

ISI UNDERWRITING GUIDE

Issued by the

Investment Savings & Insurance
Association of New Zealand
Incorporated



I·S·I

March 2000

Foreword

This Underwriting Guide has been produced by the Investment Savings & Insurance Association for the assistance of Underwriters and others in the industry. It is also intended to provide clarity and further information for those outside the industry who are involved in the underwriting process, for example as providers of medical services.

The Underwriting Guide also incorporates the ISI policy on genetic testing.

We would also like to record our appreciation for permission to use the Life Investment and Superannuation Association of Australia (now the Investment and Financial Services Association) Underwriting Guide as the basis for development of this Guide. The ISI recognised the close relationship which exists between many NZ and Australian Life Insurance Companies and, in the interests of harmonisation, endeavoured to produce a Guide similar to that in use in Australia.

The ISI is keen to promote best practice throughout the industry and we trust this Guide will prove useful and informative.

Vance Arkinstall
Chief Executive

ISI UNDERWRITING GUIDE

Contents	Page
1 Introduction.....	4
2 Principles of Voluntary Insurance	5
3 General Underwriting Principles.....	8
4 Legislation Affecting Underwriting	10
5 Medical Authorities	13
Appendix 1 Notes for Guidance in Completing Medical Reports for Life and Disability Insurance Purposes	
Appendix 2 Types of Insurance Contracts	
Appendix 3 Genetic Testing Policy	

NOTE: This document is intended only as a Guide and should not be relied upon in place of legal or other advice in specific circumstances.

1. INTRODUCTION

This Guide applies to the underwriting of life and disability business in New Zealand by life insurance companies registered under the Life Insurance Act 1908. Most of those companies are members of the Investment Savings and Insurance Association.

There have been significant changes recently to the environment in which life insurance companies, and their Underwriters, work. The level of disclosure requested by consumers, and required by legislation, is increasing. The Human Rights Act 1993 and the Privacy Act 1993 both affect the underwriting process. Developments in testing, treatment and medical technology will have an increasing impact upon life expectancy and consequently upon underwriting.

Legislation affecting underwriting is covered in Section 4. At this point it is sufficient to note that the trend in recent legislation has been towards consumer protection, whether in respect of privacy or in measures to prevent discrimination.

Increasing publicity about genetic testing, genetic engineering and associated treatments has also raised some concerns in the community about the effect on their access to insurance.

These are all factors which life insurance companies need to be aware of, and the underwriting process needs to balance the concerns of consumers with the business realities of providing life insurance and disability cover in a voluntary insurance environment.

This Guide brings together a broad range of information to assist with underwriting. For Underwriters new to the industry the Guide will be a valuable training resource. For experienced Underwriters it will serve to reinforce the logic and arguments supporting the way the life insurance industry currently operates. The Guide emphasises the importance of the risk classification process and highlights the arguments for this process in voluntary life and disability insurance. The Guide has been written in such a way as to allow parts of it to be shared with external parties who may from time to time query why insurers operate in the manner they do.

This Guide opens with a general introduction to the principles of voluntary insurance and underwriting. It then covers the legislation affecting underwriting issues of privacy and confidentiality, and the industry policy on genetic testing.

The appendices include general guidance for doctors in completing medical reports for life and disability insurance purposes.

Suggestions for additional issues to be covered in future editions of this Guide are welcomed.

2. PRINCIPLES OF VOLUNTARY INSURANCE

2.1 The Concept of Voluntary Insurance

Insurance is a means of sharing financial loss. Such financial losses can result from death or disability caused by illness or injury and the financial impact on an individual can be devastating. The possibility of such an event exists for any individual, but its timing and occurrence is generally unpredictable. Insurance is the means by which individuals can protect themselves against such unpredictable financial losses. In essence, the small and regular contributions of a group of people are pooled and out of this pool are paid the financial losses of the group. By sharing and spreading the impact of these unpredictable financial losses across a group of people, it is possible to better estimate the total loss for the group and to better manage the financial impact on each individual.

Risk is the term used by insurers to describe the likelihood that the insured event will occur, thus resulting in a claim being paid. Voluntary insurance allows individuals to choose how much cover they want to buy and when they want to buy it. Clearly, when making these decisions an individual will take into account their own particular circumstances and their perception of their risk. So, those individuals who perceive themselves to be at high risk, that is who believe that there is a high likelihood that they will need to make a claim on their insurance policy in future, are more likely to seek insurance cover and will generally be prepared to pay more for their insurance than those who perceive their risk to be low.

When deciding whether to offer cover, insurers must also consider the circumstances of the individual applicant. The terms of the offer of insurance must then reflect how likely they believe it is that the applicant will make a claim in future and the likely timing of such a claim. That is, they must offer terms which reflect the cost of providing the insurance.

If the insurer did not do this, but rather offered insurance at the same terms to all applicants, then those individuals who perceived their risk to be high would consider the offer to represent value for money and would be likely to accept the offer. On the other hand, individuals who perceived their risk to be relatively low would forego the cover believing that the offer did not represent good value.

As more and more of the high risk individuals and less and less of the low risk individuals take up the offer of insurance, the average cost of insurance would increase. The insurer would need to pass on this increase in cost to the insured individuals so as to ensure that premiums received were sufficient to cover the cost of claims. However, this would contribute to a further price spiral. Eventually, the majority of consumers, and/or the majority of insurers, would withdraw from the market and the remaining products would become financially unsound.

One historical example of this is the introduction of discounts for non-smokers applying for life insurance. Those companies that did not differentiate their

premiums by smoking status found non-smokers moving to those companies who provided the lower premiums. As a result, they were left with a higher proportion of smokers and their insurance costs increased. Ultimately, all companies found they had to differentiate premiums by smoking status to prevent collapse and ultimate failure.

2.2 The Process of Risk Classification

It could theoretically be argued that unique terms should be offered to every applicant for insurance on the basis of their individual circumstances, however this would not be commercially viable nor practical. Therefore, in order to offer each applicant for insurance terms appropriate to their level of risk, in a manner which is administratively practical, insurers group or “pool” risks. That is, insurers group together applicants who have a similar chance of incurring a financial loss and hence have a similar cost of providing protection against that loss. Every member of a pool is offered the same terms for insurance. The process by which individuals are placed in an appropriate pool on the basis of the likely cost of providing them with insurance is called underwriting.

In order to place individuals in an appropriate pool, insurers rely on the information that the individual provides with regard to their individual circumstances (and additional information when deemed necessary). Then, using statistics compiled from the past experience of insured persons to quantify the degree of risk, a judgement as to the overall level of risk is made. Where the necessary statistics are unavailable, incomplete or unreliable, the insurers must use expert medical and insurance opinions to decide the level of risk.

People pay premiums to insurance companies in the expectation that the insurer will be able to pay the claims in the future if and when the insured event occurs. The continuing ability of insurance companies to pay benefits to those who suffer the insured event depends, to a large extent, on their skill in assessing and classifying risks and in then pricing their policies in a way which attracts a wide range of applicants who contribute to the pool of funds. This is particularly so in the case of life insurance where, unlike general insurance, the insurer has only one opportunity at the start of the policy to classify the risk. Thereafter, the insurer is usually unable to cancel the policy or reclassify the risk even if the individual’s circumstances change or a claim is made.

2.3 The Need to Underwrite

Removal or restriction of the right to effectively classify risks has the potential to cause severe financial loss to the insurance industry and could ultimately lead to the curtailment and/or disappearance of voluntary insurance products in the private sector. Additionally, it has the potential to unfairly discriminate against average risk applicants for insurance by causing them to subsidise extreme risk applicants who may choose to purchase large policies at a fraction of the real cost.

Increasingly, the insurance industry is subject to government legislation, which impacts on the way that the industry assesses risk. In addition, the industry is being

challenged by consumer rights groups who perceive unfair treatment by the industry in its assessment process of individuals suffering from major medical conditions such as AIDS and diabetes. Also of increasing concern to Government, medical and consumer groups is the possible access by the insurance industry to genetic information as such information grows in its prognostic accuracy in future.

While the concerns of individuals, consumer groups and government can be readily understood, insurers must retain the ability to assess all relevant information necessary to reach an informed decision. If they are unable to do this, the viability of a private voluntary insurance industry is in doubt.

3. GENERAL UNDERWRITING PRINCIPLES

3.1 Sources of Information

For the purpose of classifying the risk, insurers rely on information from a range of sources. The most common of these sources is the application form, which all applicants complete regardless of the level of insurance. Other sources of information include medical examinations, paramedical examinations, ECGs, doctors reports, blood tests and financial evidence. Each company determines its own mandatory requirements for insurance applications which vary according to the type and level of insurance cover and the age of the applicant. In determining the level of cover above which certain types of information are sought, the company will consider the cost of obtaining such information and the value it may add to the assessment process. It should be noted that in determining whether cover required is in excess of the mandatory testing level, an insurer may take into account any insurance cover in force on the applicant.

Based on the information provided by the mandatory requirements, Underwriters may choose to exercise their discretion to request additional requirements. The most important consideration for the Underwriter is to obtain sufficient information to assess the risk fairly. Before requesting information the Underwriter may consider:

- the cost of obtaining the additional information;
- the value likely to be added to the assessment of the risk;
- the inconvenience to the applicant;
- the time it will take to obtain the information; and
- the inconvenience to the intermediaries.

The overriding consideration for the Underwriter will be the need to make an accurate assessment of the risk.

3.2 The Underwriting Process

The Underwriter, after considering all the relevant information, will then make an assessment of the risk. In making this assessment, the Underwriter will be guided by the information provided in the company's Underwriting Manual and expert medical opinion. Although some companies have their own manual, many choose to use the manuals provided by the reinsurance companies. These manuals, which are compiled on the basis of experience statistics and specialist medical knowledge, provide information on how particular impairments, hazardous occupations and pursuits should be assessed. It is noted that manuals provide a general guide to an appropriate assessment, and the Underwriter must apply professional judgement in weighing up the combination of factors present in any particular case.

Where, on the basis of the information available, the Underwriter concludes that the risk of claim is in line with the average, a standard assessment will be given. In fact, most applications for life insurance and disability income insurance in New Zealand are accepted at standard rates without modification to the terms on which they were applied. Some applicants, however, have pre-existing impairments which cannot be covered and which are therefore excluded.

If the Underwriter concludes that the risk of claim is higher than the population average, then the cover may be:

- accepted at higher than standard premium rates;
- accepted with an exclusion clause;
- accepted with a modification to terms such as a limited benefit period or limited term or amount of cover;
- accepted with a combination of the above options;
- postponed for later consideration, possibly following further medical tests if not quantifiable at the time.

4. LEGISLATION AFFECTING UNDERWRITING

The main pieces of legislation covering life insurance are the Life Insurance Act 1908 and the Insurance Law Reform Acts of 1977 and 1985. The Insurance Law Reform Act 1977 Section 4 covers the effect of mis-statements in contracts of life insurance and allows life insurance companies to avoid (ie refuse to recognise) policies where statements made in the proposal or associated documents were:

- substantially incorrect; and
- material, and
- made either
 - ⇒ fraudulently; or
 - ⇒ within 3 years before the date of death or the date the policy is sought to be avoided, whichever is earlier. (This time limit does not apply to disability policies).

Section 10 of the Insurance Law Reform Act 1977 deems the life insurance company to know everything that has been told to a representative of the company in the course of negotiating and accepting a new proposal.

Human Rights Act

The Human Rights Act 1993 applies to all situations, not just to the provision of life insurance. In fact, life insurance is recognised as having a case for special treatment in some respects.

The Human Rights Act prohibits discrimination on a number of grounds: Age, sex, marital status, religious belief, ethical belief, colour, race, ethnic or national origins, disability, political opinion, employment status, family status and sexual orientation.

Section 44 makes it unlawful for anyone to be refused goods and services (including insurance) on any of those prohibited grounds. This has the effect of preventing life insurance companies from refusing to provide cover on risks they may consider uninsurable.

However, Section 48 of the Act does provide an exception in relation to insurance which allows companies to provide insurance on different terms or conditions by reason of sex, age or disability if the different treatment:

- (a) Is based on:
 - (i) Actuarial or statistical data, upon which it is reasonable to rely, relating to life expectancy, accidents, or sickness; or

- (ii) where no such data is available in respect of persons with a disability, reputable medical or actuarial advice or opinion, upon which it is reasonable to rely, whether or not contained in an underwriting manual; and
- (b) Is reasonable having regard to the applicability of the data or advice or opinion, and of any other relevant factors, to the particular circumstances.

Section 65 of the Act distinguishes between direct and indirect discrimination.

Direct discrimination occurs when a person with a particular characteristic, eg race, is treated less favourably than a person without that characteristic.

Indirect discrimination occurs when requirements or practices which do not appear to be in breach of the Act nevertheless have the effect of treating a person or group of persons less favourably on one of the prohibited grounds. An example is a height requirement for employment. Height is not a prohibited ground but the effect of discriminating on the basis of height is that more females than males are treated unfavourably. Section 65 does allow a defence of good reason to a charge of indirect discrimination.

The Insurance Guidelines issued by the Human Rights Commission in April 1997 provide further information on the circumstances in which the life insurance company may apply an extra premium, an exclusion or a deferral of cover.

Privacy Act

The Privacy Act 1993 provided for the appointment of the Privacy Commissioner and established certain principles with regard to personal information about individuals. Those principles cover collection, use, disclosure and retention of information by agencies, and access to and correction of the information by the individuals concerned.

The basic aim of the Act is to promote and protect individual privacy.

The underwriting process involves applicants providing intimate personal information to the life insurance company, which then retains that information for the duration of the contract or otherwise as long as there is a need to do so.

The quality of information provided and held will be improved if the individuals involved have faith in the adherence of the life insurance companies to the principles of the Privacy Act. By providing consumers with a sense of confidence in the manner in which personal information from them is obtained and handled, especially sensitive information, it is more likely that information will be freely and openly volunteered.

Life insurance companies are responsible for the actions of their employees and representatives. If proceedings are brought against a life insurance company, damages may be applied. It would, however, be a defence against those

proceedings if the life insurance company could show that it had taken “such steps as were reasonably practicable to prevent the employee from doing that act,” such steps would of course include staff training and may also include a confidentiality agreement.

5. MEDICAL AUTHORITIES

5.1 Medical Authorities

From time to time, insurers will need to seek personal medical information on an insurance applicant from their personal medical attendant. This may occur either on initial application or when a claim is submitted.

The ISI urges all life companies to ensure that properly constituted authorities are used when requesting medical information from members of the medical profession.

Initial Application

In order to obtain medical information with which to consider an application for insurance, the insurer will require the applicant's written consent before requesting the information from the medical practitioner.

The written authority should:

- bear the signature of the applicant;
- be in a legally recognised form;
- carry a reasonably recent date.

Assessment of Claims

It may be necessary for the insurer to seek further medical information before a death claim is paid. In such circumstances the insurer will endeavour to process the claim as quickly as possible using the following means of authorisation:

- The insured at the time of application, if it is reasonably recent.
- The insured at the time of claim in the event of living benefit claims.
- From a person holding a written power of attorney.
- From the executors or other recognised representative of the estate.

Appendix 1

NOTES FOR GUIDANCE IN COMPLETING MEDICAL REPORTS FOR LIFE AND DISABILITY INSURANCE PURPOSES

Purpose

Medical practitioners are often asked to provide information to life insurance companies to enable the risk assessment of a patient who wishes to take out life and/or disability insurance (the “proposer”, “client” or “patient”).

This brief guide is intended to identify the nature of the medical information required.

Medical Factors in Life Reports

The Underwriter at the life insurance company requires certain information to assess the degree of risk of a “client” and to calculate the premium appropriate to that risk. The more complete the medical information the more likely it is that the insurer can accurately offer terms to the “client”. An insurer must manage its expenses and therefore can only afford to buy a fixed amount of information from medical practitioners. The use of different types of forms, each with their own average time commitments and fees reflects this point.

Private Medical Attendant’s Report Form (PMAR)

There are two versions of the PMAR, the standard report and the extended report. Information is required about medical diagnoses including the assessment of severity of relevant conditions, taken from the patient’s medical history, but it does not require an examination. It is understood by the insurer that any opinion offered on the basis of a medical history, which may be extensive, is necessarily limited by the circumstances of the request.

Doctors should ignore trivial childhood complaints where there have been no sequelae. It would be quite acceptable, for example, to refer to “20 consultations between 1986 and 1995 for URIs, pap smears and contraception” where there were no abnormalities. Reference to more significant medical conditions should include diagnosis, date, duration of condition, results of investigations, treatment and an opinion on the prognosis.

The Medical Examination

A Medical Examination and Report is usually requested where the applicant for insurance has an existing medical condition, is of an advanced age, or where the sum assured is high. The Medical Examination and Report consists of a personal statement (which should be completed by the client/patient but requires the doctor to review and, where appropriate, clarify the medical history) and a physical examination. Whilst the doctor must attempt to ensure that the report is accurate and complete, it is acknowledged that the client/patient may deliberately attempt to conceal or innocently forget information.

The doctor is required to record the facts and comment on the risk of death, disease and temporary or permanent disability. The doctor should pay particular attention to known ailments. Standard tests may be requested, eg. HIV, ECG. No additional tests should be performed at the insurer's expense without the prior authority of the company's Underwriter.

Confidentiality of Medical Reports

Utmost confidentiality of medical reports must be maintained at all times. Medical Practitioners and Life offices are bound by the Privacy Act 1993. The request for the report must be accompanied by an appropriate authority from the patient/client. When completed, medical reports must not be given or sent to an intermediary of the life insurance company or the patient/client although a doctor will often be asked to do so. They should be placed in an envelope marked "CONFIDENTIAL" and sent directly to the Underwriting Manager or Chief Medical Officer at the Head Office of the life insurance company.

Lifestyle Questions & HIV Testing

Risks arising from factors such as alcohol abuse, smoking, drug abuse, or those associated with HIV infection are important to the insurer and their assessment of the client's risk.

An HIV test may be requested routinely for sums assured above a certain level. That is necessary because unlike other well-established fatal diseases, HIV may not be obvious for many years. A person who is asked to undergo an insurance HIV test should receive information from the clinician conducting the test explaining the circumstances and implications associated with the test. This counselling material will generally be adequate for the purposes of a routine insurance HIV test. A test performed because the patient is at high risk of HIV infection or because of another clinical indication may involve more extensive counselling.

Appendix 2

TYPES OF INSURANCE CONTRACTS

1. Disability Income Insurance (DII)

DII is a form of income replacement benefit paid when a person is medically incapacitated and unable to work. After the initial deferred period, a benefit is usually paid until the individual is declared fit to return to work. Different underwriting considerations apply to disability insurance because there is a higher likelihood of incapacity than of early death. Various conditions affect disability insurance, eg. backache or chronic tennis elbow, as well as other conditions eg. heart disease, cancer. For ongoing disability an independent examination may be necessary for clarification.

2. Total & Permanent Disablement Insurance (TPD)

Total and Permanent Disablement cover may provide a lump sum when an individual is considered to be so disabled as to be unlikely to ever be able to resume employment for which he or she was suited. Each policy will be different and the entitlement to a benefit will depend upon the definition of total and permanent disablement in that policy.

Underwriting considerations are similar to those applying to disability income insurance, with the main concern being the likely permanency of the disability. In such claims it is likely that a number of specialist medical reports may be required to determine the permanency and extent of the condition.

3. Dread Disease Insurance (DD)

Also known as "Critical Illness" or "Trauma Insurance", this benefit may be paid on diagnosis of one of a specified range of medical conditions or accidents. The usual conditions covered will include myocardial infarction, cancer, stroke, coronary artery bypass surgery and severe injuries resulting in paraplegia, blindness or severe burns. Underwriting considerations are generally similar to those for life insurance.

Appendix 3

ISI POLICY ON GENETIC TESTING

FOREWORD

The Investment Savings and Insurance Association (“ISI”) has resolved to issue a policy on genetic testing to ensure a consistent approach by all members and clarity for the public.

During 1997 the ABI in Britain has issued a Policy Statement regarding life insurance and genetics and LISA (now IFSA) in Australia has issued an Underwriting Guide including a policy on genetic testing. As the Australian situation is substantially similar to that in New Zealand, the LISA (IFSA) policy forms the basis of the ISI policy on genetic testing.

The intention is to adopt a policy which balances the respective rights and obligations of consumers and insurers.

INTRODUCTION

Genetic Tests

For the purposes of this policy, genetic testing is defined as:

The direct analysis of DNA, RNA, genes or chromosomes for the purpose of determining inherited predispositions to a particular disease or group of diseases but excluding DNA, RNA, gene or chromosome tests for acquired disease.

In this context “acquired” refers to diseases which have been contracted other than through inheritance.

More detailed genetic information is becoming available as a result of the Human Genome project, mapping the complete human genetic code.

This genetic information will fall into two general categories:

- (1) Identification of the genetic codes for specific diseases that are known to be transmitted by dominant or recessive genes. This information would allow prediction of the probability of an individual developing a particular disease. Tests are already available in NZ for diseases such as Huntington’s Chorea and Cystic Fibrosis.

- (2) Genetic information that predicts a general predisposition to a certain disease eg coronary artery disease or some cancers. Other factors will determine whether the disease actually develops.

For some diseases genetic tests may also enable prevention and treatment strategies to be introduced for those shown to be most at risk, with a possible consequent reduction in risk for the insurer.

Human Rights Act

The Insurance Guidelines issued by the Human Rights Commission in April 1997 recognise that life insurance companies may request that existing genetic test results are made available for the purpose of classifying a risk. Although the Guidelines acknowledge they are not an authoritative statement they also state that insurance companies **cannot** insist that applicants undergo genetic tests. Life insurance companies do not currently request applicants for insurance to undergo genetic tests but may require the results of any previous tests to be disclosed. The Human Rights Commission has indicated its intention to issue further guidelines on this matter at a later date.

The Right to Underwrite

Underwriting of individual proposals for insurance and the appropriate classification of risk is essential for the maintenance of a viable insurance industry. Underwriting enables an insurance company to apply appropriate premiums for the risks insured and to deter anti-selection.

The foundation of underwriting is access to all information relevant to the risk to be insured. If insurers are restricted in their access to relevant information anti-selection is likely to occur and the level of claims will increase.

Anti-selection occurs when those people who represent a higher risk, and who may therefore be more aware of the benefit of insurance, are able to obtain cover without disclosing all relevant information and therefore not having their risk priced appropriately.

The increase in claims as a result of anti-selection will increase the insurer's costs leading to an increase in premiums and consequent disincentive for low risk individuals to apply for insurance cover.

Privacy and Ethical Issues

Life insurance companies are bound by the Privacy Act and therefore may generally use personal information only for the purpose for which it was provided. For example, information from genetic tests on one family member will not be used without authority to assess an application for insurance from another member of that family.

Similarly, this information would not be used for any other purpose without authority.

The requirement for ethical behaviour applies both to insurers and to those people applying for insurance. One feature of the law relating to life insurance is the recognition that life policies are contracts of utmost good faith. The insurer relies upon the information given by the applicant in assessing the risk and the applicant is therefore bound by a positive duty to disclose any material facts relevant to the application for insurance.

THE POLICY

The policy which follows applies to all members of the Investment Savings and Insurance Association.

THE INVESTMENT SAVINGS & INSURANCE ASSOCIATION OF NZ INC. GENETIC TESTING POLICY

1. For the purposes of this policy, genetic tests are defined as “the direct analysis of DNA, RNA, genes or chromosomes for the purpose of determining inherited predispositions to a particular disease or group of diseases, but excluding DNA, RNA, gene or chromosome tests for acquired disease”
2. Insurers will not initiate any genetic testing of applicants for insurance.
3. Insurers may request that all existing genetic tests results be made available to the insurer for the purposes of classifying the risk.
4. Insurers will not use genetic tests as the basis of preferred risk underwriting, (ie. offering individuals insurance at a lower than standard premium rates).
5. When assessing the overall risk associated with a particular genotype (genetic makeup), insurers may take into account the benefits of any special medical surveillance, early medical treatment, and the likelihood of successful treatment.
6. Insurers will ensure that results of existing genetic tests are only obtained with the appropriate written consent.
7. The results of genetic tests will only be used in the assessment of insurance in respect of the individual on whom the test was conducted. The result will not be used in the assessment of insurance on relatives of the tested individual.
8. Insurers will ensure that strict standards of confidentiality apply to the handling and storage of the results of genetic tests.
9. The results of genetic tests will only be available to the insurer’s risk assessors. The results will be available to other third parties with the written authorisation of the life insured or in the normal course of discovery during legal proceedings.