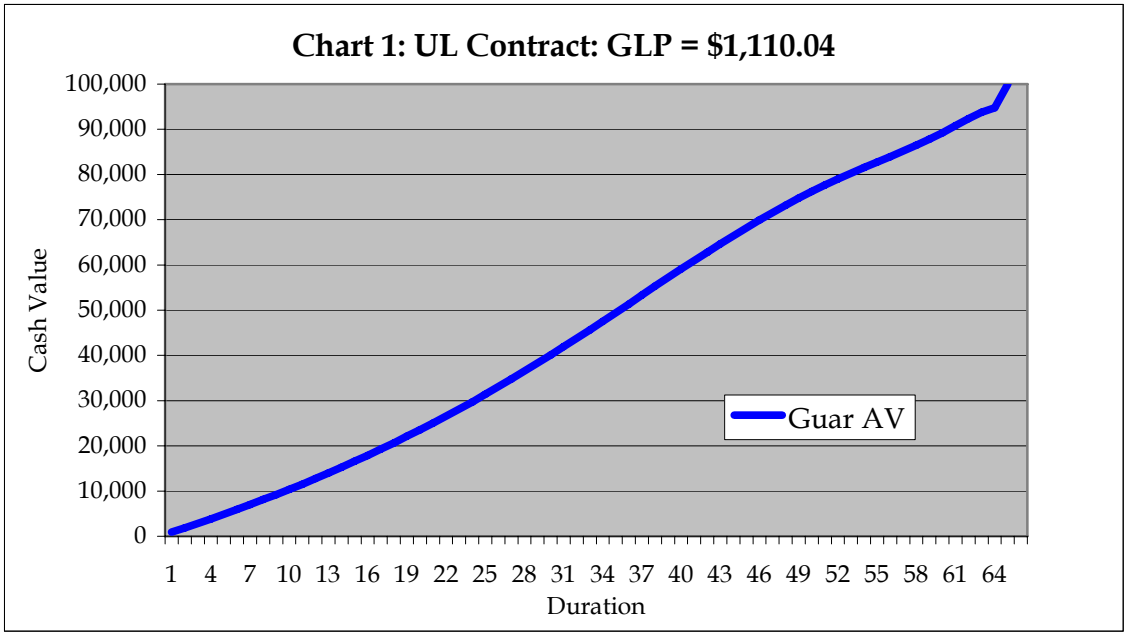
Example 1: Universal life contract design. The first example focuses on the derivation of the GLP for a universal life (UL) insurance contract. The sample contract underlying Example 1 is later modified in Examples 2 and 3, changing the form of the contract to a FPUL design, *i.e.*, with a fixed annual premium and a secondary cash value guarantee in the form of tabular cash values.

Insured:	35-year-old female
Face Amount:	$100,000
DBO:	Level

Accumulation Account Value Guarantees:

Mortality:	1980 CSO ALB Female
Interest:	4% all years
Expense:	$60 annual administrative fee

Using basic actuarial principles, the GLP for a UL contract can be determined by dividing the sum of the present value of future benefits and expenses (PVFB and PVFE) by a life annuity, where all calculations are based on the accumulation account value guarantees. This results in a GLP of $1,110.04. A similar result could be obtained by solving for the level annual premium that would endow the contract for its Face Amount, assuming successive cash values were projected using a 4% interest rate, 1980 CSO mortality, and the assessment of a $60 expense charge each year. The resulting cash value scale under the projection-based approach is illustrated in Chart 1.



As expected, the calculation of the GLP under both the projection method and the basic actuarial principles approach produces the same result.

Example 2: FPUL contract (fixed annual premium = $1,000). If the form of the contract changes from UL to FPUL, there are several changes that must be reflected in the calculation guideline premiums to account for the fact that the contract requires the payment of a fixed annual premium and provides a secondary cash value guarantee in the form of tabular cash values, as required by the SNFL for fixed premium contracts. In this example, the fixed annual premium is $1,000 per year and the tabular cash values are based on the following assumptions:

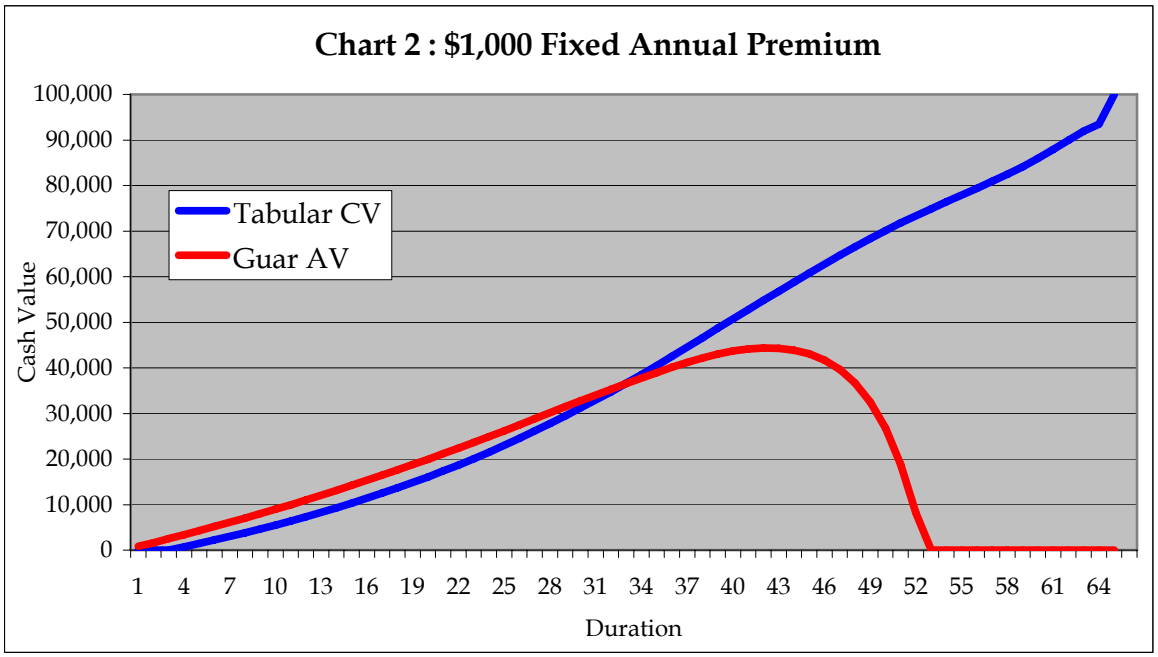
Tabular Cash Value Assumptions

SNFL Mortality:	1980 CSO ALB Female
SNFL Interest:	6% all years
SNFL Adj. Premium:	$860.31
SNFL Ann. Expense:	$139.69 (excess of $1,000 over SNFL Adjusted Premium)[59]

[59] Tabular cash values are typically defined on the basis of a net premium, adjusted premium, or nonforfeiture factor. Recognition of the nonforfeiture expense charge, identifiable from the fixed premium and tabular cash values (or nonforfeiture factor) stated on the contract specifications page, as an expense charge in the development of guideline premiums is necessary in order to establish the intended equivalence between the GLP and the gross premium.

As discussed above, where contracts have both an accumulation account value and a secondary guarantee in the form of tabular cash values, FN 53 requires that secondary guarantees be considered in selecting the appropriate policy guarantees of interest, mortality, and expense that are recognized in the determination of values under section 7702. This process requires a projection of both the guaranteed accumulation account value and the tabular cash values. The assumptions with respect to interest, mortality, and expense charges (applying the restrictions of section 7702 applicable to these assumptions, such as the reasonable expense charge rule of section 7702(c)(3)(B)(ii)) pertaining to the prevailing cash value as determined for each duration then need to be reflected in the calculation of guideline premiums under section 7702. Chart 2 illustrates the projection of both the guaranteed accumulation account value and the tabular cash values.

Chart 2 typifies the result of most FPUL designs in that the accumulation account dominates at the start, but, by design, cannot mature the contract on its guarantees. The tabular cash values eventually prevail and mature the contract on a guaranteed basis. Since the contract guarantees continuation of coverage as long as the fixed premiums are paid, the reduction of the fixed premium below the amount necessary to mature the contract under the accumulation account guarantees (*e.g.*, the premium of $1,110.04 in Example 1) effectively increases the economic value of the life insurance coverage provided by the contract to the policyholder, *i.e.*, it is reflective of interest, mortality and expense guarantees provided by the tabular value that are more favorable in at least some durations. Defining these guarantees, as well as those relating to the accumulation account when its value is prevailing, is at the heart of the FN 53 process.



In this example, the accumulation account value prevails for the first 33 years, with the tabular cash values prevailing thereafter. Table 1 details the applicable guarantees for this contract.

Table 1	**Example 2 Guaranteed Assumptions under FN 53**	
Prevailing CV	Accumulation Account	Tabular Cash Values
Durations	1-33	34-65
Mortality	1980 CSO ALB Female	1980 CSO ALB Female
Interest	4%	6%
Expense	$60 annually	$139.69 annually

FN 53 provides the means for determining policy guarantees for an FPUL contract. Once determined, the same principles would apply to the determination of the GLP as illustrated in Example 1. Put differently, if a UL contract were designed with the guarantees outlined in Table 1, the resulting GLP would be identical to the GLP for the ISWL contract defined in this Example 2. Not surprisingly, the determination of the GLP using basic actuarial principles and the assumptions defined in Table 1 is $1,000.00.

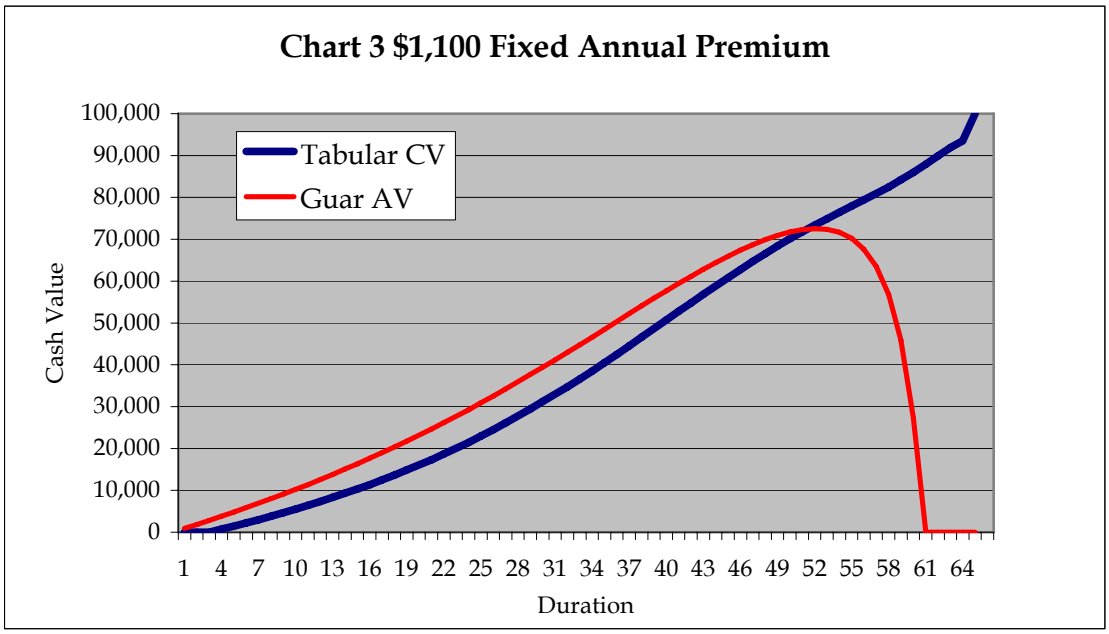
In applying the projection-based approach for determining the GLP, the process involves solving for the premium that will endow the contract for the original specified amount using the assumptions set forth in Table 1. For the first 33 contract years, the projection will be based on the accumulation account guarantees. For the remaining durations, the projection will be based on the tabular value assumptions. Under this assumption set, the projected cash value will exactly mirror the set of prevailing cash values on the guarantees, and thus the GLP under the projection-based approach is also $1,000.

Example 3: FPUL contract (fixed annual premium = $1,100). Example 3 follows the contract design in Example 2, except the gross premium is set at $1,100. Changing the premium will result in certain changes to the contract guarantees, as both the crossover duration and the "expense charges associated with an alternate State law minimum nonforfeiture value" will be different.

The applicable guarantees in the determination of the GLP for Example 3 are provided in Table 2.

Table 2	**Example 3 Guaranteed Assumptions under FN 53**	
Prevailing CV	Accumulation Account	Tabular Cash Values
Durations	1-51	52-65
Mortality	1980 CSO ALB Female	1980 CSO ALB Female
Interest	4%	6%
Expense	$60 annually	$239.69 annually

Chart 3 illustrates the projection of both the accumulation account value and the tabular cash values for this example. Because of the higher fixed premium in this example, the accumulation account will prevail for a longer period of time (51 years v. 33 years). In addition, the higher fixed premium will necessarily result in higher expense charges associated with the SNFL, effectively serving as a balancing item in the process.



As described above, applying basic actuarial principles to the determination of the GLP using the assumptions defined in Table 2 will return a GLP equal to $1,100 (the fixed premium for the contract). Similarly, under a projection-based approach, the accumulation of $1,100 annually using the Table 2 assumptions will exactly endow the contract for its original specified amount, resulting in a set of cash values equal to the prevailing cash values illustrated in Chart 3.

Comment on statutory requirements: As illustrated in Examples 2 and 3, the FN 53 process ***generally*** results in the equivalence between the gross premium and the GLP. This equivalence will hold true, however, only if the policy guarantees of interest, mortality, and expenses, as determined by the FN 53 process, are not in conflict with the statutory requirements that restrict the allowable assumptions for computing guideline premiums. Assuming this to be the case, the upper limit on the allowable premium under the guideline premium test for a level premium ISWL design is the GLP based on accumulation account guarantees ($1,110.04 in Example 1). With such a premium, the accumulation account would constitute the prevailing cash value for all durations in the above examples, and the tabular value thus would be irrelevant under FN 53. Any higher level gross premium would over-endow the contract on a guaranteed basis. Any gross premium below this amount arguably results in the equivalence between the GLP and the gross premium, the intended result of FN 53.

This equivalence between the gross premium and the GLP does not necessarily guarantee compliance under the guideline premium test, a common misconception regarding ISWL contracts. The process of monitoring the relationship between premiums paid and the guideline premium limitation is still necessary, particularly for those product designs that apply premiums to the accumulation account when received. The early payment of premiums, particularly those received (and applied) in one contract year, that are otherwise due in the following contract year, can result in premiums exceeding the guideline premium limitation, albeit for a short period of time. Nonetheless, these early premium payments can create contract failures under the guideline premium test if the prevailing guideline premium limitation is based on the sum of GLPs (*i.e.*, where the cumulative GLP exceeds the guideline single premium).

GROUP UNIVERSAL LIFE

Change of Insurer (Chapter VI, Page 141)

A 2004 waiver ruling discussed the characterization of the transfer of group universal life certificates from one carrier to another. The insurer erroneously treated the transfer as assumption reinsurance, which would have carried over the issue date related to the original carrier (as well as the original guideline premium limitation), rather than treating the transfer as an exchange of contracts.[60] Noting that several terms of the original coverage, including the guaranteed and current COI charges and the maturity date for the coverage, were altered when the change in underwriters occurred, the Service concluded that the change in the contract's terms resulted in an exchange (*i.e.*, the issuance of a new contract) rather than an assumption reinsurance arrangement for federal income tax purposes.

ACCELERATED DEATH BENEFITS AND LONG-TERM CARE RIDERS

Long-Term Care Riders (LTC) and Critical Illness Riders (Chapter VI, Page 144)

Pension Protection Act changes in LTC combination product rules: The Pension Protection Act of 2006[61] (PPA), enacted in August of 2006, included new federal income tax rules for "combination" long-term care (LTC) insurance products, albeit with a significantly delayed effective date, *i.e.*, beginning in 2010. The PPA amended rules governing the federal income tax treatment of LTC insurance that were enacted in 1996 by the Health Insurance Portability and Accountability Act (HIPAA).[62] HIPAA added section 7702B to the Code, subsection (b) of which defines a "qualified" LTC insurance contract (QLTCI

[60] PLR 200446001 (Nov. 12, 2004).

[61] Pub. L. No. 109-280 (2006).

[62] Pub. L. No. 104-191 (1996). HIPAA's provisions regarding LTC insurance contracts generally were effective for contracts issued after Dec. 31, 1996, with special transition rules for contracts issued on or before that date.

contract). A contract meeting that definition is treated as an accident and health insurance contract for federal income tax purposes, and insurance benefits paid under it generally are excludable from the recipient's gross income. Subsection (e) of section 7702B as enacted by HIPAA included rules addressing the combination of LTC insurance coverage with life insurance.

Definition of "portion" enabling tax-free benefits: Section 7702B(e) specifies that the "portion" of a life insurance contract that provides LTC coverage (whether "qualified" or not) through a rider on or as part of the contract is treated as a separate contract for purposes of section 7702B. For this purpose, the LTC "portion" was defined in section 7702B(e)(4) as originally enacted by HIPAA as "only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage." This deemed "separate contract" treatment is critical to the ability to have a life insurance-LTC combination product that provided QLTCI, since to meet the section 7702B definition of a QLTCI contract, the contract can neither provide a cash surrender value nor provide for insurance coverage of other than "qualified long-term care services," whereas the combination product (taken as a whole) did both by virtue of its life insurance features. The deemed separate contract means, in turn, that the QLTCI portion of the product can provide tax-free benefits. In particular, the legislative history of HIPAA clarified that both the cash surrender value and the net amount at risk under the life insurance portion of the combination product could be paid out as a tax-free QLTCI benefit pursuant to the QLTCI portion of the product after onset of the insured's chronic illness.[63]

While the most significant change that the PPA made to the federal income tax treatment of LTC insurance was to bring annuity-LTC combination products within the ambit of the "separate contract" rule of section 7702B(e), it retained this treatment for life insurance-LTC combinations.. More specifically, section 7702B(e)(1) as amended by the PPA provides that "in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract or an annuity contract … [t]his title shall apply as if the portion of the contract providing such coverage is a separate contract." Thus, the QLTCI portion of an annuity-LTC combination product can provide tax-free benefits in the same manner as a life insurance-LTC combination product has been able to do since the enactment of HIPAA.

Treatment of QLTCI rider charges and guideline premiums: HIPAA's rules for life insurance-LTC combination products also addressed how the imposition of charges against the life insurance contract's cash value to fund the QLTCI portion would affect the application

[63] STAFF OF THE J. COMM. ON TAX'N, GENERAL EXPLANATION OF TAX LEGISLATION ENACTED IN THE 104TH CONGRESS, at 341 (J. Comm. Print 1996) (stating that "if the applicable requirements are met by the long-term care portion of the contract, amounts received under the contract as provided by the rider are treated in the same manner as long-term care insurance benefits, *whether or not the payment of such amounts causes a reduction in the contract's death benefit or cash surrender value*") (emphasis added).

of section 7702. The rules adopted a "pay as you go" approach under which the guideline premium limitation of section 7702(c)(2) was increased by the sum of the charges imposed for QLTCI coverage to the extent that such charges did not reduce the "premiums paid" for the life insurance contract under section 7702(f)(1).[64] Generally speaking, once premiums are actually paid for a life insurance contract, the total of the premiums paid is adjusted only for certain subsequent distributions from the contract. More specifically, distributions that are taxable under section 72(e) generally do not affect the premiums paid total, while distributions that are not taxable under section 72(e) reduce the total of premiums paid. Thus, by imposing a rule under which QLTCI charges assessed against a life insurance contract affect its guideline premium limitation only if they do not reduce premiums paid, HIPAA implied that such charges were deemed to be distributed from the contract.

The PPA enacted new rules under section 72(e) to provide a more beneficial tax treatment of charges assessed against the cash value of a life insurance contract (or an annuity contract) to fund the QLTCI portion of the contract. Under the new rules, such charges continue to be treated as deemed distributions, but they are excludable from gross income in all cases, even if a distribution from the contract at the time the charges are imposed otherwise would be includible in gross income. Consistently with this treatment, the charges reduce the contract's after-tax "investment in the contract" (but not below zero), and they cannot be deducted under section 213(a).

The PPA also modified the manner in which section 7702 applies to the life insurance portion of a life/LTC combination product. Specifically, the PPA repealed (after 2009) the rule providing for an increase in the guideline premium limitation under section 7702(c) with respect to the charges imposed to fund LTC coverage. Such a rule is not necessary (after 2009) due to the PPA's treatment of QLTCI charges as non-taxable distributions in all instances. Because of that treatment, the charges for QLTCI coverage under a life insurance contract will always reduce the "premiums paid" for the contract (after 2009).

Tax-free exchanges: The PPA, in addition, amended the federal income tax rules governing tax-free exchanges of insurance contracts. Specifically, the PPA allows a life insurance contract, endowment contract, annuity contract, or QLTCI contract to be exchanged for a QLTCI contract tax-free under section 1035. In addition, tax-free exchanges among life insurance and annuity contracts that were allowed under prior law will not be prevented by reason of a life insurance contract or annuity contract including a QLTCI rider or feature.

[64] Section 7702B(e)(2), as in effect prior to the PPA. No similar rule expressly applied for purposes of the cash value accumulation test of section 7702(b) because funding on a "pay as you go" basis could be accomplished under contracts subject to this test without the need for any special rule.

Delayed effective date: The effective date provision of the PPA states that the new rules generally apply to "contracts issued after December 31, 1996, but only with respect to taxable years beginning after December 31, 2009."

VARIABLE LIFE

No Lapse Guarantees (Chapter VI, Page 131)

A number of variable life insurance policies provide a "no lapse" guarantee which provides that the policy will not go into default even if the account value is exhausted (or a policy loan plus accrued interest exceeds the cash surrender value), provided the "no lapse" requirements are met. These are generally one of two types:

1. *Minimum premium*—the no lapse guarantee is met by meeting a cumulative premium paid requirement over a specified policy period, often adjusted for partial withdrawals and policy loans. Longer no lapse guarantee periods may require higher minimum premiums.
2. *Shadow account*—the no lapse guarantee is measured by the balance of an accumulation-type account, which may reflect different interest, expense and cost of insurance assumptions than the underlying policy. The no lapse provision is based on maintaining a positive shadow account value.

At issue, a no lapse guarantee does not affect the calculation of the guideline premium, 7-pay, or the net single premium, as the test plan would by definition not lapse under the calculation assumptions. However, where a specific charge is made for the no lapse guarantee, an issue can arise as to whether the charge can be reflected in the guideline premium. The answer would appear to be that a specific no lapse charge should be ignored, and therefore treated much the same way as a non-qualified additional benefit.

Even under the broad definition of cash value in Chapter II, a shadow account would not seem to be a cash value, so the shadow account would have no effect on the corridor, either under the guideline premium limitation or the CVAT. Similarly, payments to maintain a policy in force would not seem to create an issue under the guideline test. Where the cash surrender value is zero, section 7702(f)(6) provides that "the payment of a premium which would result in the sum of the premiums paid exceeding the guideline premium limitation shall be disregarded for purposes of subsection (a)(2) if the amount of such premium does not exceed the amount necessary to prevent the termination of the contract on or before the end of the contract year (but only if the contract will have no cash surrender value at the end of such extension period). However, an issue may arise where there is a policy loan outstanding and payments which exceed the guideline limitation are made to maintain the policy in force.

SPECIAL PRODUCTS

Burial or Pre-Need Contracts (Chapter VI, Page 145)

The NAIC recently (as of the time of this writing) adopted a model regulation establishing new minimum mortality standards for reserves and non-forfeiture values for burial or pre-need life insurance (Pre-Need Model). The Pre-Need Model provides that "for preneed insurance contracts … and similar policies and contracts, the minimum mortality standard for determining reserve liabilities and non-forfeiture values for both male and female insureds shall be the Ultimate 1980 CSO." The Ultimate 1980 CSO, in turn, means the Commissioners' 1980 Standard Ordinary Life Valuation Mortality Tables without 10-year selection factors, as incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983. While the Pre-Need Model is generally effective for "policies and certificates" issued on or after Jan. 1, 2009, it contains transition rules permitting continued use of the 2001 CSO tables for pre-need policies and certificates issued before Jan. 1, 2012.

As previously noted in the discussion of the 2001 CSO, the determination of guideline premiums, net single premiums, and 7-pay premiums under sections 7702 and 7702A is in part made on the basis of the "reasonable mortality" rule in section 7702(c)(3)(B)(i), which states that the calculations must be based on "reasonable mortality charges which meet the requirements (if any) prescribed in regulations and which (except as provided in regulations) do not exceed the mortality charges specified in the prevailing commissioners' standard tables (as defined in section 807(d)(5)) as of the time the contract is issued." By cross-referencing section 807(d)(5), section 7702 generally permits use of the same mortality assumption as permitted to be reflected in calculating the "federally prescribed reserves" with which section 807(d) is concerned. Thus, if the Pre-Need Model is adopted by at least 26 states in accordance with section 807(d)(5), the 1980 CSO would appear to constitute the "prevailing commissioners' standard tables" for purposes of sections 7702 and 7702A, subject to the discussion below regarding certain transition rules. At present, the 2001 CSO tables are the prevailing commissioners' standard tables under section 807(d), and hence sections 7702 and 7702A, for pre-need contracts. The adoption of the Model by the NAIC and 26 states would undo the effect of the adoption of the 2001 CSO for such contracts—an unprecedented step as far as the federal tax law is concerned.

In considering the effect of the Pre-Need Model on calculations under sections 7702 and 7702A, it is necessary to take account of the effect, if any, of the various notices and other guidance that the Treasury Department and the Service has issued on the reasonable mortality rule, *e.g.*, Notice 2006-95 (discussed above). These notices establish safe harbors, *i.e.*, if the conditions for application of a safe harbor are satisfied, the assumption made with respect to mortality will be deemed to meet the requirements of section 7702(c)(3)(B)(i). Significantly, none of the safe harbors described in the notices will apply to allow use of the 1980 CSO for a contract issued after Dec. 31, 2008. Thus, if the 1980 CSO is desired to be used for such a contract's section 7702 and 7702A

calculations, it generally will be necessary to rely on the statutory rule in section 7702(c)(3)(B)(i) as the sole governing authority. In light of that rule's reference to "reasonable" mortality and the life insurance industry's repeated requests for guidance as to what that reference connotes, there is necessarily some uncertainty regarding the scope of that rule.

In defining the "prevailing commissioners' standard tables," section 807(d)(5)(B) provides for transitional relief, allowing insurance companies to continue to treat a table as prevailing during the three-year period following the year during which a new table is approved by the 26th state. Thus, for example, if the Pre-Need Model, as prescribed by the NAIC, was adopted by the 26th state during 2009, it would be permissible to continue to use the 2001 CSO for contracts issued during 2010–2012. On closer analysis, there may be some question about the interrelationship between the three-year transition rule of section 807(d)(5)(A) and that provision's basic rule, which states that "the term 'prevailing commissioners' standard tables' means, with respect to any contract, the *most recent* commissioners' standard tables prescribed by the [NAIC] which are permitted to be used in computing reserves for that type of contract under the insurance laws of at least 26 States when the contract was issued" (emphasis added). On the one hand, the three-year transition rule is permissive, since section 807(d)(5)(B) states that an insurance company "may" apply it and, conversely, seemingly could choose not to do so (*i.e.*, an insurance company could choose to apply the Pre-Need Model and the 1980 CSO for pre-need contracts issued on and after the date of the approval of the Model by the 26th state, assuming this is after the effective date of the Model). On the other hand, one question that would need to be addressed is whether the transition rule set forth in the Pre-Need Model affects the identification of the "most recent" commissioners' standard mortality tables "permitted to be used in computing reserves for that type of contract" for purposes of section 807(d)(5)(A). If it does, then the 2001 CSO (being more recent than the 1980 CSO) may constitute the prevailing commissioners' standard tables during such transition period, and it therefore would not be permissible to use 1980 CSO during the Model's transition period. This question has not arisen before, as there has not been a reversion to a prior mortality table during the nearly quarter-century history of sections 807(d) and 7702.

Intentionally Failed Contracts (Chapter VI, Page 147)

There have been instances where a company may wish to market, and a buyer is willing to purchase, a contract that intentionally fails to meet the definition of life insurance under section 7702. Once a contract fails (as discussed in detail in Chapter VII), taxable income, equal to the income on the contract under section 7702(g), must be reported annually to the policyholder. A failed contract is treated as term insurance for the net amount at risk and a taxable fund.

Even though a policy by its terms may be designed to fail the CVAT (*e.g.*, an endowment for the full face amount prior to age 95), a policy will not factually fail the section 7702 definition until the premiums paid exceed the guideline premium limitation. Thus, a

policy designed to intentionally fail may nevertheless be life insurance under section 7702 for some period before it becomes disqualified. All the accrued income on the contract will be taxable at the point the contract factually fails the guideline premium limitation. Put differently, there is no provision in the Code for a policyholder or an issuer to choose to treat a contract as taxable by simply declaring that as their intention.

Return of Premium Plans (Chapter VI, Page 148)

As noted above, the Service has adopted a broad rulings position that would seem to sweep a return of premium (ROP) under a term insurance plan into the definition of cash value. Giving additional support to the Service's view, the NAIC has proposed Actuarial Guideline CCC—*The Application of the Standard Nonforfeiture Law for Life Insurance to Certain Policies Having Intermediate Cash Benefits*. It applies to individual life insurance policies, other than variable and non-variable adjustable life policies and current assumption whole life policies, that "provide for an endowment benefit, materially less than the policy face amount, at a specified intermediate duration during a longer period of life insurance protection." Policies that offer a return of premium benefit are considered a special case of the policies subject to the Guideline. The Guideline is effective for all policy forms filed on or after Jan. 1, 2009, and affects all contracts issued on or after Jan. 1, 2010. It provides a methodology for computing minimum cash values for return of premium products that is based on the period over which premiums are returned, even if the policy could continue in force for a longer period. This will raise the minimum cash values to be provided. By bringing return of premium plans under the scope of the state nonforfeiture requirements, if there were any remaining question whether return of premium benefits were not considered to be "cash value" under section 7702, the NAIC seems to have settled the matter.

<u>*Non-formulaic cash values:*</u> Where cash values are equal to a return of premium (or other non-formulaic pattern), the interest assumption that must be used to compute the test plan values (either guideline premiums or net single premium) may be the rate implied by the scale of cash values. The DEFRA Blue Book is the source of the method for imputing an interest rate to contracts that do not expressly guarantee an interest rate. It says, "The rate or rates guaranteed on issuance of the contract may be explicitly stated in the contract or may be implicitly stated by a guarantee of particular cash surrender values."[65] In the context of a return of premium plan, this can be taken to mean that by knowing the beginning and ending of the year cash values and the mortality table, the interest rate is the balancing item.

For an ROP product, where the beginning and ending of year n-cash value are equal to (n × GP), where GP is the contract gross premium (which may include rider premiums that are returned), then the implied interest rate in year n of the ROP accumulation period is:

[65] Revenue Provisions of the Deficit Reduction Act of 1984, 649.

$$q_{x+n-1} \times (Face - (n \times GP))/(n \times GP).$$

In this case, the interest amount for the year is equal to the mortality charge for the year, $q_{x+n-1} \times$ (Face - (n × GP)). Following the Blue Book method, guideline or net single premiums would be computed for an ROP product using these implied rates, which, especially in the early years, can be rather high, particularly where a graded percentage of the premiums is returned at intermediate policy durations.

For a guideline product, the interest rate shown above for year n makes it clear that an increase in GP will lower the implied interest rates. (An increase in GP both lowers the amount at risk in the numerator and increases the denominator.) As the statutory minimum interest rates used for the guideline level premium cannot be lower than 4%, this may affect the calculation. If the 4% minimum rate is never actually imposed, then GLP will be the contract premium. However, if the input premium is too high, the 4% minimum will become effective at some duration or durations, and the resulting guideline premium will be less than the input gross premium, thus disqualifying the plan when the sum of the premiums exceeds the guideline single premium.

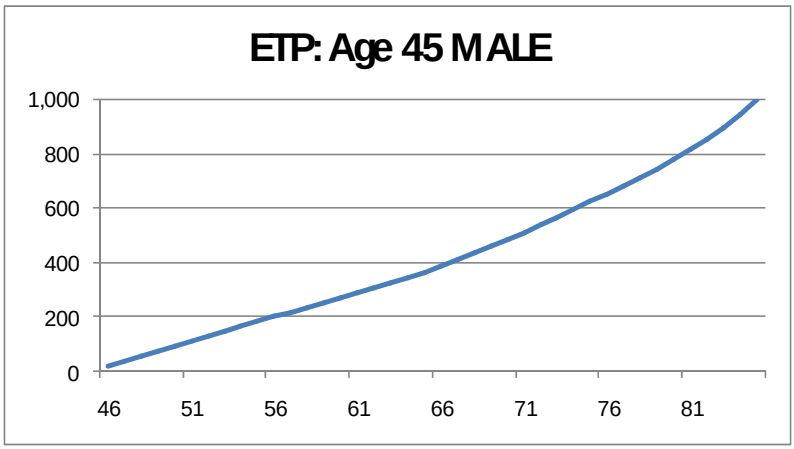
It is possible to compute the largest gross premium that does not call the 4% minimum into the calculation. That amount is as high as the contract premium can get and still qualify as the guideline level premium for the contract. (To clarify what's happening, if the minimum 4% is never imposed, the interest rate for each duration is just the rate that connects a cash value of n times the input premium in year n to a value of (n+1) times the input premium in year n+1. In that case, a premium computation for the contract using those interest rates gives back the input premium.) Thus, as long as the premium being returned is within the amount that will not generate an implied rate greater than 4%, the guideline limitation is met.

Note that the difficulty of applying the CVAT to these products is that the implied interest rate will vary with the gross premium being returned. In effect, the CVAT will impose the same premium limitation as the guideline test.

United States and Canada Dual Compliant Policy (Chapter VI, Page 150)

In some instances, a policyholder may have a need for a policy that meets both the U.S. and Canadian requirements. In some cases (for example an Option 2 universal life where the death benefit is the face amount plus the cash value and therefore the net amount at risk (NAR) is constant), the same policy can meet the dual limitations without modifications. For policies where the NAR varies, policy modifications may be necessary. However, because the Canadian test does not require a NAR after age 85, while the U.S. test requires a NAR until age 95 (and perhaps later), a U.S.-compliant policy may have higher mortality costs, particularly in the later durations. Because of the higher insurance costs, a U.S.-compliant policy may also require larger premiums to maintain the policy in force. However, unless a policy is specifically written to incorporate both the U.S. and Canadian limits, dual compliance remains a facts-and-

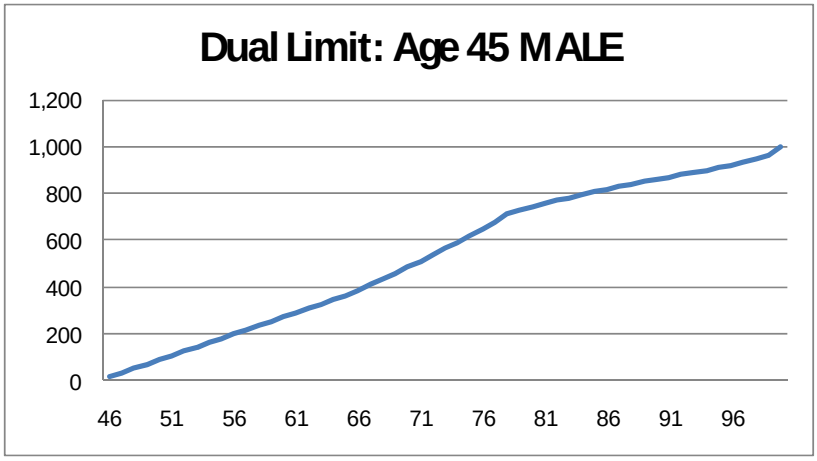
circumstances exercise. As of this writing, the authors are not aware of an insurer that offers such a dual compliant policy.



The Canadian limitation is determined by the so-called "MTAR line" (Maximum Tax Actuarial Reserve). The test policy is based on the cash surrender value of a 20-pay endowment at age 85. The limit is expressed as a linear reserve interpolation in the first 20 years and the calculated reserve thereafter to age 85. The MTAR of the policy is the greater of the cash surrender value, and the one-and-one-half-year preliminary term reserve. In practice, it appears that the accumulating fund used to compare to the ETP is based on the policy account value less surrender charge, where the surrender charges are often designed to maintain the policy in compliance with the ETP limitation.

The Canadian exempt test in its entirety is comprised of three different components: the pre-test, the annual test and the 250% test. In the pre-test, the projected operation of the policy is compared to the MTAR limitation. In applying the pre-test, the insurer is to assume that the terms and conditions of the policy do not change from those in effect on the last policy anniversary. For example, this includes assumptions that the dividend option elected will not change and that future premiums will be paid. The insurer must also make reasonable assumptions about all other factors, including the assumption that the amounts of dividends paid will follow the current dividend scale. In order to negate the need for pre-testing, many companies include contract wording committing to take action to ensure that the policy will retain its exempt status (*i.e.,* fail-safe language). Where there is no contractual wording, this pre-test must be performed at each anniversary along with the annual test.

The Act states that the actual policy must be tested by the life insurance carrier on every policy anniversary. For the annual test, the policy's death benefit is compared to the policy's death benefit at the previous anniversary. If the death benefit of the policy has grown by more than 8%, the excess must be treated like a brand new policy with a new ETP. A new and separate ETP is created for the excess with an issue date of that policy anniversary. In addition to the standard anniversary exempt test, another test is performed on the tenth and subsequent anniversaries of the policy. This test commonly referred to as the "anti-dump in rule" or "250% test" prevents large lump-sum deposits to a policy after the seventh anniversary date. The 250% test applies beginning at the 10th policy anniversary, and every policy year thereafter with a three-year look back. Under the rule, the MTAR of the policy cannot exceed 250% of the value that existed at the seventh policy anniversary. If the policy fails the test, excess funds must be placed in an external account with possible tax implications. The implication of the 250% test is that if a policy has been minimum funded through the seventh policy anniversary, the allowable funding in the 10th year and later years will be significantly lower.



The dual limitation is based on the minimum of the Canadian ETP and the U.S. CVAT. However, one of the key differences in the Canadian and U.S. requirements is that the U.S. requirements apply to the cash value *before* the imposition of surrender charges, while the Canadian requirements, by virtue of the application of the MTAR, are generally *after* surrender charges. As a result, it seems easier to graft the U.S. requirements to a Canadian policy than to start with a U.S. policy. That being said, however, some way must still be found to meet the CVAT "by the terms of the contract" if it is not inherent in the design of the policy.

WAIVER AND CLOSING AGREEMENT PROCESSES (Chapter VII, Page 154)

A statutory precondition to the granting of a waiver under section 7702(f)(8) with respect to any failed contract requires the Service to determine not only that the error giving rise to the failure is "reasonable" but also that "reasonable steps are being taken to remedy the error." In making this determination, the Service considers, *inter alia*, whether the error was brought to the Service's attention via the waiver proceeding within a reasonable period of time after the error was discovered. If there is evidence that the personnel of an insurer discovered the existence of the error but chose not to

apply for a waiver (or a closing agreement), and thereafter, following the lapse of some time, the insurer initiated a proceeding seeking the waiver, the Service likely will deny the waiver on the ground that reasonable steps were not taken in a timely manner, sometimes referred to as "laches." It is unclear what extent of a time lapse would trigger such a conclusion. The Service should recognize that, because the waiver process is very fact-intensive, requiring considerable investigation of the source of the error (and often, multiple errors leading to multiple failures are involved in a waiver proceeding), it typically will take many months to delineate the failures and the errors causing them and assemble the facts for a filing with the Service, a speedy turnaround typically is not possible. At the same time, insurers should recognize that the failure to pursue a section 7702 compliance problem in a prompt manner seriously jeopardizes the opportunity to obtain a waiver for what may otherwise be a perfectly reasonable error.

See also THE REMEDIATION REVOLUTION below.

CORRECTION OF UNINTENTIONAL MECS

Derivation of the Earnings Rates (Chapter VII, Page 162)

See also THE REMEDIATION REVOLUTION below.

Revenue Procedures 2008-39 (the revenue procedure for correcting inadvertent MECs) and 2008-40 (the revenue procedure for correcting failed life insurance contracts) both provide for alternative toll charge calculations that are based in whole or in part on the "earnings" that accrue on amounts in excess of the respective premium limitation. As was the case under Revenue Procedures 99-27[66] and 2001-42,[67] Revenue Procedure 2008-39 continues to provide a toll charge calculation based on "overage earnings" (*i.e.*, the earnings that accrue on a contract's "overage") while Revenue Procedure 2008-40 provides a new toll charge alternative based on "excess earnings" (*i.e.*, the earnings that accrue on "excess premiums").

While both revenue procedures define "earnings" using different terminology (overage earnings v. excess earnings), both are determined based on the same set of earnings rates. In defining the earnings that underlie the development of the toll charge, the revenue procedures do not look to the actual earnings accruing inside the life insurance contract, but instead base the earnings calculation on proxy earnings rates. These earnings rates are defined in section 3.07 of Revenue Procedure 2008-39, vary based on whether the contract qualifies as a variable contract under section 817(d), and apply on a contract year basis according to the calendar year in which the contract year begins.

---

[66] 1999-1 C.B. 1186, *superseded by* Rev. Proc. 2001-42.

[67] 2001-2 C.B. 212, *modified and amplified by* Rev. Proc. 2007-19, 2007-7 I.R.B. 515.

Methodology for Computing Earnings Rates: For contract years beginning in calendar years 1988 through 2007, the earnings rates are specified in section 3.07(2)(a) and (3)(a) of Revenue Procedure 2008-39. Section 3.07(2)(b) and (3)(b) provides the formulas to be used to determine the earnings rates for contract years after 2007.[68] The **general account total return** rate defines the earnings rate applicable to contracts other than variable life insurance contracts, while the **variable contract earnings rate** defines the rates applicable to variable life insurance contracts.

The **general account total return** equals:

(i) 50% of the Moody's Seasoned Corporate Aaa Bond Yield,[69] frequency annual, or any successor thereto; plus

(ii) 50% of the Moody's Seasoned Corporate Baa Bond Yield, frequency annual, or any successor thereto.

The **variable contract earnings rate** is equal to the sum of—

(i) 10% of the **general account total return**, and

(ii) 90% of the **separate account total return** for the calendar year in which the contract year begins.

Separate account total return: The separate account total return equals—

(a) 75% of the **equity fund total return**, plus

(b) 25% of the **bond fund total return**, less

(c) 1.1 percentage point.

Equity fund total return: The equity fund total return equals—

(a) the calendar year percentage return[70] represented by the end-of-year values of the Standard and Poor's (S&P) 500 Total Return Index, with daily dividend reinvestment, or any successor thereto, less

---

[68] Section 3.07(2)(a) and (3)(a) of Revenue Procedure 2008-39 only provides earnings rates back to 1988 because section 7702A was enacted in that year. However, sections 101(f) and 7702 were enacted earlier, and, as a result, earnings rates prior to 1988 will be needed to calculate excess earnings for contracts failing to comply with those sections prior to 1988. In this regard, section 4.03(5)(b)(ii) of Revenue Procedure 2008-40 provides that the applicable earnings rate for contract years beginning prior to 1988 is determined using the formulas set forth in section 3.07 of Revenue Procedure 2008-39 for contract years after 2007.

[69] Moody's Seasoned Corporate Aaa and Baa Bond Yields are publicly available at www.federalreserve.gov.

[70] The calendar year percentage return is calculated by:

(a) dividing the end-of-year value of the index for the calendar year by the end-of-year value of the index for the immediately preceding calendar year, and

(b) subtracting one from the result.

(b) 1.5 percentage point.

Bond fund total return: The bond fund total return equals—

(a) the calendar year percentage return represented by the end-of-year values of the Merrill Lynch U.S. Corporate Master Index (C0A0),[71] or any successor thereto, less
(b) 1.0 percentage point.

Incomplete calendar year: In order to compute the earnings rate for calendar year 2008 and later, the calendar year-end values for the various indices must be available. If the general account total return or the separate account total return for a calendar year cannot be determined because the calendar year in which the contract year begins has not ended, then the earnings rate for the contract year (or portion thereof) is determined by taking the average of the rates (general account total return or variable contract earnings rates) for the prior three years. For example, the general account total return for 2008 (assuming the year-end indices are not available) would be based on the average of the general account total return rates for 2005, 2006, and 2007 ((5.6% + 6.0% + 6.0%) / 3 = 5.8666% or 5.9%).

Table CCC contains the earnings rates for years 1982 to 2008. The earnings rates for years 1982 through 1987 are based on the application of the formulas contained in section 3.07(2)(b) and (3)(b) of Revenue Procedure 2008-39, while the earnings rates for 2008 are based on the arithmetic average of the earnings rates for 2005, 2006, and 2007.

Table CCC
Earnings Rates to be used to calculate
either "excess earnings" or "overage earnings"

Year	Contracts other than Variable Contracts	Variable Contracts	Source
1982	15.0%	21.8%	Application of Rev. Proc. 2008-39 Section 3.07 Formulas
1983	12.8%	16.4%	Application of Rev. Proc. 2008-39 Section 3.07 Formulas
1984	13.5%	7.0%	Application of Rev. Proc. 2008-39 Section 3.07

[71] The Merrill Lynch U.S. Corporate Master Index (C0A0) is publicly available at www.mlindex.ml.com.

			Formulas
1985	12.0%	26.1%	Application of Rev. Proc. 2008-39 Section 3.07 Formulas
1986	9.7%	15.0%	Application of Rev. Proc. 2008-39 Section 3.07 Formulas
1987	10.0%	2.7%	Application of Rev. Proc. 2008-39 Section 3.07 Formulas
1988	10.2%	13.5%	Rev. Proc. 2008-39
1989	9.7%	17.4%	Rev. Proc. 2008-39
1990	9.8%	1.4%	Rev. Proc. 2008-39
1991	9.2%	25.4%	Rev. Proc. 2008-39
1992	8.6%	5.9%	Rev. Proc. 2008-39
1993	7.5%	13.9%	Rev. Proc. 2008-39
1994	8.3%	-1.0%	Rev. Proc. 2008-39
1995	7.8%	23.0%	Rev. Proc. 2008-39
1996	7.7%	14.3%	Rev. Proc. 2008-39
1997	7.6%	17.8%	Rev. Proc. 2008-39
1998	6.9%	19.7%	Rev. Proc. 2008-39
1999	7.4%	12.8%	Rev. Proc. 2008-39
2000	8.0%	-5.5%	Rev. Proc. 2008-39
2001	7.5%	-7.1%	Rev. Proc. 2008-39
2002	7.2%	-14.1%	Rev. Proc. 2008-39
2003	6.2%	19.6%	Rev. Proc. 2008-39
2004	6.1%	6.9%	Rev. Proc. 2008-39
2005	5.6%	2.1%	Rev. Proc. 2008-39
2006	6.0%	10.0%	Rev. Proc. 2008-39
2007	6.0%	3.6%	Rev. Proc. 2008-39
2008	5.9%	5.2%	Average of Prior 3 Years

REVENUE RULING 2005-6 (Chapter VII, Page 165)

See also THE REMEDIATION REVOLUTION below.

As previously noted, Revenue Ruling 2005-6[72] (the Ruling) holds that the reasonable expense charge rule of section 7702(c)(3)(B)(ii) applies to charges for QABs. The Ruling

[72] 2005-1 C.B. 471.

provides relief to life insurance companies that previously concluded that the reasonable mortality charge rule, rather than the reasonable expense charge rule, governed the treatment of QABs. This relief comes in the form of special rules and procedures for entering into a closing agreement with the Service.

The Ruling's grant of relief for those that previously applied the rules incorrectly (in the Service's view) recognizes that the normally applicable procedures for addressing errors under sections 7702 and 7702A would not produce an equitable result in the present circumstances.[73] The Ruling's special rules and procedures deviate from the normal procedures in two significant respects. First, they do not require a life insurance company to take corrective actions with respect to QABs that have been accounted for using the reasonable mortality charge rule if the issuer requests relief through a closing agreement before Feb. 7, 2006. Second, a special toll charge structure is adopted which generally involves much reduced costs compared with those otherwise applicable. Under the special toll charge structure, the charge is determined under a sliding scale based upon the aggregate number of contracts for which relief is requested. The same special toll charge structure applies regardless of whether the failure is under section 7702, section 7702A, or both.

The Ruling's relief provisions are set forth in the "Application" part of the Ruling, which is divided into three separate alternatives—A, B, and C.

Alternative "A"

The first alternative of the Application part of the Ruling states that, where an issuer's compliance system improperly accounts for QAB charges but no contracts have failed under section 7702, the issuer may correct its system to account for charges using the reasonable expense charge rule without any need to contact the Service. It appears that this alternative is simply a restatement of actions that issuers may take under existing law. Thus, the alternative serves as a reminder to life insurance companies that they do not need to involve the Service in the circumstance where no contracts have failed to meet the definitional tests of sections 7702 and 7702A. At the same time, this alternative does not provide any relief, in and of itself, since the determination that no contracts fail

[73] Under the Service's generally applicable procedures, life insurance contracts failing to comply with section 7702 or section 7702A can only be brought into compliance through a proceeding with the Service, *i.e.,* receipt of a waiver under section 7702(f)(8) or execution of a closing agreement covering failures to comply with section 7702, and execution of a closing agreement covering inadvertent MECs. Under each of these procedures, it is generally necessary to correct systems and contracts so that the error causing the failures is corrected. For example, for a contract failing under the guideline premium test, correction often takes the form of returning premiums (with interest) in excess of the properly determined guideline premium limitation. Also, in the case of closing agreements, it is often necessary to pay a "toll charge." Deficiency interest also is payable as part of the toll charge.

must be made using the reasonable expense charge rule for QABs, and thus this alternative contemplates correction of compliance systems.

Alternative "B"

The second alternative of the Application part of the Ruling states that, where an issuer's compliance system improperly accounts for QAB charges and, as a result, some contracts do not meet the definition of life insurance contract under section 7702(a), the issuer may request a closing agreement on or before Feb. 7, 2006 on the basis described below. While this alternative's introductory language refers only to contracts that do not meet the definition of life insurance under section 7702(a), the Service has confirmed that the intent was for the relief provided also to be available for inadvertent MECs under section 7702A, even though such contracts are in compliance with section 7702. In addition, the relief provided is not, on the face of the Ruling, limited to any particular types of QABs or to particular determinations under sections 7702 or 7702A (*i.e.*, errors under the GP test, the CVA test, and the 7-pay test are all encompassed).

Under a closing agreement entered into pursuant to this Alternative B:

(1) The issuer must identify all contracts administered under the compliance system, but need not identify whether they fail under section 7702 or section 7702A. The Ruling does not state the precise manner in which such identification must be made. Under closing agreements addressing section 7702 failures in other contexts, policy numbers are used to identify contracts.

(2) The identified contracts will not be treated as failing under section 7702 or as inadvertent MECs under section 7702A by reason of improperly accounting for charges for existing QABs. This relief will extend to future charges resulting from an increase in an existing QAB or the addition of a new QAB pursuant to the exercise of a right that existed in the contract before April 8, 2005. However, the relief under the closing agreement will not extend to improper accounting for charges for an increase in an existing QAB or the addition of a new QAB that are not pursuant to the exercise of a right that existed in the contract before that date.

(3) No corrective action need be taken with respect to the compliance system or with respect to contracts identified in the closing agreement. To the extent the compliance system will be used to administer newly issued contracts, such system will of course need to apply the reasonable expense charge rule. At the latest, contracts issued on and after Feb. 7, 2006 would need to be administered in accordance with the reasonable expense charge rule.

(4) In lieu of the amount of tax and interest that would be owed by the policyholders under a normal section 7702 or section 7702A closing agreement, the amount due under a closing agreement under this Alternative B will be based on a schedule contained in the Ruling that sets forth a sliding scale of charges keyed to the

> "number of contracts for which relief is requested." This scale ranges from $1,500 for 20 contracts or fewer, to $50,000 for over 10,000 contracts.

When the Ruling states that the sliding scale charge will be based on the "number of contracts for which relief is requested," its statement seemingly is intended to correspond to the requirement of paragraph (1) above, which states that "the issuer must identify all contracts administered under the compliance system." Thus, the number so identified would be the same number for which relief is requested. The request for a closing agreement must be submitted with the user fee required by applicable procedures governing requests for private letter rulings (generally $10,000 for 2006).

Alternative "C"

The third and final alternative of the Application part of the Ruling states that after Feb. 7, 2006, an issuer with a compliance system that improperly accounts for QAB charges may request a closing agreement under the same terms and conditions as described under Alternative B above, except that (1) the closing agreement must identify the contracts that fail to satisfy the requirements of section 7702 or are inadvertent MECs under section 7702A, and (2) the closing agreement must require the issuer to correct its compliance system and to bring the identified contracts into compliance with section 7702 or section 7702A, as applicable.

The Ruling is silent regarding the effect of the Ruling on the existing waiver request process under section 7702(f)(8), but the Service has construed it to mean that waivers are no longer available. This construction is buttressed by the presence of Alternative C, given its requirement of correcting failed contracts and the need to pay the sliding scale toll charge.

It appears that the number of contracts actually failing the statutory tests, rather than the number administered on the compliance system, is intended to be used to determine the sliding scale toll charge under Alternative C. As discussed above, some issuers may want to apply the reasonable expense charge rule retroactively and seek relief under the Ruling (and calculation of the sliding scale toll charge) only for failed contracts. Alternative C seemingly permits this, provided that the requests are made after February 7, 2006. It seems reasonable that the Service would allow the identification of, and the payment of the toll charge with regard to, only the failed contracts under this alternative in circumstances where the issuer is not seeking any relief for any other contracts. Such an interpretation not only would reconcile Alternatives B and C, but also would be consistent with the principles underlying Alternative A, *i.e.*, that there is no need to involve the Service for contracts that comply (based on retroactive application of the reasonable expense charge rule) and will be administered in accordance with the correct rule on an ongoing basis.

Notice 2005-35

Notice 2005-35 provides procedures under which a list identifying the contracts subject to a closing agreement under Revenue Ruling 2005-6 may be submitted to the Service in electronic format. Under Alternatives B and C of the ruling, an issuer may request relief in the form of a closing agreement under which contracts will not be treated as having failed the requirements of section 7702(a) or as MECs under section 7702A by reason of improperly accounting for charges for existing QABs. The issuer's request for a closing agreement must include a list identifying the contracts for which relief is requested. Accordingly, an issuer may submit the list electronically, in read-only format, on either a CD-ROM or diskette.[74] The issuer must provide a total of three CD-ROMs or diskettes, one for each of the three copies of the closing agreement.

THE REMEDIATION REVOLUTION (Chapter VII, Page 171)

In Notice 2007-15,[75] the Treasury Department and the Service requested comments on how to improve the procedures that were then available to correct (1) life insurance contracts that failed to satisfy the requirements of section 101(f) or 7702, as applicable ("failed contracts"), (2) contracts that inadvertently failed the "7-pay test" of section 7702A(b) and became modified endowment contracts ("inadvertent MECs"), and (3) diversification failures under section 817(h). In response to comments received, and as part of an effort to streamline tax compliance procedures from the standpoint of both taxpayers and the government, five new revenue procedures were issued in June of 2008 (*see* Appendix D): [76]

- Revenue Procedure 2008-38, elaborating on the Alternative C QAB error correction procedure under Rev. Rul. 2005-6.
- Revenue Procedure 2008-39, revising the MEC correction revenue procedure.
- Revenue Procedure 2008-40, addressing closing agreements for contracts failing to comply with section 101(f) or 7702.
- Revenue Procedure 2008-41, revising the closing agreement procedure for section 817(h) diversification failures.
- Revenue Procedure 2008-42, providing an automatic procedure for obtaining a waiver of clerical-type errors under sections 101(f)(3)(H) and 7702(f)(8).

[74] Adobe Portable Document (PDF) format is a suitable format. According to the Notice, other formats may be arranged on a case-by-case basis.

[75] 2007-1 C.B. 503.

[76] Rev. Proc. 2008-38, 2008-29 I.R.B. 139; Rev. Proc. 2008-39, 2008-29 I.R.B. 143; Rev. Proc. 2008-40, 2008-29 I.R.B. 151; Rev. Proc. 2008-41, 2008-29 I.R.B. 155; Rev. Proc. 2008-42, 2008-29 I.R.B. 160.

The publication of these revenue procedures represents a virtual revolution in the government's approach to the correction of contract (and separate account) errors, emphasizing simplification, cost reduction, and, more generally, a pro-compliance attitude. The new procedures also entail a shifting of audit-type responsibility from the Service's National Office to its field auditors (namely, in most cases, the Large and Mid-Size Business Division (LMSB) of the Service). Each of the four new procedures dealing with compliance problems under sections 101(f), 7702, and 7702A is summarized below. Note: Revenue Procedure 2008-41 deals with the diversification requirements for separate account assets, not qualification of life insurance, and is therefore not included in the discussion below.

It should be noted that each of the revenue procedures applies by its terms not only for an original issuer but also to a "company that insures a contract holder under a contract originally issued by another company." In this manner, the procedures allow their use by a reinsurer of failed contracts or inadvertent MECs, whether via assumption reinsurance or coinsurance, as well as by the issuer of such contracts. Hence, in the summaries below references to "issuer" include a reinsurer.

Revenue Procedure 2008-38

This procedure amplifies Rev. Rul. 2005-6, discussed above, by specifically addressing the corrective action an issuer must take in order to bring the failed contracts, inadvertent MECs, and the systems on which they are administered into compliance with section 7702 or 7702A, as applicable, under Alternative C of Rev. Rul. 2005-6. To bring contracts into compliance, the issuer may increase the contract's death benefit or return the contract's excess premiums and earnings thereon to the contract holder. The issuer also must correct its compliance system to account properly for charges for QABs as provided in Rev. Rul. 2005-6, and to do so within 90 days of the execution of the closing agreement by the Service. Additionally, Rev. Proc. 2008-38 provides a model closing agreement to be used under Alternative C of Rev. Rul. 2005-6.

Revenue Procedure 2008-39

This procedure allows the issuer of an inadvertent MEC to calculate the toll charge to correct the contract using either of two alternative methodologies—

- *Alternative 1 (traditional)*—The issuer may continue to calculate the toll charge in the same manner as previously required under section 5.03 of Rev. Proc. 2001-42, although the *de minimis* overage earnings amount set forth in section 5.03(2) of Rev. Proc. 2001-40 is increased from $75 to $100.

- *Alternative 2 (100% of overage)*—The toll charge under this alternative equals 100% of the "overage" under an inadvertent MEC. Section 3.05 of Rev. Proc. 2008-39 defines "overage" as "the excess, if any, of— (1) the sum of amounts paid under the contract during the testing period for the contract year and all prior contract years, over (2) the sum of the 7-pay premiums for the contract year and all prior contract years of the testing period." In the case of a contract that is

"outside" of a 7-pay testing period, it appears that the overage for purposes of this alternative is determined as of the last contract year of the 7-pay period. (*See* the examples set forth in section 5.03(3)(a) and (b) of Revenue Procedure 2008-39.)

Rev. Proc. 2008-39 requires an issuer to represent that the MEC closing agreement toll charge calculations are correct and to retain documentation supporting the calculations; although, in a significant change from the predecessor revenue procedures, it does not require submission of the detail as part of the filing. In addition, Rev. Proc. 2008-39 eliminates most other information previously required to be submitted in the filing with respect to each contract to be covered by a MEC closing agreement. Specifically, an issuer seeking to correct inadvertent MECs under Rev. Proc. 2008-39 need only submit the policy numbers of the inadvertent MECs, a description of the errors causing the inadvertent MECs, and a description of the compliance procedures adopted to prevent further inadvertent MECs. The revenue procedure includes a revised model closing agreement that must be used to obtain relief under the revenue procedure.

Revenue Procedure 2008-40

This procedure allows an issuer to calculate the toll charge required to be paid in connection with a closing agreement to correct a section 101(f) or 7702 compliance failure (for which a waiver is not sought or could not be obtained) using, for a given contract, one of three alternative methodologies—

- Alternative 1 (traditional)—The issuer may continue to calculate the toll charge in accordance with Rev. Rul. 91-17 as supplemented by Notice 99-48.

- Alternative 2 ("excess earnings")—The issuer may calculate the toll charge by reference to the "excess earnings" that accrue under the failed contract, provided that the excess earnings do not exceed $5,000. Generally, "excess earnings" are equal to the product of "(i) the sum of a contract's excess premiums for a contract year and its cumulative excess earnings for all prior contract years," and "(ii) the applicable earnings rate as set forth in section 3.07 of Rev. Proc. 2008-39." (For contract years prior to 1988, the earnings rate is to be determined in a manner consistent with the formulas in section 3.07 of Rev. Proc. 2008-39 for calculating earnings rates for contract years after 2007.) The toll charge under this alternative equals the tax on the excess earnings and the deficiency interest on that amount, with the tax rates set forth in section 3.11 of Rev. Proc. 2008-39, which are the same as the rates prescribed in Notice 99-48.

- Alternative 3 (100% of error)—Under this alternative, the toll charge is equal to 100% of the "excess premiums," (*i.e.*, "the highest amount by which the total premiums paid under the contract exceed the guideline premium limitations under section 7702(c) at any time the contract is in force"). This effectively amounts to a toll charge equal to 100% of the error.

Rev. Proc. 2008-40 is written so that the issuer of any given failed contract may choose which of the eligible alternative methodologies its filing will use for calculating the toll charge for that contract. As in the case of Rev. Proc. 2008-39, an issuer is not required to submit the details of the Rev. Proc. 2008-40 toll charge calculations to the Service, although it is required to represent that the calculations are correct and to retain documentation supporting them.

The revenue procedure addresses in detail failures to comply with the guideline premium test. In the case of failures to comply with the CVAT, section 4.02 of Rev. Proc. 2008-40 allows an issuer to address these failures by proposing (1) modifications to the closing agreement set forth in section 5 of that revenue procedure, and (2) alternative amounts to be paid under such closing agreement. It should be noted that since a contract that was designed to comply with the CVAT but failed to do so must also fail the guideline premium test in order to fail section 7702's requirements, such a contract necessarily has "excess earnings" within the definition of the revenue procedure because it also fails the guideline test.

As do the other revenue procedures (apart from the one described next), Rev. Proc. 2008-40 includes, in section 5, a model closing agreement that must be used to obtain relief under this revenue procedure.

Revenue Procedure 2008-42

In a dramatic change from the Service's prior practice, this procedure permits certain errors leading to section 101(f) or 7702 compliance failures to be waived under IRC section 101(f)(3)(H) or 7702(f)(8), as applicable, on an automatic basis. Specifically, an issuer seeking relief under Rev. Proc. 2008-42 for "automatic waivers" is required to file an "Automatic Waiver Request under Rev. Proc. 2008-42" statement (Statement) with the Service's National Office and to attach a statement to its federal income tax return (Return Attachment); this is in lieu of filing a ruling request with the National Office. The Statement must provide a description of the error, the steps taken to remedy the error, the policy numbers of the affected failed contracts, and the representations set forth in section 4.04 of the revenue procedure. Unlike other submissions filed with the National Office, the Statement is not governed by Rev. Proc. 2008-1 (or any successor revenue procedure relating to private letter ruling requests) and, therefore, no user fee is required to be paid to the Service. The Return Attachment must provide as follows: "Issuer has submitted an Automatic Waiver Request under section 4.02 of Rev. Proc. 2008-42 for certain errors that caused one or more life insurance contracts it issued to fail to comply with §7702(f)(8) or §101(f) of the Internal Revenue Code."

Rev. Proc. 2008-42 provides that an issuer is eligible for an "automatic waiver" if it can represent that (1) it had compliance procedures in place with specific, clearly articulated provisions that, if followed, would have prevented the contract involved from failing to satisfy the requirements of section 101(f) or 7702, as applicable; (2) an employee or independent contractor of the issuer acted, or failed to act, in accordance with those

compliance procedures; and (3) the act or failure to act was inadvertent and was the sole reason that the contract failed to satisfy the requirements of section 101(f) or 7702, as applicable. The revenue procedure goes on to identify examples of the types of errors that are eligible for an automatic waiver under the procedure, such as the input of an incorrect age or sex for an insured and the input of incorrect information regarding the amount or time of a premium payment. On the other hand, the revenue procedure excludes from its purview computer programming errors and defective legal interpretation errors (*e.g.*, with respect to the interpretation of the requirements of section 101(f) or 7702).

To be eligible for an automatic waiver under Rev. Proc. 2008-42, the taxpayer must take reasonable steps to remedy the failed contracts. Specifically, the issuer must refund excess premium with interest and/or increase the death benefit under the contract no later than the date on which the issuer files the federal income tax return to which the Return Attachment is affixed. The revenue procedure points out that a reasonable step to remedy the error does not include changes to the issuer's compliance procedures. This is because, as the issuer must have represented in order to be eligible for the automatic waiver, the issuer must already have specific, clearly articulated procedures that if followed would have prevented the error.

Rev. Proc. 2008-42 states that if errors are reasonable, the taxpayer may still request a waiver by filing a private letter ruling request. This would include the types of errors that are excluded from the revenue procedure's purview. For errors that are not reasonable, taxpayers may request a closing agreement under Rev. Proc. 2008-40.

Appendix A — Attained Age Regulation

Appeals with respect to an equivalent hearing?

* * * * *

Q–I7. When must a taxpayer request an equivalent hearing with respect to a CDP Notice issued under section 6330?

A–I7. A taxpayer must submit a written request for an equivalent hearing within the one-year period commencing the day after the date of the CDP Notice issued under section 6330. This period is slightly different from the period for submitting a written request for an equivalent hearing with respect to a CDP Notice issued under section 6320. For a CDP Notice issued under section 6320, a taxpayer must submit a written request for an equivalent hearing within the one-year period commencing the day after the end of the five-business-day period following the filing of the NFTL.

Q–I8. How will the timeliness of a taxpayer's written request for an equivalent hearing be determined?

A–I8. The rules and regulations under section 7502 and section 7503 will apply to determine the timeliness of the taxpayer's request for an equivalent hearing, if properly transmitted and addressed as provided in A–I10 of this paragraph (i)(2).

Q–I9. Is the one-year period within which a taxpayer must make a request for an equivalent hearing extended because the taxpayer resides outside the United States?

A–I9. No. All taxpayers who want an equivalent hearing must request the hearing within the one-year period commencing the day after the date of the CDP Notice issued under section 6330.

Q–I10. Where must the written request for an equivalent hearing be sent?

A–I10. The written request for an equivalent hearing must be sent, or hand delivered (if permitted), to the IRS office and address as directed on the CDP Notice. If the address of the issuing office does not appear on the CDP Notice, the taxpayer should obtain the address of the office to which the written request should be sent or hand delivered by calling, toll-free, 1–800–829–1040 and providing the taxpayer's identification number (*e.g.*, SSN, ITIN or EIN).

Q–I11. What will happen if the taxpayer does not request an equivalent hearing in writing within the one-year period commencing the day after the date of the CDP Notice issued under section 6330?

A–I11. If the taxpayer does not request an equivalent hearing with Appeals within the one-year period commencing the day after the date of the CDP Notice issued under section 6330, the taxpayer foregoes the right to an equivalent hearing with respect to the unpaid tax and tax periods shown on the CDP Notice. A written request submitted within the one-year period that does not satisfy the requirements set forth in A–I1(ii) of this paragraph (i)(2) is considered timely if the request is perfected within a reasonable period of time pursuant to A–I1(iii) of this paragraph (i)(2). If a request for equivalent hearing is untimely, either because the request was not submitted within the one-year period or not perfected within the reasonable period provided, the equivalent hearing request will be denied. The taxpayer, however, may seek reconsideration by the IRS office collecting the tax, assistance from the National Taxpayer Advocate, or an administrative hearing before Appeals under its Collection Appeals Program or any successor program.

(j) *Effective date.* This section is applicable on or after November 16, 2006 with respect to requests made for CDP hearings or equivalent hearings on or after November 16, 2006.

Mark E. Matthews,
Deputy Commissioner for Services and Enforcement.

Approved October 6, 2006.

Eric Solomon,
Acting Deputy Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on October 16, 2006, 8:45 a.m., and published in the issue of the Federal Register for October 17, 2006, 71 F.R. 60827)

Section 7702.—Life Insurance Contract Defined

26 CFR 1.7702–2: Attained age of the insured under a life insurance contract.

T.D. 9287

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 1

Attained Age of the Insured Under Section 7702

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulation.

SUMMARY: This document contains final regulations explaining how to determine the attained age of an insured for purposes of testing whether a contract qualifies as a life insurance contract for Federal income tax purposes.

DATES: *Effective Date:* These regulations are effective September 13, 2006.

Applicability Dates: For dates of applicability, see §1.7702–2(f).

FOR FURTHER INFORMATION CONTACT: Ann H. Logan, 202–622–3970 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

Section 7702(a) of the Internal Revenue Code (Code) provides that, for a contract to qualify as a life insurance contract for Federal income tax purposes, the contract must be a life insurance contract under the applicable law and must either (1) satisfy the cash value accumulation test of section 7702(b), or (2) both meet the guideline premium requirements of section 7702(c) and fall within the cash value corridor of section 7702(d). To determine whether a contract satisfies the cash value accumulation test, or meets the guideline premium requirements and falls within the cash value corridor, it is necessary to determine the attained age of the insured.

A contract meets the cash value accumulation test of section 7702(b) if, by the

terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at that time to fund future benefits under the contract. Under section 7702(e)(1)(B), the maturity date of the contract is deemed to be no earlier than the day on which the insured attains age 95, and no later than the day on which the insured attains age 100, for purposes of applying the cash value accumulation test.

A contract meets the guideline premium requirements of section 7702(c) if the sum of the premiums paid under the contract does not at any time exceed the greater of the guideline single premium or the sum of the guideline level premiums as of such time. The guideline single premium is the premium that is needed at the time the policy is issued to fund the future benefits under the contract based on the following three elements enumerated in section 7702(e)(3)(B):

(i) Reasonable mortality charges that meet the requirements (if any) prescribed in regulations and that (except as provided in regulations) do not exceed the mortality charges specified in the prevailing commissioners' standard tables (as defined in section 807(d)(5)) as of the time the contract is issued;

(ii) Any reasonable charges (other than mortality charges) that (on the basis of the company's experience, if any, with respect to similar contracts) are reasonably expected to be actually paid; and

(iii) Interest at the greater of an annual effective rate of six percent or the rate or rates guaranteed on issuance of the contract.

The guideline level premium is the level annual amount, payable over a period not ending before the insured attains age 95, computed on the same basis as the guideline single premium but using a minimum interest rate of four percent, rather than six percent. Like the cash value accumulation test, the guideline premium requirements are applied by deeming the maturity date of the contract to be no earlier than the day on which the insured attains age 95, and no later than the day on which the insured attains age 100. The deemed maturity date generally is the determination date set forth in the contract or the end of the mortality table (which, when section 7702 was enacted in 1984, was age 100).

A contract falls within the cash value corridor if the death benefit of the contract at any time is not less than the applicable percentage of the cash surrender value. The applicable percentage is determined based on the attained age of the insured as of the beginning of the contract year, as follows:

APPLICABLE PERCENTAGE			
In the case of an insured with an attained age as of the beginning of the contract year of:		The applicable percentage shall decrease by a ratable portion for each full year:	
More than:	But not more than:	From:	To:
0	40	250	250
40	45	250	215
45	50	215	185
50	55	185	150
55	60	150	130
60	65	130	120
65	70	120	115
70	75	115	105
75	90	105	105
90	95	105	100

The Code does not define the attained age of the insured for purposes of applying the cash value corridor, the guideline premium limitations, or the computational rules of section 7702(e). The Senate Finance Committee explanation of the Deficit Reduction Act of 1984, Public Law 98–369 (98 Stat. 494), however, states that the attained age of the insured means the insured's age determined by reference to contract anniversaries (rather than the individual's actual birthdays), so long as the age assumed under the contract is within 12 months of the actual age. See S. Prt. No. 98–169, Vol. 1, at 576 (1984).

Section 7702A defines a modified endowment contract (MEC) as a contract that meets the requirements of section 7702 (that is, a contract that is a life insurance contract), but that fails to meet the 7-pay test set forth in section 7702A(b). A contract fails to meet the 7-pay test if the accumulated amount paid under the contract at any time during the first 7 contract years exceeds the sum of the net level premiums that would have been paid on or before that time if the contract provided for paid-up future benefits after the payment of 7 level annual premiums. Section 7702A(c)(1)(B) provides that, for purposes of this test, the computational rules of section 7702(e) generally apply, including the contract's deemed maturity no earlier than the day on which the insured attains age 95, and no later than the day on which the insured attains age 100.

In sum, the attained age of an insured under a contract that is a life insurance contract under the applicable law must be determined to test whether the contract complies with the guideline premium require-

ments of section 7702(c), the cash value corridor of section 7702(d), and (by reason of the computational rules of section 7702(e)) the cash value accumulation test of section 7702(b) and the 7-pay test of section 7702A(b), as applicable.

On May 24, 2005, the IRS and Treasury Department published a notice of proposed rulemaking (REG–168892–03, 2005–25 I.R.B. 1293, June 20, 2005) in the **Federal Register** (70 FR 29671) (the proposed regulations). The proposed regulations provide guidance on how to determine the attained age of an individual insured under a contract that is a life insurance contract under the applicable law, for purposes of testing whether the contract qualifies as a life insurance contract under section 7702 and is a modified endowment contract under section 7702A. Under the proposed regulations, the attained age of the insured is either (i) the insured's age determined by reference to the individual's actual birthday as of the date of determination (actual age) or (ii) the insured's age determined by reference to contract anniversary (rather than the individual's actual birthday), so long as the age assumed under the contract (contract age) is within 12 months of the actual age. The proposed regulations provide that the attained age of the insured under a contract insuring multiple lives on a last-to-die basis is the attained age of the youngest insured, and the attained age of the insured under a contract insuring multiple lives on a first-to-die basis is the attained age of the oldest insured.

The sole party requesting a public hearing timely withdrew its request. One written comment regarding the notice of proposed rulemaking was received.

Explanation of Provisions

After consideration of the written comment received, this Treasury decision adopts the regulations as proposed, with the modifications noted below.

A. *Identity of the Insured Individual*

The proposed regulations provide that, in the case of a last-to-die contract, the attained age of the insured means the age of the youngest individual insured under the contract. The comment letter pointed out that, in the case of such a contract, the death of the youngest insured raises a question whether the attained age under the contract should continue to be determined based on the attained age of the deceased insured, or should instead be based on the attained age of the youngest *surviving* insured. Some last-to-die life insurance contracts undergo a change in both cash value and future mortality charges as a result of the death of an insured. These changes take into account the identity of the surviving insured or insureds. Other last-to-die life insurance contracts treat the death of an insured as a non-event for purposes of measuring cash value and future mortality charges under the contract. The comment letter suggested a rule for last-to-die contracts that would take into account the age of the youngest surviving insured if the contract undergoes modifications to both the cash value and future mortality charges under the contract, so that the attained age assumptions used for Federal income tax purposes are consistent with those used under the terms of the contract. The final regulations include such a rule in §1.7702–2(c)(2).

B. *Changes in Benefits Between Policy Anniversaries*

The proposed regulations provide that the age of an individual insured under a life insurance contract is either (i) the insured's age determined by reference to the individual's actual birthday as of the date of determination (actual age), or (ii) the insured's age determined by reference to contract anniversary (rather than the individual's actual birthday), so long as the age assumed under the contract (contract age) is within 12 months of the actual age. The proposed regulations do not, however, define the attained age to be used if there is an increase in death benefits between policy anniversary dates. Specifically, should the attained age as of the beginning of the contract year continue to be used at the time of the benefit increase, even if the date of change is closer to the next contract anniversary? The comment letter requests flexibility to use the attained age as of either the previous or subsequent policy anniversary, or any age between those two ages. The final regulations address this issue by clarifying that the attained age of the insured under a contract, once determined, changes annually. This rule is set forth in §1.7702–2(b)(2).

C. *Use of Derived Ages for Multiple Life Contracts*

Under the proposed regulations, the attained age of the insured under a contract insuring multiple lives is either the attained age of the youngest insured (in the case of a last-to-die contract) or the attained age of the oldest insured (in the case of a first-to-die contract). Some issuers, however, determine mortality charges under such contracts using a single, derived age that does not correspond to the attained age of any single insured under the contract. In addition, in some cases issuers currently account for substandard risks by determining mortality charges based on an age that is older than the actual attained age of the insured under the contract. The comment letter requested a rule that would permit the use of the same derived age as the *attained age* of the insured in these circumstances, to avoid whatever administrative complexities could result from the use of different ages for different purposes in the course of testing compliance of the contracts with sections 7702 and 7702A.

The final regulations do not make this change. The manner in which age is used to determine *reasonable mortality charges* under section 7702(c)(3)(B)(i) is independent of the age that is treated as the *attained age* of the insured for purposes of determining the guideline level premium under section 7702(c)(4), or applying the cash value corridor of section 7702(d) or the computational rules of section 7702(e). The final regulations do not, nor are they intended to, endorse or prohibit any methodology for determining reasonable mortality charges under section 7702(c). Reasonable mortality charges were the subject of regulations proposed July 5, 1991, (FI–069–89, 1991–2 C.B. 963) in the **Federal Register** (56 FR 30718), and also were addressed in Notice 88–128, 1988–2 C.B. 540, and Notice 2004–61, 2004–2 C.B. 596. See §601.601(d)(2)(ii). This prior guidance is not modified, clarified, or in any other way affected by these final regulations.

D.. *Contract Anniversary*

The comment letter requested that the regulations include a definition of *contract anniversary* other than the issue date of the contract and subsequent anniversaries

of that date. The final regulations do not include such a definition because the terms *issue date* and *contract year* have broad application, and it would be inappropriate to address the matter for the first time in these final regulations.

E. *Effective Date*

The proposed regulations were proposed to apply to contracts issued on or after the date that is one year after the regulations are published as final regulations in the **Federal Register**. A taxpayer would be permitted, however, to apply these final regulations retroactively for contracts issued before that date provided the taxpayer does not later determine qualification of those contracts in a manner that is inconsistent with these regulations.

The comment letter requested that the final regulations conform more closely to the adoption dates for the 2001 Commissioners' Standard Ordinary mortality and morbidity tables (2001 CSO tables). These tables are now prevailing within the meaning of section 807(d)(5) and have a mandatory effective date of January 1, 2009. In some States, insurers have the option to use either the 1980 CSO tables or the 2001 CSO tables for contracts issued before January 1, 2009. Either changing from the 1980 CSO mortality tables to the 2001 CSO tables or adopting changes to the determination of the insured's attained age under this regulation (or both) may require filing new contract forms with the relevant state insurance commissioners and may require changes to existing compliance systems. Accordingly, the effective date of this final regulation has been adjusted to take into account the transition period for adoption of the new mortality tables. Specifically, the final regulations apply to life insurance contracts that are either (1) issued after December 31, 2008, or (2) issued on or after October 1, 2007, and based upon the 2001 CSO tables. This modification will enable issuers to make any changes required by this final regulation concurrently with the changes required by the adoption of the 2001 CSO mortality tables. In addition, taxpayers may apply the regulations for contracts issued before October 1, 2007, provided they do not later determine qualification of those contracts under section 7702 in a manner inconsistent with the regulations.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) and (d) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding this Treasury decision was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these final regulations is Ann H. Logan, Office of the Associate Chief Counsel (Financial Institutions and Products), Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the IRS and the Treasury Department participated in their development.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by adding entries in numerical order to read as follows:

Authority: 26 U.S.C. 7805 * * *

Section 1.7702–2 also issued under 26 U.S.C. 7702(k). * * *

Par. 2. Section 1.7702–0 is added to read as follows:

§1.7702–0 Table of contents.

This section lists the captions that appear in §§1.7702–1, 1.7702–2, and 1.7702–3.

§1.7702–1 Mortality charges.

(a) General rule.
(b) Reasonable mortality charges.
(1) Actually expected to be imposed.
(2) Limit on charges.
(c) Safe harbors.
(1) 1980 C.S.O. Basic Mortality Tables.
(2) Unisex tables and smoker/nonsmoker tables.
(3) Certain contracts based on 1958 C.S.O. table.
(d) Definitions.
(1) Prevailing commissioners' standard tables.
(2) Substandard risk.
(3) Nonparticipating contract.
(4) Charge reduction mechanism.
(5) Plan of insurance.
(e) Effective date.

§1.7702–2 Attained age of the insured under a life insurance contract.

(a) In general.
(b) Contract insuring a single life.
(c) Contract insuring multiple lives on a last-to-die basis.
(1) In general.
(2) Modifications to cash value and future mortality charges upon the death of insured.
(d) Contract insuring multiple lives on a first-to-die basis.
(e) Examples.
(f) Effective dates.
(1) In general.
(2) Contracts issued before the general effective date.

§1.7702–3 Definitions.

(a) In general.
(b) Cash value.
(1) In general.
(2) Amounts excluded from cash value.
(c) Death benefit.
(1) In general.
(2) Qualified accelerated death benefit treated as death benefit.
(d) Qualified accelerated death benefit.
(1) In general.
(2) Determination of present value of the reduction in death benefit.
(3) Examples.
(e) Terminally ill defined.
(f) Certain other additional benefits.
(1) In general.
(2) Examples.
(g) Adjustments under section 7702(f)(7).
(h) Cash surrender value.
(1) In general.
(2) For purposes of section 7702(f)(7).

(i) Net surrender value.

(j) Effective date and special rules.

(1) In general.

(2) Provision of certain benefits before July 1, 1993.

(i) Not treated as cash value.

(ii) No effect on date of issuance.

(iii) Special rule for addition of benefit or loan provision after December 15, 1992.

(3) Addition of qualified accelerated death benefit.

(4) Addition of other additional benefits.

Par. 3. Section 1.7702–2 is added to read as follows:

§1.7702–2 Attained age of the insured under a life insurance contract.

(a) *In general.* This section provides guidance on determining the attained age of an insured under a contract that is a life insurance contract under the applicable law, for purposes of determining the guideline level premium of the contract under section 7702(c)(4), applying the cash value corridor of section 7702(d) or applying the computational rules of section 7702(e), as applicable.

(b) *Contract insuring a single life.* (1) If a contract insures the life of a single individual, either of the following two ages may be treated as the attained age of the insured with respect to that contract—

(i) The insured's age determined by reference to the individual's actual birthday as of the date of determination (actual age); or

(ii) The insured's age determined by reference to contract anniversary (rather than the individual's actual birthday), so long as the age assumed under the contract (contract age) is within 12 months of the actual age as of that date.

(2) Once determined under paragraph (b)(1) of this section, the attained age with respect to an individual insured under a contract changes annually. Moreover, the same attained age must be used for purposes of applying sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

(c) *Contract insuring multiple lives on a last-to-die basis*—(1) *In general.* Except as provided in paragraph (c)(2) of this section, if a contract insures the lives of more than one individual on a last-to-die basis, the attained age of the insured is determined by applying paragraph (b) of this section as if the youngest individual were the only insured under the contract for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

(2) *Modifications to cash value and future mortality charges upon the death of insured.* If both the cash value and future mortality charges under a contract change by reason of the death of one or more insureds to no longer take into account the attained age of the deceased insured or insureds, the youngest surviving insured shall thereafter be treated as the only insured under the contract.

(d) *Contract insuring multiple lives on a first-to-die basis.* If a contract insures the lives of more than one individual on a first-to-die basis, the attained age of the insured is determined by applying paragraph (b) of this section as if the oldest individual were the only insured under the contract for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

(e) *Examples.* The following examples illustrate the determination of the attained age of the insured for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable. The examples are as follows:

Example 1. (i) X was born on May 1, 1947. X became 60 years old on May 1, 2007. On January 1, 2008, X purchases from IC a contract insuring X's life. January 1 is the contract anniversary date for all future years. IC determines X's annual premiums on an age-last-birthday basis. Based on the method used by IC to determine age, X has an attained age of 60 for the first contract year, 61 for the second contract year, and so on.

(ii) Section 1.7702–2(b)(1) permits the determination of attained age under either of two alternative approaches. Section 1.7702–2(b)(1)(i) provides that, if a contract insures the life of a single insured individual, the attained age may be determined by reference to the individual's actual birthday as of the date of determination. Under this provision, X has an attained age of 60 for the first contract year, 61 for the second contract year, and so on. Alternatively, §1.7702–2(b)(1)(ii) provides that the insured's age may be determined by reference to contract anniversary (rather than the individual's actual birthday), so long as the age assumed under the contract is within 12 months of the actual age as of that date. If IC determines X's attained age under §1.7702–2(b)(1)(ii), X likewise has an attained age of 60 for the first contract year, 61 for the second contract year, and so on. Whichever provision IC uses to determine X's attained age must be used consistently from year to year for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

Example 2. (i) The facts are the same as in *Example 1* except that, under the contract, X's annual premiums are determined on an age-nearest-birthday basis. X's nearest birthday to January 1, 2008, is May 1, 2008, when X will become 61 years old. Based on the method used by IC to determine age, X has an attained age of 61 for the first contract year, 62 for the second contract year, and so on.

(ii) Section 1.7702–2(b)(1) permits the determination of attained age under either of two alternative approaches. Section 1.7702–2(b)(1)(i) provides that, if a contract insures the life of a single insured individual, the attained age may be determined by reference to the individual's actual birthday as of the date of determination. Under this provision, X has an attained age of 60 for the first contract year, 61 for the second contract year, and so on. Alternatively, §1.7702–2(b)(1)(ii) provides that the insured's age may be determined by reference to contract anniversary (rather than the individual's actual birthday), so long as the age assumed under the contract is within 12 months of the actual age as of that date. If IC determines X's attained age under §1.7702–2(b)(1)(ii), X has an attained age of 61 for the first contract year, 62 for the second contract year, and so on. Whichever provision IC uses to determine X's attained age must be used consistently from year to year for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

Example 3. (i) The facts are the same as in *Example 1* except that the face amount of the contract is increased on May 15, 2011. During the contract year beginning January 1, 2011, the age assumed under the contract on an age-last-birthday basis is 63 years. However, X has an actual age of 64 as of the date the face amount of the contract is increased.

(ii) Section 1.7702–2(b)(1)(ii) provides that the insured's age may be determined by reference to contract anniversary (rather than the individual's actual birthday), so long as the age assumed under the contract is within 12 months of the actual age. Section 1.7702–2(b)(2) provides that, once determined under paragraph (b)(1) of this section, the attained age with respect to an individual insured under a contract changes annually. Accordingly, X continues to be 63 years old throughout the contract year beginning January 1, 2011, for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

Example 4. (i) The facts are the same as in *Example 1* except that in addition to X (born in 1947), the insurance contract also insures the life of Y, born on September 1, 1942. The death benefit will be paid when the second of the two insureds dies.

(ii) Section 1.7702–2(c)(1) provides that if a life insurance contract insures the lives of more than one individual on a last-to-die basis, the attained age of the insured is determined by applying §1.7702–2(b) as if the youngest individual were the only insured under the contract. Because X is younger than Y, the attained age of X must be used for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

Example 5. (i) The facts are the same as *Example 4* except that X (the younger of the two insureds) dies in 2012. After X's death, both the cash value and mortality charges of the life insurance contract are adjusted to take into account only the life of Y.

(ii) Section 1.7702–2(c)(1) provides that if a life insurance contract insures the lives of more than one individual on a last-to-die basis, the attained age of the insured is determined by applying §1.7702–2(b) as if the youngest individual were the only insured under the contract. Paragraph (c)(2) of this section provides that if both the cash value and future mortality charges under a contract change by reason of the death of an insured to no longer take into account

the attained age of the deceased insured, the youngest surviving insured is thereafter treated as the only insured under the contract. Because both the cash value and mortality charges are adjusted after X's death to take into account only the life of Y, only the attained age of Y is taken into account after X's death for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

Example 6. (i) The facts are the same as *Example 1* except that in addition to X (born in 1947), the insurance contract also insures the life of Z, born on September 1, 1952. The death benefit will be paid when the first of the two insureds dies.

(ii) Section 1.7702–2(d) provides that if a life insurance contract insures the lives of more than one individual on a first-to-die basis, the attained age of the insured is determined by applying §1.7702–2(b) as if the oldest individual were the only insured under the contract. Because X is older than Z, the attained age of X must be used for purposes of sections 7702(c)(4), 7702(d), and 7702(e), as applicable.

(f) *Effective dates*—(1) *In general.* Except as provided in paragraph (f)(2) of this section, these regulations apply to all life insurance contracts that are either—

(i) Issued after December 31, 2008; or

(ii) Issued on or after October 1, 2007, and based upon the 2001 CSO tables.

(2) *Contracts issued before the general effective date.* Pursuant to section 7805(b)(7), a taxpayer may apply these regulations retroactively for contracts issued before October 1, 2007, provided that the taxpayer does not later determine qualification of those contracts in a manner that is inconsistent with these regulations.

Deborah M. Nolan,
Acting Deputy Commissioner for Services and Enforcement.

Approved September 6, 2006.

Eric Solomon,
Acting Deputy Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on September 12, 2006, 8:45 a.m., and published in the issue of the Federal Register for September 13, 2006, 71 F.R. 53967)

Appendix B — Notice 2006-95

Part III. Administrative, Procedural, and Miscellaneous

Guidance Concerning Use of 2001 CSO Tables Under Section 7702

Notice 2006–95

SECTION 1. PURPOSE

This notice provides rules interpreting the reasonable mortality charge requirement contained in § 7702(c)(3)(B)(i) of the Internal Revenue Code. Specifically, this notice supplements Notice 88–128, 1988–2 C.B. 540, and modifies and supersedes Notice 2004–61, 2004–2 C.B. 596, by providing safe harbors regarding the use by taxpayers of either the 1980 Commissioners' Standard Ordinary mortality and morbidity tables (1980 CSO tables) or the 2001 Commissioners' Standard Ordinary mortality and morbidity tables (2001 CSO tables) to determine whether mortality charges are reasonable. These safe harbors are designed to assist taxpayers in complying with the requirements of § 7702(c)(3)(B)(i).

SECTION 2. BACKGROUND

Section 7702 of the Code defines the term "life insurance contract" for purposes of the Code. Section 7702(a) provides that a "life insurance contract" is any contract that is a life insurance contract under the applicable law, but only if such contract either (1) meets the cash value accumulation test of § 7702(b), or (2) both meets the guideline premium requirements of § 7702(c) and falls within the cash value corridor of § 7702(d).

Section 7702(c)(3)(B)(i) provides that the guideline single premium under § 7702(c) is determined on the basis of reasonable mortality charges that meet the requirements (if any) prescribed in regulations and that (except as provided in regulations) do not exceed the mortality charges specified in the prevailing commissioners' standard tables (as defined in § 807(d)(5)) as of the time the contract is issued. The mortality charges specified in § 7702(c)(3)(B)(i) are also used for determining the "net single premium" (*see* § 7702(b)(2)(B)), and the "guideline level premium" (*see* § 7702(c)(4)). The same reasonable mortality charge standard applies for purposes of determining whether a life insurance contract is a modified endowment contract under § 7702A (*see* § 7702A(c)(1)(B)).

Section 807(d)(5)(A) provides that the term "prevailing commissioners' standard tables" means, with respect to any contract, the most recent commissioners' standard tables prescribed by the National Association of Insurance Commissioners (NAIC) that are permitted to be used in computing reserves for that type of contract under the insurance laws of at least 26 states when the contract was issued. Section 807(d)(5)(B) provides a 3-year transition period during which an insurer may use either the newly prevailing CSO tables or those that were previously prevailing.

The 2001 CSO tables prescribed by the NAIC became the prevailing commissioners' standard tables within the meaning of § 807(d)(5) during calendar year 2004, and have now been adopted by all 50 states. The 1980 CSO tables may still be used in all states for contracts issued in calendar years through 2008. For contracts issued after 2008, use of the 2001 CSO tables will be mandatory.

Notice 88–128 was issued after § 7702 was amended to require that only "reasonable" mortality charges be taken into account for purposes of testing life insurance contract qualification under § 7702. Under Notice 88–128, interim safe harbors provided that the 1980 CSO tables (and, for certain previously issued contracts, the 1958 CSO tables) would satisfy the requirement that mortality charges be "reasonable" under § 7702(c)(3)(B)(i). Notice 2004–61 supplemented Notice 88–128 by providing additional safe harbors to account for the promulgation of the 2001 CSO tables. Neither Notice 88–128, Notice 2004–61, nor this notice addresses the reasonable mortality charge requirement in the case of substandard risk underwriting. *See* the Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100–647 (1988 Act), § 5011(c)(2).

SECTION 3. PUBLIC COMMENTS AND MODIFICATIONS TO NOTICE 2004–61

Notice 2004–61 requested comments on the need for additional guidance on the adoption of the 2001 CSO tables. This notice modifies Notice 2004–61 in response to the comments that were received. First, the safe harbor for contracts issued based on the 1980 CSO tables (1980 CSO contracts) is modified to remove the requirement in Notice 2004–61 that mortality charges used to determine whether a contract qualifies as a life insurance contract under § 7702 not exceed the mortality charge specified in the contract at issuance. Second, the new rules for gender- or smoker-based tables are modified to apply only to contracts issued based upon the 2001 CSO tables (2001 CSO contracts). These two changes help to ensure that the notice does not subject 1980 CSO contracts to more stringent standards, retroactively, than applied under Notice 88–128. Third, the rule for determining the issue date of a contract that undergoes an increase or decrease in death benefit is simplified by eliminating the concept of "underwriting." This change broadens the grandfather rule of Notice 2004–61 to encompass many routine transactions, but does not wholly defer to an issuer's administrative practices and procedures. Fourth, additional examples are provided of changes, modifications, or exercises of contractual provisions that will not require a change from previous tables to the 2001 CSO tables. Except as described above, this notice does not modify the definition of "issue date" that was provided in Notice 2004–61.

SECTION 4. SAFE HARBORS UNDER SECTION 7702

The following safe harbors apply for purposes of determining reasonable mortality charges under § 7702:

.01 *Notice 88–128.* The interim rules described in Notice 88–128 remain in effect, except as otherwise modified by this notice.

.02 *1980 CSO tables.* A mortality charge with respect to a life insurance contract will satisfy the requirements of

§ 7702(c)(3)(B)(i) so long as (1) the mortality charge does not exceed 100 percent of the applicable mortality charge set forth in the 1980 CSO tables; (2) the contract is issued in a state that permits or requires the use of the 1980 CSO tables at the time the contract is issued; and (3) the contract is issued before January 1, 2009.

.03 *2001 CSO tables.* A mortality charge with respect to a life insurance contract will satisfy the requirements of § 7702(c)(3)(B)(i) so long as (1) the mortality charge does not exceed 100 percent of the applicable mortality charge set forth in the 2001 CSO tables; (2) the mortality charge does not exceed the mortality charge specified in the contract at issuance; and (3) either (a) the contract is issued after December 31, 2008, or (b) the contract is issued before January 1, 2009, in a state that permits or requires the use of the 2001 CSO tables at the time the contract is issued.

SECTION 5. ISSUE DATE OF CONTRACTS

.01 For purposes of this notice, the date on which a contract was issued generally is to be determined according to the standards that applied for purposes of the original effective date of § 7702. *See* H.R. Conf. Rep. No. 861, 98th Cong., 2d Sess. 1076 (1984), 1984–3 (Vol. 2) C.B. 330; *see also* 1 Staff of Senate Comm. on Finance, 98th Cong., 2d Sess., *Deficit Reduction Act of 1984, Explanation of Provisions Approved by the Committee on March 21, 1984*, at 579 (Comm. Print 1984). Thus, contracts received in exchange for existing contracts are to be considered new contracts issued on the date of the exchange. For these purposes, a change in an existing contract is not considered to result in an exchange if the terms of the resulting contract (that is, the amount and pattern of death benefit, the premium pattern, the rate or rates guaranteed on issuance of the contract, and mortality and expense charges) are the same as the terms of the contract prior to the change.

.02 Notwithstanding section 5.01, if a life insurance contract satisfied section 4.01 or 4.02 when originally issued, a change from previous tables to the 2001 CSO tables is not required if (1) the change, modification, or exercise of a right to modify, add or delete benefits is pursuant to the terms of the contract; (2) the state in which the contract is issued does not require use of the 2001 CSO tables for that contract under its standard valuation and minimum nonforfeiture laws; and (3) the contract continues upon the same policy form or blank.

.03 The changes, modifications, or exercises of contractual provisions referred to in section 5.02 include (1) the addition or removal of a rider; (2) the addition or removal of a qualified additional benefit (QAB); (3) an increase or decrease in death benefit (whether or not the change is underwritten); (4) a change in death benefit option (such as a change from an option 1 to option 2 contract or vice versa); (5) reinstatement of a policy within 90 days after its lapse; and (6) reconsideration of ratings based on rated condition, lifestyle or activity (such as a change from smoker to nonsmoker status).

SECTION 6. RULES FOR GENDER- OR SMOKER-BASED TABLES

For purposes of section 4.03 (the 2001 CSO safe harbor), mortality charges that do not exceed the applicable charges in gender- or smoker-based variations of the 2001 CSO tables will be treated as reasonable mortality charges, provided the following requirements are satisfied:

.01 *Unisex tables.* If a state permits minimum nonforfeiture values for all contracts issued under a plan of insurance to be determined using the 2001 CSO Gender-Blended Mortality tables ("unisex tables"), then the applicable mortality charges in those tables are treated as reasonable mortality charges for female insureds provided the same tables are used to determine mortality charges for male insureds.

.02 *Smoker/nonsmoker tables.* If a state permits minimum nonforfeiture values for all contracts issued under a plan of insurance to be determined using the 2001 CSO Smoker and Nonsmoker Mortality tables ("smoker/nonsmoker tables"), then the applicable mortality charges in those tables for smoker insureds are treated as reasonable mortality charges provided nonsmoker tables are used to determine nonsmoker mortality charges.

SECTION 7. EFFECT UPON OTHER PUBLICATIONS

This notice supplements Notice 88–128 and modifies and supersedes Notice 2004–61.

SECTION 8. EFFECTIVE DATE

This notice is effective October 12, 2006, except that the provisions of this notice will not be applied adversely to taxpayers who issued, changed or modified contracts in compliance with Notice 2004–61 (without regard to the modifications made by this notice).

SECTION 9. PROCEDURAL INFORMATION

This notice serves as an "administrative pronouncement" as that term is described in § 1.6661–3(b)(2) of the regulations and may be relied upon to the same extent as a revenue ruling or a revenue procedure.

DRAFTING INFORMATION

The principal author of this notice is Ann H. Logan of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this notice, contact Ann H. Logan at (202) 622–3970 (not a toll-free call).

---

26 CFR 601.204: Changes in accounting periods and in methods of accounting.
(Also Part 1, §§ 168, 446, 1400L; 1.168(k)–1, 1.1400L(b)–1.)

Rev. Proc. 2006–43

SECTION 1. PURPOSE

This revenue procedure provides the exclusive administrative procedures under which a taxpayer described in section 3 of this revenue procedure may obtain automatic consent to change its method of accounting to comply with § 1.168(k)–1 or § 1.1400L(b)–1 of the Income Tax Regulations (the "final regulations").

SECTION 2. BACKGROUND

.01 On August 31, 2006, the Internal Revenue Service and Treasury Department published the final regulations in the Federal Register (T.D. 9283, 2006–41 I.R.B.

Appendix C — Revenue Ruling 2005-6

Section 7702.—Life Insurance Contract Defined

(Also § 7702A.)

Life insurance contracts. For purposes of determining whether a contract qualifies as a life insurance contract under section 7702 of the Code, and as a modified endowment contract under section 7702A, charges for qualified additional benefits (QABs) are to be taken into account under the expense charge rule of section 7702(c)(3)(B)(ii) rather than under the mortality charge rule of section 7702(c)(3)(B)(i). Issuers whose compliance systems do not currently account for QABs under the expense charge rule of section 7702(c)(3)(B)(ii) are provided alternatives to correct their compliance systems.

Rev. Rul. 2005–6

ISSUE

For purposes of determining whether a contract qualifies as a life insurance contract under § 7702 of the Internal Revenue Code and as a modified endowment contract under § 7702A, should charges for qualified additional benefits (QABs) be taken into account under the mortality charge rule of § 7702(c)(3)(B)(i) or the expense charge rule of § 7702(c)(3)(B)(ii)?

FACTS

IC is a life insurance company organized and licensed to do business in State. In Year, IC issued a Policy in State with a Rider that provides term life insurance coverage on the life of a family member of the individual insured by the Policy. The Policy is a life insurance contract under the law of State and was designed to qualify as a life insurance contract under § 7702 by meeting the guideline premium requirements of § 7702(c) and falling within the cash value corridor of § 7702(d). IC imposes a charge for the mortality risk that it assumed pursuant to the Rider and subtracts this charge monthly from the Policy's cash value.

LAW AND ANALYSIS

Section 7702(a) provides that, for a contract to qualify as a life insurance contract for Federal income tax purposes, the contract must be a life insurance contract under the applicable law and must either (1) satisfy the cash value accumulation test of § 7702(b), or (2) both meet the guideline premium requirements of § 7702(c) and fall within the cash value corridor of § 7702(d).

A contract meets the guideline premium requirements of § 7702(c) if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of that time. The guideline premium limitation as of any date is the greater of (A) the guideline single premium, or (B) the sum of the guideline level premiums to that date. The guideline single premium is the premium that would be required on the date the contract is issued to fund the future benefits under the contract, based on the follow-

ing three elements enumerated in section 7702(c)(3)(B):

(i) reasonable mortality charges that meet the requirements (if any) prescribed in regulations and that (except as provided in regulations) do not exceed the mortality charges specified in the prevailing commissioners' standard tables (as defined in section 807(d)(5)) as of the time the contract is issued;

(ii) any reasonable charges (other than mortality charges) that (on the basis of the company's experience, if any, with respect to similar contracts) are reasonably expected to be actually paid; and

(iii) interest at the greater of an annual effective rate of six percent or the rate or rates guaranteed on issuance of the contract.

The guideline level premium is the level annual amount, payable over a period not ending before the insured attains age 95, computed on the same basis but using a minimum interest rate of four percent, rather than six percent.

A contract meets the cash value accumulation test of § 7702(b) if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at that time to fund future benefits under the contract. This determination is made, in part, on the basis of the mortality charge rule of § 7702(c)(3)(B)(i) and, in the case of QABs, the expense charge rule of § 7702(c)(3)(B)(ii).

Section 7702(f)(4) defines the term "future benefits" to mean death benefits and endowment benefits. Section 7702(f)(5)(A)(iii) characterizes family term riders as QABs. Section 7702(f)(5)(B) provides that QABs are not treated as future benefits under the contract, but the charges for such benefits are treated as future benefits. Accordingly, charges for the Rider should be accounted for as future benefits under the Policy.

Under the mortality charge rule of § 7702(c)(3)(b)(i), reasonable mortality charges are taken into account if they meet the requirements (if any) prescribed in regulations and do not exceed the mortality charges specified in the prevailing commissioners' standard tables as of the time the contract is issued. There is no requirement that the charges taken into account be charges that are expected to be paid. In contrast, under the expense charge rule of § 7702(c)(3)(B)(ii), reasonable charges other than mortality charges are taken into account only if they are reasonably expected to be actually paid. For this reason, accounting for charges for the Rider under the mortality charge rule, rather than the expense charge rule, would in some cases produce a higher net single premium and higher guideline level premiums for purposes of testing a contract's compliance with § 7702.

Section 7702A defines a modified endowment contract (MEC) generally as a contract that meets the requirement of § 7702 but fails to meet the 7-pay test set forth in § 7702A(b) (or that is received in exchange for a contract that is otherwise a MEC). Under § 7702A(b), a contract fails to meet the 7-pay test if the accumulated amount paid under the contract at any time during the first seven contract years exceeds the sum of the net level premiums that would have been paid on or before that time if the contract provided for paid-up future benefits after the payment of seven level annual premiums. For this purpose, § 7702A(c)(1) provides that determinations under the 7-pay test are made by applying the cash value accumulation test rules of § 7702(b)(2). Under that provision, charges for QABs are accounted for under the expense charge rule of § 7702(c)(3)(B)(ii).

Section 7702 is silent on the treatment of charges for QABs for purposes of determining whether a contract satisfies the guideline premium requirements. Under § 7702(b)(2)(B), however, charges for QABs are subject to the expense charge rule of § 7702(c)(3)(B)(ii) for purposes of determining whether a contract satisfies the cash value accumulation test. The same rule applies under § 7702A(c)(1) for purposes of determining whether a contract satisfies the 7-pay test and therefore is not a MEC. There is no indication that Congress intended charges for QABs to be accounted for under one rule for purposes of the cash value accumulation test of § 7702(b) and the 7-pay test of § 7702A(b), and under a different rule for purposes of the guideline premium requirements of § 7702(c). Moreover, there is no indication that Congress intended to take into account charges with respect to QABs that exceed amounts reasonably expected to be actually paid. Accordingly, charges taken into account with respect to QABs are subject to the expense charge rule of § 7702(c)(3)(B)(ii) for purposes of the guideline premium requirements.

HOLDING

Charges for QABs should be taken into account under the expense charge rule of § 7702(c)(3)(B)(ii) for purposes of determining whether a contract qualifies as a life insurance contract under § 7702 or as a MEC under § 7702A.

EFFECTIVE DATE

This revenue ruling is effective February 7, 2005.

APPLICATION

The following alternatives are available to issuers whose compliance systems do not currently account for charges for QABs under the expense charge rule of § 7702(c)(3)(B)(ii):

A. If an issuer's compliance system does not properly account for charges for QABs but no contracts have failed to satisfy the requirements of § 7702(a) as a result of the system's deficiency, the issuer may correct its compliance system to account for those charges using the expense charge rule without contacting the Service.

B. If an issuer's compliance system does not properly account for charges for QABs and, as a result, some life insurance contracts do not meet the definition of life insurance contract under § 7702(a), the issuer may request a closing agreement on or before February 7, 2006, under the procedures set forth in Rev. Proc. 2005–1, 2005–1 I.R.B. 1. In addition to the modifications to the ruling process provided by Rev. Proc. 2001–42, 2001–2 C.B. 212 (concerning inadvertent MECs), and Rev. Rul. 91–17, 1991–1 C.B. 190, as supplemented by Notice 99–48, 1999–2 C.B. 429 (concerning failures under § 7702(a)), the following modifications will apply to a closing agreement requested under this revenue ruling:

1. the issuer must identify all contracts administered under the compliance system, but need not identify which contracts fail to meet the requirements of § 7702(a) or are inadvertent MECs under § 7702A;
2. the contracts identified in the closing agreement will not be treated as fail-

ing the requirements of § 7702(a) or as MECs under § 7702A by reason of improperly accounting for charges for existing QABs, including future charges resulting from an increase in an existing QAB or the addition of a new QAB pursuant to the exercise of a right that existed in the contract before April 8, 2005; relief under the closing agreement will not extend to improper accounting for charges for an increase in an existing QAB or the addition of a new QAB that are not pursuant to the exercise of a right that existed in the contract before that date;

3. no corrective action need be taken with respect to the compliance system or with respect to contracts identified in the closing agreement;

4. in lieu of an amount based on the tax and interest that would have been owed by the policyholders if they were treated as receiving the income on the contract, the amount due under the closing agreement will be based on the aggregate number of contracts for which relief is requested, as set forth in the following schedule:

Number of Contracts	Amount due
20 or fewer	$1,500.00
21 to 50	$2,000.00
51 to 100	$5,000.00
101 to 500	$10,000.00
501 to 1,000	$16,000.00
1,001 to 5,000	$30,000.00
5,001 to 10,000	$40,000.00
Over 10,000	$50,000.00

5. the request for a closing agreement must be submitted to the appropriate address and with the appropriate user fee set forth in Rev. Proc. 2005–1; in addition, the closing agreement should reflect the following address for mailing the closing agreement and amount due, after the closing agreement has been executed by the Service: Internal Revenue Service, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

C. After February 7, 2006, an issuer whose compliance system does not properly account for charges for QABs may request a closing agreement under the terms and conditions set forth above, except that (1) the closing agreement must identify the contracts that fail to meet the requirements of § 7702(a) or are inadvertent MECs under § 7702A; and (2) the closing agreement must require the issuer to correct its compliance system and to bring the identified contracts into compliance with § 7702(a) or § 7702A, as appropriate.

DRAFTING INFORMATION

The principal author of this revenue ruling is Melissa S. Luxner of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this revenue ruling, contact Melissa S. Luxner at (202) 622–3970 (not a toll-free call).

Appendix D — Remediation Revenue Procedures

SECTION 8. DRAFTING INFORMATION

The principal authors of the revenue procedure are Christopher C. Woodin, Tax Exempt Bonds, Compliance and Program Management, and Timothy L. Jones, Office of Chief Counsel (Financial Institutions and Products), Internal Revenue Service. For further information regarding this revenue procedure, contact Mr. Woodin at 202–283–9780 or Mr. Jones at 202–622–3980 (not toll-free numbers).

---

26 CFR 301.7121–1: Closing agreements.
(Also Part I, §§ 7702, 7702A.)

Rev. Proc. 2008–38

SECTION 1. PURPOSE

This revenue procedure provides a procedure by which an issuer of a life insurance contract may remedy a failure to account for charges for qualified additional benefits (QABs) under the expense charge rule of § 7702(c)(3)(B)(ii) of the Internal Revenue Code. Rev. Rul. 2005–6, 2005–1 C.B. 471, is amplified.

SECTION 2. BACKGROUND

.01 *Definition of a life insurance contract.*

(1) Section 7702(a) provides that, for a contract to qualify as a life insurance contract for Federal income tax purposes, the contract must be a life insurance contract under the applicable law and must either—

(a) satisfy the cash value accumulation test of § 7702(b), or

(b) both meet the guideline premium requirements of § 7702(c) and fall within the cash value corridor of § 7702(d).

(2) A contract meets the cash value accumulation test of § 7702(b) if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at that time to fund future benefits under the contract.

(3) A contract meets the guideline premium requirements of § 7702(c) if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of that time. The guideline premium limitation as of any date is the greater of the guideline single premium, or the sum of the guideline level premiums to that date. The guideline single premium is the premium that would be required on the date the contract is issued to fund the future benefits under the contract.

(4) A contract falls within the cash value corridor of § 7702(d) if the death benefit under the contract at any time is not less than the applicable percentage of the cash surrender value, based on the table set forth in § 7702(d)(2).

(5) Section 7702 is effective for contracts issued after December 31, 1984, in tax years ending after that date.

.02 *Definition of a modified endowment contract (MEC).*

(1) Section 7702A(a) provides that a life insurance contract is a MEC if the contract—

(a) is entered into on or after June 21, 1988, and fails to meet the 7-pay test of § 7702A(b), or

(b) is received in exchange for a contract described in paragraph (a) of this section 2.02(1).

(2) A contract fails to meet the 7-pay test if the accumulated amount paid under the contract at any time during the first 7 contract years exceeds the sum of the net level premiums that would have to be paid on or before such time if the contract were to provide for paid-up future benefits after the payment of 7 level annual premiums.

(3) Section 72(e)(12) provides that, for purposes of determining amounts includible in gross income, all MECs issued by the same company to the same contract holder during any calendar year are treated as one MEC.

.03 *Accounting for charges for QABs.* Section 7702(f)(5) identifies five categories of benefits as QABs: guaranteed insurability; accidental death or disability benefit; family term coverage; disability waiver benefit; or other benefits prescribed under regulations. These benefits are not treated as future benefits under the contract, but charges for the benefits are treated as future benefits. For purposes of the cash value accumulation test of § 7702(b), § 7702(b)(2)(B) requires that charges for QABs be accounted for using the expense charge rule of § 7702(c)(3)(B)(ii), rather than the mortality charge rule of § 7702(c)(3)(B)(i). Section 7702A(c)(1) requires that the same rule be used for purposes of the 7-pay test as well. Although § 7702 is silent on the treatment of charges for QABs for purposes of applying the guideline premium requirements, Rev. Rul. 2005–6 concludes that charges for such benefits are to be taken into account under the expense charge rule of § 7702(c)(3)(B)(ii) for that purpose as well.

.04 *Authority to enter into closing agreements.* Under § 7121, the Secretary is authorized to enter into an agreement in writing with any person relating to the liability of such person (or of the person or estate for whom he acts) in respect of any internal revenue tax for any period. Such agreement is generally final and conclusive, except upon a showing of fraud, malfeasance, or misrepresentation of a material fact.

.05 *Correction procedure for QABs.* Rev. Rul. 2005–6 sets forth three alternatives for issuers whose compliance systems do not currently account for charges for QABs under the expense charge rule of § 7702(c)(3)(B)(ii):

(1) Alternative A provides that, if an issuer's compliance system does not properly account for charges for QABs but no contracts have failed to satisfy the requirements of § 7702(a) as a result of the system's deficiency, the issuer may correct its compliance system to account for those charges using the expense charge rule without contacting the Internal Revenue Service (Service).

(2) Alternative B provides a correction procedure for closing agreements that were requested on or before February 7, 2006.

(3) Alternative C provides that an issuer whose compliance system does not properly account for charges for QABs may request a closing agreement under terms and conditions that are enumerated in Rev. Rul. 2005–6.

.06 *Changes to correction procedure.* In Notice 2007–15, 2007–1 C.B. 503, the Service requested comments as to how various correction procedures — including those for improper accounting for charges for QABs under Rev. Rul. 2005–6 — may be improved. This revenue procedure incorporates a number of changes that taxpayers suggested in response to Notice 2007–15. Most significantly, this revenue procedure sets forth a model closing agree-

ment and explains in more detail the terms and conditions that apply under Alternative C of Rev. Rul. 2005–6.

SECTION 3. SCOPE

This revenue procedure applies to any issuer of one or more contracts that failed to meet the definition of a life insurance contract under § 7702(a) or to meet the requirements of § 7702A by reason of a compliance system that does not account for charges for QABs under the expense charge rule of § 7702(c)(3)(B)(ii). For this purpose, the term "issuer" means any company that issues a contract that is intended to satisfy the definition of a life insurance contract under § 7702. The term also includes a company that insures a contract holder under a contract originally issued by another company.

SECTION 4. PROCEDURE

.01 *Request for a ruling.* An issuer that seeks relief under this revenue procedure must submit a request for a ruling that meets the requirements of Rev. Proc. 2008–1, 2008–1 I.R.B. 1 (or any successor). Additionally, the submission must contain an exhibit setting forth the policy number for each contract for which relief is requested.

.02 *Closing Agreement.* The issuer also must submit a proposed closing agreement, in triplicate, executed by the issuer, in the same form as the model closing agreement in section 5 of this revenue procedure. The amount shown in Section 1(A) of the proposed closing agreement is the amount required to be paid (determined under section 4.03 of this revenue procedure) for all of the contracts covered by the agreement.

.03 *Determination of amount required to be paid.* The amount required to be paid is based on the aggregate number of contracts for which relief is requested, as set forth in the following schedule:

Number of Contracts	Amount Due
20 or fewer	$1,500.00
21 to 50	$2,000.00
51 to 100	$5,000.00
101 to 500	$10,000.00
501 to 1,000	$16,000.00
1,001 to 5,000	$30,000.00
5,001 to 10,000	$40,000.00
Over 10,000	$50,000.00

.04 *Payment of amount.* The issuer is required to pay the amount determined under section 4.03 of this revenue procedure within 60 days of the date of execution of the closing agreement by the Service. Payment shall be made by check payable to the "United States Treasury" delivered, together with a fully executed copy of the closing agreement, to Internal Revenue Service, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

.05 *Correction of contracts and compliance system.* With respect to each contract that is in force on the effective date of the closing agreement, the issuer must bring the contract into compliance with § 7702 (or § 7702A, as applicable), either by increasing the contract's death benefit or returning the contract's excess premiums and earnings thereon to the contract holder. The issuer also must correct its compliance system to account properly for charges for QABs as provided in Rev. Rul. 2005–6. The issuer must take the corrective action required under this section 4.05 within 90 days of the date of execution of the closing agreement by the Service.

.06 *Representations.* The submission must include representations to the effect that the issuer is within the scope of section 3 of this revenue procedure and that the amount due to the Service under the closing agreement is computed correctly under section 4.03. The representations must be executed under penalties of perjury by an appropriate party (as set forth in section 7.01 of Rev. Proc. 2008–1 (or its successor)). The issuer must retain documentation available for audit to support the representations.

.07 *Electronic Submissions.* The exhibit required under section 4.01 of this revenue procedure may be submitted to the Service electronically, in read-only format, on a CD-ROM. Adobe Portable Document format is a suitable format. Other formats may be arranged on a case-by-case basis. The issuer must provide a total of three CD-ROMs, one for each of the three copies of the closing agreement. *See* Notice 2005–35, 2005–1 C.B. 1087.

SECTION 5. MODEL CLOSING AGREEMENT

Effective as of date executed by Internal
Revenue Service _____

CLOSING AGREEMENT AS TO FINAL DETERMINATION
COVERING SPECIFIC MATTERS
UNDER REV. PROC. 2008–38

THIS CLOSING AGREEMENT ("Agreement") is made pursuant to § 7121 of the Internal Revenue Code (the "Code") by and between ***[Insert Taxpayer name, address and EIN]*** ("Taxpayer") and the Commissioner of Internal Revenue (the "Service").

WHEREAS,

A. Taxpayer is the issuer of one or more contracts that were intended to qualify as life insurance contracts under § 7702 ***[;that were not intended to be treated as modified endowment contracts under § 7702A;]*** and that provided qualified additional benefits (QABs) within the meaning of § 7702(f)(5).

B. Pursuant to Rev. Proc. 2008–38, 2008–29 I.R.B. 139, the Service under certain circumstances will waive civil penalties for failure of a taxpayer to satisfy the reporting, withholding and/or deposit requirements for income received or deemed received under § 7702(g).

C. By letter dated ***[Insert date]***,Taxpayer submitted to the Service, pursuant to Rev. Proc. 2008–1, 2008–1 I.R.B.1 ***[or successor Rev. Proc., if applicable]***, a request for this Agreement covering ***[Insert number]*** life insurance contracts identified in Exhibit A attached to this Agreement (the "Contracts").

D. Taxpayer intended that each of the Contracts meet the definition of a life insurance contract under § 7702 ***[and not be a modified endowment contract under § 7702A]***. Taxpayer, however, maintained a compliance system for the contracts that did not account properly for charges for qualified additional benefits (QABs) under § 7702(c)(3)(B)(ii). As a result, the Contracts identified in Exhibit A failed to satisfy the requirements of § 7702 or § 7702A.

E. Taxpayer represents that the errors described in D above qualify the Taxpayer for the remedy described in Rev. Proc. 2008–38.

F. Taxpayer represents that the amount determined under section 4.03 of Rev. Proc. 2008–38 is $ ***[Insert amount]***. Taxpayer represents that this amount has been computed correctly under the provisions of Rev. Proc. 2008–38.

G. Taxpayer represents that it has corrected its compliance system, or will correct the compliance system within the time limit prescribed in Section 1(F), to account properly for charges for QABs.

H. To ensure that the Contracts satisfy the requirements of § 7702 ***[and § 7702A, if applicable]***, Taxpayer and the Service have entered into this Agreement.

NOW THEREFORE IT IS HEREBY FURTHER DETERMINED AND AGREED BETWEEN TAXPAYER AND THE SERVICE AS FOLLOWS:

1. In consideration for the agreement of the Service as set forth in Section 2 below, Taxpayer agrees as follows:

   (A) To pay the Service the amount of $ ***[Insert amount]*** at the time and in the manner described in Section 3 below.

   (B) The amount paid pursuant to Section 1(A) above is not deductible, nor is such amount refundable, subject to credit or offset, or otherwise recoverable from the Service.

   (C) For purposes of Taxpayer's complying with its reporting and withholding obligations under the Code,

      (i) neither the investment in the contract for purposes of § 72, nor the premiums paid for purposes of § 7702, on any Contract can be increased by any portion of the amount set forth in Section 1(A) above. If any such increases are made, they are entitled to no effect.

      (ii) neither the investment in the contract for purposes of § 72, nor the premiums paid, for purposes of § 7702, on any Contract can be increased by any portion of the amount which Taxpayer represents to be the income on the contract for all of the Contracts in the aggregate. If any such increases are made, they are entitled to no effect.

   (D) With respect to each Contract that is in force on the effective date of this Agreement, to the extent necessary in order to bring such Contract into compliance with § 7702 ***[and § 7702A, if applicable]***:

      (i) If the sum of the premiums paid as of the effective date of this Agreement exceeds the amount necessary to keep the Contracts in compliance with the requirements of § 7702 ***[and § 7702A, if applicable]***, Taxpayer will take the following corrective action:

(a) Increase the death benefit to not less than an amount that will ensure compliance with § 7702 ***[and § 7702A, if applicable]***, or

(b) Refund to the Contract holder the amount of such excess with interest; or

(ii) If the sum of the premiums paid as of the effective date of this Agreement does not exceed the amount necessary to keep the contracts in compliance with the requirements of § 7702 ***[and § 7702A, if applicable]***, Taxpayer will take no corrective action.

(E) With respect to any Contract which terminated by reason of the death of the insured (i) prior to the date this Agreement is executed by the Service and (ii) at a time when the premiums paid exceeded the guideline premium limitation for the Contract, Taxpayer will pay the Contract holder or the Contract holder's estate such excess with interest.

(F) Taxpayer represents that it, if it has not already done so, will correct its compliance system within 90 days of the effective date of this Agreement to account properly for charges for QABs.

2. In consideration of the agreement of Taxpayer set forth in Section 1 above, the Service agrees as follows:

(A) To treat each Contract that is still in force as of the effective date of this Agreement as having satisfied the requirements of § 7702 ***[and § 7702A, if applicable]***, during the period from the date of issuance of the Contract through and including the latest of (i) the date this Agreement is executed by the Service, (ii) the date of any corrective action described in Section 1(D) above, or (iii) the date of any corrective action described in Section 1(F) above;

(B) To treat each Contract that terminated prior to the effective date of this Agreement as having satisfied the requirements of § 7702 ***[and § 7702A, if applicable]*** during the period from date of issuance of the Contract through and including the date of the Contract's termination;

(C) To treat the failures described above, and any corrective action described in Section 1(D) or 1(E) above, as having no effect on the date the Contract was issued, entered into, or purchased for purposes of any provision of the Code or the regulations thereunder;

(D) To treat any amount paid to any beneficiary prior to the effective date of this Agreement under a Contract by reason of the death of the insured as paid under a life insurance contract for purposes of the exclusion from gross income under § 101(a)(1);

(E) To waive civil penalties for failure of Taxpayer to satisfy the reporting, withholding, or deposit requirements that would be applicable but for the relief otherwise provided by this Agreement; and

(F) To treat no portion of the amount described in Section 1(A) above as income to the Contract holders.

3. Any action required of Taxpayer in Section 1(D) or 1(E) above shall be taken by Taxpayer no later than 90 days after the date of execution of this Agreement by the Service. Payment of the amount described in Section 1(A) above shall be made within 60 days after the date of execution of this Agreement by the Service by check payable to the "United States Treasury" delivered together with a copy of this executed Agreement, to Internal Revenue Service, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

4. This Agreement is, and shall be construed as being, for the benefit of Taxpayer. Contract holders covered by this Agreement are intended beneficiaries of this Agreement. This Agreement shall not be construed as creating any liability of Taxpayer to the Contract holders.

5. Neither the Service nor Taxpayer shall endeavor by litigation or other means to attack the validity of this Agreement.

6. This Agreement may not be cited or relied upon as precedent in the disposition of any other matter.

NOW THIS CLOSING AGREEMENT FURTHER WITNESSETH, that the Service and Taxpayer mutually agree that the matters so determined shall be final and conclusive, except as follows:

1. The matter to which this Agreement relates may be reopened in the event of fraud, malfeasance, or misrepresentation of material facts set forth herein.

2. This Agreement is subject to sections of the Code that expressly provide that effect be given to their provisions (including any stated exception for Code § 7122) notwithstanding any other law or rule of law.

3. To the extent this Agreement relates to any tax period after the date on which it is executed, it is subject to any law, enacted after such date, that applies to that tax period.

IN WITNESS WHEREOF, the parties have subscribed their names in triplicate. By signing, the above parties certify that they have read and agreed to the terms of this document.

[Insert Taxpayer name]

Date Signed: _____ By: _____

Title: _____

COMMISSIONER OF INTERNAL REVENUE

Date Signed: _____ By: _____

Title: _____

SECTION 6. EFFECTIVE DATE

This revenue procedure is effective July 21, 2008, the date of its publication in the Internal Revenue Bulletin.

SECTION 7. EFFECT ON OTHER DOCUMENTS

Rev. Rul. 2005–6 is amplified to provide terms and conditions and a model closing agreement for use by taxpayers seeking the relief described in Alternative C.

SECTION 8. PAPERWORK REDUCTION ACT

The collections of information in this revenue procedure have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545–1752.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books and records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally tax returns and return information are confidential, as required by 26 U.S.C. 6103.

DRAFTING INFORMATION

The principal author of this revenue procedure is Katherine A. Hossofsky of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this revenue procedure, contact Branch 4 of that office at (202) 622–3970 (not a toll-free call).

---

26 CFR 301.7121–1: Closing agreements. (Also Part I, § 7702A.)

Rev. Proc. 2008–39

SECTION 1. PURPOSE

This revenue procedure provides a procedure by which an issuer of a life insurance contract may remedy an inadvertent non-egregious failure to comply with the modified endowment contract rules under § 7702A of the Internal Revenue Code. Rev. Proc. 2001–42, 2001–2 C.B. 212, and Rev. Proc. 2007–19, 2007–1 C.B. 515, are superseded.

SECTION 2. BACKGROUND

.01 *Definition of a modified endowment contract (MEC).*

(1) Section 7702A(a) provides that a life insurance contract is a MEC if the contract—

(a) is entered into on or after June 21, 1988, and fails to meet the 7-pay test of § 7702A(b), or

(b) is received in exchange for a contract described in paragraph (a) of this section 2.01(1).

(2) A contract fails to meet the 7-pay test if the accumulated amount paid under the contract at any time during the first 7 contract years exceeds the sum of the net level premiums which would have to be paid on or before such time if the contract were to provide for paid-up future benefits (as defined in §§ 7702A(c)(3) and 7702(f)(4)) after the payment of 7 level annual premiums.

(3) Section 72(e)(12) provides that, for purposes of determining amounts includible in gross income, all MECs issued by the same company to the same contract holder during any calendar year are treated as one MEC.

.02 *Tax treatment of amounts received under a MEC.* Section 72(e)(10) provides that a MEC is subject to the rules of § 72(e)(2)(B), which tax non-annuity distributions on an income-out-first basis, and the rules of § 72(e)(4)(A) (as modified by §§ 72(e)(10)(A)(ii) and 72(e)(10)(B)), which generally deem loans and assignments or pledges of any portion of the value of a MEC to be non-annuity distributions. Moreover, under § 72(v), the portion of any annuity or non-annuity distribution received under a MEC that is includible in gross income is subject to a 10% additional tax unless the distribution is made on or after the date on which the taxpayer attains age 59½, is attributable to the taxpayer's becoming disabled (within the meaning of § 72(m)(7)), or is part of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the taxpayer or the joint lives (or joint life expectancies) of such taxpayer and the taxpayer's beneficiary.

.03 *Authority to enter into closing agreements.* Under § 7121, the Secretary is authorized to enter into an agreement in writing with any person relating to the liability of such person (or of the person or estate for whom he acts) in respect of any internal revenue tax for any period. Such agreement is generally final and conclusive, except upon a showing of fraud, malfeasance, or misrepresentation of a material fact.

.04 *Correction procedure for inadvertent MECs.* Rev. Proc. 2001–42 set forth circumstances under which the Internal Revenue Service (Service) would enter into closing agreements under which life insurance contracts would be treated as if they were not MECs, notwithstanding inadvertent non-egregious failures to comply with the rules of § 7702A. Under Rev. Proc. 2001–42, an issuer was required

to provide information about the contracts that were subject to the closing agreement, including a template for each contract setting forth the cumulative amounts paid under the contract, the contract's cumulative 7-pay premium, the overage, if any, for each contract year, the earnings rate applicable for each contract year, and the overage earnings for each contract year. In addition, the issuer was required to pay under the closing agreement an amount based on the contract's overage, overage earnings, and tax and interest thereon. Rev. Proc. 2001–42 was modified and amplified by Rev. Proc. 2007–19, primarily to use indices that are more accessible to taxpayers than those previously required to be used and to permit the submission of information in an electronic format.

.05 *Changes to correction procedure.* In Notice 2007–15, 2007–1 C.B. 503, the Service requested comments as to how various correction procedures — including those for inadvertent MECs under Rev. Proc. 2001–42 — may be improved. This revenue procedure incorporates a number of changes that taxpayers suggested in response to Notice 2007–15. Significant changes include providing an alternative computation of the amount required to be paid under a closing agreement with regard to an inadvertent MEC, eliminating certain informational items that must be submitted, and revising some language of the model closing agreement.

SECTION 3. DEFINITIONS

The following definitions and rules apply solely for purposes of this revenue procedure.

.01 *Testing period.* The 7-year period described in § 7702A(b) or such additional period as may be required under § 7702A(c)(3) if a contract undergoes a material change.

.02 *Amount paid.* The amount paid (as defined in § 7702A(e)(1)) under a contract in any contract year (as defined in § 7702A(e)(2)) equals the premiums paid for the contract during the year, reduced by amounts to which § 72(e) applies (determined without regard to § 72(e)(4)(A)) but not including amounts includible in gross income. For this purpose, premiums paid do not include—

(1) any portion of any premium paid during the contract year that is returned (with interest) to the contract holder within 60 days after the end of the contract year in order to comply with the 7-pay test, or

(2) the cash surrender value (as defined in § 7702(f)(2)(A)) of another life insurance contract (other than a contract that fails the 7-pay test) exchanged for the contract.

.03 *7-pay premium.*

(1) *In general.* Except as otherwise provided in section 3.03(2) of this revenue procedure, the 7-pay premium for a contract is the net level premium (computed in accordance with the rules in § 7702A(c)) that would have to be paid for the contract if the contract were to provide for paid up future benefits after the payment of 7 level annual premiums.

(2) *7-pay premium for a contract that undergoes a material change.* If a contract (other than a contract that fails the 7-pay test) is materially changed, the contract is treated as newly issued on the date of the material change and the 7-pay premium for the changed contract is an amount equal to the excess, if any, of—

(a) the net level premium (computed in accordance with the rules in § 7702A(c)) that would have to be paid for the changed contract if the contract were to provide for paid up future benefits after the payment of 7 level annual premiums, over

(b) a proportionate share of the cash surrender value (as defined in section 3.04 of this revenue procedure) under the contract.

.04 *Proportionate share of cash surrender value.* The proportionate share of the cash surrender value of a contract is the amount obtained by multiplying—

(1) the cash surrender value (as defined in § 7702(f)(2)(A)) of the contract, by

(2) a fraction, the numerator of which is the net level premium (computed in accordance with the rules in § 7702A(c)) that would have to be paid for the changed or new contract if such contract were to provide for paid up future benefits after the payment of 7 level annual premiums, and the denominator of which is the net single premium (determined using the rules in § 7702) for such contract at that time.

.05 *Overage.* A contract's overage is the amount of the excess, if any, of—

(1) the sum of amounts paid under the contract during the testing period for the contract year and all prior contract years, over

(2) the sum of the 7-pay premiums for the contract year and all prior contract years of the testing period.

.06 *Overage earnings.* The overage earnings for a contract year is the amount obtained by multiplying—

(1) the sum of a contract's overage for the contract year and its cumulative overage earnings for all prior contract years, by—

(2) the earnings rate set forth in section 3.07 of this revenue procedure.

.07 *Earnings rates.*

(1) *Contracts other than variable contracts.* Except as otherwise provided in sections 3.07(3) and 3.07(8) of this revenue procedure, the earnings rate applicable to a contract year is the general account total return (as defined in section 3.07(2) of this revenue procedure) for the calendar year in which the contract year begins.

(2) *General account total return.*

(a) *Pre-2008 contract years.* The general account total return applicable to a contract year that begins before January 1, 2008, is the rate set forth in the following table for the calendar year in which the contract year begins.

Year	General Account Total Return
1988	10.2%
1989	9.7%
1990	9.8%
1991	9.2%
1992	8.6%
1993	7.5%
1994	8.3%
1995	7.8%
1996	7.7%
1997	7.6%
1998	6.9%
1999	7.4%
2000	8.0%
2001	7.5%
2002	7.2%
2003	6.2%
2004	6.1%
2005	5.6%
2006	6.0%
2007	6.0%

(b) *Post-2007 contract years.* The general account total return applicable to a contract year that begins after December 31, 2007, is the arithmetic average (weighted on a 50–50 basis) of the following two rates:

(i) Moody's Seasoned Corporate Aaa Bond Yield, frequency annual, or any successor thereto; and

(ii) Moody's Seasoned Corporate Baa Bond Yield, frequency annual, or any successor thereto. Both rates are publicly available at *www.federalreserve.gov.* Thus, for example, under this methodology the general account total return for 2007 is (5.555833 + 6.4825)/2 = 6.0191665 = 6.0%.

(3) *Variable contracts described in § 817(d).*

(a) *Pre-2008 contract years.* The earnings rate applicable to a contract year that begins before January 1, 2008, is the rate set forth in the following table for the calendar year in which the contract year begins.

Year	Variable Contracts Earnings Rate
1988	13.5%
1989	17.4%
1990	1.4%
1991	25.4%
1992	5.9%
1993	13.9%
1994	-1.0%
1995	23.0%
1996	14.3%
1997	17.8%
1998	19.7%
1999	12.8%
2000	-5.5%
2001	-7.1%
2002	-14.1%
2003	19.6%
2004	6.9%
2005	2.1%
2006	10.0%
2007	3.6%

(b) *Post-2007 contract years.* Except as otherwise provided in section 3.07(8) of this revenue procedure, the earnings rate applicable to a contract year that begins after December 31, 2007, is equal to the sum of—

(i) 10 percent of the general account total return (as defined in section 3.07(2) of this revenue procedure), and

(ii) 90 percent of the separate account total return (as defined in section 3.07(4) of this revenue procedure) for the calendar year in which the contract year begins.

(4) *Separate account total return.* Except as otherwise provided in section 3.07(8) of this revenue procedure, the separate account total return equals—

(a) 75 percent of the equity fund total return (as defined in section 3.07(5) of this revenue procedure), plus

(b) 25 percent of the bond fund total return (as defined in section 3.07(6) of this revenue procedure), less

(c) 1.1 percentage point.

(5) *Equity fund total return.* The equity fund total return equals—

(a) the calendar year percentage return (as defined in section 3.07(7) of this revenue procedure) represented by the end-of-year values of the Standard and Poor's (S&P) 500 Total Return Index, with daily dividend reinvestment, or any successor thereto, less

(b) 1.5 percentage point.

(6) *Bond fund total return.* The bond fund total return equals—

(a) the calendar year percentage return (as defined in section 3.07(7) of this revenue procedure) represented by the end-of-year values of the Merrill Lynch U.S. Corporate Master Index (C0A0), or any successor thereto, less

(b) 1.0 percentage point.

The Merrill Lynch U.S. Corporate Master Index (C0A0) is publicly available at *www.mlindex.ml.com*. Under this methodology, the bond fund total return for 2007 is (1689.135-1614.188) /1614.188 - .01 = 3.64301 percent.

(7) *Calendar year percentage return.* The calendar year percentage return for an index described in section 3.07(5) or section 3.07(6) of this revenue procedure is calculated by—

(a) dividing the end-of-year value of the index for the calendar year by the end-of-year value of the index for the immediately preceding calendar year, and

(b) subtracting 1 from the result obtained under paragraph (a) of this section 3.07(7).

(8) *Incomplete calendar year.* If the general account total return or the separate account total return for a calendar year cannot be determined because the calendar year in which the contract year begins has not ended, then the earnings rate for the contract year (or portion thereof) is determined using the general account total return and, if applicable, the average separate account total return, for the 3 calendar years immediately preceding the calendar year in which the contract year begins.

.08 *Proportionate share of overage earnings allocable to taxable distributions.* The proportionate share of overage earnings allocable to taxable distributions under a contract is the amount obtained by multiplying—

(1) the total amount of the taxable distributions under the contract, by

(2) a fraction, the numerator of which is the contract's cumulative overage earnings and the denominator of which is the total income on the contract.

.09 *Total income on a contract.* The total income on a contract as of any date is an amount equal to the excess, if any, of—

(1) the contract's cash surrender value (as defined in § 7702(f)(2)(A)) on such date, over

(2) the premiums paid under the contract before such date, reduced by amounts to which § 72(e) applies (determined without regard to § 72(e)(4)(A)) but not including amounts includible in the contract holder's gross income.

.10 *Distribution frequency factor.* The distribution frequency factor for a contract is—

(1) .8, if—

(a) the interest rate with respect to any portion of a policy loan that could be made under the contract at any time (including policy loans that could be made after a contractually specified date in the future) is guaranteed not to exceed the sum of:

(i) 1 percentage point, plus

(ii) the rate at which earnings are credited to the portion of the contract's cash surrender value (as defined in § 7702(f)(2)(A)) that is allocable to such portion of the policy loan; or

(b) the contract holder has an option to make a partial withdrawal of the contract's cash surrender value that reduces the death benefit (as defined in § 7702(f)(3)) under the contract by less than an amount determined by multiplying—

(i) the death benefit under the contract immediately before the withdrawal, by (ii) the percentage obtained by dividing the withdrawn amount by the contract's cash surrender value (as defined in § 7702(f)(2)(A)) immediately before the withdrawal; and

(2) .5 for all other contracts.

.11 *Applicable percentage.*

(1) *In general.* The applicable percentage for a contract is—

(a) 15%, if the death benefit under the contract is less than $50,000,

(b) 28%, if the death benefit under the contract is equal to or exceeds $50,000 but is less than $180,000, and

(c) 36%, if the death benefit under the contract is equal to or exceeds $180,000.

(2) *Determination of amount of death benefit.* For purposes of determining the applicable percentage, the death benefit under the contract is the death benefit (as defined in § 7702(f)(3)) as of any date within 120 days of the date of the request for closing agreement, or the last day the contract is in force.

.12 *Reported amount.* The reported amount for a contract is the amount that—

(1) the issuer reports on a timely filed information return as includible in the contract holder's gross income, or

(2) the contract holder includes in gross income on a timely filed income tax return.

.13 *Aggregation of contracts.* All MECs issued by the same issuer to the same contract holder during any calendar year are treated as one MEC.

SECTION 4. SCOPE

.01 *Applicability.* Except as provided in section 4.02, this revenue procedure applies to any issuer of one or more life insurance contracts that desires to remedy the inadvertent non-egregious failure of contracts to comply with the requirements of § 7702A. For this purpose, the term "issuer" means any company that issues a contract that is intended to satisfy the definition of a life insurance contract under § 7702 and comply with the MEC rules under § 7702A. The term also includes a company that insures a contract holder under a contract originally issued by another company.

.02 *Inapplicability.* The Service may exclude a contract from the correction mechanism provided under this revenue procedure if the contract's status as a MEC resulted from a failure to comply with the requirements of § 7702A that—

(1) is attributable to one or more defective interpretations or positions that the Service determines to be a significant feature of a program to sell investment oriented contracts, or

(2) arises where the controlling statutory provision, as supplemented by any legislative history or guidance published by the Service, is clear on its face and the Service determines that failure to follow the provision results in a significant increase in the investment orientation of a contract.

.03 *Example.* Pursuant to section 4.02 of this revenue procedure, the Service generally will not apply the correction mechanism under this revenue procedure to a MEC if the contract provides for paid-up future benefits after the payment of less than 7 level annual premiums.

SECTION 5. PROCEDURE

.01 *Request for a ruling.* An issuer that seeks relief under this revenue procedure must submit a request for a ruling that meets the requirements of Rev. Proc. 2008–1, 2008–1 I.R.B. 1 (or any successor). Additionally, the submission must contain the following information:

(1) the policy number for each contract;

(2) a description of the defect[s] that caused the contract[s] to fail to comply with the 7-pay test, including an explanation of how and why the defect[s] arose; and

(3) a description of the administrative procedures the issuer has implemented to ensure that none of its contracts will inadvertently fail the 7-pay test in the future.

.02 *Closing agreement.* The issuer also must submit a proposed closing agreement, in triplicate, executed by the issuer, in the same form as the model closing agreement in section 6 of this revenue procedure. The amount shown in Section 1(A) of the proposed closing agreement is the amount required to be paid (determined under section 5.03 of this revenue procedure) for all of the contracts covered by the agreement.

.03 *Determination of amount required to be paid with regard to a contract.* The amount required to be paid with regard to a contract under this section 5.03 is either the amount determined based on overage earnings under section 5.03(1) or, at the election of the issuer, the amount determined based on overage under section 5.03(2).

(1) *Amount determined based on overage earnings.*

(a) *In general.* Except as provided in section 5.03(1)(b) of this revenue procedure, the amount determined based on overage earnings under this section 5.03(1) is the sum of—

(i) the income tax (determined using, in lieu of the contract holder's actual tax rate, the applicable percentage for the contract under section 3.11 of this revenue procedure) and the additional tax under § 72(v) with regard to amounts (other than reported amounts (as defined in section 3.12 of this revenue procedure)) received (or deemed received) under the contract during the period commencing with the date 2 years before the date on which the contract first failed to satisfy the MEC rules and ending on the effective date of the closing agreement;

(ii) any interest computed under § 6621(a)(2) as if the amounts determined under section 5.03(1)(a)(i) of this revenue procedure are underpayments by the contract holder[s] for the tax year[s] in which the amounts are received (or deemed received); and

(iii) an amount, not less than $0, obtained by multiplying— (A) the excess, if any, of the contract's cumulative overage earnings over the proportionate share of overage earnings allocable to taxable distributions under the contract, by

(B) the applicable percentage for the contract, and by

(C) the distribution frequency factor for the contract under section 3.10 of this revenue procedure.

(b) *Special rule for contracts with de minimis overage earnings.* If the overage earnings of a contract at all times during the testing period do not exceed $100, then the amount determined under this section 5.03(1) of this revenue procedure is determined without regard to paragraphs (i) and (ii) of section 5.03(1)(a) of this revenue procedure.

(2) *Amount determined based on overage.* An issuer may elect to pay an amount equal to 100% of the overage as defined in section 3.05 of this revenue procedure, rather than the amount determined under section 5.03(1)(a) of this revenue procedure based on overage earnings with respect to a contract.

(3) *Examples of the determination of the amount required to be paid with regard to a contract.*

(a) *Example 1.* *A*, an individual, purchases a life insurance contract other than a contract described in sections 3.07(3) or 4.02 of this revenue procedure. The death benefit of the contract exceeds $180,000 on every day within 120 days of the date of the request for closing agreement. The net level premium (assuming paid-up future benefits after seven annual premium payments) for the contract is $10,490. The contract provides that, within 60 days after the end of a contract year, the issuer will return (with interest) the amount of any excess premium that would cause the contract to be a MEC under § 7702A.

The interest rate on all portions of any policy loans will always exceed the rate at which interest is credited to the contract's associated cash value by more than 1 percentage point. A partial withdrawal of the cash surrender value (within the meaning of § 7702(f)(2)(A)) always reduces the death benefit by an amount not less than the amount determined by multiplying the death benefit immediately before the withdrawal by the percentage obtained by dividing the withdrawn amount by the cash surrender value immediately before the withdrawal.

A pays a premium of $10,000 when the contract is issued on January 1, 2001. At the beginning of each of the next 6 contract years, *A* pays additional premiums of $10,750, $10,800, $10,700, $11,500, $11,000, and $10,000, respectively. Due to an inadvertent error, the issuer fails to return any of the excess premiums.

The issuer desires to enter into a closing agreement to remedy the failure to comply with § 7702A. The issuer prepares the following template with regard to the contract.

Contract Year	Cumulative Amounts Paid	Cumulative 7-pay Premium	Overage	Earnings Rate	Overage Earnings
1 (2001)	10,000	10,490	0	7.5%	0
2 (2002)	20,750	20,980	0	7.2%	0
3 (2003)	31,550	31,470	80	6.2%	4.96
4 (2004)	42,250	41,960	290	6.1%	17.99

Contract Year	Cumulative Amounts Paid	Cumulative 7-pay Premium	Overage	Earnings Rate	Overage Earnings
5 (2005)	53,750	52,450	1,300	5.6%	74.09
6 (2006)	64,750	62,940	1,810	6.0%	114.42
7 (2007)	74,750	73,430	1,320	6.0%	91.89

Prior to *A*'s payment of the $10,800 premium at the beginning of contract year 3, the cumulative premiums paid for the contract do not exceed the contract's cumulative 7-pay premiums. Therefore, there are no overage earnings in contract years 1 and 2.

Upon payment of the $10,800 premium at the beginning of contract year 3, however, the cumulative amount paid for the contract ($31,550) exceeds the contract's cumulative 7-pay premiums ($31,470) by $80. As the earnings rate for the calendar year in which contract year 3 begins is 6.2%, the contract's overage earnings for contract year 3 equal $4.96 ($80 x 6.2%).

For contract year 4, the overage is $290 ($42,250 - $41,960). The cumulative overage earnings for all prior contract years equal $4.96. The earnings rate is 6.1%. The overage earnings for contract year 4 equal $17.99 (($290 + $4.96) x 6.1%).

For contract year 5, the overage is $1,300 ($53,750 - $52,450). The cumulative overage earnings for all prior contract years equal $22.95 ($4.96 + $17.99). The earnings rate is 5.6%. The overage earnings for contract year 5 equal $74.09 (($1,300 + $22.95) x 5.6%).

For contract year 6, the overage is $1,810 ($64,750 - $62,940). The cumulative overage earnings for all prior contract years equal $97.04 ($4.96 + $17.99 + $74.09). The earnings rate is 6.0%. The overage earnings for contract year 6 equal $114.42 ($1,810 + $97.04) x 6.0%).

For contract year 7, the overage is $1,320 ($74,750 - $73,430). The cumulative overage earnings for all prior contract years equal $211.46 ($4.96 + $17.99 + $74.09 + $114.42). The earnings rate is 6.0%. The overage earnings for contract year 7 equal $91.89 (($1,320 + $211.46) x 6.0%).

The cumulative overage earnings for the contract equal $303.35 ($4.96 + $17.99 + $74.09 + $114.42 + $91.89). Under sections 3.10 and 3.11 of this revenue procedure, the distribution frequency factor is .5 and the applicable percentage is 36%. Accordingly, the amount determined based on overage earnings under section 5.03(1) of this revenue procedure is $54.60 ($303.35 x .5 x 36%).

The amount determined based on overage under section 5.03(2) of this revenue procedure is equal to 100% of the overage, or $1,320. The issuer may elect to pay either this amount or the amount determined under section 5.03(1) of this revenue procedure ($54.60) under the terms of the closing agreement with regard to the contract.

(b) *Example 2.* The facts are the same as in *Example 1* except that, at the beginning of contract year 5, *A* receives $3,000 as a policy loan. The contract's cash value (within the meaning of § 72(e)(3)(A)(i)) immediately prior to the loan is $58,500, which exceeds *A*'s investment in the contract ($53,750) by $4,750. Each year *A* pays the interest on the policy loan. The issuer does not file a timely information return with regard to the deemed distribution resulting from the policy loan and *A* does not include the distribution in gross income reported on the income tax return for the taxable years in which the deemed distribution is received. The total income on the contract (as defined in section 3.09 of this revenue procedure) is $14,500.

The amount determined based on overage earnings under section 5.03(1) of this revenue procedure is the sum of—

(1) an amount equal to the income tax (determined using an applicable percentage of 36%) and the additional tax under § 72(v) with regard to the $3,000 deemed distribution in contract year 5;

(2) interest computed under § 6621(a)(2) as if the amounts determined under (1) were underpayments for the taxable year in which the distributions are deemed to have occurred; and

(3) 36% of $120.30, which is the excess of the contract's cumulative overage earnings over the proportionate share of the overage earnings allocable to taxable distributions ($303.35 - $62.76), multiplied by the distribution frequency factor (.5). (The proportionate share of overage earnings allocable to taxable distributions is obtained by multiplying the total amount of the taxable distribution under the contract ($3,000), by a fraction, the numerator of which is the contract's cumulative overage earnings ($303.35) and the denominator of which is the total income on the contract ($14,500).)

The amount determined based on overage under section 5.03(2) of this revenue procedure is equal to 100% of the overage, or $1,320. The issuer may elect to pay either this amount or the amount determined under section 5.03(1) of this revenue procedure under the terms of the closing agreement with regard to the contract.

.04 *Payment of amount.* The issuer is required to pay the amount determined under section 5.03 of this revenue procedure within 60 days of the date of execution of the closing agreement by the Service. Payment shall be made by check payable to the "United States Treasury" delivered, together with a fully executed copy of the closing agreement, to Internal Revenue Service, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

.05 *Correction of contracts.*

(1) *General rules.* If, on the date of the execution of the closing agreement by the Service, the testing period (as defined in section 3.01 of this revenue procedure) for a contract has more than 90 days remaining, then the issuer must bring the contract into compliance with § 7702A. The issuer may bring a contract into compliance with § 7702A either by either increasing the contract's death benefit or returning the contract's excess premiums and earnings thereon to the contract holder. The issuer shall take the corrective action required under this section 5.05(1) of this revenue procedure within 90 days of the date of execution of the closing agreement by the Service.

(2) *No corrective action required if Service executes closing agreement on a date within ninety (90) days of the expiration of testing period.* If the testing period for a contract expires on or before the date within 90 days of the execution of the closing agreement by the Service, then the issuer is not required to take any corrective action under section 5.05(1) of this revenue procedure.

.06 *Representations.* The submission must include representations to the effect that the issuer is within the scope of section 4 of this revenue procedure and that amount due to the Service under the closing agreement is computed correctly under section 5.03(1) or (2) of this revenue procedure, as applicable. The representations must be executed under penalties of perjury by an appropriate party (as set forth in section 7.01 of Rev. Proc. 2008–1 (or its successor). The issuer must retain documentation available for audit to support the representations.

.07 *Electronic submissions.* The information required under section 5.01(1) of this revenue procedure may be submitted to the Service electronically, in read-only format, on a CD-ROM. Adobe Portable Document format is a suitable format. Other formats may be arranged on a case-by-case basis. The issuer must provide a total of three CD-ROMs, one for each of the three copies of the closing agreement.

SECTION 6. MODEL CLOSING AGREEMENT

Effective as of date executed by Internal Revenue Service _____

CLOSING AGREEMENT AS TO FINAL DETERMINATION
COVERING SPECIFIC MATTERS
UNDER SECTION 7702A

THIS CLOSING AGREEMENT ("Agreement") is made pursuant to § 7121 of the Internal Revenue Code (the "Code") by and between ***[Insert Taxpayer name, address, and EIN]*** ("Taxpayer") and the Commissioner of Internal Revenue (the "Service").

WHEREAS,

A. Taxpayer is the issuer of one or more life insurance contracts under § 7702.

B. Pursuant to Rev. Proc. 2008–39, 2008–29 I.R.B. 143, an issuer under certain circumstances may remedy an inadvertent non-egregious failure to comply with the modified endowment contract rules under § 7702A.

C. By letter dated ***[Insert date]***, Taxpayer submitted to the Service, pursuant to Rev. Proc. 2008–1, 2008–1 I.R.B. 1 ***[or successor Rev. Proc., if applicable]***, a request for this Agreement covering ***[Insert number]*** modified endowment contracts identified on Exhibit A attached to this Agreement (the "Contracts").

D. Taxpayer intended that each of the Contracts not be a modified endowment contract under § 7702A. Taxpayer represents that the Contract[s] is [are] not described in Sec. 4.02 of Rev. Proc. 2008–39 and that the Contracts identified on Exhibit A are eligible for relief under Rev. Proc. 2008–39.

E. Taxpayer represents that the amount determined under Sec. 5.03 of Rev. Proc. 2008–39 is $ ***[Insert amount]***. Taxpayer represents that this amount has been computed correctly under the provisions of Rev. Proc. 2008–39.

F. To ensure that the Contract[s] is [are] not treated as [a] modified endowment contract[s], Taxpayer and the Service have entered into this Agreement.

NOW THEREFORE IT IS HEREBY FURTHER DETERMINED AND AGREED BETWEEN TAXPAYER AND THE SERVICE AS FOLLOWS:

1. In consideration for the agreement of the Service as set forth in Section 2 below, Taxpayer agrees as follows:

   (A) Taxpayer will pay to the Service the amount of $ ***[Insert amount]*** at the time and in the manner described in Section 3 below.

   (B) The amount paid pursuant to Section 1(A) above is not deductible by Taxpayer, nor is such amount refundable, subject to credit or offset, or otherwise recoverable by Taxpayer from the Service.

   (C) For purposes of Taxpayer's complying with its reporting and withholding obligations under the Code,

      (i) neither the investment in the contract for purposes of § 72, nor the premiums paid for purposes of § 7702, on any Contract can be increased by any portion of the amount set forth in Section 1(A) above. If any such increases are made, they are entitled to no effect.

      (ii) neither the investment in the contract for purposes of § 72, nor the premiums paid, for purposes of § 7702, on any Contract can be increased by any portion of the amount which Taxpayer represents to be the income on the contract for all of the Contracts in the aggregate. If any such increases are made, they are entitled to no effect.

   (D) To bring Contract[s] for which the testing period (as defined in Sec. 3.01 of Rev. Proc. 2008–39) will not have expired on or before the date 90 days after the execution of this Agreement into compliance with § 7702A, either by an increase in death benefit[s] or the return of the excess premiums and earnings thereon to the Contract holder[s].

2. In consideration of the agreement of Taxpayer set forth in Section 1 above, the Service agrees as follows:

   (A) To treat each Contract as having satisfied the requirements of § 7702A during the period from the date of issuance of the Contract through and including the later of—

      (i) date of the execution of this Agreement, and

      (ii) the date of the corrective actions described in Section 1(D) above;

(B) To treat the corrective action described in Section 1(D) above as having no effect on the date the Contract was issued, entered into, or purchased for purposes of any provision of the Code or the regulations thereunder;

(C) To waive civil penalties for failure of Taxpayer to satisfy the reporting, withholding, and/or deposit requirements for income subject to tax under § 72(e)(10) that was received or deemed received by a Contract holder under a Contract in a calendar year ending prior to the date of execution of this Agreement; and

(D) To treat no portion of the amount described in Section 1(A) above as income to the Contract holders.

3. The actions required of Taxpayer in Section 1(D) above shall be taken by Taxpayer no later than 90 days after the date of execution of this Agreement by the Service. Payment of the amount described in Section 1(A) above shall be made within 60 days of the date of execution of this Agreement by the Service by check payable to the "United States Treasury," delivered together with a copy of this executed Agreement to Internal Revenue Service, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

4. This Agreement is, and shall be construed as being, for the benefit of Taxpayer. The Contract holders covered by this Agreement are intended beneficiaries of this Agreement. This Agreement shall not be construed as creating any liability of an issuer to the Contract holders.

5. Neither the Service nor Taxpayer shall endeavor by litigation or other means to attack the validity of this Agreement.

6. This Agreement may not be cited or relied upon as precedent in the disposition of any other matter.

NOW THIS CLOSING AGREEMENT FURTHER WITNESSETH, that Taxpayer and the Service mutually agree that the matters so determined shall be final and conclusive, except as follows:

1. The matter to which this Agreement relates may be reopened in the event of fraud, malfeasance, or misrepresentation of material facts set forth herein.

2. This Agreement is subject to sections of the Code that expressly provide that effect be given to their provisions (including any stated exception for Code § 7122) notwithstanding any other law or rule of law.

3. To the extent this Agreement relates to any tax period after the date on which it is executed, it is subject to any law, enacted after such date, that applies to that tax period.

IN WITNESS WHEREOF, the parties have subscribed their names in triplicate. By signing, the above parties certify that they have read and agreed to the terms of this document.

[Insert Taxpayer name]

Date Signed: _____ By: _____

Title: _____

COMMISSIONER OF INTERNAL REVENUE

Date Signed: _____ By: _____

Title: _____

SECTION 7. EFFECTIVE DATE

This revenue procedure is effective July 21, 2008, the date of its publication in the Internal Revenue Bulletin.

SECTION 8. EFFECT ON OTHER DOCUMENTS

This revenue procedure supersedes Rev. Proc. 2001–42 and Rev. Proc. 2007–19.

SECTION 9. PAPERWORK REDUCTION ACT

The collections of information in this revenue procedure have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545–1752.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books and records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally tax returns and return information are confidential, as required by 26 U.S.C. 6103.

DRAFTING INFORMATION

The principal author of this revenue procedure is Katherine A. Hossofsky of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this revenue

procedure, contact Branch 4 of that office at (202) 622–3970 (not a toll-free call).

---

26 CFR 301.7121–1: Closing agreements.
(Also Part I, Section 7702.)

Rev. Proc. 2008–40

SECTION 1. PURPOSE

This revenue procedure provides a procedure by which an issuer of a life insurance contract may remedy the failure of one or more contracts to meet the definition of a life insurance contract under § 7702(a) or to satisfy the requirements of § 101(f) of the Internal Revenue Code. Rev. Rul. 91–17, 1991–1 C.B. 190, is superseded in part; Notice 99–48, 1999–2 C.B. 429, is superseded.

SECTION 2. BACKGROUND

.01 *Definition of a life insurance contract.*

(1) Section 7702(a) provides that, for a contract to qualify as a life insurance contract for Federal income tax purposes, the contract must be a life insurance contract under the applicable law and must either—

(a) satisfy the cash value accumulation test of § 7702(b), or

(b) both meet the guideline premium requirements of § 7702(c) and fall within the cash value corridor of § 7702(d).

(2) A contract meets the cash value accumulation test of § 7702(b) if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at that time to fund future benefits under the contract.

(3) A contract meets the guideline premium requirements of § 7702(c) if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of that time. The guideline premium limitation as of any date is the greater of the guideline single premium, or the sum of the guideline level premiums to that date. The guideline single premium is the premium that would be required on the date the contract is issued to fund the future benefits under the contract.

(4) A contract falls within the cash value corridor of § 7702(d) if the death benefit under the contract at any time is not less than the applicable percentage of the cash surrender value, based on the table set forth in § 7702(d)(2).

(5) Section 7702 is effective for contracts issued after December 31, 1984, in tax years ending after that date.

.02 *Tax treatment of a contract that does not meet the requirements of § 7702(a).* Section 7702(g)(1)(A) provides that if at any time a contract that is a life insurance contract under the applicable law does not meet the definition of a life insurance contract under § 7702(a), the income on the contract for any taxable year of the policyholder is treated as ordinary income received or accrued by the policyholder during such year. Further, § 7702(g)(1)(C) provides that if, during any taxable year of the policyholder, a contract that is a life insurance contract under the applicable law ceases to meet the definition of a life insurance contract under § 7702(a), the income on the contract for all prior taxable years is treated as received or accrued during the taxable year in which such cessation occurs.

.03 *Definition and treatment of a flexible premium life insurance contract.* A flexible premium life insurance contract is a life insurance contract that provides for the payment of one or more premiums that are not fixed by the insurer as to both timing and amount. Section 101(f) provides that any amount paid by reason of the death of the insured under a flexible premium life insurance contract is excluded from gross income only if the contract satisfies either (1) the guideline premium limitation and the applicable percentage of cash value test of § 101(f)(1)(A)(i) and (ii), or (2) the cash value test of § 101(f)(1)(B). The limitations of § 101(f) generally apply to contracts issued before January 1, 1985.

.04 *Recordkeeping, reporting, withholding, and deposit requirements for failed contracts.* The issuer of a contract that fails to satisfy the requirements of § 7702(a) or § 101(f) may have recordkeeping, reporting, withholding, and deposit obligations.

An issuer that fails to meet these obligations also may be subject to penalties. *See* Rev. Rul. 91–17 (concerning failures to satisfy the requirements of § 7702(a)).

.05 *Authority to enter into closing agreements.* Under § 7121, the Secretary is authorized to enter into an agreement in writing with any person relating to the liability of such person (or of the person or estate for whom he acts) in respect of any internal revenue tax for any period. Such an agreement is generally final and conclusive, except upon a showing of fraud or malfeasance, or misrepresentation of a material fact.

.06 *Correction procedure for failures to satisfy the requirements of § 7702(a).*

Rev. Rul. 91–17, concludes that if a contract fails to meet the definition of a life insurance contract under § 7702(a), then the holder of the contract is deemed to have received a nonperiodic distribution as ordinary income under § 7702(g) or (h), and the issuer is subject to the recordkeeping, reporting, withholding, and deposit requirements applicable to nonperiodic distributions. In addition, Rev. Rul. 91–17 states that the Internal Revenue Service (Service) will waive civil penalties for an issuer's failure to satisfy those requirements if, prior to June 3, 1991, the issuer requested and, in a timely fashion, executed a closing agreement under which the issuer agreed to pay a specified amount. Notice 99–48, indicated that since June 3, 1991, the Service has continued to exercise its authority under § 7121 to enter into closing agreements as set out in Rev. Rul. 91–17. Notice 99–48 also set forth the rates to be used for the purpose of computing the amount due pursuant to such a closing agreement. As a matter of practice, the Service has entered into closing agreements to address contracts that failed to satisfy the requirements of § 101(f), as well.

.07 *Changes to correction procedures.* In Notice 2007–15, 2007–1 C.B. 503, the Service requested comments as to how various correction procedures — including those for correcting the failure of a contract to satisfy the requirements of § 7702(a) — may be improved. This revenue procedure incorporates a number of changes that taxpayers suggested in response to Notice 2007–15. Most significantly, this revenue procedure (1) sets forth a model closing agreement for issuers that seek relief, and (2) provides alternative calculations of the amount due under the closing agreement.

SECTION 3. SCOPE

This revenue procedure applies to any issuer of one or more contracts that qual-

ified as life insurance contracts under the applicable law, but otherwise failed to meet the definition of a life insurance contract under § 7702(a) or to meet the requirements of § 101(f). For purposes of this revenue procedure, the term "issuer" is any company that issues a contract that is intended to satisfy the definition of a life insurance contract under § 7702 or § 101(f). The term also includes a company that insures a contract holder under a contract originally issued by another company.

SECTION 4. PROCEDURE

.01 *Request for ruling.* An issuer that seeks relief under this revenue procedure must submit a request for a ruling that meets the requirements of Rev. Proc. 2008–1, 2008–1 I.R.B. 1 (or any successor). Additionally, the submission must contain the following information:

(1) the policy number for each contract;

(2) a description of the defects that caused the contracts to fail to comply with § 7702 or § 101(f); and

(3) a description of the administrative procedures the issuer has implemented to prevent additional failures to meet the requirements of § 7702 or § 101(f) in the future.

.02 *Closing agreement.* In the case of a failure to meet the guideline premium requirements of § 7702(c), the issuer must submit a proposed closing agreement, in triplicate, executed by the issuer, in the same form as the model closing agreement in section 5 of this revenue procedure. The amount shown in Section 1(A) of the proposed closing agreement is the amount required to be paid (as determined under section 4.03 of this revenue procedure) for all of the contracts covered by the agreement. In the case of any other failure, the issuer may propose amendments to the proposed closing agreement set forth in section 5 of this revenue procedure, including the amount required to be paid, as appropriate on a case-by-case basis.

.03 *Determination of amount required to be paid with regard to a contract.*

(1) *In general.* The amount required to be paid with regard to a contract under this section 4.03 of this revenue procedure depends on the amount of excess earnings with respect to the contract. For a contract with excess earnings greater than $5,000, the amount required to be paid is the amount determined based on income on the contract under section 4.03(2) of this revenue procedure; for a contract with excess earnings less than or equal to $5,000, the amount required to be paid is the amount determined based on excess earnings under section 4.03(3) of this revenue procedure. In lieu of the amount determined under section 4.03(2) or section 4.03(3) of this revenue procedure, however, the issuer may elect to pay the amount determined based on excess premiums under section 4.03(4) of this revenue procedure.

(2) *Amount determined based on income on the contract.* The amount required to be paid with regard to a contract with excess earnings greater than $5,000 is the amount determined based on income on the contract. This amount is equal to (i) the amount of tax that would have been owed by the contract holder if the contract holder were treated as receiving the income on the contract, plus (ii) any interest with regard to such tax. For this purpose, the income on the contract is determined in the manner set forth in section 4.03(5)(a) of this revenue procedure; the tax rate is assumed to equal the applicable percentage for the contract determined under section 3.11 of Rev. Proc. 2008–39, page 143, this Bulletin; and the amount of interest is the amount computed under § 6621(a)(2) as if the amounts treated as received by the contract holder as income on the contract caused underpayments of tax in the appropriate years.

(3) *Amount determined based on excess earnings.* The amount required to be paid with regard to a contract with excess earnings less than or equal to $5,000 is the amount determined based on excess earnings. This amount is equal to the amount of tax that would have been owed by the contract holder if the contract holder were treated as receiving the excess earnings on the contract. For this purpose, the excess earnings on the contract is the amount determined under section 4.03(5)(b) of this revenue procedure; the tax rate is assumed to equal the applicable percentage for the contract determined under section 3.11 of Rev. Proc. 2008–39, and the amount of interest is the amount computed under § 6621(a)(2) as if the amounts treated as received by the contract holder as excess earnings caused underpayments of tax in the appropriate years.

(4) *Amount determined based on excess premiums.* In lieu of the amount determined based on income on the contract set forth in section 4.03(2) of this revenue procedure or the amount determined based on excess earnings set forth in section 4.03(3) of this revenue procedure, as applicable, an issuer may elect to pay an amount with regard to a contract equal to 100% of the excess premiums as defined in section 4.03(5)(c) of this revenue procedure.

(5) *Definitions.*

(a) *Income on the contract.* The income on the contract is the amount determined with regard to the contract under § 7702(g)(1)(B).

(b) *Excess earnings.* The excess earnings for a contract is equal to the amount obtained by multiplying—

(i) the sum of a contract's excess premiums for a contract year and its cumulative excess earnings for all prior contract years, by

(ii) the applicable earnings rate as set forth in section 3.07 of Rev. Proc. 2008–39. (For contract years before 1988, the applicable earnings rate is the rate determined in a manner consistent with the formulas set forth in section 3.07 of Rev. Proc. 2008–39 for contract years after 2007.)

(c) *Excess premiums.* The excess premiums with regard to a contract is equal to the highest amount by which the total premiums paid under the contract exceed the guideline premium limitations under § 7702(c) at any time the contract is in force.

.04 *Payment of amount.* The issuer is required to pay the amount determined under section 4.03 of this revenue procedure within 60 days of the date of execution of the closing agreement by the Service. Payment shall be made by check payable to the "United States Treasury" delivered, together with a fully executed copy of the closing agreement, to Internal Revenue Service, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

.05 *Correction of contracts.* With respect to each contract that is in force on the effective date of the closing agreement, to the extent necessary to bring the contract into compliance with § 7702, the issuer is

required, no later than 90 days after the date of execution of the closing agreement with the Service, either (1) to increase the death benefit to not less than an amount that will ensure compliance with § 7702 or § 101(f), as applicable, or (2) to refund to the contract holder the excess of the sum of the premiums paid as of the effective date of the closing agreement over the guideline premium limitation as of that date. If the sum of the premiums paid does not exceed the guideline premium limitation, no corrective action is necessary.

.06 *Required representations.* The submission must include representations to the effect that (1) the issuer is within the scope of section 3 of this revenue procedure; (2) the issuer properly computed the amount required to be paid with regard to the contracts in accordance with section 4.03 of this revenue procedure; and (3) the issuer has brought the contracts into compliance with the requirements of § 7702 or § 101(f), as applicable, or will do so within the time period specified in the model closing agreement set forth in section 5 of this revenue procedure. The representations must be executed under penalties of perjury by an appropriate party (as set forth in section 7.01 of Rev. Proc. 2008–1 (or its successor). The issuer must retain documentation available for audit to support the representations.

.07 *Electronic submissions.* The information required under section 4.01 of this revenue procedure may be submitted to the Service electronically, in read-only format, on a CD-ROM. Adobe Portable Document format is a suitable format. Other formats may be arranged on a case-by-case basis. The issuer must provide a total of three CD-ROMs, one for each of the three copies of the closing agreement.

SECTION 5. MODEL CLOSING AGREEMENT

Effective as of date executed by Internal Revenue Service _____

CLOSING AGREEMENT AS TO FINAL DETERMINATION
COVERING SPECIFIC MATTERS
UNDER § 7702 ***[Insert "or § 101(f)" if applicable]***

THIS CLOSING AGREEMENT ("Agreement") is made pursuant to § 7121 of the Internal Revenue Code (the "Code") by and between ***[Insert* Taxpayer name, *address and EIN number]*** ("Taxpayer") and the Commissioner of Internal Revenue (the "Service").

WHEREAS,

A. Taxpayer is the issuer of one or more contracts that were intended to qualify as life insurance contracts under § 7702 ***[Insert "or § 101(f)" if applicable].*** For each contract, however, Taxpayer accepted and retained premiums that exceeded the contract's guideline premium limitations. As a result, the contract[s] failed to satisfy the requirements of § 7702 ***[Insert "or § 101(f)" if* applicable].**

B. Pursuant to Rev. Proc. 2008–40, 2008–29 I.R.B. 151, the Service under certain circumstances will waive civil penalties for failure of a taxpayer to satisfy the recordkeeping, reporting, withholding, or deposit requirements for income received or deemed received under § 7702(g).

C. By letter dated ***[Insert date]*** Taxpayer submitted to the Service, pursuant to Rev. Proc. 2008–1, 2008–1 I.R.B. 1 ***[or successor if* applicable]**, a request for this Agreement covering ***[Insert number]*** of Taxpayer's life insurance contracts identified on Exhibit A attached to this Agreement (the "Contracts").

D. Taxpayer represents that the failure[s] described in A above are eligible for relief under Rev. Proc. 2008–40.

E. Taxpayer represents that the amount determined under section 4.03 of Rev. Proc. 2008–40 is $ ***[Insert amount].*** Taxpayer represents that this amount has been computed correctly under the provisions of Rev. Proc. 2008–40.

F. To ensure that the Contracts satisfy the requirements of § 7702(a) ***[Insert "or § 101(f)" if* applicable],** Taxpayer and the Service have entered into this Agreement.

NOW THEREFORE IT IS HEREBY FURTHER DETERMINED AND AGREED BETWEEN TAXPAYER AND THE SERVICE AS FOLLOWS:

1. In consideration for the agreement of the Service as set forth in Section 2 below, Taxpayer agrees as follows:

   (A) To pay the Service the amount of $ ***[Insert amount]*** at the time and in the manner described in Section 3 below.

   (B) The amount paid pursuant to Section 1(A) above is not deductible, nor is such amount refundable, subject to credit or offset, or otherwise recoverable from the Service.

   (C) For purposes of complying with Taxpayer's reporting and withholding obligations under the Code,

(i) neither the investment in the contract for purposes of § 72, nor the premiums paid, for purposes of § 7702 ***[Insert "or § 101(f)" if*** **applicable]**, on any Contract can be increased by any portion of the amount set forth in Section 1(A) above. If any such increases are made, they are entitled to no effect.

(ii) neither the investment in the contract, for purposes of § 72, nor the premiums paid, for purposes of § 7702 ***[Insert "or § 101(f)" if*** **applicable],** on any Contract can be increased by any portion of the amount which Taxpayer represents to be the income on the contract for all of the Contracts in the aggregate. If any such increases are made, they are entitled to no effect.

(D) With respect to each Contract that is in force on the effective date of this Agreement, to the extent necessary in order to bring such Contract into compliance with § 7702 ***[Insert "or §101(f)" if applicable],*** no later than 90 days after the date of execution of this Agreement by the Service:

(i) If the sum of the premiums paid as of the effective date of this Agreement exceeds the guideline premium limitation as of such date, Taxpayer will take the following corrective action:

(a) Increase the death benefit to not less than an amount that will ensure compliance with § 7702 ***[Insert "or § 101(f)" if applicable]***, or

(b) Refund to the Contract holder the amount of such excess, with interest at the Contract's interest crediting rate; or

(ii) If the sum of the premiums paid as of the effective date of this Agreement does not exceed the guideline premium limitation of § 7702 ***[insert "or § 101(f)" if applicable]*** as of such date, to take no corrective action.

(E) With respect to any Contract which terminated by reason of the death of the insured (i) prior to the date this Agreement is executed by the Service and Taxpayer and (ii) at a time when the premiums paid exceeded the amounts necessary to keep the Contracts in compliance with the requirements of § 7702 ***[Insert "or § 101(f)" if applicable]*** guideline premium limitation for the Contract, Taxpayer will pay the Contract holder, or the Contract holder's estate, the amount of such excess with interest.

2. In consideration of the agreement of Taxpayer set forth in Section 1 above, the Service agrees as follows:

(A) To treat each Contract that is still in force as of the effective date of this Agreement as having satisfied the requirements of § 7702 ***[Insert "or § 101(f)" if applicable]*** during the period from the date of issuance of the Contract through and including the later of (i) the date of the execution of this Agreement by the Service or (ii) the date of corrective action described in Section 1(D) with respect to that Contract;

(B) To treat each Contract that terminated prior to the effective date of this Agreement as having satisfied the requirements of § 7702 ***[Insert "or § 101(f)" if applicable]*** during the period from date of issuance of the Contract through and including the date of the Contract's termination;

(C) To treat the failure(s) described above, and any corrective action described in Section 1(D) or 1(E) above, as having no effect on the date the Contract was issued, entered into, or purchased for purposes of any provision of the Code or regulations thereunder;

(D) To treat any amount paid prior to the effective date of this Agreement to any beneficiary under a Contract by reason of the death of the insured as paid under a life insurance contract for purposes of the exclusion from gross income under § 101(a)(1);

(E) To waive civil penalties for failure of Taxpayer to satisfy the reporting, withholding, or deposit requirements for income deemed received by Contract holders due to the Contract's failure to satisfy the requirements of § 7702 ***[Insert "or 101(f)" if applicable]***; and

(F) To treat no portion of the amount described in Section 1(A) above as income to the Contract holders.

3. Any action required of Taxpayer in Section 1(D) or 1(E) above shall be taken by Taxpayer no later than 90 days after the date of execution of this Agreement by the Service. Payment of the amount described in Section 1(A) above shall be made within 60 days after the date of execution of this Agreement by the Service by check payable to the "United States Treasury," delivered together with a copy of this executed Agreement, to Internal Revenue Service, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

4. This Agreement is, and shall be construed as being, for the benefit of Taxpayer. Contract holders of the Contracts covered by this Agreement are intended beneficiaries of this Agreement. This Agreement shall not be construed as creating any liability of Taxpayer to the Contract holders.

5. Neither the Service nor Taxpayer shall endeavor by litigation or other means to attack the validity of this Agreement.

6. This Agreement may not be cited or relied upon as precedent in the disposition of any other matter.

NOW THIS CLOSING AGREEMENT FURTHER WITNESSETH, that the Service and Taxpayer mutually agree that the matters so determined shall be final and conclusive, except as follows:

1. The matter to which this Agreement relates may be reopened in the event of fraud, malfeasance, or misrepresentation of material facts set forth herein.

2. This Agreement is subject to sections of the Code that expressly provide that effect be given to their provisions (including any stated exception for Code § 7122) notwithstanding any other law or rule of law.

3. To the extent this Agreement relates to any tax period after the date on which it is executed, it is subject to any law, enacted after such date, that applies to that tax period.

IN WITNESS WHEREOF, the parties have subscribed their names in triplicate. By signing, the above parties certify that they have read and agreed to the terms of this document.

[Insert Taxpayer name]

Date Signed: _____ By: _____

Title: _____

COMMISSIONER OF INTERNAL REVENUE

Date Signed: _____ By: _____

Title: _____

SECTION 6. EFFECTIVE DATE

This revenue procedure is effective July 21, 2008, the date of its publication in the Internal Revenue Bulletin.

SECTION 7. EFFECT ON OTHER DOCUMENTS

Rev. Rul. 91–17, 1991–1 C.B. 190, is superseded in part to set forth new terms and conditions under which the Service will enter into a closing agreement to remedy the failure of a contract to qualify as a life insurance contract; Notice 99–48 is superseded.

SECTION 8. PAPERWORK REDUCTION ACT

The collections of information in this revenue procedure have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545–1752.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books and records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally tax returns and return information are confidential, as required by 26 U.S.C. 6103.

DRAFTING INFORMATION

The principal author of this revenue procedure is Melissa S. Luxner of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this revenue procedure, contact Branch 4 of that office at (202) 622–3970 (not a toll-free call).

---

26 CFR 301.7121–1: Closing agreements.
(Also Part I, Section 817; 1.817–5.)

Rev. Proc. 2008–41

SECTION 1. PURPOSE

This revenue procedure provides a procedure by which an issuer of a variable contract may remedy an inadvertent failure of a variable contract to satisfy the diversification requirements of § 817(h) of the Internal Revenue Code. Rev. Rul. 91–17, 1991–1 C.B. 190, is amplified; Rev. Proc. 92–25, 1992–1 C.B. 741, is superseded; Notice 2000–9, 2000–1 C.B. 449, is obsolete.

SECTION 2. BACKGROUND

.01 *Definition and tax treatment of a variable contract.*

(1) Section 817(d) defines the term "variable contract" to mean a contract that (a) provides for the allocation of all or part of the amounts received under the contract to an account that, pursuant to state law or regulations, is segregated from the general asset accounts of the company, and (b) provides for the payment of annuities, or is a life insurance contract, or provides for funding of insurance on retired lives. In the case of an annuity contract or a contract that provides funding of insurance on retired lives, the amounts paid in or the amounts paid out are required to reflect the investment return and the market value of the segregated asset account. In the case of a life insurance contract, the amount of the death benefit (or the period of coverage) must be adjusted on the basis of the investment return and the market value of the segregated asset account.

(2) Section 817(h) of the Code provides that a variable contract (other than a pension plan contract) based on a segregated

asset account shall not be treated as an annuity, endowment, or life insurance contract if the investments made by the account are not adequately diversified in accordance with regulations prescribed by the Secretary.

(3) Section 1.817–5(a)(1) provides that a variable contract is treated as based on a segregated asset account for a calendar quarter period if amounts received under the contract (or earnings thereon) are allocated to the account at any time during the period. Section 1.817–5(e) of the Income Tax Regulations provides that a "segregated asset account" consists of all assets the investment return and market value of each of which must be allocated in an identical manner to any variable contract invested in any of such assets. Section 1.817–5(g) illustrates the application of this provision.

(4) Section 1.817–5(a) provides that, if a variable contract that is a life insurance contract under applicable law is not treated as a life insurance or endowment contract under § 7702(a), the income on the contract for any taxable year of the policyholder is treated as ordinary income received or accrued by the policyholder during such year in accordance with § 7702(g) and (h). Likewise, if a variable contract is not treated as an annuity contract under § 72, the regulation provides that the income on the contract for any taxable year of the policyholder shall be treated as ordinary income received or accrued by the policyholder during such year in the same manner as a life insurance or endowment contract under § 7702(g) and (h).

.02 *Diversification requirements.*

(1) Section 1.817–5(b)(1) provides that the investments of a segregated asset account are adequately diversified for purposes of § 817(h) only if—

(a) No more than 55% of the value of the total assets of the account is represented by any one investment;

(b) No more than 70% of the value of the total assets of the account is represented by any two investments;

(c) No more than 80% of the value of the total assets of the account is represented by any three investments, and

(d) No more than 90% of the value of the total assets of the account is represented by any four investments.

For purposes of § 1.817–5, all securities of the same issuer, all interests in the same real property project, and all interests in the same commodity are each treated as a single investment. In the case of government securities, each government agency or instrumentality is treated as a separate issuer.

(2) Section 817(h)(2) provides a safe harbor under which the investments of a segregated asset account are adequately diversified for purposes of § 817(h) if (a) the account meets the requirements of § 851(b)(3), and (b) no more than 55% of the value of the total assets of the account are assets described in § 851(b)(3)(A)(i) (*i.e.*, cash, cash items (including receivables), Government securities, and securities of other regulated investment companies).

(3) Under § 1.817–5(c)(1), a segregated asset account that satisfies the requirements of § 1.817–5(b) as of the last day of any calendar quarter period (or within 30 days after that last day) is considered adequately diversified for that period.

.03 *Recordkeeping, reporting, withholding, and deposit requirements for nondiversified contracts.*

An issuer of a variable contract that fails to satisfy the requirements of § 817(h) may have recordkeeping, reporting, withholding, and deposit obligations. An issuer that fails to meet these obligations also may be subject to penalties. *See* Rev. Rul. 91–17.

.04 *Authority to enter into closing agreements.* Under § 7121, the Secretary is authorized to enter into an agreement in writing with any person relating to the liability of such person (or of the person or estate for whom he acts) in respect of any internal revenue tax for any period. Such agreement is generally final and conclusive, except upon a showing of fraud or malfeasance, or misrepresentation of a material fact.

.05 *Correction procedure for failure to satisfy the diversification requirements of § 817(h).*

(1) Section 1.817–5(a)(2) provides that, in the event of an inadvertent failure to diversify, the investments of a segregated asset account are nevertheless treated as satisfying the diversification requirements of § 1.817–5(b) for one or more periods if —

(a) the issuer or holder of the variable contract shows that the failure to satisfy the diversification requirements was inadvertent;

(b) the investments of the account satisfy the diversification requirements within a reasonable item after discovery of the failure; and

(c) the issuer or holder agrees to make such adjustments or pay such amounts as the Commissioner may require.

For this purpose (and for purposes of this revenue procedure), income on the contract is computed under § 7702(g)(1)(B), without regard to § 7702(g)(1)(C), and is computed using the period or periods of nondiversification instead of the "taxable year" referred to in § 7702(g)(1)(B). Thus, for example, income attributable to each segregated asset account on which a contract is based (including accounts that at all times were adequately diversified) is included in the computation of income on the contract.

(2) Rev. Proc. 92–25, 1992–1 C.B. 741, set forth the procedure by which an issuer of a variable contract could request the relief described in § 1.817–5(a)(2) with regard to an inadvertent failure to satisfy the diversification requirements of § 817(h). Among the requirements set forth in Rev. Proc. 92–25 was a requirement that the issuer pay an amount under the closing agreement based on all the income on the annuity contracts that invested in the nondiversified accounts, including income with regard to accounts that were adequately diversified.

(3) Notice 2000–9, 2000–1 C.B. 449, reminded issuers of variable annuity contracts that the special rules of § 817(h)(3) and § 1.817–5(b)(3), concerning diversification of accounts with respect to variable life insurance contracts, do not apply with respect to variable annuity contracts. Notice 2000–9 provided a one-time procedure to cure diversification failures that resulted from a misapplication of that rule. That procedure applied to requests for closing agreement relief that were received on or before August 1, 2000.

.06 *Changes to correction procedure.* In Notice 2007–15, 2007–7 I.R.B. 503, the Service requested comments as to how various correction procedures — including those for inadvertent failures to satisfy the diversification requirements of § 817(h) — may be improved. This revenue procedure incorporates a number of changes that taxpayers suggested in response to Notice 2007–15. Most significantly, this revenue procedure (1) updates the model closing

agreement set forth in Rev. Proc. 92–25, and (2) provides both an alternative computation of the amount due under the closing agreement and an overall limit on the amount that must be paid.

SECTION 3. SCOPE

This revenue procedure applies to any issuer of a variable contract that inadvertently failed to satisfy the diversification requirements of § 817(h), provided the issuer is entitled to relief under § 1.817–5(a)(2). For purposes of this revenue procedure, the term "issuer" is any company that issues a contract that is a variable contract under § 817(d) and is intended to satisfy the diversification requirements of § 817(h). The term also includes a company that insures a contract holder under a contract originally issued by another company.

SECTION 4. PROCEDURE

.01 *Request for ruling.* An issuer that seeks relief under this revenue procedure must submit a request for a ruling that meets the requirements of Rev. Proc. 2008–1, 2008–1 I.R.B. 1 (or any successor). Additionally, the submission must —

(1) identify the period or periods during which the investments of the segregated asset account did not satisfy the diversification requirements;

(2) show that the failure to diversify was inadvertent;

(3) demonstrate that the investments of the account were brought into compliance with the diversification requirements within a reasonable time after discovery of the failure; and

(4) if the amount required to be paid is determined under section 4.03(2) of this revenue procedure, describe the method used to compute the amount of income that all holders of contracts based on the account would be treated as receiving during the period or periods of nondiversification if the account were not treated as adequately diversified under §1.817–5(a)(2). (This computation is to be made without regard to contracts that were completely surrendered during the nondiversification period.) Otherwise, indicate whether the amount required to be paid was determined under section 4.03(3) or section 4.04(4) of this revenue procedure.

.02 *Closing agreement.* The issuer must also submit a proposed closing agreement, in triplicate, executed by the issuer, using the model closing agreement in section 6 of this revenue procedure. The amount shown in Section 1(A) of the proposed closing agreement is the amount determined under section 4.03 of this revenue procedure for all of the contracts covered by the agreement.

.03 *Determination of amount required to be paid.*

(1) *In general.* Except as provided in section 4.03(4) of this revenue procedure, the issuer must remit to the Service the lesser of the amount determined based on income on the contracts under section 4.03(2) of this revenue procedure, or the amount determined based on the amount by which the segregated asset account was nondiversified under section 4.03(3) of this revenue procedure.

(2) *Amount determined based on income on the contracts.* The amount required to be paid based on income on the contracts is the sum of the following amounts for variable annuity contracts and for variable life insurance or endowment contracts, as applicable:

(a) With regard to variable annuity contracts, an amount equal to the sum of —

(i) 20% of income on annuity contracts from which payments have not been made as of the end of the period; plus

(ii) 15% of income on annuity contracts from which payments have been made as of the end of the period; plus

(iii) any interest computed under § 6621(a)(2) as if the amounts determined under sections 4.03(2)(a)(i) and (ii) of this revenue procedure were underpayments by the contract holders for their tax year(s) containing the period(s) of nondiversification; and

(b) With regard to variable life insurance or endowment contracts, an amount equal to the sum of —

(i) 28% of the income on the contracts; plus

(ii) any interest computed under § 6621(a)(2) as if the amount determined under section 4.03(2)(b)(i) of this revenue procedure were an underpayment by the contract holders for their tax year(s) containing the period(s) of nondiversification.

(3) *Amount determined based on the amount by which the segregated asset account was nondiversified.* The amount determined based on the amount by which the segregated asset account was nondiversified is an amount equal to 100% of the amount by which the account's interest in a single investment exceeded the applicable limitation of § 1.817–5(b). Thus, for example, if a segregated asset account's investment in a single security exceeded both the 55% limitation of § 1.817–5(b)(1)(i)(A) and the 70% limitation of § 1.817–5(b)(1)(i)(B), the amount determined under this section 4.03(3) is the total amount by which the investment would need to be reduced in order to satisfy both requirements and comply with the rules of § 817(h) and § 1.817–5(b). This amount is determined as of the 30th day after the last day of each calendar quarter for which the segregated asset account was not diversified. If nondiversification spans multiple calendar quarters, the amount payable under this section is based on the calendar quarter that produces the highest amount.

(4) *Limitation on amount required to be paid.* Notwithstanding section 4.03(2) or section 4.03(3) of this revenue procedure, as applicable, the amount required to be paid shall not exceed the lesser of $5,000,000 or 5% of the total asset value of the segregated asset account on the 30th day after the last day of each calendar quarter for which the segregated asset account was not diversified. If nondiversification spans multiple calendar quarters, the amount payable under this section is based on the calendar quarter that produces the highest amount. The limitation applies on a per segregated asset account basis, and is not increased by any interest computed under § 6621(a)(2).

.04 *Payment of amount.* The issuer is required to pay the amount determined under section 4.03 of this revenue procedure within 60 days of the date of execution of the closing agreement by the Service. Payment shall be made by check payable to the "United States Treasury" delivered, together with a fully executed copy of the closing agreement, to Internal Revenue Service, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

.05 *Correction of contracts.* The issuer is required to have satisfied the requirements of § 817(h) and § 1.817–5(b) of the regulations within a reasonable time after

the discovery of the failure to satisfy those requirements.

.06 *Required representations.* The submission must include representations to the effect that (1) the issuer is within the scope of section 3 of this revenue procedure; (2) the issuer properly computed the amount required to be paid with regard to the contracts in accordance with section 4.03 of this revenue procedure; and (3) the issuer has brought the contracts into compliance with the requirements of § 817(h) and § 1.817–5(b) of the regulations. The representations must be executed under penalties of perjury by an appropriate party (as set forth in section 7.01 of Rev. Proc. 2008–1 (or its successor)). The issuer must retain documentation available for audit to support the representations.

.07 *Electronic submission.* The information required under this revenue procedure may be submitted to the Service electronically, in read-only format, on a CD-ROM. Adobe Portable Document is a suitable format. Other formats may be arranged on a case-by-case basis. The issuer must provide a total of three CD-ROMs, one for each of the three copies of the closing agreement.

SECTION 6. MODEL CLOSING AGREEMENT

Effective as of date executed by Internal Revenue Service _____

CLOSING AGREEMENT AS TO FINAL DETERMINATION
COVERING SPECIFIC MATTERS
UNDER SECTION 817(h)

THIS CLOSING AGREEMENT ("Agreement") is made pursuant to section 7121 of the Internal Revenue Code (the "Code"), by and between ***[Insert Taxpayer name, address and EIN]*** ("Taxpayer") and the Commissioner of Internal Revenue (the "Service").

WHEREAS,

A. Taxpayer is the issuer of one or more variable contracts, as defined in § 817(d) (without regard to § 817(h)) (the "Contracts"), which are based, in whole or in part, on a segregated asset account (the "Account") and that provides for the allocation of amounts received under the variable contracts to the Account.

B. Pursuant to Rev. Proc. 2008–41, 2008–29 I.R.B. 155, the Service may treat the investments of a segregated asset account on which a variable contract is based as satisfying the diversification requirements of § 817(h) and § 1.817–5(b) of the Income Tax Regulations for periods during which there was an inadvertent failure to diversify.

C. By letter dated ***[Insert date]*** Taxpayer submitted to the Service, pursuant to Rev. Proc. 2008–1, 2008–1 I.R.B. 1 ***[or successor, if applicable]*** and Rev. Proc. 2008–41 a request for this Closing Agreement that ***[Insert account name]*** (the Account) be treated as adequately diversified under § 817(h) for the period ***[Insert period of nondiversification]*** ("the period of nondiversification").

D. Taxpayer represents that the failure of the Account to satisfy the requirements of § 817(h) is eligible for relief under Rev. Proc. 2008–41.

E. Taxpayer represents that the failure of the investments in the Account to satisfy the requirements of § 1.817–5(b) was discovered on ***[Insert date]***, and the investments came into compliance with those requirements on ***[Insert date]***.

F. Taxpayer represents that the amount determined under section ***[Insert 4.03(2), (3) or (4), as appropriate]*** of Rev. Proc. 2008–41 is $ ***[Insert amount]***. Taxpayer represents that this amount has been computed correctly under the provisions of Rev. Proc. 2008–41.

G. To ensure that variable contracts that provide for the allocation of amounts received thereunder to Account are treated as annuity, endowment, or life insurance contracts, as applicable, Taxpayer and the Service have entered into this Agreement.

NOW THEREFORE IT IS HEREBY DETERMINED AND AGREED BETWEEN TAXPAYER AND THE SERVICE AS FOLLOWS:

1. In consideration for the agreement of the Service as set forth in section 2 below, Taxpayer agrees as follows:

   (A) Taxpayer will pay the Service $ ***[Insert amount]*** at the time and manner described in section 3 below.

   (B) The amount paid pursuant to section 1(A) above is not deductible by Taxpayer, nor is such amount refundable, subject to credit or offset, or otherwise recoverable from the Service;

   (C) For purposes of Taxpayer's complying with its reporting and withholding obligations under the Code,

      (i) neither the investment in the contract for purposes of § 72, not the premiums paid for purposes of section § 7702 on any Contract can be increased by any portion of the amount set for the in section 1(A) above. If any such increases are made, they are entitled to no effect.

(ii) neither the investment in the contract for purposes of § 72, nor the premiums paid, for purposes of § 7702 on any Contract can be increased by any portion of the amount which Taxpayer represents to be the income on the contract for all of the Contracts in the aggregate. If any such increases are made, they are entitled to no effect.

2. In consideration of the agreement of Taxpayer set forth in Section 1 above, the Service agrees as follows:

(A) To treat the investments of the Account as adequately diversified for purposes of § 817(h) during the period of nondiversification;

(B) To treat no portion of the amount described in Section 1(A) above as income to the Contract holders;

(C) To treat the failure(s) described above, and any corrective action described in Section 1(A) above, as having no effect on the date the Contracts were issued, entered into or purchased for purposes of any provision of the Code or regulations thereunder; and

(D) To waive civil penalties for failure of Taxpayer to satisfy the reporting, withholding, or deposit requirements for income deemed received by Contract holders due to the Contracts' failure to satisfy the requirements of § 817.

3. Payment of the amount described in Section 1(A) above shall be made within 60 days of the date of execution of this Agreement by the Service. This payment must be made by check payable to the "United States Treasury," delivered, together with a copy of this executed Agreement, to Internal Revenue Service Center, Receipt & Control Stop 31, 201 W. Rivercenter Blvd., Covington, KY 41011.

4. This Agreement is, and shall be construed as being, for the benefit of Taxpayer. Holders of contracts based on the Account are intended beneficiaries of this Agreement. This Agreement shall not be construed as creating any liability of Taxpayer to the holders of the contracts based on the Account.

5. Neither the Service nor Taxpayer shall endeavor by litigation or other means to attack the validity of this Agreement.

6. This Agreement may not be cited or relied upon as precedent in the disposition of any other matter.

NOW THIS CLOSING AGREEMENT FURTHER WITNESSETH, that the Service and Taxpayer mutually agree that the matters so determined shall be final and conclusive, except as follows:

1. The matter to which this Agreement relates may be reopened in the event of fraud, malfeasance, or misrepresentation of material facts set forth herein.

2. This Agreement is subject to sections of the Code that expressly provide that effect be given to their provisions (including any stated exception for Code § 7122) notwithstanding any other law or rule of law.

3. To the extent this Agreement relates to any tax period after the date on which it is executed, it is subject to any law, enacted after such date, that applies to that tax period.

IN WITNESS WHEREOF, the parties have subscribed their names in triplicate. By signing, the above parties certify that they have read and agreed to the terms of this document.

[Insert Taxpayer name]

Date Signed: _____

By: _____

Title: _____

COMMISSIONER OF INTERNAL REVENUE

Date Signed: _____

By: _____

Title: _____

SECTION 7. EFFECTIVE DATE

This revenue procedure is effective July 21, 2008, the date of its publication in the Internal Revenue Bulletin.

SECTION 8. EFFECT ON OTHER DOCUMENTS

Rev. Rul. 91–17, 1991–1 C.B. 190, is amplified to provide terms and conditions and a model closing agreement for use by taxpayers seeking the relief described in § 1.817–5(a)(2) of the regulations; Rev. Proc. 92–25, 1992–1 C.B. 741, is superseded; Notice 2000–9, 2000–1 C.B. 449, is obsolete.

SECTION 9. PAPERWORK REDUCTION ACT

The collections of information in this revenue procedure have been reviewed

and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545–1752.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books and records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally tax returns and return information are confidential, as required by 26 U.S.C. 6103.

DRAFTING INFORMATION

The principal author of this revenue procedure is Melissa S. Luxner of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this revenue procedure, contact Branch 4 of that office at (202) 622–3970 (not a toll-free call).

---

26 CFR 601.105: Examination of returns and claims for refund, credit or abatement; determination of correct tax liability.
(Also Part I, §§ 101, 7702.)

Rev. Proc. 2008–42

SECTION 1. PURPOSE

This revenue procedure provides a procedure by which an issuer of a life insurance contract may automatically obtain a waiver, under § 7702(f)(8) or § 101(f)(3)(H) of the Internal Revenue Code, for certain reasonable errors that caused the contract to fail to satisfy the requirements of § 7702 or § 101(f), as applicable. Rev. Rul. 91–17, 1991–1 C.B. 190, is amplified.

SECTION 2. BACKGROUND

.01 *Definition of a life insurance contract.*

(1) Section 7702(a) provides that, for a contract to qualify as a life insurance contract for Federal income tax purposes, the contract must be a life insurance contract under the applicable law and must either—

(a) satisfy the cash value accumulation test of § 7702(b), or

(b) both meet the guideline premium requirements of § 7702(c) and fall within the cash value corridor of § 7702(d).

(2) A contract meets the cash value accumulation test of § 7702(b) if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at that time to fund future benefits under the contract.

(3) A contract meets the guideline premium requirements of § 7702(c) if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of that time. The guideline premium limitation as of any date is the greater of the guideline single premium, or the sum of the guideline level premiums to that date. The guideline single premium is the premium that would be required on the date the contract is issued to fund the future benefits under the contract.

(4) A contract falls within the cash value corridor of § 7702(d) if the death benefit under the contract at any time is not less than the applicable percentage of the cash surrender value, based on the table set forth in § 7702(d)(2).

(5) Section 7702 is effective for contracts issued after December 31, 1984, in tax years ending after that date.

.02 *Definition and tax treatment of a flexible premium life insurance contract.* A flexible premium life insurance contract is a life insurance contract that provides for the payment of one or more premiums that are not fixed by the insurer as to both timing and amount. Section 101(f) provides that any amount paid by reason of the death of the insured under a flexible premium life insurance contract is excluded from gross income only if the contract satisfies either (1) the guideline premium limitation and the applicable percentage of cash value test of § 101(f)(1)(A)(i) and (ii), or (2) the cash value test of § 101(f)(1)(B). The limitations of § 101(f) generally apply to contracts issued before January 1, 1985.

.03 *Correction procedure for reasonable errors.* Section 7702(f)(8) provides that if a taxpayer establishes to the satisfaction of the Secretary that the requirements of § 7702(a) for any contract year were not satisfied due to reasonable error, and reasonable steps are being taken to remedy the error, the Secretary may waive the failure to satisfy those requirements. The Internal Revenue Service (Service) may waive civil penalties for failure to satisfy the reporting, withholding, and deposit requirements for income deemed received under § 7702(g) and (h), as well. *See* Rev. Rul. 91–17. Section 101(f)(3)(H) provides similar authority for the Secretary to waive the failure to satisfy the requirements of § 101(f). In order to request a waiver under § 7702(f)(8) or § 101(f)(3)(H), a taxpayer generally must request a letter ruling from the Service under the procedures set forth in Rev. Proc. 2008–1, 2008–1 I.R.B. 1 (or any successor).

.04 *Changes to correction procedure.* In Notice 2007–15, 2007–1 C.B. 503, the Service requested comments as to how various correction procedures — including those for obtaining a waiver with respect to errors that are reasonable within the meaning of § 7702(f)(8) or § 101(f)(3)(H) — may be improved. This revenue procedure incorporates a number of changes that taxpayers suggested in response to Notice 2007–15. Specifically, this revenue procedure provides a simplified procedure under which a taxpayer may obtain a waiver for a limited class of errors under these provisions without incurring the cost of requesting a letter ruling.

SECTION 3. SCOPE

.01 *In general.* This revenue procedure applies to any issuer of a life insurance contract that failed to satisfy the requirements of § 7702 or § 101(f), as applicable, due to an eligible reasonable error, provided reasonable steps are taken to remedy the error.

.02 *Issuer.* For purposes of this revenue procedure, the term "issuer" is any company that issues a contract that is intended to satisfy the requirements of § 7702 or § 101(f). The term also includes a company that insures a contract holder under a contract originally issued by another company.

.03 *Eligible reasonable error.* An eligible reasonable error for purposes of this revenue procedure exists if: (1) the issuer has compliance procedures with specific, clearly articulated provisions that if followed would have prevented the contract from failing to satisfy the requirements of

§ 7702 or § 101(f); (2) an employee or independent contractor of the issuer acted, or failed to act, in accordance with the compliance procedures; and (3) such act or failure to act was inadvertent, and was the sole reason that the contract failed to satisfy the requirements of either § 7702 or § 101(f). Thus, for example, the term eligible reasonable error includes an employee's incorrect recording of the age or gender of the insured, or of the incorrect amount or time of payment of the insured's premium payment.

.04 *Reasonable steps to remedy.* The requirement that reasonable steps be taken to remedy the eligible reasonable error is satisfied for purposes of this revenue procedure if the issuer refunds excess premium with interest and/or increases the death benefit on the contract no later than the date on which the issuer files the federal income tax return to which the tax return attachment described in section 4.03 of this revenue procedure is affixed. The remedy required under this section 3.04 of this revenue procedure does not include changes to the issuer's compliance procedures, since the definition of an eligible reasonable error under section 3.03 of this revenue procedure requires that the system already have specific, clearly articulated procedures that if followed would have prevented the error.

.05 *Non-eligible errors.* Although the automatic waiver provided under this revenue procedure is not available with respect to an error that is not described in section 3.03 of this revenue procedure, relief may be available under other correction procedures. For example, neither a defective legal interpretation nor a computer programming error would satisfy the requirement of section 3.03(1) of this revenue procedure that the issuer's compliance procedures, if followed, would have prevented the error. If such an error is reasonable, however, the issuer may request a waiver by letter ruling under the procedures set forth in Rev. Proc. 2008–1 (or any successor). In addition, errors that are not reasonable may be eligible for correction by closing agreement under the procedure set forth in Rev. Proc. 2008–40, page 151, this Bulletin.

SECTION 4. PROCEDURE

.01 *Automatic waiver.* The failure of one or more life insurance contracts to satisfy the requirements of § 7702 or § 101(f), as applicable, due to reasonable error will be treated as waived pursuant to the authority of § 7702(f)(8) or § 101(f)(3)(H), as applicable, provided the issuer (1) is within the scope of section 3.01 of this revenue procedure, and (2) files both the waiver statement described in section 4.02 and the tax return attachment described in section 4.03 of this revenue procedure.

.02 *Waiver statement.* An automatic waiver for a reasonable error described in section 3 of this revenue procedure is available to an issuer only if it files with the Service, in duplicate, a statement entitled "Automatic Waiver Request under Rev. Proc. 2008–42" in which the issuer (1) provides a brief description of the error and the steps taken to remedy the error; (2) lists the policy numbers of the life insurance contracts for which it seeks an automatic waiver; and (3) provides the representations described in section 4.04 of this revenue procedure. This statement should be signed and dated, and submitted to the Commissioner of Internal Revenue, Attn: CC:FIP:4, Room 3550, 1111 Constitution Avenue, NW, Washington, DC 20224, no later than the date on which the issuer files the federal income tax return to which the tax return attachment described in section 4.03 of this revenue procedure is affixed.

.03 *Tax return attachment.* In addition, the issuer must attach to its timely-filed (including extensions) Federal income tax return, for the taxable year during which the issuer relies upon this revenue procedure to obtain a § 101(f)(3)(H) or § 7702(f)(8) waiver, a statement that reads: "Issuer has submitted an Automatic Waiver Request under section 4.02 of Rev. Proc. 2008–42 for certain errors that caused one or more life insurance contracts it issued to fail to comply with § 7702(f)(8) or § 101(f) of the Internal Revenue Code. An issuer filing its return electronically should attach this statement as an Adobe Portable Document format (PDF) file named "Rev. Proc. 2008–42."

.04 *Representations.* The waiver statement required under section 4.02 of this revenue procedure must include representations to the effect that the issuer is within the scope of section 3 of this revenue procedure and that the issuer is otherwise entitled to the requested waiver. The representations must be executed under penalties of perjury by an appropriate party (as set forth in section 7.01 of Rev. Proc. 2008–1 (or its successor)). The issuer must retain documentation available for audit to support the representations.

.05 *Electronic submissions.* The waiver statement required under section 4.02 of this revenue procedure may be submitted to the Service electronically, in read-only format, on a CD-ROM. Adobe Portable Document format is a suitable format. Other formats may be arranged on a case-by-case basis. The issuer must provide a total of two CD-ROMs.

SECTION 5. EFFECTIVE DATE

This revenue procedure is effective July 21, 2008, the date of its publication in the Internal Revenue Bulletin.

SECTION 6. EFFECT ON OTHER DOCUMENTS

Rev. Rul. 91–17, 1991–1 C.B. 190, is amplified to provide an automatic procedure by which an issuer of a life insurance contract may automatically obtain a waiver for certain reasonable errors that caused the contract to fail to satisfy the requirements of § 7702 or § 101, as applicable.

SECTION 7. PAPERWORK REDUCTION ACT

The collections of information in this revenue procedure have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545–1752.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

Books and records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally tax returns and return information are confidential, as required by 26 U.S.C. 6103.

DRAFTING INFORMATION

The principal author of this revenue procedure is Josephine H. Firehock of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this revenue procedure, contact Branch 4 of that office at (202) 622–3970 (not a toll-free call).