Association of British Insurers

Statement of Best Practice

for Sales of

Individual and Group Private Medical Insurance

September 2011

Introduction

This Statement of Best Practice applies to ABI members selling private medical insurance (PMI) to UK residents that covers private treatment in the UK. It is designed to help make sure that people can make the right choice about which plan will suit their needs. It aims to help people:

- Get clear, timely information about policies they are considering
- Understand the extent and limitations of cover under the policies they are considering
- Compare key aspects of the cover offered by different insurers
- Choose the best underwriting approach and policy for their needs

This Statement covers individual, and group (including corporate) private medical insurance schemes. It requires insurers to:

- Use common definitions for specific terms.
- Use standard examples to explain the scope of cover. The examples about cancer were originally developed with Cancerbackup, now part of Macmillan Cancer Support, and we gratefully acknowledge their ongoing contribution.
- Make information available to individual and group applicants, or the intermediary, if there is one.

Private medical insurers are required to comply with all UK and EU legislation. They are also regulated by the Financial Services Authority. All information insurers provide must be clear, fair and not misleading. This Statement builds on the existing legislation and regulations to cover the specific information needs of people considering private medical insurance.

This Statement is in addition to (and, in the event of a conflict, is overruled by) any regulatory or legal requirements and is mandatory for all private medical insurers that are ABI members. It can therefore be taken into account by the Financial Ombudsman Service in considering any complaints about private medical insurance.

This Statement supersedes and replaces all previous editions. Members should implement the revised Statement as soon as possible, but in any event within eighteen months, as necessary to accommodate IT updates and publication cycles.

The Association of British Insurers (ABI) is the trade association for the UK insurance industry. The ABI is the voice of insurance, representing the general insurance, investment and long-term savings industry. It was formed in 1985 to represent the whole of the industry and today has over 300 members, accounting for some 90% of premiums in the UK.

Contents

1 About Private Medical Insurance

1.1 Private medical insurance (PMI) aims to cover the costs of private medical treatment for 'acute conditions' that start after the policy begins.

The ABI defines an acute condition as follows:

A disease, illness or injury that is likely to respond quickly to treatment which:

- *aims to return the claimant to the state of health they were in immediately before suffering the disease, illness or injury, or*
- *which leads to a full recovery.*

Please note:

PMI is designed to work alongside, not to replace, all the services offered by the NHS and in all cases customers retain their right to use the NHS. Some policies may cover certain types of treatment for, or elements of, chronic conditions, but this is not usually the main purpose of PMI.

Types of PMI

1.2 The type of PMI depends on who the policyholder is. The policyholder is the person with whom the contract for the policy is made, who takes out the policy and pays the premiums.

- **Individual PMI** – where the policyholder is an individual. The policy covers the policyholder and may also cover their family.
- **Group (including Corporate) PMI** – where the policyholder is a legal entity, usually an employer. The policy covers the scheme members (usually employees and sometimes their families). It is the person representing the employer (not the insurer) who chooses the scope of the cover and how any information about the policy is made available to their employees.

Please note:

- Any policyholder is free to decide to be represented by a third party acting as an intermediary – for example, a firm of independent financial advisers, a specialist health insurance intermediary, or employee benefit consultants.
- Individuals and members of a group scheme can have an unresolved complaint referred to the Financial Ombudsman Service.

2 What insurers are required to do

Legislation

2.1 Private medical insurers are already required to comply with all UK and EU legislation, including on the following:

- Marketing and promotional material
- Unfair contract terms

- Anti-discrimination on age, disability, gender, race, ethnic origin, faith, sexual orientation and political beliefs
- Client confidentiality and data protection
- Contract structures
- Allowing customers to change their mind, and
- Competition

Regulation

2.2 Private medical insurers are also regulated by the Financial Services Authority requiring them, amongst other things, to follow eleven principles:

1. Integrity - Conduct business with integrity.
2. Skill, care and diligence - Conduct business with due skill, care and diligence.
3. Management & Control - Take reasonable care to organise and control its affairs responsibly and effectively, with adequate risk management systems.
4. Financial prudence - Maintain adequate financial resources.
5. Market conduct - Observe proper standards of market conduct.
6. Customers' Interests - Pay due regards to the interests of customers and *treat them fairly.*
7. Communication with clients - Pay due regard to the information needs of clients, and communicate information to them in a way that which is clear, fair and not misleading.
8. Conflicts of interest - Manage conflicts of interest fairly, both between our customers and ourselves and between a customer and another client.
9. Customer: relationships of trust - Take reasonable care to ensure the suitability of advice and discretionary decisions for any customer who is entitled to rely upon its judgement.
10. Clients' assets - Arrange adequate protection for clients' assets when it is responsible for them.
11. Relation with regulators - Deal with its regulators in an open co-operative way, and must disclose to the FSA appropriately anything relating to the firm of which the FSA would reasonably expect notice.

2.3 In accordance with Principle 7, where a policy summary is provided, FSA regulation requires an overview of the policy without overloading the customer with detail and for the policy summary to contain only the following information:

- Key facts logo
- Statement that the policy summary does not contain the full terms of the policy, which can be found in the policy document
- Name of the insurance undertaking
- Type of insurance and cover
- Significant features and benefits
- Significant or unusual exclusions or limitations, not limited to:

- Deferred payment periods
- Exclusion of certain conditions, diseases or pre-existing medical conditions
- Moratorium periods
- Limits on the amounts of cover
- Limits on the period for which benefits will be paid
- Restrictions on eligibility to claim such as age, residence or employment status
- Excesses
- Limits on the cover in terms of where treatment may be obtained, or any requirement for approval before treatment is begun

- Duration of the policy.
- A statement, where relevant, that the customer may need to review and update the cover periodically to ensure it remains adequate.
- Price information (optional).
- Existence and duration of the right of cancellation (other details may be included).
- Contact details for notifying a claim.
- How to complain to the insurance undertaking and complaints may subsequently be referred to the Financial Ombudsman Service (or other applicable named complaints scheme).
- That, should the insurance undertaking be unable to meet its liabilities, the customer may be entitled to compensation from the compensation scheme (or other applicable compensation scheme), or that there is no compensation scheme. Information on the extent and level of cover and how further information can be obtained is optional.

Any cross-references to the relevant policy document provisions, must be in addition to the policy summary and only contain information that is in the policy document.

This Statement of Best Practice

2.4 This Statement builds on existing legislation and regulations to cover the specific information needs of individual or group/corporate customers who are deciding whether or not to purchase PMI, are choosing between PMI policies, or having recently taken out cover are in their cooling-off period.

To do this, in addition to meeting all the legislative and regulatory requirements, including those above, this Statement requires insurers to do all of the following:

1. Comply with the principles set out in this Statement in section 3 below including:
    - Make the required information available to individual and group scheme policyholders as set out in Principle 4.
    - Use the common definitions set out in the Annex A wherever they apply to help customers understand their cover and compare policies. This means that, these terms have the same meaning in all PMI policies.
    - Make the information as set out in the Annex B available to potential customers so they can make a rational buying decision:

- Give customers a clear explanation of the underwriting choices available and how each option works as set out in the Annex B.1.
- Explain the cover, if any, for long-term treatment or chronic conditions as set out in the Annex B.2.
- Have a separate section to explain the cover, if any, for cancer as set out in the Annex B.3.
- Explain the cover, if any, for drugs as set out in the Annex B.4.

2. Use the templates as set out in the Annex B to set out information so that customers can compare policies they are considering and make a rational buying decision.
3. Use the relevant standard examples as set out in the Annex B to explain the scope of cover provided.
4. Inform people what information they need to disclose and their rights to ensure that the contract is set up on a fair basis as set out in the Annex C.

2.5 Insurers will make all the mandated documents described in this Statement available to individual and group applicants, either directly or through the intermediary, if there is one. The information prepared by insurers for the policyholder (and in the case of group PMI, for employees) will comply with this Statement.

3 Principles

PMI insurers must ensure that their business complies with the following ABI principles:

Principle 1 The ABI PMI common definitions must be used in all policy documents, where those words apply.

Principle 2 **For individual customers** it is the insurer's responsibility to work with any intermediary to ensure that each customer receives all of the mandated documentation described in this Statement.

For group business it is in the interest of the insurer for individual members of group/corporate schemes to know what cover they have. Insurers will make information available to the employer (the group customer) or the intermediary, if there is one.[1] It is the employer's responsibility to give the information to scheme members. All information provided by the insurer, for the employer to give to their employees, will comply with the requirements of this Statement. This will not affect the right of any individual member of a group/corporate scheme to take any complaint they might have to the Financial Ombudsman Service.

Principle 3 Insurers must provide explanations of core terms and conditions that are appropriate to the customer's circumstances and that are clear and in plain and intelligible language, to explain the details of cover.

[1] FSA ICOBS 6.1.12G – The firm should tell the employer to pass the information on to the employee.

In particular:

a) What treatment is and is not covered by the policy including significant exclusions, exclusions for pre-existing conditions and conditions related to pre-existing conditions, cancer, exacerbations of an ongoing condition, information around limits to cover, withdrawal of cover (including when the policy holder cancels, or stops paying the premium for, all or part of the policy) and the terms that may need to be applied for the customer to transition to the NHS.

b) Benefits and features including healthcare provider networks.

c) Potential for there to be changes to the premium and/or policy terms at renewal.

d) Implications for cover when switching from one policy or insurer to another including from a group scheme to an individual scheme.

e) Any requirement for pre-authorisation before getting treatment.

f) Processes including how to claim on, complain about and cancel the policy.

g) Where applicable, an explanation of moratorium underwriting, including that underwriting is undertaken at point of claim, how regular check-ups affect the moratorium, and how symptoms affect cover where there is no diagnosis.

h) Where applicable, an explanation of full medical underwriting – including that underwriting is undertaken at point of application, how symptoms affect cover where there is no diagnosis.

i) Requirement to make full disclosure in response to insurer's question, in particular on pre-existing conditions.

Principle 4 Insurers must provide the following information to individual customers, and group scheme customers if applicable to the scheme, at the point of sale or as soon as possible thereafter, but in any event before the conclusion of the contract, including:

a) 'Are you buying PMI?' – the ABI consumer guide.

b) 'Your underwriting options' - a clear explanation of the underwriting options and what each option means. The explanation should meet the requirements set out in the annex A.

c) 'Your PMI Cover for treatment for long-term/chronic condition(s)' - the format is prescribed so customers can compare different companies cover and exclusions as set out in the Annex A.

d) Cover for cancer in a distinct section, using the prescribed headings and content of the Explanation of Cover for Cancer, separately from other conditions. The explanation should meet the requirements set out in the Annex A.

In addition, insurers must make this information available to customers by drawing it to their attention and telling them where it is, for example on the website, on the following occasions:

- When there is a change to the terms and conditions

- When a new person is added to the policy, such as a spouse
- As part of the renewal process

A Common Definitions

Insurers must use the common definitions set out in this section where that word is used in policy documents (with the exception of those relating to international products). The common definitions are not designed to describe the scope of cover provided by a product. Their purpose is to ensure that in whatever context the defined word or phrases are used they will have the same meaning.

Members may use additional information or support material to describe the extent, or otherwise, of cover provided.

Acute condition
A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

Cancer

A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chronic condition

A disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

Day patient

A patient who is admitted to a hospital or day patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

Diagnostic tests

Investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.

Inpatient

A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.

Nurse

A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.

Out patient

A patient who attends a hospital, consulting room, or outpatient clinic and is not admitted as a day patient or an inpatient.

Pre-existing condition

Any disease, illness or injury for which:

- you have received medication, advice or treatment; or
- you have experienced symptoms;

whether the condition has been diagnosed or not in the xxx years before the start of your cover. (The same period is not common to all insurers)'

Treatment

Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.

It is recognised that some firms use the term 'active treatment'. This has the potential to confuse customers given the current agreed definition of treatment. If firms do use the term it must be accompanied by a specific definition.

B Templates for setting out key information about PMI

B.1 Explaining the choice of underwriting

Insurers must provide the following information to customers taking out individual policies before the contract is concluded. This applies to employers of group/corporate schemes if the members are medically underwritten.

'YOUR UNDERWRITING CHOICES'

Required headings with sample format and wording:

1. Explanation

Explain the choice of underwriting options and what each option means.

Then give a general description of PMI including:

- PMI, like other insurance policies, provides cover against an unexpected event happening after the start of the policy. In health insurance this means cover for the cost of unforeseen private medical treatment arising after the policy starts.
- PMI is not intended to cover the cost of medical conditions, and related conditions that arose before the start of the policy. A related condition is one that is caused by, or could be the cause of, another condition.
- The policy does not cover the cost of all medical treatments and customers should check their policy carefully so they know which treatments are covered, and any limits on this cover.
- How PMI works with the NHS.

Sample wording:

- 'New medical conditions arising after the start of the policy will be covered subject to the policy terms and conditions'.
- 'You must answer all questions as fully and as accurately as you can, to the best of your knowledge and belief.'
- 'PMI may provide cover for initial investigations needed to diagnose a new condition and the initial short term treatment up to the point of stabilisation.'
- 'PMI does not cover treatment for medical conditions that keep on coming back or are likely to continue, and/or need regular or periodic monitoring, treatment, medication or medical advice.'
- PMI is designed to work alongside, not to replace all the services offered by the NHS and in all cases customers retain their right to use the NHS. Some policies may cover certain types of treatment for, or elements of, chronic conditions but this is not usually the main purpose of PMI.

2. First heading

Understanding your PMI underwriting options

Include:

- What the underwriting process is (that is, the process by which an insurer decides on what terms it will accept a person for cover based on the information they supply).

Sample wording

- 'Underwriting for PMI is the process by which an insurer decides on what terms it will accept a person for cover based on the information they supply.'
- 'You have a choice between two ways of applying for the cover (insurer's name/product) provides.'

3. Second heading

Full medical underwriting

Explain the full medical underwriting option, including:

- A customer choosing this option will be asked a number of questions about their health. The answers should be carefully considered as they will form the basis on which the insurer will accept cover. It might be necessary for the insurer to approach a doctor for more information.
- Cover for the cost of pre-existing conditions that might need treatment in the future. How the customer will be notified about cover for conditions and exclusions.

Sample wording

- 'You need to complete a health questionnaire (also called a medical history declaration).'
- 'We will review your information and decide what cover we can offer you. If necessary, we may need to ask your doctor for more information to help us do this.'
- 'If you have a pre-existing condition that may need treatment in the future, we will usually exclude it from the cover along with any conditions related to it.'
- 'We will show any exclusion on the policy schedule you receive from us when we have processed your application. (The same process will also apply for any members of your family included in your application.)'
- 'If we exclude treatment for a pre-existing condition at the time when your policy starts we can, in some cases, review the exclusion in future if you ask us to do so.'

4. Third heading

Why some customers choose full medical underwriting?

Explain why some customers choose full medical underwriting for example, saving time at point of claim and certainty about the extent of cover for the cost of treating pre-existing conditions at point of joining:

Sample wording

- 'With full medical underwriting new medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.'
- A fully underwritten policy does not cover medical conditions that you (and your family) already have, (including any related conditions), when you take out the policy/join the company scheme/policy. On the application form we ask you to give us details of your (and your family's) medical history and if necessary, we may write to your doctor for more information.
- 'It is essential that you give us all the information we ask for, even if you have symptoms that have not been diagnosed. If you don't, we will not pay any claim that you make in the future, or may even cancel your policy / group scheme membership / policy. If you are not sure whether or not to mention something, you should do so'.
- 'If you have a medical condition which our underwriters feel is likely to come back, we will issue a policy, but that condition (and any related to it) will not be covered, either indefinitely, or for a set period of time'.

5. Fourth heading

Moratorium

Explain the moratorium underwriting option, including:

- A customer choosing this option does not need to fill in a health statement but will be automatically excluded for the cost of treating any pre-existing conditions during the first (usually) two years of the policy, for which they have received treatment and/or medication, or asked advice on, or had symptoms of (whether or not diagnosed), during the (usually) five years immediately before the PMI cover started.
- Whether or not conditions that arise after the policy starts but are related to the pre-existing condition would also be excluded.
- What happens if the customer has no symptoms, treatment, medication, or advice for those pre-existing conditions, and any directly related conditions, for (x) years after the policy starts.
- Warning the customer if the cost of treating medical conditions that are likely to continue to need regular or periodic treatment, medication or medical advice, will never be covered by the policy.

Sample wording

- 'You should not delay seeking medical advice or treatment for a pre-existing condition simply to obtain cover under your policy.'
- 'You do not need to fill in a health statement. Instead, we automatically exclude during the first (usually) two years of the policy any pre-existing conditions for which you (and any family member included in your application) have received treatment and/or medication, or asked advice on, or had symptoms of (whether or not diagnosed), during the (usually) five years immediately before your PMI cover started.'

6. Fifth heading

Why some customers choose moratorium underwriting

Explain why some customers choose the moratorium underwriting option, for example:

- Only basic information needs to be provided by the person who is to be covered when they join and they will not be asked to disclose details of their medical history.
- If the customer satisfies the criteria (usually two years) for a pre-existing condition, then treatment for that condition will automatically be covered should it later recur, subject to the policy terms and conditions.

Sample wording

- 'With moratorium underwriting if you do not have any symptoms, treatment, medication, or advice for those pre-existing conditions, and any directly related conditions, for (usually) two continuous years after your policy starts, then we will reinstate cover for those conditions.'

Example 1 - How both options work

Customer question - I had an operation on my right knee recently. **Will I be covered for any further treatment to it after my policy starts?**
Insurer's response, Full Medical Underwriting
Insurer's response, Moratorium Underwriting

B.2 Explaining the cover for long-term treatment / chronic conditions

'YOUR PMI COVER FOR LONG-TERM TREATMENT / CHRONIC CONDITION(S)'

The format is prescribed so customers can compare different companies cover and exclusions.

This information is intended to explain to customers any cover for treatment that is provided for conditions that are likely to continue or keep recurring and are sometimes called chronic conditions.

Insurers must provide the explanation at the point of sale or as soon as possible thereafter, but in any event before the conclusion of the contract. It is recommended that members also send it to existing retail customers.

Members may choose to produce this information in the form of a leaflet or to incorporate it within their other point of sale material.

Only those examples relevant to the product need be used.

The explanation of cover for cancer must be provided in a distinct section, separately from information on other conditions (see annex B.3).

Members are free to provide information on specific conditions where they believe that their customers would find this helpful. Some insurers produce separate leaflets giving details of their coverage of particular conditions. The Statement of Best Practice is designed to permit this flexible approach.

Member firms must use the following prescribed format when giving details of their coverage:

1. Explanation

   Include:

   - An introductory paragraph stating its purpose.
   - The statement 'Exclusions that would normally apply to long-term/chronic conditions may not apply to cancer. Please refer to the section on cancer.'

2. First Heading:

   'What is a xxx condition?'

   Include:

- The agreed Common Definition followed by a general description of the insurers' own approach to covering these.

3. Second Heading:

   'What does this mean in practice?'

   Explain:

   - The process undertaken by the insurer to establish whether or not a treatment for a condition is, or has become, long-term and the subsequent actions arising from this.
   - The situation where a person may transition from PMI to NHS care or if cover will stop once the treatment is considered to have become long term for a condition, and the implications of this.

   Sample wording

   'Payment for treatment may stop at some point – this could be because of a policy limit, or because the condition is no longer short term and therefore the treatment is not something that your policy covers. There are many different conditions that can be acute or chronic and, for example, there are over 200 types of cancer. By the time you need to claim on your policy the treatment that is available may well have developed and improved from the time you first bought the policy. We consider your individual circumstances and examples are set out below to explain this. If you are receiving treatment which is covered by your policy at the time your cover ends, we may contact you so that you can discuss this and make arrangements with your specialist such as, a transfer to NHS care or for you to continue funding private treatment yourself.

4. Third Heading:

   'What if your condition gets worse?'

   Explain:

   - What happens when treatment for a condition has been deemed long-term and then the condition has an acute flare-up.
   - PMI is intended to complement the NHS not replace it and patients may need to return to the NHS at a point where treatment for their condition is no longer covered under their policy. Different insurers manage this transition in different ways.

   Sample wording

   'It is not usually possible to predict accurately the cost of a course of treatment at the time of cancer diagnosis. It is also difficult to estimate whether the amount of treatment available within a set time or financial limit will be sufficient to complete your treatment. If the costs of your treatment exceeded this limit, you may need to move to the NHS or choose to self-pay for your own treatment. This might require you to change hospitals, change doctors and change drug therapies or other treatments, part way through a cycle of treatment, potentially limiting the scope of your overall treatment.'

5. Fourth Heading:

   'Examples'

   The following examples should be worded exactly as they are shown below, with each insurer explaining how they would respond in the circumstances described. Where the example relates to a benefit which is not included in the product it need not be used, for example *Example 4* relates to treatment by an osteopath, if osteopathy is not covered under the policy this example should not be used.

Example 1 – Angina and Heart Disease

Alan has been with *insurer's name* for many years. He develops chest pains and is referred by his GP to a specialist. He has a number of investigations and is diagnosed as suffering from a heart condition called angina. Alan is placed on medication to control his symptoms. **Will Alan be covered?**
Insurer's response (to be included here)
Two years later, Alan's chest pain recurs more severely and his specialist recommends that he have a heart by-pass operation. **Will Alan be covered?**
Insurer's response (to be included here)

Example 2 – Asthma

Eve has been with *insurer's name* for five years when she develops breathing difficulties. Her GP refers her to a specialist who arranges for a number of tests. These reveal that Eve has asthma. Her specialist puts her on medication and recommends a follow-up consultation in three months, to see if her condition has improved. At that consultation Eve states that her breathing has been much better, so the specialist suggests she have check-ups every four months. **Will Eve be covered?**
Insurer's response (to be included here)
Eighteen months later, Eve has a bad asthma attack. **Will Eve be covered?**
Insurer's response (to be included here)

Example 3 – Diabetes

Deidre has been with *insurer's name* for two years when she develops symptoms that indicate she may have diabetes. Her GP refers her to a specialist who organises a series of investigations to confirm the diagnosis, and she then starts on oral medication to control the diabetes. After several months of regular consultations

and some adjustments made to her medication regime, the specialist confirms the condition is now well controlled and explains he would like to see her every four months to review the condition. **Will Deidre be covered?**
Insurer's response (to be included here)
One year later, Deidre's diabetes becomes unstable and her GP arranges for her to go into hospital for treatment. **Will Deidre be covered?**
Insurer's response (to be included here)

Example 4 – Hip Pain

Bob has been with *insurer's name* for three years when he develops hip pain. His GP refers him to an osteopath who treats him every other day for two weeks and then recommends that he return once a month for additional treatment to prevent a recurrence of his original symptoms. **Will Bob be covered?**
Insurer's response (to be included here)

B.3 Explaining the cover for cancer

This information is intended to explain to customers how insurers cover cancer. The explanation of the cover for cancer must be available before the conclusion of the contract.

Member firms must have a distinct section in their policy documents to explain the cover for cancer. To allow for flexibility in approach, firms may consider having a separate leaflet, or a separate section in a leaflet, to explain the cover for cancer.

The following example(s) should be worded exactly as below, with each insurer explaining how they would respond in the circumstances described.

Example 1 –Cancer

Beverley has been with *insurer's name* for five years when she is diagnosed with breast cancer. Following discussion with her specialists she decides: • to have the tumour removed by surgery. As well as removing the tumour, Beverley's treatment will include a reconstruction operation • to undergo a course of radiotherapy and chemotherapy • to take hormone therapy tablets for several years after the chemotherapy has finished **Will her policy cover this treatment plan, and are there any limits to the cover?**
Insurer's response (to be included here)
During the course of chemotherapy Beverley suffers from anaemia. Her resistance to infection is also greatly reduced. Her specialist: • admits her to hospital for a blood transfusion to treat her anaemia • prescribes a course of injections to boost her immune system **Will her policy cover this treatment plan, and are there any limits to the cover?**
Insurer's response (to be included here)
Despite the injections to boost her immune system, Beverley develops an infection and is admitted to hospital for a course of antibiotics. **Will her policy cover this treatment and are there any limits to the cover?**
Insurer's response (to be included here)
Five years after Beverley's treatment finishes the cancer returns. Unfortunately it has spread to other parts of her body. Her specialist has recommended a treatment plan: • a course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months • monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years) • weekly infusions of a drug to suppress the growth of the cancer. These infusions

are to be given for as long as they are working (hopefully years) **Will her policy cover this treatment plan, and are there any limits to the cover?**
Insurer's response (to be included here)
David has been with *insurer's name* for X years when he is diagnosed with cancer. Following discussion with his specialist he decides to undergo a course of high dose chemotherapy, followed by a stem cell (sometimes called a 'bone marrow') transplant. **Will his policy cover this treatment plan, and are there any limits to the cover?**
Insurer's response (to be included here)
When his treatment is finished, David's specialist tells him that his cancer is in remission. He would like him to have regular check-ups for the next five years to see whether the cancer has returned. **Will his policy cover this treatment plan, and are there any limits to the cover?**
Insurer's response (to be included here)
Jenny has been diagnosed with cancer. Her policy has a limit and she decides to commence private treatment. **What help will be available if the policy limit is reached and she needs to transfer into the NHS?**
Insurer's response (to be included here)
Eric would like to be admitted to a hospice for care aimed solely at relieving symptoms. **Will his policy cover this, and are there any limits to the cover?**
Insurer's response (to be included here)

Where the policy provides cover for cancer, firms must explain clearly the cover for cancer using the mandated headings and content below, including:

- Limits on time periods
- Cycles of treatment
- Maximum payments
- Circumstances in which firms would not provide cover
- When cover might be withdrawn

For individual business – firms will use the table, format and detail (headings and content) of the template below.

For group (including corporate) business – firms will use the detail (headings and content) in a format that is appropriate to the other information provided to their customers.

Firms may choose to provide additional separate information that is specific to a type of cancer.

Format for a section to explain the cover for cancer

Headings	**Content – including limits and what is not covered**
Place of treatment	• Hospice • Hospital – inpatient • Hospital – out patient • At home
Diagnostic	• What types do you cover? • Consultation • Test eg screening, monitoring • Scan • Genetics
Surgery	• What types do you cover? • Preventative • Treatment eg of secondary cancer • Palliative • Reconstructive
Preventative	• Screening • Surgery • Vaccines
Drug therapy	• What types do you cover? • Chemotherapy • Biological therapy • Drug status eg pre-licence, not NICE approved • To maintain remission • Maintenance therapy
Radiotherapy	• Symptom relief eg for pain • Treatment • To maintain remission • Maintenance therapy
Palliative	• Maintenance therapy
End of life care	• Maintenance therapy • Nursing support
Monitoring	• Follow-up appointments • Tests • Time limits
Limits	• Time • Financial • Stage of illness • Clinical research trials • Other
Other benefits	Is there a level of cover that is specific to cancer? • Experimental treatment • Advanced therapy • Pre-licensed • NICE appraised • Clinical research trials Are any additional services available to cancer patients? • Psychiatric

Headings	Content – including limits and what is not covered
	• Physiotherapy • Nutritional support • Stem cell/bone marrow transplant

B.4 Explaining the cover for drug treatment

The explanation of the cover for drug treatment should include:

- Instances where the insurance cover might end before drug treatment is completed and that not all drug treatment may be available on the NHS.
- What options may be available to the customer in such a case. These could be:
    - Return to the NHS and receive the same treatment, if available
    - Return to the NHS and receive alternative treatment
    - Pay for the treatment privately on a self-pay basis

Sample wording

'If you are receiving treatment which is covered by your policy at the time your cover ends, we may contact you so that you can discuss this and make arrangements with your specialist such as, a transfer to NHS care or for you to continue funding private treatment yourself.'

C Applicant requirements to disclose and their rights

C.1 Applicants need to know about requirements to disclose in response to the insurer's questions.

Sample wording

'You must answer any questions you are asked as fully and as accurately as you can, to the best of your knowledge and belief. If you do not your insurer may refuse to pay your claim and could cancel your policy.'

C.2 Applicants are under no obligation to:

a) Find out medical information not known to him/her to complete the application form.

b) Consent to disclosure of identifiable personal information to another party outside of the insurance company unless they are directly involved in assessing or managing the application or claim, or in reinsuring the risk.

C.3 Applicants have the right to Fair Treatment[2] including to:

a) Change their mind about proceeding with the application for insurance.

b) Apply to another insurer.

c) Expect the insurer to assess an insurance application fairly, based solely on relevant evidence.

d) See a medical report prepared by their doctor before it is sent to the insurer, and to amend or add comments to it, under the Access to Medical Reports Act 1988 (or equivalent legislation in Northern Ireland).

e) To find out what personal, including medical, information the insurer has on file about themselves other than in specific circumstances, under the data protection legislation.

[2] FSA principle 6 - Customers' interests - A firm must pay due regard to the interests of its customers and treat them fairly.

D Group (including Corporate) Schemes – roles and responsibilities