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Person to Contact:

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February 26, 1999

Legend

Taxpayer =

Association =

Year A =

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Dear

This is in response to your authorized representative's letter dated October 22, 1998, and supplemental submissions requesting rulings concerning the general death benefit and accidental death and dismemberment coverage provided by Taxpayer.

FACTS

Taxpayer represents that it is a collectively bargained, multiemployer health and welfare fund, exempt from federal taxation under § 501(a) and (c)(9) of the Internal Revenue Code, and a welfare benefit plan that is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. § 1001 et seq.

Taxpayer is sponsored by Union and Association, an association of some of the employers who contribute to Taxpayer pursuant to the applicable collective bargaining agreement. As of Date 1, there were x employers ("Employers") that made contributions to Taxpayer on behalf of y eligible participants.

Taxpayer is governed by a Board of Trustees ("Trustees") consisting of an equal number of representatives from Union and the Employers, pursuant to a written Plan of Benefits and written amendments thereto ("Plan"). Fiduciary duties are imposed on the Trustees by ERISA.[1] The Plan confers broad powers on the Trustees. They are given the power to construe and interpret the provisions of the Plan, and their decisions are binding "on all persons dealing with the Plan or claiming a benefit from the Plan." The Plan, however, also provides:

> If any decision of the Trustees or those acting on behalf of the Trustees is appealed or questioned in any judicial process, including arbitration, it is the intention of the parties to this Trust that such decision is to be upheld unless it is judicially determined to be arbitrary and capricious.[2]

The Plan also reserves to the Trustees the right, in their sole discretion, to: (1) establish, amend, or terminate the amount, eligibility requirements or conditions with respect to any benefits; (2) amend any provision of the Plan, prospectively or retroactively; and (3) terminate or merge the Taxpayer.

Taxpayer provides health, dental, vision, and disability benefits to eligible participants and their dependents.[3] Taxpayer also provides general death benefits and accidental death and dismemberment coverage. This coverage is provided to eligible

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[1]See 29 U.S.C. § 1104(a)(1), which requires fiduciaries to discharge their duties: (1) for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan; (2) under a prudent man standard for the conduct of a like enterprise; and (3) by diversifying investments so as to minimize the risk of large losses unless under the circumstances it is clearly prudent not to do so. 29 U.S.C. § 1132(l) provides for the imposition by the Secretary of Labor of civil penalties on fiduciaries for the violation of their fiduciary duties.

[2]29 U.S.C. § 1132(a)(1)(B) provides that a plan participant or beneficiary may bring a civil action to recover benefits due under the terms of the plan or to enforce his or her rights under the terms of the plan. 29 U.S.C. § 1132(a)(3) provides that a plan participant or beneficiary may obtain equitable relief in such a civil action.

[3]The term "dependents," as used in the text, generally includes spouses of participants of Taxpayer.

participants, but not to their dependents. The coverage is provided to actively employed participants without regard to years of service or other conditions. Retirees are, in general, eligible for plan benefits, including the general death benefit, if they retired at age 55 or older, worked at least 25 years under an applicable collective bargaining agreement, and are receiving benefits from Union's pension fund. Retirees are not eligible for accidental death and dismemberment coverage. The Plan provides that Taxpayer will pay benefits, as provided in the Plan, only to the extent that Taxpayer's assets are sufficient. In the event of Plan termination, neither the Plan nor the enabling trust agreement under which the Plan is created, provides for the return of any of Taxpayer's assets to the Employers or the participants; any remaining assets are to be used to pay out claims for eligible Plan benefits and to pay administrative expenses, for so long a period of time as assets remain.

Upon the death of an eligible participant, a general death benefit in the amount of $10,000 is paid by Taxpayer to the designated beneficiary or beneficiaries of the participant. In the case of an actively employed eligible employee, Taxpayer will pay an additional $10,000 to the designated beneficiary or beneficiaries, if the death occurred as a result of an accident. The maximum dismemberment benefit is also $10,000.

The benefits paid by Taxpayer to eligible participants and their dependents are entirely self-funded by the Employers as a result of their contributions to a pooled trust fund, which are invested to generate further benefits. In other words, Taxpayer does not purchase insurance from commercial insurance companies to fund its benefits. The Employers contribute a negotiated amount to Taxpayer for each hour that an employee is paid wages. Taxpayer represents that a professional consultant's annual projection of its income and expenses is used by the Trustees as an important factor in determining whether the Employers need to increase the contribution rate for funding Taxpayer's benefits.

Taxpayer represents that the Plan's reserving to the Trustees the right to terminate or retroactively amend the Plan does not alter the Taxpayer's liability to pay a death benefit when death has occurred prior to termination or amendment. Taxpayer represents that this reservation of rights to the Trustees has never been exercised to deprive a beneficiary of an earned death benefit.[4] Taxpayer represents that an eligible

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[4]Citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), Taxpayer represents that the language in the Plan reserving broad rights in the Trustees has the function of measuring the decisions of the Trustees in an action under 29 U.S.C. § 1132(a)(1)(B) by an "arbitrary and capricious standard," instead of subjecting them to de novo review by the court. In Firestone, the Court held that the de novo standard of review was proper in an action under 29 U.S.C. § 1132(a)(1)(B) unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the provisions of the plan. 489 U.S. at 115.

participant's death determines Taxpayer's obligation to pay death benefits as mandated by the Plan, that it has always had ample funds on hand to pay such benefits, and that such benefits have always been paid to the beneficiaries of eligible participants.[5]

As stated above, Taxpayer represents that it is a welfare benefit plan that is governed by ERISA. Taxpayer represents that the doctrine of federal preemption applies so that ERISA preempts state insurance laws that might otherwise apply to regulate the provision of death benefits by Taxpayer or Taxpayer's operation within the state's jurisdiction.[6] Taxpayer further represents that no state has attempted to regulate it in any fashion other than that which is permitted by ERISA, and that it makes no filings with any state with regard to plan participants and the Employers, other than for income tax compliance purposes.

REQUESTED RULINGS

1. Whether amounts received as death benefit payments from Taxpayer are amounts received under a life insurance contract that are excludable from gross income under § 101(a).

2. Whether contributions to Taxpayer that fund the death benefits provided to the beneficiaries of eligible participants of Taxpayer are includable in the gross income of the participants.

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[5]Taxpayer represents that, beginning approximately in Year A, it stopped funding its benefits through commercial insurance policies and began to self-fund. Taxpayer further represents that its general death benefit has been at the current $10,000 level for at least the last six years.

[6]In support of this representation, Taxpayer cites the portions of 29 U.S.C. § 1144 discussed in this footnote. 29 U.S.C. § 1144(a) (ERISA's "preemption clause"), generally provides, that the provisions of ERISA supersede state laws insofar as they relate to any employee benefit plan. 29 U.S.C. § 1144(b)(2)(A) (ERISA's "savings clause") provides that, except as provided in 29 U.S.C. § 1144(b)(2)(B) (ERISA's "deemer clause"), ERISA is not to be construed to exempt or relieve any person from any state law regulating insurance. 29 U.S.C. § 1144(b)(2)(B), however, provides:

> Neither an employee benefit plan . . . (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . .

LAW AND ANALYSIS

Section 1.501(c)(9)-6(a) of the Income Tax Regulations provides that cash and noncash benefits realized by a person on account of the activities of an organization described in § 501(c)(9) of the Code shall be included in gross income to the extent provided in the Code, including, but not limited to, §§ 61, 72, 101, 104, and 105 of the Code and the regulations thereunder.

Section 101(a) of the Code provides, generally, that gross income does not include amounts received under a life insurance contract, if such amounts are paid by reason of the death of the insured.

For purposes of the entire Code, the term "life insurance contract" is defined in § 7702(a) as

> any contract which is a life insurance contract under the applicable law, but only if such contract --
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> > (1) meets the cash value accumulation test of [§ 7702(b)], or
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> > (2)(A) meets the guideline premium requirements of [§ 7702(c)], and
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> > (B) falls within the cash value corridor of [§ 7702(d)].

Section 7702(b)(1) provides that a contract meets the cash value accumulation test if, by the terms of the contract, the cash surrender value of such contract may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits under the contract.

Section 79 of the Code provides, in general, that the cost of group-term life insurance provided under a policy (or policies) carried directly or indirectly by an employer (or employers) is included in the gross income of the employee, but only to the extent that the cost exceeds the sum of (1) the cost of $50,000 of such insurance, and (2) the amount (if any) paid by the employee toward the purchase of such insurance. Section 79(e) provides that, for purposes of § 79, the term “employee” includes a former employee. Section 1.79-0 of the regulations provides that a policy of life insurance is “carried directly or indirectly” by an employer if the employer pays any part of the cost of the life insurance directly or through another person.

Section 1.79-1(a)(1) of the regulations provides that, in order to qualify as group-term life insurance under § 79 of the Code, the insurance must provide a general death benefit that is excludable from gross income under § 101(a).

Section 1.79-3 of the regulations provides that to determine the amount

includible in an employee's gross income, the proceeds payable upon the death of the employee under each policy of group-term life insurance provided directly or indirectly by an employer (or employers) must be aggregated. (Section 6052(a) of the Code provides that, for purposes of the employer reporting requirements under § 6052, the extent to which the cost of group-term life insurance is includible in the employee's gross income under § 79 shall be determined as if the employer were the only employer paying such employee remuneration in the form of such insurance.)

Section 106 of the Code provides that, except as otherwise provided in § 106, the gross income of an employee does not include employer-provided coverage under an accident or health plan.

Section 1.105-4(a) of the regulations provides that, in general, an accident or health plan is an arrangement for the payment of amounts to employees in the event of personal injuries or sickness.

Section 1.105-4(g) of the regulations provides that the term "personal injury" means an externally caused sudden hurt or damage to the body brought about by an identifiable event.

Section 1.79-1(f)(3) of the regulations states: "See section 106 and § 1.106-1 for rules relating to certain insurance that does not provide general death benefits, such as travel insurance or accident and health insurance (including amounts payable under a double indemnity clause or rider)."

Requested Ruling 1

Taxpayer's death benefit payments are paid under a "life insurance contract," as defined in § 7702(a), if they are paid under "[a] contract which is a life insurance contract under the applicable law" that "meets the cash value accumulation test of [§ 7702(b)]." To satisfy this requirement there must be a contract, the contract must be a life insurance contract under the applicable law, and the contract must satisfy the cash value accumulation test.

The death benefits paid by Taxpayer are paid under a contract. The Plan, which resulted from the collective bargaining agreement between the Union and the Employers, is the contract in question. ERISA, in 29 U.S.C. § 1132(a), provides Plan participants and their beneficiaries with a civil action to enforce their contractual rights under the Plan.

The Plan, which is the contract here, satisfies the cash value accumulation test of § 7702(b) because it has no cash surrender value. Neither the general death benefit coverage nor the accidental death coverage give the Employers or Taxpayer's participants the right to receive, during their lives, cash benefits on demand, in addition

to the health and welfare benefits provided by the Plan.

There remains the question of whether the Taxpayers's death benefits coverage "is a life insurance contract under the applicable law." The Conference Committee Report accompanying the addition of § 7702 to the Code by the Tax Reform Act of 1984 provides that "[a] life insurance contract is defined as any contract, which is a life insurance contract under the applicable State or foreign law . . . ." H.R. Conf. Rep. No. 861, 98th Cong., 2d Sess.1075 (1984), 1984-3 (Vol. 2) C.B. 329. The legislative history of § 7702 indicates that the chief purpose of "the applicable law requirement" was to distinguish annuity contracts from life insurance contracts. See H.R. Rep. No. 432, part 2, 98th Cong., 2d Sess. 1443 (1984); 1 Senate Committee on Finance, Deficit Reduction Act of 1984 -- Explanation of Provisions Approved by the Committee on March 21, 1984, 98th Cong., 2d Sess. 572 (1984).

Ordinarily, domestic insurance contracts are subject to state regulation. See 15 U.S.C. § 1012(a) (1994) (McCarran-Ferguson Act).[7] Accordingly, the applicable law with regard to domestic insurance contracts is usually state law. However, Taxpayer represents that, under ERISA, state insurance laws are preempted with regard to its insurance business. Based on this representation, we conclude that the appropriate "applicable law" for purposes of determining whether Taxpayer's death benefit coverage is a life insurance contract under § 7702(a) is federal law. We do not consider this result to be precluded by the legislative history of § 7702. The Conference Committee's reference to state or foreign law provides guidance in the vast majority of cases, where there is an applicable state or foreign law. Here, under Taxpayer's representation, the laws of the states are preempted by ERISA from applying to Taxpayer's death benefits coverage, and thus, cannot be the "applicable law" for purposes of § 7702(a). Moreover, no foreign law has any conceivable nexus to Taxpayer's death benefits coverage. Also, the text of § 7702(a) does not preclude the use of federal law as the applicable law.

Having determined that federal law is the applicable law for purposes of § 7702(a), the question remains, what is the federal law defining the term "life insurance contract." ERISA does not contain a definition of the term "life insurance contract." Section 1.501(c)(9)-6(a) of the regulations provides, in substance, that benefits paid by an organization exempt under § 501(c)(9) are not to be given special treatment or characterization because they are paid by such an organization. In particular, no indication is provided as to whether death benefits provided by such organizations

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[7] 15 U.S.C. § 1012(a) provides:

> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

constitute payments under a life insurance contract. Section 7702(a) defines the term "life insurance contract," but is not of much use in this case, because, instead of categorically stating what constitutes a "life insurance contract," it refers to "applicable law." Section 1035(b)(3) defines "[a] contract of life insurance," but this definition is expressly stated to be for purposes of § 1035. Taxpayer has not called to our attention any other general federal statutory provision defining the term "life insurance contract," and none has been found through our own research.

Given the absence of federal statutory law, federal case law defining the term "life insurance contract" is dispositive.[8] Prior to the enactment of § 7702, except for § 1035(b)(3), the definition of a life insurance contract, for purposes of federal tax law, was determined only under case law. See H.R. Conf. Rep. No. 861, at 1074, 1984-3 (Vol. 2) C.B. at 328. The baseline definition of a life insurance contract under federal law is an agreement to pay a certain sum of money upon the death of the insured in consideration of the payment of premiums. Central Bank of Washington v. Hume, 128 U.S. 195, 205 (1888); Barnes v. United States, 801 F.2d 984, 985 (7th Cir. 1986), cert. denied, 480 U.S. 945 (1987). Federal tax cases have held life insurance contracts to exist in situations where there is not a standard commercial life insurance contract between the insured and the insurer. See Ross v. Odom, 401 F.2d 464 (5th Cir. 1968); Commissioner v. Treganowan, 183 F.2d 288 (2d Cir.), cert. denied sub nom. Estate of Strauss v. Commissioner, 340 U.S. 853 (1950); Estate of Moyer v. Commissioner, 32 T.C. 515 (1959), acq. in relevant part, 1960-2 C.B. 6. Conversely, the landmark case of Helvering v. Le Gierse, 312 U.S. 531 (1941), established the principle that a contract in the form of a standard commercial life insurance contract is not treated as a life insurance contract for purposes of federal law unless it provides for risk-shifting and risk-distributing.

In Le Gierse, the decedent, an otherwise uninsurable elderly woman, was issued a life insurance contract by an insurance company only because she simultaneously

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[8] See Textile Workers Union v. Lincoln Mills, 353 U.S. 448 (1957), in which the Court held that federal case law determines issues arising under § 301(a) of the Labor Management Relations Act of 1947 that are not expressly resolved by that statute. See also Clearfield Trust Co. v. United States, 318 U.S. 363 (1943), a case involving commercial paper issued by the United States. The Court held that the rights and duties of the United States, concerning commercial paper issued by the United States, are governed by federal, not local law. Id. at 366. The Court stated, "In absence of an applicable Act of Congress it is for the federal courts to fashion the governing rule of law according to their own standards." Id. at 367.

The present case, like Textile Workers Union and Clearfield Trust Co. presents a question of federal law. Therefore, resort to federal case law is appropriate in the absence of federal statutory law.

purchased a lifetime annuity from the same company. The issue in Le Gierse was whether proceeds from the life insurance contract were "amounts receivable as insurance" under the applicable federal estate tax law. The Court held that, while the life insurance contract contained all the usual provisions, it lacked an essential element of insurance:

> We think the fair import of [the estate tax provision] is that the amounts must be received as the result of a transaction which involved an actual "insurance risk" at the time the transaction was executed. Historically and commonly insurance involves risk-shifting and risk-distributing. That life insurance is desirable from an economic and social standpoint as a device to shift and distribute risk of loss from premature death is unquestionable. That these elements of risk-shifting and risk-distributing are essential to a life insurance contract is agreed by courts and commentators.

312 U.S. at 539. The Court held that the life insurance contract lacked insurance risk because the annuity contract neutralized the insurance risk that the insurer had with respect to the life insurance policy.

The basic concept set forth in Le Gierse has more recently received articulation by the Seventh Circuit in Barnes:

> Risk shifting is transferring the risk of loss caused by premature death from the insured and his or her beneficiaries to the insurer. Risk distribution is spreading the risk of this economic loss among the participants in the insurance program.

801 F.2d at 985. See also Odom, 401 F.2d at 467; Treganowan, 183 F.2d at 291.

In Odom, the State of Georgia established a program to provide death benefits to designated beneficiaries of certain state employees. Under this program, amounts were deducted from the pay of participating employees and paid to the Survivors' Benefit Fund ("SBF"). These amounts were matched by the state. The amounts that were deducted from the pay of the participants and matched by the state were determined actuarially. The amounts payable to SBF beneficiaries were not funded or reinsured by any independent insurance company. At the time of his death, the taxpayer's spouse in Odom was one of approximately 20,000 participants in the SBF.

The SBF was administered by the Board of Trustees of the Employees Retirement System ("Georgia Board"). The Georgia Board was characterized by the court as independent and accountable to the people as a public body. The Georgia Board's investment of the SBF funds was restricted by the standards applicable to Georgia life insurance companies. The Georgia Board had the right to suspend the SBF program for one year, and unless the program was revived by the Georgia Board within that year, the program would terminate. Termination could not be limited to any

subgroup of state employees. Moreover, state law provided that termination of the SBF could not prejudice any survivors benefits pending in the case of a deceased participant. The court stated that the death of a covered employee gave the designated beneficiary both a vested claim and a right to sue in an open forum.

The Fifth Circuit, in Odom, held that the death benefits received by the taxpayer from the SBF were amounts received under a life insurance contract, excludable from gross income under § 101(a). The court found that the risk-shifting and risk-distributing requirements for insurance were met. By paying a small percentage of his salary, the taxpayer's spouse had, to the extent of the prescribed benefits, effectively shifted the economic risk that could arise from his untimely death from his survivors to the SBF. Further, the court found that the risk-distributing requirement was met because the risk of an employee's death was spread among 20,000 participating employees and the state. Moreover, the court found that the plan was actuarially sound: "[The actuarial expert's testimony] was uncontradicted that on accepted actuarial principles, the size and composition of the group, and relevant expectancy and investment factors, the benefits prescribed could be discharged by the Survivors' Benefit Fund." 401 F.2d at 468.[9]

The court, in Odom, addressed a Government argument that drew an analogy between the SBF program and a self-insurance program set up by a private employer. The self-insured private employer plan would require the employer to set aside (either wholly from employer contributions or from a mix of employer and employee contributions) in a separate account, but still under employer control, an amount of money to adequately fund the specified death benefits for all covered employees. Also, the private plan would expressly reserve to the employer the right to terminate the plan or the right not to pay individual death benefit claims as due. The court distinguished the SBF from the hypothetical private employer death benefit plan,[10] stating that the

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[9]Compare Davis v. United States, 323 F. Supp. 858, 862 (S.D. W. Va. 1971), in which one ground for the court's holding that payments received by plaintiff from the West Virginia Judges' Retirement Fund by virtue of her being the widow of a deceased judge were not excludable under § 101(a) was the "patent lack of actuarial soundness of the Fund." Compare also Edgar v. Commissioner, T.C.M. 1979-524, in which death benefits paid by the Teacher Retirement System of Texas were held not to be life insurance proceeds, excludable from gross income under § 101(a). The Tax Court distinguished Odom, inter alia, on the basis that there was no evidence, in Edgar, that the Teacher Retirement System was actuarially sound.

[10] The court, in commenting on the Government argument, stated: "The argument is a good one – good in the sense of an appealing one – for if that [a plan with the features of the private self-insured plan described in the text] is all the Georgia plan afforded we would hasten to allay the Government's fears that § 101(a) could work

Georgia Board's rights regarding suspension and termination of the SBF program "[had] not been exercised nor [was] there the slightest indication that [they] would be." 401 F.2d at 471. Moreover, the court stated that in the SBF program the death of a covered employee served to vest the survivors' benefits in the designated beneficiary. The court also noted other features of the SBF system that served to eliminate uncertainty, concerning the payment of the death benefits, including the public accountability of the Georgia Board, restrictions on the Georgia Board's investment of SBF funds, and state laws requiring state employer-agencies to pay the employer's share, and remit the employee's share of contributions, to the SBF.

The court, in Odom, concluded:

> Thus this arrangement not only satisfies risk-shifting, risk-distributing, it does so in a binding enforceable way with death irretrievably liquidating a determinable obligation which can be paid in fact through ample funds collected, segregated, invested and husbanded under severe restrictions which assure both availability and sufficiency of the funds to discharge the obligation.
>
> If that does not satisfy every element of a life insurance contract we are at a loss to identify the defect.

401 F.2d at 473.

Upon the death of an eligible participant, Taxpayer is required to pay $10,000 ($20,000 if death was accidental) to the designated beneficiary or beneficiaries. As in Odom, to the extent of the prescribed benefits, the eligible participants have effectively shifted the economic risk that could arise from their untimely death from their designated beneficiaries to Taxpayer. There were y eligible participants on Date 1. This number is clearly sufficient to meet the requisite test for risk distribution. See Odom; Treganowan (1374 participants); Estate of Moyer (200 participants).

In view of the fiduciary obligations that ERISA imposes on the Trustees, and Taxpayer's representations concerning the sufficiency of its funding and the event of death determining Taxpayer's liability to pay the death benefits specified in the Plan, we conclude, with one exception, that as in Odom:

> [T]his arrangement not only satisfies risk-shifting, risk-distributing, it does so in a binding enforceable way with death irretrievably liquidating a determinable obligation which can be paid in fact through ample funds collected, segregated, invested and husbanded under severe restrictions which assure

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so well and cheaply, especially for insiders in closely held businesses." 401 F.2d at 471.

both availability and sufficiency of the funds to discharge the obligation.

401 F.2d at 473. The exception referred to is that Taxpayer's death benefits are paid from Taxpayer's general account, rather than from a particular fund, like the SBF, that is only used to pay death benefits. Under Taxpayer's representation that it has ample funds to pay Plan benefits, this difference with Odom should not affect the result. See generally Haynes v. United States, 353 U.S. 81 (1957), holding that a contract between an employer and its employees constituted health insurance within the meaning of § 22(b)(5) of the 1939 Code. The Supreme Court stated in Haynes that "[t]here is no necessity for a definite fund set aside to meet the insurer's obligations." 353 U.S. at 84.

Another difference between this case and Odom is that Taxpayer's participants are not required to make cash contributions for the funding of their death benefits, all of the cash contributions are made by the Employers. However, the funding of Plan benefits, including death benefits, is attributable to the rendering of services by the employees. The lack of premium payments in cash by the employees in Haynes did not prevent the Court from holding that the arrangement in that case was insurance. It does not prevent us from so holding either.

Also, in Odom, employer and employee contributions were determined on the basis of an actuarial computation. In this case, Taxpayer represents that a professional consultant's annual projection of its income and expenses is used by the Trustees as an important factor in determining whether the Employers need to increase the contribution rate for funding Taxpayer's benefits. This variation from the facts of Odom does not alter our conclusion that Taxpayer's benefits are paid under a life insurance contract. See Treganowan; Estate of Moyer, involving stock exchange gratuity funds that made death benefit payments to beneficiaries of their members. Each of the two funds was funded by a fixed initiation fee and assessments upon a member's death. In both cases, the beneficiaries were held to have received amounts under life insurance contracts.

In summary, Taxpayer's death benefits payments are made under a "life insurance contract," as that term is defined in § 7702(a). Based upon Taxpayer's representation that ERISA preempts state insurance laws that might otherwise apply to regulate the provision of death benefits by Taxpayer or Taxpayer's operation within the state's jurisdiction, we have concluded that federal law is the "applicable law" for purposes of § 7702(a). The source of federal law in this case is federal common law. Under the criteria set forth in federal common law, Taxpayer's death benefits coverage constitutes a life insurance contract. Also, the contract providing Taxpayer's death benefits coverage satisfies the cash value accumulation test of § 7702(a), because the contract has no cash surrender value.

Thus, both the general death benefit and the accidental death benefit are amounts received under a life insurance contract by reason of the death of the insured,

excludable from gross income under § 101(a).

Requested Ruling 2

First, the accidental death benefit coverage provided by Taxpayer does not qualify as group-term life insurance under § 79. See § 1.79-1(a)(1) of the regulations. Second, because the Employers make contributions to Taxpayer that are used to pay the cost of the death benefits coverage, the coverage is "carried directly or indirectly" by the Employers for purposes of § 79. Third, we have concluded that Taxpayer's $10,000 general death benefit is provided under a life insurance contract, as defined in § 7702, and accordingly, it is excludable from the designated beneficiary's gross income under § 101(a). Thus, Taxpayer's general death benefit coverage is subject to the rules of § 79. Under § 79, the cost of up to $50,000 of group-term life insurance carried directly or indirectly by an employer or employers on an employee's life is excludable from the employee's gross income. Therefore, each eligible participant must aggregate all group-term coverage provided by his or her employers, including that provided by Taxpayer, to determine whether any amounts are includible in gross income.

The regulations under § 79 of the Code anticipate that death benefits may be paid under accident and health insurance and, unless the accident and health insurance provides a general death benefit, the cost of such insurance is subject to § 106 of the Code.

Taxpayer's accidental death and dismemberment benefit does not provide a general death benefit. Accordingly, amounts contributed to Taxpayer by the Employers to provide accidental death and dismemberment coverage are excludable from the gross incomes of actively employed eligible participants under § 106.

CONCLUSIONS

1. Amounts received as death benefit payments, both general and accidental, from Taxpayer are amounts received under a life insurance contract that are excludable from gross income under § 101(a).

2. Taxpayer's general death benefit coverage is subject to the rules of § 79. Under § 79, the cost of up to $50,000 of group-term life insurance carried directly or indirectly by an employer or employers on an employee's life is excludable from the employee's gross income. Therefore, each eligible participant must aggregate all group-term coverage provided by his or her employers, including that provided by Taxpayer, to determine whether any amounts are includible in gross income. Taxpayer's accidental death coverage is not subject to the rules of § 79.

Amounts contributed to Taxpayer by the Employers to provide accidental death and dismemberment coverage are excludable from the gross incomes of actively

employed eligible participants under § 106.

Except as expressly provided herein, no opinion is expressed or implied concerning the tax consequences of any aspect of any transaction or item discussed or referenced in this letter. In particular, no opinion is expressed concerning the legal correctness of Taxpayer's representations, including Taxpayer's obligations under the Plan and the application of the federal doctrine of preemption.

The rulings contained in this letter are based upon information and representations submitted by the taxpayer and accompanied by a penalty of perjury statement executed by an appropriate party. While this office has not verified any of the material submitted in support of the request for rulings, it is subject to verification on examination.

This ruling is directed only to the taxpayer requesting it. Section 6110(k)(3) of the Code provides that it may not be used or cited as precedent. Temporary or final regulations pertaining to one or more of the issues addressed in this ruling have not yet been adopted. Therefore, this ruling will be modified or revoked by the adoption of temporary or final regulations to the extent that the regulations are inconsistent with any conclusion in the ruling. See section 12.04 of Rev. Proc. 99-1, 1999-1 I.R.B. 6, 47. However, when the criteria in section 12.05 of Rev. Proc. 99-1 are satisfied, a ruling is not revoked or modified retroactively, except in rare or unusual circumstances.

In accordance with the Power of Attorney on file with this office, a copy of this letter is being sent to your authorized representative.

A copy of this letter must be attached to any tax return to which it is relevant.

Sincerely,

Assistant Chief Counsel
(Financial Institutions and Products)

By: SIGNED BY MARK S. SMITH
Mark S. Smith
Chief, Branch 4