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Types of Health Insurance Available To You

Topics Covered:

Bodily Injury: General Information and What You Should Know About Coverage

Burial Insurance: Important Information for You and Your Family

CHIP: What is it and How Can it Help You?

COBRA: What You Need To Know

What You Need to Know About COBRA Insurance

Health Insurance Plans for Your Pet

Health Insurance For Pets

Workman's Compensation: Who Pays for It

The Difference Between Health Insurance and Life Insurance

Types of Health Insurance Available To You

Bodily Injury: General Information and What You Should Know About Coverage

Bodily injury liability coverage is an element of many different types of insurance policies (auto, homeowner's and business insurance) and is meant to protect an individual should physical harm come to him or her through the action or inaction of another.

Auto Insurance and Bodily Injury Coverage

There are generally six parts to an all-inclusive auto insurance policy: personal property liability, personal injury protection (PIP), uninsured motorist coverage, comprehensive coverage, collision and bodily injury liability.

Personal property liability covers the policyholder against property damage he or she causes in the event of an accident; PIP covers the policyholder and his or her passengers in case of injury; uninsured motorist coverage protects the driver in the event that he or she is involved in an accident with another driver who is uninsured; comprehensive coverage protects the car owner against theft and natural disasters; and, collision coverage pays for repairs to the policyholder's vehicle should it be involved in accident.

The bodily injury portion of the coverage is designed to protect the policyholder in the event that he or she causes physical injury to another person while operating a vehicle.

Every U.S. state requires that drivers in their jurisdictions include a set minimum amount of bodily injury coverage as part of the auto insurance policy. These state-mandated limits, however, are generally not enough to cover a very serious accident and most insurance experts suggest purchasing more than the legal minimum.

In the event of a serious bodily injury claim and subsequent lawsuit, a policyholder could be in jeopardy of losing his or her home and property. Those who have substantial assets to protect might also want to consider purchasing an umbrella policy that provides supplemental coverage to the existing ones.

Homeowner's Insurance and Bodily Injury Coverage

One of the most nightmarish scenarios any homeowner can imagine is one in which a visitor to the home is seriously injured in some way. Friendships and family ties have been broken over such circumstances and finances have been left in ruin. Every responsible homeowner should review his or her existing homeowner's policy and determine what sorts of accidents or injuries are the responsibilities of the homeowner and which are not.

All homeowner's policies offer some sort of bodily injury liability coverage for both visitors and residents. This coverage protects against just about every possible circumstance that could lead

to physical injury in the home and includes injuries caused by the homeowner and anyone residing within the home. Any injuries caused by household pets are also covered.

There are some situations, however, in which bodily injury that occurs on a homeowner's premises is not covered by the homeowner's insurance policy. If the homeowner runs a business from the home and the injury sustained relates to the business in any way, there is no coverage.

If the injury occurs in a rented property, then the homeowner's insurance will not cover it "renter" insurance should contain the necessary coverage. Another circumstance in which coverage is not provided through the homeowner's policy is when the injury is proven to be intended or expected by the homeowner.

Business Insurance and Bodily Injury Coverage

There are two types of insurance that every business owner needs in order to ensure that he or she is not left vulnerable to lawsuits stemming from bodily injuries that occur at the place of business--liability insurance and workman's compensation insurance.

Liability insurance (optional) is purchased separately from any other policy and protects the policyholder in case anyone within the place of business is injured. If the property is not actually owned by the business owner then whoever does own the property will have to carry an additional liability policy or be added to the business owner's existing one.

Workman's compensation coverage is designed to protect the employees of a business in case they are injured while on the job. Every state requires that businesses carry it and each jurisdiction has a different set of rules for how it works. In general, the employee is covered for any death or injury that occurs on the job or any illness that is caused by the job.

Workman's compensation coverage covers medical expenses, rehabilitation expenses, lost wages and any other costs incurred because of the injury or illness. Although an employee is covered even if the accident leading to injury is his or her fault, intentional acts are not covered - neither is those injuries sustained because of drug or alcohol use.

Burial Insurance: Important Information for You and Your Family

Most people hate either contemplating or talking about their own death or burial and try to avoid both subjects whenever possible, perhaps they want to believe it will never happen to them. The reality, however, is that everyone dies and if you don't plan ahead for the inevitable costs associated with a funeral and burial, your survivors could be left with a mountain of bills that they cannot afford to pay. All other members of your family should be included in any burial plan or should have policies of their own.

When considering the need for burial insurance, the first thing you should do is determine the costs currently associated with a funeral and burial. Even if you have a burial plan, the benefit amount may not be sufficient (especially if the policy is an old one) to cover the actual costs.

After you determine the estimated funeral and burial costs, you can start looking for a burial insurance plan that best suits your needs. A reputable insurance agent will be able to point you in the right direction.

Look at the Numbers

You won't know what kind of burial insurance plan you need; or if the one you have is sufficient - until you estimate the costs of a funeral and burial. This will take a bit of time and research, but the effort will definitely be worth it. The items you must include in this estimate are: medical bills not covered by insurance, debts, cemetery plot, casket, vault, headstone, funeral service and viewing, floral arrangements, limousine service, minister' fees, body preparation fees, and other miscellaneous expenses. A funeral home could give you a rough estimate of most of these costs.

Estimating the costs associated with a funeral and burial accomplishes two things: it allows you to choose an adequate burial plan and gives you an idea of the bill you or your survivors could be stuck with.

Do You Need a Burial Plan?

Before you begin shopping for a burial insurance plan, make sure that you really need one. Go through all of your existing policies and check for burial coverage. If you have insurance through your place of employment, burial costs may already be covered.

If you find that you are not covered through your workplace, see if your employer offers such a plan and whether or not you are eligible to participate, premiums paid through an employer can be a lot lower than those paid through an independent plan. If you or a loved one is a veteran of the U.S. Military, then a funeral, burial plot and other miscellaneous expenses are most likely part of your veteran's benefits.

If you have a current burial insurance policy, compare the benefit to the current estimated costs. Funeral costs increase every year and your current plan (especially if it's an old one) may not pay enough to cover everything. If this is the case, consider modifying your current policy or getting an additional one.

Buying Burial Insurance

Once you've decided to buy a burial insurance plan, do a lot of shopping around and make sure that the plan you choose fits your needs. You'll want a policy that will cover all funeral and burial expenses and one that takes into account the increasing associated costs as well. For example, if you've used today's prices to calculate that the cost of your funeral and burial would be \$10,000, a policy with a benefit in that amount will probably not cover the same expenses 10 or 15 years from now. You will need to make an educated guess as to the future cost or purchase a plan that takes these ever-increasing numbers into account.

The burial insurance plan that you choose may simply require that you send in an application through the mail. If you are relatively young and have no major medical problems, then the premiums should be low and qualifying for the policy won't be a problem. If, on the other hand,

you have been diagnosed with any major or terminal illnesses, have recently been hospitalized, had an organ transplant or been denied insurance in the past 6 months, you will not qualify.

An alternative to the traditional burial plan is something called “pre-need” insurance. This type of burial plan allows you to prepay for your burial expenses at current prices. It also lets you plan all aspects of the funeral, from the music played and passages read to the clothing you’ll be buried in.

CHIP: What is it and How Can it Help You?

American parents work hard to ensure the health and well being of their children. Sometimes, however, the bills get to be too much, and they need help. Financing the soaring costs of children’s health care could bankrupt most parents, but the costs are particularly prohibitive for parents of families who do not or cannot benefit from employer-sponsored or individual health care insurance.

Recognizing the short and long-term benefits and value of consistent health care for children, the government provides a number of insurance options to help parents access the medical care they need for their families. This investment in the health of America’s children comes in two major formats: Medicaid assistance for low-income families and the Children’s Health Insurance Program, or CHIP. CHIP is also sometimes referred to as the State Children’s Health Insurance Program (SCHIP).

CHIP was introduced in 1997 as a means of increasing the number of children able to access consistent, quality health care. Medicaid was designed to provide assistance to the elderly, disabled and very poor, but a huge segment of the American population is made up of working families who earn too much money to qualify for Medicaid assistance, but who are realistically unable to afford private health insurance coverage or to pay out-of-pocket for medical expenses. The result? Millions of children were not getting the medical care they so desperately needed, but that they could not afford to receive.

Since its inception in the late 1990s (the program celebrated its eighth anniversary Oct. 1, 2005), the Child Health Insurance Program has allowed children to benefit from regular checkups, immunizations, eye care, dental care and discounted prescriptions at little or no cost to their families.

It is difficult to measure the impact this insurance has had on the children who were able to receive care because of it, but aside from the financial and social benefits, it has been proven that children who receive regular preventative medical care such as check ups and vaccinations are sick less often and miss less time away from school.

Administered by the Centers for Medicare & Medicaid Service and by each state, the Child Health Insurance Program committed \$40 billion in federal matching funds over a ten-year period. Although much of the funding for CHIP comes from federal coffers, each state has its own guidelines and eligibility requirements for participation in the program. While there are variations depending on where you live, the income cut-off for a family of four is about \$35,000

per year. Additionally, children must also be under the age of 19, and not be insured under any other program.

Of the more than 40 million Americans who still do not have any health insurance protection, many are immigrants who fear enrolling their children in a government-sponsored program will have a negative impact on their green card application status. With the exception of situations where children require long-term care such as in a nursing home, participation in CHIP is available without penalty to children of immigrant adults seeking their green card.

Children who need long-term care may receive it, but this may be considered as part of their families' green card applications. Generally, all so-called "qualified aliens" who fall under one or more of nine categories (defined by the U.S. Citizenship and Immigration Services - USCIS) are able to apply for CHIP: lawfully admitted permanent residents; refugees; aliens seeking asylum; aliens granted a minimum one year parole; aliens whose deportation has been withheld; aliens granted conditional entry; battered aliens; and, victims of a severe form of trafficking.

Another group of children who are often overlooked when it comes to health care insurance coverage are the homeless. Uninsured children who do not have a home may be eligible for either Medicaid or CHIP even without a mailing address. In some states, the application process is simplified with a single application process, which may make obtaining either CHIP or Medicaid health care insurance more attractive for parents who are confused about which program for which they and their children are eligible.

Although millions of children remain uninsured for health care, CHIP is an effective way to help families just out of reach of Medicaid gains the protection they need until they are able to acquire independent or employment-based coverage.

COBRA: What You Need To Know

COBRA Insurance coverage is something many people don't understand or how it works for them and the benefits they can draw from it. COBRA might just be what you're looking for to fill those insurance needs. But lets look at what COBRA is and if it's in your best interest to continue it or end it.

COBRA is also known as the Consolidated Ominbus Budget Reconciliation Act of 1985 or COBRA for short. COBRA is still a very useful law to many and people still use it today. COBRA makes it possible to keep health insurance coverage from their employer for up to 18 months if their employment status changes. Some of these changes could be layoff, reduced work hours or a termination of employment by either party involved.

COBRA has helped countless Americans keep insurance coverage. Now, is it good for you or not? Many times when individuals lose health coverage they have a very hard time getting coverage in the private sectors for various reasons. If they do find insurance coverage it's extremely expensive and many times not feasible for the displaced worker. For the worker to continue his insurance coverage through his employer he must pay the monthly premium, which can add up because he's not getting a discounted price anymore.

Internet access has helped many people find various health care programs. Now people can get on the Internet and do their own research and find out which company can give them the best deal and will give them the most benefits for the money. Since the Internet encompasses so much information more choices and comparison-shopping has become the buzzword.

Now one of the most important questions you need to ask yourself is whether or not to continue COBRA insurance coverage from your employer. If you have many health problems that are being treated right now you probably should strongly consider using the COBRA insurance option. Having health problems with pre-existing conditions could make it very difficult for you to get insurance coverage. If you do get health care coverage it will be so expensive it wouldn't be worth it.

If you are changing jobs and you know that your new employer doesn't offer health care coverage or if you know you won't qualify for the new company's health plan then highly consider COBRA as a viable option. It is also a good idea not to have gaps in health care coverage, as this tends to get you a better deal.

If you tend to be on the healthy side then you can choose not use COBRA as an option. There are a few reasons for that. Being healthy you should shop around as you will be able to get better coverage and at a more affordable price. Insurance companies love to insure young healthy individuals as they know it usually costs them a lot less money therefore, they will be glad to give you a good deal on your health care needs.

There are a few things you should know about COBRA so you can make a very informed decision. Once your health care coverage is lost, you are given a 60 day grace period in which time you must chose to use COBRA or not, otherwise you will lose it all together. Once the 60 days has past, it is not offered again. COBRA also has provisions that give certain former employees, retirees and spouses the right to get temporary continuation of health care coverage at group rates.

Some of the things that COBRA will continue to cover if you decide to keep the coverage are:

- Inpatient and outpatient hospital care
- Physician care is also covered under COBRA
- Surgery and major medical benefits
- Prescription drugs are also covered but life insurance is not covered under COBRA.

COBRA has many advantages and disadvantages and just like anything else an informed decision will take some time and research. COBRA has been helpful to many employees and will continue to provide coverage when needed for many more years to come. For some COBRA just doesn't fit into their plans; each individual will have to choose whether COBRA can benefit them.

What You Need to Know About COBRA Insurance

COBRA, also known as 'The Consolidated Omnibus Budget Reconciliation Act' of 1985, is a federal law that ensures that a person's health insurance coverage will continue for up to 18 months after the date of his or her termination. Most companies that offer group health insurance to their employees are subject to COBRA and certain situations can extend this deadline from 18 months to 29 months and even up to 36 months.

Who Benefits from COBRA?

COBRA insurance protects those who have lost their job against simultaneously losing their health insurance benefits. COBRA is a temporary measure that's designed to help individuals through this potentially difficult time. Not every terminated employee qualifies for COBRA insurance, but all employers know whether these rules apply to their company and their employees.

The law enables a terminated employee to buy health insurance for himself (and his family if he had family coverage while employed) at the group rate even though that employee is technically no longer part of the group. The price of coverage is high and the former employee is responsible for paying 100% of the cost each month, plus a 2% surcharge.

COBRA kicks in when an eligible employee is terminated, laid-off or experiences some other type of change in his or her employment status (such as reduced hours, or divorce from or death of the eligible employee). COBRA continues according to the schedule above or until the terminated employee is covered by an individual health insurance plan or another group health insurance plan.

Employers are required by law to notify eligible former employees of their option to purchase health insurance through COBRA. Employers need to also specify the cost for this coverage. Those receiving this notification have up to 60 days to accept COBRA coverage.

Because COBRA basically extends a terminated employee's health insurance for a period of 18 months, those who participate in COBRA need not worry about a change in their benefits. Coverage itself does not change; the only change is the person responsible for paying the monthly premium.

All family members who were covered prior to termination remain covered during the course of COBRA as well. In fact, the only way that coverage will change is if the person's former employer changes the health insurance plan it is offering to its current employees.

COBRA Designed to be Temporary

The important thing to keep in mind about COBRA is that it is intended to be used as a temporary measure. It guarantees you won't be without health insurance for 18 months, but once that period expires, you will find yourself without health insurance if you have not secured it otherwise, either from a new employer or by obtaining an individual health insurance plan. And, although it's unpredictable, you never want to find yourself in a situation where you detect for the first time a serious medical condition (such as cancer) while covered under COBRA. Such

a situation could cause you to become 'uninsurable' later on because you've since developed a pre-existing condition.

Health Insurance Plans for Your Pet

Many pet owners dread the news that Rover or Kitty are seriously ill or injured. Too often, an anxious pet-lover is forced to make a fiscal decision when veterinary care is needed, and quite a few have had to endure the heartbreak of saying good-bye to a beloved pet that could be saved -- but only at a cost prohibitive expense.

To many of us, a pet is a member of the family. Treated sometimes like a child, the animal is companion, friend, confidante, and even dinner guest! It is no surprise that the insurance industries realized the advantages of this widely untapped market, and fortunately for us pet lovers, health insurance for pets is no longer a wished for ideal, but a new reality!

There are some similarities to health insurance for humans; for example, be sure to read the fine print! The most common misconception is the myth that all the distraught pet owner needs to do at the time of an emergency is to present an insurance card, and no money changes hands. Nothing could be further from the truth! As a matter of fact, most pet insurance plans will require the pet's owner to make an upfront payment at the time of service. Later on, a claim may be sent to the insurance company, and a reimbursement is made.

Many plans cost as little as \$30 a month, but it is imperative that the pet owner understands the scope of coverage. Minimum cost implies minimum coverage. For example, one major pet health insurance plan will cover the same illnesses and emergencies at different plan levels, yet those who choose to purchase a minimum plan will receive less of a reimbursement than those who choose a more expensive plan.

In addition to the foregoing, pet insurance is not without its complications. For example, benefits are limited when it comes to an initial diagnosis. While your veterinarian may charge \$150 to examine Rover's bite wound after he had a run-in with the neighbor's Doberman, the insurance plan will only cover about \$92. If Rover needs to undergo anesthesia, the insurance is willing to pay an extra \$44, but will not pay any more.

In addition to the foregoing, if the bite wound is considered a secondary diagnosis, and Rover is instead treated for a puncture wound, then the coverage for the bite wound is reduced to only \$65 in its entirety. On the other hand, if you choose to purchase the higher level plan, then a similar situation will result in the reimbursement of \$154 for the examination of the bite wound, \$74 for anesthesia, and \$108 in case of the bite wounds being a secondary diagnosis.

Some pet owners don't think that such coverage is worth the money, but they had best think again! While a pet is young, veterinary visits are few and far between, but once Rover ages, new problems crop up. Additionally, if Kitty begins to venture into the great outdoors, the risks and potential for injury increases. Also, it is noteworthy that pet health insurance does not only cover the catastrophic injuries, but even the mundane dental cleanings, shots, heartworm medication, flea prevention, and more.

In closing, concerned pet owners owe it to their furry (or feathered) friends to ensure that adequate care will be available in case of an emergency. Yet, they owe it to themselves to become well educated in the multifaceted aspects of pet insurance, and the exclusions and limitations. To this end, here are some suggestions:

1. Understand the deductible

The pet's age and even pre-existing conditions may change the deductible the plan applies. Additionally, a co-payment may be charged that can run as high as 20% of the veterinary fee.

2. Understand the exclusions

Just like human insurance, pet insurance too has exclusions. They may vary from company to company, and often deal with pre-existing conditions. Other exclusions may apply to dental care, vaccinations, etc.

3. Know the caps

The insurance plan will only pay a certain amount per covered incident. Discuss hypothetical fees with your veterinarian and find out if these caps are realistic. Additionally, are these caps applicable to a lifetime treatment, or to a per-occurrence charge?

Health Insurance For Pets

For those of us who own animals and have taken them to the vet's office for one reason or another, we know just how quickly the costs of maintaining a pet add up. Not only can the yearly physicals and immunizations be costly, but add in any unexpected injuries or illnesses and the costs can easily run into the hundreds, if not thousands of dollars. Most of us carry health insurance on ourselves and our family members for this very reason, so why not on our pets too?

There are many options available to you for pet insurance. Depending on the coverage you pick, the cost can vary just like in health insurance policies for humans. Let's go over a few of your options and just what they mean for you and your pet.

What Does Pet Insurance Cover?

Like with our health insurance, different policies will cover different things. How much coverage you have will depend on what you want to spend. If you only want to cover injuries and medical emergencies, the coverage will be cheaper than if you wanted the whole package, including all well-pet check-ups and immunizations.

There are policies that will only cover what is called catastrophic illnesses, like cancer. These policies can be quite cost effective for those on a budget and still give you some peace of mind knowing that if anything major happened, you would be able to have your pet treated. Some

policies even offer you the option of having kennel coverage. If you travel a fair amount and your pet spends that time in the kennel, this may be an option that would work for you.

These policies will also work on the deductible set-up. How much of a deductible you choose will also affect the cost of the policy.

When Do I Need Pet Insurance?

Really, anytime you have a pet. Some may think that older pets that are prone to some of the aging medical issues are the only ones that need coverage, but that would be like covering your child only once they are no longer a toddler. That really doesn't make any sense. Young animals can also get sick and injured. As a matter of fact, some of the more serious and costly illnesses that animals are prone to occur when they are in their infancy.

Even if you keep your pet indoors, this doesn't protect them completely. Although outdoor pets are probably more likely to get injured, indoor pets are more likely to get into household poisons and other chemicals. And illnesses don't care if your pet is kept indoors or not.

Where To Get Pet Insurance

Check out the Internet for a large array of pet insurance companies. These companies offer many different types of coverage for many different animals, not just the traditional dog or cat. Before you purchase one though, check with your veterinarian to make sure the company is reputable, the coverage is adequate and that the vet accepts that particular plan.

Workman's Compensation: Who Pays for It

Workman's compensation insurance, also known as "workman's comp", is a state-mandated insurance program designed to protect workers who have been injured on the job or rendered ill because of workplace conditions. All companies, with a few exceptions, are required to maintain this type of insurance coverage no matter where they are located, in all 50 U.S. states require it. Although some details of workman's compensation coverage may differ slightly from state to state, the basics are fairly uniform.

Workman's compensation insurance typically consists of two parts: compensation for the worker and employer's liability coverage. The first covers the injured worker's medical bills, rehabilitation costs, lost wages and most other costs directly related to the injury, even if the injury was the employee's fault. Employer's liability, on the other hand, covers the employer's legal costs should an employee bring suit against the business.

The location and size of the business will determine what sort of workman's compensation policy an employer must carry. Most states allow employers to purchase their plans through a traditional insurance company. There are some states, however, that require the insurance be purchased exclusively through programs run by the state itself. North Dakota, Ohio, Washington, West Virginia and Wyoming all require the use of state-run workman's compensation programs.

Puerto Rico and the U.S. Virgin Islands require this type of plan as well. Not all states that provide a state-run plan, however, demand that the companies within their jurisdiction use it exclusively. Arizona, California, Colorado, Idaho, Maryland, Michigan, Minnesota, Montana, New York, Oklahoma, Oregon, Pennsylvania and Utah all sponsor workman's compensation plans that compete with programs in the private sector.

In some U.S. states, a company that is big enough and reputable enough may create its own workman's compensation fund, without having to go through either the state or a private insurance carrier. The states that allow this option are: Arizona, California, Colorado, Hawaii, Idaho, Kentucky, Louisiana, Maine, Maryland, Minnesota, Missouri, Montana, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas and Utah. Any company that is self-insured in this manner, however, must be authorized by the state.

Cost to the Employer

No matter where the coverage comes from, workman's compensation insurance is expensive for an employer. Indeed, American businesses pay over \$100 billion in premiums each year. The coverage is wholly paid for by the employer, who is prohibited from passing any portion of the expense on to his or her employees.

The cost of workman's compensation insurance is dependent upon many factors. One important factor has to do with the classification of employees. Some employees are more expensive to cover than others because their jobs are considered more hazardous. For example, it costs more to cover a roofer than it does to cover a secretary because the roofer's job duties require more potentially risky behavior.

Two other important factors that determine the rise or fall of workman's compensation premiums are: the existence and implementation of a company's safety programs and its history of accident and injury. If an employer shows a concern for workplace safety and can prove that concern by keeping accidents down to a minimum, then the likelihood of a rise in premium rates is minimal.

Keeping Costs Down

There are many ways in which an employer can make sure that he or she is getting the lowest workman's compensation premium rate possible. The easiest way is for the employer to make sure that all workers are classified correctly. The premium rate for each classification is different--depending on the risk associated with it--and even the slightest error in classification can cost an employer dearly.

For example, keyboard use is considered a somewhat risky behavior because of the possibility of developing carpal tunnel syndrome. If an office worker who does not use a keyboard is mistakenly classified as one who does, then the employer could be paying an unnecessary premium.

Another method of keeping workman's compensation premium costs down is for the employer to institute safety programs, seminars and workshops. Very few employees purposefully injure themselves in order to obtain benefits. Sometimes workplace injuries are simply the result of an

unaware and uneducated workforce.

So, if an employer's concern for workplace safety is evident and ever-present (posters, signs, announcements, etc.), safety issues are more likely to remain on the minds of the employees and accidents are less likely to occur--fewer accidents mean lower premiums. An employer's overt preoccupation with safety also lets the insurance carrier know that he or she is doing everything possible to enforce employee safety. This often leads to lower premium rates as well.

The Difference Between Health Insurance and Life Insurance

Health insurance protects the insured against incurring extensive medical expenses by offering full or partial coverage for certain medical treatments and procedures. Life insurance, on the other hand, is an insurance policy that pays out the face value of the policy, in a lump-sum payment, to the person designated as the beneficiary, upon the death of the insured.

There are two basic types of life insurance: whole life and term life. Term life insurance is by far the less expensive of the two because it offers just life insurance. A term life insurance policy can be purchased for as little as one year and for as long as 30 years. In order for the beneficiary to cash in on the policy, the insured must die sometime during the term. This is probably why so many people wait until they are older before purchasing life insurance.

Whole life insurance is a combination of a life insurance policy and an investment plan. The premium associated with the whole life policy is shared between the two with a portion going towards the life insurance premium and the balance being invested into whichever investment vehicle has been chosen: mutual fund, money market, stock and bonds, etc.

The benefit of a whole life policy is that it forces the insured to save money for retirement by using a portion of the premium as investment money. In reality however, these policies are typically loaded with fees and commissions, and after taking these costs into consideration, it often is not the best use of an individual's investment dollars.

A life insurance policy is totally different from a health insurance policy and the price for each ultimately depends upon a person's age and physical wellbeing. In general, individuals who are young and healthy pay less than those who are older, and especially those who are older and in poor health.

It's not possible to advise a person, which is better, a health insurance policy or a life insurance policy. Many people obtain health insurance through their employer, and many employers also offer as a benefit the ability to purchase a low face value life insurance policy for a nominal cost. If this is your situation, it's advisable to take advantage of both these benefits.

Otherwise, deciding which insurance policies to purchase becomes more a matter of how much you can afford each month and your personal situation. It's advisable to choose health insurance coverage, even though it probably will be more expensive because it only takes one uninsured medical illness or accident to leave you with insurmountable medical bills. Also

consider this. If you don't have health insurance, and your medical bills (and/or other bills) are considerable, it might be a good idea to purchase term life insurance with a face value high enough to pay off your bills and designate your spouse as your beneficiary. That way, your spouse won't have to worry about inheriting your sizeable debt!

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