

“He who asserts must prove”



On 30 January Hannover Life Re (UK) held a seminar dedicated to the issue of non-disclosure and looking specifically at the ABI's new guidance on non-disclosure and treating customers fairly (TCF). The event was well received and led on to a very useful question and answer session in which we fielded queries on a wide range of specific issues.

In this special issue of In Focus we present a brief overview of the key points covered in January's seminar and, in a FAQ section at the end, we reflect some of the issues raised in Q&As on the day – as well as one or two others that have arisen since the ABI's guidance was issued. It is still too early to offer any definitive answers to some of

these. Accepted industry best practice will only gradually emerge as the guidance beds in and specialist advice is sought on specific issues.

Treating customers fairly

As an industry we have all put a great deal of time and effort into making our application form questions clear and unambiguous. A growing proportion of protection insurance business is now transacted via telephone or online and customers are given every opportunity to disclose all relevant information about their medical history when they apply. So the time seemed right for the industry to turn its attention to the fraught issue of declined protection claims.

Hannover Life Re (UK) has been closely involved in the process that led to the ABI's recently issued guidance on non-disclosure and TCF – as a member both of the ABI working group that produced and issued it and of the Health Committee that approved it.

The industry's previous practice of declining claims where policyholders 'non-disclosed' had become very unpopular with the general public and consumer groups who saw it as unfair. In the light of the strong current focus on TCF, the time had clearly come to look again at non-disclosure.

Compiled in consultation with the Financial Ombudsman Service (FOS), the new ABI

guidance aims to reduce the proportion of protection claims declined and ensure fair treatment of non-disclosure discovered at the point of claim. In preparing this guidance, we tried to look at the issue from a policyholder's perspective and align our processes as closely as possible with consumer expectations of fair treatment.

The main changes and their likely effects;

The guidance defines three categories of non-disclosure, each associated with a different remedy:

- **innocent non-disclosure**
remedy: full payment offered
- **deliberate non-disclosure**
remedy: claim declined and payment avoided
- **negligent non-disclosure**
remedy: proportionate ie full payment, reduced payment or claim declination and premium refund depending on what terms would have been offered had the non-disclosure not occurred.

The overall principle is that the severe remedy of avoiding policy from outset should be restricted to the most serious instances of non-disclosure.

We need to ask the customer to explain why they non-disclosed, and to ensure any medical evidence requested to validate a claim is relevant and justifiable.

For menu and multi-benefit policies, we should not decline a claim for non-disclosure if the omitted information was material only to a severable benefit such as waiver or TPD which is not the subject of a claim.

Where non-disclosure would have meant applying a loading of +50% (or £1/£1000) or less, this should always now attract a proportionate remedy. This figure was deliberately chosen. Around half the rated business that goes on the books is currently rated at +50%, and £1/1000 was taken to be a comparable cash extra. This meant that we should be able to quantify the effect of this 'concession' and that we would all have to adhere to the guidance.

This consistency of approach is better for insurers, reinsurers, the FOS, and the consumer.

Impact on Claim Costs

One obvious impact of the new guidance is that a lower proportion of potential claims will be declined for non-disclosure and more will result in a proportionate payment being made. The effects of this increase in payments will be mainly limited to claims early in the life of a policy since few potential claims are investigated for non-disclosure and declined beyond five years.

How much of an impact the new guidance has on your claims costs will depend both on the level of non-disclosure within your portfolio and on how far your current philosophy varies from that set out in the new guidance. The impact will be greatest within

portfolios that contain a high proportion of recently written business and will be less for more mature portfolios.

Newly introduced limitations on our ability to gather medical evidence should not have a material affect on claims costs as we would still expect to be able to gather the necessary evidence in the vast majority of cases.

Many providers have already improved their underwriting processes in recent years – resulting in lower levels of non-disclosure for their recently written business. But most will probably want to consider further action to reduce non-disclosure following the new guidance.

Providers will no doubt want to look more closely than ever at the influence of different underwriting standards – for example tele-underwriting compared with short form applications – as these will influence the expected level of non-disclosure and therefore claim costs.

The key to understanding the real effects of the new guidance will be gathering and analysing good quality management information. This will enable providers to produce realistic cost benefit analyses for proposed and actual non-disclosure reduction initiatives and will also be helpful in negotiations with reinsurers.

Remember, we are here to help and will be very happy to discuss the scope of the management information needed and its implications.

Hannover Life Re (UK)'s Position

We are confident that implementation of the new guidelines will eventually result in more claims paid, fewer disputes, less bad press, and improved customer confidence. We should all welcome a claims landscape that looks like this, so the new guidance deserves our wholehearted support.

Having compared the new categories of non-disclosure with the overarching principles in the non-disclosure section of our claims philosophy, we are happy to confirm that they are very much in line. The only real distinction is our willingness in certain instances to make a proportionate payment where non-disclosure relates purely to smoking status.

That said, we are aware that many of our own reinsurance treaty portfolios were being adjudicated against more robust standards where insurers had multi-reinsurance arrangements and needed to apply a single claims philosophy.

We understand that more claims will be paid; but we see this as a positive tool in the battle to regain consumer's trust.

We can confirm that we fully support our clients in applying the new guidance.

Frequently Asked Questions Section

Within this section we are simply offering an opinion and not legal or compliance advice, and you should always check with your internal legal and compliance experts.

Q Does the Data Protection Act stop us accessing 'full' medical records or indeed any medical records?

A Strictly speaking the DPA only applies to living individuals, but the ABI guidance applies to all long-term products, so we expect insurers will broadly apply the same process to all claims.

The DPA has not changed. It has always required us to comply with a range of principles with all personal data we process. In particular Principle 3 requires that personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.

The DPA needs to be seen in parallel with industry guidance. As a general rule it should always be taken into consideration even where the latter is non-binding.

If 'full' medical records means from birth to the current date, then we cannot request this, as it would certainly be excessive.

We can obtain limited duration full medical notes, providing we can justify our request and show the data is relevant, not excessive, and has been obtained with the specific informed consent of the insured.

Q How should 'informed' claim consent be worded?

A The consent on the claim form should be carefully worded to ensure it is sufficiently wide to allow you to consider the claim properly. It should not be constructed in a way that limits your review to the condition or benefit claimed for.

If the construction did limit your use of information this could mean you may have forfeited your right at a later date to use any information obtained.

We would suggest avoiding phrases such as "to allow us to consider your claim for this benefit" or "in connection with this claim." The consent should allow you to "seek information to support the payment of any claim" and should describe potential sources e.g. any medical practitioner, hospital, consultant etc.

We believe this will allow you to show that your request for medical information has been obtained with the specific informed consent of the insured.

Q Would you suggest we get limited duration full medical notes in every early claim?

A No, not in all cases.

If, for instance, you had medical evidence at underwriting stage and this included either medical notes or a GPR you would need only a targeted report or a death certificate.

Road traffic accidents may also warrant a lighter touch in the first instance. Unless the coroner's or police report, or the circumstances of the claim suggest non-disclosure, limited duration medical notes will not be required.

You will, however, want to protect the portfolio against non-disclosure, and in many early claims limited duration full medical notes will be requested.

You will need to provide evidence of a process that looks first at the merits of each particular claim – and then consider what information you require and can justify.

Q Do we have to ask every customer to explain the circumstances surrounding their non-disclosure?

A Yes, we need to establish the facts before deciding which category of non-disclosure applies.

Q Does Hannover Life Re (UK) believe that the threshold of +50% and £1/1000 for treating non-disclosure as negligent should be increased, and would Hannover support such an increase?

A We would not support any increase, and do not believe that the threshold should be increased for the following reasons:

- It would not be appropriate to undermine the guidance
- It would send out the wrong message about our attitude to non-disclosure
- It could reduce the incentive to disclose

- It would not protect the honest applicant who may need to pay higher premiums
- It would not treat customers fairly – since a claimant could effectively be disadvantaged because they chose a provider whose reinsurer did not offer the higher threshold

Q How should non-disclosure of smoking be treated?

A The new ABI guidance clearly indicates that non-disclosure of lifestyle information will be treated as deliberate unless there is a particularly credible and convincing explanation. The Law Commission also took the view that lifestyle non-disclosure should be treated as deliberate.

This is a decision each insurer needs to make for themselves. No doubt many will continue as a matter of policy to treat non-disclosure of lifestyle information as deliberate. If this is the position you take, we will support you.

We will be happy to discuss with you in what circumstances we would be prepared to offer a proportionate solution.

Q Should non-disclosure following application (continuing duty of disclosure) always be regarded as 'negligent'?

A The guidance is quite clear "insurers will need to have a particularly robust case for classifying non-disclosure occurring after the application was completed as deliberate or without any care (that is when the non-disclosure results from a change in health or other circumstances after the application was completed but before the cover starts)."

We expect most instances of non-disclosure during this period will be treated as negligent, but we would rather focus on working with you to solve the problem altogether. With a properly engineered process, we believe the onus of ongoing disclosure can cease at the point of acceptance and that we can satisfy all of the aspirations expressed in the quoted passage above without affecting cost.

Q Will the guidance increase Hannover Life Re (UK) reinsurance costs?

A The first thing to say is that Hannover Life Re (UK)'s Managing Director David Brand fully supports our clients in applying the ABI TCF guidelines.

We do expect that adopting the new guidance for existing business will increase the total of claims paid. Hannover Life Re (UK) is committed to paying the reinsured share of any additional claims that arise in line with the new guidance.

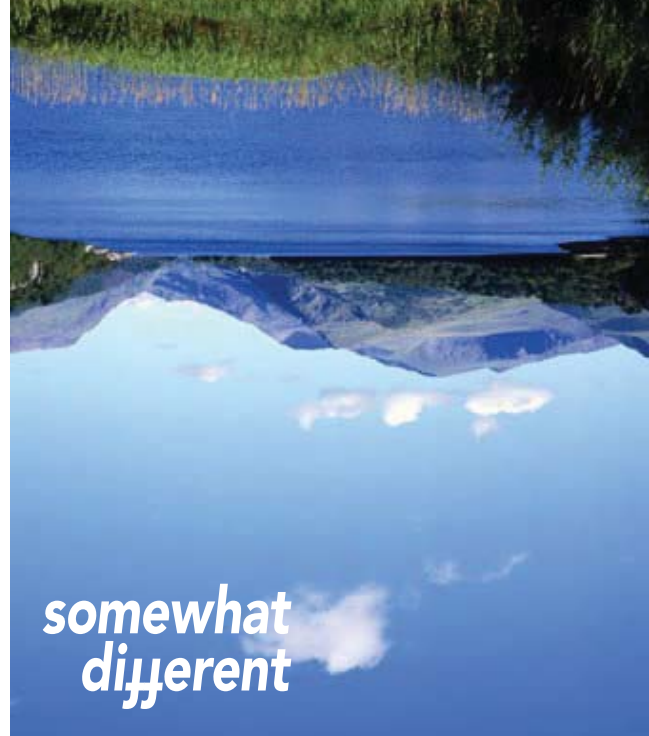
Provided your approach is consistent with the guidelines, we can confirm that our reinsurance premium rates will not be impacted for existing business.

Overall claims philosophy and process is one of a number of things we consider when reviewing new business premium rates.

We will work with our existing clients to develop philosophies and processes so that claims costs and reinsurance premiums will not increase as a result of the new guidance.

Summary

We hope you have found this brief overview interesting and helpful. As ever we would be delighted to talk through any of the issues raised with our clients. We are also happy to get involved in developing your claim philosophy and processes and to assisting you with internal claims trainings sessions. For our part Hannover Life Re (UK) will continue – as we always have – to take a flexible and pragmatic approach to claims assessment.



somewhat different

We hope you enjoy **In Focus** and we welcome your feedback, please forward any comments to Kirsteen Grant. If you wish to be added to our mailing list contact Kirsteen on 01 344 846833 or email uk.marketing@hannover-re.com.

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CONTACT



Julie Hopkins
Head of Underwriting
and Claims Strategy