



Social Security

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Background

Social Security is a program created by the **SOCIAL SECURITY ACT OF 1935** to provide old age, survivors', and [DISABILITY](#) insurance benefits to workers and their families in the United States. 42 U.S.C.A. sections 301 et seq. The program is administered by the Social Security Administration (SSA), an independent federal agency. Unlike welfare, which is financial assistance given to persons who qualify on the basis of need, Social Security benefits are paid to individuals on the basis of their employment record and the amount they contributed to Social Security during their employment careers. In 1965 Social Security was expanded to include health insurance benefits under the **MEDICARE** program. 42 U.S.C.A. sections 1395 et seq.

As a more general term, "social security" refers to any plan designed to protect society from the instability caused to workers and their families by the unemployment or death of a wage earner. Statistics show that unemployment will affect at least 4 percent of U. S. workers each year. But it is impossible to know in advance which workers will lose their jobs. A government-run plan of social insurance helps spread the risk of unemployment among all members of society so that no single family will be completely ruined by the interruption of incoming wages.

History

Germany was the first industrial nation in Europe to adopt a general program of social security that extended beyond military veterans. In the 1880s Chancellor Otto von Bismarck instituted a plan of compulsory sickness and old age insurance to protect most wage earners and their dependents. Over the next thirty years, other European and Latin American countries created similar plans with various features to benefit different categories of workers.

In the United States the federal government first provided insurance only to veterans who had been disabled in war. During the late eighteenth and early nineteenth centuries the U. S. federal government provided pensions to veterans disabled in the American Revolution. In 1820 the federal government established a [PENSION](#) for needy or disabled veterans of the War of 1812. After the Civil War, the U. S. government broadened the category of veterans eligible for governmental assistance, paying pensions not only to needy and disabled veterans but also to most veterans age 65 or older.

However, Congress did not take any significant legislative action to create an old-age pension for the rest of America's workforce until the early twentieth century. Until that time, retired, unemployed, and chronically ill workers were left to manage by resorting to their personal savings, relying on private charities, or forming

beneficial associations that provided a modicum of sickness, old-age, and funeral insurance to workers who joined the association.

Yet membership in these associations was never widespread. Nor were such associations designed to address the catastrophic effects of the Great Depression. Triggered in part by the stock market crash of 1929, the Great Depression was ravaging the U.S. economy by 1932, when businesses reported losses of approximately \$6 billion, wages suffered declines of close to 60 percent, and 13 million workers headed for the unemployment lines. A year later another million Americans lost their jobs, and the unemployment rate hit 25 percent for the entire economy and 38 percent outside farm-related industries. By 1934 nearly every state was home to at least a few communities comprised of penniless and hungry families living in squalor, including many families with members who were senior citizens.

Congress tried to ameliorate some of these conditions by enacting the Social Security Act of 1935, which was part of the economic-stimulus and social-reforms package of President Franklin D. Roosevelt's New Deal. The act provided for the payment of monthly benefits to qualified wage earners who were at least 65 years old or the payment of a lump-sum death benefit to the estate of a wage earner who died before reaching age 65. In 1939 Congress added dependent spouses, widows, widowers, and parents of wage earners to the class of beneficiaries entitled to Social Security benefits upon the retirement or death of a working family member.

Social Security originally protected only workers in industry and commerce. Other classes of workers were excluded as beneficiaries after Congress concluded that it would be too expensive and inconvenient to collect their contributions. For example, household workers, farmers, and workers in family businesses were excluded as Social Security beneficiaries because Congress believed that these three classes of workers were unlikely to maintain adequate employment records. By the 1950s Congress had reversed its position, extending Social Security protection to most self-employed individuals, most state and local government workers, members of the armed forces, and members of the clergy. Federal employees, who had their own retirement and benefit system, were given Social Security coverage in 1983.

Old Age, Survivors' and Disability Insurance

Federal Old Age, Survivors', and Disability Insurance (OSADI) benefits are monthly payments made to retired workers, to families whose wage earner has died, and to workers who are unemployed because of sickness, injury, or disability. Workers qualify for these benefits by having been employed for the mandatory minimum amount of time and by having made contributions to Social Security. There is no financial need requirement that must be satisfied. Once a worker qualifies for OSADI benefits, his family is entitled to those benefits as well. The entire program is geared toward helping families as a matter of social policy.

Two large funds are held in trust to pay benefits under OASDI: the Old Age and Survivors' Trust Fund (OASTF) and the Disability Insurance Trust Fund (DITF). As workers and employers make payroll contributions to these funds, money is paid out in benefits to people currently qualified to receive monthly checks. The OASTF provides benefits to retired workers, their spouses, their children, and other survivors of deceased workers, such as parents and divorced spouses. The DITF provides benefits to disabled workers, their spouses, and their dependent children. DITF also pays for rehabilitation services provided to the disabled.

The OASDI program is funded by payroll taxes levied on employees, employers, and the self-employed. The tax is imposed upon the employee's [TAXABLE INCOME](#), up to a maximum amount, with the employer contributing an equal amount. Self-employed workers contribute twice the amount levied on employees. However, to put self-employed individuals in approximately the same position as employees, self-employed

individuals can deduct half of these taxes for both Social Security and [INCOME TAX](#) purposes.

Old Age Benefits

There are three requirements for an individual to be eligible to receive old age Social Security benefits. First, the individual must have attained the age of 62. Second, the individual must file an application for old age benefits. Third, the application must demonstrate that the individual is "fully insured." The extent to which an individual is insured depends on the number of quarters of coverage credited to his or her Social Security earnings record. 20 CFR section 404.101(a). A quarter is a three-month period ending March 31, June 30, September 30, or December 31. A worker becomes "fully insured" when the individual has been credited with working the requisite number of quarters. 42 U.S.C.A. section 414(a). The Social Security Administration's regulations contain a table specifying by birth date the quarters of coverage required to obtain fully insured status. 20 CFR § 404.115. But irrespective of birth date, any worker who has 40 quarters (i.e., 10 years) of coverage is fully insured.

Workers born before 1950 can retire at age 65 with full benefits based on their average income during their working years. For workers born between 1950 and 1960, the retirement age for full benefits has increased to age 66. Workers born in 1960 or later will not receive full retirement benefits until age 67. However, any worker, regardless of birth date, may retire at age 62 and receive less than full benefits. At age 65, a worker's spouse who has not contributed to Social Security receives 50 percent of the amount paid to the worker.

Workers who continue to work past retirement age may lose some benefits because Social Security is designed to replace lost earnings. If earnings from employment do not exceed the specified amount exempted by law, persons working past the age of retirement will receive full benefits. If earnings are greater than the exempt amount, one dollar of benefit is withheld for every two dollars in wages earned above that amount. Once a worker reaches age 70, however, he or she no longer has to report earnings to SSA, and thus his or her Social Security benefits will cease to be reduced.

Since 1975 Social Security benefits have increased annually to offset inflation. Known as cost of living adjustments (COLAs), these increases are based on the annual increase in consumer prices as reflected by the [CONSUMER PRICE INDEX](#) (CPI). Allowing benefits to increase automatically eliminated the need for Congress to pass special acts each year to address the issue. However, critics complain that COLAs are responsible for unnecessarily driving up the costs of Social Security. They contend that the CPI overestimates current rates of inflation, and, as a result, Social Security benefits are overadjusted upward.

Survivors' Benefits

Survivors' benefits are paid to family members when a worker dies. Survivors can receive benefits if the deceased worker was employed and contributed to Social Security long enough for someone his or her age to qualify. Surviving spouses of deceased wage earners are the primary class of beneficiaries entitled to survivors' benefits under the Social Security Act. Although sometimes referred to as "widow's" or "widower's" benefits, beneficiaries also include surviving divorced spouses who have minor or disabled children in their care. However, neither a surviving spouse nor a surviving divorced spouse may collect survivors' benefits if they have re-married following the death of the wage earner. Surviving spouses and surviving divorced spouses can begin collecting survivors' benefits at age 60, unless the surviving spouse or surviving divorced spouse is disabled, then he or she can begin collecting survivors' benefits at age 50. In addition to monthly checks, a worker's widow or widower may receive a lump-sum payment of \$255 upon the worker's death.

Survivors' benefits are also payable to unmarried, dependent children under age 18 and to unmarried children of any age who are disabled prior to age 22. Thus, if a disabled, unmarried, dependent child of a worker

became disabled prior to age 22, he or she will be entitled to receive survivors' benefits for the duration of the disability. However, if the disabled surviving child remarries, his or her survivors' benefits will be terminated, unless the disabled child marries another Social Security recipient.

Disability Benefits

The original Social Security Act of 1935 included programs for needy elderly persons and blind persons. In 1950 a program for needy DISABLED PERSONS was created under the act. Known as the "adult categories," these three programs were administered by state and local governments with partial federal funding. By the late 1960s, studies showed that the programs were being unevenly administered by more than 1,300 state and local agencies, resulting in a gross disparity of benefit payments to beneficiaries in different jurisdictions. These disparities were eliminated in 1972, when Congress federalized the "adult categories" by creating Supplemental Security Income (SSI). 42 USCA sections 1381 et seq.

SSI is payable to workers who become "disabled," which the law says occurs when a worker is unable to engage in substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months. 42 USCA section 1382c. Courts have said that "substantial gainful activity" means more than the ability to find a job and physically perform it. It also requires the ability to hold the job for a significant period of time. *Andler v. Chater*, 100 F.3d 1389 (8th Cir. 1996). Examples of disabilities that meet the criteria set forth in the Social Security law include brain damage, heart disease, kidney failure, severe arthritis, and mental illness.

In cases where the gravity of a disability is less clear, the SSA uses a sequential evaluation process to decide whether a person's disability is serious enough to justify awarding SSI benefits. If the impairment is so severe that it significantly affects a "basic work activity," the worker's medical records are compared with a set of guidelines known as the Listing of Impairments. 42 USCA APP., 20 CFR § 404.1529. A claimant found to suffer from a condition on this listing is entitled to receive SSI benefits. If the condition is less severe, the SSA will make a determination as to whether the impairment prevents the worker from doing his or her former work. If not, the application will be denied. If so, the SSA proceeds to the final step, in which it determines whether the impairment prevents the applicant from doing other work available in the economy.

In making this determination, the SSA relies on a series of medical-vocational guidelines that consider the applicant's residual functional capacity as well as the applicant's age, education, and experience. The guidelines look at three types of work, "sedentary work," "light work," and "medium work." Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like [DOCKET](#) files, ledgers, and small tools. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. 42 USCA APP., 20 CFR § 404.1567.

If the SSA finds that an applicant can perform work that falls into one of these three categories, benefits will be denied. A claimant may appeal this decision to an administrative law judge (ALJ), who will then hear [EVIDENCE](#) presented by both the claimant and the SSA. If the ALJ denies the claim for benefits, the claimant may appeal to the SSA's Appeals Council. Claimants who lose this appeal may file a [CIVIL ACTION](#) in federal district court seeking review of the appeal's council decision. 42 U.S.C. section 405(g).

Workers who meet the disability eligibility requirements may receive three types of benefits, monthly cash payments, vocational rehabilitation, and medical insurance. Monthly cash payments begin with the sixth month of disability. The amount of a monthly benefit payment depends upon the amount of earnings on which the worker has paid Social Security taxes and the number of the worker's eligible dependents. The maximum

payment for a family is roughly equal to the amount that the disabled worker is entitled to receive as an individual, plus allowances for dependents.

Vocational rehabilitation services are provided through a joint federal-state program. A person receiving cash payments for a disability may continue to receive them for a limited time after beginning to work at or near the end of a vocational rehabilitation program. Called the "trial work period," this period may last for as long as nine months.

Medical insurance is available through the Medicare program (a federally sponsored program that provides hospital and medical insurance). A recipient of disability benefits may begin to participate in Medicare twenty-five months after the onset of a disability. The Medicare program is discussed in more detail in the next section.

Disabled workers are eligible for disability benefits even though they have not reached the age of retirement, so long as they have worked enough years under Social Security prior to the onset of the disability. The number of work years required to qualify for SSI depends on the worker's age at the time of the disability. For workers under 24 years of age, the number of work years can be as few as one and a half years of work in the three years before the onset of the disability. However, the number of work years required for SSI eligibility can never exceed ten for any worker, regardless of his or her age.

A waiting period of five months after the onset of the disability is imposed before SSI payments begin. A disabled worker who fails to apply for benefits when eligible can sometimes collect back payments. But no more than twelve months of back payments may be collected. Even if a worker recovers from a disability that lasted more than twelve months, the worker can apply for back benefits within fourteenth months from the date of recovery. If a worker dies after a long period of disability without having applied for SSI, his or her family may apply for disability benefits within three months from the date of the worker's death. Family members are also eligible for survivors' benefits.

The Contract with America Advancement Act of 1996 changed the basic philosophy underlying the disability program. Pub.L. No. 104-121, March 29, 1996, 110 Stat 847. The act provides that new applicants for Social Security or SSI disability benefits will no longer be eligible for SSI benefits if drug addiction or alcoholism is a material factor in their disability. Unless new applicants can qualify on some other medical basis, they will not receive Social Security disability benefits. Individuals who were receiving Social Security disability benefits prior to the act's passage had their benefits terminated as of January 1, 1997.

Congress also narrowed the class of beneficiaries eligible for SSI payments when it passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Pub.L. No., 104-193, August 22, 1996, 110 Stat 2105. The law terminated SSI eligibility for most non-citizens, including most non-citizens who were receiving SSI payments at the time the law was passed. Before its enactment, nearly all [ALIENS](#) lawfully admitted to the United States could receive SSI if they met certain other requirements.

Medicare

Medicare is a federal program that provides health insurance to the elderly and the disabled. 42 U.S.C. sections 1395 et seq. It is funded through the Social Security Trust Fund and is administered by the Centers for Medicare & MEDICAID Services (CMMS), formerly known as the Health Care Financing Administration (HCFA). However, Medicare is not like other federal programs that have large organizational hierarchies. Instead, the federal government enters into contracts with private insurance companies for the processing of Medicare claims made by qualified patients.

Encyclopedia of Everyday Law: Social Security

The concept of federal health insurance was first proposed in the United States during the late 1940s by President Harry S. Truman. However, the proposal languished in Congress for parts of the next two decades. President Lyndon B. Johnson revived the proposal during his administration, and it came to fruition in 1965, when Congress passed the Health Insurance for the Aged Act (Medicare Act), Pub. L. No. 89-97, 79 Stat. 343 (1965). As originally enacted, Medicare provided health insurance only to the elderly. In 1972 Congress expanded coverage to include disabled persons.

A patient's eligibility for Medicare does not depend on his or her income. Patients generally qualify for Medicare coverage if they are 65 years or older and (1) qualify for Social Security or Railroad Retirement benefits; (2) have received Social Security or Railroad Retirement disability benefits for at least 24 months; (3) or suffer from end-stage renal disease. Individuals who have not worked long enough to receive Social Security benefits may still enroll in Medicare by paying a monthly premium. Individuals who are too poor to pay the monthly premium may apply for Medicaid, a state and federal health insurance program for low income persons.

Health care providers may participate in Medicare and receive Medicare payments if they satisfy state and federal licensing requirements and comply with any standards set by CMMS. A health care provider must also enter into an agreement with the Secretary of Health and Human Services. The agreement designates the amounts the provider will charge Medicare patients and the manner in which it will provide medical services. Hospitals, skilled nursing facilities, home health agencies, clinics, rehabilitation agencies, public health agencies, comprehensive outpatient rehabilitation facilities, hospices, critical access hospital, and community mental health centers (CMHCs) may all generally seek to participate in Medicare under a provider agreement. However, clinics, rehabilitation agencies, and public health agencies may enter into provider agreements only for services involving outpatient physical therapy and speech pathology. CMHCs may only enter into provider agreements to furnish certain hospitalization services.

Medicare is divided into three programs, a hospital insurance program, a supplementary insurance program, and a Medicare+Choice program. The hospital insurance plan is funded through a 2.9 percent Social Security payroll tax. The money is placed in a trust fund and invested in U.S. Treasury [SECURITIES](#). The hospital insurance plan covers reasonable and medically necessary treatment in a hospital or skilled nursing home, meals, regular nursing care services, and the cost of necessary special care.

The hospital insurance plan offers coverage for inpatient hospital services based on "benefit periods." An episode of illness is termed a benefit period and starts when the patient enters the hospital or nursing home facility and ends sixty days after the patient has been discharged. A new benefit period starts with the next hospital stay, and there is no limit to the number of benefit periods a person can have. Medicare will pay the cost of hospitalization for up to 90 days. The patient must pay a one-time [DEDUCTIBLE](#) for the first sixty days of a benefit period and an additional daily fee called a co-payment for hospital care provided during the following thirty days. Apart from these payments, Medicare covers the full cost of inpatient hospital care.

Medicare's supplementary medical insurance program is primarily financed by the federal government out of general tax revenues. The balance of the program is funded by those enrolled in it. Persons enrolled in Medicare pay a regular monthly premium and a small annual deductible for any medical costs incurred above the amount of the deductible during a given year.

Once the deductible and premiums have been paid, the supplementary medical insurance program covers 80 percent of any bills incurred for physician's services, including surgery, laboratory and diagnostic tests, consultations, and home, office, and institutional calls, but it excludes services that constitute inpatient hospital care under the hospital insurance plan. Chiropractic services are covered by the program if the chiropractor meets specified regulatory requirements relating to education. 42 C.F.R. section 410.22(a). However, the supplementary medical insurance program does not cover routine physical checkups,

eyeglasses, hearing aids, dentures, or orthopedic shoes. Nor does it cover the cost of drugs or medicines that can be self-administered.

Medicare computes its 80 percent responsibility based on the medical expenses and charges it deems reasonable for each kind of service provided to the patient pursuant to the supplementary insurance plan. Under the reasonable charge system, Medicare reimburses the lowest of the actual charge in question, the physician's customary charge for the service, or the applicable prevailing charge for the service. A physician's customary charge is based on the physician's actual charges for the same service during a twelve-month historical data collection period. When the charges vary during the historical period, the charges are then arrayed, weighted by frequency, and a customary charge is established at a level equal to the median of the charges. The prevailing charge is determined by a similar methodology, applied to all charges in the charge location by all physicians, with the prevailing charge fixed at an amount that would cover the full customary charges of the physicians whose billings accounted for at least 75 percent of the charges in the array.

The Medicare+Choice program is essentially a privatized medical savings plan that is funded partly by [BENEFICIARY](#) premiums and partly by government contributions. The premiums and contributions are maintained by the Medicare+Choice MSA Trust Fund. As of January 1, 1999, beneficiaries are offered the following private health care delivery options under the program: Medicare health maintenance organizations (HMOs), medical savings accounts (MSAs), preferred provider organizations (PPOs), private fee-for-services (PFFS), and provider sponsored organizations (PSOs). However, individuals are only eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization (MCO) if the plan serves the geographic area in which the individual resides.

Beneficiaries who reside in an area served by a Medicare+Choice plan may opt out of either the health insurance or supplementary insurance plans and elect to enroll in Medicare+Choice, except those with end-stage renal disease. Beneficiaries may only enroll during November of each year, and plan elections become effective in January of the following year. Beneficiaries who do not elect any option will automatically be enrolled in traditional fee-for-service Medicare. If a beneficiary does not make an election for a particular year and is already enrolled in a Medicare+Choice plan from the previous year, he or she will automatically be re-enrolled in that plan. Beneficiaries can also change plans if their plan contract terminates or if they move from their plan's service area. 42 U.S.C.A. section 1395w-21(e)(3).

The Secretary of Health and Human Services has established a process through which elections under the Medicare+Choice program are made and changed. Individuals seeking to elect a Medicare+Choice plan must complete and sign an election form, provide the information required for enrollment, and agree to abide by the rules of the plan. Within 30 days from receipt of the election form, MCOs transmit the information necessary for CMMS to add the beneficiary to its records as an enrollee of the MCO. A beneficiary's enrollment may not be terminated unless the beneficiary engages in disruptive behavior, provides [FRAUDULENT](#) information on the election form, permits abuse of the enrollment card, or fails to timely pay premiums. Monthly premiums for Medicare+Choice plans are calculated based on the rules set forth in 42 U.S.C.A. section 1395w-24(b)(1)(A).

A Medicare+Choice plan offered by an MCO satisfies the basic requirements for benefits and services if the plan provides payment in an amount that is equal to at least the total dollar amount of payment for such items and services as would otherwise be authorized under the health insurance or supplementary insurance plans. The Medicare+Choice plan must also comply with (1) CMMS's national coverage decisions; and (2) written coverage decisions of local carriers and intermediaries for jurisdictions handling claims in the geographic area for which services are covered under the plan.

Payments provided under the health insurance plan, supplementary insurance plan, or the Medicare+Choice plan can be sent directly to the health care provider or to the patient. Regardless of the method of payment, the

patient must receive notice that the provider has filed a medical insurance claim. The notice should detail the medical services provided, identify the expenses that are covered and approved by Medicare, and [ITEMIZE](#) any expenses that have been credited toward the annual deductible and any expenses Medicare has already paid in full. Patients or providers who are dissatisfied with a decision made regarding a Medicare claim may ask CMMS or the insurance carrier to reconsider the decision, depending on the nature of the claim. Following reconsideration, either party may request a formal hearing before an administrative law judge, though no formal hearing will be granted for claims made under supplementary medical insurance plans unless the claim is for at least \$100. Once the administrative law review process has been completed, aggrieved parties may appeal to federal district court. Supplementary medical insurance claims must total at least \$1,000, however, before a federal district court will hear the appeal.

The Future of Social Security and Medicare

Approximately 76 million Americans born between 1946 and 1964 are expected to retire in the next 28 years. In 2001 39 million Americans were enrolled in Medicare, and that number is expected to swell to 77 million in 2030. In 2001 35 million Americans were eligible to collect Social Security, while in 2030 more than 70 million will be eligible. The ratio between employed workers and Social Security recipients is expected to drop from 3.4 in 2001 to 2.1 in 2030.

These figures have alarmed both politicians and voters, who have demanded that something be done to save Social Security from a possible future of [BANKRUPTCY](#) and chaos. Proposals to "fix" the system have varied from conservative efforts aimed at "privatizing" Social Security by allowing workers to invest their payroll deductions in the securities market to more liberal efforts aimed at placing Social Security funds in a "lock box" to keep them safe from tampering and theft.

Following the inauguration of George W. Bush as the 43rd President of the United States, Congress began debating the future of Social Security. In December of 2001 the Presidential Commission on Social Security put forward three proposals that would allow workers to invest varying portions of their payroll taxes in stocks and [BONDS](#). Comprised of 16 members handpicked by the White House, the commission disclosed that it would probably take \$2 trillion to \$3 trillion of new revenue to shore up Social Security for 75 years, money that could only come from increased borrowing, higher taxes, or spending cuts in other programs. It is now up to Congress and the president, members of the commission said, to make tough decisions about choosing among the approaches, apportioning the associated benefit cuts, and coming up with the trillions of dollars necessary to improve Social Security's long term financial condition.

Additional Resources

American Jurisprudence. West Group, 1998.

http://guide.biz.findlaw.com/01topics/17govbenefit/gov_laws... . FindLaw: Government Benefits Law.

West's Encyclopedia of American Law. West Group, 1998.

Organizations

American Association of Retired Persons (AARP)

Encyclopedia of Everyday Law: Social Security

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